



# Waltham Forest

## Joint Strategic Needs Assessment

### 2012-13

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# Executive Summary

The purpose of this document is to inform the priorities for the refresh of the Commissioning Strategy Plan (CSP) for 2012/13. The Joint Strategic Needs Assessment for 2012/13 builds on a series of health needs assessments that describe the health needs in Waltham Forest and make recommendations for prioritisation within the Commissioning Strategic Plan (CSP).

Public Health NHS ONEL Waltham Forest led the development of the 2012/13 Joint Strategic Needs Assessment, in partnership with the London Borough of Waltham Forest, Whipps Cross University Hospital (WXUH), North East London NHS Foundation Trust, Local Involvement Network (LINKs), and the voluntary sector. Each section of the JSNA summarises detailed health needs assessments for a specific health topic.

The process for reviewing findings of this JSNA included review and discussions by

- The relevant Board or Local implementation Team where recommendations were agreed
- Each of the three GP Commissioning Boards
- NHS Waltham Forest Federated Clinical Commissioning Group (Clinical Senate)
- The local authority councillor leads for Adults and Health and for Children

Waltham Forest LINKs and Voluntary Action Waltham Forest supported the public engagement work that formed the local residents' input into the JSNA.

Recognising increasing demand stemming partly from an ageing population and increasing costs, attention needs to concentrate on preventing disease, improving productivity and eliminating waste while focusing relentlessly on clinical quality. The JSNA therefore adopts a QIPP approach to identify opportunities for prevention and to improve productivity and quality, while pointing to opportunities for savings.

This JSNA follows the life course framework adopted by the Strategic Review of Health Inequalities in England post 2010<sup>1</sup>. The framework proposed by this review starts with the determinants of health model that states that health is an interaction of what we are born with (our genetics), our lifestyle choices, the social and physical environments in which we live and health care services.

The Marmot framework built on this model to propose that these influences accumulate across our lives. Some influences are protective and others present risks. Where risk outweighs protective factors, chronic disease, disability and mortality begin manifesting from around age 50.

While the review noted that reducing health inequalities will require universal action rather than a focus on the most disadvantaged, the authors have since recognised that during a period of economic uncertainty, it is best

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<sup>1</sup> Fair Society, Healthy Lives. 2010. The Marmot Review Strategic Review of Health Inequalities in England Post 2010.

to target scarce resources to those most in need. The local health inequalities strategy adapted the Review's framework, recommending a focus on the key determinants of health at each life stage as follows:

- Early Years – early childhood development
- Children of School Age – education
- Working Age Adults – healthy work
- Older People (retirement) - maintaining independence.

The first part of this document examines demographic characteristics of our population and the wider factors that influence health and wellbeing in Waltham Forest such as the socio-economic determinants. It then sets out current health and wellbeing trends in the population for the most significant causes of mortality and morbidity in Waltham Forest. Health inequalities are a high level indicator of unmet need and these are described in relation to London and England but also within the Borough and between localities or GP Commissioning Groups, where data is available.

Waltham Forest has a population of some 247,503<sup>2</sup> persons living in over 98,000 households. Population density tends to be higher in the middle and southern wards of the borough compared to the northern wards. In terms of ethnicity the middle and southern wards of the borough also tend to be more diverse whilst a higher percentage of the borough's white population is found in the northern wards.

The GLA 2009 Round Ethnic Group Projections revised data for 2011 show that Waltham Forest's BAME (Black Asian and Minority Ethnic) population 97,570 is the 13<sup>th</sup> highest across the London boroughs and the 8<sup>th</sup> highest when expressed as a percentage of total population (42%). Pakistanis (9.5%) form the largest BAME group, followed by Black Caribbean (9.2%), Black African (6.8%) and Black Other/Asian Other (4.1% each). Other groups include Eastern Europeans, Somali, Ghanaians and Nigerians.

The 2012/13 JSNA confirmed the continuing existence of health inequalities between Waltham Forest and the rest of the country and London and between localities within Waltham Forest. These inequalities are influenced by the broader inequalities in the social and economic environments.

The summary set out in the table below compares the 2012/13 JSNA needs and evidence analysis against the proposed priorities for the 2012/13 CSP. While most of the priorities remain the same as for 2011/12, best practice interventions are noted within existing priorities. Recommended priorities include:

2012/13 CSP priority	2012/13 JSNA evidence of need	2012/13 CSP proposed priority and example best practice interventions
<b>Health inequalities male and female</b>	Measured by <ul style="list-style-type: none"> <li>• infant mortality</li> <li>• Infant mortality higher in Waltham Forest</li> </ul>	Infant mortality –Improvements provide opportunities to gain most life years.

<sup>2</sup> 2011 Mayhew Harper Population Count

	<p>than London but equal to England.</p> <ul style="list-style-type: none"> <li>• See Maternal and Child Health</li> </ul> <p>and</p> <ul style="list-style-type: none"> <li>• life expectancy</li> <li>• Life expectancy increasing but not as quickly as London and England and differences in life expectancy across Waltham Forest.</li> <li>• See ACSCs, CVD and Cancer</li> </ul>	<p>Life expectancy - Improvements provide opportunities for quickest increase in fewer number of life years.</p>
<b>Determinants of Health</b>		
<b>Prevention</b>	<p>Proliferation of fast food, alcohol and betting shop outlets</p> <p>Poverty and education levels worse than London and England</p> <p><b>Lifestyle Risk Factors</b></p> <p><b>Alcohol</b></p> <ul style="list-style-type: none"> <li>• Rate of alcohol related hospital admissions in 2009/10 was higher than London and England averages. It is predicted to increase over the coming years.</li> </ul> <p>Alcohol specific hospital admissions for under 18s in Waltham Forest is higher than the London average</p> <p><b>Smoking</b></p> <ul style="list-style-type: none"> <li>• 19.3% estimated prevalence in the general population aged 16+.</li> <li>• 24% estimated prevalence in people aged 40-74 attending a health check.</li> <li>• Smoking attributable hospital admissions third highest in London for 2009-10</li> <li>• Smoking is the leading cause of health inequality.</li> </ul> <p><b>Adults – Obesity</b></p> <ul style="list-style-type: none"> <li>• Adult obesity in Waltham Forest was 25% compared to Croydon 23.5%, Enfield 23.2%, Greenwich 23.4% and 24.2% for England</li> </ul> <p><b>Adults – Physical Activity</b></p> <ul style="list-style-type: none"> <li>• In the period 2007-2009, 7% of adults in Waltham Forest participated in sport and active recreation, compared to Greenwich 9.5%, Enfield 7.5%, Croydon 7.4% in 2007-2009 and 11.2% in England.</li> </ul> <p><b>Children – Obesity</b></p> <ul style="list-style-type: none"> <li>• Childhood obesity increased between 2008-2009 and 2009-2010 in Reception pupils from 9.9% to 10.9% and is higher than the national average (from 9.6% to 9.8%).</li> <li>• In the same period, the obesity rate in Year 6 pupils</li> </ul>	<ul style="list-style-type: none"> <li>• Raise the profile of work within the Council for joint working between spatial planning and public health to consolidate and expand areas of partnership, to develop healthy policies including food provision, betting shops and alcohol outlets, for example.</li> <li>• Adopt/develop simple health impact assessment format and process to assess impact of influences on health before implementation</li> <li>• Use the Healthier Fairer Waltham Forest Board to raise the profile of health inequalities and prevention among the Health and Well being Board and the local authority</li> <li>• Refresh the current Waltham Forest Alcohol Strategy and set up an implementation group to drive the strategy</li> <li>• Invest in prevention and health promotion strategies to improve knowledge of tobacco related harm locally, and to divert young people from tobacco use.</li> <li>• Embed tobacco control messages in the local education curriculum developed with input from pupils, community and health leaders.</li> <li>• Increase efforts to tackle barriers to cycling and walking in the borough.</li> <li>• Develop business travel policies for large employers, which promote active, green travel and set the standard for other organisations within the borough.</li> <li>• Develop walking strategy and update cycling strategy.</li> <li>• Ensure pathway developed to cover Tiers 1 – 3, with appropriate interventions based on NICE guidance for adults and children</li> <li>• Increase participation in physical activity by creating social, cultural and physical environments that supports and encourage active lifestyles.</li> </ul>

