

Director of Public Health  
Annual Report 2014

# Growing the borough to improve health



# One borough; one community; London's growth opportunity

The Council's vision recognises that over the next twenty years the borough will undergo its biggest transformation since it was first industrialised and urbanised, with regeneration and renewal creating investment, jobs and housing.

The borough's corporate priorities that support the vision are:

### Encouraging civic pride

- Build pride, respect and cohesion across our borough
- Promote a welcoming, safe, and resilient community
- Build civic responsibility and help residents shape their quality of life
- Promote and protect our green and public open spaces
- Narrow the gap in attainment and realise high aspirations for every child

### Enabling social responsibility

- Support residents to take responsibility for themselves, their homes and their community
- Protect the most vulnerable, keeping adults and children healthy and safe
- Ensure everyone can access good quality healthcare when they need it
- Ensure children and young people are well-educated and realise their potential
- Fully integrate services for vulnerable children, young people and families

### Growing the borough

- Build high quality homes and a sustainable community
- Develop a local, skilled workforce and improve employment opportunities
- Support investment in housing, leisure, the creative industries and public spaces to enhance our environment
- Work with London partners to deliver homes and jobs across our growth hubs
- Enhance the borough's image to attract investment and business growth

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# Foreword

**Matthew Cole**

Director of Public Health

Matthew Cole pictured with Dr Jagan John (local GP and a Clinical Director on the Board of Barking and Dagenham's Clinical Commissioning Group), at the 2014 'Walk a mile in her shoes' event; as part of the '16 Days of Activism' campaign against domestic violence.

In 2015 Barking and Dagenham commemorates its 50th anniversary of becoming one borough. It will be another defining point in our borough's history and brings with it a once in a generation opportunity to radically transform the relationship between our residents and the Council as well as between patients and the NHS.

A perfect storm of financial austerity, demographic change, legal change and policy proposals are fundamentally altering the way in which resources are deployed and the way in which we and our partners deliver services that better meet our health and wellbeing outcomes in priority areas. Implementation of the Care Act 2014, the Children and Families Act 2014 and the Welfare Reform Act 2013 impact on every individual's rights, responsibilities and support. *Better Health for London*<sup>1</sup>, the report of the London Health Commission published in October 2014, and *The NHS Five Year Forward View*<sup>2</sup> published in October 2014 by NHS England, will



Becontree Heath Leisure Centre in Dagenham – the country's busiest pool

shape the future organisation and delivery of London's health and public health policies and services for the foreseeable future.

In response, the Council has set out our new vision and priorities for the borough as our predecessors did in the 1920's and 30's, based on growing the borough as a key asset for London and on regeneration of the community. Four key themes of transformation underpin this:

- **Thrive through austerity**
- **Realise potential**
- **Modernisation of the Council**
- **New models of delivery**

The Health and Wellbeing Board is currently refreshing our joint Health and Wellbeing Strategy to protect and improve the health of residents, and engagement with partners across all agencies to achieve this goal continues. The Board's key public health task is to deliver an innovative approach tailored to local needs that tackles the diseases

and consequences of modern living, as well as strives to raise standards of care and address health inequalities. Growth and regeneration provide an opportunity by developing and using our community assets, strengthening partnership between those who deliver and those who benefit from our services, and looking beyond needs and treatments to a healthy and prosperous community where residents and businesses contribute as well as gain.

In supporting the concept of wellness the Board has continued to advocate shifting care away from traditional paternalistic approaches to the redesign of patient pathways focusing on prevention, on keeping people out of hospital and encouraging residents to take personal responsibility for managing their own and their family's health, and social responsibility for the health of their neighbours and communities. To achieve this, we want to see innovations that fundamentally change the shape and

1 [http://www.londonhealthcommission.org.uk/wp-content/uploads/London-Health-Commission\\_Better-Health-for-London.pdf](http://www.londonhealthcommission.org.uk/wp-content/uploads/London-Health-Commission_Better-Health-for-London.pdf)

2 <http://www.england.nhs.uk/ourwork/futurenhs/>



The Healthy Schools programme includes the 'Seed to Plate' project, encouraging school children to grow their own food

scope of health and caring services and meet local needs in new ways within a tighter financial framework. However, translating innovative models into practical delivery of care on the ground is fraught with challenge and requires a transformation in the way we listen, engage and communicate with residents. Social media can play a huge role in realising this opportunity and we need to fully realise the benefits that it can bring.

This year my annual report explores five areas where there is a case for change, highlights the issues and challenges, and considers some change opportunities where partnership between residents, funders and care givers can evolve new models that improve health and wellbeing, deliver the public health agenda and ensure appropriate access to and uptake of high quality health and social care. The report gives a professional perspective based on sound epidemiological evidence and objective interpretation taken from our Joint Strategic Needs Assessment and

other published data. My aim is not to make recommendations but to pose questions for the reader to investigate and find solutions.

## Chapter 1

Chapter 1 examines the evidence and analysis on how we have funded interventions using the Public Health Grant to improve population health outcomes. The National Audit Office has recently reviewed the early evidence about the funding of the new public health arrangements and the work of Public Health England. They conclude that, while it is too early to say whether the new arrangements will lead to improvements in outcomes, there is increased transparency of public health spending and improved understanding of the services provided in each locality, while further work is needed to align resources with need<sup>3</sup>. Within this context I consider both how we have spent the Public Health Grant in Barking and Dagenham and what return we got for our money.

## Chapter 2

In Chapter 2 I build on last year's report that explored the opportunities presented by *Transforming Primary Care in London: General Practice – A Call to Action*<sup>4</sup>. In looking at new models of delivery that contain cost and manage demand on the health and social care system, the role of early detection of disease is critical. *The NHS Five Year Forward View* promises a radical upgrade in prevention and public health that acts to address the rising burden of avoidable illnesses that are the consequence of lifestyles and behaviours. Locally we know that almost one in four adults smoke, one in six drink enough alcohol to risk damaging their health, two in three are overweight or obese and one in three men and one in two women are not getting enough exercise. The transformation question for us to consider is: "Can we deliver proactive primary care on a scale that halts or slows the progress of conditions or diseases in their earliest stages?"

3 <http://www.nao.org.uk/wp-content/uploads/2014/12/Public-health-england%E2%80%99s-grant-to-local-authorities.pdf>

4 <http://www.england.nhs.uk/london/wp-content/uploads/sites/8/2013/12/london-call-to-action.pdf>



New housing in Dagenham that reflects the needs of older people



Older People's Week – a range of signposting, including this 'Get Walking' booklet

### Chapter 3

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Chapter 3 examines what prevention means in the context of the Care Act 2014 and the Children and Families Act 2014 and how we can both transform care for our most vulnerable residents and deliver the necessary services on tightening budgets. This will depend on influencing both social and environmental issues, as well as health and social care services, and the continued commitment of residents, councillors, and officers is essential in making this happen.

For the new prevention agenda to deliver we need to grow and strengthen our communities, building on the energy and compassion that exists within them. The proposals in the *NHS Five Year Forward View* outlining better support for carers, creating new options for health-related volunteering, and designing easier ways for voluntary organisations to work alongside the NHS mirror the Council's vision and the responsibilities that result from the new legislation.

### Chapter 4

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Chapter 4 examines my concerns about sexual health in the borough through the lens of technology and internet services for sexual healthcare. The emergence of the self care market opens our minds to what we can and should be doing for ourselves; increasing our own confidence and skills to self-manage our own and our family's wellbeing. In five years time we can expect that a new civic culture will recalibrate our perspective on how we live supported by affordable public services that both enhance the quality of our lives and improve our neighbourhoods.

### Chapter 5

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In the final chapter, I revisit my great concern that for too many of our residents their lifestyle choices are adversely affecting their health and wellbeing. This year I focus on the harms from drinking alcohol. A lot of good work is already happening and

the Community Safety Partnership has agreed an outstanding strategy which now needs to be translated into effectively executed delivery.

I hope you enjoy reading this report as well as finding it of interest and value.

**Matthew Cole**

**Director of Public Health**



# Investing in Public Health

## **Barking and Dagenham**

is investing in supporting people to improve their health and wellbeing

Health Roadshow 2014 – a 'have a go' healthy food workshop for children and parents, run by the Adult College Barking and Dagenham - <http://adultcollege.lbbd.gov.uk/>



## Investing in Public Health – value for money from public health interventions

Responsibility for promoting and protecting the public's health was returned to local authorities as part of the changes included in the Health and Social Care Act 2012<sup>5</sup>, thus reinstating many of the responsibilities that local government had held until 1974. These changes recognised the perspective and opportunities for local government in respect of their:

- Population focus as democratically accountable stewards of their local population's wellbeing
- Ability to shape services to meet local needs, including the environment within which people live, work and play, the housing they live in, the green spaces around them, and their opportunities for work and leisure, which are all critical to health and wellbeing
- Ability to influence the wider social determinants of health; the conditions in which people are born, grow, live, work and age
- Ability to tackle health inequalities, taking strategic actions to prevent inequalities across a number of functions such as housing, economic and environmental regeneration, strategic planning, education, children and young people's services, fire and road safety<sup>6</sup>.

The local authority responsibility to promote the health of the their



Investing in '16 Days of Activism'; raising awareness of the impact of domestic violence on individuals, families, communities and services. Supporters included Councillor Maureen Worby, Cabinet Member for Adult Social Care and Health, and Chair of the borough's Health and Wellbeing Board.

population is expected to be delivered through translation of local knowledge and experience about local needs, set out in the Joint Health and Wellbeing Strategy<sup>7</sup>, into policies and services that improve population health and wellbeing, resulting in measurable improvement in outcomes as demonstrated in the Public Health Outcomes Framework<sup>8</sup>. A small number of services were mandated – sexual health services (sexually transmitted infections and contraception), NHS Health Check Programme, National Child Measurement Programme, providing public health advice to NHS commissioners and ensuring plans

are in place to protect the health of the public. The Healthy Child Programme for children aged 0-5 years will be added to the mandated services from October 2015.

To support local authorities in carrying out their new public health functions, a ring-fenced public health grant is allocated by the Department of Health. The amount of the grant is based on the estimated spend on public health by primary care trusts prior to the transfer of responsibilities. The estimated spend per head varied widely across the country, with the average for England at £47, and the range from £18 to £186. Barking and Dagenham

5 <http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted>

6 [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/216709/dh\\_131898.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216709/dh_131898.pdf)

7 <http://www.barkinganddagenhamjsna.org.uk/Pages/jsnashome.aspx>

8 <http://www.phoutcomes.info/>



Engaging with older people at Harmony House

was reasonably well placed with an inherited spend per head of £60, which was increased to £66 per head in the actual 2013/14 allocation and £71 per head in 2014/15. Nevertheless the borough is still below the calculated target and well short of the grant level in some other London Boroughs such as Tower Hamlets and Islington. Over time there is an intention to move to a needs based grant taking account of factors that influence need such as deaths under the age of 75, population age distribution and unavoidable cost differences in delivering services.

The ring fenced grant for the London Borough of Barking and Dagenham in 2013/14, was £12.921m, rising to £14.213m for 2014/15 and 2015/16. Monitoring of spend is undertaken by the Department for Communities and Local Government and by Public Health England on behalf of the Department of Health, and the Council's Chief Executive (or Section 151 Officer) and the Director of Public Health are required to return a statement confirming that the grant has been used in line with the conditions set<sup>9</sup>.

The National Audit Office has recently reviewed the early evidence about the funding of the new public health

arrangements and the work of Public Health England. They conclude that, while it is too early to say whether the new arrangements will lead to improvements in outcomes, there is increased transparency of public health spending and improved understanding of the services provided in each locality, while further work is needed to align resources with need<sup>10</sup>.

## The Public Health Grant in Barking and Dagenham – how has it been spent?

At the time of writing we are coming to the close of the second year of the Council's responsibilities for Public Health and therefore detailed data on spend is only available for the first year (2013/14), with budget estimates for the second year (2014/15). In the first year the Council inherited many of the programmes and contracts put in place by the former Barking and Dagenham NHS Primary Care Trust and therefore had limited opportunity for change. Nevertheless, the integration of public health functions within the totality of the Council's responsibilities has enabled

us to strengthen the Council's role and purchasing power for services such as those aimed at children and young people and services to promote and enable increasing physical activity amongst children and adults.

The Government requires expenditure returns based on defined categories of public health spend, and these enable comparison across geographies between the proportion of the budget spent on various categories. In 2013/14 94% of the budget was spent, with the remainder carried forward and added to the 2014/15 budget. Figure 1 shows the distribution of spend between programme areas for Barking and Dagenham compared with London as a whole. It shows that Barking and Dagenham spends a greater proportion of the Grant on Children aged 5-19 years and on Physical Activity and less on Sexual Health Services than the London average, reflecting the high proportion of children in the borough and our concerns about the low levels of physical activity amongst children and adults.

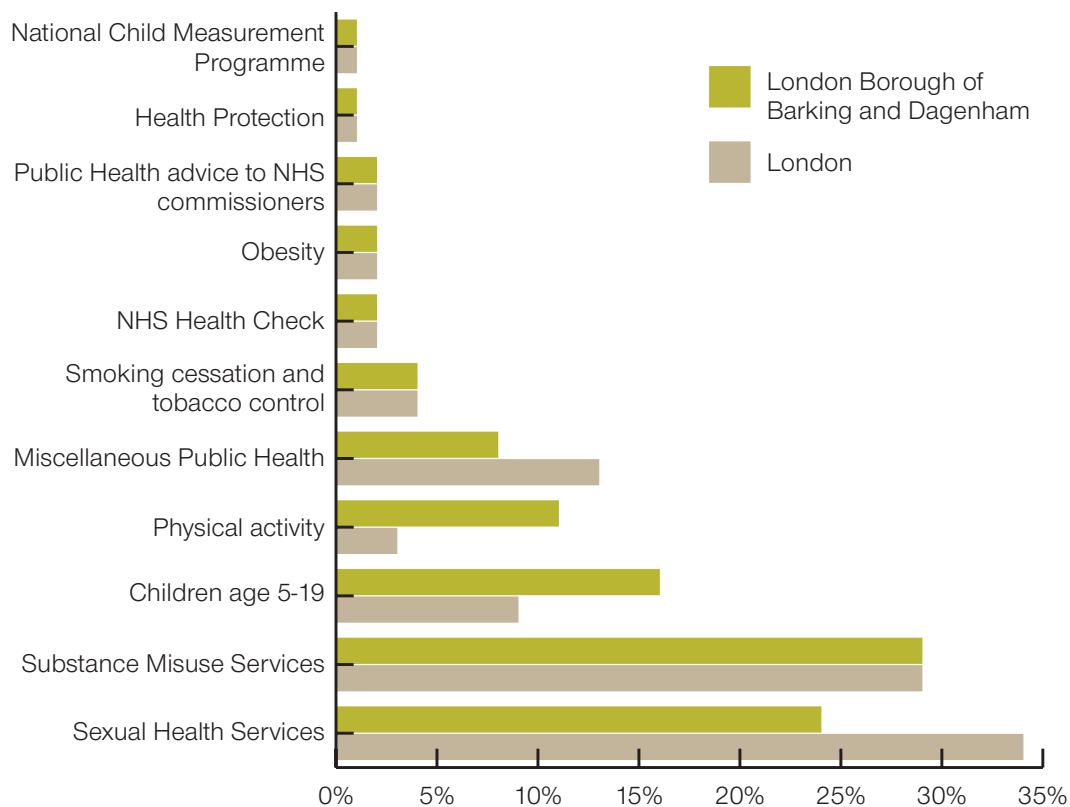
9 [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/388172/final\\_PH\\_grant\\_determination\\_and\\_conditions\\_2015\\_16.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/388172/final_PH_grant_determination_and_conditions_2015_16.pdf)  
 10 <http://www.nao.org.uk/wp-content/uploads/2014/12/Public-health-england%E2%80%99s-grant-to-local-authorities.pdf>



Inclusive cycling with Cycle4All (c) Cycle4All www.cycle4all.com

Figure 1:

**Distribution of spend by programme areas, % of Public Health Grant,  
London Borough of Barking and Dagenham and London, 2013/14**



Source: <https://www.gov.uk/government/statistics/local-authority-revenue-expenditure-and-financing-england-2013-to-2014-individual-local-authority-data-outturn>

## The Public Health Grant in Barking and Dagenham – what do we get for our money?

The Public Health Grant (PHG) funds a wide range of services as well as the technical expertise for analysis of health and wellbeing needs and evaluation of the evidence to maximise the impact of what we commission. Figure 2 gives a general description of the service areas that are resourced through the PHG and details some of the programmes commissioned to meet local needs.

Figure 2:

### Public Health Programmes resourced through the Public Health Grant (mandated programmes in bold)

Programme name	Summary of programme
<b>Sexual Health Services</b>	Mandated requirement to commission open access sexual health services for everyone present in the area, covering free sexually transmitted infections testing and treatment, notification of sexual partners of infected persons, free contraception and reasonable access to all methods of contraception
Substance Misuse Services	Prevention and treatment programmes for children, young people and adults who misuse drugs and alcohol or are affected by the misuse by others
Children's services for age 5-19	School health assessments, promotion of health and wellbeing, immunisation programme for school age children, safeguarding
Physical activity	Enabling and encouraging children and adults to increase their levels of physical activity
Obesity	Promoting healthy eating and commissioning weight management services
Smoking Cessation and Tobacco Control	Smoking cessation services, tobacco control initiative and work to prevent people taking up smoking
<b>NHS Health Check</b>	Programme to invite all adults aged 40-74 years without pre-existing conditions to check circulatory and vascular health and risk of certain diseases
<b>Public Health Advice to NHS Commissioners</b>	Mandated support to NHS Barking and Dagenham Clinical Commissioning Group to provide specialist public health expertise and advice to support them in delivering their objectives to improve the health of their population
<b>Health Protection</b>	Ensure plans are in place to protect the health of the population and respond to health incidents and emergencies
<b>National Child Measurement Programme</b>	Measure the weight and height of children in reception class (aged 4 to 5 years) and year 6 (aged 10 to 11 years) to assess overweight and obese levels for children within primary schools.

## The Public Health Grant in Barking and Dagenham – is our spending in line with our priorities?

While we are required by Government to provide detailed information about how we spend our PHG by defined programme areas, we also need to know whether we are directing our resources at the things that we have agreed locally through our Health and Wellbeing Board to be our priorities. Our commissioning priorities were agreed in November 2013 and are detailed in Figure 3.

