Barking and Havering Health Authority

Annual Report of the Director of Public Health 1999 / 2000

Health in Upminster 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

September 2000
ISSN 0968 9818

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Executive summary

Upminster Primary Care Group (PCG) has a larger proportion of people aged 65+ than Barking and Havering Health Authority (BHHA) as a whole (18.6% compared to 16.9%). Age related mental, physical, co-morbidity and social problems will be a significant factor in health and social care planning.

More comparative data is now available and this confirms that overall people in Upminster are less deprived than their counterparts in other parts of BHHA. However within the PCG area there is wide variation between wards. Gooshays, Hilldene, and Heaton wards are considerably more deprived than the other wards in the PCG area. The health needs associated with these wards are high and still need to be addressed to ensure equity of health across all the wards.

The PCG has identified that a GP's workload relates to the extremes of age and the support required for nursing homes. It is noted that the average number of patients per GP is 2,335, which is greater than the national target of 1,900. The proportion of single-handed practices is high, at 43.75%, although this represents only 20% of the GPs. There are 22 residential homes and 7 nursing homes in the Upminster PCG. To make a fuller assessment of needs the PCG and Public Health could collaborate to register the bed occupancy, age and sex of those in these homes as well as relating their geographical location to the practices providing services.

The overall death rate for all cancers is similar to BHHA, which is 10% higher than England. The overall death rate masks a higher death rate in the wards with high deprivation indices. Nearly 60% of cancer deaths occur in these three wards.

National improvements have been noted in coronary heart disease (CHD) but it remains second to 'all cancers' as a cause of death. Heaton and Hilldene wards have a high death rate in persons under 65 years when compared to BHHA.

The death rate for stroke in all age groups is similar to BHHA, which has lower rates than England and Wales. The rate for Cranham East is 2.5 times the rate for BHHA. It is hoped that the National Service Framework for Stroke will be published in October 2000. The PCG needs to consider a modern approach to stroke. The Stroke Association and the Royal College of Physicians now define stroke as an acute brain emergency requiring integrated acute care and transfer to long-term care. The preventative aspects of the disease and its subsequent illness need further work by the PCG.

The overall experience of mental health problems in Upminster is similar BHHA. The incidence of serious mental illness is, however, significantly higher in Heaton and Hilldene wards, closely followed by Gooshays. Psychiatric admission rates reflect this pattern of mental illness.

Osteoporosis and consequent illness and death are significant health hazards in Upminster with a projected 700 men and 3300 women likely to have the condition. Illness levels are similar to BHHA levels.

The prevalence of respiratory disease and diabetes in Upminster is significantly lower than the BHHA mean. This is reflected in the lower admission ratios for these conditions in Upminster when compared to BHHA.

Many of the health needs within the Upminster PCG area are associated with deprivation and social exclusion, particularly in Heaton, Hilldene and Gooshays wards. These problems are such that plans to aid smoking cessation, monitor blood pressure, control diabetes and reduce teenage pregnancies, if implemented, may have a significant impact on health.

New resources, in the form of nurse specialists, have recently been provided to enhance the care of patients with respiratory disease. The PCG should ensure that practices make the best use of this service.

The PCG should consider how best it can support the implementation of the agreed plans to reprovide acute mental health services and ensure that local community services complement these new developments.

Preventing both falls and osteoporosis would reduce the number of elderly persons who suffer hip fracture. Primary care has a significant role to play in this regard. Periodic review of patients' medication and home circumstances may reduce falls. Persons at risk of osteoporosis can be identified. Their risk can be reduced through lifestyle measures and/or the appropriate prescribing of HRT, calcium supplements etc. Clinical guidelines regarding the management of osteoporosis have been developed. PCGs should encourage individual practices to adopt the approach advocated.

Smoking is a common risk factor for cancers, CHD, respiratory disease and osteoporosis. Smoking is much more common than it is in BHHA or the country as a whole - 39% of all men and 34% of all women smoke. In the medium term, the inequalities experienced by residents of BHHA in terms of higher than average rates of ill health and premature death might be addressed through a reduction in smoking rates. The PCG should contribute to and/or commission additional community programmes to reduce the prevalence of smoking based on best available evidence. Some clinical interventions, including the provision of brief advice by health professionals, nicotine replacement therapy and specialist advice have been proven to increase cessation rates. Although the effects of these interventions are not dramatic, they may be cost effective given the serious and wide ranging effects of smoking on health.

The Upminster PCG and all who work for residents of the PCG area have many challenging tasks ahead. I look forward to working with you over the next twelve months and hope to support you in the same way as Dr Beaver who retired this year.

The Public Health lead is Dr Charles Easmon Telephone 020 8532 6269
The Health Promotion lead is Rashida Choudhery of BHB Health Promotion.
Telephone 01708 465723

The purpose and sources of this report

Author: Dr Mark Ansell

Purpose

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

The PCG Board's aims are to achieve 'the best health and social care for the constituent populations, within available resources'.

This document is the third in a series and should be viewed in conjunction with Information Packs 1 and 2, produced by BHHA in August 1998 and 1999.

Information Pack Number 2 provides 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. These 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).

Sources

These data were previously only available by locality, local authority and health authority. Reconfiguring these data has entailed considerable work, which has been undertaken by the IM and T department of BHHA. This process is on going and further data will become available in due course. PCGs with particular information needs should liase with their designated Public Health support in the first instance.

Authors

This report was prepared by the Public Health PCG lead, Dr Charles Easmon, with acknowledgements to Dr Richard Beaver. Other contributors are acknowledged in the text.

The population of Upminster

Author: Dr Richard Beaver with additions by Dr Charles Easmon

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

An update on population characteristics

Some new data are available from the Health of Londoners project: see Table 1. These are not directly comparable to the previous data shown in Table 2, but allow the PCG to view its population in a smaller number of age bands. These data were collected from Office for National Statistics estimates of local areas and confirm the previously stated high level of elderly population. The structure of the resident Upminster population compared to that of BHHA is shown in Table 2 and Figure 1.

Table 1 Population of Upminster, percentages by age group

Age group	% population
0-14	18.1
15-25	11.3
25-45	27.4
45-64	24.6
65-74	10.2
75+	8.4