	<p>increased from 20.6% to 21%, higher than the national average (1)8.3% to18.7%.</p>	<ul style="list-style-type: none"> <li>Promote healthy eating by increasing the availability of and access to healthy food choices and reducing the availability of and access to food that are high in fat, sugar and salt including promoting taking nutritious school meals</li> </ul>
<b>Maternal and Child Health</b>		
<p><b>Infant mortality</b></p>	<ul style="list-style-type: none"> <li>Infant mortality higher in Waltham Forest than London but equal to England.</li> <li>Still births, perinatal mortality, low birth weight higher than London and England.</li> <li>Early booking to maternity services (by 12 weeks gestation) below local target 88%</li> <li>Healthy Start Vitamins uptake for women and babies – lower than London and Eng.</li> <li>Prevalence of Breastfeeding at 6-8 weeks – below local target of 72%.</li> <li>Childhood immunisations coverage – below local targets and World Health Organisation (WHO) target of 95%.</li> <li>Oral Health – higher percentage with decayed, missing or filled teeth (dmft) than England.</li> <li>Child Well-being index – rank below England average.</li> <li>Child and Adolescent Mental Health Service– numbers of children and young people accessing services are larger in the higher tier of services (tier 4) and lower numbers in tier 2 and 3 where the reverse would have been expected.</li> <li>Gastrointestinal emergency admissions for persons &lt;5 years old – higher than London but lower than England.</li> <li>Asthma emergency hospital admissions for &lt;18 year olds – higher than London and England.</li> <li>Injury related hospital admissions for &lt;18 year olds – higher than London and England.</li> <li>Elective hospital admissions for 15-19 year olds - higher than London.</li> <li>Teenage Pregnancy – higher than London and England.</li> <li>Looked After Children – rate of children in care is higher than national average.</li> <li>Young Carers – Numbers accessing specialist provisions and known to local authority is lower than estimated numbers of young carers in the borough.</li> <li>Domestic Violence - In 2009/10 there were 524 episodes of domestic violence involving 417 children and young people reported to the</li> </ul>	<ul style="list-style-type: none"> <li>Pilot the Best Start in Life scheme, evaluate and roll out as appropriate across Waltham Forest <ul style="list-style-type: none"> <li>Early antenatal booking</li> <li>No smoking in pregnancy</li> <li>Teenage pregnancy</li> <li>Immunisations</li> <li>Breastfeeding</li> <li>Family Nurse Partnership</li> </ul> </li> <li>Develop a strategy that covers pregnancy through childhood to 18 years and action plan to include recommendations from the report Early Intervention: The Next Steps and other key documents. Ensure identified gaps are delivered and make investment where necessary to achieve objectives of strategy.</li> <li>Implement the action plans developed from the detailed Antenatal and Newborn Screening programme audits and new national guidelines.</li> <li>During transition and changes, ensure the sustainability of a coordinated immunisations programme between primary care, child health and other partners.</li> <li>Commissioners should make an investment to set up GP payments for immunisations based on the RiO Child Health Information system which should improve the coverage reported.</li> <li>Develop the Unicef Baby Friendly 7-step plan initiative in the community, align commissioning to the breastfeeding commissioning guidance tool and deliver the ONEL wide Breastfeeding Strategy.</li> <li>Develop an Oral Health Strategy for children and young people up to the age of 18 in the borough based on an assessment of needs.</li> <li>Embed childhood prevention work in frontline staff work e.g. GPs, Children’s Centre’s, Midwifery, Health Visiting, School Nurses to includes areas such as increasing awareness of importance of immunisations and breastfeeding.</li> <li>Review local data on emergency hospital</li> </ul>

Councils' children's services.

admissions for asthma to look at coding issues that may be evident in the data and put appropriate actions in place to reduce admissions, including education programmes for children and their families who attend accident and emergency for Asthma to reduce re-attendance if appropriate.

- Develop a children's mental health strategy that takes the CAMHS work across the four boroughs that use North East London Foundation Trust mental health services as a starting point to include prevention and early diagnosis.
- Review adequacy of therapy provision such as Physiotherapy and Speech and Language Therapy for Waltham Forest Children and Young People with disabilities. Through increased investment, ensure Occupational Therapy services meet the needs of Waltham Forest Children.
- Review data recording systems already used for recording data on children with disabilities and establish a central system for recording this data.
- Ensure progress to deliver a quality Health Visiting service to meet the needs including continuing efforts to deliver increased 1 year health reviews coverage, while maintaining 2 year reviews. The Health Visiting service should also expand in line with the Health Visitor Implementation plan 2011–2015.
- Review the Healthy Schools Programme with a view to continuing best practice beyond March 2012.
- Develop a Strategy for Looked After Children in Waltham Forest.
- Improve early identification of, and data collection on young carers as well as support provided.
- Increase the number of CAF assessments completed, broadening the range of practitioners using CAF. Supporting professionals through provision of training and support to complete CAF process should increase numbers. Health professionals and others should ensure the CAF process is embedded in normal practice for staff in different services.
- Commission a domestic violence service that offers therapeutic interventions including counselling and practical support for perpetrators to cease their violent and /or controlling behaviour, and support, counselling and advice to victims including children and young people affected.