Figure 3:  
**Public Health Commissioning Priorities 2014/15**

Commissioning Priority	Areas to address	Examples of investment	Budgeted spend % of Public Health Grant 2014/15
<b>Transformation of Health and Social Care</b>	Early disease identification; Prevention including immunisation, breast feeding, dementia; Reducing the impact of isolation and other support for vulnerable people; Effective care for chronic conditions and end of life	Contribution to the Better Care Fund, including support to Active Age Centres, Leisure offer for people aged 60 years and over, Tenancy Support Scheme and Winter Warmth Programme	7%
<b>Improving premature mortality</b>	Cancer prevention and early diagnosis; Smoking cessation	Smoking cessation services, Pulmonary Rehabilitation Programme, Health Promotion Campaigns	6%
<b>Tackling obesity and increasing physical activity</b>	Promotion of breast feeding, healthy child nutrition and physical activity programmes for children; Effective treatment pathways and weight management programmes; Availability and uptake of sports and physical activity programmes	Weight management and activity programmes for children and adults	11%
<b>Improving sexual and reproductive health</b>	Halting the spread of sexually transmitted infections and reducing teenage pregnancies; Improving access to services that are non-judgemental and widely promoted; Increasing the focus on prevention and knowledge to reduce the risk of infection and unintended pregnancy	Clinic and support services to diagnose, prevent and treat sexually transmitted diseases, contraceptive services, prevention of unintended pregnancy and HIV infection	22%
<b>Improving child health and early years</b>	Safe transfer of effective health visiting services to Council responsibility; Increasing school nursing services; Caring for Looked After Children; Provision of alcohol advice where needed for children and young people; Increasing support to vulnerable families	Early Years Prevention Programme, Breast Feeding and Early Years Nutrition, Healthy Child Programme	14%

<b>Commissioning Priority</b>	<b>Areas to address</b>	<b>Examples of investment</b>	<b>Budgeted spend % of Public Health Grant 2014/15</b>
<b>Improving community safety</b>	Working with young people to reduce young offenders re-offending rates; Addressing sexual exploitation and domestic and sexual violence	Domestic Violence Programme	3%
<b>Alcohol and substance misuse</b>	Early identification and brief intervention to reduce alcohol misuse; Increasing access to community detoxification; Availability of high strength lagers and beers; Reducing alcohol related crime through preventive policing of alcohol hotspots; Continuing to deliver successful drug treatment services	Drug and alcohol prevention and treatment services	19%
<b>Improving mental health</b>	Develop a mental wellbeing strategy to address the economic and social determinants of poor mental health, prevention and accessible support and treatment; Improve access to psychological therapies and school based programmes	Mental Health and Wellbeing Services for children and adults	1%
<b>Reducing injuries and accidents</b>	Safety measures to support safe walking and cycling; Reducing falls and accidents among older people	Accident Prevention Programme	<1%
<b>Mandated public health programmes and wider Council priorities</b>	Health protection; Public health advice to NHS commissioners; Mandated Public Health Programmes	Emergency Planning, National Child Measurement Programme, NHS Health Check	5%
<b>Staff and corporate costs</b>	Public Health staff team and corporate support	Public Health qualified staff, public health commissioning	12%

**Note:** For the purposes of the Government return detailing spend by Public Health Programme area, staff and corporate costs are distributed across programme areas depending on staff resource needed to support delivery of the programme. The proportion of spend on each programme will therefore vary from that shown in this table, where staff and corporate costs are shown separately.

## Investing to make a difference – the evidence base

There is a substantial body of research on where to intervene to address the social determinants of health and consequent health inequalities, and the transfer of public health functions to local authorities has stimulated the publication of useful reports gathering together information about effective interventions, such as *Improving the Public's Health* published by The King's Fund<sup>11</sup>. In addition, the National Institute of Health and Care Excellence (NICE) publish both economic analysis and cost effectiveness tools which enable councils to calculate the return on investment for a number of public health interventions. NICE analysed 200 cost-effectiveness estimates of various interventions that informed public health guidance they published between 2006 and 2010 and found that 15% were costs saving and 70% were good value for money, as determined by the cost per QALY<sup>12</sup> being less than £20,000, the level which NICE apply to treatments deemed to be cost effective<sup>13</sup>. The most extensively studied interventions are those that support smoking cessation, with brief advice programmes using self-help material and nicotine replacement therapy being cost saving, and a wide range of programmes that identify smokers as people at risk of dying prematurely and offering advice and



The 2014 Healthy Schools awards event

incentives are highly cost-effective. Other cost effective interventions include information about exercise and exercise on prescription to increase levels of physical activity amongst adults and brief advice to prevent harmful levels of alcohol consumption, especially when given by the GP when new patients are registered or during a consultation.

Value for money depends on knowing where to direct attention, investing in the right interventions and delivering

those interventions effectively. The commissioning priorities agreed by the Health and Wellbeing Board identify those areas where action is agreed to be needed and where the majority of the Public Health Grant resource is invested.

11 <http://www.kingsfund.org.uk/publications/improving-publics-health>

12 QALY or Quality-adjusted Life Year is a measure of the state of health of a person or group in which the benefits, in terms of length of life, are adjusted to reflect the quality of life. One QALY is equal to 1 year of life in perfect health. QALYs are calculated by estimating the years of life remaining for a patient following a particular treatment or intervention and weighting each year with a quality of life score (on a zero to 1 scale). It is often measured in terms of the person's ability to perform the activities of daily life, freedom from pain and mental disturbance. <https://www.nice.org.uk/glossary?letter=q>

13 <http://jpubhealth.oxfordjournals.org/content/early/2011/09/20/pubmed.fdr075.full.pdf+html>



Walk4Days volunteers

## Public Health Outcomes Framework – measuring health and wellbeing

The Public Health Outcomes Framework (PHOF) sets out the key measures which demonstrate the health status of local people, and how our population compares with other parts of London and England. There are over 60 indicators, many of which are broken down into sub-indicators based on age or gender, and they demonstrate the many and varied influences on people's health, and the extent to which health is affected by a wide range of actions and policies implemented by the Council and by NHS Barking and Dagenham Clinical Commissioning Group. While the Public Health Grant can contribute resources, the impact of spending plans and reductions on people's health needs to be considered across the totality of Council and NHS spend. The responsibility to protect health and prevent and treat disease ranges from ensuring that the air we breathe is monitored for pollution, our parks and leisure services are safe and welcoming and places that people want to visit, that people have the information they need to be healthy and to know when they have a health problem that

needs investigating, to rapid access and effective treatment for those who are ill, and compassionate care in a place of their choosing for those who are dying.

There are two overarching indicators included in the PHOF; firstly to increase healthy life expectancy and secondly to reduce differences in life expectancy and healthy life expectancy between communities. Healthy life expectancy is a measure that summarises both morbidity and mortality, reflecting as it does both the extent to which people report that they are in good health as well as the age at which people die. In Barking and Dagenham Healthy Life Expectancy is 59.4 years for men and 57.3 years for women. These figures are significantly below those for London (63.2 years for men, 63.6 years for women), which are similar to those for England (63.4 years for men, 64.1 years for women). Of particular note is that for women in Barking and Dagenham Healthy Life Expectancy is two years less than it is for men, even though life expectancy is longer for women than for men (82 years for women, 77.6 years for men), meaning that women can expect to live for more years in poor health than men. Tower Hamlets is the only other London borough where all the measures of Healthy Life Expectancy and Life

Expectancy are significantly worse than the England average, and both Barking and Dagenham and Tower Hamlets experience life expectancy levels that are much more similar to those in the north of England than the south.

The contributing factors that result in our lower life expectancy levels can be identified through indicators that set out our position on the wider determinants of health, such as children in poverty and people who are homeless, health improvement indicators such as excess weight in children, percentage of adults that are physically inactive, and smoking prevalence, health protection indicators such as low uptake of some immunisations and high levels of late diagnosis of HIV infection, and healthcare and premature mortality indicators such as the mortality rates from conditions considered to be preventable. The detailed data, including trend data, is published on the Public Health England Outcomes Framework website and updated quarterly with new data as it is published<sup>14</sup>. While trend data is limited for some of our most important indicators, Figure 4 highlights a selection of indicators where trends suggest greater effort is needed to achieve improvement in local people's health.

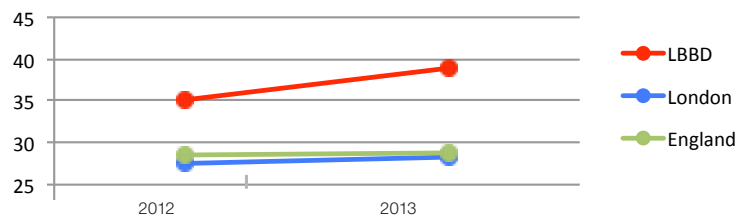
<sup>14</sup> <http://www.phoutcomes.info/>



Figure 4:

**Public Health Outcomes Framework – selected indicators where action is needed to address adverse trends**

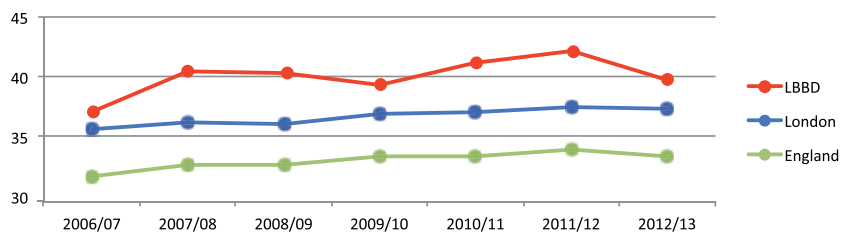
**Percentage of inactive adults**



Period	Sig	LBBB	London	England
2012	●	35.1	27.5	28.5
2013	●	38.8	28.4	28.9

Proportion %

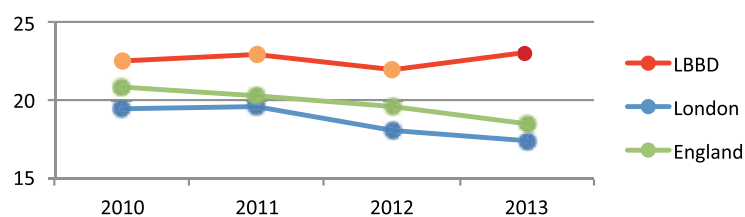
**Excess weight in 10-11 year olds**



Period	Sig	LBBB	London	England
2006/07	●	37.1	35.6	31.7
2007/08	●	40.5	36.2	32.6
2008/09	●	40.3	36	32.6
2009/10	●	39.3	36.9	33.4
2010/11	●	41.2	37	33.4
2011/12	●	42.2	37.5	33.9
2012/13	●	39.8	37.4	33.3

Proportion %

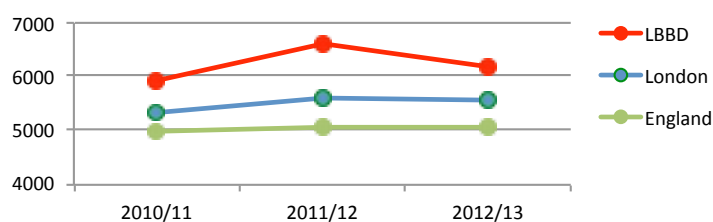
**Smoking prevalence**



Period	Sig	LBBB	London	England
2010	●	22.5	19.4	20.8
2011	●	22.9	19.5	20.2
2012	●	21.9	18	19.5
2013	●	23.1	17.3	18.4

Proportion %

**Injuries due to falls in people aged 80 and over**



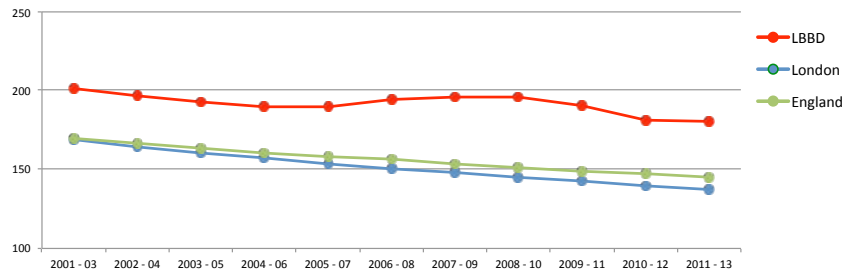
Period	Sig	LBBB	London	England
2010/11	●	5,909	5,297	4,953
2011/12	●	6,595	5,596	5,034
2012/13	●	6,188	5,528	5,015

Directly standardised rate per 100,000

Figure 4 continued:

**Public Health Outcomes Framework – selected indicators where action is needed to address adverse trends**

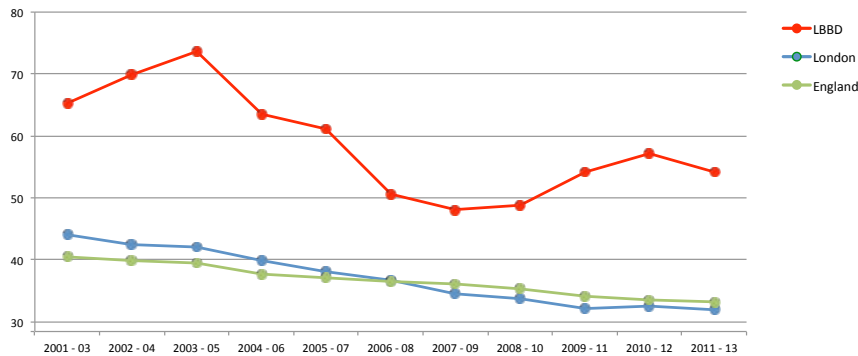
**Under 75 mortality rate from cancer (persons)**



Period	Sig	LBB	London	England
2001 - 03	●	200.9	168.3	169.4
2002 - 04	●	196.7	164	166.2
2003 - 05	●	192.6	159.6	162.7
2004 - 06	●	189.4	156.6	160
2005 - 07	●	189.5	152.7	157.8
2006 - 08	●	193.9	149.5	155.7
2007 - 09	●	195.6	147.1	153.2
2008 - 10	●	195.7	144	150.6
2009 - 11	●	189.8	142.2	148.5
2010 - 12	●	180.5	139.1	146.5
2011 - 13	●	179.7	136.5	144.4

Directly standardised rate per 100,000

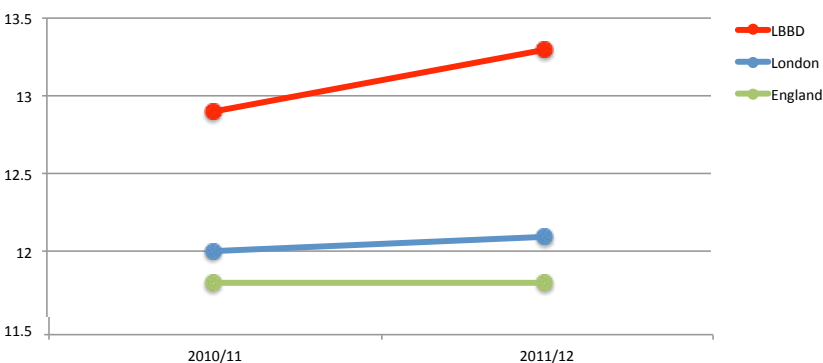
**Under 75 mortality rate from respiratory disease (persons)**



Period	Sig	LBB	London	England
2001 - 03	●	65.3	44	40.5
2002 - 04	●	69.8	42.4	39.8
2003 - 05	●	73.6	42	39.4
2004 - 06	●	63.5	39.8	37.6
2005 - 07	●	61.1	38	37.1
2006 - 08	●	50.5	36.6	36.5
2007 - 09	●	48.1	34.6	36
2008 - 10	●	48.9	33.7	35.3
2009 - 11	●	54.1	32.1	34.2
2010 - 12	●	57.2	32.6	33.5
2011 - 13	●	54.1	31.9	33.2

Directly standardised rate per 100,000

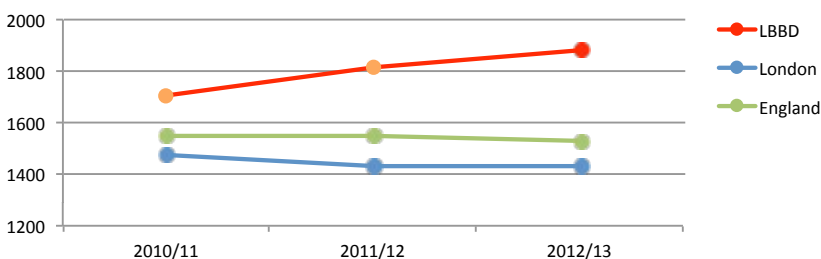
**Emergency readmissions within 30 days of discharge from hospital (persons)**



Period	Sig	LBB	London	England
2010/11	●	12.9	12	11.8
2011/12	●	13.3	12.1	11.8

Indirectly standardised proportion %

**Hip fractures in people aged 80 and over**



Period	Sig	LBB	London	England
2010/11	●	1,705	1,474	1,551
2011/12	●	1,812	1,430	1,545
2012/13	●	1,884	1,430	1,528

Directly standardised rate per 100,000

## Moving forward – local and national policies

Improving people's health does not happen in a vacuum, and the Public Health Grant is a tiny proportion of the resource that influences people's health, albeit one which we can use specifically to address issues of concern, and stimulate, pilot or pump prime initiatives which, if they are effective, will be mainstreamed in future. In order to be most effective we need to influence and work with local and national policies to maximise the positive and minimise the negative impacts on people's health.

### One borough; one community; London's growth opportunity

The vision that the Council has for the borough is summarised as: One borough; one community; London's growth opportunity. This recognises that over the next twenty years the borough will undergo its biggest transformation since it was first industrialised and urbanised, with regeneration and renewal creating investment, jobs and housing.

The borough's corporate priorities that support the vision are:

#### Encouraging civic pride

- Build pride, respect and cohesion across our borough
- Promote a welcoming, safe, and resilient community
- Build civic responsibility and help residents shape their quality of life
- Promote and protect our green and public open spaces
- Narrow the gap in attainment and

realise high aspirations for every child

#### Enabling social responsibility

- Support residents to take responsibility for themselves, their homes and their community
- Protect the most vulnerable, keeping adults and children healthy and safe
- Ensure everyone can access good quality healthcare when they need it
- Ensure children and young people are well-educated and realise their potential
- Fully integrate services for vulnerable children, young people and families

#### Growing the borough

- Build high quality homes and a sustainable community
- Develop a local, skilled workforce and improve employment opportunities
- Support investment in housing, leisure, the creative industries and public spaces to enhance our environment
- Work with London partners to deliver homes and jobs across our growth hubs
- Enhance the borough's image to attract investment and business growth

There is a strong relationship between many of these priorities and the measures of health and improvement included in the PHOF, either directly or indirectly, and focusing and delivering on these priorities will make a real contribution to the health and wellbeing of people in the borough.