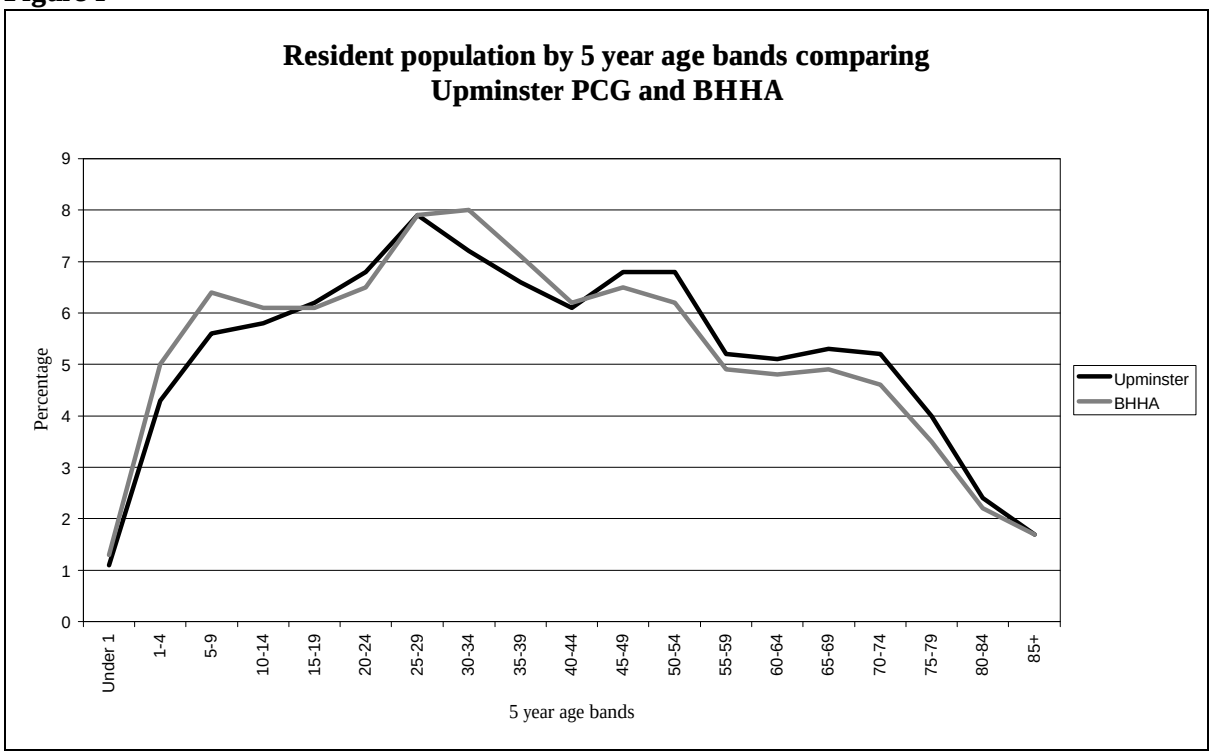
Source: ONS Census data 1991

Table 2 Resident population by age group, Upminster, BHHA

Age group	Upminster Number	Upminster %	BHHA %
under 1	408	1.1	1.3
1-4	1,576	4.3	5.0
5-9	2,163	5.6	6.4
10-14	2,177	5.8	6.1
15-19	2,333	6.2	6.1
20-24	2,513	6.8	6.5
25-29	2,955	7.9	7.9
30-34	2,705	7.2	8.0
35-39	2,440	6.6	7.1
40-44	2,212	6.1	6.2
45-49	2,433	6.8	6.5
50-54	2,406	6.8	6.2
55-59	1,864	5.2	4.9
60-64	1,765	5.1	4.8
65-69	1,742	5.3	4.9
70-74	1,674	5.2	4.6
75-79	1,229	4.0	3.5
80-84	633	2.4	2.2
85+	315	1.7	1.7

Source: ONS Census data 1991

Figure 1



Source: ONS Census data 1991

The Upminster PCG proportion of children aged 0 to 14 years (18.1%) is similar to that for Hornchurch (18.8%) but less than that for Dagenham (21.7%) and Barking (21.6%). This is an important correction on last year's wrongly listed figure. The number of residents aged between 25 and 34 years (the child bearing years) is also lower. Conversely the proportion of residents aged 65 to 84 years in Upminster (18.6 %) is higher than in BHHA (16.9%). The higher proportion of residents aged 65 to 84 has a significant impact on primary care for reasons including the presence of co-morbidity and social isolation.

Several other indicators of deprivation are available and some of these are shown in Table 3. From this it is clear that Dagenham and Barking are the areas with the biggest deprivation problems. However, Upminster can use this data to focus on access to care (no car households) and elderly care. The latter may involve co-working with social services to ensure further reduction in the proportion of households with inadequate heating.

Table 3 Selected census-based indicators of deprivation, BHHA by PCG area 1991

Indicator	Upminster	Hornchurch	Romford	Dagenham	Barking
% of economically active residents unemployed at 1991 census	8.1	7	7.8	11	12.7
% of households with no car available to household members	27	25	27	40	44
% of households without central heating	14	13	17	33	34
% of residents living in households that are overcrowded	4	3	4	9	9

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

Cancers

Author: Dr Frances Haste

Key points of interest

For London Borough of Havering (LBH) as a whole

- Cancer causes 27% of deaths 44% of deaths of people under 65 years.
- Lung cancer is the most common cause of cancer deaths among males, and breast cancer among 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 cancers which 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 Upminster in particular

- Deaths from cancers in people under 75 years were 7th highest in London in 1998.
- Lung cancer death rates are lower than London rates.
- Death rates from stomach cancer are slightly higher than London rates.
- Breast cancer death rates are the lowest of the Havering PCGs but higher than London rates.

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 PCGs in London and these have been used for comparison where appropriate.

Deaths from cancer: all ages

Numbers of deaths from each tumour type in LBH in 1998 are detailed in Table 4. 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. Male

cancer deaths in Upminster are slightly but not significantly higher than in London. Female cancer deaths are also just above the London average.

Table 4 Cancers: deaths by major tumour site and age group, 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**

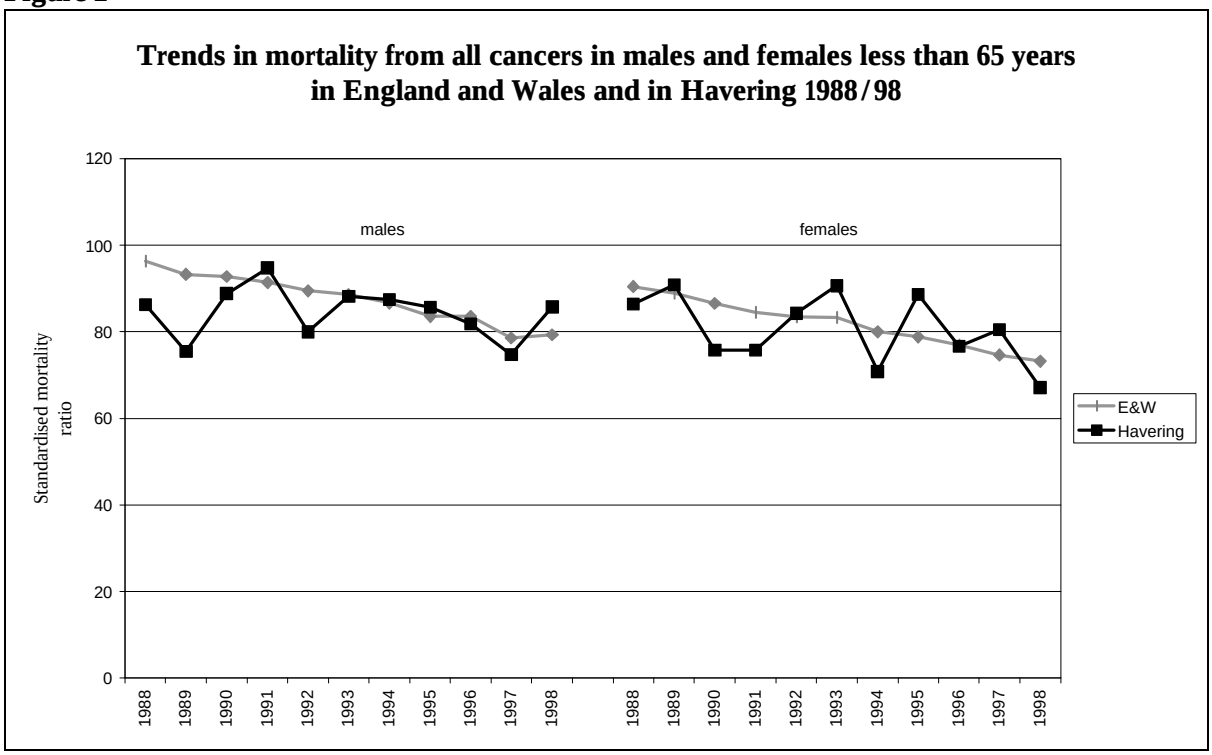
Source: Mortality statistics, Office of National Statistics

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 of 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 aged under 65 of about 18% over the last decade. 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: see Figure 2. Whilst death rates for women are lower than London rates, those for men are higher.

Figure 2



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

Of the three PCG areas in LBH, Upminster has the highest rates of cancer deaths of people less than 75 years old, and the 6th highest rates in London (out of 66 London PCGs). Using the registered population base, there were 129 deaths from cancer in people under 75 years in Upminster in 1998, a higher rate than London: see Table 5.

Table 5 Cancers: death rates, all ages and less than 75 years, Upminster, London and England and Wales, 1998

Area	Males SMR*	Females SMR*	Rate per 100,000 population aged under 75
Upminster	105	105	155
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 Upminster in 1997/98 were significantly lower than 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 decrease for females: see Figure 3. The pattern for people under 75 years is similar.

Colorectal cancer

There have been 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 not been a consistent decrease: see Figure 4. Overall rates are slightly higher for both men and women than London rates.