<b>Working Age</b>		
<b>Cardiovascular Disease (CVD) Mortality</b>	<ul style="list-style-type: none"> <li>• Circulatory diseases account for the leading cause of mortality within the borough, although mortality has been decreasing over last 15 years, it remains above London and national averages.</li> <li>• Lower spend and poor outcomes.</li> <li>• Lack of a robust system to detect and treat people at high risk of Cardiovascular disease (CVD).</li> <li>• Poor awareness among public of early symptoms of Coronary Heart Disease (CHD), stroke/TIA.</li> <li>• Variation in quality of care in managing CHD, stroke, HF and AF.</li> </ul>	<p>Prevention to address lifestyle risk factors embedded in all frontline contacts</p> <ul style="list-style-type: none"> <li>• Embed NHS health checks</li> <li>• Provide culturally appropriate social marketing to improve knowledge and change behaviour to seek early treatment and improve compliance to medication.</li> <li>• GPs with Special Interests (GPwSI) for Cardiology.</li> <li>• Develop community development model to provide outreach services aimed at disadvantaged groups.</li> <li>• Train primary care staff to improve early detection and management of established disease.</li> </ul>
<b>Ambulatory care sensitive conditions (ACSCs)</b>	<ul style="list-style-type: none"> <li>• High rates of hospital admissions are considered a failure of the health care system.</li> <li>• Mortality from respiratory diseases – third highest cause of mortality.</li> <li>• Gap in recorded and expected prevalence in ACSCs. (see CVD and cancer section)</li> </ul>	<ul style="list-style-type: none"> <li>• Embed Health Promoting GP Practice scheme in primary care</li> <li>• Address all ACSCs, especially Chronic Obstructive Pulmonary Disease (COPD) (respiratory diseases 3<sup>rd</sup> biggest killer).</li> <li>• Manage childhood asthma and epilepsy in community.</li> <li>• Implement the diabetes pilot on care planning.</li> <li>• Establish better communication between secondary care clinicians and primary care.</li> </ul>
<b>Cancer Mortality</b>	<ul style="list-style-type: none"> <li>• Cancer mortality is declining but not as quickly as London and England. Remains second highest cause of mortality In Waltham Forest.</li> <li>• Overall incidence rate is one of the lowest in London</li> <li>• Significantly lower rates of one year survival rates for people with lung cancer; in men prostate cancer and for women with colorectal cancer.</li> </ul>	<ul style="list-style-type: none"> <li>• Prevention to address lifestyle risk factors embedded in all frontline contacts</li> <li>• Outreach to at risk groups to raise awareness of cancer symptoms and need for early presentation</li> <li>• Increase cancer screening rates</li> <li>• Continued GP education for improving urgent referrals.</li> </ul>
<b>Mental Health Learning Disabilities</b>	<ul style="list-style-type: none"> <li>• Mental health problems estimated to be 33% higher than England.</li> <li>• High inequalities by ethnicity, age and geographic location.</li> <li>• Very high level of A&amp;E attendance.</li> <li>• Lack of evidence based integrated clinical care pathways for psychotic disorders and dementia</li> </ul>	<ul style="list-style-type: none"> <li>• Redesign clinical care pathways for psychotic disorders.</li> <li>• Address inequalities- Strengthen culturally appropriate services aimed at BME groups.</li> <li>• Raise awareness among public and health professionals to reduce stigma</li> </ul>
<b>Sexual Health (adults &amp; young people) Tuberculosis</b>	<ul style="list-style-type: none"> <li>• Late diagnosis of HIV.</li> <li>• High level of STIs.</li> <li>• High number of repeat abortions.</li> <li>• High prevalence of TB</li> <li>• HIV patients not being offered T spot testing for TB</li> <li>• No outreach TB service in Waltham Forest</li> </ul>	<ul style="list-style-type: none"> <li>• GP screening for Chlamydia.</li> <li>• Expand provision of LARC, condoms, etc. – youth clinics and GPs.</li> <li>• Expand HIV testing to point of care testing.</li> <li>• Establish an outreach treatment service for TB patients</li> <li>• Raise awareness of TB in the community</li> </ul>
<b>Older People</b>		
<b>Falls Dementia</b>	<ul style="list-style-type: none"> <li>• Provides opportunities to strengthen health and social care working together</li> </ul>	<ul style="list-style-type: none"> <li>• Develop Falls Prevention pathway and strategy</li> <li>• Joint dementia strategy calls for dementia care</li> </ul>

<b>Seasonal Flu</b>  <b>End of Life</b>	<ul style="list-style-type: none"> <li>• Increasing needs for continuing care and dementia.</li> <li>• The percentage of residents in Waltham Forest dying in acute hospital settings is 70% with only 16% dying at home.</li> </ul>	<p>pathway redesign.</p> <ul style="list-style-type: none"> <li>• Increase seasonal flu and pneumococcal immunisation.</li> <li>• Increase percentage of residents dying at home who wish to do so.</li> </ul>
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It is clear from the analysis and recommendations in this JSNA that much remains to be done but now within reducing resources. It therefore becomes imperative to identify unsuccessful interventions for decommissioning, while scaling up successful local interventions and best practice. The challenge of doing more with less is real, while ensuring quality. Working differently is not a choice; prevention, increased productivity and innovation offer opportunities for meeting this challenge.

# Section 1

## introduction



- Development of the 2012-13 JSNA
- Organisation of the JSNA

# Development of the 2012/13 Joint Strategic Needs Assessment

## Purpose

The purpose of this document is to inform the priorities for the refresh of the Commissioning Strategy Plan (CSP) for 2012/13. The Joint Strategic Needs Assessment for 2012/13 builds on a series of health needs assessments that describe the health needs in Waltham Forest and make recommendations for prioritisation within the Commissioning Strategic Plan (CSP).

## Process

A multi-agency steering group was set up to oversee the development of the JSNA, chaired by the Director of Public Health. The group comprised representatives from NHS ONEL Waltham Forest, London Borough of Waltham Forest, Whipps Cross University Hospital, North East London NHS Foundation Trust, Local Involvement Network (LINKs), and the voluntary sector.

Each section of the JSNA summarises detailed health needs assessments for a specific health topic that were carried out in collaboration with colleagues from commissioning, local authority, primary care, community services and the voluntary sector.

Results of each of the health needs assessment were reviewed by the relevant Board or Local Implementation Team (LIT) where recommendations were agreed. The draft JSNA was presented to each of the three GP Commissioning Boards and discussed with the local authority councillor leads for Adults and Health and for Children.

The Public Health team with support from Waltham Forest LINKs and Voluntary Action Waltham Forest undertook the public engagement work that sought local residents' views on proposed priorities. A consultation event was held on 18th November 2011 at the Score Centre in Leyton where members of the community, voluntary, business and third sector organisations were invited to participate.

Views were gathered during the workshop for local people to validate emerging issues and to discuss implications for commissioning, service delivery and the role of the voluntary sector. Participants worked through sub-groups to discuss the refreshed priorities proposed in the JSNA. Participants felt that these priorities were generally correct based on the evidence presented but that further detail was required. Below is the feedback received.

## Generic Feedback

- The JSNA should look at the long-term trends. If analysis of ethnicity, for example, highlights that there is an inequality between a particular ethnic group and other ethnic groups, follow-up analysis should be undertaken after any interventions to see whether there was an impact in reducing health inequalities.

- When differences in groups are highlighted, there should be interventions put in place to address the issues identified.
- There needs to be better partnership working between the London Borough of Waltham Forest (LBWF), Community and Voluntary Sector and the NHS to tackle issues locally. Community and Voluntary groups already do a lot in the community but this is not highlighted in the JSNA.
- There needs to be some work with Public Health and LBWF around identifying community and voluntary groups that work on certain areas i.e. Maternal and Child Health, Physical Activity, Healthy Eating etc. Public Health can engage with groups that work on similar topics.
- Locally there is a need to look at sharing resources e.g. organising joint events around different topics. A series of events can take place looking at different topics.
- There needs to be a greater commitment and a rolling programme across the year of activities and events to get input into the JSNA, targeting a range of groups.

