Improving health
Increasing life

2007/08
DIRECTOR OF PUBLIC HEALTH
ANNUAL REPORT
Contents

Chapter 01: Introduction 06

Chapter 02: Determining need 08

Joint Strategic Needs Assessment 10
— Production of the Joint Strategic Needs Assessment 11
— Identified needs – results from the Joint Strategic Needs Assessment 14

Summary of key findings from the East Sussex Joint Strategic Needs Assessment 40

Chapter 03: Determining need through comprehensive needs assessments 42

Older people needs assessment 43
— Stroke 44
— Dementia 44
— Chronic obstructive pulmonary disease 45
— Falls 45
— Summary – older people 46

Children’s needs assessment 47
— Risky behaviour 47
— Complex health needs 48
— Chronic disease 48
— Looked after children 49

Mental health needs assessment 50
— How much poor mental health is there in East Sussex? 51
— Mental health services 51
— Service user involvement 52

Learning disabilities needs assessment 53
Figures & Tables

**Figures**

**Figure 01:** Change in total population projections 2012  
**Figure 02:** Index of multiple deprivation 2004 score  
**Figure 03:** Income deprivation – percentage of children affected by income deprivation IMD 2004  
**Figure 04:** Income deprivation – percentage of older people affected by income deprivation IMD 2004  
**Figure 05:** Benefits data relating to people on low incomes – percentage working age people claiming income support February 2007  
**Figure 06:** Dependency on health related benefits – percentage working age people claiming incapacity benefit or severe disablement allowance February 2007  
**Figure 07:** Percentage of households on low income (less than 60% of national median income) 2007  
**Figure 08:** Trends in life expectancy of males at birth 1996-2005  
**Figure 09:** Trends in life expectancy of females at birth 1996-2005  
**Figure 10:** Comparison of trends in circulatory disease mortality rates  
**Figure 11:** Comparison of trends in stroke mortality rates  
**Figure 12:** Summary of what we need to do to increase life expectancy  
**Figure 13:** Under 18 conceptions  
**Figure 14a&b:** Number of MRSA and C. Difficile infections at East Sussex Hospitals NHS Trust with target values April 2007–March 2008  
**Figure 15:** Many strands of clinical governance  
**Figure 16:** Comparison of trends in statin prescribing

**Tables**

**Table 01:** The commissioning framework for health and well-being minimum data set for joint strategic needs assessment production  
**Table 02:** Life expectancy of the lowest 20 wards 2003/05  
**Table 03:** Rolling average under 18 conception rates per 1000 young people age 15-17 by ward/borough 1998/2000 and 2004/2006 and proportion of conceptions leading to abortion  
**Table 04:** 2001 census ethnicity figures for super output areas  
**Table 05:** Comparing MRSA and C. difficile  
**Table 06:** Estimated numbers of smokers  
**Table 07:** Proposed service details of new three-tier managed smoking cessation service  
**Table 08:** Estimated numbers of patients in the 20 wards with the lowest life expectancy with relevant disease diagnoses
Introduction
This is the first Annual Report of the Director of Public Health since the inception of the new Primary Care Trusts in October 2006. The merger of the four former East Sussex Primary Care Trusts: Eastbourne Downs; Sussex Downs & Weald; Hastings and St Leonards and Bexhill & Rother; and the joint appointment of the Director of Public Health with East Sussex County Council has provided many exciting and new opportunities for improving the health and well-being of the population of East Sussex.

This report identifies the important public health issues facing the people living in East Sussex and makes recommendations on the actions that will be needed in the coming year to improve their health.

In the last year, in partnership with East Sussex County Council, a major review of the baseline health status and health and social care needs of the residents across East Sussex has been undertaken. The key findings are described in Chapter 02. In addition, we have also conducted a number of comprehensive healthcare needs assessments for older people; children; mental health and learning disabilities. These are presented in Chapter 03.

Chapter 04 outlines some of the health improvement and well-being work currently being undertaken across East Sussex and identifies priorities for the coming year.

Chapter 05 outlines the health protection measures to reduce hospital acquired infection and other infectious disease risks and tackle screening issues and the processes in place to manage emergencies.

Chapter 06 describes the quality improvement agenda, ensuring that health services are safe, improve health and reduce health inequalities.

Finally the report outlines the next steps and the investment priorities for the Primary Care Trust based on the identified needs that will enable us to work with communities to improve life expectancy and reduce health inequalities.

Diana Grice, Director Public Health & Well-Being and Medical Director East Sussex Downs & Weald Primary Care Trust
Recent government policy creates a favourable environment in which to work for health improvement. The Department of Health’s 2007 Commissioning Framework for Health and Well-Being, recognises that the health service is still too focused on commissioning for volume and price, rather than for quality and outcomes. It takes into account that the focus has been on treating illness rather than preventing it. The framework’s stated aims are to enable commissioners to achieve:

- a shift towards services that are personal, sensitive to individual need and that maintain independence and dignity;
- a strategic reorientation towards promoting health and well-being, investing now to reduce future ill health costs;
- a stronger focus on commissioning the services and interventions that will achieve better health across health and local government, with everyone working together to promote inclusion and tackle health inequalities.
The commissioning framework covers commissioning of services for all the population of a locality and recognises that needs assessment is an essential tool for commissioners to inform service planning and commissioning strategies. The Local Government and Public Involvement in Health Act (2007) placed a duty on upper-tier Local Authorities and Primary Care Trusts to undertake a Joint Strategic Needs Assessment, defined as ‘a systematic method for reviewing the health and well-being needs of a population, leading to agreed commissioning priorities that will improve health and well-being outcomes and reduce inequalities’. The assessments are to be based on:

— a joint analysis of current and predicted health and well-being outcomes;
— an account of what people in the local community want from their services; and
— a view of the future, including potential new or unmet need.

This work is critical in informing the development of sustainable community strategies and Local Area Agreements and is the means by which the Primary Care Trusts and the Local Authorities describe the future health, care and well-being needs of the local population and guide the future direction of service delivery to meet those needs over the next three to five years. It is an aggregated assessment of need and should be used to identify groups where needs are not being met and that are experiencing poor outcomes and not for individual needs identification.

A Joint Strategic Needs Assessment will:

— Provide analysis of data to show the health and well-being status of local communities;
— Define where inequalities exist; and
— Use local community views and evidence of effectiveness of interventions to shape the future investment and disinvestment of services.

Its outcomes are:

— Define achievable improvements in health and well-being outcomes for the local community;
— Send signals to existing and potential providers of services about potential service change;
— Support the delivery of better health and well-being outcomes for the local community;
— Inform the next stages of the commissioning cycle;
— Aid better decision-making; and
— Underpin the Local Area Agreement and the choice of local outcomes and targets, as well as the Primary Care Trust Prospectus.
PRODUCTION OF THE EAST SUSSEX JOINT STRATEGIC NEEDS ASSESSMENT

The Joint Strategic Needs Assessment was developed during the summer of 2007, in partnership between East Sussex County Council and East Sussex Downs & Weald and Hastings & Rother Primary Care Trusts. It was based upon the description of the minimum data set and analyses outlined in *The Commissioning Framework for Health & Well-being* (Table 01). This minimum was built upon and complemented by other locally available information.

Important locally was the inclusion of data at the three different aggregation levels of the Primary Care Trust and Local Authority:

**A Local Authority hierarchy:**
County (1) – District/Borough (5) – Ward (101)

**A Primary Care Trust hierarchy:**
Primary Care Trust (2) – Practice based commissioning cluster (14) – GP Practice (79)

It was possible to achieve this by developing an algorithm, which enabled estimation of the proportion of each practice population residing in each ward. Similarly, it was possible to estimate, for populations registered with practices, what proportion of each electoral ward was registered with each practice.

Over 150 indicators have been included and analysed. Data has been extracted from general practice, hospital, Primary Care Trust and social care systems in addition to nationally available data and specific analyses carried out by public health information specialists.

A Quality and Outcome Framework Benchmarking Tool, developed by the Doncaster Public Health Intelligence Unit, was used to investigate predicted versus known prevalence of specific diseases/conditions. *East Sussex in Figures* is a data observatory developed by East Sussex County Council, which provides web-based information. The Primary Care Trust has worked closely with East Sussex County Council and the outputs from this work will be integrated with *East Sussex in Figures*. Further work will be needed to maintain and develop this information data in the future.

Detailed scorecards have been developed to show scores/performance against the indicator set at the different levels of aggregation. These scorecards are being used to support specific development plans, strategies and other joint working. Limited children’s data was included in the original work and more recently, additional scorecards for children’s data have been produced and will be used to inform the development of children’s services during next year.
The scorecards are being used to enable staff in Local Authorities and primary care practices and clusters to inform service planning, the community strategy and the Local Area Agreement about the range of services that should be provided to their patients in the future to reduce health inequalities and meet needs.

The detailed information for all indicators included within the East Sussex Joint Strategic Needs Assessment are available through the public health section of the Hastings and Rother Primary Care Trust website (www.hastingsandrotherpct.nhs.uk) and will be available on East Sussex in Figures (www.eastsussexinfigures.org.uk) shortly. This chapter provides detailed commentary on selected key indicators.
### Table 01: The commissioning framework for health and well being minimum data set for Joint Strategic Needs Assessment production

<table>
<thead>
<tr>
<th>Demography</th>
<th>Population numbers</th>
<th>— Current population estimates x 5-year bands D and gender</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Births</td>
<td>— Current births and projected rates</td>
</tr>
<tr>
<td></td>
<td>Older people</td>
<td>— Current total aged 65+, male and female and five-year projections</td>
</tr>
<tr>
<td></td>
<td>Ethnicity</td>
<td>— Current numbers, percentages and projections</td>
</tr>
<tr>
<td>Social &amp; environmental context</td>
<td>Benefits data</td>
<td>— Children under 16 in households dependent upon Income Support</td>
</tr>
<tr>
<td></td>
<td>Deprivation</td>
<td>— IMD 2004</td>
</tr>
<tr>
<td></td>
<td>Characteristics</td>
<td>— Housing tenure</td>
</tr>
<tr>
<td></td>
<td></td>
<td>— Living arrangements / over-crowding</td>
</tr>
<tr>
<td></td>
<td></td>
<td>— No access to car or van</td>
</tr>
<tr>
<td></td>
<td></td>
<td>— Employment data</td>
</tr>
<tr>
<td></td>
<td></td>
<td>— Average incomes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>— Rural or urban location</td>
</tr>
<tr>
<td>Current known health status of population</td>
<td>Illness &amp; lifestyle</td>
<td>— British Health Survey 2004</td>
</tr>
<tr>
<td></td>
<td></td>
<td>— Quality and Outcomes Framework</td>
</tr>
<tr>
<td></td>
<td></td>
<td>— GP QMAS data</td>
</tr>
<tr>
<td></td>
<td></td>
<td>— Risk factor data (smoking prevalence)</td>
</tr>
<tr>
<td></td>
<td>Teenage conceptions</td>
<td>— Age &lt;16 rate plus 95% CI</td>
</tr>
<tr>
<td></td>
<td>Census 2001</td>
<td>— Age &lt;18 rate plus 95% CI</td>
</tr>
<tr>
<td></td>
<td></td>
<td>— Standardised limiting long-standing illness ratio (persons in household)</td>
</tr>
<tr>
<td>Current met needs of the population</td>
<td>Social Care</td>
<td>— RAP 3: Source of referrals</td>
</tr>
<tr>
<td></td>
<td></td>
<td>— P1: Clients receiving community-based services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>— RAP P2f: Clients receiving community-based services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>— RAP C1: Carers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>— SWIFT</td>
</tr>
<tr>
<td></td>
<td>Primary Care</td>
<td>— Predicted prevalence versus known prevalence of diseases</td>
</tr>
<tr>
<td></td>
<td></td>
<td>— Dental: % DMFT 5-year olds trend</td>
</tr>
<tr>
<td></td>
<td></td>
<td>— Immunisation: Resident-based uptake rates</td>
</tr>
<tr>
<td></td>
<td>Hospital Care (HES data)</td>
<td>— Top 10 causes of admission</td>
</tr>
<tr>
<td></td>
<td></td>
<td>— Top 10 diagnoses consuming most bed days</td>
</tr>
<tr>
<td></td>
<td></td>
<td>— Average, median and range of length of stay</td>
</tr>
<tr>
<td>Patients / service user voice</td>
<td>Social Care</td>
<td>— User surveys</td>
</tr>
<tr>
<td></td>
<td>Primary &amp; Community-based care</td>
<td>— GPAQ</td>
</tr>
<tr>
<td></td>
<td></td>
<td>— PALS/LINKS data (qualitative and quantitative)</td>
</tr>
</tbody>
</table>
IDENTIFIED NEED – RESULTS FROM THE EAST SUSSEX JOINT STRATEGIC NEEDS ASSESSMENT

DEMOGRAPHY

Approximately half a million people live in East Sussex, the population is older than the national profile with one in four residents being over pensionable age. It is predicted that between 2001 and 2016 the population of East Sussex will increase by just below 4%. Within this there will be:

— A 23% increase in people aged over 65;
— A 12% increase in those aged 50-64;
— A 15% decrease in those aged 30-49;
— A 12% increase in those aged 15-29; and
— An 11% decrease in the number of children aged 0-14.

In overall terms, birth rates are projected to fall. Estimates for East Sussex indicate a 3% reduction by 2012.

Within East Sussex, the greatest increase in population is expected to be in Eastbourne Borough Council area, the smallest increase will be in Hastings. Of the 20 wards with the greatest increase in population, eight are in Eastbourne Borough, six are in Wealden District, three are in Rother District and three are in Lewes District. None are in Hastings Borough.

Projected population increase is lower in Hastings and Rother Primary Care Trust than in East Sussex County. Bexhill Centre is the practice based commissioning cluster expected to have the biggest population increase, with all its constituent GP practices having a population increase above the median for East Sussex. Rural Rother has the greatest range of projected population increase of the constituent GP practices, but all are below the median for East Sussex.
Figure 01: Change in total population, projections 2012

PBC Cluster chart (ordered by IMD 2004 score)
Deprivation indices measure the proportion of households in a defined small geographical area with a combination of circumstances indicating low living standards or a high need for services, or both.

The Joint Strategic Needs Assessment report used the Index of Multiple Deprivation 2004 to measure deprivation. This is made up of seven domains:

- income;
- employment;
- health and disability;
- education, skills and training;
- barriers to housing and services;
- crime;
- living environment.

Each of these domains is made up of various indicators which are used to build up an overall index of deprivation.