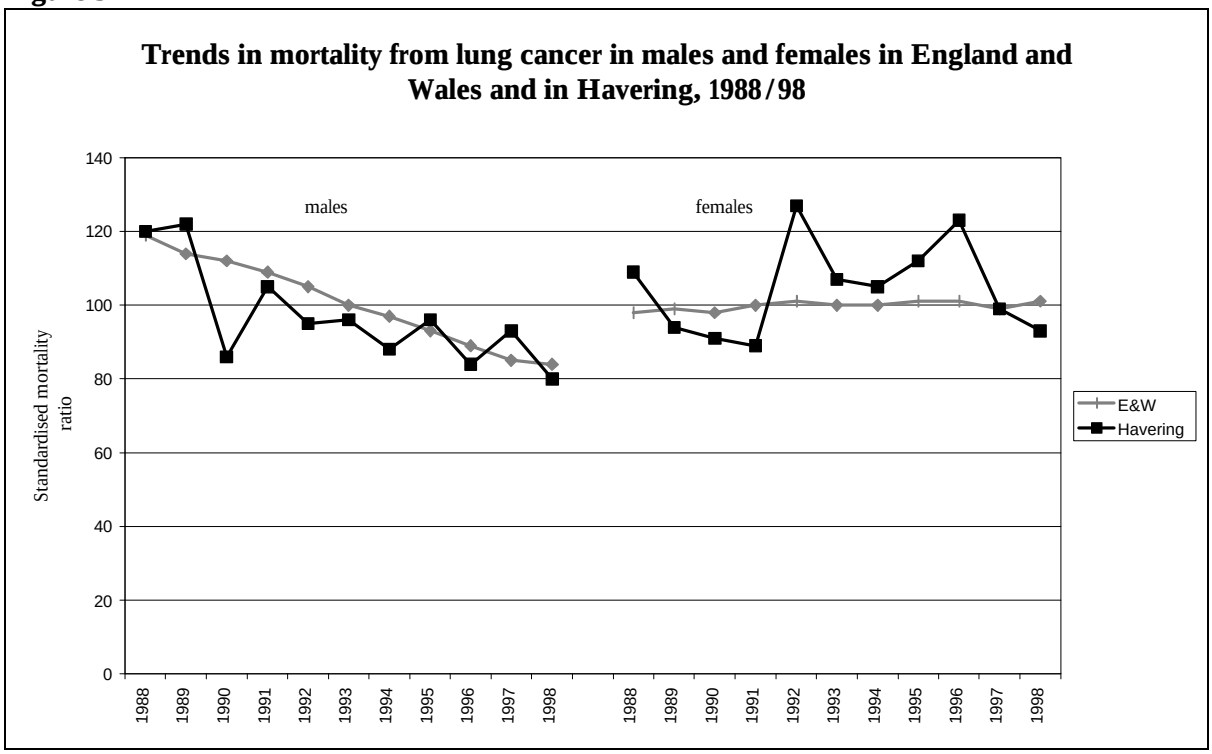
Stomach cancer

Death rates from stomach cancer have decreased by a third in the last ten years in LBH and rates in 1998 were slightly higher than the London average, although lower than national rates: see Figure 5.

Breast cancer

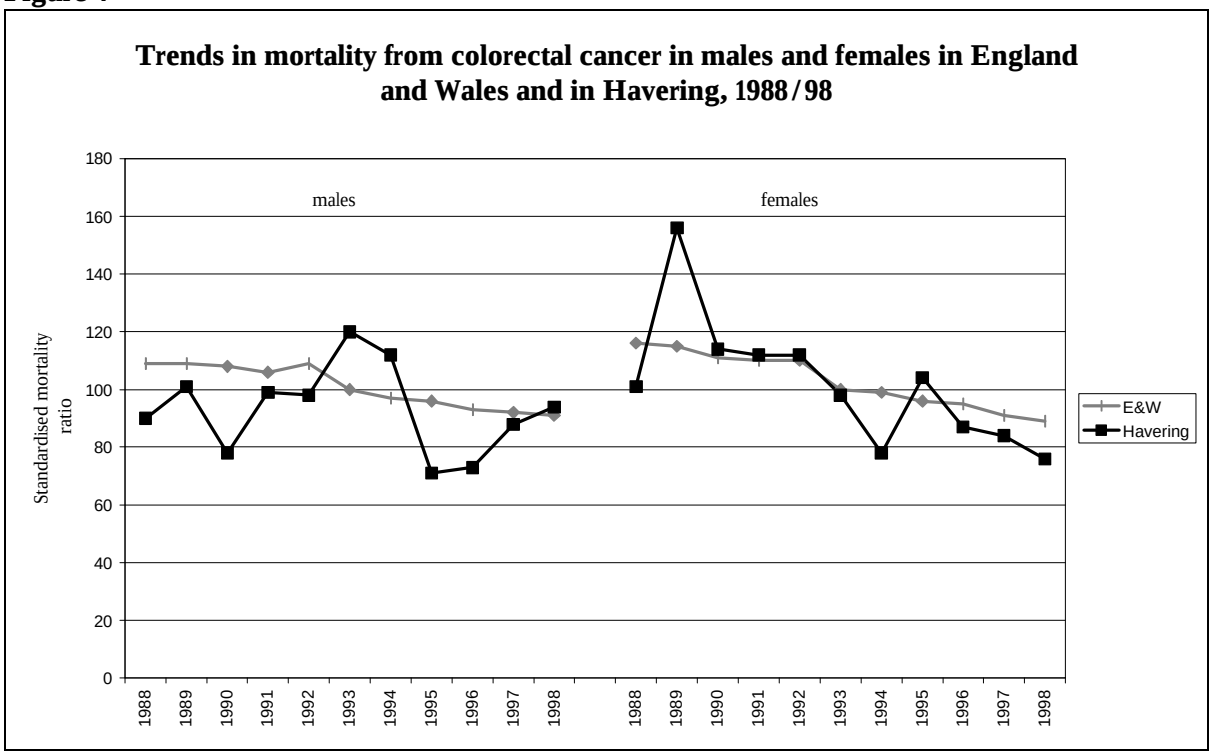
Deaths from breast cancer (all ages) nationally and in London have shown a steady decline of about 20% in the last ten years. Although there has been some decline in LBH, it has not been as great and rates remain higher than national or London ones. In 1998 deaths were the 4th highest in London. For women aged 50-69 years decreases in LBH have also been less than in London: see Figure 6. Upminster has lower death rates from breast cancer than the other PCG areas in LBH but there are still higher than London rates.

Figure 3



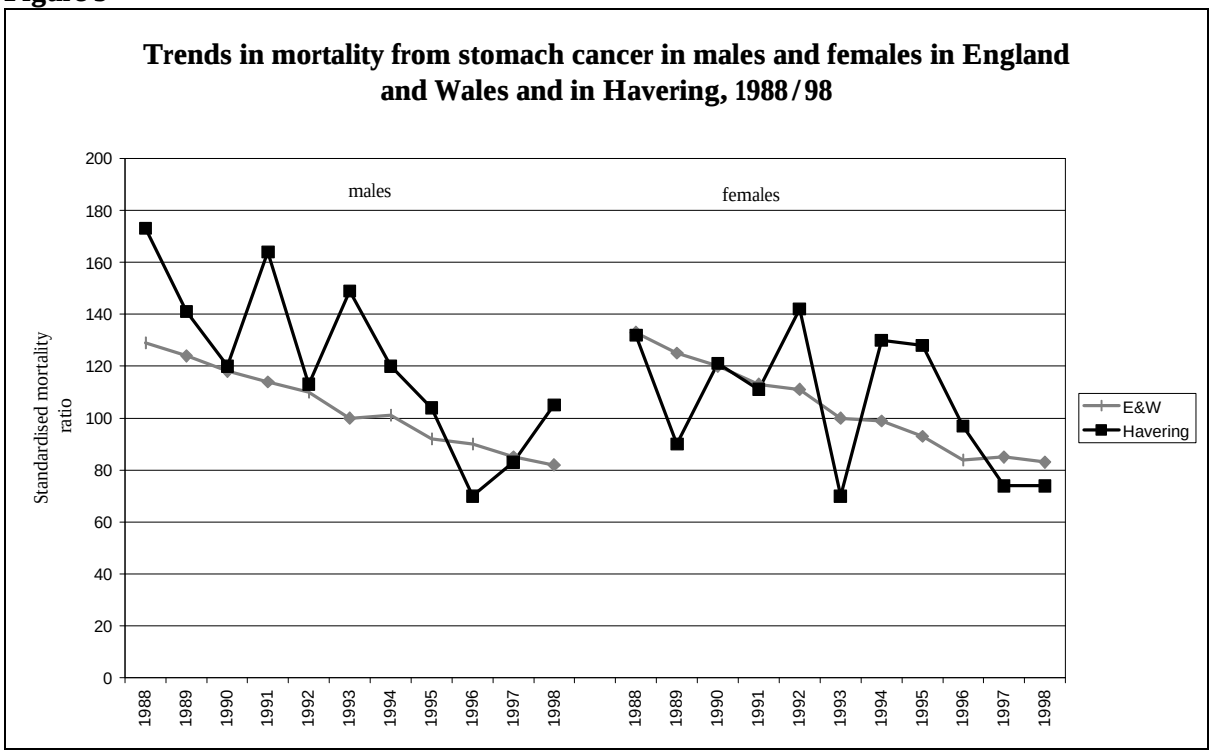
Source: Compendium of Clinical and Health Indicators. Centre for Public Health Monitoring. 1999