## NHS Barking and Dagenham Clinical Commissioning Group

Our local Clinical Commissioning Group (CCG) commissions prevention, care and treatment services for local people. Member practices also provide primary care services and the CCG are developing a new way of working that will bring GP practices together in groups, based on where they are located. This means they will be able to provide more joined up, or 'integrated', care along with social services to make more of a difference to local people.

To deliver the strategic objectives and vision developed in their Commissioning Strategic Plan, the following areas have been prioritised for action:

### 1. Properly design, contract and manage (commission) safe, sustainable, high quality services for the local population

Improving quality and ensuring the safety of acute hospital services, primary care, community services, mental health and specialist services is of the highest priority.

### 2. Working together to integrate care

Improvements in joining up health care services across general practice, community services and hospitals, result in a better experience, improved results and better value for money for our residents.

### 3. Redesign urgent and emergency care services

Ensuring patients and the public have access to convenient, high quality,

timely and cost effective urgent and emergency care services and patients know where to get help at the right place and at the right time.

#### 4. Staying healthy

Taking action to reduce the need for healthcare and to improve the health of the local population.

#### 5. Increasing productivity

Increase productivity; understand that high quality services are also productive services; and know that productivity measures can improve results and patient experiences<sup>15</sup>.

## The London Health Commission

*Better Health for London*<sup>16</sup>, the report of the London Health Commission, an independent inquiry established by the Mayor of London and chaired by Professor the Lord Darzi of Denham, drew on the views of many Londoners to propose the biggest public health drive in the world. The report makes 64 recommendations which are intended to support the Commission's aspirations for London:

- Give all London's children a healthy, happy start to life
- Get London fitter with better food, more exercise and healthier living
- Make work a healthy place to be in London
- Help Londoners to kick unhealthy habits
- Care for the most mentally ill in London so they live longer, healthier lives
- Enable Londoners to do more to look after themselves
- Ensure that every Londoner is able to see a GP when they need to and at a time that suits them

- Create the best health and care services of any world city, throughout London and on every day
- Fully engage and involve Londoners in the future health of their city
- Put London at the centre of the global revolution in digital health

The recommendations set out actions for all levels of administration, and to be effective we need borough, London and national actions to be aligned. This may mean putting pressure up the system to take actions that support our local strategies, and to keep engaged with actions taken at London and national levels to ensure the best local impact.

## The NHS Five Year Forward View

The *NHS 5 Year Forward View*<sup>17</sup> was published in October 2014 by NHS England, promising a radical upgrade in prevention and public health, greater control for patients and new support for carers, breaking down of the barriers in how care is provided and radical new care delivery options. It reminds us of the need to act to address the rising burden of avoidable illnesses which are the consequence of the lifestyles and behaviours of people across England, with one in five adults smoking, one in three drinking too much alcohol, two in three being overweight or obese and one in three men and one in two women not getting enough exercise.

The *Forward View* commits the health service to supporting the public health priorities and working to deliver them both nationally and locally. Proactive primary care is recognised as central to secondary prevention – actions to halt or slow the progress of conditions or diseases in their earliest stages. More broadly, the *Forward View*

demonstrates the contribution of the NHS as a partner to support people to get and stay in employment, to empower patients to manage their own health, and to engage communities in their role as carers and volunteers. A range of examples of new models of care including urgent care networks and better care at home are intended to benefit patients through more flexible care and reduce the need for hospital care.

The factors that are seen as most important in keeping people well at home or in employment are widely recognised by partners across the system:

- Self-management – to stay healthy and to manage disease
- Information for early diagnosis – so people check out symptoms sooner and health professionals identify disease promptly
- Social connectedness – strong communities supporting people and reducing isolation
- Children getting a good start in life – to lay the foundations for a healthy and fulfilling life
- Information on prevention and support to change lifestyle behaviours – stopping smoking, reducing alcohol consumption, eating healthily and being physically active

The *NHS England Five Year Forward View* and the CCG strategy demonstrate that the priorities for people's health and wellbeing are very similar regardless of whether you come from the NHS perspective or the Council perspective. We need to take advantage of these shared values and aspirations to work together for local people.

15 <http://www.barkingdagenhamccg.nhs.uk/About-us/Our-plans/strategy-csp.htm>

16 [http://www.londonhealthcommission.org.uk/wp-content/uploads/London-Health-Commission\\_Better-Health-for-London.pdf](http://www.londonhealthcommission.org.uk/wp-content/uploads/London-Health-Commission_Better-Health-for-London.pdf)

17 <http://www.england.nhs.uk/ourwork/futurehhs/>



Regular outreach and events to help people make a change



The 2014 World Mental Health Day event

## Moving Forward – Investing to improve health in Barking and Dagenham

As we move into the third year since the Council regained responsibility for Public Health, and what may be the final year that the Public Health Grant is ring-fenced to defined public health investment, it is timely to remember that Public Health is not just an isolated issue, with only specific spending from the Public Health Grant being used to improve people's health.

Public health is about supporting people to stay healthy, and protecting them from threats to their health. While helping people to make healthier choices is an important part of public health, it is not the whole, nor is it just about what people as individuals do. There is a health impact of all policies – economic decisions result in people becoming wealthier or poorer, planning decisions may make it easier for people to be active or for them to access green spaces or even hospitals, but may also blight the lives of people whose community is split by a new road or

whose lives are affected by noise or air pollution. Health in all policies<sup>18</sup> is not just a catch phrase but needs to be recognised as the reality, both by those of us who are public health specialists and those with whom we work. Our role in the Council gives us the opportunity to work from within to articulate how the policies and actions taken by the Council impact on health and to demonstrate to the Council the leadership role that it carries, not just through the Director of Public Health, but through the Leader, every Councillor, and every Officer.

As the Public Health function becomes more fully integrated into the Council, we need both to focus the Public Health Grant to get the most impact, and strengthen the recognition across the wider Council of the impact on people's health of the totality of the Council's spend. Public health is everyone's responsibility and relies on everyone's contribution, it is not just the responsibility of public health specialists nor is it addressed simply through the Public Health Grant. In recognising this and working together, both within the Council and with our partners, we create the momentum to realise potential through an increased sense of

personal and social responsibility, the establishment of a thriving community and economy and the implementation of new models of delivery that are fit for the 21st Century environment and realise the health and wellbeing outcomes that we seek.

18 [http://en.wikipedia.org/wiki/Health\\_in\\_All\\_Policies](http://en.wikipedia.org/wiki/Health_in_All_Policies)



# Diagnosing early and managing well

Outreach sessions around the borough, like this Hearty Lives event, help raise awareness and signpost residents to a range of health interventions

'Prevention is better than cure' is a saying that most of us will have heard from our earliest years, and remains true in almost all circumstances. While modern medicine can reduce the impact and improve the outcome of many diseases and conditions, not developing the condition is surely preferable. Nevertheless, even an active life with a good diet eaten in moderation, and not smoking, can only reduce risk of disease and not eliminate our chances of developing conditions which will reduce the years of life that we live in good health.

If we develop a disease, diagnosing the condition early in its course will generally enable us to get advice and treatment which will either reduce its impact or enable us to plan for the future. Some conditions have few symptoms, but if diagnosed early and managed well can have less serious outcomes than if left undiagnosed. High blood pressure is a good example of where treatment can prevent much more serious circulatory diseases. Cancer detected at an early stage can result in less invasive treatment and a much greater chance of cure. Detecting diseases earlier or case-finding of conditions that, if left untreated, will lead to much more serious diseases,



Hearty Lives outreach – heart healthy cookies

may avoid the consequences of poorer quality of life, early death, and substantial costs to the health and social care system and the wider economy.

Early diagnosis depends firstly on the individual; taking up opportunities offered for early diagnosis, such as cancer screening, taking advantage of access to good information about signs and symptoms that should be discussed with a health professional, and actually accessing advice and diagnostic tests. Secondly the systems for early diagnosis have to be accessible and effective; appointments easy to make and change, symptoms recognised and appropriate testing undertaken, results interpreted accurately and further care provided in a timely and acceptable way.

For the individual, knowledge is power,

and encouraging and supporting people to access the huge range of high quality information available through the internet helps people to take control. In Britain 83% of households have access to the internet with 73% of adults accessing the internet every day and 72% of adults buying goods or services online<sup>19</sup>. As people become better able to access information about prevention, symptoms and treatments which was formerly only available to professionals we need to find ways of using this access to stimulate the behaviour changes that would address the shortfall in demand from individuals for screening and early diagnosis and their demand for effective treatment with no unnecessary variation in care or outcomes.

19 <http://www.ons.gov.uk/ons/rel/rdit2/internet-access--households-and-individuals/2013/stb-ia-2013.html>

## Cancer screening uptake in Barking and Dagenham

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Cancer screening programmes are provided for cervical cancer (for women aged 25-64 years), breast cancer (for women aged 50-70 years, and being extended to 47-73 years) and lower bowel cancer (for men and women aged 60-69 years and being extended to age 75 years). These programmes were established because there is good evidence that screening can detect cancer earlier than without screening, and because treatment at an early stage is more effective than at late stages when symptoms are more evident.

### Cervical cancer screening

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Screening for cervical cancer involves taking a sample of cells from the cervix. The cells obtained are looked at under the microscope for abnormalities which may develop into cancer. Women are invited when they reach 25 years, then every 3 years until the age of 49 years, and every 5 years until the age of 64 years. Cervical cancer screening was first introduced in the late 1980's, when a threefold increase in deaths from cervical cancer had been seen over the previous 20 years, and it is estimated that if that increase had continued there would now be about 4,500 deaths each year which are avoided through the screening programme<sup>20</sup>.

The incidence of cervical cancer in the UK has almost halved since the introduction of the screening programme in the late 1980's, but there are still around 2,700 cases of invasive cancer per year. Not enough women in Barking and Dagenham take advantage of the opportunity to have cervical cancer screening. At 31 March 2014, 72.4% of eligible women had been screened within the appropriate time period. In comparison, 77.8% of women in Havering had been screened<sup>21</sup>. Although screening levels in Barking and Dagenham are above those for London as a whole (70.3%), they are significantly below the level for England (74.2%). On average 3 women a year in Barking and Dagenham die from cervical cancer, (incidence of cervical cancer 7.8 per 100,000 female population) while in Havering on average one woman a year dies from this disease (incidence of cervical cancer 5.3 per 100,000 female population)<sup>22</sup>.

Data for England shows that the lowest uptake for cervical screening is amongst women aged 25-29 (63%), while this age group also has the highest percentage of high grade abnormalities found in the samples (3.34%), twice the incidence of abnormalities in samples from women aged 30-34 years (1.7%), the group with the next highest level of abnormalities<sup>23</sup>. Although in the longer term the introduction of HPV immunisation for girls aged 12-13 years in 2008 will result in a lower incidence of cervical cancer (certain types of Human Papilloma Virus are

associated with an increased risk of cervical cancer), the benefit will not be seen for at least another five years and it remains very important to take up the opportunity for cervical screening when it is first offered at the age of 25 years.

### Breast cancer screening

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Breast cancer is the most common cancer in the UK, comprising 15% of all cancer cases, with nearly 50,000 cases of invasive breast cancer diagnosed in women every year. Breast cancer also occurs in men, but less than 1% of breast cancer cases are men. Around 11,600 women and 75 men die each year from breast cancer, which is 7% of all cancer deaths. The risk of breast cancer is increased when a close family member has been diagnosed with the disease, but eight out of every nine cases occur in women with no family history. Around 9% of cases are linked to obesity, 6% to excess alcohol consumption and 3% to being physically inactive. Around 85% of women with breast cancer survive five or more years, and death rates have fallen by around one-fifth in the last ten years, although breast cancer is remains the second most common cause of cancer death in women after lung cancer<sup>24</sup>.

Breast cancer screening was introduced in England in the late 1980's and means having mammography (an x-ray) of the breasts. It is estimated that breast cancer screening in the UK diagnoses

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20 [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(04\)16674-9/abstract](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(04)16674-9/abstract)

21 <http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000042/pat/6/ati/102/page/3/par/E12000007/are/E09000002>

22 [http://www.ncin.org.uk/cancer\\_information\\_tools/eatlas/pct/atlas.html?select=Eav&indicator=i0](http://www.ncin.org.uk/cancer_information_tools/eatlas/pct/atlas.html?select=Eav&indicator=i0)

23 <http://www.hscic.gov.uk/article/2021/Website-Search?productid=16474&q=cervical+cancer+screening&sort=Relevance&size=10&page=1&area=both#top>

24 <http://www.cancerresearchuk.org/cancer-info/cancerstats/keyfacts/breast-cancer/>



15,500 cancers, of which 4,000 are over-diagnosed (a breast cancer that would not have caused any harm to the individual) and 1,300 lives are saved. Breast cancer screening is one of the best ways of detecting breast cancer at an early stage when treatment is more likely to be effective.

In Barking and Dagenham at 31 March 2014, 71.2% of eligible women had been screened in the previous three years, significantly less than the 75.9% level for England and well below the 79% level achieved by Havering, although above the very poor London level of 68.9%<sup>25</sup>. Nearly 100 new cases of breast cancer are diagnosed every year in Barking and Dagenham women, and around 27 women die each year from the disease<sup>26</sup>. While incidence is significantly lower than the UK average, and mortality rates similar to the UK average, higher levels of screening could increase early diagnosis and reduce the death rate in women under the age of 75 years, which is above the national average<sup>27</sup>.

## Bowel cancer screening

Screening for bowel cancer was first introduced in 2006 and has been fully implemented since 2010. It involves looking for hidden traces of blood in the faeces, using a testing kit that is sent to people at home. Bowel cancer is the third most common cancer in men after prostate and lung cancer, and also in

women after breast and lung cancer. In the UK there are around 41,000 cases and 16,000 deaths every year, and only 55% of people with bowel cancer survive more than five years<sup>28</sup>. Incidence in Barking and Dagenham is similar to the UK average, with around 78 new cases each year (44.9 per 100,000 population) and 33 deaths (15.5 per 100,000 population)<sup>29</sup>.

Bowel screening uptake is generally low, and is particularly low in Barking and Dagenham. Uptake locally was 38.6% in 2012/13 (unpublished data), below the average uptake for North East London of 45.4% and for London of 48%<sup>30</sup>. The highest uptake in England is in Dorset, with 66% of people being screened, but uptake varies widely across the country and there are many parts of the north of England with high uptake. Local uptake is worrying, and

action needs to be taken to improve the rate and reduce the impact of bowel cancer. Research evidence about reasons for not taking up screening demonstrate that many people find the need to collect a sample of faeces to be distasteful and potentially risk spreading infection, and do not like the need to take the sample personally. In addition, people find the sending of kit tests through the post to be something that comes out of the blue and that the detachment of the test from clinical surroundings meant they were less likely to see it as relevant to themselves<sup>31</sup>. With only just over one in three people locally returning the test there is an urgent need to understand barriers locally and particularly for GPs and their teams to discuss the test when they see people in the screening age group.

NHS

Joan Brown, 81, cancer survivor

**1 in 3 women who get breast cancer are over 70, so don't assume you're past it.**

A lump isn't the only sign of breast cancer. If you're worried about any changes to your breasts, tell your doctor straight away. Finding it early makes it more treatable and could save your life.

**BE CLEAR ON CANCER**

nhs.uk/breastcancer70

25 <http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000042/pat/6/ati/102/page/3/par/E12000007/are/E09000002>

26 [http://www.ncin.org.uk/cancer\\_information\\_tools/eatlas/pct/atlas.html?select=Eav&indicator=i0](http://www.ncin.org.uk/cancer_information_tools/eatlas/pct/atlas.html?select=Eav&indicator=i0)

27 <http://www.england.nhs.uk/wp-content/uploads/2014/11/cfv-bark-dagenhm.pdf>

28 <http://www.cancerresearchuk.org/cancer-info/cancerstats/keyfacts/bowel-cancer/>

29 [http://www.ncin.org.uk/cancer\\_information\\_tools/eatlas/pct/atlas.html?select=Eav&indicator=i0](http://www.ncin.org.uk/cancer_information_tools/eatlas/pct/atlas.html?select=Eav&indicator=i0)

30 <http://www.publications.parliament.uk/pa/cm201314/cmhansrd/cm140401/text/140401w0001.htm#1404026000191>

31 <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3974074/>



Be Clear on Cancer national campaigning supported locally

## Early diagnosis of cancer

Only around two in every five cases of cancer are diagnosed at an early stage (stage one or two) before the cancer has spread to other parts of the body. Increasing the number of cases diagnosed early is a high priority for Public Health England and NHS England. In January 2015 NHS England launched an early diagnosis programme to test seven new approaches to identifying cancer more quickly. Public Health England have launched a national 'Be Clear on Cancer' campaign urging people to visit their doctor if they have heartburn most days for 3 weeks or more, as this can be a sign of oesophageal or stomach cancer. We can expect to see further national actions to encourage people to become more aware of symptoms that may be caused by cancer and to act on them by seeing their doctor or taking other advice.

The likelihood of a symptom being due to a cancer and getting the threshold right for which patients need to be referred for further investigation is another issue under the spotlight.

NICE recently consulted on new guidelines about when to refer for suspected cancer<sup>32</sup> and the revised guidelines are due to be published in May 2015. Although these guidelines are designed for health professionals, they will be accessible to the public via the internet, as is another tool that is becoming increasingly used by GPs to consider whether investigation for cancer is appropriate. This tool, QCancer<sup>33</sup>, primarily intended for doctors and nurses, works out the risk of a patient having a current but yet undiagnosed cancer, in a similar way to the much more familiar tool, QRISK<sup>34</sup>, that can work out the risk of having a heart attack or stroke.

Alongside the advances in information technology that aid prediction and earlier diagnosis of cancer, there is an urgent need to increase awareness of the improving effectiveness of treatment, especially with earlier diagnosis. It is estimated that more than 8,000 lives a year could be saved in England if more cancers were diagnosed earlier. The diagnosis of cancer is still one of the most feared diagnoses in people's lives, leading to reluctance to undertake screening or discuss symptoms with a health

professional for fear of a cancer diagnosis, even though late diagnosis is a significant contributor to poor outcomes. Early diagnosis of cancer depends not just on recognition of symptoms but addressing the psychological aspects that concern people, and we need to explore how best we can understand and support local people with their natural anxieties about these diseases.