It is important to note that ecological measures of deprivation (i.e. measures based on geographical areas, rather than individual circumstances) are limited in their ability to describe individual circumstances: not all deprived people live in deprived wards, just as not everyone in a ward ranked as deprived are themselves deprived. Deprivation indices can be used to identify areas of relative concentration of disadvantage, especially in the absence of data at the personal level, or where the fact of geographical concentration is pertinent.

However, disadvantaged people also live elsewhere and could be excluded in large numbers if, for example, interventions were planned purely on the basis of a local census based, deprivation score. For maximum effectiveness, policies and services need to target individuals as well as deprived areas.

Of the 20 most deprived wards in East Sussex, 12 are in Hastings Borough and four in Rother District. The most deprived ward in East Sussex is Central St Leonards (Hastings).

Deprivation is considerably higher in Hastings & Rother Primary Care Trust than in the East Sussex county. Lower St Leonards is the most deprived cluster, but four of the clusters have a deprivation score that exceeds that of the Primary Care Trust. Lower St Leonards cluster also has the greatest range in the deprivation scores of the constituent GP practices, although all are significantly deprived and above the 75th percentile for East Sussex. All the constituent GP practices in East and West Hastings clusters also have deprivation scores above the 75th percentile for East Sussex.

There are two supplementary domains of the Index of Multiple Deprivation 2004 which relate to income deprivation affecting children and older people, these do not contribute to the overall Index of Multiple Deprivation 2004 score, but can be used additionally to demonstrate income deprivation relating to these two groups. These are in effect a sub-set of the main income domain but very useful in their own right.
Figure 02: Index of multiple deprivation 2004 score

PBC Cluster chart (ordered by IMD 2004 score)
Hastings Borough has the highest proportion of children affected by income deprivation in East Sussex. Nearly 1 in 3 children are affected in Hastings. Of the 20 wards with the highest proportion of affected children, 10 are in Hastings Borough, and five in Rother District. The ward with the highest proportion of affected children is Hollington (Hastings) with over 1 in 2 children being affected.

The proportion of children affected by income deprivation is much higher in Hastings & Rother Primary Care Trust than in the East Sussex county. Lower St Leonards is the cluster with the highest proportion of affected children, but four of the clusters have proportions of affected children higher than that of the Primary Care Trust. Of the clusters, the Upper St Leonards cluster has the greatest range in the proportion of affected children of the constituent GP practices, although all are above the median for East Sussex. All the constituent GP practices in West Hastings and Lower St Leonards clusters have proportions of affected children above the 75th percentile for East Sussex.
Figure 03: Income deprivation – percentage of children affected by income deprivation (IMD 2004)

PBC Cluster chart (ordered by IMD 2004 score)
Hastings Local Authority has the highest proportion of older people affected by income deprivation in East Sussex. Nearly 1 in 5 older people are affected in Hastings. Of the 20 wards with the highest proportion of affected older people, 12 are in Hastings and two are in Rother. The ward with the highest proportion of affected older people is Gensing (Hastings) with more than 1 in 4 older people being affected.

The proportion of older people affected by income deprivation is higher in Hastings & Rother Primary Care Trust than in the East Sussex county. Lower St Leonards cluster is the cluster with the highest proportion of affected older people, but four of the clusters have proportions of affected older people higher than that of the Primary Care Trust. Of the clusters, Upper St Leonards has the greatest range in the proportion of affected older people of the constituent GP practices. All the constituent GP practices in Lower St Leonards and West Hastings clusters have proportions of affected older people above the 75th percentile for East Sussex.
Figure 04: Income deprivation – percentage of older people affected by income deprivation (from IMD 2004)

PBC Cluster chart (ordered by IMD 2004 score)
InCOME SUPPORT

Hastings Local Authority has the highest proportion of working age people claiming income support. Nearly 1 in 10 working age people are claimants in Hastings. Of the 20 wards with the highest proportions of working age people claimants, 10 are in Hastings and four are in Rother. The ward with the highest proportion of working age claimants is Central St Leonards (Hastings) with more than 1 in 6 claimants.

The proportion of working age people claiming income support is higher in Hastings & Rother Primary Care Trust than in the East Sussex county. Lower St Leonards cluster has the highest proportion of claimants, but three of the clusters have proportions of claimants higher than that of the Primary Care Trust. Lower St Leonards cluster also has the greatest range in the proportion of claimants of the constituent GP practices. All the constituent GP practices in West Hastings practice based commissioning cluster have proportions of claimants above the 75th percentile for East Sussex.
Figure 05: Benefits data relating to people on low incomes – percentage working age people claiming income support, February 2007

PBC Cluster chart (ordered by IMD 2004 score)
Hastings Local Authority has the highest proportion of working age people claiming health related benefits. Over 1 in 9 working age people are claimants in Hastings. Of the 20 wards with the highest proportion of claimants, 10 are in Hastings and four in Rother. The ward with the highest proportion of claimants is Central St Leonards (Hastings) where nearly 1 in 5 are claimants.

The proportion of working age people claiming health related benefits is higher in Hastings & Rother Primary Care Trust than in the East Sussex county. Lower St Leonards is the cluster with the highest proportion of claimants, but three of the clusters have proportions of claimants higher than that of the Primary Care Trust. Lower St Leonards cluster also has the greatest range in the proportion of claimants of the constituent GP practices. All the constituent GP practices except two in West Hastings cluster have proportions of claimants above the 75th percentile for East Sussex.
Figure 06: Dependency on health-related benefits – percentage working age people claiming incapacity benefit or severe disablement allowance, February 2007

PBC Cluster chart (ordered by IMD 2004 score)
Hastings Borough has the highest proportion of households with low income (less than 60% of national median income). Over 1 in 4 households have low incomes in Hastings. Of the 20 wards with the highest proportion of low income households, seven wards are in Hastings and six are in Rother.

The proportion of households with low income is higher in Hastings & Rother Primary Care Trust than the East Sussex county. Lower St Leonards cluster has the highest proportion of low income households, but four of the clusters have proportions of low income households higher than that of the Primary Care Trust. Rural Rother cluster has the greatest range in the proportion of low income households of the constituent GP practices. All the constituent GP practices in East Hastings practice based commissioning cluster have proportions of low income households above the 75th percentile for East Sussex.
Figure 07: Percentage of households on low income (less than 60% of national median income), 2007
PBC Cluster chart (ordered by IMD 2004 score)
Life expectancy at birth in years is a useful measure of how deprived or affluent an area is. It is affected by genetic inheritance and by some modifiable factors including housing, employment, environment, lifestyle factors and our access to healthcare.

The population of East Sussex is generally healthy in comparison to other areas in England. On average men and women in East Sussex expect to live longer than in England. However, there are large differences at district/borough level (Figures 08 and 09). Generally, the more affluent the people are the better their health will be and the longer they will live. Conversely, less affluent the people are the worse their health will be and the shorter they live.
Figure 08: Trends in life expectancy of males at birth from 1996–2005

Source: ONS

Figure 09: Trends in life expectancy of females at birth from 1996–2005

Source: ONS
Across East Sussex there was a 13.3 year gap in life expectancy by ward, the lowest being 72 years in Gensing (Hastings and Rother) and the highest being 85.6 years in Mayfield (East Sussex Downs and Weald). Improving the health of disadvantaged people in East Sussex will do most to reduce these inequalities.

The National Health Inequalities Public Service Agreement Target is to:

— *Reduce health inequalities by 10% by 2010 as measured by infant mortality and life expectancy at birth.*

This target is underpinned by two more detailed objectives:

— *Starting with children under one year, by 2010 to reduce by at least 10% the gap in mortality between routine and manual groups and the population as a whole.*

— *Starting with Local Authorities, by 2010 to reduce by at least 10% the gap in life expectancy between the fifth of areas with the worst health and deprivation indicators and the population as a whole.*

Within East Sussex, the life expectancy at birth target has been interpreted locally and included in the current Local Area Agreement:

— *By 2010 to reduce by at least 10% the gap in life expectancy between the fifth of wards in East Sussex with the lowest life expectancy and the remainder of the population as a whole in East Sussex.*

The fifth of wards with the lowest life expectancy in East Sussex are detailed in Table 02:
Table 02: Life expectancy of the lowest 20 wards in East Sussex, in Hastings & Rother 2003–05

<table>
<thead>
<tr>
<th>Primary Care Trust</th>
<th>Local Authority Area</th>
<th>Ward</th>
<th>Life Expectancy (persons, years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hastings &amp; Rother</td>
<td>Hastings</td>
<td>Central St Leonards</td>
<td>72.1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Maze Hill</td>
<td>75.5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Gensing</td>
<td>75.7</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Wishing Tree</td>
<td>77.4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ore</td>
<td>77.8</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Braybrooke</td>
<td>78.1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hollington</td>
<td>78.9</td>
</tr>
<tr>
<td></td>
<td>Rother</td>
<td>Sackville</td>
<td>74.9</td>
</tr>
<tr>
<td></td>
<td></td>
<td>St Michaels</td>
<td>75.9</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sidley</td>
<td>76.2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Old Town (Bexhill)</td>
<td>78.2</td>
</tr>
<tr>
<td>East Sussex (excluding the 20 wards with the lowest life expectancy)</td>
<td></td>
<td></td>
<td>81.1</td>
</tr>
</tbody>
</table>

Source: Recorded deaths 2003-05.
Figures 10 and 11 examine circulatory disease & stroke mortality rates.

Figure 10 shows that there is a persistent gap in mortality from circulatory disease between the wards with the worst life expectancy and the rest of East Sussex. Further analysis of this gap shows that the gap remains constant for females but is widening for males.

Figure 11 shows the gap in mortality from stroke between the wards with the worst life expectancy and the rest of East Sussex. It demonstrates that the gap is widening as a result of the mortality rate for the wards with the worst life expectancy remaining constant but the rate for the rest of East Sussex decreasing.
Figure 10: Comparison of trends in circulatory disease mortality rates

Figure 11: Comparison of trends in stroke mortality rates
KEY INTERVENTIONS

Tackling vascular disease, including coronary heart disease, stroke, diabetes, renal disease and peripheral arterial disease, will be the key to achieving the life expectancy target. Action needs to be focused on preventing the early deaths of people who already have disease and those who are at high risk. In particular, reducing smoking levels and increasing the use of statins are two key interventions that, as part of a comprehensive programme, will rapidly reduce the number of early deaths. National Institute for Health and Clinical Excellence guidance states that statin therapy is recommended as part of the management strategy for the primary prevention of coronary vascular disease for adults who have a 20% or greater 10 year risk of developing coronary vascular disease. Improving diet and increasing exercise also have benefit in reducing vascular disease. Implementation of the National Service Frameworks for coronary heart disease, diabetes and renal disease and the new Stroke Strategy will all be important in achieving the target.

In terms of targeting what needs to be done to improve life expectancy in the 11 wards with the worst life expectancy, reducing smoking levels and increasing the use of statins are key interventions alongside lifestyle advice. The introduction of coronary vascular disease ‘at-risk’ registers and implementation of the National Service Frameworks for coronary heart disease, diabetes, renal failure and the Stroke Strategy will also support this work. These next steps are described in more detail in Chapter 08.

CURRENT MET NEEDS OF THE POPULATION - PRIMARY CARE

Primary care is the major provider of healthcare in the UK with over 90% of patient contacts occurring in this setting. The Quality and Outcomes Framework was introduced as part of the new general medical services contract for primary care in 2004. It provides a rich new resource of information about primary care services. It is hoped that this system will improve the management of chronic diseases and the quality of care offered to patients. It is also thought that over time this new system could help the NHS to tackle health inequalities by focusing resources and targeting those at risk of ill health. This data collated provides a useful collection of disease registers and quality of care indicators.
Figure 12: Summary what we need to do to increase life expectancy

Starting with Local Authorities, by 2010 to reduce by at least 10% the gap in life expectancy between the fifth of areas with the worst health and deprivation indicators and the population as a whole.

By 2010 to reduce by at least 10% the gap in life expectancy between the 20 wards with the lowest life expectancy and the rest of East Sussex.

Target Conditions:
- Vascular
- Heart disease
- Stroke
- Diabetes
- Renal disease
- Peripheral arterial disease

Prevention:
- Reducing smoking levels
- Improving diet
- Increasing exercise
- Increasing the use of statins

Treatment:
- Increasing the use of statins
- Coronary heart disease National Service Framework
- Diabetes National Service Framework
- Renal National Service Framework
- Stroke Strategy
This information is collected at an aggregate level for each general practice. The Doncaster Public Health Intelligence Unit has produced a tool-kit that defines expected prevalence rates for several conditions that adjust for socioeconomic conditions. These were applied to the East Sussex Quality and Outcomes Framework actual prevalence results.

On the whole the prevalence of the following conditions is higher throughout East Sussex than might be anticipated from application of the Doncaster Model: cancer, atrial fibrillation, hypothyroidism, mental health. The prevalence of the following conditions is lower throughout East Sussex than might be anticipated: chronic kidney disease, hypertension, coronary heart disease, asthma, stroke, heart failure, epilepsy, obesity, dementia, learning disability.

NEXT STEPS – PREVALENCE DATA

It is recommended that the Primary Care Trust and all practices should invest time and resource in validating their disease prevalence data. These data are of vital importance in improving health and reducing inequalities. The reported prevalence of specific conditions does not seem to be well correlated with social economic disadvantage or be consistent with other sources of information. This is important because it suggests that illness is not being detected within the groups most at risk of chronic conditions or early death when preventative and healthcare services could make a difference to the patient’s health.

SOCIAL CARE

Social care and health partnerships are central facets of the government’s approach to social care and health policy. Choosing Health emphasised that partnerships and sharing information would be the basis for reducing inequalities and improving the health of the population. Our Health, Our Care, Our Say reinforced the drive for a greater focus on improved health and well-being as a partnership between people and public services.

The need for health and social care resources is determined by the complex interplay of a number of factors including age, deprivation, spatial distribution of the population, the availability of services, and individuals ability to contribute towards health and social care costs. Contributing factors include: morbidity and mortality levels; levels of disability; social disadvantage; deprivation; and structural issues such as rurality.
Rother District has the highest referral rate for adult social care. Of the 20 wards with the highest referral rates in East Sussex, three are in Hastings Borough and eight in Rother District. The ward with the highest referral rate is Bexhill Sackville (Rother).

Hastings and Rother Primary Care Trust has a higher referral rate of adult social care than that of East Sussex. Bexhill Centre cluster has the highest referral rate. All the other clusters have referral rates lower than that for the Primary Care Trust. Rural Rother cluster has the greatest range in referral rates of the constituent GP practices. All the constituent GP practices in Bexhill Centre cluster have referral rates above the 90th percentile for East Sussex.