Figure 4



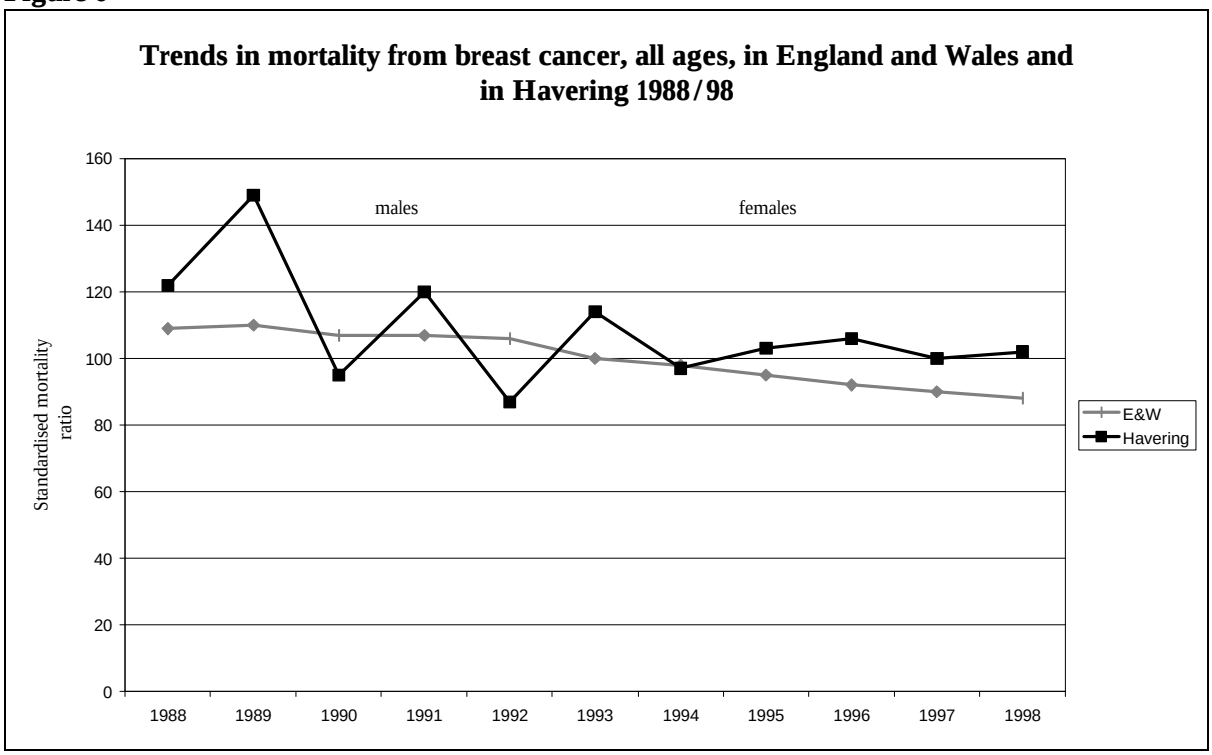
Source: Compendium of Clinical and Health Indicators. Centre for Public Health Monitoring. 1999

Figure 5



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

Figure 6



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

Coronary heart disease

Author: Mark Ansell

Key points of interest

- There has been some improvement recently in terms of CHD deaths.
- Despite this CHD remains second only to cancers in terms of deaths caused.

Key action points

- Upminster PCG, in common with all PCGs, must address the National Service Framework (NSF) for CHD, specifically standards 3 and 4 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 530 deaths from CHD in the Upminster PCG in the three-year period 1997/99. This represents a 12% reduction on the preceding three-year period: see Table 6.

Sixty-one people under 75 years died from CHD during 1997/99. This represents a 40% decline on the preceeding three-year period: see Table 7.

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

Nationally, deaths from CHD continue to decline steadily. After several years where rates actually increased, deaths from CHD in LBH now appear to be following a similar downward trend: see Figures 7 and 8. Currently rates of death from CHD in Upminster are similar to those elsewhere in LBH, London and the country as a whole: see Tables 6, 7 and 8.

Deaths at ward level are prone to considerable fluctuation due to the small number of events involved. However it would appear that death rates in Gooshays, Harold Wood, Heaton and Hilldene wards are consistently higher than other wards in the PCG area: see Tables 9 and 10.

Rates of revascularisation in Upminster are low relative to those observed in other local PCG areas, except Dagenham and are lower than the London average. Rates will have rise considerably to achieve the ultimate target level established in the CHD NSF: see Table 11.

Rates of admission for heart failure, seen as an indicator of effective primary care management are consistently lower than the BHHA average: see Figure 9.

Detail of trends in death rates

Table 6 CHD: death rates for persons of any age by PCG area, 1994/96 to 1997/99

Area	1994/96			1997/99		
	No.*	Rate*	SMR*	No.*	Rate*	SMR*
Barking PCG	446	207.5	108	425	190.4	114
Dagenham PCG	866	191.6	103	796	170.6	104
Hornchurch PCG	575	180.1	99	509	157.4	98
Romford PCG	590	176.1	97	516	149.1	95
Upminster PCG	605	177.6	94	530	147.4	92
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

* No. = number of deaths recorded
Rate = the directly aged standardised death rates rate/100000
SMR = standardised mortality ratio
Source: Public Health Mortality File

Table 7 CHD: death rates for persons aged under 75 years by PCG area, 1994/96 to 1997/99

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

*No. = number of deaths recorded
Rate = the directly aged standardised death rates rate/100000
SMR = standardised mortality ratio
Source: Public Health Mortality File

Table 8 Ischaemic heart disease: death rates, all ages, BHHA PCG areas, London and England 1997/98

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

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

Table 9 CHD: deaths of persons aged under 75 years, Upminster 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
Cranham East	100	88	40	32	67	82	29	34
Cranham West	68	64	29	42	52	62	21	44
Emerson Park	82	79	35	36	82	93	32	26
Gooshays	118	107	60	19	73	74	44	39
Harold Wood	105	101	51	25	56	64	25	43
Heaton	131	111	61	15	111	119	58	14
Hilldene	165	130	64	7	108	107	53	20
Upminster	47	46	26	44	53	62	27	45

Source: Public Health Mortality File

Table 10 CHD: deaths of persons of any age, Upminster by ward 1992/95 and 1996/99

	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
Cranham East	193	98	89	30	169	107	83	15
Cranham West	163	82	65	37	126	75	49	43
Emerson Park	148	78	66	40	162	96	75	26
Gooshays	209	102	133	22	155	89	117	35
Harold Wood	192	102	116	24	144	91	96	32
Heaton	205	99	121	29	176	99	119	23
Hilldene	225	100	111	25	193	108	109	13
Upminster	119	68	86	44	125	79	93	41

Source: Public Health Mortality File

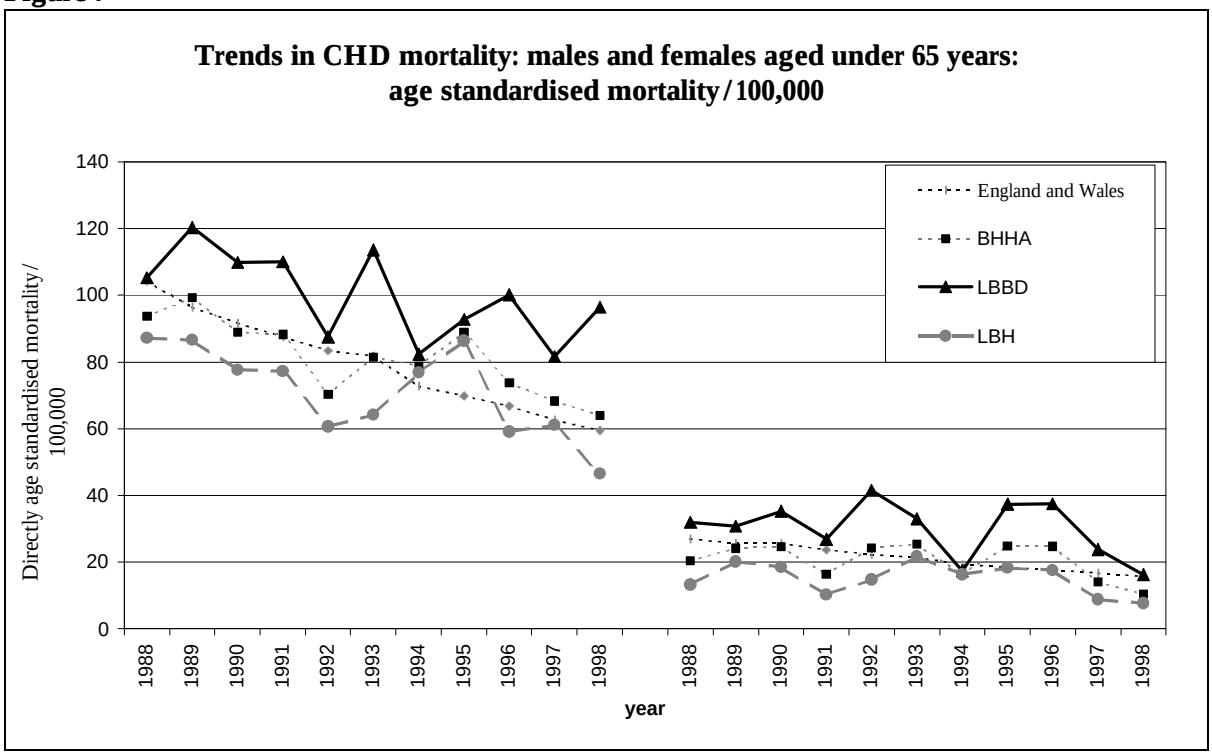
Table 11 Coronary artery bypass grafts (CABG) and percutaneous transluminal angioplasty (PTCA): age standardised hospital admission rates (ASR), BHHA by PCG and London