## Identifying risk factors – NHS Health Check

Taking advantage of screening programmes to detect cancers is one aspect of early diagnosis. What other opportunities can be taken to identify precursor conditions or the early stages of disease? The NHS Health Check is commissioned by the Council and available to people aged 40-74 years, and aims to assess their risk of heart disease, stroke, kidney disease, diabetes and certain types of dementia. The programme is based on inviting people who are not known to be suffering from these diseases for a range of checks, once every five years. The programme is now in its second round; in the first round between

32 <https://www.nice.org.uk/guidance/gid-cgwave0618/resources/suspected-cancer-update-draft-nice-guideline2>

33 <http://www.qcancer.org/>

34 <http://www.qrisk.org/>

Figure 5:

**Risk factors and health outcomes which could be detected and addressed by the NHS Health Check, London Borough of Barking and Dagenham**

Risk Factor or Health Outcome	London Borough of Barking and Dagenham	London	England
Overweight and obese	63.5%	57.3%	63.8%
Physically inactive	38.8%	28.4%	28.9%
Smoking prevalence	23.1%	17.3%	18.4%
Alcohol related admissions to hospital (persons per 100,000)	552	554	637
Estimated proportion of detected hypertension prevalence	58.4%	Not available	54.3%
Diabetes prevalence recorded in Quality and Outcome Framework	7.25%	6.00%	6.21%
Dementia prevalence recorded in Quality and Outcomes Framework	0.37%	0.39%	0.62%
Under 75 mortality rate from cardiovascular diseases considered preventable (persons per 100,000)	64.0	50.2	50.9
Under 75 mortality rate from cancers considered preventable (persons per 100,000)	107	79.6	83.8
Under 75 mortality rate from liver disease considered preventable (persons per 100,000)	18.7	15.7	15.7
Under 75 mortality rate from respiratory disease considered preventable (persons per 100,000)	29.9	17.1	17.9

2009 and 2013 around 23,500 people received a Health Check, out of around 42,000 people who were eligible. In the first year of the new five year period (2013/14 – 2017/18), 45% of those people who were invited for the check received it, meaning that 4,800 people were checked.

Across England, around half of people offered the NHS Health Check take advantage of this simple opportunity to have key checks on their health and advice given about how to address any risk factors. In Barking and Dagenham the proportion of those invited who take up the check is a little lower, at 45%. In a borough ranking 128th out of 150 local authorities for premature mortality and with high levels of risk factors that could be addressed (see Figure 5), advantage is not being taken of an important opportunity to improve health.

Significance levels where available:

Red = worse than England, Yellow = similar to England, Green = better than England

Sources: Public Health Outcomes Framework: <http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000042/pat/6/ati/102/page/0/par/E12000007/are/E09000002>

Except –Estimated proportion of detected hypertension prevalence: <http://fingertips.phe.org.uk/profile/general-practice/data#mod,5,pyr,2014,pat,19,par,E38000004,are,-,sid1,2000010,ind1,727-4,sid2,-,ind2,->

Diabetes and Dementia Prevalence : 2013/14 QOF <http://www.hscic.gov.uk/article/2021/Website-Search?productid=16273&q=Quality+outcomes+framework&sort=Relevance&size=10&page=1&area=both#top>

## Preventing Lung Disease in Barking and Dagenham – the impact of smoking

In the 'league tables' for premature deaths in England, Barking and Dagenham ranks at 141st out of 149 local authorities for lung disease<sup>35</sup> with a premature mortality rate of 54.1 per 100,000 population. In the group of local authorities with similar socioeconomic deprivation only Nottingham and Salford have a higher mortality rate<sup>36</sup>.

Smoking is the main cause of chronic obstructive pulmonary disease and nine out of every ten deaths from lung cancer can be attributed to smoking. To address smoking related mortality locally we estimate that around 7,000 people each year need to quit smoking, far more than the number reported as quitting using NHS Stop Smoking Services (around 1150 per year)<sup>37</sup>.

In general practice information is recorded for the Quality and Outcomes Framework (QOF) about the smoking status of people with chronic conditions including chronic obstructive pulmonary disease (COPD). The data shows that for nearly 96% of people who are on the practice registers with these conditions, smoking status is recorded, and across the borough 94% of these people have been offered smoking cessation support and treatment<sup>38</sup>. Nevertheless, with an estimated 3,405 people with COPD in the borough (QOF prevalence 2013/14), there are certain to be many people with COPD who continue to smoke.

Figure 6:

**Premature mortality for lung disease and smoking prevalence in areas with similar socioeconomic deprivation to London Borough of Barking and Dagenham**

Rank	Local Authority	Premature deaths from lung disease per 100,000 population	Smoking Prevalence
1	Brent	26.5	16.9
2	Walsall	34.4	20.5
3	Lewisham	38.6	20.6
4	Greenwich	41.6	16.6
5	Leicester	45.4	23.6
6	Lambeth	45.7	19.9
7	Wolverhampton	47.1	22.0
8	Bradford	48.9	22.6
9	Rochdale	49.4	22.7
10	Blackburn with Darwen	49.6	22.5
11	Hartlepool	50.1	24.0
12	Halton	53.0	18.4
13	Barking and Dagenham	54.1	23.1
14	Nottingham	54.9	24.4
15	Salford	58.4	22.9

Colours denote significance:

Premature deaths: Red = worst, Orange = worse than average, Yellow = better than average, Green = best  
Smoking prevalence: Red = worse, Yellow = similar, Green = better. Benchmark = England

Source: Premature Mortality 2011-13: Public Health England Healthier Lives <http://healthierlives.phe.org.uk/topic/mortality/comparisons#are/E09000002/par/cat-2-2/ati/102/pat/>

Smoking Prevalence 2013: Public Health England Local Tobacco Control Profiles <http://www.tobaccoprofiles.info/profile/tobacco-control/data>

35 <http://healthierlives.phe.org.uk/topic/mortality/area-details#are/E09000002/par/E92000001/ati/102/pat/>

36 <http://healthierlives.phe.org.uk/topic/mortality/comparisons#are/E09000002/par/cat-2-2/ati/102/pat/>

37 <http://www.hscic.gov.uk/article/2021/Website-Search?productid=15174&q=stop+smoking+services&sort=Relevance&size=10&page=1&area=both#top>

38 <http://fingertips.phe.org.uk/profile/general-practice/data#mod,5,pyr,2014.pat,19,par,E38000004,are,-,sid1,2000006,ind1,90616-4,sid2,-,ind2,->

Around 123 Barking and Dagenham residents develop lung cancer every year and nearly 100 die each year from this disease<sup>39</sup>. Lung cancer is no longer a disease primarily in men – in Barking and Dagenham on average 66 men and 58 women develop the disease every year. While breast cancer is a more common disease, with nearly 100 women developing it every year in Barking and Dagenham, more women die each year from lung cancer (around 40 women dying from lung cancer compared with 27 dying from breast cancer) because survival is so poor; 95% of women with breast cancer survive at least one year, while only 30% of people with lung cancer survive for a year.

Smoking affects health in many ways and contributes to many diseases as well as lung disease. Smoking levels are a major challenge for Barking and Dagenham, and, regardless of any other actions to improve health taken by the Council, the CCG, and our partners, reducing smoking remains the single most important disease risk factor that we need to address on an industrial scale. Evidence for effectiveness of smoking cessation methods still points to the superiority of the structured smoking cessation programmes formerly commissioned by the NHS and now commissioned by councils from the Public Health Grant. In Barking and Dagenham around £1m per year is invested by the Council in smoking prevention and smoking cessation programmes, with particular emphasis on the role of pharmacies and general practice in supporting smoking cessation and we need to promote widely the support available.

## Improving care for long term conditions

In my 2013 Report I wrote in detail about the variation in care for people in Barking and Dagenham with diabetes, and showed that general practices vary substantially in the extent to which they provide high standards of care by carrying out all of the care processes that are necessary to reduce the risk of complications from diabetes and admissions to hospital. These variations continue to exist, and apply not just to diabetes, but to a range of other conditions. Further examples of variation in care are considered here for cardiovascular disease.

## Preventing and managing cardiovascular disease

Cardiovascular diseases include a range of conditions that affect the heart and circulation, including myocardial infarction (heart attack), stroke and atrial fibrillation (a disorder of the heart rhythm which can cause a stroke), peripheral arterial disease and heart failure. Lifestyle factors such as poor diet, lack of exercise, smoking and excess alcohol consumption influence the risk of developing these conditions and the course of the disease.

High blood pressure (hypertension) is an important indicator that cardiovascular disease is developing, and diagnosing high blood pressure may provide an early opportunity to both reduce the risk of serious cardiovascular disease by reducing blood pressure, and to provide lifestyle advice. While the NHS Health Check provides a systematised opportunity to do this, with

less than half of people invited to the Health Check taking up the opportunity, opportunistic checking that a blood pressure measurement has been taken in the last five years should be a routine part of primary care – available both at the general practitioner and the pharmacy. The importance of blood pressure checks has also been taken up by a charity, Blood Pressure UK, who hold a Know your Numbers! week<sup>40</sup> every year to highlight the importance of blood pressure testing and provide opportunities for checks to be done.

Data from the 2013/14 QOF<sup>41</sup> gives insight into how many people registered with a GP have a record of their blood pressure being checked in the previous five years and whether lifestyle advice has been given to those with high blood pressure. For people aged 40 and older, 92% of people have had a blood pressure check, although at practice level the proportion varies from 84% to 98% (denominator includes those stated as exceptions).

Having diagnosed hypertension, NICE Guidance states that Blood Pressure should be maintained at 140/90mm Hg or less, that people should be assessed for their level of physical activity using the General Practice Physical Activity Questionnaire<sup>42 43</sup>, and that those found to be 'less than active' should receive a brief intervention, that is advice about how active they should ideally be and how best to achieve this. The percentage of patients on the practice Hypertension Register varies from 5% to 18%; some of this variation will be due to the difference in age structure and other demographics, and some due to difference in case-finding. Variation in the percentage of patients with tightly managed blood pressure extends from 47% to 86% (Figure 7), for the

39 [http://www.ncin.org.uk/cancer\\_information\\_tools/eatlas/pct/atlas.html?select=Eav&indicator=i0](http://www.ncin.org.uk/cancer_information_tools/eatlas/pct/atlas.html?select=Eav&indicator=i0)

40 <http://www.bloodpressureuk.org/microsites/kyn/Home>

41 <http://www.hscic.gov.uk/catalogue/PUB15751>

42 [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/192450/GPPAQ\\_-\\_pdf\\_version.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/192450/GPPAQ_-_pdf_version.pdf)

43 [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/192453/GPPAQ\\_-\\_guidance.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/192453/GPPAQ_-_guidance.pdf)

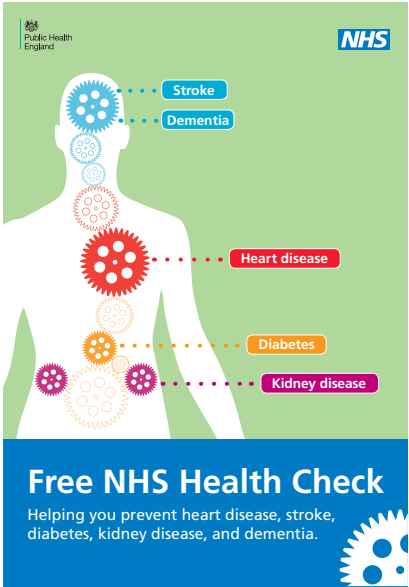
questionnaire assessment from 49% to 95% and giving brief advice on physical activity from 31% to 100%. Other lifestyle advice on smoking cessation, safe alcohol consumption and a healthy diet is also recommended. Practices report on having given this lifestyle advice in the previous 12 months, the variation between practices is from 18% to 97%.

Similar variation is also seen in the management of established cardiovascular disease. As an example, people who have had a myocardial infarction are advised to take aspirin, or alternative anti-coagulation treatment, for life. The percentage of patients

who actually receive this intervention varies from 72% to 100% (Figure 8). The percentage of patients recorded as an exception, which is patients for whom this intervention is not considered appropriate varies from none to 23%.

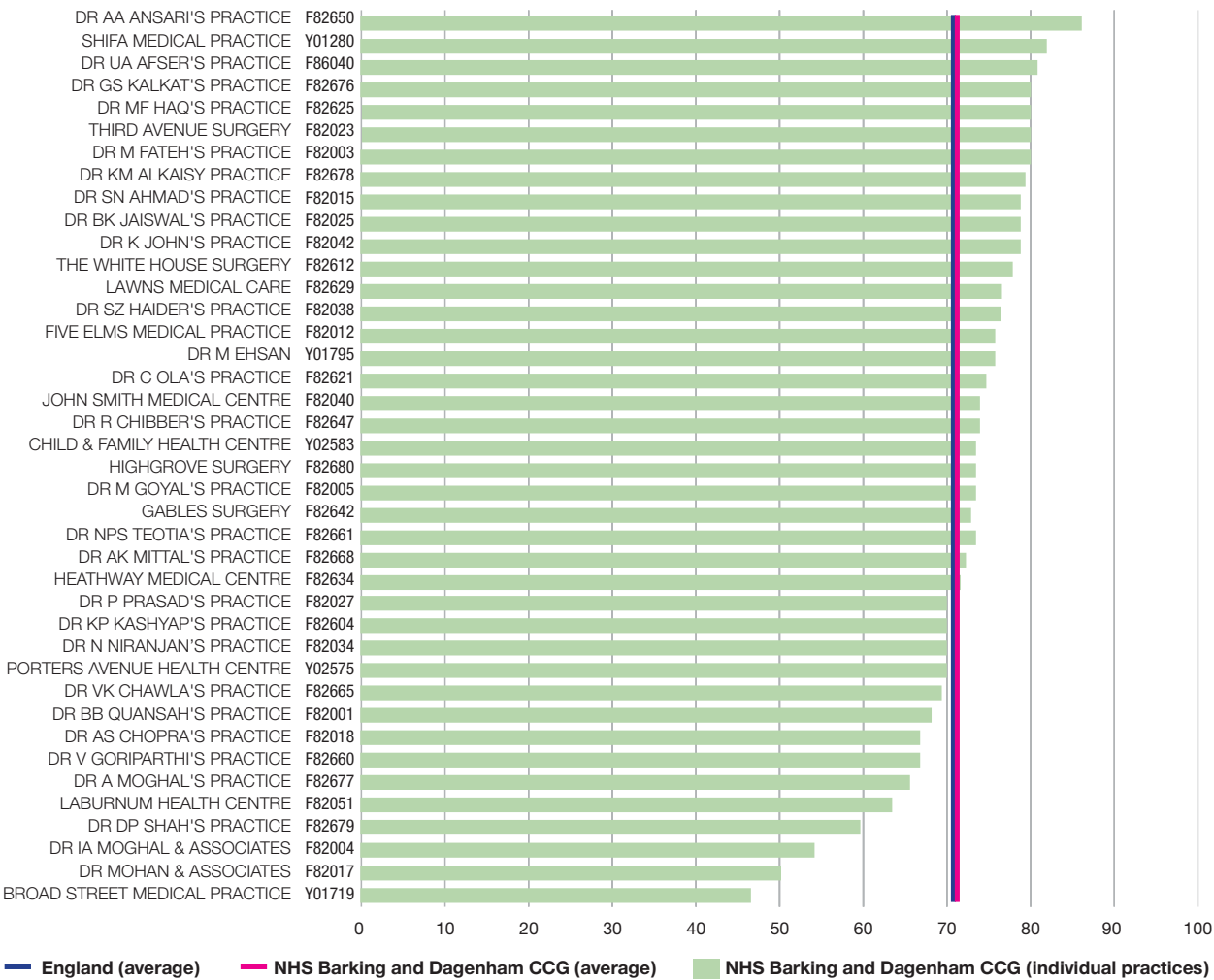
## Reducing variations in patient care in general practice

Variation in the quality of patient care in general practice has been recognised for years, and publication of data is one way of identifying variation and working with practices to address the



consistency of care delivered. NHS England is now driving forward action to address what it describes as 'the care and quality gap' by reshaping models of care and care pathways and developing co-commissioning models with CCGs to increase the flexibility in use of

Figure 7: Blood Pressure measured in last 9 months at or below 140/90



Source: Indicator HYP003 Blood Pressure measured in last 9 months at or below 140/90 at <http://fingertips.phe.org.uk/profile/general-practice/data#mod,5,pyr,2014,pat,19,par,E38000004,are,.,sid1,3000010,ind1,91234-4,sid2,-,ind2,->

Figure 8:

**Percentage of patients with coronary heart disease with a record that aspirin or an appropriate alternative is being taken**



Source: CHD 005 at <http://fingertips.phe.org.uk/profile/general-practice/data#mod,5,pyr,2014,pat,19,par,E38000004,are,-,sid1,3000008,ind1,90999-4,sid2,-,ind2,->

resources and the local insight into how services can be organised to maximise clinical effectiveness<sup>44</sup>.

Primary care co-commissioning is intended to harness the clinical insight that CCGs have about local services and local providers and give them greater power and influence over the commissioning of primary medical care. The benefits of co-commissioning are intended to be improved access to primary care and wider out-of-hospital services, with more services available closer to home, high quality out-of-hospital care, improved health outcomes, equity of access, reduced inequalities and better patient

experience through more joined up services<sup>45</sup>. NHS Barking and Dagenham CCG have welcomed this opportunity and have recently been approved for full delegated powers to commission general medical services<sup>46</sup>. Actions to address variations in patient care are key to optimising the benefits that the greater freedoms and more local decision making that co-commissioning is intended to achieve.

### Living longer, living healthier

While no one can be guaranteed a long and healthy life, there is good evidence

that too many people in Barking and Dagenham die at an earlier age than they need to. While unhealthy lifestyles make a major contribution to the causes of diseases, and addressing lifestyle issues reduces risk of illness and early death, early diagnosis and effective treatment make a real difference to the course of the condition and the likelihood of early death. Preventing disease, diagnosing early and having the best possible treatment is a partnership between individual and care giver, and addressing the many opportunities to intervene effectively in this pathway is a challenge on which we all need to work together.

45 <http://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2014/11/nxt-steps-pc-cocomms.pdf>

46 <http://www.england.nhs.uk/2015/02/18/commissioning-of-gp/>



# Care and prevention

Carers of Barking and Dagenham, based in Dagenham, celebrate Carers' Week in June 2014  
[www.carerscentre.org.uk/](http://www.carerscentre.org.uk/)



## Introduction

With increasing life expectancy and advances in treatment and technology for people of all ages, the number of people who need care and support inevitably also increases. For older people, smaller family size and greater geographic mobility means that there may be no family members living nearby to provide help and support – an estimated 2.9 million people aged 65 years and over feel they have no-one to go to for help and support<sup>47</sup>. In addition, one in eight adults, or 6.5 million people, in the UK are carers, many of whom have had to give up work to care, and both struggle financially and become depressed because of their caring role<sup>48</sup>.