**NEXT STEPS – SOCIAL CARE**

Health and social services are essential to the well-being of the population and it is important that they are resourced appropriately and delivered efficiently and effectively. However, further investigation of the interpretation of social care indicators and how they link to health indicators is necessary to enable them to fully inform commissioning and strategy development.

**ACUTE CARE**

Increasingly, the focus of healthcare is extending the treatment of patients in an attempt to improve the health of local populations through preventative campaigns, and targeting neighbourhoods at highest risk of particular diseases. Hospital admission rates are often used as a proxy to reflect patterns of morbidity or health need in population subgroups or across geographic areas. The interpretation of variations in hospital utilisation rates is complex.

There is variation in referral practice and a variety of hospital providers are used. This information is more meaningful at local practice level.

The main findings are that across East Sussex admissions relating to trauma and injuries, problems of the respiratory system, neurological conditions and upper gastrointestinal conditions appears to be broadly correlated with deprivation.

The case for investment and disinvestment can only be substantiated in the light of more detailed investigation.

There may be opportunities for financial savings by investigating the reasons for the varying lengths of stay for maternity and reproductive health and agreeing a standard of best practice.

Bed utilisation for patients with cancers and tumours is highest in Bexhill Centre.
Bed utilisation rates for chronic heart disease patients from the Lower St Leonards practice based commissioning cluster reflect anticipated need for an area with relatively high deprivation levels. However, reported prevalence of chronic heart disease is low. Admissions relating to trauma and injuries appear correlated to social deprivation within Hastings and Rother Primary Care Trust. There may also be close correlation with binge drinking data.

**NEXT STEPS – ACUTE CARE**

- **Hospital utilisation data needs further interpretation at local practice level.**
- **Further work is needed to reduce accidents and reduce alcohol consumption, especially binge drinking.**

**PATIENTS AND SERVICE USER VOICE & PUBLIC DEMANDS**

*Strong and Prosperous Communities* emphasises that citizens and communities know what they want from services and what needs to be done where they live. Across East Sussex, residents regard the provision of high quality health services and low levels of crime as the two most important features of a good place to live.

The population of Hastings and Rother Primary Care Trust were less inclined to respond to the GP satisfaction survey than the population of East Sussex as a whole. Response rates by practice across the Primary Care Trust ranged from 36% to 67%. The indicators that elicited the greatest range of responses were: 48 hour access to a GP; satisfaction with opening hours. The practice based commissioning clusters of Upper and Lower St Leonards and West Hastings fared less well than groups such as Rural Rother. Most patients were offered choice of provider, although less frequently at the practice based commissioning clusters of East Hastings (88%) and West Hastings (92%). There were 747 reported Patient Advise and Liaison Service contacts for the Primary Care Trust.
These most frequently related to access to NHS dentistry and confusion over charging for dental services. 79% of complaints were resolved locally by the Primary Care Trust.

Community involvement in the Joint Strategic Needs Assessment process, through planning, delivery and evaluation, is considered key to making it relevant to local populations. Careful and appropriate community engagement can facilitate and empower people by giving them the chance to voice their needs, whilst local ownership of the process will increase the relevance of services, improving their uptake and sustainability. Locally it is recognised that further work is required to systematically capture and incorporate the views of patients, service users, carers and the wider public in order to ensure that service developments and changes are shaped by local communities.

**NEXT STEPS – PATIENTS AND SERVICE USER AND PUBLIC VOICES**

Further work is needed to systematically capture and incorporate the views of patients, service users, carers and the wider public to ensure that service development and changes are shaped by local communities.
Summary of key findings from the East Sussex Joint Strategic Needs Assessment

— There is a predicted increase in the older population and a decline in the birth rate for people living in East Sussex.
— There is considerable variation in levels of deprivation across the Primary Care Trust.
— Attitudes and behaviours that affect health outcomes, such as smoking, binge drinking, poor diet, are linked to deprivation.
— There is a 13.3 year variation in life expectancy across East Sussex. At ward level it ranges from 85.6 years for Mayfield (Wealden) to 72.3 years for Gensing (Hastings).
— Primary Care data about the reported prevalence of specific conditions does not seem to be well correlated with social disadvantage or be consistent with other sources of deprivation. This suggests that illness is not being detected within the groups most at risk of chronic conditions or early death.
The Joint Strategic Needs Assessment work needs further development as an ongoing information resource jointly with East Sussex County Council to include better children’s ethnic, transient and migrant population needs, public views and primary care data to inform service planning to meet needs.

The findings of the assessment and the individual comprehensive needs assessments should be used by East Sussex County Council, Local Authorities, Primary Care Trust and GP practices to inform strategic commissioning of services to meet needs and then later evaluation to assess the service impact on needs.

To improve the health of the public and reduce health inequalities resources should be invested in initiatives to increase life expectancy in the 20% of wards across East Sussex with the lowest life expectancy compared to the rest of East Sussex. Initially by tackling vascular disease in the 11 wards within Hastings & Rother Primary Care Trust with the lowest life expectancy.

**Older people:** resources should be channelled to maintaining and improving the health of older people, increase investment in services that promote health and well-being in older people.

**Chronic disease management:** improve detection and systematic management and treatment of patients with these conditions, which includes cardiovascular disease, stroke, chronic obstructive pulmonary disease and diabetes. The Primary Care Trust and all GP practices should invest time and resource in validating Quality and Outcomes Framework prevalence data.

**Improving health:** investment is needed in Choosing Health priority areas and health protection measures – vaccination, immunisation and screening, particularly in the most deprived areas to improve the uptake of these prevention services.

**Mental health and well-being:** needs improvement especially in the most deprived areas.

---

Cynthia Lyons  
Deputy Director Public Health

Joanne Bernhaut  
Consultant in Public Health
Determining need through comprehensive needs assessments
Healthcare needs assessment is a way of estimating the nature and extent of the healthcare needs of a population so that services can be planned to meet these needs. The purpose of undertaking a needs assessment is to help focus effort and resources where they are needed most. A robust needs assessment provides a range of information that can inform the planning stage of the commissioning cycle, for example:

- Help estimate the current and future needs of a population;
- Indicate the geographical distribution of need;
- Identify those people who are at greatest risk of needing community services; and
- Help identify the gap between met and unmet need.

During 2007/08 a series of comprehensive needs assessment were carried out across East Sussex. These have informed the Primary Care Trust’s strategic commissioning plans and Joint Commissioning Strategies for the Primary Care Trusts and East Sussex County Council. This chapter outlines some of the key findings of four of these needs assessments:

- Older people;
- Children;
- Mental health; and
- Learning disabilities.

Increasing numbers of people are living longer. In both absolute and relative terms, older people are the biggest consumers of health and social services due both to the large – and growing – size of this group and the fact that the risk of experiencing poor health increases with age. It is important to note that older people are not just consumers of health and social services, but also major providers of care. Many of those providing care are themselves in poor health.

Increasingly, older people are enjoying very active and fulfilling lives throughout later life. Nevertheless, older age can present illness and incapacity for many. People need to be able to draw upon a range of services that provide information, support and treatment. A careful balance must be achieved by the health and social services between arrangements that allow older people to lead fully active lives – and similarly provide those who are less independent to get the right level of support.

To inform the development of an East Sussex Joint Commissioning Strategy for Older People, an epidemiological health needs assessment was undertaken. This reflects what is known about the incidence and prevalence of conditions and the effectiveness of treatments and services. The top four impact conditions considered in the needs assessment were stroke, dementia, chronic obstructive airways disease and falls.
STROKE

Stroke is a leading cause of death and permanent disability in older age. It is caused by an interruption to the normal blood supply to the brain. The risk factors are primarily those of lifestyle – poor diet, smoking, physical inactivity, excessive alcohol intake resulting in obesity and high blood pressure. Prevention relies on lifestyle changes and specific medical interventions. The use of aspirin and treatment of hypertension are particularly important. After a stroke, the risks of death, permanent disability and institutional care are reduced by organised multi-disciplinary rehabilitation.

It is estimated that there are 1150 first strokes per year in East Sussex currently, rising to 1350 by 2016. Over half of these will be aged 80 or over. It will become more common as the population ages. If we assume that 25% of people die early after a stroke, and 70% of the remainder need rehabilitation, then there are about 607 East Sussex residents suitable for organised stroke care per year. Providing this form of care would save about 20 lives per year and enable about 32 people to be discharged home rather than to institutional care. About 9% will be left with severe residual disability. This equates to some 80 people per year in East Sussex.

DEMENTIA

Dementia is a progressive loss of memory and other cognitive functions. It progressively undermines older people’s independence, leading to complex patterns of severe disability in advanced cases. The two main causes of dementia are Alzheimer’s disease and cerebro-vascular disease. The cause and risk factors for Alzheimer’s disease are unknown. Vascular dementia is caused by damage to the brain’s blood supply.

The frequency of dementia increases with age and the disease is quite common over the age of 80 years. Those aged over 85 constitute 17% of the total over 65 population in East Sussex, but make up 51% of those with dementia. It is estimated that there are about 9950 East Sussex residents with dementia. More than half of these people are over the age of 85 years, and will have disabilities exacerbating the effects of dementia. The numbers are likely to rise by 1.2% per year, due to the increasing numbers of older people, and reach about 11300 in 2016.
Most people with dementia live in the community although, once the disease becomes severe, most move into care. There are many people with marked disability due to dementia living in the community. It is estimated that in the region of 680 people with severe dementia currently live in the community. Few interventions used in dementia are informed by research evidence of their effectiveness. One exception is cholinesterase drugs, which have a limited role.

**CHRONIC OBSTRUCTIVE PULMONARY DISEASE**

Chronic obstructive pulmonary disease occurs when narrowing of the airways blocks normal movement of air in and out of the lungs. It is progressive; people become increasingly disabled by breathlessness. It often proves fatal. It is usually caused by smoking, 15% of smokers get it and 80% of cases are because of smoking.

Prevalence rates are estimated at between 4-10%. Assuming prevalence is at the lower end of the range, it is estimated that there will be approximately 4500 patients with chronic obstructive pulmonary disease rising to 5500 by 2016. Rates may be higher in Hastings where there are more areas of severe deprivation and higher prevalence of smoking. This is supported by the higher death rates there. Assuming a prevalence of 6–8% the numbers will be in the region of 900–1200 rising to 1100–1400 by 2016. Men are more likely to be admitted to hospital with chronic obstructive pulmonary disease than women.

Chronic obstructive pulmonary disease is usually caused by smoking. Smoking prevention and cessation programmes have great potential in preventing the disease. Several interventions are of value in treating chronic obstructive pulmonary disease, including pulmonary rehabilitation and non-invasive ventilation. A National Service Framework will be developed for chronic obstructive pulmonary disease, to be published in 2008.

**FALLS**

Falls in older people can cause fractures, especially hip, which in turn lead to increased mortality and have an impact on long-term independence. Even if they do not sustain a fracture, older people who fall may experience a loss of confidence, which impairs their ability to lead full lives.
The risk of falls and fractures can be reduced by adoption of healthy lifestyles. Multi-disciplinary falls clinics can identify and reduce risk factors for falls. It is estimated that about 7600 older people in East Sussex attend Accident & Emergency departments after a fall each year, about a third of whom are admitted. The number of serious falls is expected to rise by about 1.4% per year over the next ten years due to the increasing numbers of older people, and reach about 8700 in 2016. The number of admissions to hospital will rise at a similar rate to reach about 3000 by the same date.

In the over 75s, admission to hospital following a fall often results in discharge to long-term care. It is estimated that about 650 people in East Sussex are discharged to long-term care each year after a fall-related admission, a number set to rise to about 720 in 2016, assuming no change in incidence, and that there are sufficient places in care to accommodate them.

**SUMMARY: OLDER PEOPLE**

The results of the older people’s needs assessment were used to inform the development of the East Sussex Joint Commissioning Strategy for Older People, published in 2007.

This strategy sets out a wide and comprehensive range of proposals for change, which relate to five different stages at which people come to need and use health and social services:

- *Fit and well although growing old.*
- *Experiencing problems which might be preventable.*
- *In immediate need of help or treatment.*
- *Ready or preparing to go home.*
- *In need of long term support.*

**NEXT STEPS – COMPREHENSIVE NEEDS ASSESSMENT – OLDER PEOPLE**

The results of the older people’s needs assessment work needs to inform the commissioning strategy for older people and its ongoing work and be used to evaluate the impact of any service changes in meeting the needs and improving the health of older people.
Securing physical and emotional health and well-being of children and young people is essential to providing good life opportunities for our population. Many lifestyle behaviours are shaped in early life. Support to children and young people can both increase their health and well-being and also that of their families.

In general, the majority of children and young people have good health, although there are some with rare conditions and complex needs. While many areas in East Sussex are relatively affluent, there are areas of rural isolation and some marked deprivation. Child poverty is a key issue in many of the deprived areas. Being brought up in a low income household is related to poorer health and lower educational achievement.

The needs assessment focused on four specific areas: risky behaviours, complex health needs, chronic disease and looked after children. The information presented in this report are some of the key findings and further analysis is being undertaken and the detailed findings will be made available in 2008.

**RISKY BEHAVIOURS**

There are strong links between smoking, alcohol, drug use and sexual health. Risky behaviours are associated with higher rates of teenage pregnancy and lower educational achievement. Locally, initiatives to reduce risky behaviours for children and young people include the national Healthy Schools Initiative. Almost all schools in the county have signed up to the Healthy Schools Status.

A Healthy School promotes the health and well-being of its pupils and staff through a planned taught curriculum promoting healthy lifestyle choices.

- The proportion of young people ever having taken a drug has reduced, while the proportion using alcohol has increased.
- It is reported that 14% of 14-15 year olds had smoked a cigarette in the last week.
- Cannabis is reported to be the most widely used drug among 14-15 year olds, although use of the drug has almost halved since the last survey in 2004. In 2007 16% of 14-15 year olds reported that they had ever used cannabis, compared to 30% in 2004.

The external researchers for the children’s needs assessment work highlighted the following areas of good practice:

- The young people smoking cessation service because it is delivered within existing youth services and events, accessing young people where they are.
- It is reported that 75% 14-15 year olds have not had a sexual relationship.
- A total of 61% know where they can get free condoms and 44% know how to access emergency contraception free of charge.
- Only 23% of boys and 29% of girls know where they can have a Chlamydia test.
COMPLEX HEALTH NEEDS

Complex health needs cover children and young people with conditions such as cerebral palsy, Duchenne muscular dystrophy and cystic fibrosis. Life expectancy for young people with these conditions has risen dramatically. Two thirds of children with cerebral palsy are now living to at least 20 years (depending on the severity of their impairment), while there has been decade on decade improvement in survival for young people with Duchenne muscular dystrophy who now live well into their late 20s and beyond in some areas. Survival rates for young people with cystic fibrosis have doubled in the last 20 years with newborns now likely to live into their 40s.