### **Maternal and Child Health**

- The Maternal and Child Health Section is quite comprehensive and includes a wealth of information on the needs of pregnant women, children and young people
- There was discussion around including more information/ statistics about local nurseries especially the Private Nurseries and how they are able to deliver/are delivering messages to families. There is a Certificate of Minimum Standards for Nurseries that the LBWF manages. Public Health can link with the LBWF lead to make sure that more information is included next year. Public Health may be able to influence the standards that are being set for nurseries based on evidence and the needs of babies and families locally.
- The LINKS is doing some work with BME young carers around what their needs are i.e. undertaking focus groups. This will inform young carers' pathways and strategy. When completed, this information can be included in next year's JSNA.
- There are Patient Participation Groups in each GP practice and it would be interesting to find out how young people are engaged with these patient participation groups and how their needs are raised at a GP practice level.

### **Falls Prevention** issues included

- Poor housing conditions - inadequate lighting, slippery floors.
- Environmental – unkempt hedges to block pavements and slippery footpath.
- The voice of older people to be heard.
- Loneliness – to be included in the community social networks.
- Close proximity to local events.
- Involve older people in health and social care decision-making; particularly transfer of care arrangements when being discharged from acute hospital care.

## End of Life issues included

- Older people's dignity needs to be respected.
- Support older people to make healthy decisions.
- Appropriate training for frontline staff to recognise older people's needs.
- Care homes should be seen as a home and not as a hospital.
- Insufficient money to warm their homes.
- Involve older people in health and social care decision-making particularly transfer of care arrangements when being discharged from acute hospital care.

## Cancer issues included

- Lung cancer – Air pollution. Air pollution not monitored extensively – what data is available. Smoking – Under age smoking and illegally imported cigarettes contaminated/adulterated with harmful substances.
- Skin cancer – sunbeds. A large scale campaign such as that carried out in Australia could be carried out to highlight the dangers of sun exposure.
- Breast cancer – need to raise awareness in males on self examination. Recall age limit should be extended to older age groups.
- Prostate cancer – poor awareness in men. Lower incidence in sexually active males of older ages. Ethnic risks attached to Black Caribbean/African men.
- Need to disseminate health messages to men via locations where they gather regularly e.g. barber shops, pubs etc. Sporting figures could have a role in health promotion, especially ethnic minority footballers.
- Bowel cancer – embarrassment important in low uptake of screening opportunities. Again sporting figures could promote awareness and screening. 2012 Olympics opportunity could be exploited.
- Chemists understand the importance of bowel screening and could provide a point for screening samples to be collected.
- Opticians and dentists have a role in spotting malignancies on routine examinations. Working closely with them could play a key role or route to improving awareness on eye and mouth cancers.
- Regular community events where health checks (blood pressure/weight/HBA1C/exercise-lifestyle) could be offered are a good idea, with extensive advanced publicity on dates set for the entire year, ideally at quarterly intervals.
- GPs should see all patients aged 18+ for a health check annually involving the completion of a 10 health point questionnaire.
- Schools and colleges should be targeted for cervical screening promotion.
- Work more closely with the community in order to raise awareness.
- Up to date communication to deliver health messages is important – use of text messaging to young people.

## Mental Health issues included

- Lesbian Gay Bisexual and Transgender (LGBT) people are over represented in mental health, sexual health, eating disorders, self harm, smoking and substance misuse issues but there is no targeted work with LGBT communities.
- Mainstream /"generic" services do not meet the needs of LGBT communities. Need for targeted services.
- There is a need to commission talking therapy/counselling for LGBT around alcohol, sexual health and self harm.
- Not enough mental health interventions for all communities.
- East London Out Project (ELOP) not commissioned by Waltham Forest to deliver services. They are commissioned by Waltham Forest Council to engage with and provide a voice for LGBT people.
- Voluntary organisations need to work together to promote healthy lifestyles.
- More involvement of GPs in managing common mental disorders e.g. knowledge of available services and referral procedures.
- GPs to provide more support to patients.
- Gap around crisis intervention
- We need a directory of mental health services for GPs and other front line workers in health and social care services.

## CVD issues included

- More community prevention interventions.
- Integrate prevention/healthy lifestyles into education.
- Education on use of health care system.
- Healthy eating "workshops" run by peers.
- More linkage between mental health and healthy lifestyles.
- Monitoring of mental health services around physical health interventions.
- GPs to make more "targeted" referrals to avoid inappropriate referrals.

## Sexual Health issues included

- Sex education should be given by peers (role models) and not by teachers e.g. by teenagers.
- There should be easy access to clinics (currently only one at Oliver Road).
- There should be work with teenagers to see if what is currently provided is what they want.
- Education should begin in primary schools.
- The current services provided should be evaluated.
- Work should also be done with deprived communities on estates and better use of youth bus.

**TB** issues included

- TB should be seen as a priority in Waltham Forest.
- There should be outreach programme in the community to raise awareness.
- Raising awareness is crucial. Awareness should also be raised with Councillors.
- There should be more posters displayed around the borough about TB e.g. bus stops, halls, community centres, colleges etc. One resident highlighted if she did not attend this session she wouldn't know that TB was a problem in Waltham Forest.

**Seasonal Flu**

- More clinics to be available and not only at GP surgeries.

**QIPP**

The Department of Health has established Quality, Innovation, Productivity and Prevention (QIPP) as the guiding principles to help the NHS deliver its quality and efficiency commitments during a period of financial challenge, building on the progress made in implementing Lord Darzi's Next Stage Review.

Recognising increasing demand stemming partly from the fact that our population is ageing and to mitigate increasing costs, attention needs to concentrate on preventing disease, improving productivity and eliminating waste while focusing relentlessly on clinical quality. The JSNA therefore adopts a QIPP approach to identify opportunities for prevention and to improve productivity and quality, while pointing to opportunities for savings.

The commissioning of health and social care is now focused on care pathways. These may be developed for population groups e.g. children, but more commonly for specific conditions or groups of conditions. The health pathway is shown in Figure 1.

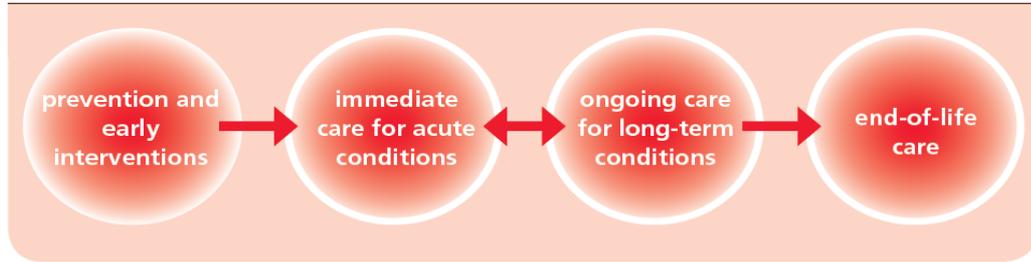
**Figure 1**  
The health pathway – factors influencing the production of health

Determinants of health	Primary prevention lifestyle	Secondary prevention	Early diagnosis	Treatment	Tertiary prevention – rehabilitation	End of life
<ul style="list-style-type: none"> <li>• Education</li> <li>• Income</li> <li>• Housing</li> <li>• Crime/safety</li> </ul>	<ul style="list-style-type: none"> <li>• Smoking</li> <li>• Diet</li> <li>• Exercise</li> <li>• Alcohol</li> <li>• Teenage pregnancy</li> </ul>	<ul style="list-style-type: none"> <li>• Perinatal</li> <li>• Cancer</li> <li>• Health checks</li> </ul>	<ul style="list-style-type: none"> <li>• Early presentation</li> <li>• Improved primary care referrals</li> </ul>	<ul style="list-style-type: none"> <li>• Treatment</li> </ul>	<ul style="list-style-type: none"> <li>• Improving quality of life for those living with vulnerability disability or disease</li> </ul>	

This may be focused on four main stages across this pathway including prevention and early interventions, immediate care for acute conditions, ongoing care for long-term conditions, and end-of-life care (see Figure

1.2). The quality of care has become the focus of NHS reform. It is recognised that variation in care and in outcomes is unacceptable. This may be seen, for example, locally in poor survival rates for cancer or different levels of compliance with evidence-based practice in primary care in managing someone with heart disease.