Recognition of the increasing needs of people and their carers has resulted in new responsibilities set out in the Care Act 2014 and the Children and Families Act 2014. Together these Acts of Parliament describe how individuals and their carers should have their needs assessed and met, the approach to prevention which is intended to maintain independence and reduce the need for care and support and the financial framework for charging depending on assets and savings.

For public health professionals the term 'prevention' focuses primarily on the prevention of disease. We think about primary prevention – reducing the risk of people getting a disease by healthy eating, being physically active, not smoking and not drinking alcohol to excess, and many of our

actions and programmes are aimed at addressing these lifestyle actions. We also address secondary prevention – halting or slowing the progress of a disease or preventing a recurrence, for example daily low dose aspirin to prevent a stroke, and tertiary prevention – managing long term health problems to prevent further deterioration and maximise quality of life. This is a disease based interpretation, and a narrow reflection of 'the science and art of preventing disease, prolonging life and promoting health through the organized efforts of society', the accepted definition of modern public health in England included in the 1998 report by Sir Donald Acheson about the future development of the public health function<sup>49</sup>.

Times, society and needs have moved on, and with the public health function now delivered at local level by local authorities, we need to expand our public health thinking with a much broader and more flexible approach to prevention, in the context of the Council's wellbeing role and the many facets of prevention that are implicit and explicit within Care Act responsibilities, focusing on independence and wellbeing and the care and support needs that enable people to live independently. As we look across the lifespan, we need to rebalance our efforts and interests so that we engage as enthusiastically with how people are helped to remain in their own homes as with smoking cessation or preventing the spread of sexually transmitted diseases.

## Care Act 2014

The Care Act 2014 places a series of new duties and responsibilities on local authorities about the care and support of adults and improving their independence and wellbeing. Local authorities have to make sure that people who live in their areas:

- Receive services that prevent their care needs from becoming more serious, or delay the impact of their needs;
- Can get the information and advice they need to make good decisions about care and support;
- Have a range of providers offering a choice of high quality, appropriate services.

The Care Act makes clear that councils must provide or arrange services that help prevent people developing needs for care and support or delay people deteriorating such that they would need ongoing care and support. They have to consider the services, facilities and resources available in the area and identify the people, and the carers, who have care and support needs that are not being met. Key to their role is the provision of comprehensive information on the care and support available, the process to get it, and financial advice to help plan and prepare for the costs of care<sup>50</sup>.

Under the Care Act, councils have a duty to carry out an assessment to determine whether an adult has needs for care and support. This assessment must be provided to all

47 <http://www.ageuk.org.uk/latest-news/1-in-4-older-people-feel-they-have-no-one/>

48 <http://www.carersuk.org/>

49 [http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Aboutus/MinistersandDepartmentLeaders/ChiefMedicalOfficer/Features/FeaturesArchive/Browsable/DH\\_5017805](http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Aboutus/MinistersandDepartmentLeaders/ChiefMedicalOfficer/Features/FeaturesArchive/Browsable/DH_5017805)

50 [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/366080/Factsheet\\_1\\_-\\_General\\_responsibilities.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/366080/Factsheet_1_-_General_responsibilities.pdf)



## Care and support is changing for the better

From April 2015, the new Care Act will help make care and support more consistent across England.

If you receive care and support, or you support someone as a carer, you could benefit from the changes. To find out more, contact:

Barking and Dagenham Council  
 1 Town Square, Barking, London, IG11 7LU  
 020 8215 3000 or 3000Direct@lbbd.gov.uk  
[www.lbbd.gov.uk/careandsupport](http://www.lbbd.gov.uk/careandsupport)



those who appear to have needs for care and support, regardless of finance and whether the individual will be eligible to have those needs met, and the assessment must be of the person's needs and how they impact on their wellbeing. This means that the assessment is based on needs and wants, and the outcomes that the individual aims to achieve, rather than the services that exist or their eligibility to receive funded care<sup>51</sup>. Carers should also have their needs assessed, taking into consideration what they want to achieve in their own day-to-day life<sup>52</sup>.

Care and support needs that people may have can include the very basics of everyday life – getting out of bed, washing and dressing, eating and drinking, going to the toilet or managing incontinence, as well as the next level of function such as cooking, shopping, and seeing family, friends and neighbours. The guiding principle is that at the heart of care and support is the promotion of a person's wellbeing, defined in the statutory guidance as a broad concept relating to:

- personal dignity (including treatment of the individual with respect)
- physical and mental health and emotional wellbeing
- protection from abuse and neglect
- control by the individual over day-

to-day life (including over care and support provided and the way it is provided)

- participation in work, education, training or recreation
- social and economic wellbeing
- domestic, family and personal
- suitability of living accommodation
- the individual's contribution to society

Promoting wellbeing means actively seeking improvements in these aspects of wellbeing and supporting an individual to achieve their desired wellbeing outcomes, based on their own beliefs and wishes and the importance of preventing or delaying the need for care or reducing needs that already exist<sup>53</sup>.

## Prevention and the Care Act 2014

The Care Act Statutory Guidance essentially defines prevention as any population or individual level intervention or action that helps people to maintain their independence and reduces the risk of needing care or support or delays the need for increased care and support. Preventative activity includes population based health promotion measures as well as individual interventions to improve skills or functioning. Rather than give a precise definition the Guidance gives examples of the kinds of activities that may be preventative, using the primary, secondary and tertiary approach familiar to public health<sup>54</sup> (See Figure 9).

51 [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/366083/Factsheet\\_3\\_-\\_Assessments\\_and\\_eligibility.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/366083/Factsheet_3_-_Assessments_and_eligibility.pdf)

52 [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/366089/Factsheet\\_8\\_-\\_Carers.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/366089/Factsheet_8_-_Carers.pdf)

53 [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/366104/43380\\_23902777\\_Care\\_Act\\_Book.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/366104/43380_23902777_Care_Act_Book.pdf) Pages 1-3

54 [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/366104/43380\\_23902777\\_Care\\_Act\\_Book.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/366104/43380_23902777_Care_Act_Book.pdf) Pages 8-9

Figure 9:

### Prevention as described by The Care Act 2014

Prevention Level	Definition	Example of service or activity
<b>Prevent:</b> primary prevention/ promoting wellbeing	Services, facilities or resources provided or arranged that may help an individual avoid developing needs for care and support, or help a carer avoid developing support needs by maintaining independence and good health and promoting wellbeing. Generally universal.	<ul style="list-style-type: none"> <li>• Provide universal access to good quality information</li> <li>• Support safer neighbourhoods</li> <li>• Promote healthy and active lifestyles (e.g. exercise classes)</li> <li>• Reduce loneliness or isolation (e.g. befriending schemes)</li> <li>• encourage early discussions in families or groups about potential changes in the future (e.g. conversations about potential care arrangements or suitable accommodation should a family member become ill or disabled)</li> </ul>
<b>Reduce:</b> secondary prevention/early intervention	More targeted interventions aimed at individuals who have an increased risk of developing needs, where the provision of services, resources or facilities may help slow down or reduce any further deterioration or prevent other needs from developing.	<ul style="list-style-type: none"> <li>• Falls prevention clinic</li> <li>• Adaptions to housing to improve accessibility or provide greater assistance,</li> <li>• Handyman services</li> <li>• Short term provision of wheelchairs</li> <li>• Telecare services</li> </ul>
<b>Delay:</b> tertiary prevention	Interventions aimed at minimising the effect of disability or deterioration for people with established or complex health conditions, (including progressive conditions, such as dementia), supporting people to regain skills and manage or reduce need where possible.	<ul style="list-style-type: none"> <li>• Services, resources or facilities that maximise independence for those already with needs, e.g. interventions such as rehabilitation/reablement services, community equipment services and adaptations and the use of joint case-management for people with complex needs.</li> <li>• Improving the lives of carers by enabling them to continue to have a life of their own alongside caring, e.g. respite care, peer support groups like dementia cafés, or emotional support or stress management classes</li> </ul>

## Children and Families Act 2014

The Children and Families Act 2014<sup>55</sup> has made changes to the law to give greater protection to vulnerable children, better support for children whose parents are separating, a new system to help children with special educational needs and disabilities, and help for parents to balance work and family life. It includes responsibilities for assessment of the need for care and support for children that mirror those in the Care Act 2014, and complementary requirements that are intended to ensure that the transition from children to adult services are seamless and safe.

A similar approach to wellbeing is taken in the Children and Families Act to that in the Care Act. Wellbeing for children and young people is described as:

- physical and mental health and emotional well-being
- protection from abuse and neglect
- control by them over their day-to-day lives
- participation in education, training or recreation
- social and economic well-being
- domestic, family and personal relationships
- the contribution made by them to society.

The main focus of the Act is on vulnerable children – those with special educational needs or with a disability, as well as those who are in the care of the local authority or are vulnerable due to family circumstances including parental separation and adoption.

While there is not the same emphasis on prevention in the Children and Families Act as there is in the Care Act, the need to take a preventative approach is implicit in the requirement

to put the needs and desired outcomes of the individual child or young person at the heart of planning and for them to realise their ambitions such as those for education, employment, independent living and participation in society. The Act also requires a duty of collaboration and of joint commissioning, thus ensuring that education, children's social care and health work together to provide personalised, integrated care that delivers positive outcomes for children and young people.

## Better Care Fund

The Better Care Fund (BCF) was announced by the Government in the June 2013 Spending Round, to support transformation and integration of health and social care services to ensure local people receive better care. The BCF is a mechanism to pool relevant health and social care budgets and use them to develop interventions and services that strengthen care and support for individuals whose needs encompass clinical and social care. The Fund is a reallocation from existing budgets intended to improve patient experience and outcomes by better integrating health and social care, thus enabling a combined approach that focuses on needs and reduces duplication. The Fund requires local bodies to:

- bring health and social care planning together
- support people's health and independence in the community
- meet the challenges of increasing demand for care and constraints on public funding.

The overarching principle behind the BCF is integration, with the content of the programme designed to move resources across the system towards prevention and short term care interventions and away from high cost packages in acute or care

home settings. There is a particular focus on the requirement to reduce the rate of emergency admissions to hospital, thus directing attention towards care programmes that maintain independence and identify potential deterioration in long term conditions, ensuring timely support at home rather than emergency hospital admission. The BCF should therefore stimulate investment in services that are necessary to meet the implications of the Care Act, and creates a practical, programme based approach for the Council and NHS Barking and Dagenham Clinical Commissioning Group to work together to deliver the interventions that prevent, reduce and delay the need for care and support and enable people to retain their independence in their own homes for as long as possible.

In Barking and Dagenham the vision for the BCF is a plan that is intended to put residents at the heart of the health and social care system, and aims to:

- Improve how people experience care and ensure the best possible quality that delivers the right care, in the right place, at the right time
- Ensure the health and social care system is 'future proof' and able to effectively manage increasing demand and need, not only today, but in years to come
- Reduce reliance upon bed based services and ensure improved support closer to home
- Ensure that services are efficient, sustainable and deliver value for money.

The BCF in Barking and Dagenham is invested in 11 schemes (Figure 10) which are intended to address a wide spectrum of opportunities to refocus and integrate services around the needs of individuals. These fit well with the key

<sup>55</sup> <http://www.legislation.gov.uk/ukpga/2014/6/contents/enacted>

areas for intervention and the examples of schemes recommended by The Kings Fund<sup>56</sup>.

Around £1m of the Public Health Grant is invested in schemes that contribute to this programme of transformation of health and social care delivered through the BCF. Just under half of this investment is in programmes that support older people to be more physically active, and the remainder is invested in a range of schemes that support people's wellbeing and ability to remain independent. These

schemes fall more within the spectrum of services that may be referred to as 'social prescribing'<sup>57</sup>, services often provided by volunteers and third sector organisations that are specifically focused on peer support and reducing social isolation, including community health champions and befriending schemes.

The effectiveness of the BCF as a pathway to improving integration across health and social care, reducing emergency admissions and making savings overall to support people's care

and support at home remains to be proven. The National Audit Office, in their November 2014 report *Planning for the Better Care Fund*, question the ability of local areas to achieve the required reduction to emergency admissions and criticise the impact of changes in the planning requirements on the time available to a local area to move forward with workforce planning and training to deliver the service changes necessary to achieve the goals of the BCF<sup>58</sup>.

Figure 10:

#### Barking and Dagenham Better Care Fund

Scheme		Intervention
1	Integrated Health and Social Care Teams	Integration of services for Case Management, community nursing, therapies, integration of mental health social worker support and long term conditions services
2	Admissions avoidance and improved hospital discharge	Joint Assessment and Discharge service and seven day working
3	New model of intermediate care	Introduction of Community Treatment Team and an Intensive Rehabilitation Service
4	Mental health support outside hospital	Bringing together health and social care commissioned services that work to support people with mental health problems through talking therapies, primary care, social care, accommodation and employment and recovery services
5	Integrated commissioning	Integrated Programme Management to ensure delivery of the programme
6	Support for family carers	Supporting carers and taking into account the requirements of the Care Act
7	Care Act implementation	Contributing to the additional costs of the services required by the Care Act
8	Prevention	Evaluating current prevention work that is already in place e.g. physical activity and falls prevention and co-ordinating disparate activity which contributes towards improved prevention and well being
9	End of life care	Focusing on supporting training and service improvements across agencies and services, and integrating this into cluster teams
10	Equipment and adaptations	Bringing together commissioning and provision of equipment and adaptations that are required to support people in their homes. The scope also includes commissioning and provision of Assistive Technology and Tele-health
11	Dementia support	Improving early diagnosis and support to people with dementia.

56 [http://www.kingsfund.org.uk/sites/files/kf/field/field\\_publication\\_file/making-best-use-of-the-better-care-fund-kingsfund-jan14.pdf](http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/making-best-use-of-the-better-care-fund-kingsfund-jan14.pdf)

57 [http://www.nesta.org.uk/sites/default/files/more\\_than\\_medicine.pdf](http://www.nesta.org.uk/sites/default/files/more_than_medicine.pdf)

58 <http://www.nao.org.uk/report/planning-better-care-fund-2/>



Council Leader Councillor Darren Rodwell joined residents for a line dancing session at Park Active Age Centre

## Rising demand, insufficient resources

The winter of 2014/15 has seen unprecedented pressure on the NHS, as evidenced by an increase in the percentage of people waiting more than 4 hours in accident and emergency departments, an increase in the number of operations cancelled at the last minute, a reduction in the percentage of patients with cancer receiving their first treatment within the target of 85% starting treatment within two months of GP referral and the number of hospital beds still occupied by patients who are well enough to leave being at a six year high<sup>59</sup>. The implementation of many of the responsibilities of the Care Act in April 2015 will add to the pressures on Social Care and the need for health and social care and support to help people stay in their own homes will continue to increase. It is estimated that there will be a £30bn funding gap between NHS demand and available resources by 2020/21<sup>60</sup> and a £65bn gap by 2030<sup>61</sup>,

with differences of opinion about the extent to which efficiency savings can mitigate these funding pressures. In addition, Government funding for local authorities has fallen by 28% in real terms over the 2010 Spending Review period<sup>62</sup>, with substantial cuts in the spending and volume of social care services for older adults across England<sup>63</sup>. Some commentators question whether the current funding models for health and social care can survive, and whether a single ring-fenced budget for health and social care with a single local commissioner in conjunction with a simpler graduated pathway of support would make better use of resources and provide more equal support for equal need<sup>64</sup>.

These pressures on health and social care may in part be the outcome of people's lifestyle – smoking, drinking alcohol, being overweight and not taking enough exercise, but they largely represent the impact of current and existing disease. People who are ill today need care and support which we

cannot ignore while we are investing to prevent the illnesses of tomorrow.

## Approaches to wellbeing and prevention

*The NHS Five Year Forward View* proposes a radical upgrade in prevention and public health, taking a traditional perspective about 'this rising burden of ill health driven by our lifestyles, patterned by deprivation and other social and economic influences' and the need to address this burden, highlighting Public Health England's new strategy which 'sets out priorities for tackling obesity, smoking and harmful drinking; ensuring that children get the best start in life; and that we reduce the risk of dementia through tackling lifestyle risks, amongst other national health goals'<sup>66</sup>. *The Forward View* sets out an exciting approach which takes forward the principles previously described by Sir Derek Wanless<sup>67</sup> and Professor Sir Michael Marmot<sup>68</sup> and

59 <http://qmr.kingsfund.org.uk/2015/14/>

60 <http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>

61 [http://www.health.org.uk/public/cms/75/76/313/5297/Briefing\\_NHS%20finances.pdf?realName=rHrtG.pdf](http://www.health.org.uk/public/cms/75/76/313/5297/Briefing_NHS%20finances.pdf?realName=rHrtG.pdf)

62 <http://www.nao.org.uk/wp-content/uploads/2014/12/Public-health-england%E2%80%99s-grant-to-local-authorities-summary.pdf>

63 [http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/140326\\_qualitywatch\\_focus\\_on\\_social\\_care\\_older\\_people\\_0.pdf](http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/140326_qualitywatch_focus_on_social_care_older_people_0.pdf)

64 <http://www.kingsfund.org.uk/publications/new-settlement-health-and-social-care>

66 <http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf> Page 10

67 [http://webarchive.nationalarchives.gov.uk/20130129110402/http://www.hm-treasury.gov.uk/consult\\_wanless04\\_final.htm](http://webarchive.nationalarchives.gov.uk/20130129110402/http://www.hm-treasury.gov.uk/consult_wanless04_final.htm)

68 <http://www.instituteoftheequity.org/projects/fair-society-healthy-lives-the-marmot-review>



Residents, Council staff and health partners took up the Dementia Friends challenge, as part of the Alzheimer's Society national campaign

describes how the NHS can work with local government on targeted prevention, helping people to get and stay in employment, workplace health, empowered patients with a better understanding about their condition and ability to manage their care and engaged communities supporting carers, volunteers and voluntary organisations.