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

CI = Confidence Interval

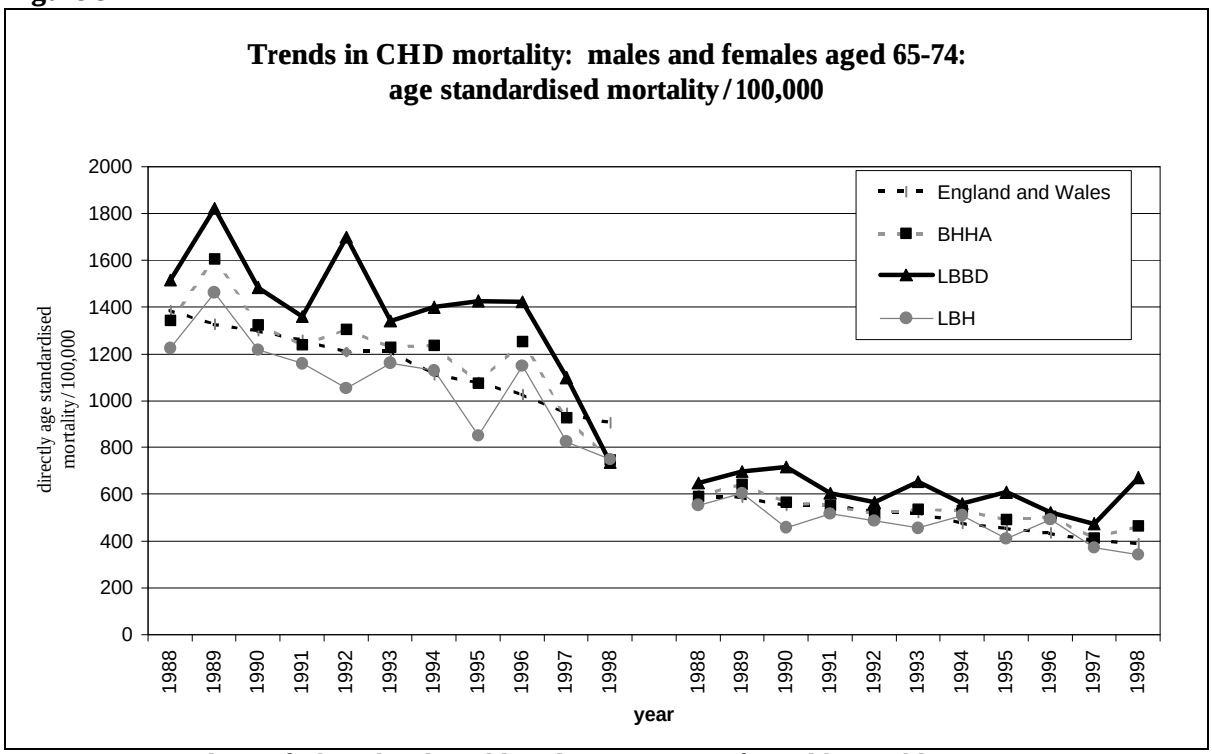
Source: Mapping Health for Primary Care Groups, Health of Londoners Project, 2000

Figure 7



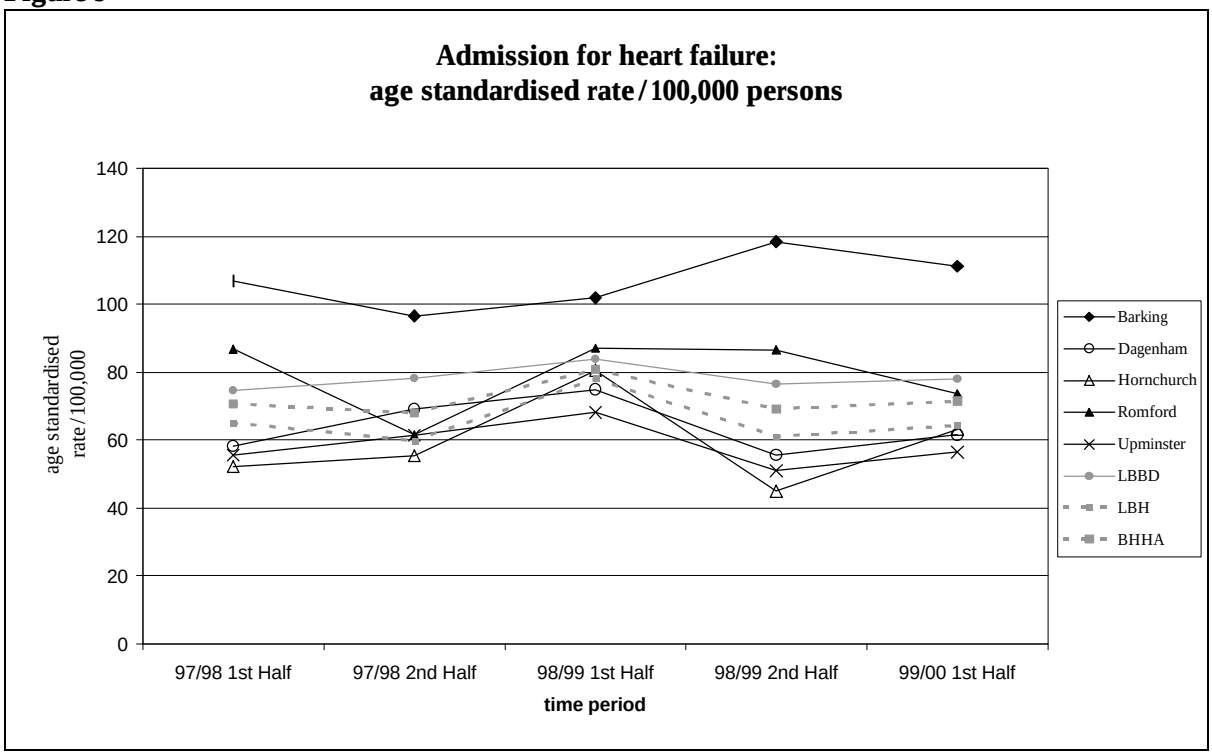
Source: Compendium of Clinical and Health Indicators. Centre for Public Health Monitoring. 1999

Figure 8



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

Figure 9



Source: Hospital Episode Statistics

Mental health

Author: 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 HImP (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 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 (NSF) Standards 2 and 3 include:

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

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/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. This summary has been produced by the NSF co-ordinating team, which includes representatives from BHHA, BHB Community Health Care Trust (BHB), LBBD and LBH Social Services, one of the local PCGs and voluntary and user organisations.