The East Sussex Early Support and Care Co-ordination Scheme co-ordinates support for young people and families at the time a diagnosis is made, provides information and refers on to existing services for complex health needs. There is also a Family Intensive Support Service, which is recognised as a model of good practice regionally, as reported in the Ara Darzi review, for providing respite care and support to families.

CHRONIC DISEASE

Across East Sussex in 2006/07 there were 339 emergency admissions by 259 children, to hospital via Accident & Emergency with asthma. Rates of emergency admission for asthma have increased in East Sussex since 2001.

The number of newly diagnosed children with Type 1 diabetes doubled in 2007 from 16 in 2006 to 30 in 2007. There is one paediatric specialist diabetes nurse in East Sussex covering 144 children.

There has been a rise in the total number of admissions for epilepsy in East Sussex from 126 in 1997/98 (78% emergency admissions) to 150 in 2006/07 (but only 63% emergency admissions). While the number of admissions for epilepsy has nearly doubled between 2001/02 and 2004/05, from 114 477 to 217 854, the rate per 10 000 population aged 0-19 has fallen in most areas.

This fall has been particularly great in Eastbourne, falling from a rate of 14.99 admissions per 1000 population in 2001 to 4.84 per 10 000 population in 2004/05. The rate has at least halved in all other areas of East Sussex over the same period.

Whilst there is a specialist epilepsy clinic in Eastbourne (every two months), which is supported by an adult specialist neurologist, there is no specialist nurse or Children and Young People (CYP) epilepsy service other than this so young people are seen with adults although their cases may be more complex.
LOOKED AFTER CHILDREN

There are 450 local children looked after in East Sussex at any one time, including 30 in placements outside of the county. In addition there are around 300 looked after children from other Local Authorities living within the county who use resources such as education and health facilities. 38% of looked after children are in Hastings.

CHILD PROTECTION

— During 2006/07 373 children per 100 000 population were referred to the Child Protection Register.
— 37% of children on the Child Protection Register live in Hastings.
— Of these, 37% are on the register because of problems in the family due to domestic violence; 34% because of alcohol and substance misuse issues; and 22% because of parental mental health problems.
— The number of children on the Child Protection Register has increased by around 50% in 2007.
— The 2007 OFSTED review of Children’s Services cited this as a positive indication of improved working across agencies, increased awareness of child protection issues across health and social care; and effective referral processes.

NEXT STEPS – COMPREHENSIVE NEEDS ASSESSMENT – CHILDREN

The results of this comprehensive needs assessment for children will be made widely available in 2008 and used to inform the development and evaluate the Joint Commissioning Strategy for Children’s Services across East Sussex and by local practices for their service developments.

More detailed data on children and young people with complex needs will be included in future Joint Strategic Needs Assessment with the County Council.
Mental health needs assessment

Poor mental health refers to a range of conditions including depression, anxiety, compulsive disorders, eating disorders, psychosis and schizophrenia. Some of these disorders are relatively common, for example around one in three people might experience mild to moderate depression and/or anxiety in their lifetime. Other conditions are less common, including psychosis and schizophrenia, which might affect only one in 100 of the population through their lifetime.

It is thought that poor mental health is becoming the most important cause of disability in both childhood and adulthood. Certain groups of people, including those on low incomes, those who have been recently bereaved, young parents, people who are unemployed and/or live alone, those who are homeless, prisoners, refugees and asylum seekers and black and minority ethnic groups are generally at higher risk of developing poor mental health than the population as a whole.

We know that, to a certain extent, the foundations for good mental health are established in childhood. The quality of our emotional and social support provided by parents, families and teachers has a large impact on how we develop coping strategies and on our mental health. In later life, our environment including our lifestyle (especially drug/alcohol use), housing, neighbourhood, families and employment all have an impact on our mental health and well-being.
However, there are some conditions that may be linked to factors that we cannot influence, for example our genetic and biological make-up and family history.

A mental health needs assessment for adults has been undertaken across Sussex and a summary of the findings is described here.

**HOW MUCH POOR MENTAL HEALTH IS THERE IN EAST SUSSEX?**

The rate of poor mental health in East Sussex is lower than the national average. Estimated rates for all types of mental health problems are highest in Hastings and Eastbourne. In East Sussex around 12 per 100 000 people per year die due to suicide or from injury of undetermined intent.

The Office of Population Censuses and Surveys 2001 predicted a rate of 173 per 100 000 16-64 year olds in East Sussex suffering from any neurotic disorder in the last week. However, these predictions did not take deprivation or any other factors into consideration, which are known to impact on mental well-being.

**MENTAL HEALTH SERVICES**

Cognitive behaviour therapy has been recommended as part of the treatment of depression in primary care. It has been estimated that every GP practice in East Sussex will require the equivalent of at least one cognitive behaviour therapist (to treat 80 patients) to meet demand.

The National Institute for Health and Clinical Excellence has recommended that everyone with mild to moderate depression and everyone with anxiety should have access to cognitive behaviour therapy via a computer package. Graduate workers are a new initiative to increase the number of staff available to deliver evidence-based psychological treatments in primary care. The services in East Sussex need to employ more graduate workers to be in line with government recommendations.
The majority of care for people with poor mental health is delivered by community mental health teams. Other teams include the following:

— Crisis resolution teams provide short-term, intensive, home-based care for people who might otherwise need admission to hospital;
— Assertive outreach teams provide long-term intensive support to patients who risk falling out of care;
— Rehabilitation teams provide long-term less intensive care for patients with chronic disabling illness;
— Early intervention teams provide expert assessment, treatment and support during the early months and years of psychotic illness.

Further crisis resolution team staff and further early intervention staff are required in East Sussex.

Physical illness in people with mental health problems are often neglected or poorly managed. It is good practice for patients to have their physical health checked annually including reviews for screening uptake, misuse of alcohol/drugs, smoking and risk factors for heart disease and diabetes.

**SERVICE USER INVOLVEMENT**

Services for people with poor mental health should be developed using the views and involvement of service users. In East Sussex there is a need to ensure that there is greater service user involvement across the county, and especially with difficult to reach groups including black and minority ethnic communities.

**NEXT STEPS – COMPREHENSIVE NEEDS ASSESSMENT - MENTAL HEALTH**

Mental health is poor in areas of deprivation and services to improve mental well-being need to be targeted on areas of greatest deprivation.

The results of this comprehensive needs assessment for mental health are being used to inform the development and evaluation of a commissioning strategy for adult mental health for East Sussex.
Learning disabilities needs assessment

Learning disability is a descriptive diagnosis or concept, not a disease or illness, and it does not infer a particular aetiology. Social functioning is an integral part of the diagnosis.

Learning disability data collection is poor. It is not possible to establish exact incidence or prevalence of learning disability because of differences in classification and incomplete coding at NHS service provision level. Data is available on the numbers of people known to general practices, adult social care and children’s services, but these do not reflect the true prevalence of learning disability.

There is an increased longevity amongst people with learning disability and an increase in the numbers of older people in the general population we expect to see numbers of older people with learning disability increasing at both a national and local level. Another unpredictable factor that will influence population growth is increased migration to the South East. Using population estimates we might anticipate a local increase of 10% in numbers of service users by 2011, measured from a 2001 baseline.

Information about children is contradictory. Numbers of children and young people are predicted to drop in the East Sussex County Council area to 2026. The rise in numbers of young people aged 10 – 19 locally seen over the last five years will gradually drop back from 2011 onwards.

To counteract this, there is anecdotal evidence that young people with more severe and complex needs survive longer into childhood and young adulthood.

The numbers of children with statements of special education need in the area over the last seven years has been fairly steady, with a slight downward trend. The areas of definitive growth are the numbers of children with a diagnosis of Autistic Spectrum Disorder, and a new category (since 2004) of profound and multiple learning disabilities. If there is a real growth in need in the local population of children, the question arises about the numbers of children being assessed but not receiving a service.
Health service data about numbers of people with learning disability and levels of health service activity they receive is poor. Primary care registers are promising and will increase access to services including screening. Currently 1738 people are recorded in general practice registers of people with learning disabilities. Better health service information needs to be developed to enable the monitoring of access and outcomes for the many conditions that people with learning disabilities are most susceptible too, including gastro-intestinal cancers, diabetes, and epilepsy.

The evidence base for most interventions is weak with the exception of work on challenging behaviour, supported employment and some pharmacological interventions. There is much evidence to suggest that overall health status of people with learning disabilities is poor and that this is exacerbated by poor access to healthcare services.

**NEXT STEPS – COMPREHENSIVE NEEDS ASSESSMENT - LEARNING DISABILITIES**

The areas where local actions are needed to improve the health and well-being of people with learning disabilities include:

- Increase service user evaluation of healthcare.
- Improve uptake of preventative health screening programmes, including cervical screening and mammography.
- Monitoring health improvement outcomes from primary and secondary care health services need to be developed.
- Planning services to meet the needs of older people with learning disabilities, including planning for old age for people with Downs Syndrome from age 40, and from age 50 for others.

The full report and its recommendations have been used to underpin and inform the East Sussex Countywide Learning Disability Commissioning Strategy to develop improved services for people living with learning disabilities.
Recommendations: Comprehensive needs assessment

The findings of the comprehensive needs assessments in older people, mental health, learning disabilities and children should be used to inform and evaluate commissioning strategies to ensure service developments better meet these needs.

Further comprehensive needs assessments will be done in 2008, and will include:

- Working age adults which includes people with physical and sensory disabilities
- HMP Lewes
- Sexual Health
Staying well & improving health
The public health white paper ‘Choosing Health: making healthy choices easier’ embraced a joined up approach to the delivery of public health, which focused on empowering and enabling people to take responsibility for their own health and on tackling health inequalities faced by those living in deprivation, prisoners, children, older people, carers, Black and Minority Ethnic groups, the disabled and others. It also set out key principles for supporting the public to make healthier and informed choices in regards to their health.

**Informed choice**: people want to be able to make their own decisions about choices that impact on their health and to have credible and trustworthy information to help them do so.

**Personalisation**: support has to be tailored to the realities of individual lives, with services and support personalised sensitively and provided flexibly and conveniently.

**Working together**: real progress depends on effective partnership across communities.

There were six overarching priority areas highlighted:

- Reducing numbers of people who smoke
- Tackling obesity
- Improving physical activity
- Improving sexual health
- Improving mental health
- Encouraging sensible drinking

The report recognised that there need to be locally available services and support promoting healthy choices, and it emphasised the importance of co-delivery between local government and the NHS, in partnership with local communities and the business, voluntary and community sectors. This chapter presents descriptions of a range of health improvement projects, designed to meet and develop the Choosing Health priority areas, across the Primary Care Trust.
Reduction numbers of people who smoke

Smoking remains the leading cause of preventable mortality and morbidity across the UK. Smoking related illnesses include lung and other cancers, circulatory disease, respiratory disease, ulcers of the stomach and tooth loss. Smoking is responsible for over 80% of all lung cancer diagnoses. Across the South East it has been estimated that 16% of all deaths are attributable to smoking, and 1000 people died from smoking in East Sussex between 2003 and 2005.

Smoking rates are highest amongst the most deprived sections of the population: 31% of people in manual employment smoke, compared with just 19% of management groups. In order to reduce the number of people who smoke a range of local services are in place and we aim to achieve:

- A reduction in adult smoking in all social classes, so that the overall rate falls to 20% or less in 2010.
- A reduction in smoking in children to 9% or less by the year 2010.
- A reduction in the percent of women who smoke during pregnancy to 15% by the year 2010.
- A reduction in smoking rates among manual groups to 26% in 2010.

Adults smoking prevalence is estimated to be 27% in Hastings and Rother compared with the East Sussex figure of 23.6%

Women who smoke during pregnancy (at time of delivery) is estimated to be 26.8% in Hastings and Rother compared with the East Sussex figure of 17.9%.

The Hastings and Rother Stop Smoking Service has continued to develop clinic activity and publicity focusing on the areas of high smoking prevalence. A total of 25 weekly drop-in clinics now run across the area. Advertising campaigns on local radio and buses have been recognised as effective in raising awareness amongst smokers of how to get advice and support. GP practice based services contributed 50% of the 1400 4-week quits achieved in 2006/07 and continue to be a highly effective partner in the overall programme of service delivery. Community Pharmacy based services have also begun to develop, thus supporting our aim of services in highly accessible venues.
Children’s Centres are a key delivery mechanism for achieving the objectives set out in the government’s *Every Child Matters* programme. They will provide a “core offer” of services that will include offering information, advice and support to fathers, mothers and carers as well as health services, family support and outreach, employment advice and early years childcare provision. Children’s Centres are a permanent mainstream community service which will serve every community by 2010. With this in mind, stop smoking service drop-in clinic provision has been developed at sites across Hastings and Rother.

Smoking in pregnancy is an important area to reduce. In order to increase effective targeting of pregnant women who continue to smoke, new referral systems came into effect on December 1st 2007. All women who smoke when booking in with midwifery services are offered a referral into the specialist service. This is already resulting in increased referrals and quit rates will be monitored to determine overall effectiveness.

**RECOMMENDATIONS: SMOKING CESSION**

Reduction in smoking is the most important health improvement measure that we can make to improve the public’s health.

Smoking cessation services have been evaluated and additional investment agreed in specialist and primary care services in order to achieve further improvements on smoking cessation in 2008. The effectiveness of these initiatives will need to be monitored and reviewed.
The numbers of overweight and obese people have trebled over the last 20 years. In 1980 the percentage of the UK population classed as obese was 7%, by 1998 this had increased to over 20%. In England about 46% of men and 32% of women are overweight with an additional 17% of men and 21% of women classified as obese.