**Figure 1.2 the main elements of a care pathway**



## Organisation of the JSNA

This JSNA follows the life course framework adopted by the Strategic Review of Health Inequalities in England post 2010<sup>3</sup>. The framework proposed by this review starts with the determinants of health model that states that health is an interaction of what we are born with, our lifestyle choices, the environments in which we live and health care services. The Marmot framework builds on this model to propose that these influences accumulate across our lives. Some influences are protective and others present risks. Where risk outweighs protective factors, chronic disease, disability and mortality begin manifesting from around age 50. This is discussed in more detail in Section 3.2 on Social determinants and a life course framework.

While the review noted that reducing health inequalities will require universal action rather than a focus on the most disadvantaged, the authors have since recognised that during a period of economic uncertainty, it is best to target scarce resources to those most in need. The local inequalities strategy adapted the Review's framework, recommending a focus on the key determinant of health at each life stage as follows:

- Early Years – early childhood development.
- Children of School Age – education.
- Working Age Adults – healthy work.
- Older People (retirement) - maintaining independence

The first part of this document examines the demography of Waltham Forest and the wider factors that influence health and wellbeing in Waltham Forest. It then sets out current health and wellbeing trends in the population for the most significant causes of mortality and morbidity in Waltham Forest. Health inequalities are a high level indicator of unmet need and these are described in relation to London and England but also within the Borough and between localities or GP Commissioning Groups.

The remainder of the chapters follow the life course and offer recommendations for priorities for children and young people, younger adults, and older adults. These priorities will need to be narrowed down by examining these criteria:

- Prevalence – how many people are affected?
- Contributions to equity and reducing health inequalities
- Effectiveness of available interventions
- Feasibility
- National priorities

Data presented throughout the JSNA is the most recent available with comparators. This is adequate for identifying key priorities for commissioning, while more recent numbers would be required for actual service provision planning.

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<sup>2</sup> Fair Society, Healthy Lives. 2010. The Marmot Review Strategic Review of Health Inequalities in England Post 2010

# Section 2

the people and the place



- The people
- The place

## **Waltham Forest – The People**

### **Executive Summary**

Waltham Forest has a population of some 247,503<sup>4</sup> persons living in over 98,000 households. Population density tends to be higher in the middle and southern wards of the borough compared to the northern wards. In terms of ethnicity the middle and southern wards of the borough also tend to be more diverse whilst a higher percentage of the borough's white population is found in the northern wards.

Just over half the borough is female (51%) and the borough has a similar age profile to London as a whole. The largest number of households in the borough is single households (29% of all households) although 41% of the borough population live in family households with dependent children (23% of all households). Data on arrivals from other countries over the last 8 years show that Poland, Pakistan and Lithuania have supplied the greatest number of migrants.<sup>5</sup>

### **Population Count**

There are three sources that use different methodologies to construct a population estimate of the borough. Each has a different use. The most accurate of these is the Mayhew Harper Population Count (conducted in March 2011), which showed that the borough has a population of 247,503.

Often used for comparisons on a pan-London basis, the most recent population projection from the Greater London Authority data gives Waltham Forest a population of 232,726 (as of 2011). This is marginally smaller than the London wide average of 239,400.

Used for determining levels of funding allocation and for official central government planning, the Office for National Statistics Mid Year Estimates gives Waltham Forest a population of 227,145 as at 2010.

### **Ethnicity**

The GLA 2009 Round Ethnic Group Projections revised data for 2011 show that Waltham Forest's BAME (Black Asian and Minority Ethnic) population was 97,570. This is the 13<sup>th</sup> highest across the London boroughs and the 8<sup>th</sup> highest when expressed as a percentage of total population (42%).

Pakistanis (9.5%) form the largest BAME group, followed by Black Caribbean (9.2%), Black African (6.8%) and Black Other/Asian Other (4.1% each).

The 2011 Mayhew Harper Population count also estimated that, of more recent arrivals to the borough just under 9,000 were Eastern Europeans. Other ethnic minorities in the GLA data include almost 5,000 Turkish, almost 4,000 Somali and over 2,500 Ghanaians and Nigerians.

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<sup>4</sup> 2011 Mayhew Harper Population Count

<sup>5</sup> Ibid

Figure 1 and Map 1 show the distribution of the borough's population at a ward level and the proportion of the population that is White British and Irish, BAME (Black, Asian and Minority Ethnic) or of unknown ethnicity. It shows that there are a greater proportion of White British and Irish residents in wards in the north and middle of the borough. Conversely it also shows BAME residents are proportionally more likely to be found in the middle and southern wards of the borough than the northern.<sup>6</sup> Map 2 on ethnic diversity illustrates that the population becomes more ethnically diverse going from north to south.