Osteoporosis

Author: Dr Richard Beaver

Key points of interest

- The variance of illness and deaths due to osteoporosis between the PCG areas and the local authorities is relatively small. All PCGs will need to address the prevention and treatment of osteoporosis in their residents.
- PCGs should ensure that health promotion programmes to people of all ages target measures that support and promote lifestyles enabling the development of normal bone mass and density
- Accident prevention should form a key task for all who provide services to people, especially those who visit or inspect homes and institutions caring for older people
- Hormone replacement therapy (HRT) should be prescribed for women at high risk of osteoporosis. When HRT is contra-indicated in women or bone densiometry indicates osteoporosis in both sexes, the use of other bone mineral content maintaining therapies such as the bisphosphonates should be considered. In older men and women, supplements of calcium and vitamin D are recommended.
- PCGs should commission bone density measurement by means of dual X-ray absorbtiometry (DEXA) in accordance with guidelines approved by local practitioners and the Department of Health for:
  (i) the assessment and management of patients with established osteoporosis 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 2 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 common and economically important cause of illness, death and poorer quality of life in the community. The prevalence increases with age.
- COPD accounted for 4% of all deaths in the three years 1995/97.
- The electoral wards of Cranham East and Hilldene have higher SMRs than BHHA.
- National studies show that respiratory diseases account for a significant proportion (17.8%) of all GP consultations and acute medical admissions (25%).
- Emerging evidence suggests that a specialist nurses team for COPD is beneficial in achieving better management of patients and reducing hospital usage.
- The British Thoracic Society (BTS) guidelines on COPD offer a structured approach to managing patients.
- Spirometry should be made widely accessible to general practice.
- Admission rates and SARs for asthma are lower than BHHA across all ages. Nurse led training and better prescribing can reduce hospital admissions for asthma.

Key action points

- Train all practice nurses in COPD and asthma management.
- Adopt a targeted approach to smoking cessation for COPD patients.
- Increase uptake of influenza vaccine to all COPD patients.
- Improve patients' knowledge and ability to self-manage and access appropriate services.
- Implement agreed COPD guidelines.

Deaths from COPD

Upminster had 99 deaths from COPD in the three-year period 1995/97, accounting for 4% of all deaths. The death rate and standardised mortality ratio (SMR) are significantly lower than for BHHA. However, the electoral wards of Cranham East and Hilldene have higher SMRs than BHHA: see Table 12.

Table 12 Chronic obstructive pulmonary disease (COPD)*: deaths, all ages, LBH by ward 1995/1997

Ward	Number of deaths	**Rate per 100,000 population	Standardised Mortality Ratio (SMR)
Cranham East	15	60.52	102.16
Cranham West	6	28.19	47.59
Emerson Park	10	41.59	70.21
Gooshays	17	40.35	68.11
Harold Wood	9	27.47	46.37
Heaton	15	43.74	73.83
Hilldene	19	60.16	101.56
Upminster	8	24.43	41.24
Upminster	99	40.63	68.60
LBH	327	47.64	80.43
BHHA	690	59.24	100.00

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

Hospital admissions for COPD

Upminster has lower admission rates and standardised admission ratio (SAR) for COPD compared to BHHA: see Table 13.

Table 13 Chronic obstructive pulmonary disease (COPD)*: hospital admissions, all ages, Upminster, LBH, and BHHA 1995/96 - 1997/98

Area	Number of admissions (3 years)	Rate per 100,000 population per year	Standardised Admission Ratio (SAR)
Upminster	256	92.91	82.09
LBH	695	86.81	76.70
BHHA	1,527	113.18	100.00

* ICD 10 code: J40 - J47
Source: Hospital Episode Statistics

Hospital admissions for asthma

Admission rates and standardised admission ratios (SARs) for asthma in Upminster are lower than for BHHA across all ages: see Table 14.

Table 14: Asthma*: hospital admissions by age group, Upminster, LBH, and BHHA 1995/96 - 1997/98

Area	Number of admissions (3 years)	Rate per 100,000 population per year	Standardised Admission Ratio (SAR)
Age 0-14 years			
Upminster	101	302.95	77.47
LBH	298	345.08	88.24
BHHA	862	391.07	100.00
Age 15-44 years			
Upminster	79	89.47	86.03
LBH	216	75.07	72.18
BHHA	501	104.00	100.00
Age 45-64 years			
Upminster	46	87.66	79.31
LBH	133	81.22	73.48
BHHA	280	110.54	100.00
Age 65+ years			
Upminster	28	67.40	63.56
LBH	87	77.01	72.62
BHHA	199	106.03	100.00

* ICD 10 code: J45, J46; LBH; BHHA
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 1,450 persons could be affected with diabetes in Upminster.
- Death rates for diabetes in Upminster are higher than the BHHA average.
- The burden of hospital admission for diabetes (as the primary cause of admission) is lower in Upminster compared to BHHA.
- Recent evidence from UK Prospective Diabetes Study suggests that tight control of blood glucose and blood pressure is important in reducing complications from diabetes. Annual review is an important element of this regime. Considerable potential exists for reducing the burden of complications.
- A multi-disciplinary team of specialist nurses, dieticians, and chiropodists are essential for providing optimal care of diabetes in a primary care setting.
- A properly implemented retinopathy screening programme can prevent blindness in diabetic patients.
- PCGs have a vital role in implementing locally agreed diabetes guidelines.

Key action points

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

Deaths

There were 24 deaths from diabetes mellitus as the underlying cause of death within Upminster in the three year period 1997/00. There were no deaths in persons below 45 years of age. Diabetes is a known risk factor for CHD and stroke. Deaths from these conditions, when

diabetes mellitus is an important co-morbidity, are not included in the above figures. The death rate and the standardised mortality ratio are higher than for BHHA: see Table 15.

Table 15 Diabetes mellitus* (underlying cause of death): deaths by age group, Upminster, 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	
Upminster	24	0.0	18.7	6.7	108
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 (SAR) for Upminster are lower than for BHHA: see Table 16. There were 186 finished consultant episodes (FCEs) with diabetes mellitus as the main cause of admission. We have excluded all FCEs where diabetes mellitus is mentioned in any other diagnosis field. This will exclude, for instance, admissions from CHD and stroke if diabetes mellitus is mentioned in one of the other diagnosis fields.

Table 16 Diabetes mellitus*: finished consultant episodes, all ages, Upminster, LBH, and BHHA 1997/00

Area	Number of admissions (3 years)	Rate per 100,000 population per year	Standardised Admission Ratio (SAR)
Upminster	186	70.1	92
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 Upminster are low overall compared to other local PCG areas and to London. They are, however, concentrated in the Harold Hill area and two-thirds of conceptions in women under 18 years occur in this area.
- Teenage pregnancies are decreasing.
- The proportion of babies that have low birthweight is generally low but lone parents have much higher rates.
- There is a relatively high and increasing proportion of older mothers

Key action points

- PCGs should ensure that appropriate contraceptive services are available for young people particularly in the Harold Hill area.
- Increasing maternal age may have implications for obstetric services that are required.

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Teenage pregnancies

Conception rates in young women less than 18 years in LBH are in the lowest 20% of the London boroughs. Teenage pregnancies account for only 5.9% of births in Upminster PCG. There are, however, differences within the PCG. The Harold Hill wards (Gooshays, Hilldene and Heaton) have considerably higher rates of teenage pregnancies than other wards in Upminster: see Table 17. Eighty four percent of conceptions in Upminster to girls under 16 years and 68% of conceptions under 18 years were in Harold Hill wards. Some wards had no conceptions in girls under 16 years in a 6 year period.

Table 17 Conceptions under 16 for 1992/97 and under 18 for 1992/94 and 1995/97

Area	Under 16	Under 18	Under 18
	1992/97	1992/94	1995/97
Upminster PCG	55	145	139
Cranham East	-	5	5
Cranham West	-	5	6
Emerson Park	6	9	12
Gooshays	17	33	30
Harold Wood	3	10	12
Heaton	15	33	34
Hilldene	14	41	30
Upminster	-	9	10

Source: Office of National Statistics (ONS)

Overall in Upminster there was a slight decrease in teenage conceptions between 1992/94 and 1995/97. Harold Hill showed a decrease, particularly in Hilldene ward.

Marital status

In line with national trends there has been a slight decrease in Upminster in the proportion of babies born within marriage from 68.8% in 1993/95 to 61.7% in 1996/98. There has also been a slight increase in the proportion of women who register their babies with only one named parent: see Table 18. Lone registration generally indicates a lone parent.

Table 18 Marital status and low birthweight in Upminster PCG, 1993/95 and 1996/98

Time period	% of births within marriage	% of births in marriage that are <2500g	% of births which are lone registrations	% of lone registrations where birthweight is <2500g
1993/95	68.8	5.9	6.4	6.6
1996/98	61.7	6.2	7.3	10.5

Source: ONS

The proportion of babies that are of low birth weight (less than 2500g) has increased in married women and lone mothers in that period. Babies of lone parents are more likely to be low birthweight babies.

Harold Hill wards have considerably higher rates of lone registrations than other wards in Upminster and in these 3 wards the percentage of births within marriage is less than 50%: see Table 19.