For councils, the lifestyle approach to prevention and public health is reinforced by the requirement to submit data on how the Public Health Grant is spent according to a defined list of programme areas based on the lifestyle approach (see Figure 1, Page 9). This adds weight to the expectation that the primary focus of public health spend will be on lifestyle programmes that are expected to prevent future ill health, such as those addressing smoking, substance misuse, obesity, and physical activity. The best of these investments will be in programmes that can demonstrate cost effectiveness over the lifespan, and many compare very favourably with other investments approved by the National Institute for Health and Care Excellence (NICE) because of their long term benefits. Much of the investment in schemes that are part of the Better Care Fund fall

within the category of 'Miscellaneous Public Health' making it difficult to identify across the country how the Public Health Grant is supporting innovative approaches to promoting independence and reducing the need for care and support, including social prescribing.

How then do the expectations for prevention and public health described by the NHS and Public Health England sit alongside the descriptions of wellbeing and prevention set out by the Care Act 2014? The contradiction between the long term, and hopefully cost effective, lifestyle programmes intended to increase wellbeing and prevent disease in ten, twenty and thirty years and the responsibility for wellbeing and prevention as described by the Care Act and the pressure on health and care services today is stark. Is it possible to reconcile these approaches and the demands and pressures on today's services? What is clear is that the partnership between the NHS and the Council is crucial and mutually reinforcing when considering how best to support people to live healthy lives and remain independent. The role of the GP and primary care team in advising on diet and exercise is reinforced by the Council's approach to fast food

outlets and provision of parks and leisure services. Education about self-management for people with long term conditions interlinks with programmes for carer support. Whatever the lifestyle concern or care issue, input from both the NHS and the Council, supported where possible by the voluntary sector, are essential to maximise impact.

## Wellbeing

Wellbeing has come to prominence over the last twenty years and has increasingly been associated with the 'happiness' lobby. An accepted broad definition of wellbeing used by the OECD is of 'good mental states, including all of the various evaluations, positive and negative, that people make of their lives and the affective reactions of people to their experiences'<sup>69</sup>. The Public Health Outcomes Framework includes indicators of wellbeing based on four questions from the Annual Population Survey carried out by the Office for National Statistics:

1. Overall, how satisfied are you with your life nowadays?
2. Overall, how happy did you feel yesterday?
3. Overall, how anxious did you feel yesterday?

4. Overall, to what extent do you feel the things you do in your life are worthwhile?

Wellbeing as described in the Care Act Guidance<sup>70</sup> is much more specific and practical, and while one could describe a path from the specifics such as personal dignity and control over one's life, to an outcome around feeling happy and not anxious, it is hard to see that effectively addressing the wellbeing requirements of the Care Act will contribute to improvement in the measures of wellbeing included in the Public Health Outcomes Framework. Nevertheless, the wellbeing principles described in the Care Act Guidance do provide meaningful questions for individuals, their carers, and their care assessors to ask, for example: Will this intervention help me to maintain or recover my personal dignity? There is therefore some conflict between the different improvements that councils are expected to address.

## Prevention

Prevention is the action that stops something from happening or arising<sup>71</sup>. Prevention of disease is fundamental to public health responsibilities, and the public health system prioritises actions that address the causes or underlying causes of disease, primarily through actions that seek to influence people's lifestyle choices. These actions are generally termed primary prevention, but prevention also encompasses those actions that reduce or delay the impact of diseases and conditions that have

developed, both to avoid deterioration and to enable better management of the impact of the condition. Collectively such actions aggregate to influence the overarching indicators for public health outcomes, those of life expectancy and healthy life expectancy.

Within the Council's broad responsibilities for prevention, those years during which people describe themselves as not in good health have a big impact on care and support needs and therefore the demand for resources. In Barking and Dagenham healthy life expectancy data suggests that men may live for 18 years, and women for 25 years, in less than good health, and we know that the need for healthcare and home care and support increases with increasing age. In considering therefore the Council's prevention responsibilities, now enshrined in legislation within the Care Act 2014, we have to take account not only of the need to influence lifestyles amongst children, young people and adults, but also what actions could prevent the breakdown of people's ability to live independently and precipitate the need for some form of institutionalised care, whether in hospital or a nursing home.

This takes us into a much more comprehensive approach to prevention, perhaps based on the life course approach but with more emphasis on the needs of old age and those who are in the later stages of long term conditions. This suggests the need for the public health system to move beyond its comfort zone of smoking

cessation and obesity, important though these things are, and work to better understand the actions that are necessary to reduce and delay the deterioration of those who are already ill, particularly with long term conditions. Some of this will be territory that we well understand, for example the importance of the annual review for people with diabetes, and some will be territory where we need to work more closely with our social care colleagues, for example to address social isolation and loneliness.

The opportunity within our grasp is a truly comprehensive prevention strategy, that includes not just prevention as public health people know it, or prevention as understood by children's or adults services, or by the NHS, or as defined by the Care Act, but a truly joined up approach which our residents, as well as all our departments and services, recognise as including them. This does not mean being all things to all people, but an overarching strategy that is inclusive and recognises that there are immediate pressure points and short term preventative actions as well as long term investments, that prevention is not only about the birth of a healthy baby but also about the dignity and independence of someone who is dying, that some actions are cost effective and some are cost containing, and that prevention is a collective responsibility to which we can all contribute.

70 [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/366104/43380\\_23902777\\_Care\\_Act\\_Book.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/366104/43380_23902777_Care_Act_Book.pdf)

71 <http://www.oxforddictionaries.com/definition/english/prevention>





# 21<sup>st</sup> century healthcare opportunities

Daynight Pharmacy in Barking and Dagenham opens till 12 midnight, offering a full pharmacy service

## Modern technology is transforming the potential for self-diagnosis and self-care.

An increasingly wide range of testing kits can be purchased via the internet, and a number of prescription only treatments can also be purchased using online doctor services associated with pharmacies. While this approach has been available from other countries for some years, the introduction of UK based services that comply with UK quality standards including Care Quality Commission registration, opens up new opportunities for people to take charge of their own care, and while these services have to be paid for, costs are relatively low and the benefits of convenience and confidentiality, as well as taking control of one's own care, will outweigh the costs for some people.

Self-care includes all health decisions people make for themselves and their families in order to manage their health needs and stay well. It includes the actions people take to eat well, exercise and avoid unhealthy habits such as smoking and drinking excess alcohol, as well as taking care of oneself in respect of minor ailments, long term conditions or after discharge from hospital. Taking advantage of opportunities to identify the early stages of disease such as through screening programmes, recognising that one has symptoms that need investigating are decisions that we make when caring for ourselves and becoming well-informed about our conditions in order to ensure that we, and our health and care professionals, are taking advantage



World AIDS Day 2014 - a cupcake treat for everyone taking up an HIV test on the day

of the most effective treatment and management are issues that are considered in Chapter 2 of this report. In this Chapter I review the potential impact of technology and internet services on sexual healthcare.

Sexual healthcare is readily available online. Testing kits for chlamydia, gonorrhoea and HIV are available as well as treatment for chlamydia, herpes and genital warts. Contraceptive pills, patches and vaginal contraceptive rings are all available for purchase following online assessment by a doctor. From around £30 per year the oral contraceptive pill can be prescribed following an online consultation with a doctor and purchased online. Emergency hormonal contraception, the

'morning after pill' is available without prescription and can be purchased over the counter at pharmacies.

The availability of such services challenges our preconceptions not only about the safety of making prescriptions only drugs available to an individual who has not physically met a healthcare professional, but also our longstanding belief in the importance of that interaction and the balance of control between individual and healthcare professional. In recent years patient autonomy has come to the fore, with the 'doctor knows best' approach of benevolent paternalism out of fashion<sup>72</sup>. However that autonomy is controlled; while information availability has been revolutionised by the internet,

72 [http://www.medscape.com/viewarticle/827006#vp\\_1](http://www.medscape.com/viewarticle/827006#vp_1)



Posters and viral videos were produced by young people for young people, throughout the year, with commissioned organisation Chain Reaction Theatre Company

treatment availability can still be a matter of interpretation, with one healthcare professional recommending a treatment that another refuses.

The availability of sexual healthcare services online, supported in some cases by High Street pharmacies, provides a relatively safe area to consider our approach to patient autonomy and the extent to which we are prepared to support a patient's right to choose and to take advantage of services that they can access from their armchair. Are self-care services a way of reducing the stigma of accessing tests and treatments, as well as increasing access? Do they normalise care and contribute to a more comprehensive public health approach to health and wellbeing services? Are we encouraged or threatened by the opportunities our patients and population have to receive care without our involvement? This section considers some of the services available in the context of local needs and health status and explores how we might respond to these advances in care.

## HIV infection

In 2013, the prevalence of diagnosed HIV infection in Barking and Dagenham was 6.07 per 1000 persons aged 15-59 years. This prevalence is higher than that in London as a whole (5.69) and a lot higher than the overall prevalence in England (2.14)<sup>73</sup>.

The pattern of HIV infection in Barking and Dagenham is very different to that seen across the UK. Locally, Men who have Sex with Men (MSM) are 10% of those infected, whereas nationwide 44% of those diagnosed with HIV are MSM. 83% of those people known to be living with HIV in Barking and Dagenham are heterosexual, compared with 50% nationally. Both nationally and locally the main ethnic group affected is Black African; around two-thirds of those infected are Black African, and around two thirds of Black Africans known to have HIV are women. Overall 59% of those known to be living with HIV locally are women. Prevalence is highest in those aged 35-49 years. In 2013, 764 people who live in Barking and Dagenham were receiving treatment and care for HIV<sup>74</sup>.

The local pattern of HIV infection is important as an indicator of need for HIV testing and where to target testing. It is a real concern locally that many people with HIV are diagnosed late. In Barking and Dagenham, 54.2% of adults aged 15 and over newly diagnosed with HIV infection had CD4 counts of less than 350 cells per mm<sup>3</sup> as a percentage of the number of adults newly diagnosed with HIV infection. Barking and Dagenham has a higher proportion of people diagnosed late than London (40.5%) and England (45%) (2011–2013, three year moving averages). Only 6 London boroughs have higher rates of late diagnosis than we do in Barking and Dagenham, and all of those boroughs have diagnosed prevalence rates below that of Barking and Dagenham. Late diagnosis means that treatment is started too late to be most effective, and can result in poor outcomes for patients, as well as being more costly. People living with HIV can expect to have a near normal lifespan if diagnosed promptly. Those diagnosed late have a ten-fold increased risk of death in the year following diagnosis compared with those diagnosed promptly<sup>75</sup>.

73 <http://www.phoutcomes.info/profile/sexualhealth/data#gid/8000035/pat/6/ati/102/page/0/par/E12000007/are/E09000002>

74 Public Health England HIV Surveillance Data (unpublished)

75 [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/377194/2014\\_PHE\\_HIV\\_annual\\_report\\_19\\_11\\_2014.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/377194/2014_PHE_HIV_annual_report_19_11_2014.pdf)



HIV testing at the Barking Learning Centre

## Testing for HIV infection

HIV testing is integral to the treatment and management of HIV and knowledge of HIV status means that treatment can be offered appropriately and the risk of transmission can be reduced. HIV testing should be offered to all those who attend Sexual Health Services unless they are known to be HIV positive or testing is otherwise inappropriate.

In Barking and Dagenham, 89% of MSM attending a sexual health clinic at least once during the year accepted an HIV test. However for men overall acceptance was lower at 79%, and for women even lower at 72%. The majority of people who are offered the test accept, 93.5% of MSM, 84.6% of all men, and 80.9% of women. Given our local circumstances with a high proportion of HIV being in heterosexual women, ensuring that women attending our sexual health clinics are both offered and accept HIV testing is crucial – in 2013 only 7 out of every 10 women did so.

As well as testing for HIV infection in sexual health clinics, women are tested as part of antenatal screening, and men and women have access to outreach

services. Testing of new patient registrations in primary care is being introduced, and this is an important step to normalising HIV testing as a routine part of every person's care. The recent introduction of self-sampling arranged and paid for online has offered another way of testing and we need to consider whether we should acknowledge and encourage the use of these services.

## Self-testing and self-sampling for HIV infection

One approach to address late HIV diagnosis is to encourage people to test themselves at home. Information can be confusing, but whether called home-testing or self-sampling the currently available method is to request a self-sampling kit, which is readily available through online pharmacies, and costs around £30-£40. Kits are also available free on the NHS, through the Dean Street Clinic, part of Chelsea and Westminster NHS Trust. Blood and saliva tests are both available, and involve obtaining a test kit and returning the relevant sample, taken according to instructions sent with the kit. Blood tests are more reliable, and

can detect infection around 4 weeks after exposure, compared with the saliva test which is not positive until around 14 weeks after exposure. Results are generally given by text message or logging on to the website if negative, or by phone call if positive.

Self-testing is a new approach, which was legalised in the UK in advance of any tests being approved for use in the UK (CE marked)<sup>76</sup>, although tests are available in other countries that can be shipped to the UK. It is likely that UK approved tests will become available in 2015. Full self-testing means purchasing a kit that can be used at home and gives the results within a few minutes, without any need to send the sample away for testing. Although it will always be recommended that a positive test should be repeated by a health professional, self-testing will give an individual complete control over the test and finding out the result without intervention from a health professional.

Concern remains about the psychological impact of receiving a provisional diagnosis of HIV infection in a context unsupported by a healthcare professional. Finding out that you have HIV can be an emotionally devastating experience, and an individual who

76 <http://www.bbc.com/news/health-26888272>

does a test at home that turns out to be positive may still be reluctant to access care, and to admit to the home test when they do visit a sexual health clinic or their GP. Nevertheless, if the individual would otherwise have been delaying testing, treatment may be started earlier as a result of them finding out their diagnosis through self-testing and then approaching the health system for care. With prompt treatment being critical to life expectancy, widening access to testing should not only mean

managed testing through physical healthcare services, and we should recognise that self-testing will have a role to play in our approach to reducing late diagnosis.

## Sexually Transmitted Infections

Barking and Dagenham has moderately high rates of the common sexually transmitted infections, especially

compared with our neighbours in Redbridge and Havering, although rates in inner London and therefore London as a whole are generally much higher (Figure 11). In addition, rates for chlamydia diagnosis, an infection which is frequently asymptomatic in women but can result in infertility, are related to the proportion of the population screened, so the local diagnosis rate is a positive result reflecting higher levels of testing.

Figure 11:

### Rates of Sexually Transmitted Infections, outer north east London, London and England, 2013

Sexually Transmitted Infection	Barking and Dagenham	Havering	Redbridge	London	England
Syphilis (Diagnosis rate per 100,000 population)	6.8	2.1	3.5	19.8	5.9
Gonorrhoea (Diagnosis rate per 100,000 population)	80.8	43.8	56.2	155.4	52.9
Chlamydia (Diagnosis rate per 100,000 people aged 15-24)	2087	1589	1176	2179	2016
Chlamydia (Proportion of 15-24 population screened)	30.0%	22.2%	22.1%	27.7%	24.9%
Genital warts (Rate of 1st episode diagnosis per 100,000 population)	144.8	170.2	106.8	163.9	133.4
Genital Herpes (Rate of 1st episode diagnosis per 100,000 population)	76.6	70.5	48.8	89.9	58.8

Source: <https://www.gov.uk/government/statistics/sexually-transmitted-infections-stis-annual-data-tables>

Self-sampling kits for chlamydia, gonorrhoea and vaginal infections are readily available online, as are antibiotic treatments when the tests for chlamydia prove positive. Gonorrhoea treatment is usually given by injection and so treatment at a sexual health clinic is advised. Self-sampling and treatment for chlamydia means that tracing and notification of sexual partners is

totally dependent on the individual, whereas those cases diagnosed and treated as part of the National Chlamydia Screening Programme will discuss partner notification with a health professional and have support for advising partners of the need for treatment.

Data on sexually transmitted infections that present to NHS services and those

identified as a result of council or NHS commissioned tests are collected by Public Health England and published annually. This data collection helps us understand the epidemiology and need for services for diagnosis and treatment. Data about infections diagnosed through private healthcare need not be collected, and in the past the number of infections identified in this way would

be very small. In the future, with online testing services, the numbers may be more significant, affecting not only our knowledge of the frequency of infection but also the targets for testing that we work to meet.

## Contraception and fertility control

The use of the oral contraceptive pill, and the newer associated hormonal methods such as the contraceptive ring and patches have become widespread since 'the pill' was first introduced in the 1960's. Over the last 50 years the pill has revolutionised women's health and separated sex from the risk of pregnancy, although it was only in 1974 with the introduction of NHS Family Planning clinics that it became widely available to single women. It is estimated that 3.75 million women in the UK use oral contraception<sup>77</sup> and that over 70% of women in Britain use the pill at some time in their lives<sup>78</sup>.

Data on use of contraception is limited. Around 1.2million women in England attend community clinics of whom around 47% use oral contraception. In Barking and Dagenham in 2013 there were 6175 attendances at the community contraception service run by Barking, Havering and Redbridge University Hospitals NHS Trust made by around 4400 people. 44% of these attendances were related to long acting methods of contraception such as intrauterine devices and injections, while 31% were for oral contraception. Nearly 60% of attendances are made by women aged 25 and over and 54% of these attendances are for long acting methods, 26% for oral contraception

and 19% for condoms. Over 97% of those attending community clinics are women, although male condoms are available to men who attend. In 44% of attendances the current method of contraception was maintained, in 20% a new method of contraception was provided and in 13% the method was changed<sup>79</sup>.

In Barking and Dagenham around 9 per 100 females aged 13-44 years use community contraception services, below the average rate for London of 12.5 and for England of 10.6 per 100 females aged 13-44 years. Contraception prescribed in general practice is complicated by the data being based on numbers of prescriptions rather than the number of individuals receiving contraception. In Barking and Dagenham in 2013 there were over 23,000 prescriptions for oral contraception. Based on two prescriptions per year of a six month pill supply this would equate to around 11,000 women getting the pill from their GP. Data on the provision of long acting methods by GPs, estimates a rate of 45 per 1,000 women aged 15-44 years, the second highest rate in London (the London average is 25 per 1,000 women) and fairly close to the England rate of 52.7. This equates to around 2,000 women. Prescribing data shows that about half of these women use injectable contraception, 20% use implants and the remainder an intrauterine contraceptive.

Modelling the likely use of contraception by women in Barking and Dagenham and comparing with what we know nationally, we can draw on the survey that the Office for National Statistics used to carry out on contraceptive

methods used, although the last of these was done in 2008/09<sup>80</sup>, covering women aged 16-49 years. This survey found that there had been little change in the use of methods of contraception over the previous 9 years, with 25% of women under 50 using oral contraception (34% of those using contraception) and 25% not using any contraceptive method. In Barking and Dagenham there are nearly 50,000 women aged 16-49 years<sup>81</sup>, so if national patterns were followed locally around 12,000 women could be using oral contraception. An approximate estimate of those using community clinics for oral contraception is around 1,500, and of those getting the pill from their GP around 11,000, which suggest that contraceptive use locally is in line with what would be expected.