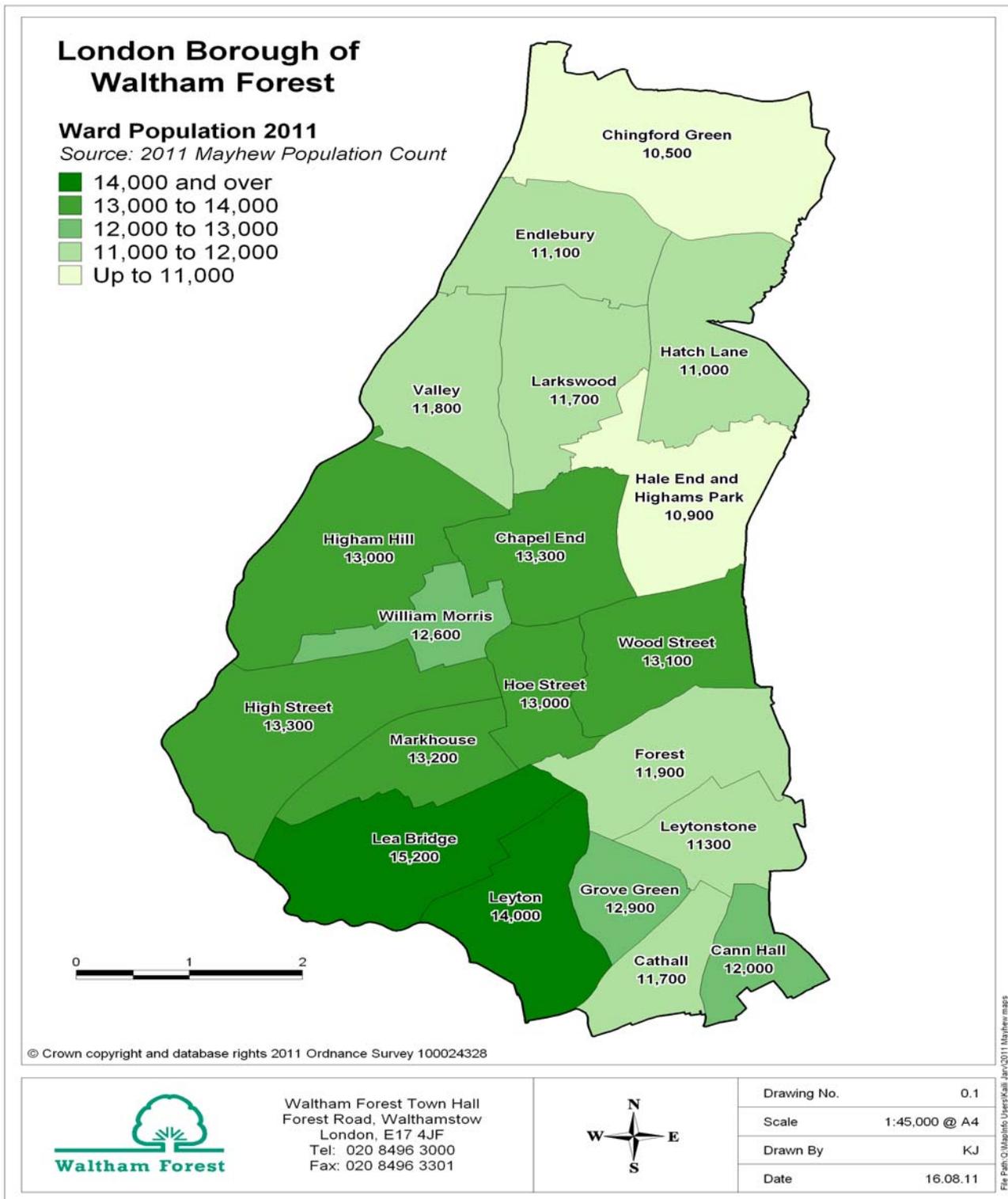
**Figure 1: Ward populations of Waltham Forest by broad ethnicity**

Ward Name	White British		BAME / (%)		Unknown /		Total
<b>Northern wards</b>							
Chingford Green	6,700	56%	3,000	25%	800	7%	10,500
Endlebury	6,500	54%	3,900	32%	700	6%	11,100
Hale End and Highams	5,500	46%	4,600	38%	800	7%	10,900
Hatch Lane	6,500	54%	3,700	31%	800	6%	11,000
Larkswood	5,900	50%	5,000	42%	800	7%	11,700
Valley	5,300	44%	5,700	47%	900	7%	11,800
<b>Wards in the middle of the borough</b>							
Chapel End	4,600	38%	7,400	62%	1,300	11%	13,300
Higham Hill	4,000	34%	7,700	64%	1,300	11%	13,000
High Street	3,600	30%	7,900	66%	1,900	16%	13,300
Hoe Street	3,800	32%	7,500	62%	1,700	14%	13,000
Lea Bridge	2,900	24%	10,500	88%	1,800	15%	15,200
Markhouse	3,000	25%	8,800	73%	1,400	12%	13,200
William Morris	3,600	30%	7,400	61%	1,600	13%	12,600
Wood Street	4,200	35%	7,400	62%	1,500	12%	13,100
<b>Southern wards</b>							
Cann Hall	3,100	26%	7,200	60%	1,700	14%	12,000
Cathall	2,600	22%	7,400	62%	1,600	13%	11,700
Grove Green	3,100	26%	7,900	66%	2,000	16%	12,900
Forest	2,900	24%	7,600	64%	1,400	12%	11,900
Levton	2,900	24%	9,400	79%	1,700	14%	14,000
Leytonstone	3,600	30%	6,200	52%	1,600	13%	11,300
<b>Borough Total</b>	<b>84,200</b>	<b>34%</b>	<b>136,100</b>	<b>55%</b>	<b>27,300</b>	<b>11%</b>	<b>247,500</b>

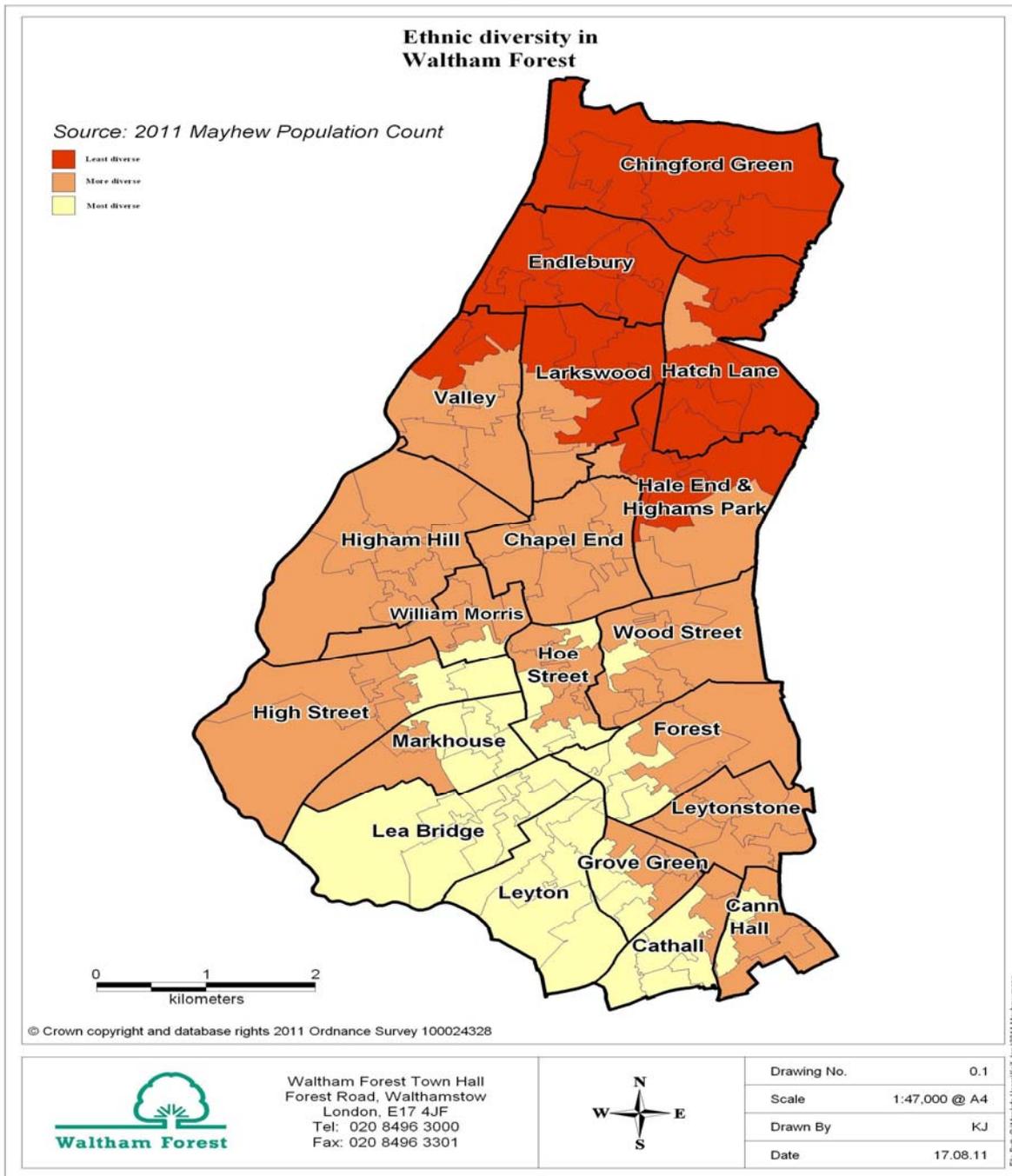
Note: data has been rounded to improve legibility