Table 19 Marital/registration status by ward, Upminster PCG, 1996/98

Ward	% lone registration	% births in marriage
Cranham East	3.6	68.5
Cranham West	3.8	82.1
Emerson Park	2.9	78.9
Gooshays	9.8	49.5
Harold Wood	4.6	71.8
Heaton	10.7	46.3
Hilldene	13.2	46.4
Upminster	1.9	80.5

Source: ONS

Birthweight

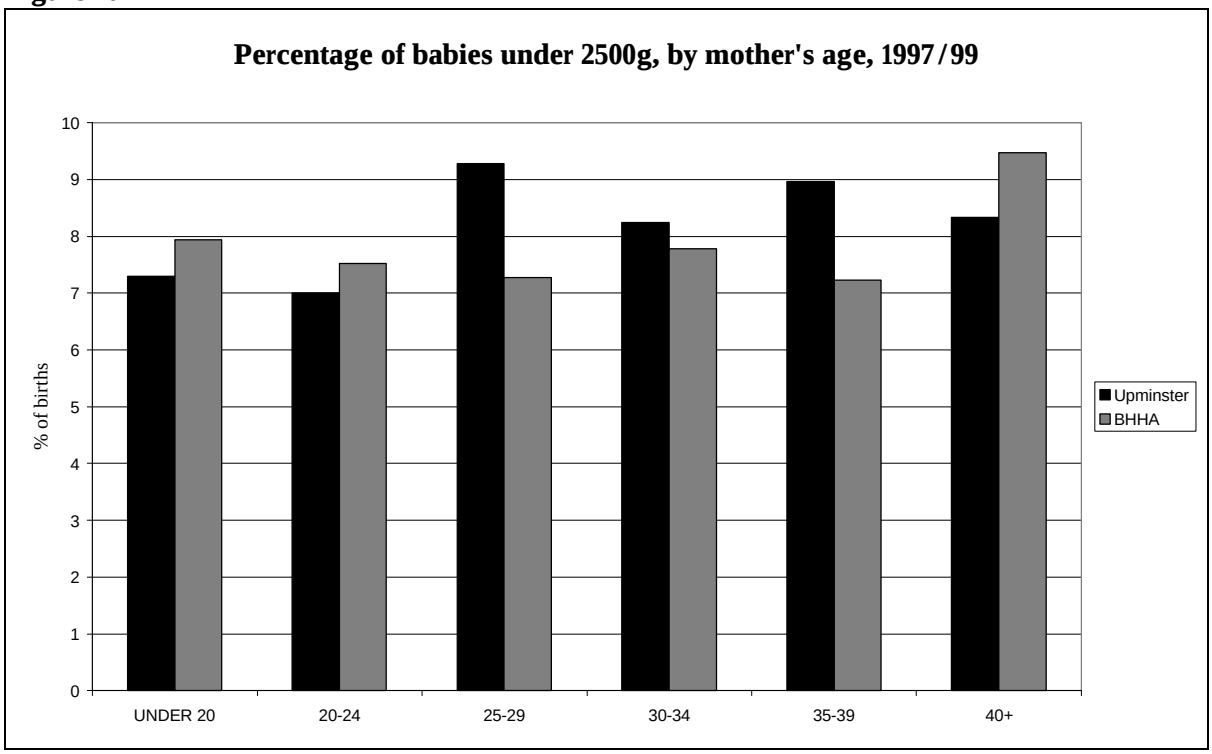
Upminster PCG had a higher proportion of babies of low birthweight in 1997/99 than nationally or in London: see Table 20. This seems to be mainly due to the higher rates of low birthweight in women aged 25-40 years: see Figure 10. This is unusual as low birthweight is more commonly associated with very young or older mothers.

Table 20 Rates of low birthweight in Upminster PCG, London and England and Wales

Area	% of babies born less than 2500g
England and Wales 1998	7.8
London 1998	8.3
Upminster PCG 1997/99	8.4
BHHA 1997/99	7.6

Source: Regional Integrated Child Health Surveillance (RICHS)

Figure 10



Source: RICHS

Upminster has a larger proportion of older mothers than BHHA or England and Wales: see Table 21.

Table 21 Proportion of births to older and younger women

Area	% of babies born to women <20 yrs	% of babies born to women 35+ yrs
England and Wales 1998	7.6	14.5
London 1998	5.2	18.6
Upminster PCG 1997/99	5.9	15.0
BHHA 1997/99	6.8	12.4

Source: RICHS

The proportion of babies born in Upminster PCG to women 35+ years has increased slightly from 14.5% in 1995/97 to 15.% in 1997/99.

Older women tend to have higher rates of pregnancy complications, particularly those relating to hypertensive conditions.

Health needs identified in community nursing

Authors: Upminster Community Nursing Team

Introduction

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

- local health needs and target activities at the Primary Care Integrated Team level and/or the PCG level;
- specific health problems and issues within those populations in which community nurses work within the primary care setting;
- what community nurses currently do and how they work with those populations;
- whether there are important gaps in current service provision;
- how the work of community nurses does and could address the priorities of the HImP and the Primary Care Investment Plan.

The data and information used in producing the profiles has been drawn from a range of sources that include: ONS, PCG Public Health Reports, analysis of current caseloads and the new Regional Integrated Child Health Surveillance (RICHS) system that encapsulates both patient information and nursing contacts. The RICHS system's reliability is currently being strengthened in respect of data collection and collation.

Health visitors'report

Populations with which health visitors work

Health visitors work primarily with children under five. There is, however, a health visitor at Harold Wood who works one day a week visiting the elderly. Many of the other health visitors visit a small percentage of elderly.

Numbers of children under five by caseload are:-

- Upminster and Cranham 1253
- Harold Wood 1618
- Harold Hill 1626

Table 22 Number of babies born annually, under 2500g and under 1500g, and those mothers under the age of 20 by ward

Ward	Total Births	Under 2500g	% under 2500g	Under 1500g	% under 1500g	Under 20 years	% under 20 years
Cranham East	57	2	3.5	0	0	2	3.5
Emerson Park	89	6	6.7	1	1.1	4	4.5
Gooshays	130	12	9.2	3	2.3	10	7.7
Harold Wood	103	9	8.7	3	2.9	4	3.9
Heaton	154	14	9.1	3	1.9	9	5.8
Hilldene	107	8	7.5	2	1.9	10	9.3
Upminster	98	9	9.2	2	2	2	2
Cranham West	45	3	6.7	2	4.4	1	2.2
Total	**783**	**63**	**8**	**16**	**2.1**	**42**	**5.4**

Source: RICHS

These figures are not a true reflection of the health visitors' caseloads as they are aligned to GP practices and undertake cross boundaries to visit in other areas. Table 23 shows the number of children on the child protection register and vulnerable families with social or special needs, by caseloads, December 1999:-

Table 23 Number of children on the child protection register and vulnerable families with social or special needs, by caseloads, Upminster PCG area December 1999

Caseload	Number on child protection register	Vulnerable families
Upminster and Cranham	2	48
Harold Wood	3	73
Harold Hill	17	46

Source: BHB Child Protection Register

A number of factors which affect the workload of health visitors are:-

- low birth weight babies;
- premature babies;
- children on the child protection register;
- numbers of teenage mothers, which in Upminster and Cranham total nine teenage mothers and in Harold Hill represent 7.5% of combined caseloads;
- vulnerable families;
- older first-time mothers, who may be socially isolated (especially in Upminster and Cranham);
- unsupported lone parents;
- poor dietary intake (especially in Harold Hill);
- low numbers of breastfeeding mothers in Harold Hill totalling only 4% of combined caseloads;
- smoking, the percentage of which for Upminster PCG is 35.2% of males and 28.4% of females;
- refugees/asylum seekers;
- homelessness;
- unemployment (especially in Harold Hill);
- parental depression/mental illness;
- domestic violence;

- behaviour and sleep problems;
- asthma and eczema, both of which have been highlighted by Upminster and Cranham as requiring additional health visiting input;
- mild post-natal depression, identified by several of the teams, although at Upminster and Cranham a statistical analysis of the 305 mothers in 1999 revealed that only 10 were seen specifically with post-natal depression.

How health visitors work with these populations

Routine health visiting is defined in the job description of the nurses. However many of the above factors require additional health visiting input. This includes increased home visiting and multi-agency working and liaison. Attendance is also required at multi-disciplinary assessments, case conferences, core groups and reviews. This is especially the case in Harold Hill where there is a higher percentage of teenage mothers and children on the child protection register.