A range of local services are in place. The Primary Care Trust and its partner organisations aim to achieve the following:

— To halt the year-on-year rise in obesity among children under 11 by 2010.
— To improve the numbers of people consuming a healthy diet, including consuming five portions of fruit and vegetables a day.
— To increase the number of adults who engage in a minimum of 30 minutes of moderate intensity physical activity on five or more days a week from 32% to 70% by 2020.
— To increase the number of children doing a minimum of 60 minutes of moderate intensity physical activity each day.
— To enhance the take-up of sporting opportunities by five to 16 year olds so that the percentage of school children who spend a minimum of two hours a week physical education and sport within and beyond the curriculum increases from 25% in 2002 to 85% in 2008.
ADULTS

Nationally, overweight and obesity increase with age: 28% of men and 27% of women aged 16-24 are overweight or obese; 76% of men and 68% of women aged 55-64 are overweight or obese. Overweight and obesity are more common in lower socio-economic and socially disadvantaged groups, particularly among women. Women's obesity prevalence is far lower in managerial and professional household (18.7%) than in households with routine or semi-routine occupations (29.1%).

LIFESTYLE CHANGE FACILITATION SERVICE

Providing patients with individual advice and support in relation to diet and exercise is another element of the Health Improvement Team’s work. The Lifestyle Change Facilitation Service has been available to GP practices in priority areas of Hastings and St Leonards for two years. During Physical Activity Clinics in the GP practices, the Lifestyle Change Adviser provides patients with one to one behaviour change counselling and gives specific advice regarding exercise. Referrals come from a GP or Practice Nurse within the practice. Based on follow-up questionnaires sent to 300 patients, the service has been successful in increasing participation rates and enhancing people’s motivation for change. Based on these outcomes achieved by a single adviser we have in 2007/08 invested in further advisers who are now developing clinic activity in the priority GP practices across Hastings and Rother.
The increase in the prevalence of overweight and obese children is a major concern. In the UK 20% of four year olds are now overweight and 8% are obese. In England 17% of 15 year olds are now obese, a threefold increase between the years 1990 and 2000. Children are at considerably increased risk of obesity in adulthood if:

— they are from a manual background;
— they are overweight in childhood; and/or
— their parents are overweight or obese.

For the period 2006/08 Hastings and Rother children’s weight was recorded as follows:

— Reception Year – 11.6% overweight – compared to an East Sussex figure of 13.1%
— Reception Year – 7.0% obese – compared to an East Sussex figure of 8.2%
— Year 6 – 13.2% overweight – compared to an East Sussex figure of 13.9%
— Year 6 – 13.9% obese – compared to an East Sussex figure of 15.3%
Almost one third of primary schools have now benefited from the Food in Schools programme. Providing valuable evidence for their Healthy Schools submission, it has helped to increase school meal uptake and improve lunchboxes in the majority of cases and provided a catalyst in some schools to develop a whole series of new and motivating lunchtime procedures and policies. It has actively involved and motivated thousands of pupils to try new foods that they may not otherwise have tried and encouraged hundreds of their parents to try school meals and experience the quality and professionalism of the school meal caterers. The 2007/08 academic year Action Plan for the programme is targeting schools in priority areas as identified by the Childhood Obesity Measurement Programme and following agreement with East Sussex County Council and Primary Care Trust Children’s Services Locality Managers.

Breastfeeding Peer Supporters are volunteer mums who have all breastfed their own children and undertaken a training course in how to support other families in breastfeeding their children. They attend ante and post natal groups, parent and toddler groups, drop-ins and baby clinics in order to offer informal, mother-to-mother support. This scheme has been running in Hastings for around five years. In the last two years it has been rolled out across Bexhill and Rother, meaning that we now have over 50 Peer Supporters.

We are now working with East Sussex Hospitals Trust to enable those peer supporters to work with mums on the wards in those very early days when a bottle can seem like the easy option. Each Breastfeeding Peer Support team now has a mobile phone to offer phone and text support to mums who may find it hard to get out of the house or for whom transport may be an issue.
Improving sexual health

The health problems resulting from sexual health needs, such as pelvic inflammatory disease, infertility, HIV, cervical and other cancers, Hepatitis, and others can be devastating to individuals in later life.

Choosing Health identified a number of key action points to improve sexual health that have been adopted as priorities for the Primary Care Trust:

— Information campaigns: targeting younger men and women to ensure they understand the risks of unprotected sex and the benefits of using condoms.
— Teenage pregnancy strategy: to strengthen delivery to reach vulnerable groups and target areas with high rates of under-18 conception.
— Modernised sexual health service: to invest in more accessible and effective contraception, abortion and sexually transmitted infection services; fully integrated care pathways and networks; developing new service models and implementing standards for HIV services.
— Faster access to services: to make progress towards the national target of appointments being offered within 48 hours of contacting genito-urinary medicine service; national roll-out of screening programmes.
— Advice and contraceptive services for young people: coordinated programmes involving the NHS, Local Authorities and schools.

PROMOTING SEXUAL HEALTH

The Primary Care Trust has worked closely with key partners such as the East Sussex Teenage Pregnancy Co-ordinator, local schools, PULSE and the Youth Development Service to establish a robust plan of health promotion campaigns and events which have been reviewed to ensure their effectiveness for local young people.

During the week leading up to Valentine’s Day, schools and places where young people congregate were the focus for a campaign which was delivered by a team of multi agency workers that provided young people with advice, information, free condoms and Chlamydia screening. 1200 young people attended an event which was held on a Saturday at Priory Meadow shopping centre and they were encouraged to provide feedback about services and the materials used for the campaign.

PULSE’s new youth health trainer programme, “Generation H”, has recruited in February 2008 four 16 to 25 year olds to work with vulnerable young people. They will endeavour to find out which health issues are most important to young people. A population wide sexual health needs assessment and a health related behaviour survey of Year 10 students is being undertaken to enable equitable youth friendly sexual health services to be available throughout Hastings and Rother.
National targets for sexual health service include:

— Percentage of first attendances at a genito-urinary medicine service who were offered an appointment to be seen within 48 hours of contacting a service – 100% by March 2008. Hastings & Rother performance 88%.(December 2007).

— Percentage of first attendances who were seen within 48 hours of contacting a genito-urinary medicine service – 95% by March 2008. Hastings & Rother performance 80% (December 2007).

The Primary Care Trust have agreed an investment programme for sexual health services to improve access in 2008.

THE NATIONAL CHLAMYDIA SCREENING PROGRAMME

Chlamydia is an infection caused by the bacterium Chlamydia trachomatis. Genital Chlamydia is the most common sexually transmitted infection diagnosed in genito-urinary medicine clinics in England, with high prevalence being documented among young men and women aged under 25. It is most common in women under 25 (About 1 in 12 women aged 20 are infected).

Untreated infection can have serious long-term consequences, particularly for women, in whom it can lead to pelvic inflammatory disease, ectopic pregnancy and tubal factor infertility. In men it can result in painful testicles and in both men and women it may lead to Reiter’s syndrome. Since many infections are asymptomatic, a large proportion of cases remain undiagnosed, although infection can be diagnosed easily and effectively treated.

The National Chlamydia Screening Programme was established in 2003 with the objective of controlling Chlamydia through the early detection and treatment of asymptomatic infection, thus preventing the development of sequelae and reducing onward disease transmission. It is a targeted screening programme and consequently represents only a proportion of Chlamydia tests that occur in England each year. It does not include tests conducted in genito-urinary medicine clinics. In 2005/06 positivity rates in those screened were approximately 10% for both men and women under the age of 25.

The current performance for Chlamydia screening in Hastings and Rother Primary Care Trust is 3.4% against a target for 2007/08 of 15%. This needs to be improved during the period 2008–2001 to 17% and investment will be needed.
TEENAGE PREGNANCY

The UK has the highest rate of teenage pregnancies in Western Europe. Teenage pregnancy is associated with increased risk of poor social, economic and health outcomes for both mother and child. Reducing the rates of teenage pregnancy is an important part of reducing health inequalities.

The Departments of Health and Children, Schools and Families share the Public Service Agreement target ‘to halve under 18 conceptions by 2010’. This is within a broader strategy to improve the sexual health of the nation. All Local Authorities have in place ten year strategies in line with national policy and Local Area Agreement targets to prevent teenage pregnancy and support teenage parents.

Nationally, provisional data shows an overall decline of 11.4% in the under 18 conception rate since 1998. However, figures for East Sussex suggest that there has been an increase in the rate of conceptions from 36.9 to 37.2 per 1000 female population aged 15-17 between 1998 and 2006. There is a 14 month time lag in the publication of national conception statistics due to the complexities of recording. It is recognised that at the county and Primary Care Trust level yearly figures are potentially unrepresentative of overall trends as year-on-year fluctuations can be quite marked. Figure 13 and Table 03 provide details at the Local Authority level on under 18 conceptions.
Figure 13: Under 18 conceptions

PBC Cluster chart (ordered by IMD 2004 score)
Table 03: Rolling average under 18 conception rates per 1000 young people aged 15-17 by ward/borough 1998/2000 and 2004/2006; and proportion of conceptions leading to abortion.

<table>
<thead>
<tr>
<th></th>
<th>1998 Number</th>
<th>1998 Rate</th>
<th>1998 % leading to abortion</th>
<th>2004-06 Number</th>
<th>2004-06 Rate</th>
<th>2004-06 % leading to abortion</th>
<th>% change in rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>East Sussex County</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hastings</td>
<td>291</td>
<td>65.1</td>
<td>33</td>
<td>310</td>
<td>59.3</td>
<td>39</td>
<td>-8.9%</td>
</tr>
<tr>
<td>Rother</td>
<td>129</td>
<td>32.0</td>
<td>49</td>
<td>159</td>
<td>34.7</td>
<td>51</td>
<td>8.5%</td>
</tr>
</tbody>
</table>

Table 03 provides the data by ward/district and also the percentage change in rate between 1998/2000 and 2004/2006. (Three year rolling average data is combined in order to show the trend). This shows that the rates have reduced in Hastings by nearly 9% between 1998/2000 and 2004/2006. In Rother, over the same time period, they have increased by 8.5%. It is important to note that the actual rate is still far higher in Hastings (59.3 per 1000) than in Rother (34.7 per 1000).

In Hastings and Rother the proportion of conceptions that result in abortion has increased between 1998/2000 and 2004/2006. An additional one in 10 (10%) of conceptions currently result in abortion in Rother compared to Hastings.

The county-wide Teenage Pregnancy Partnership Board provides strategic support to reducing the under 18 conception rate in East Sussex. This work is being implemented by a local action group.

Across East Sussex there are a number of priority actions which have been identified:

- **Ensuring that all schools have up to date, accessible information available on local services including where they are, what is provided and what times/days they can be accessed. This could be on general information notice-boards.**
- **Ensuring that all schools are providing high quality Sex and Relationships Education (as part of a broader Personal, Social and Health Education programme).**
- **Ensuring that all sexual health services are young-people friendly.**
- **Regular campaigns for increasing awareness of sexual health services and reducing teenage pregnancy will take place in community settings and be evaluated throughout the year.**
- **Using social marketing techniques to promote services and to provide public health messages about delaying sexual activity and use of condoms.**
Further development of the role of school nurses in providing sexual health promotion in schools is also recommended and Hastings & Rother Primary Care Trust are currently working towards this standard, although the numbers of school nurses are not yet in place.

Research shows that effective sex and relationships education is essential to enable young people to make responsible and well informed decisions about their lives. This is currently being reviewed together with the use of peer mentors, where young people are trained to provide sex and relationship education and have been well evaluated elsewhere.

RECOMMENDATIONS: SEXUAL HEALTH

Our performance in reducing sexual health needs requires improvement in the areas of access to services, teenage pregnancy rates and Chlamydia screening in 2008.

Increased investment has been agreed by the Primary Care Trust to improve genito-urinary medicine service access, Chlamydia screening and reduce teenage pregnancy rates. Progress with these will need regular monitoring by the Primary Care Trust and its partners.
Improving mental health

Poor mental health is one of the most important causes of disability in both childhood and adulthood. Our environment including our housing, neighbourhoods, families, schools and employment status have an impact on our mental health and well-being. Similarly, our lifestyle behaviours including diet, exercise and alcohol intake also contribute to our mental health and well-being.

Mental health promotion is relevant to the whole population, individuals at risk vulnerable groups and people with mental ill health. Mental health promotion is key to reducing risk factors and increasing resilience helping to prevent poor mental health. Early identification of poor mental health, starting from birth and maternal well-being and helpful parenting support and prompt intervention is important in supporting people to be managed effectively. Focusing resources in primary and community care ensures that we maximise efforts to reduce the likelihood of people requiring specialised services from secondary care.
There are ten priorities locally for the promotion of mental health and well-being:

01. Marketing mental health and well-being – ensuring that people are well informed and motivated to look after their own and others’ mental health. People have positive and accepting attitudes towards people with mental health problems.

02. Equality and inclusion – reducing inequalities in access to a wide range of sources of support for emotional and psychological problems.

03. Tackling violence and abuse – reduction in prevalence of mental health problems.

04. Parent and early years – parents and carers have the knowledge, skills and capacity to meet the emotional and social needs of infants and young children.

05. Schools, young people and parents – all schools to be working towards the new National Healthy Schools status by 2009 and 70% of primary schools to be working with the Social and Emotional Aspects of Learning programme.

06. Employment – reduction in mental health related unemployment.

07. Workplaces – increase the number of workplaces that adopt the Health and Safety Executive’s stress management standards. Ensuring there is support in place to enable people to return to work.

08. Communities – improved quality of life and life satisfaction. Increase the proportion of areas with a high ‘liveability’ score.

09. Older people – improve life satisfaction and increase opportunities for older people to participate in the wider community.

10. Prisoners – work with local prisons to support the mental well-being of the prison population.

Mental well-being is often a determining factor in an individual's physical health. The Primary Care Trust is fully engaged with its partners both in the statutory and voluntary sectors to improve the mental well-being of the residents of East Sussex. Working closely with Sussex Partnership Trust’s Mental Health in Primary Care Teams projects such as Books on Prescription and Arts on Referral have benefited significant numbers of people across the county. The Primary Care Trust also works closely with its partners to monitor and promote interventions to reduce suicide attempts within the county.
Safe. Sensible. Social. The next steps in the National Alcohol Strategy were published in 2007. It highlighted that alcohol related harm costs an estimated £1.7 billion in healthcare every year in England and Wales. If crime and disorder, and loss of productivity costs are added then the total annual cost is closer to £20 billion. Preventing alcohol misuse and providing treatment for those that need it can materially reduce these costs.

Alcohol-related illness and injury accounts for 180,000 hospital admissions per year. Men who regularly drink more than eight units a day, and women who regularly drink more than six units per day, are at increased risk of developing various diseases, such as liver disease, stroke etc.

Around four million people use at least one illicit drug each year and around one million people use at least one of the Class A drugs such as ecstasy, heroin and cocaine. There are approximately 250,000 ‘problematic’ drug users in England and Wales. The social and economic costs of drug misuse are estimated at between £10 billion and £18 billion a year. By targeting young people, limiting the supply, improving treatment services and working in partnership with the criminal justice system national targets aim to reduce drug misuse.