<sup>6</sup> Sources: 2011 Mayhew Harper Population Count / GLA 2011 Population projections based on Strategic Housing Land Availability Assessment (SHLAA) / ONS MYE 2011

Map 1: Waltham Forest ward population



Map 2: Waltham Forest ethnic diversity

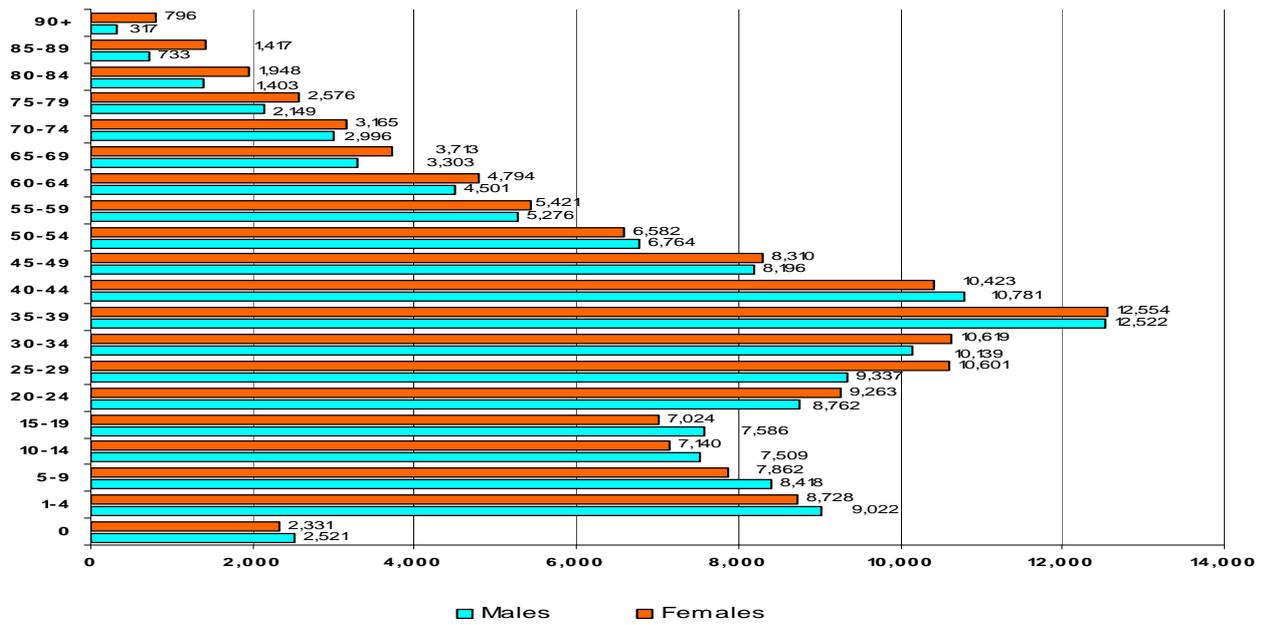


Source: GLA 2011 Population projections based on Strategic Housing Land Availability Assessment (SHLAA) (revised) projection, 2010)

### Population by Age and Gender

Just over half of Waltham Forest's population is female (51%) and the borough has a similar age structure to London as a whole with a larger percentage of children and people aged 25-50 than the UK average. Residents aged 50 and over comprise a smaller proportion of the population than the UK average but is similar to the London profile. The bar chart below shows the number of residents by gender and age group.

**Age and Gender profile of Waltham Forest**  
 Source: 2011 Mayhew Harper population count

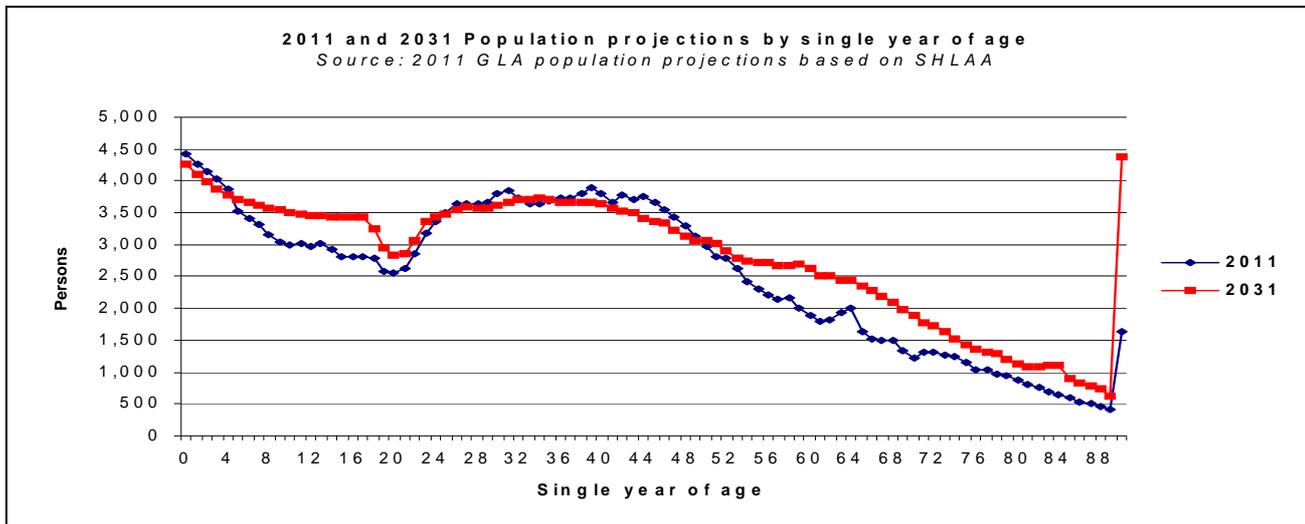


Source: 2011 Mayhew Harper Population Count / ONS MYE 2011

**Population Projections**

Population growth projections from the GLA for the year 2031 suggest notable increases in those of school age (4-15 years) and those aged 50 and over. Specifically there will be around 4,600 more children of school age (4-15 years) and 13,000 more people above the state pension age (over 65s) living in Waltham Forest by 2031, although the state pension age will have changed by that time. Overall increases in population between 2011 and 2031 are projected to be around 23,500. See Figure 2.