Another way of looking at contraceptive need is to look at fertility and abortion statistics. In 2012 there were an estimated 5,237 conceptions to women living in Barking and Dagenham, with 27% leading to abortion. The conception rate of 119 per 1,000 women aged 15-44 years compares with a rate of 86.7 for London as a whole and 78.8 for England. This conception rate is the highest in England, with the next highest being Newham, where the rate is 103.3<sup>82</sup>. There is also a high birth rate in Barking and Dagenham as measured by the General Fertility Rate (GFR, the number of live births per 1,000 women aged 15-44 years) and Total Fertility Rate (TFR, average number of live children a woman would bear). The GFR is 85.5 compared with 64.0 for London and 62.4 for England, and the TFR is 2.45 compared with 1.74 for London and 1.85 for England. Both of

77 <http://www.theguardian.com/society/2010/jun/06/rachel-cooke-fifty-years-the-pill-oral-contraceptive>

78 <http://www.bbc.co.uk/news/uk-15984258>

79 <http://www.hscic.gov.uk/article/2021/Website-Search?productid=16268&q=srhad&sort=Relevance&size=10&page=1&area=both#top>

80 <http://www.ons.gov.uk/ons/rel/lifestyles/contraception-and-sexual-health/2008-09/index.html>

81 <http://www.ons.gov.uk/ons/taxonomy/index.html?nscl=Population#tab-data-tables>

82 <http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcn%3A77-332828>



www.selfcareforum.org

these rates are the highest for any local authority in England<sup>83</sup>. The abortion rate is also the highest in England, 31.4 per 1,000 women aged 15-44 years, compared with 21.7 for London and 16.1 for England<sup>84</sup>.

Research about pregnancy planning suggests that around half of pregnancies are planned, and of those that are not planned around one-third are 'unplanned' and two-thirds are 'ambivalent'. While the highest proportion of unplanned pregnancies occurs in women in aged 16 -19 years, the most unplanned pregnancies are in women aged 20-34<sup>85</sup>. While it is not possible to know how many conceptions locally are intended, taken as a whole the fertility and abortion rates suggest that a high proportion of pregnancies are unintended, resulting in both a high rate of pregnancy continuation and a high abortion rate, with 72% of abortions in 2013 in women aged 20-34 years. While it can be argued that the demography and ethnic make-up of our population contributes to our conception rates, with a high proportion of women of child bearing age from cultures that are more likely to have larger families, the substantial difference between Barking and Dagenham conception rates and those in every other part of the country suggests that this cannot be the whole

story, and we should be looking hard at increasing the use of contraception overall as well as increasing the use of the more reliable long acting methods.

The cost effectiveness of contraception services is well established, with a figure of £1 spent on provision of contraception saving £11 in NHS costs being widely used as an overall figure since the work of McGuire and Hughes was first published in 1995<sup>86</sup>. More recent work has shown the increased cost effectiveness of long acting methods of contraception compared with oral contraception<sup>87 88</sup>. While long acting contraception is the ideal from the perspective of effectiveness – with the lowest risk of failure and the highest cost effectiveness of reversible methods of contraception, we should take every opportunity to maximise the use of all reliable methods of contraception and the availability of hormonal methods online is another source that can be considered.

Of the numerous online providers of oral contraception in the UK, some will supply them after an online Doctor's assessment to new pill users, and others will only supply to women who have already been using the pill for 3 or more months. The American Society of Obstetricians and Gynaecologists have recommended that oral contraception

should be available without prescription<sup>89 90</sup>, although commentators have described wider support for this change as a politically motivated attempt to reduce healthcare costs by taking contraceptive care outside of the American insurance system.

There has been very little discussion about removing the prescription only status from oral contraception in the UK, although emergency hormonal contraception has been available over the counter since 2001 to women over the age of 16. It is interesting that the limitation of oral contraception to prescription only status is a feature of Western Europe, USA, Canada and Australia, with most of the rest of the world allowing it to be sold either with a pharmacy consultation or no formal approval process at all<sup>91</sup>. There have been a small number of pilot studies assessing the benefits of making oral contraception available through pharmacies in England<sup>92</sup>, and it is unclear why there is not more interest in this approach using the system of Patient Group Directions, whereby prescription only drugs can be supplied within a legal framework.

Recommended standards for oral contraception are published by the Faculty of Sexual and Reproductive Healthcare<sup>93</sup> and include the need

83 <http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-317529>

84 [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/319460/Abortion\\_Statistics\\_\\_England\\_and\\_Wales\\_2013.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/319460/Abortion_Statistics__England_and_Wales_2013.pdf)

85 <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3898922/>

86 Published in 1995 by the Family Planning Association, subsequently published in 1996 and available at <http://pubhealth.oxfordjournals.org/content/18/2/189.full.pdf>.

87 <http://humrep.oxfordjournals.org/content/23/6/1338.full.pdf>

88 <http://www.nice.org.uk/guidance/cg30/resources/longacting-reversible-contraception-cost-impact-report2>

89 <http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Gynecologic-Practice/Over-the-Counter-Access-to-Oral-Contraceptives>

90 <http://www.acog.org/About-ACOG/News-Room/Statements-and-Advisories/2014/ACOG-Statement-on-OTC-Access-to-Contraception>

91 [http://cdn3.vox-cdn.com/assets/4662559/Screen\\_Shot\\_2014-06-24\\_at\\_1.45.04\\_PM.png](http://cdn3.vox-cdn.com/assets/4662559/Screen_Shot_2014-06-24_at_1.45.04_PM.png)

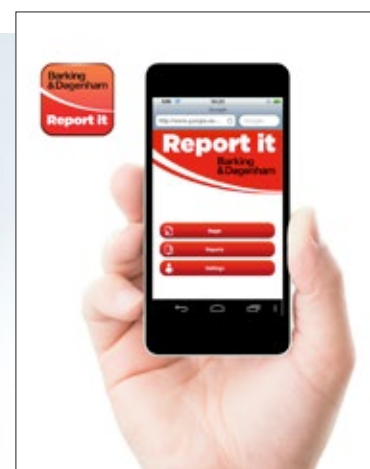
92 <http://www.theguardian.com/society/2012/apr/25/the-pill-13-girls-nhs?uni=Article:in%20body%20link>

93 <http://www.fsrh.org/pdfs/CEUGuidanceCombinedHormonalContraception.pdf>

for a detailed history for medical conditions such as migraine, family history of medical conditions and use of prescription and non-prescription drugs. Such a requirement is readily amenable to self-assessment and studies have found greater than 90% agreement between clinicians and clients when assessing medical history using a self-completed questionnaire<sup>94</sup>. A blood pressure recording is necessary prior to first use of oral contraception as raised blood pressure carries well documented risk, and this is easily available at pharmacies or by the purchase and use of home blood pressure monitors<sup>95</sup>. Similarly, BMI or body mass index is also recommended, and can be easily measured at home or elsewhere with a set of scales. Information on risks and use is readily available, and even with a conservative approach to a Patient Group Direction many thousands of women could easily be supplied with oral contraception through their local pharmacy.

## Self-care – a public health opportunity?

The increasing availability of internet services, including access to diagnostic kits and treatments collected from local pharmacies or delivered by post, for sexual healthcare adds to the range of opportunities that individuals have to manage and control their own health and disease. While commercial ventures are driving many of these opportunities, with their basis being that individuals buy the services, some localities are using similar approaches to improve access for residents by commissioning charities and business providers to



Hand held devices play an increasingly important role in everyday life for many

provide similar services so that the individual's ability or choice to pay is not the deciding factor. Remote access to service provision also challenges professional belief that health care and support is best given as part of a face to face interaction, which may be outmoded as the use of the internet and social media brings access to information and services to our smartphones wherever we are.

The interface between personal health choices and behaviours and personal responsibility for the health consequences is a complex ethical debate and a high proportion of public health and healthcare investment is directed at addressing the consequences of lifestyle choices that have costly health implications, as well as promoting and supporting healthy choices. We tread a path where there is conflict between holding individuals responsible for their own health related

choices, attempting to retain and control access to diagnostic and treatment services which may be safe for people to manage for themselves, and fulfilling our societal obligations to treat the consequences of poor lifestyle choices or difficult access to care. Perhaps self-care for sexual health offers an opportunity to challenge our thinking and reconsider individual freedom to access diagnosis and treatment and our assessment of the risks and benefits to both individuals and society as a whole.

94 <http://jfprhc.bmj.com/content/34/1/51.long>

95 <http://www.bhsoc.org//index.php?cID=246>





# 5

# Lifestyle challenges

Recovery Café – healthy food and good company in a drug and alcohol free environment  
Copyright Homestyle Health – [www.homestylehealth.org](http://www.homestylehealth.org)

## Addressing harm from alcohol consumption

Challenges and disincentives to adopting healthy lifestyles operate at individual, community and population level. The conditions in which people are born, grow, live, work and age, the so-called social and economic determinants of health which are largely responsible for health inequalities, can be influenced by national and local action to create healthier environments and to make healthier choices the easier choices, although we also make personal choices that have a big impact on our health. While it can be argued that our choices about what food to eat are affected by affordability and access – foods with high sugar and fat content are generally cheaper and easier to buy than fresh fruit and vegetables, neither tobacco nor alcohol are necessary for life and both are expensive and damaging to health.

Smoking is the biggest single cause of preventable mortality; around 250 people die each year in Barking and Dagenham because they smoke and the smoking attributable mortality rate is 384 per 100,000 population aged 35 years and over. This compares with a rate for London of 275.9 and for England of 288.7. Smoking prevalence locally is 23% of those aged 18 years and over, rising to nearly 30% in those from routine and manual groups. Every £1 spent on smoking cessation is estimated to save £10 in future health care costs and health gains,

and a 20-a-day smoker saves around £3,000 a year by quitting<sup>96</sup>. Supporting more people to quit smoking, and discouraging more people from starting to smoke, is the most important thing we can do to improve people's health and reduce health inequalities, given that smoking is a greater source of health inequality than social position<sup>97</sup>.

Problems resulting from drinking alcohol are also widespread. In England, 9 million adults drink at levels that increase the risk of harm to their health, 1.6 million adults show some signs of alcohol dependence and alcohol is the third biggest risk factor for illness and death<sup>98</sup>. Public Health England estimate that the NHS incurs £3.5bn a year in costs related to alcohol. Deaths from alcohol related liver disease have doubled since 1980, and one quarter of all deaths in 16-24 year old men are attributable to alcohol. Alcohol misuse contributes to a wide range of conditions and diseases, including high blood pressure, heart conditions and stroke, a number of cancers (liver, mouth, tongue, larynx, oesophagus and breast), pancreatitis, depression and anxiety, and infertility, as well as harming the unborn child.

Alcohol misuse not only harms the individual, but also has a big impact on families, communities and society. Misuse of alcohol contributes to almost half of all violent assaults, is instrumental in many cases of domestic violence and marital breakdown and in the psychological and behavioural problems of children of parents with alcohol



Alcohol Concern leads on national campaigns with Public Health England: Alcohol Awareness Week and Dry January

problems. To control the impact of alcohol misuse and improve the safety of public places and public transport, alcohol is often banned from public events and drinking in public places may be prevented by local bye laws.

Data from the Health Survey for England (2012) found that, among adults who had drunk alcohol in the last week, 55% of men and 53% of women drank more than the recommended daily amounts, including 31% of men and 24% of women who drank more than twice the recommended amounts<sup>99</sup>.

In Barking and Dagenham, 16% of people, around 20,000, are estimated to be drinking alcohol at levels that may be damaging their health, and about 8,000 of them are already likely to have damaged their health. Around 30,000 accident and emergency attendances every year are related to alcohol, and nearly 3,000 hospital admissions. Alcohol related healthcare costs are estimated to be £10m per year, and around 50 people die every year from

96 <http://www.nta.nhs.uk/uploads/why-invest-tobacco-final.pdf>

97 <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2645845/>

98 <http://www.nta.nhs.uk/uploads/why-invest-2014-alcohol-and-drugs.pdf>

99 <http://www.hscic.gov.uk/catalogue/PUB13218>



Alternatives to alcohol offered by 'Company' – a community led enterprise

alcohol-related causes<sup>100</sup>.

## Alcohol drinking guidelines

Lower risk drinking guidelines advise that women should not drink more than 2-3 units a day (a large glass of wine is about 3 units, depending on the strength of the wine) and no more than 14 units a week. For men the lower risk level is 3-4 units a day (about a pint of strong beer or lager) and no more than 21 units a week. While no level of alcohol is completely safe, these levels are thought to carry a low risk of harm<sup>101</sup>. Above these levels, harm to the body from alcohol becomes increasingly likely – at 22 units a week for women and 35 units for men, harm is likely and at 35 units for women and 50 for men, harm is almost certain, although it may not be obvious for some time<sup>102</sup>. The difference in the number of units that lead to risk between women and men, and also between people of different body weight, is to do with the amount and proportion of fat in the body – fat helps to slow down the absorption of alcohol and therefore

slows the rate at which blood alcohol levels increase and ultimately the highest blood levels achieved.

Alcoholic drinks also contribute to obesity as they tend to have high numbers of calories. A pint of beer or lager has about the same number of calories as a sugar doughnut or a large slice of pizza. A large glass of wine has about the same number of calories as a small burger or a piece of cake. As alcohol tends to be drunk in addition to food, and the calories are mostly sugar and bring no nutritional benefit to the body, it can make a significant contribution to overweight and obesity.

## Binge drinking

Binge drinking is defined as drinking double the recommended amount of alcohol in one session<sup>103</sup>. It is often also considered to be about drinking a lot of alcohol quickly with the intention of getting drunk. Because the alcohol is drunk quickly, faster than it can be metabolised by the body, it can make you drunk quickly and also do physical harm, such as directly on the brain cells damaging mood and memory as

well as affecting balance so leading to accidents and falls. Serious overdosing on alcohol can lead to death through stopping the heart or breathing, or through choking on vomit. Binge drinking can lead to aggressive, anti-social and violent behaviour.

Many people will not be aware how little alcohol needs to be drunk to cause harm to oneself by binge drinking. Double the recommended alcohol level means drinking about 3 pints of strong beer for a man, or just less than 3 large (250ml) glasses of wine. For a woman, drinking about 2 pints of strong beer or 2 large glasses of wine is enough alcohol to be a binge, especially if drunk in an hour or two. Binge drinking accounts for about half of the alcohol drunk in the UK<sup>104</sup>.

Even if this quantity of alcohol is drunk once a week, and therefore weekly consumption of alcohol is within the recommended limits, drinking this amount of alcohol quickly is enough to cause harm to the body. The body metabolises alcohol at the rate of about one unit per hour. This means that, after a heavy bout of drinking, blood alcohol

100 <https://www.alcoholconcern.org.uk/for-professionals/alcohol-harm-map/>

101 <http://www.nhs.uk/change4life/Pages/alcohol-lower-risk-guidelines-units.aspx>

102 <http://www.nhs.uk/Livewell/alcohol/Pages/Effectsofalcohol.aspx>

103 <https://www.drinkaware.co.uk/understand-your-drinking/is-your-drinking-a-problem/binge-drinking>

104 <https://www.gov.uk/government/policies/reducing-harmful-drinking>



Public Health England's national campaign, Change 4 Life, includes advice on safe use of alcohol

levels will still be high the next day, not only leaving you with a 'hangover' but meaning that you are still above the legal alcohol limit for driving.

## Young drinkers

Children who begin drinking at a young age drink more frequently and in greater quantities than those who delay drinking, and are more likely to drink and to get drunk, particularly if they start to drink before the age of 13<sup>105</sup>. Drinking at a young age is frequently associated with other risky behaviours, and changes in brain function associated with heavy drinking may affect brain function in the short and longer term. Parents and carers own drinking behaviours influence children's drinking behaviours, as does the drinking habits of their peers.

Since 2003 there has been a downward trend in the number of children aged 11-15 years who said they had drunk alcohol at least once, from 61% in 2003 to 43% in 2012<sup>106</sup>. However, of those underage drinkers who do drink, the number of units drunk in the week is high at 12.5 on average,

and the majority had drunk over the recommended levels for adults on each drinking day<sup>107</sup>. Although in adults males are more likely to be admitted to hospital with alcohol related problems (65%), amongst children (under 16 years) the reverse is true, with females more likely to be admitted (55%) than males. In 2012/13, 2,400 children under the age of 16 and 20,670 people aged 16-24 years were admitted to hospital in England with conditions wholly attributable to alcohol consumption, mainly acute intoxication or toxic effects.

Young people's drinking habits differ from older people as they drink less often during the week and are more likely to drink heavily when they do drink. Average weekly consumption of alcohol by people aged 16-24 years was 11.1 units in 2010, having reduced from 16.9 units in 2005. 54% of people aged 16-24 reported drinking alcohol in the previous week in 2011<sup>108</sup>. Young people now drink less than the national average, and drink fewer times a week than most age groups, but when they do drink a significant proportion binge drink.

A review commissioned by Drinkaware to investigate 'drunken nights out' by young people found that such nights out are entirely normal, at least from the perspective of those who participate in them<sup>109</sup>. Participants in the study reported that drunken nights out were beneficial in terms of escaping from everyday life, bonding and belonging, providing the opportunity for more extreme social interactions such as sexual encounters or fighting, and providing shared experiences for storytelling. Underage drinking was described as a learning phase, testing the effects of alcohol, and increasing age, with changing personal circumstances and priorities, generally signifies reduced participation in such nights out.

## Older drinkers

Alcohol related problems are increasing in people over the age of 60, especially women. A recent survey<sup>110</sup> found that 15% of people aged 60 and over drank alcohol daily, compared with 1% of people aged 16-30 years, and that 25% of people aged 16-30 years stated that

105 [http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/documents/digitalasset/dh\\_110256.pdf](http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_110256.pdf)

106 <http://www.hscic.gov.uk/catalogue/PUB14184>

107 <http://www.ias.org.uk/Alcohol-knowledge-centre/Underage-drinking/Factsheets/Prevalence-of-underage-drinking.aspx>

108 <http://www.ias.org.uk/Alcohol-knowledge-centre/Young-people-and-alcohol/Factsheets/Changing-trends-in-young-peoples-drinking.aspx>

109 [https://www.drinkaware.co.uk/media/264229/drinkaware\\_exec\\_summary\\_vfinal\\_individualpages.pdf](https://www.drinkaware.co.uk/media/264229/drinkaware_exec_summary_vfinal_individualpages.pdf)

110 [http://comres.co.uk/polls/Channel\\_4\\_Drinking\\_habits\\_survey\\_26\\_September\\_2014.pdf](http://comres.co.uk/polls/Channel_4_Drinking_habits_survey_26_September_2014.pdf)

Figure 12:

### AUDIT-C questionnaire guidance

## This is one unit of alcohol...



## ...and each of these is more than one unit



they never drank alcohol, compared with 14% of the over 60's. Although regular drinking in older people is associated with a 'drink to mark the end of the day' or drinking with their evening meal, alcohol related problems are rising fast in the over 60's, particularly amongst women, with the number of women over the age of 65 years treated for alcoholism in the last 5 years more than doubling<sup>111</sup>.