The Substance Misuse Team provides a range of training. The two-day Drug and Alcohol Basic Awareness Course, which is accredited by the Open College, runs eight times a year and provides a comprehensive introduction to adult substance misuse for people working in health, housing, social care, criminal justice, further and higher education and similar sectors. The team runs other half-day courses, such as “What Drugs Really Look Like” and “Reefer Madness” (about cannabis), and are able to provide sessions in the workplace covering identification, screening and referral of substance misuse. In 2006/7 six hundred individuals attended our courses in East Sussex. Details of courses can be found at www.safeineastsussex.org.uk.

The Substance Misuse Team work with partners to produce a range of information targeted at specific audiences. A leaflet on avoiding overdose aimed at injecting drug users developed in conjunction with drug service users, in consultation with the specialist treatment services. A booklet about alcohol for parents and children written and designed jointly with the Personal Social Health Education advisory service and is aimed at children in school year 6 and their parents which will be distributed through every school in the county.

This annual event is held across Sussex and involves local practitioners, ex-users and national speakers. The 12th conference will be held on 17th July 2008.
HEALTH TRAINERS

The 2004 Department of Health White Paper “Choosing Health: Making healthy choices easier” proposed the development of a new role for improving health and reducing health inequalities - accredited health trainers. Health trainers will be drawn from local communities and will be trained to reach those who want to adopt healthier lifestyles, but who have little contact with services. The role of the health trainer encompasses much more than advice and support. It involves training people in skills to actively set their own behavioural goals and manage their own behaviour and, more broadly, events and circumstances in their lives that they would like to change. In targeting those people who would like to change behaviours relevant to their health, and have previously been “hard to reach” via other services, the health trainer has the potential to reduce health inequalities. Health trainers will have a caseload with built in performance indicators through which individual behaviour change can be monitored. The planned impact on these health trainers will be relating to reducing smoking prevalence, tackling obesity, improving diet, reducing alcohol consumption and increasing physical activity participation.

A Health Trainer Co-ordinator is now in post for Hastings and Rother and a team of health trainers will be recruited in the coming months. The impact of their work on health improvement and reducing health inequalities will be evaluated.

CHILDREN AND YOUNG PEOPLE

People’s patterns of behaviour are often set early in life and influence their health throughout their lives. Infancy, childhood and young adulthood are critical stages in the development of habits that will affect people’s health in later years. Addressing health inequalities among children and young people is a major priority for all local agencies.

The Choosing Health action plan on physical activity highlighted that the need for children and young people to be offered more affordable, stimulating and accessible activities which will develop skills and extend healthy choices.
**OLDER PEOPLE**

Older people are the biggest users and ‘core customers’ of health and social care services and are a key focus for health plans. The emphasis of projects tackling inequalities in health outcomes for older people in line with Choosing Health priorities has been on partnership working and engagement with older people.

Regular activity is important for older adults, not only for the beneficial effects on conditions such as diabetes and cardiovascular disease, but also for the maintenance of mobility and independent living and well-being. Taking part in activities such as local walking schemes, swimming sessions, or other activity sessions for older people provide opportunities at an individual level to socialise and tackle issues of isolation; they also have community-wide benefits through building social networks and community participation.

**KICKSTART**

Kickstart is a ball-skills based activity for children under five and their parents. The aim of Kickstart is to offer fathers and working parents opportunity to engage in physical activity with their very young children. It has been carefully planned to be as accessible as possible, through being held on Saturdays and at a central location such as Summerfields sports centre.

**STAY ACTIVE KEEP WELL**

These courses are run in day centres and lunch clubs and in partnership with statutory and voluntary agencies. These courses run weekly for four to six weeks and cover issues and local information on core topics such as falls prevention, healthy eating, physical activity.

Promoting physical activity, a brief mapping of classes and availability of suitably trained leaders led the Primary Care Trust to sponsor places on chair-based exercise leaders training course. Working with partners has helped establish new exercise sessions in Sedlescombe, Ticehurst, Hastings Town Centre and Robertsbridge. A Seniors Cycling Programme, encouraging those aged over 50 back to cycling for pleasure, has offered regular rides, training and advice with those taking part enjoying the chance to ride off road and improve their strength and stamina.

Older adults are more likely to live on their own, ‘Cooking for One’ sessions, led by a chef and focusing on healthy eating, sessions have also looked at creating and managing a store cupboard and cutting down on salt, fat and sugar without losing flavour and enjoyment in food. During this year sessions have taken place in Rye and Sidley, the provision of transport ensured equity of access.
The ‘Are You a Carer?’ information pack was developed and distributed to all GP waiting rooms and pharmacists with the aim of helping those caring for someone else to access information about healthy lifestyle and support available for them as a carer. An awareness day was also held in Priory Meadow when carers could have a 1:1 discussion with specialist support organisations.

BLACK AND MINORITY ETHNIC GROUPS

Hastings and Rother Primary Care Trust is a member of both the national Race for Health and Pacesetters programmes. Both are designed to assist the Primary Care Trust to improve its delivery of services for under represented communities. According to the 2001 national census, the proportion of people from an ethnic group other than ‘white British’ was 5.9% in Hastings and 4.7% in Rother. Whilst these figures are below the national (13%) and regional figures (8.7%) there are some areas within these Local Authorities where the figures are higher. Table 04 (overleaf) looks at areas known as Super Output Areas. These are geographic areas that average 1,500 in population size. Nearly half of the Super Output Areas in Hastings have higher proportions of people from ‘non white British’ ethnic groups than for the county of East Sussex. In Rother there is an Super Output Area that contains 22% from this group.

It is important to ensure that issues of health status and access to services for Black and Minority Ethnic populations are tackled specifically. For gypsies and travellers for example, the figures from the caravan count are very small for Hastings and Rother (Hastings 3rd lowest and Rother 5th lowest out of 24 Local Authorities across Surrey & Sussex). Notwithstanding this, there is a robust cross county forum for gypsies and travellers that seeks to ensure health plans and the needs of this client group are met in Hastings and Rother.

The nature of the health challenge facing this client group has prompted the Primary Care Trust, to begin to develop in consultation with the gypsy and traveller community, a Health Record, which will seek to provide some continuity of healthcare.
Hastings and Rother Primary Care Trust has built on close partnership working with Hastings Borough and Rother District Councils and established agreed priorities around the health and well being of the population. The Hastings and St Leonards Community Strategies identify the need for greater involvement of Black and Minority Ethnic groups in decision-making group.

The Primary Care Trust has established and funded LINKS in Hastings. A service for asylum seekers refugees and newly arrived communities; it seeks, in partnership with Womens Royal Voluntary Service, Migrant Helpline and others to improve the access to health services for these client groups.

The Primary Care Trust smoking cessation programmes have undertaken equity audits to determine whether our Black and Minority Ethnic population is accessing services effectively. These have shown that Black and Minority Ethnic groups are underrepresented in the service users. As a result we have targeted more services in our priority wards in Hastings and will be recruiting and training Health Trainers to reach out to people in our Black and Minority Ethnic communities of all ages to encourage them to adopt healthier lifestyles and access health services.

The absence of effective ethnicity recording by local health services means that it is not possible to say whether services are improving the health of the Black and Minority Ethnic population.

Table 04: 2001 Census ethnicity figures for super output areas

<table>
<thead>
<tr>
<th>Area</th>
<th>Total Population</th>
<th>% non-white British</th>
<th>No. of SOA* in area</th>
<th>SOA with min % non-white British</th>
<th>SOA with max % non-white British</th>
<th>No. of SOA above the East Sussex average</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>49 138 831</td>
<td>13.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>South East GOR</td>
<td>8 000 645</td>
<td>8.7</td>
<td>5319</td>
<td>1.1</td>
<td>83.1</td>
<td>3055</td>
</tr>
<tr>
<td>East Sussex</td>
<td>492 324</td>
<td>5.4</td>
<td>327</td>
<td>1.8</td>
<td>22.1</td>
<td>112</td>
</tr>
<tr>
<td>Hastings</td>
<td>85 029</td>
<td>5.9</td>
<td>53</td>
<td>3.3</td>
<td>10.7</td>
<td>26</td>
</tr>
<tr>
<td>Rother</td>
<td>85 428</td>
<td>4.6</td>
<td>58</td>
<td>1.8</td>
<td>22.0</td>
<td>9</td>
</tr>
</tbody>
</table>

*SOA = Super Output Area  Source: 2001 Census
Recommendations: Staying well & improving health

Evaluation of all the existing health improvement programmes will be undertaken in 2008 to ensure that they are having the greatest impact on improving health of our most deprived residents.
Protecting health
Healthcare associated infections

Health protection remains one of the key components of public health practice. Healthcare associated infections (HCAI) have become the focus of government and media attention in the last twelve months. However, other important issues such as the monitoring of the incidence of tuberculosis infections and the introduction of the human papilloma virus vaccination also pose challenges to health protection across the county.

Healthcare associated infections are infections acquired in hospitals or as result of healthcare interventions. In many hospitals in the UK it is MRSA (Meticillin Resistant Staphylococcus Aureus) and Clostridium difficile that have caused particular problems recently. As well as causing serious illness, and possibly death; an infection with MRSA in the bloodstream can cause a patient to spend an extra ten days in hospital, Clostridium difficile infection an extra 21 days. These infections can cost an extra £4-10,000 per patient. Many measures are being introduced across the country to start tackling these infections more effectively.

MRSA is a form of the common skin bacteria Staphylococcus aureus that can be difficult to treat with antibiotics. It causes serious medical problems if it enters the bloodstream and especially if it infects patients who are already vulnerable. Clostridium difficile lives in the gut of 3% of healthy adults (colonisation). Antibiotics may allow the bacteria to multiply, or the infection is spread from patient to patient. Over 80% of cases occur in people aged over 65.
As can be seen in Figure 14 (a and b) there was a rise in reported cases of MRSA bacteraemia in cases in September 2007. This was fully investigated.

East Sussex Hospitals Trust have introduced many of the measures recommended by the Department of Health to cut the rates of these infections. An ‘Intravenous team’ introduced to take blood cultures in the hospitals, has resulted in a large reduction in contamination of blood cultures. A blood culture policy is also being introduced. Exemplar wards, with historically higher levels of MRSA and C. difficile, are being used as a testing ground for new working practices, including screening and decolonisation of emergency admissions. This is planned from April 2008, with all elective admissions already screened for MRSA. Any patients found to be colonised with MRSA are decolonised, and continue to receive chlorhexidine washes. Hand hygiene has improved with compliance rising to 89% during December 2007. On the wards greater integration between housekeeping and nursing staff has made a difference, and the deep cleaning of wards on both hospital sites with hydrogen peroxide is ahead of schedule. Work is underway on a hospital trust wide antibiotic policy.

The hospital trust met its monthly targets for both C. difficile and MRSA in December 2007 and January 2008. (Figure 14 a and b)

The Primary Care Trust and its staff are also actively working to reduce healthcare associated infections.

In November 2007, the Primary Care Trust Director of Infection Prevention and Control presented the Infection Control Action Plans to the Board. The Action Plan for Improved Delivery and Reduction in Healthcare Associated Infections centred on the following six challenges:

— Challenge 1 – engage with staff throughout the organisation to promote and secure the implementation of best practice in the prevention and control of infection control.

— Challenge 2 – review the patient/client journey in order to reduce the risk of transmission of infection.

— Challenge 3 – ensure that written procedures and guidance on the prevention and control of infections are implemented and reflect legislation and published professional guidance.

— Challenge 4 – ensure effective auditing of infection control standards.

— Challenge 5 – ensure a programme of education and training for infection control.

— Challenge 6 – ensure healthcare environments reflect best practice design for effective cleaning services are available.
Figure 14 (a & b): Number of MRSA and *C. difficile* infections at East Sussex Hospitals NHS Trust with target values. April 2007–March 2008
The Action Plan on prevention and control of **Clostridium difficile** in the community focuses on interventions as follows:

- **Infection control measures**
- **Prudent anti-biotic prescribing**
- **Surveillance**
- **Outbreak management**
- **Laboratory investigation**

The Primary Care Trust should continue to support enhanced training programmes in primary care to reduce healthcare associated infections, and continue to closely monitor rates of healthcare associated infections in acute trusts locally and in the community and take action immediately if there are any concerns.

---

**Table 05: Comparing MRSA and Clostridium difficile**

<table>
<thead>
<tr>
<th>MRSA</th>
<th>Clostridium difficile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transmitted through contact with colonised skin or contaminated equipment.</td>
<td>Transmitted through contact with spores from infected faeces, or contact with contaminated environment and equipment.</td>
</tr>
<tr>
<td>Eliminated from hands with alcohol hand rub, and cleaning with most disinfectants.</td>
<td>Reduce by washing hands with soap and water, and cleaning with chlorine based disinfectants.</td>
</tr>
<tr>
<td>Key risk of bloodstream infection through piercing of skin (cannula or open wounds).</td>
<td>Key risk through ingesting spores, together with antibiotic treatment.</td>
</tr>
<tr>
<td>Bacteria survives less well in environment.</td>
<td>Spores survive well in the environment.</td>
</tr>
<tr>
<td>Screening for colonisation through nose and skin swabs. Colonisation increases risk of infection and transmission.</td>
<td>Screening for colonisation is not appropriate, colonisation doesn’t increase risk of transmission.</td>
</tr>
<tr>
<td>Handwashing and using alcohol hand rub, isolating and cohorting infected patients help reduce spread.</td>
<td>Isolation, good handwashing, use of gloves and aprons, ward cleaning and improved antibiotic prescription are effective prevention and control measures.</td>
</tr>
</tbody>
</table>

*Ref DH, Clean Safe Care Reducing infections and saving lives 2008*

---

**RECOMMENDATIONS:**

**HEALTHCARE ASSOCIATED INFECTIONS**

The Primary Care Trust aspires to further reductions of hospital acquired infections by 2010. This will require increased efforts by all staff to improve infection control procedures, screening of patients prior to hospital admission and continued close monitoring and investigation of individual cases.
Tuberculosis

From 2003 to 2007 there have been 12-15 cases of tuberculosis (TB) reported annually within Hastings and Rother Primary Care Trust. In 2007 there were 12 cases reported, which equates to an incidence rate of 3/100 000. This compares with rates of 44.8/100 000 in London and 8.5/100 000 in the south east, (14/100 000 nationally). With reported tuberculosis cases increasing nationally over the past seven years, improving the management and control of tuberculosis remains a priority. Poor contact tracing increases the risks of spreading the disease, and of drug resistant cases which are estimated to cost £50-70,000 each to manage.