Upminster and Cranham have a higher proportion of older first-time mothers. They also have a higher service uptake and a successful uptake of evening classes/contacts and health promotion activities such as parent craft and post-natal groups. All areas run post-natal groups. In Upminster and Cranham one health visitor runs a post-natal exercise class. A class is also available for fathers, in which men's health and welfare is discussed. Upminster and Cranham also run ante-natal classes, while in Harold Wood two of the health visitors make ante-natal contact at the GP surgeries.

Integral to the Health Visiting role is the identification of vulnerable children and families which results in the appropriate referral to local professional/lay groups or services according to need. Early identification is essential and to this end a tool has been developed which can be used at routine visits to identify families which require additional input. This is being piloted across BHB. Routine child development checks also enable early detection of problems and referral to appropriate agencies. In Upminster and Cranham a nursery nurse may be involved in follow up care.

Over recent years there has been a significant increase in refugees/asylum seekers in the two hostels at Harold Hill. This has had a significant impact on the health visiting service there. The following needs have been highlighted:-

- access to appropriate translation services;
- increased amount of follow up work, i.e. contacting relevant health visitors;
- extra strain on GP's services when asked to accept refugees/asylum seekers on to their caseloads;
- obtaining personal child health records for the children;
- older children's health and liaison with school nurse;
- lack of information, i.e. previous immunisation status;
- clients financial difficulties and lack of knowledge/services of the area;
- education i.e. lack of places in local schools and in some instances refusal to send children to school;
- antagonism from local residents.

Some problems encountered include lack of basic hygiene, family planning, infertility, miscarriage and a lack of parenting skills when caring for a premature baby.

Parents who have worries over their children's sleep frequently consult health visitors. Many parents are concerned by patterns of sleep behaviour, which are disruptive to marital and family

life. It is not uncommon for problems to be presented as chronic and intractable, but many sleep difficulties resolve with simple interventions.

It is worth noting that a local health visitor has undertaken a programme of sleep management using a behavioural management approach.

Perceived issues around the key aspects of the work or client group

Professional/service issues

- Feedback from agencies is often scanty or late.
- Length of waiting times to services, i.e. speech therapy has a six-month waiting time.
- Lack of local resources, i.e. early years.
- Difficulties in referring to mental health service.

Population/client issues

- Lack of insight/acknowledgement by client of actual problem(s).
- Client non-compliance, i.e. non-attendance at clinic and specialist services.

The contribution of health visitors to the HImPs and other PCG targets

The Health Visiting contribution in relation to CHD and diabetes emphasises the role of diet in relation to disease prevention. This starts with ante-natal contacts and continues through the child's/family's development milestones, with the promotion of breastfeeding, good weaning practices and a healthy diet. Weaning is also incorporated into the post-natal classes run by each team. Exercise and smoking cessation advice is given to all families.

Other contributions to PCG targets and the overall health of the Upminster PCG population include:-

- education and advice given to mothers on sun protection for the family;
- national and local targets for skin cancer reduction;
- mothers encouraged in breast self-awareness, to attend for regular cervical screening and to attend a regular women's health clinic at Upminster Clinic;
- a multi-disciplinary ante-natal group (includes a health visitor, midwife and a community psychiatric nurse) to assist in the prevention and early detection of post-natal depression;
- early intervention, appropriate referrals and close working partnerships with the key agencies, e.g. portage and early years centres may prevent those vulnerable children on caseloads from being registered on the child protection register.

Recommendations

- Improve communication via regular primary health care meetings.
- Integrated projects and services between health visitors, practice nurses and district nurses
- Use community development approaches in conjunction with other agencies.
- Improve the clarity of referral for children and families with special needs by a framework of key professionals, their remit and referral criteria.
- Provide a health visiting service to the ageing population of Upminster and Cranham. (Previous initiatives involved health promotion via an exercise programme for retired citizens. Future plans incorporating post-retirement health promotion groups have been considered which would include accident prevention and screening.)
- Promote breastfeeding, including better liaison with the midwifery service. (Discussion points could include whether to ban the sale of all formula milks from community clinics and stop the provision of formula milks in maternity units.)
- Adopt a multi agency approach involving primary care professionals to promote and improve the health and social care of refugees/asylum seekers.

- Strategies are required to deal with behavioural problems in children. Note that Harold Wood have been considering a 'toddler taming' group and a sleep management programme.
- Consider a wider use of General Health Questionnaire 12, in view of the perceived levels of post-natal depression.

District nursing

Local features/factors affecting district nurse practice

Age structure

Upminster PCG has a higher level of elderly compared to other PCGs in the area, with 18.6% aged 65 and over. The proportion of people over age 75 is higher than in BHHA. Age related illnesses would be a significant factor in health and social care planning.[2]

Caseload description

District nurses work predominantly with the elderly and their families. In the Upminster and Cranham area an analysis of a caseload revealed the following:

Percentage of patients

- Retired 72
- Non white 0
- Living alone 39
- Receiving social services support 35

District nurses record their activity in terms of the nature and duration of the interventions. Table 24 describes district-nursing interventions over the course of the last year:

Table 24 Number of district nurse interventions for each care category in Upminster PCG and BHB average April 99 - June 99.

Intervention	Upminster No of Interventions	Upminster % Total Duration	BHB % Total Duration
Blood pressure	137	0.7	0.6
Cancer care	920	11.6	10.3
Continence	1049	9.5	10.0
Diabetes	1736	8.6	8.3
Elderly care	191	2.1	2.5
Eye care	516	2.5	3.2
Wound management	5792	51.8	50.1
Other advice/ counselling	157	1.6	2.3
Other assess	217	3.1	2.3
Other injection/Hickman/VP	92	0.1	1.8

Note. % total duration - this is the time spent on each activity group expressed as a % of total activity time.

Identified needs in Upminster and Cranham

A local case analysis in December 1999 identified the following health needs:-

Chronic illness

Chronic illness was the highest category of need for district nurse and reflects the ageing population which has multiple health problems. These include recurrent leg ulcers/wounds, gastro-intestinal disorders e.g. constipation, and genito-urinary health issues associated with prostatic or continence problems.

Palliative care

Palliative care was the second highest category for district nurse care particularly in the Cranham area, with clients in Upminster being diagnosed more frequently with bowel cancers.

Identified needs in Harold Hill

Genito-urinary care was identified as representing 18.9% of the district nurse caseload and this reflects referrals for continence assessment as well as routine catheter care. Seventeen per cent of care was palliative care, which involve the longest visits.

Identified professional/service issues

- Community care projects/services such as Home from Hospital, Community Orthopaedic Project in Essex (COPE) and Health Case Management are currently inaccessible to district nurses and GPs. Each one of the aforementioned services requires the client to be admitted for inpatient care in hospital for eligibility.
- A clearer criteria measuring health and social care is vital within the ageing population of Upminster PCG. A universal assessment tool between these services needs to be developed in order to provide seamless community care.
- There is a need to coordinate assessment of need and continuity of care
- District nursing teams within Upminster PCG are heavily involved, together with the specialist continence team, in helping to promote continence and manage incontinence.
- There are a high number of patients with dementia and confusion who require detailed nursing assessments to be carried out to facilitate appropriate placement in residential and nursing homes. District nurses also offer practical support and advice to carers of this highly vulnerable group.
- There is a high proportion of district nurses who care for those over 75 years of age, with a significant proportion of housebound patients.

Recommendations

- To work in closer liaison with practice nursing colleagues to ensure best possible use is made of the local skill base and collaborative care pathways. An example of a project that is currently being considered is developing routine monitoring to housebound patients with diabetes.
- A joint partnership approach to developing a single assessment tool for use by professionals from both health and social services is strongly advocated particularly for those requiring community based palliative care.
- To support the proposed Hospice at Home scheme.
- To support community development approaches and closer working with other professionals to support early intervention and promotion of continence.
- The establishment of leg ulcer clinics in Upminster PCG contributes significantly to an evidenced based approach to wound care management

References

1. Department of Health. *Making a Difference – Strengthening the nursing, midwifery and health visiting contribution to health and healthcare*. HMSO. July 1999.

2. Barking and Havering Health Authority. *Public Health Report Information Pack Number 2 Upminster* 1999

Health promotion

Authors: BHB Health Promotion

Key action points

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

Health Promotion Unit reorganisation

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

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

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

GP health promotion scheme

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

Patient participation groups

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

Specialist smoking cessation services

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

Healthy Schools Initiative

The BHB Healthy Schools Initiative is now well-established in local primary schools. The Health Promotion Strategic Alliance, in partnership with LBBD and LBH, have agreed funding to extend the initiative into local secondary schools. There are currently two primary schools signed up to the Healthy Schools Initiative in Upminster: see Table 25.

Table 25 Upminster 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
Parklands Junior													
Ingrebourne Primary													

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.