In 2013/14, 9,000 people aged 60 and over were in treatment programmes for alcohol use, 63% of whom were male. Trend data shows a continuing increase in alcohol related hospital admissions in the over 65's, as well as in the number of deaths from alcohol related causes. Of nearly 400,000 admissions wholly or partly attributable to alcohol in people aged 65 and over, 12.5% were wholly attributable to alcohol<sup>112</sup>.

### Middle age drinkers

40% of those admitted to hospital with conditions wholly or partly attributed to alcohol are aged 45-64 years. Hospital admissions peak in those aged 40-49. A history of problem drinking in middle age more than doubles the risk of developing severe memory problems and dementia in later life<sup>113</sup>. Men aged 55-64 years consume the highest average number of units per week (21 units), but for women the highest average number of units consumed is at a much younger age, 35-44 years (12 units per week)<sup>114</sup>.

### Addressing alcohol consumption by individuals - identification and brief intervention

At the individual level, every opportunity should be taken to identify those with drinking habits that put them at risk of current and future health and social problems and to use effective brief intervention techniques to help reduce or stop alcohol consumption.

The Alcohol Use Disorders Identification Test or AUDIT<sup>115</sup> is the gold standard screening test and is used internationally. Locally the AUDIT-C test is used (see Figure 13), which has three initial questions about frequency and quantity of drinking, followed by further detailed questions if necessary.

111 <http://www.nta.nhs.uk/uploads/adult-alcohol-statistics-report-2013-14.pdf>

112 <http://www.hscic.gov.uk/catalogue/PUB14184>

113 <http://www.bmj.com/content/349/bmj.g4908?sso>

114 <http://www.ias.org.uk/Alcohol-knowledge-centre/Consumption/Factsheets/Drinking-patterns-and-trends.aspx>

115 <http://www.alcohollearningcentre.org.uk/Topics/Browse/BriefAdvice/?parent=4444&child=4896>

[http://www.alcohollearningcentre.org.uk/\\_library/WHO\\_-\\_AUDIT.pdf](http://www.alcohollearningcentre.org.uk/_library/WHO_-_AUDIT.pdf)

Figure 13:

**Audit-C questionnaire**

Questions	Scoring System					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 - 2	3 - 4	5 - 6	7 - 9	10+	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Scoring: A total of 5+ indicates increasing or higher risk drinking An overall total score of 5 or above is AUDIT-C positive.						
<b>TOTAL</b>						

**Remaining AUDIT questions**

Questions	0	1	2	3	4	Your score
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	
Scoring: 0 – 7 Lower risk, 8 – 15 Increasing risk, 16 – 19 Higher risk, 20+ Possible dependence						
<b>TOTAL Score equals AUDIT C Score (above) + Score of remaining questions</b>						



Substance misuse display at 2014 health event: left to right, Sonia Drozd, Cllr Saima Ashraf, Margaret Hodge MP

## Brief interventions

Brief interventions can be effectively used by a wide range of trained staff including those in primary care including pharmacies, A&E and a range of other hospital departments, criminal justice, social services, drug services and youth services.

The recommended intervention is an evidence-based approach using the FRAMES<sup>116</sup> principles:

**Feedback** on the client's risk of having alcohol problems

**Responsibility** – change is the client's responsibility

**Advice** – provision of clear advice when requested

**Menu** – what are the options for change?

**Empathy** – an approach that is warm, reflective and understanding

**Self-efficacy** – optimism about the behaviour change

It should cover the potential harm caused by the client's level of drinking and reasons for changing their behaviour, including the health and wellbeing benefits and the barriers to change. Practical strategies to help

reduce alcohol consumption should be outlined and a set of goals should be arrived at. Where possible, monitoring of progress should be undertaken<sup>117</sup>.

There is good evidence for the effectiveness and cost effectiveness of this type of approach. For every eight people who receive simple alcohol advice, one will reduce their drinking to within lower-risk levels<sup>118</sup>. This compares favourably with smoking where only one in twenty will act on the advice given, improving to one in ten with nicotine replacement therapy<sup>119</sup>.

## Treatment services for problem drinkers

Treatment services are provided in primary care for those needing simple or extended brief interventions, and commissioned from community and hospital services for those requiring more complex care. Treatment is organised in tiers depending on the extent of the alcohol problem and the scale of the intervention needed:

Tier 1: identification of hazardous, harmful and dependent drinkers; information on sensible drinking; simple brief interventions to reduce alcohol-related harm; and referral of those with alcohol dependence.

Tier 2: alcohol specific advice; information and support; extended brief interventions to help alcohol misusers reduce alcohol-related harm; and assessment and referral of those with more serious alcohol-related problems for care-planned treatment.

Tier 3: provision of community-based specialised alcohol misuse assessment, and alcohol treatment that is care co-ordinated and care-planned.

Tier 4: provision of residential, specialised alcohol treatments which are care-planned and co-ordinated to ensure continuity of care and aftercare<sup>120</sup>.

Helpful guidance has been published by Public Health England to show the necessary approach for young people attending A&E departments (Figure 14)<sup>121</sup>.

Localising such guidance with contact details relevant to Barking and Dagenham, and producing a similarly localised pathway for adults attending primary care as well as A&E and appropriate training and promotion for a wide range of staff could help to ensure a more consistently implemented approach to identification and appropriate interventions for higher risk drinkers.

116 [http://www.alcohollearningcentre.org.uk/alcoholLearning/learning/IBA/Module4\\_v2/D/ALC\\_Session/300/tab\\_909.html](http://www.alcohollearningcentre.org.uk/alcoholLearning/learning/IBA/Module4_v2/D/ALC_Session/300/tab_909.html)

117 <http://pathways.nice.org.uk/pathways/alcohol-use-disorders/brief-interventions-for-alcohol-use-disorders#path=view%3A/pathways/alcohol-use-disorders/brief-interventions-for-alcohol-use-disorders.xml&content=view-index>

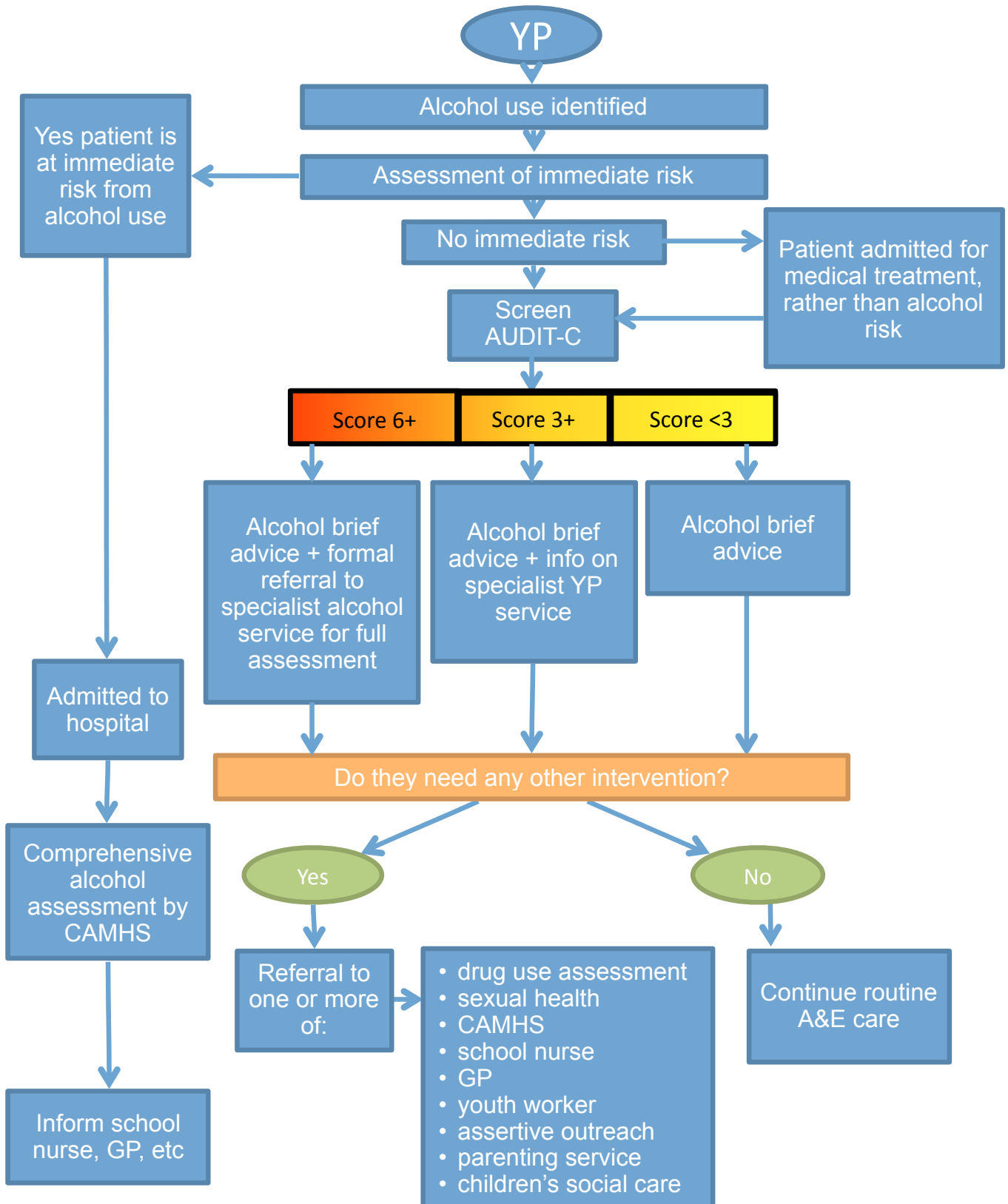
118 <http://www.ncbi.nlm.nih.gov/pubmed/11964101>

119 <http://www.thecochranelibrary.com/userfiles/ccoch/file/World%20No%20Tobacco%20Day/CD000165.pdf>

120 [http://www.alcohollearningcentre.org.uk/\\_library/care\\_pathways1\\_Bexley.pdf](http://www.alcohollearningcentre.org.uk/_library/care_pathways1_Bexley.pdf)

121 <http://www.nta.nhs.uk/uploads/young-peoples-hospital-alcohol-pathways-support-pack-for-ae-departments.pdf>

Figure 14:  
**Model care pathway for alcohol misusing adolescents in A&E**





## Policy approaches to reducing harm from alcohol

Policies that regulate the economic and physical availability of alcohol are effective in reducing alcohol related harm and interventions directed at those already drinking and at risk of

harm are also effective. Information and education programmes do not reduce alcohol-related harm, but have a role in increasing knowledge and attracting attention towards the political and public opportunities to regulate alcohol availability, interventions which are highly cost-effective. The most cost-effective policy options to reduce alcohol-related harm are increasing and enforcing tax,

reducing access, banning advertising and brief advice to drinkers<sup>122</sup>.

In 2009 the Department of Health published suggested commissioning interventions to reduce alcohol related harm in their community. Included in this guidance are seven high impact changes that guide our approach to addressing alcohol-related harm (Figure 15).

Figure 15:  
**High impact changes to reduce alcohol-related harm**

High Impact Change		What this means	What we do in Barking and Dagenham
1	Work in partnership	Co-ordinated action at local level through multi-agency groups	The Alcohol Alliance, a committee of the Substance Misuse Strategy Board, brings together partners to progress actions from the Alcohol Strategy <sup>123</sup>
2	Develop activities to control the impact of alcohol misuse in the community	Make use of all the existing laws, regulations and controls available to all the local partners to minimise alcohol related harm	The whole of the borough is a designated No Drinking Zone, no alcohol consumption in public places is permitted. There is a test purchasing programme to check licensed premises comply with alcohol purchasing age requirements and alcohol misuse screening of people arrested
3	Influence change through advocacy	Find high-profile champions to provide leadership within partner organisations and a focus for action to reduce alcohol harm	Council support for Alcohol Awareness Week, in 2014 there were 26 events in 20 locations, support also from business
4	Improve the effectiveness and capacity of specialist treatment	Providing evidenced based, effective treatment as well as increasing treatment opportunities for dependent drinkers may offer the most immediate opportunity to reduce alcohol-related admissions	Community detoxification programme and panel of providers for Tier 4 residential services

122 [http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0020/43319/E92823.pdf](http://www.euro.who.int/__data/assets/pdf_file/0020/43319/E92823.pdf)

123 <http://moderngov.barking-dagenham.gov.uk/documents/s66622/Alcohol%20Strategy%20Report%20-%20App.%201%20Strategy.pdf>



5	Appoint an Alcohol Health Worker	<p>Appointment of a dedicated alcohol liaison Nurse in each major acute hospital, to provide a focus for:</p> <ul style="list-style-type: none"> <li>• Medical management of patients with alcohol problems within the hospital</li> <li>• Liaison with community alcohol and other specialist services</li> <li>• Education and support for other healthcare workers in the hospital</li> <li>• Implementation of case-finding strategy and delivery of brief advice within the hospital</li> </ul>	<p>Established alcohol liaison workers in BHRUT with good links between A&amp;E and other departments, carrying out Identification and Brief Advice and highlighting the pathway to the Community Alcohol Service (CAS)</p>
6	Identification and Brief Advice (IBA) – Provide more help to encourage people to drink less	<p>Opportunistic case-finding followed by the delivery of simple alcohol advice in primary care, A&amp;E, specialist settings (such as fracture clinics and sexual health clinics) and criminal justice settings</p>	<p>In place, but opportunity to review consistency of delivery and use of AUDIT-C approach to identification and ensure brief advice widely available, with an IBA trained professional in every GP practice and a comprehensive plan for widespread delivery of IBA across the borough</p>
7	Amplify national social marketing priorities	<p>Social marketing is the systematic application of marketing, alongside other concepts and techniques, to achieve specific behavioural goals, for a social good. For alcohol, the goal is to reduce alcohol-related hospital admissions by influencing those drinking at higher risk to reduce their use of alcohol to within lower risk levels</p>	<p>Promotion of Alcohol Awareness week on annual basis, increasing use of social media including Apps that help to keep track of drinking and associated events (eg <a href="http://www.drinkcoach.org.uk/download-alcohol-app-for-ios-and-android.html">http://www.drinkcoach.org.uk/download-alcohol-app-for-ios-and-android.html</a>). Targeting of regular drinkers to increase recognition of how quickly units add up to harmful levels.</p>

Source: [http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/documents/digitalasset/dh\\_104854.pdf](http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_104854.pdf) and London Borough of Barking and Dagenham Community Safety Partnership

## Addressing alcohol in Barking and Dagenham – our alcohol strategy

In 2013 the Community Safety Partnership agreed a local strategy<sup>124</sup> that takes a comprehensive approach to the personal, community and environmental aspects of alcohol consumption. The focus areas for the strategy are:

- Advice and information
- Alcohol related crime, domestic violence and anti-social behaviour
- Children, young people and families
- Adults
- Alcohol related hospital admissions, treatment and health
- Licensing and alcohol retail
- Economic impact

This comprehensive approach continues to drive our work, and in particular we have made good progress with the collection of anonymised A&E data to identify alcohol hotspots, reduce violent crime and address A&E attendance and admission.

## Addressing harmful drinking – a partnership approach

Reducing the impact of alcohol on our community and the numbers of people who drink at higher risk and harmful levels will only be achieved through a partnership between national and local government, and between health and care services and individuals. The recently published manifesto from the All Party Parliamentary Group (APPG) on Alcohol Misuse<sup>125</sup> sets out a clear ten

point plan which is a useful approach to the necessary actions.

Most of the actions proposed by the APPG are aimed at central government – making reducing alcohol harm the responsibility of a single government minister, introducing a minimum price for alcoholic drinks, introducing public health as a fifth licensing objective, strengthening regulation of alcohol marketing to protect children and young people, including a health warning on all alcohol labels, and reducing the blood alcohol level for driving. Their proposal to introduce the widespread use of sobriety orders, which require an offender to abstain from alcohol for a fixed period of time following a conviction, with alcohol levels monitored either through regular breath tests or electronic tags, is being trialled around the country and offers an approach to breaking the cycle of violent crime and domestic violence.

The remaining actions proposed by the APPG are aimed at local commissioners and providers, and these are within the remit of our health and care services. There is good evidence that identification and brief advice from GPs and other health professionals are effective in enabling people to understand and address harmful levels of drinking and that good treatment services help to reduce alcohol-related hospital admissions. We need to work together to prioritise training for professionals in a wide range of health and care settings, so that identification of people drinking at hazardous and harmful levels is a routine part of care, and every opportunity is taken to reduce the overall burden of alcohol related disease. Training for social workers, midwives and healthcare professionals on parental substance misuse, foetal

alcohol syndrome and alcohol-related domestic violence is within our strategy and we need to ensure that it is effective in identifying those at risk. The final action in the strategy is a proposal to increase funding and improve access to treatment services to the target of 15% of problem drinkers having treatment locally from the current national level of 6%. We will be reviewing access and care pathways as we refresh our alcohol strategy and commissioning to assess our current treatment programme.

While central and local government builds an environment which makes problem drinking more of a challenge and supports people to reduce harmful drinking habits, and local government and the NHS continue to invest in treatment services, individuals themselves share responsibility to be aware of the risks associated with their drinking levels and seek to control harm, accessing support if this is the most effective approach for themselves. Partnership for health and wellbeing is as much about individuals as it is about organisations, and regardless of the extent of legislation and support, behaviour change depends on each individual understanding their own drinking habits and taking the necessary steps to change their behaviour to protect their own health and wellbeing.

124 <http://moderngov.barking-dagenham.gov.uk/documents/s66622/Alcohol%20Strategy%20Report%20-%20App.%201%20Strategy.pdf>

125 [http://www.alcoholconcern.org.uk/wp-content/uploads/2014/10/APPG\\_Manifesto.pdf](http://www.alcoholconcern.org.uk/wp-content/uploads/2014/10/APPG_Manifesto.pdf)

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