The local service continues to feel the impact of the national change in the BCG policy under which newborn babies born themselves, or with parents or grandparents born in high incidence countries (greater than or equal to 40/100 000) receive BCG, while the school age programme has been withdrawn. The Primary Care Trust has been working to identify all those in this higher risk group and ensure they receive the vaccine. National Institute for Health and Clinical Excellence guidance for the clinical diagnosis and management of tuberculosis, and measures for its prevention and control prioritises the following:

- management of active tuberculosis;
- improving treatment adherence;
- new entrant screening; and
- BCG vaccination.

The Health Protection Agency and the Department of Health are reviewing the effectiveness of tuberculosis screening at ports of entry and the likely trend is a greater emphasis on diagnosis in primary care.

**NEXT STEPS - TUBERCULOSIS**

Sufficient capacity in the specialist tuberculosis service is required to ensure that the responsibilities outlined in the Department of Health Tuberculosis Commissioning Toolkit are undertaken.

A lead tuberculosis consultant needs to be identified.

Reporting on tuberculosis case outcomes for the national enhanced surveillance system need to be improved.

**RECOMMENDATIONS: TUBERCULOSIS**

The Primary Care Trust needs to ensure that the service commissioned for tuberculosis meet the local population needs.
HPV vaccine

A new vaccine protecting teenage girls against human papilloma virus (HPV) will be introduced during Autumn 2008. Several strains of HPV cause up to 99% of cervical cancer in women and this vaccination will protect against the two strains causing 70% of cases. HPV is spread by sexual contact and is very common, infecting most people at some time in their lives. Cervical screening will need to continue.

The programme will start by immunising year eight (12-13 year olds) in 2008; a catch up programme will immunise 16-18 year olds from 2009, and 15-17 year olds from 2010. Each girl will receive three doses over a six month period and the programme will be carried out within schools. Within East Sussex 2000-2200 girls are eligible in each year group within state schools. The programme will use a dedicated team of nurses who would work across both Primary Care Trusts in East Sussex. This would add to the capacity of the school nurse workforce to cope with additional workload associated with introducing the programme.

RECOMMENDATIONS: HUMAN PAPILLOMA VIRUS

It is recommended that the Primary Care Trust invests in implementing the HPV vaccine programme.
Screening

Screening is a public health service in which members of a defined population, who do not necessarily perceive they are at risk of a disease or its complications, are asked a question or offered a test, to identify those individuals who are more likely to be helped than harmed by further tests or treatment to reduce the risk of a disease or its complications. Screening attempts to save lives or improve quality of life through early diagnosis of serious conditions such as cervical or breast cancer.

The purpose of cervical screening is to detect and treat early abnormalities in a woman’s cervix that may lead to cancer. Early detection and treatment can prevent 75% of cancers developing; all women between the ages of 25 and 64 are eligible for a free cervical screening test every three to five years. Similarly, the breast screening programme aims to identify breast cancer at an early stage in order to offer treatment. The NHS Breast Screening Programme provides free breast screening every three years for all women in the UK aged 50 and over. Around 1.5 million women are screened in the UK each year. Women aged between 50 and 70 are now routinely invited.

There are high uptake rates of cervical screening across the northern half of the Primary Care Trust. The lowest rates appear to be in Bexhill and St Leonards including St Michaels, Sidley, St Stephens, Bexhill Central and Sackville; and in West St Leonards, Maze Hill, Gensing and Central St Leonards. The low uptake rates may be related to ethnicity and deprivation factors.

Eastern Rother also has relatively low rates. It is important that both in less affluent areas and across Black and Minority Ethnic populations, efforts are made to increase the uptake of cervical screening tests.

There is wide variation in uptake rates for breast screening across the Primary Care Trust from 55% in Ticehurst and Etchingham to 69% in Battle Town. It would appear that some of the lowest rates are in the north of the Primary Care Trust including Ticehurst and Etchingham, as well as in parts of Bexhill.

There are clear geographical differences in take up of breast and cervical screening programmes across the county. The reasons for these variations require further investigation in terms of potential inequalities.

RECOMMENDATIONS: SCREENING

The PCT needs to work with practices to improve the uptake of screening services especially in the areas of poor uptake in 2008.
Under the Operating Framework for the NHS for 2008/09 emergency planning is one of the five national priorities for all Primary Care Trusts; with a key emphasis being placed on the preparation for pandemic flu.

The Civil Contingencies Act of 2004 requires all responding organisations to adopt a formal process within their structure for emergency planning, and to have emergency plans for specific identified local risks.

The Primary Care Trust recognises the importance of emergency preparedness and has employed a manager within public health dedicated to emergency planning and response; liaising closely with colleagues in partner agencies to ensure a co-ordinated response to emergency planning; and participating in the local resilience forum structure across Sussex. All health services are a vital element for emergency response; whether providing support to Local Authority rest centres or facilitating acute hospital discharges at times of heightened pressure. Arrangements are in place in the Primary Care Trust’s emergency plan to ensure this takes place.

Already in place is a formal structure for reviewing and updating the organisational emergency plan in conjunction with local partners. Emergency control room resources are being upgraded and telecoms resilience has been bolstered with the purchase of satellite telephones.

Planning is aimed at ensuring that Primary Care Trust staff are trained to be able to respond effectively to the challenges of an emergency, whatever it may be; to work with partners to protect vulnerable members of the community; and to ensure delivery of the core services of the organisation as far as possible.

A pandemic flu contingency plan has been developed, and work throughout 2008 will focus on production of a supporting framework of plans, culminating in testing by December.

Elements of emergency planning training have been incorporated onto the mandatory training program for all Primary Care Trust employees. This way it is planned to further prepare the organisation for the challenges that an emergency would pose.

It is essential that the Primary Care Trust is well prepared to respond effectively to major incidents, so that it can mitigate the risks to public and patients, and maintain a functioning health service. Development of emergency plans requires involvement across the entire organisation and with primary care practices.
RECOMMENDATIONS:
EMERGENCY PREPAREDNESS & PANDEMIC FLU PREPARATIONS

The Primary Care Trust needs to support emergency planning training and the testing of planning arrangements throughout the organisation and with local partners.

Implementable pandemic influenza plans need to be in place by December 2008.

REFERENCES

01. Clean Safe Care Reducing Infections and Saving Lives DH 2008
02. Focus on Tuberculosis Annual surveillance report Health Protection Agency 2006
04. Clinical diagnosis and management of tuberculosis, and measures for its prevention and control, NICE 2006
05. Proposal for the introduction of the human papilloma virus (HPV) vaccine across East Sussex. East Sussex Downs and Weald Primary Care Trust and Rother Primary Care Trust.
06. Changes to the BCG vaccination programme CMO letter July 2005, Department of Health.

Angela Iversen
Director Surrey & Sussex Health Protection Unit

Katie Cumming
Specialist Registrar

Peter Boorman
Head of Emergency Preparedness & Response
Improving quality
Within the NHS, developing high quality services for patients and expanding choice is a major focus of the current phase of reform. Primary care and acute sector providers need to be ready to respond to the challenge of expanding choice and improving quality.

There are differences in understanding the various definitions of quality currently in use within health services, and often these are based on differing management or clinical perspectives. Services that meet national targets for access or implement current best practice are usually viewed as quality services, and doubtless good accessibility and best practice are vitally important. However, to patients other indicators of quality may be just as vital.

As commissioners acting as agents on behalf of the local population, Primary Care Trusts need to ensure that the patient perspective is reflected in the drive for quality.

The Primary Care Trust is currently developing its Clinical Governance and Quality Improvement Strategy. The definition of Quality used within the Clinical Governance and Quality Improvement Strategy is:

"The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current best practice."
The Primary Care Trust strategy for improving choice and quality is to develop and implement a quality improvement strategy which will:

— Foster a “quality” culture as the norm within the organisation using a combination of managerial and clinical leadership from the top driven by evidence based and effective Clinical Governance policies and structures (this is considered fully in the following section).

— Change Healthcare organisations so that all commissioned and provided services prioritise: Quality, standards, good practice and outcomes.

— Harness the energy of clinicians in improving quality by both actively promoting clinical engagement with clinicians and between clinicians.

— Change the interface between clinicians and patients to support shared decision making and understand the differing perspectives and responsibilities of both.

— Develop and foster a ‘whole system’ perspective in commissioning starting with the individual and their needs for support over time. Working with clinicians to map the care pathway will provide the opportunity to understand the linkages between different elements of the services that need to come together to provide seamless support and care. It will also highlight where inequities are occurring that can lead to unequal access and health inequalities.
What is clinical governance?

Clinical governance is an important mechanism for delivering quality improvement, yet it is a term much misunderstood. In essence, clinical governance is how health services are held accountable for the safety, quality and effectiveness of clinical care delivered to patients and is certainly a vehicle to assist NHS organisations in achieving a culture of service quality and excellence and improving the patient experience.

Clinical governance is a statutory requirement of Primary Care Trust Boards and achieved by co-ordinating the following interlinking strands of work:

— Development of effective systems and structures that help identify, safeguard, implement and report on quality improvement and standards of care, seeking to continuously improve quality of services.
— Evidence-based quality improvement work involving healthcare professionals, patients and the public.
— Establishment of a supportive, inclusive learning culture for improvement.

Figure 15 highlights the drawing together of the many strands of clinical governance into a cohesive programme of action.

To be effective, clinical governance needs to establish the right culture and the right leadership to drive quality.

To develop and maintain the culture it is imperative both senior management and frontline staff understand their roles and responsibilities.

Improving the quality of commissioned healthcare

As commissioners of services Primary Care Trusts are accountable for service quality and, therefore, for the need to develop robust contracting mechanisms to provide the necessary assurance of the quality of all the services they procure.

One of the aims of the Clinical Governance and Quality Improvement Strategy is to ensure that the provision of contracted primary care services and the commissioning of primary and secondary care services are based on clear evidence and standards and to ensure that the work of the Primary Care Trust, in terms of service development and commissioning, is based on best available evidence.

In essence the Primary Care Trusts needs to ensure that all services meet certain standards and that these should be reflected in the quality schedule of all contracts, namely to:

- Consistently meet all national requirements including access;
- Consistently use clinical evidenced based practice;
- Consistently deliver high levels of patient experience;
- Consistently meet the standards set out in the core standards of National Service Frameworks and Standards for Better Health; and
- Continuously improve their service as good practice develops.

This includes services being developed as part of practice based commissioning. Where a practice proposes to provide services to other practices, the Primary Care Trust will need to ensure that Providers meet agreed quality standards, national standards of clinical governance including those set out in Standards for Better Health and any other relevant data to ensure they have the expected level of skill and quality to provide a specified service. The clinical governance team will be working with practice based commissioning clusters to developed clear working governance arrangements as a basis for both their commission and providing activities.
Summary

Improving clinical and service quality represents a challenge for the Primary Care Trust. The Primary Care Trust needs to act as change catalysts and work with clinicians and patients to support quality improvement. There is no one way to foster a culture of quality, and the Primary Care Trust needs to use the many different vehicles to close the “quality gap” between what is achievable and what we currently have in place.

When used carefully and correctly, quality indicators can provide information that can help health services to improve the quality of care it commissions for patients. These should be used to examine performance and where necessary, take appropriate action to improve the delivery and outcomes of patient care. A Quality Improvement Working Group will be established to develop key performance indicators and priorities. This group will report to the Joint Clinical Governance Committee.

Recommendations: Improving quality

The Primary Care Trust needs to develop a Quality Improvement Strategy and its implementation to establish and develop priorities and key performance indicators to improve standards of clinical care.

The Primary Care Trust needs to develop clear working clinical governance arrangements with practice based commissioning clusters as a basis for both their commissioning and providing activities to assure quality of these services.

Anne Cross
Head of Clinical Governance
The next steps
The Primary Care Trust has set a strategic aim of reducing health inequalities, and particularly improving life expectancy, within the geographical areas with the lowest life expectancy.

A period of “dialogue” has recently been undertaken with our major stakeholders, staff and patient representative groups, as a result of the production of the Primary Care Trust Strategic Commissioning Plans. This “dialogue” focused heavily on the outcomes of the Joint Strategic Needs Assessment, and the levels of life expectancy within the Primary Care Trust. The feedback from this was to address health inequalities and invest to increase life expectancy, particularly in the 20 wards in East Sussex with the lowest life expectancy.

There are five recommended clinical areas for action to reduce premature death from vascular disease: heart disease, stroke, diabetes, renal disease and peripheral arterial disease. This will involve:

- Reducing smoking;
- Increasing statin prescribing;
- Improve diet & exercise;
- Implementation of the relevant National Service Frameworks of care standards;
- Cardiovascular ‘At-Risk’ registers.

New, targeted investments in these areas can be divided into two categories: those that target increased services throughout the Primary Care Trust; and those which will be directly targeted to the 20 specific wards and 38 GP practices whose practice populations mainly cover those wards with the lowest life expectancy.

The estimates from the Health Survey for England shows that the overall smoking prevalence in East Sussex is 23%, but in these 20 wards it is higher: for the 11 wards in Hastings and Rother Primary Care Trust smoking prevalence is estimated at 28.8%;

The estimated number of smokers for East Sussex are outlined in the table overleaf.
In order to increase the percentage of referrals to smoking cessation services and the percentage of quitters coming from the 20 wards with the lowest life expectancy to at least 50% it is recommended that:

— Primary Care Trust Stop Smoking Services should prioritise working in the 20 wards.
— The 38 GP practices covering these 20 wards should increase smoking cessation services.
— Community Pharmacies covering these wards should be targeted to provide smoking cessation services.

Currently within the Primary Care Trust smoking cessation services operate at three levels:

01. *GP practice in a limited form, via Enhanced Services,*
02. *Pharmacy Services,* and
03. *Centralised Specialist Smoking Cessation Services, managed by the Primary Care Trust.*

In order to strengthen services a new Primary Care Trust-wide approach to smoking cessation services is proposed, with higher levels of engagement of primary care practitioners, and a new annual health check for all smokers.

This will focus activity at prevention within practices, or practice based commissioning cluster, or a geographical area, and will reward for each element of service activity for each patient.

By targeting all smokers in the Primary Care Trust in this way, higher levels of service, and higher levels of funding will be delivered, to those areas within the highest smoking levels and, therefore, those areas of greatest need. Simplistically the new approach can be illustrated as a three-tier managed service and the service details are shown in Table 07, together with the details of potential new and expanded multi-agency providers.

It is proposed that in future the providers of the services are incentivised and rewarded for their smoking intervention services as delivered, rather than only based on the number of individuals who “quit” smoking for a four week period. This will reward the service providers for the actual levels of work undertaken, and should result in a more proactive campaign within these wards.

<table>
<thead>
<tr>
<th>Area</th>
<th>East Sussex Downs &amp; Weald</th>
<th>Hastings &amp; Rother</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within the wards with the lowest life expectancy</td>
<td>31 800</td>
<td>25 000</td>
</tr>
<tr>
<td>Remaining population</td>
<td>45 000</td>
<td>19 300</td>
</tr>
</tbody>
</table>
Table 07: Proposed service details of new three-tier managed smoking cessation service

<table>
<thead>
<tr>
<th>Service Tier</th>
<th>Service</th>
<th>Potential service provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>01.</td>
<td>Ensure patient level data is updated annually to provide accurate information on smokers within the population.</td>
<td>GP practice.</td>
</tr>
<tr>
<td></td>
<td>Each smoker to be invited to attend an annual 1:1 health check, to focus on their health, and also the effects of smoking, with an aim to onward referral to a smoking cessation adviser</td>
<td>GP practice or pharmacist</td>
</tr>
<tr>
<td>02.</td>
<td>Smoking cessation service – advice to patient, support (1:1, and on-going help sessions and networking).</td>
<td>Pharmacy enhanced service or GP cluster scheme</td>
</tr>
<tr>
<td></td>
<td>Continued free prescription of smoking cessation aids to individuals that are exempt from prescription charges.</td>
<td>or Specialist smoking cessation team</td>
</tr>
<tr>
<td>03.</td>
<td>Targeted information schemes aimed directly at the populations particularly in the 20 wards. Specific emphasis on teenager/young people, smoking &amp; pregnancy, the black minority ethnic population, and cannabis cessation services.</td>
<td>Specialist smoking cessation team.</td>
</tr>
<tr>
<td></td>
<td>Working age (particularly manual worker groups), disease groups e.g. chronic obstructive pulmonary disease, and then older adults.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Monitoring of progress from quality and outcomes framework and from service (key performance indicators) from above.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Training and advice/ support to practice staff and smoking cessation service providers</td>
<td></td>
</tr>
</tbody>
</table>
Increasing the use of statins & aspirin

Figure 16: Comparison of trends in statin prescribing

Table 08: Estimated number of patients in the 20 wards with the lowest life expectancy with relevant disease diagnoses.

<table>
<thead>
<tr>
<th></th>
<th>East Sussex Downs &amp; Weald</th>
<th>Hastings &amp; Rother</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of wards</td>
<td>9</td>
<td>11</td>
</tr>
<tr>
<td>Estimated number of patients</td>
<td>44 000</td>
<td>31 100</td>
</tr>
</tbody>
</table>
Statins are a range of prescribed drugs which are used to lower cholesterol. Statin therapy is recommended by National Institute for Health and Clinical Excellence as part of the management strategy for the primary prevention of cardiovascular disease with certain types of patients. Statins, as part of a comprehensive programme (e.g. diet and exercise), can rapidly reduce the number of early deaths.

The West of Scotland Coronary Prevention Study (1998) demonstrated that statin usage could be associated to a 23% reduction in non-hemorrhagic strokes.

Currently, there is more statin prescribing within the practices which cover the 20 wards with lowest life expectancy (Figure 16).

Analysis of the Quality and Outcomes Framework data for the relevant disease group demonstrates that the number of patients registered (target group) can be seen opposite (Table 08).

Mortality rates suggest that statin prescribing in these wards needs to increase. It is proposed that the 38 practices will be actively encouraged to increase prescribing of both statins and aspirin for their patients with identified cardiovascular disease, both now, or at risk groups for the future.
Lifestyle advice: diet & exercise

‘Healthy living’ in terms of diet and exercise, is part of the comprehensive programme of interventions for reducing cardiovascular disease, both current and within the population in the future. Chapter 05 describes some of the health improvement partnership work aimed at meeting “Choosing Health” priorities. In the case of Tackling Obesity our intended outcomes of reducing obesity in our population are around the areas of improving diet and increasing physical activity groups. Local Food and Physical Activity Action Groups develop annual action plans that aims to deliver a programme of work to achieve these outcomes in partnership with other agencies including education for programmes within schools, sports & leisure agencies. This work forms part of the health improvement set within the Local Area Agreement and as part of the Local Strategic Partnerships.

The following health promotion work is in place is being evaluated to show effectiveness of interventions:

**Food and Physical Activity** - The development of programmes to meet the outcomes of increased access and consumption of fruit and vegetables and increased physical activity participation.

**The Health Trainer Programme** will target individuals who have one or more of the following ‘health’ behaviours present:

- They smoke;
- Are physically in-active; and
- Are not eating five-a-day.

They will target individuals in the 11 priority wards, engaging with them using motivational interviewing and behaviour change approaches to discuss changes to their lifestyle and referrals where appropriate into local projects and services. Outcomes are based on a range of performance indicators including effective referrals that result in a behaviour change such as increased physical activity participation or stopping smoking.

**The Lifestyle Facilitation Service** will take referrals from GPs and Practice Nurses in the 11 priority wards. The Adviser will provide patients with 1:1 behaviour change counselling and gives specific advice regarding exercise. Patients are followed up with outcomes measured by their pre and post intervention physical activity participation rate.

In addition to the above in Hastings and Rother Primary Care Trust there are a number of Enhanced Service budgets available to support both diet and exercise programmes within the GP practices, the budgeted value of these is £115 000 in 2007/08, although take up by the practices has been slow.
In Hastings and Rother we need to review and evaluate the success of the current initiatives and programmes, and the potential for changing and reconfiguring the services to meet new requirements. This would include:

- **The benefits review of increasing Health Trainers,**
- **Food and Health programme developments, and**
- **Physical Activity and Health programme development.**

Primary care engagement in this programme of work is essential if we are to achieve our life expectancy outcomes. This can be achieved by general practice identifying patients most in need, and setting up effective referral systems into clinically based services such as Lifestyle Change Facilitation; referring suitable patient’s enabling access to gyms via a GP scheme; or community initiatives.

The establishment of a 10 week Gym Exercise Local Enhanced Service for patients who are obese is also recommended. It is estimated that 152,000 patients within the Primary Care Trust that might be suitable for this programme.

GP Practices and Community Pharmacists can also play an important part in ensuring that the public have up to date information on key health promotion messages, services and community projects and in the management of weight loss programmes. In 2007/08 in Hastings and Rother a pilot of a Weight Management Local Enhanced Service was undertaken, which is providing a “Weight Watchers” style programme of weekly weighting, plus lifestyle advice, via eight pharmacies, we are recommending the extension of this in Hastings & Rother Primary Care Trust.
As part of the implementation plan to improve the life expectancy within the 20 wards, the Primary Care Trust will ensure that the following national service frameworks are implemented fully:

— Chronic heart disease; diabetes;
— Renal failure; and
— The stroke strategy.

For chronic heart disease, diabetes and renal failure the 2008/09 costs of the implementation of these strategies have already been accounted for within commissioning services budgets of the Primary Care Trust.

Improving stroke services are a priority for the Primary Care Trust and we will be ensuring improved acute services performance by improved access to Magnetic Resonance Imaging scanning, and by implementing the recommendations from the national service frameworks for stroke services.
At present within the Quality and Outcomes Framework system, GP practices are not required to maintain a register of patients ‘at-risk’ of cardiovascular disease although they do maintain registers of patients with specific diseases.

It is proposed that a new Enhanced Service is established to commence the development of an ‘at-risk’ register for cardiovascular disease/chronic heart disease. In the main it identifies patients at risk of these diseases opportunistically (i.e. when the patient visits the practice), and where the patient is obese, or has hypertension and is between 35–74 years of age. This will allow ‘at risk’ patients to be offered preventative services to improve their health.

It is recommended that a new Local Enhanced Service be developed for all GP practices, where GPs would be paid a set fee for each patient that they risk assess and undertake basic checks such as weight, blood pressure, body mass index, and then add to the cardiovascular disease ‘at-risk’ register where the patient is at risk and meets the risk criteria.
Return on investment in years of life gained

There is limited clinical evidence available currently to demonstrate the potential gained years of life by the reduction in serious diseases through the changes in investment patterns within healthcare by investing in prevention rather than treating the condition.

Our local work predicts that through continued investment in the five areas over a sustained period, then the gains in years of life, from the 2003–2005 period to the 2009–2011 period for the population of East Sussex could be:

— + 2.1 years of life in the 20 most deprived wards and;
— + 1.7 years of life in the remainder of the wards.

The life expectancy gap of 4.0 years in the period of 2003-2005 could be reduced to 3.6 years by the period of 2009–2011.

Additional, targeted investment is required to improve the life expectancy and health outcomes of the population of East Sussex, and particularly for those in the 20 wards with the lowest life expectancy. It is expected that the gains in years of life will be supplemented by gains in the reduction of healthcare treatment costs for cardiovascular disease in the future.
Recommendations: The next steps

The Primary Care Trust should fund and ensure implementation of the Investing in Life programme in 2008/9 which involves a range of services to reduce vascular disease. This will particularly focus on the 11 wards with the lowest life expectancy with the aim of reducing the life expectancy gap across East Sussex.
This Director of public health annual health report outlines some of the health needs and the opportunity for improving the health of people living in Hastings and Rother Primary Care Trust. It represents a great deal of work by members of my public health team in partnership with colleagues in the Primary Care Trust, clinicians and members of the public and East Sussex County Council and local district and borough councils to establish the needs and priorities for action and investment to reduce health inequalities and improve well being for people living in East Sussex.

The recommendations for the Primary Care Trust from this report are summarised overleaf:
CHAPTER 02: DETERMINING NEED

The Joint Strategic Needs Assessment work needs further development as an ongoing information resource jointly with East Sussex County Council to include better children’s, ethnic, transient and migrant population needs, public views and primary care data to inform service planning to meet needs.

The findings of the assessment and the individual comprehensive needs assessments should be used by East Sussex County Council, Local Authorities, Primary Care Trust and GP practices to inform strategic commissioning of services to meet needs and then later evaluation to assess the service impact on needs.

To improve the health of the public and reduce health inequalities resources should be invested in initiatives to increase life expectancy in the 20% of wards across East Sussex with the lowest life expectancy compared to the rest of East Sussex. Initially by tackling vascular disease in the 11 wards within Hastings and Rother Primary Care Trust with the lowest life expectancy.

**Older people:** resources should be channelled to maintaining and improving the health of older people, increase investment in services that promote health and well-being in older people.

**Chronic disease management:** improve detection and systematic management and treatment of patients with these conditions, which includes cardio vascular disease, stroke, chronic obstructive pulmonary disease and diabetes. The Primary Care Trust and all GP practices should invest time and resource in validating quality and outcomes framework prevalence data.

**Improving health:** investment is needed in *Choosing Health* priority areas and health protection measures – vaccination, immunisation and screening, particularly in the most deprived areas to improve the uptake of these prevention services.

**Mental health and well-being:** needs improvement especially in the most deprived areas.
CHAPTER 03: DETERMINING NEED THROUGH COMPREHENSIVE NEEDS ASSESSMENT

The findings of the comprehensive needs assessments in older people, mental health, learning disabilities and children should be used to inform and evaluate commissioning strategies to ensure service developments better meet these needs.

Further comprehensive needs assessments will be done in 2008, and will include:

- Working age adults which includes people with physical and sensory disabilities).
- HMP Lewes.
- Sexual Health.

CHAPTER 04: STAYING WELL & IMPROVING HEALTH

Evaluation of all the existing health improvement programmes will be undertaken in 2008 to ensure that they are having the greatest impact on improving health of our most deprived residents.

SMOKING CESSATION

Reduction in smoking is the most important health improvement measure that we can make to improve the public’s health.

Smoking cessation services have been evaluated and additional investment agreed in specialist and primary care services in order to achieve further improvements on smoking cessation in 2008. The effectiveness of these initiatives will need to be monitored and reviewed.

SEXUAL HEALTH

Our performance in reducing sexual health needs requires improvement in the areas of access to services, teenage pregnancy rates and Chlamydia screening in 2008.

Increased investment has been agreed by the Primary Care Trust to improve genitor-urinary medicine service access, Chlamydia screening and reduce teenage pregnancy rates. Progress with these will need regular monitoring by the Primary Care Trust and its partners.
CHAPTER 05: PROTECTING HEALTH

HEALTHCARE ASSOCIATED INFECTIONS

The Primary Care Trust aspires to further reductions of hospital acquired infections by 2010. This will require increased efforts by all staff to improve infection control procedures, screening of patients prior to hospital admission and continued close monitoring and investigation of individual cases.

TUBERCULOSIS

The Primary Care Trust needs to ensure that the service commissioned for tuberculosis meet the local population needs.

HUMAN PAPILLOMA VIRUS

It is recommended that the Primary Care Trust invests in implementing the HPV vaccine programme.

SCREENING

The Primary Care Trust needs to work with practices to improve the uptake of screening services especially in the areas of poor uptake in 2008.

EMERGENCY PREPAREDNESS & PANDEMIC FLU PREPARATIONS

The Primary Care Trust needs to support emergency planning training and the testing of planning arrangements throughout the organisation and with local partners.

Implementable pandemic influenza plans need to be in place by December 2008.
CHAPTER 06: IMPROVING QUALITY

The Primary Care Trust needs to develop a Quality Improvement Strategy and its implementation to establish and develop priorities and key performance indicators to demonstrate improved standards of clinical care.

The Primary Care Trust needs to develop clear working clinical governance arrangements with practice based commissioning clusters as a basis for both their commission and providing activities to assure quality of these services.

CHAPTER 07: THE NEXT STEPS

The Primary Care Trust should fund and ensure implementation of the Investing in Life programme in 2008/9 which involves a range of services to reduce vascular disease. This will particularly focus on the 11 wards with the lowest life expectancy with the aim of reducing the life expectancy gap across East Sussex.
I would like to offer my personal thanks to the following staff and partners who have contributed to this report:

— Cynthia Lyons
— Angela Iversen
— Claire Turner
— Katie Cummings
— Joanne Bernhaut
— Graham Evans
— Anne Cross
— Ivan Rudd
— Stuart Ramsbottom
— Richard Watson
— Nigel Hussey
— Jennifer Hopkin
— Cate Carmichael
— Sara Corben
— Liz Saunders
— Angela Paice