**Figure 2**



**Population Turnover (in- and out-migratory moves)**

The most significant element of migration for Waltham Forest is from and to other London boroughs. Not surprisingly, neighbouring boroughs prove to be the most popular source of in-flows. Of those moves registered at the end of June 2009, some 1,530 came from Newham, 1,240 from Hackney, 1,000 from

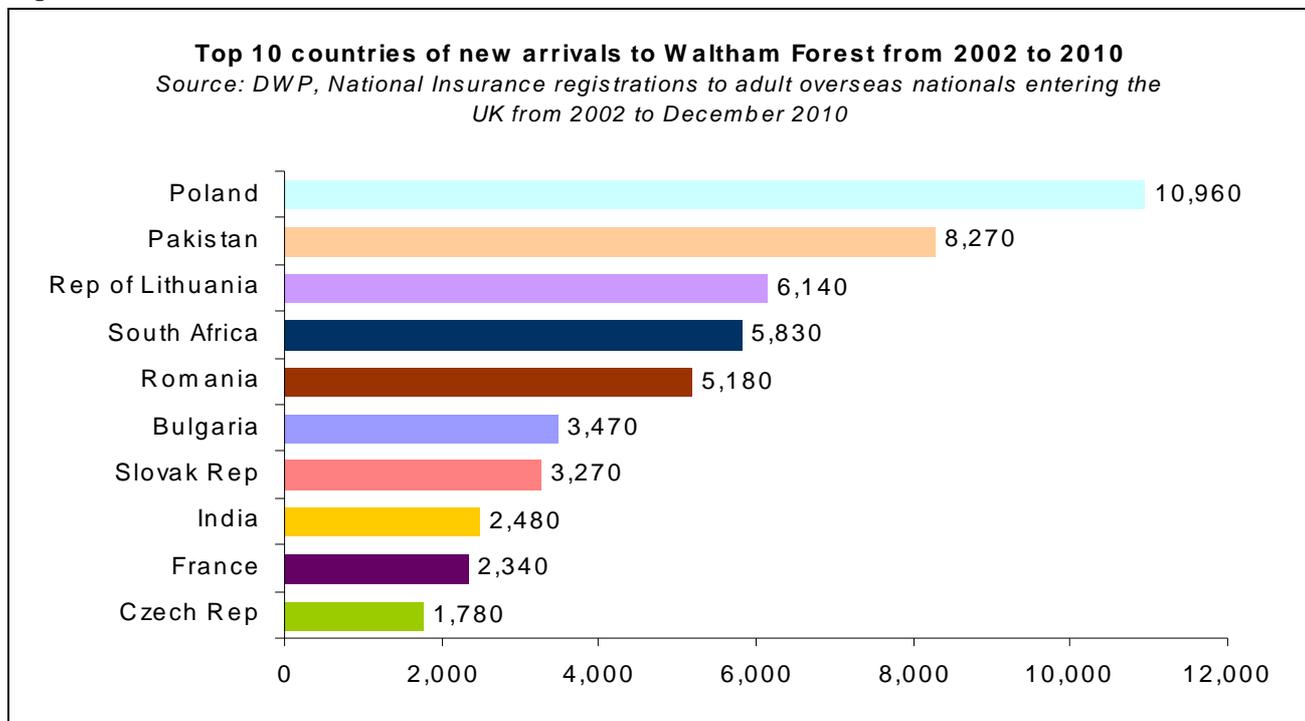
Haringey and 950 from Redbridge. Out-flows from Waltham Forest share a similar geography with 1,920 going to Redbridge, 1,440 to Newham, while 600 went to Barking and Dagenham and 600 to Enfield.<sup>7</sup>

### Recent Arrivals

Data from the Department for Work and Pensions on those registering for a National Insurance number is useful in estimating the relative scale of different arrivals into the borough. This data does need careful interpretation since it is only a measure of inflows and does not take into account those who have subsequently left the borough.

The data show that the greatest number of National Insurance registrations in the borough over the last 8 years have come from residents originally from Poland (10,960), followed by Pakistan (8,270) and the Republic of Lithuania (6,140). Other arrivals from Eastern Europe include Romania (5,180) and Bulgaria (3,470).<sup>8</sup> This is described in Figure 3.

**Figure 3**



Although not a definitive dataset on the variety of languages spoken in Waltham Forest, two sources provide useful guides. The first is the Pupil Level Annual Schools Census (PLASC) that records the first language spoken by pupils in the borough. According to the most recent copy of the school census, over:

- 3,500 pupils had Urdu as their first language followed by:
- 1,000 pupils speaking Turkish.
- 950 pupils speaking Somali.

<sup>7</sup> ONS Migration Statistics unit (Moves registered during the year ending 2009)

<sup>8</sup> DWP, National Insurance registrations to adult overseas nationals entering the UK from 2002 to December 2010

- 850 pupils speaking Punjabi.
- 650 pupils speaking Polish.
- 600 pupils speaking Bengali.
- 570 pupils speaking French.
- 500 pupils each speaking Arabic or Tamil<sup>9</sup>.

The other source for languages spoken in the borough is from the translation support services. This suggests a broadly similar mix to the PLASC data and the top ten requests (in order) are for translations to: Urdu/Polish/Bulgarian/Turkish/Portuguese/Romania/Somali/ Mandarin/Punjabi/French.

### **Family Types**

The total number of households in Waltham Forest is 98,616 with an average 2.51 people living in one property. The most common types of households are single adults (29%), families with children (23%) and cohabiting adults without children (19%). As a proportion of the borough's population, most people live in either family households with children (41%) or cohabiting households without children (20%). A significant number lives in single parent households (11%), or older cohabiting households (8%). There are 8,104 households with an older person living alone and 11,615 people living in 3-generational households.<sup>10</sup>

### **Lesbian, Gay, Bisexual and Trans (LGBT) Population**

Statistics for the size and composition of the LGBT population in Britain remain imperfect due to the lack of robust national data. Estimates range from 0.3% to 10% depending on the measures and sources employed.

The Office for National Statistics has developed a sexual identity question that was included in the Integrated Household Survey (IHS) in 2009. The first results from this survey suggest that 0.9% of the population surveyed classified themselves as gay / lesbian with a further 0.5% bisexual. Extrapolating the national figures to a projected borough population of 243,280 would suggest that Waltham Forest has a LGBT population of around 3,400.<sup>11</sup>

However, a recent study commissioned by Waltham Forest, aimed at gaining a greater understanding of local LGBT population, suggested the number of lesbian, gay, or bisexual people in the borough to be somewhere between 7,000 and 10,000 people in 2007 (4-6% of the adult population).<sup>12</sup>

It is much harder to obtain information about transgender people due to the ambiguity in the definitions and the low prevalence of transgender persons in the population. The above-mentioned study on LGBT people in Waltham Forest suggests that there might be at least 35 transgender individuals living in the borough.<sup>13</sup>

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<sup>9</sup> 2010 PLASC School census for Waltham Forest

<sup>10</sup> 2011 Mayhew Harper Population Count

<sup>11</sup> Measuring Sexual identity: An Evaluation report September 2010, Office for National Statistics

<sup>12</sup> Waltham Forest LGBT Matters. The needs and experiences of lesbians, gay men, bisexual and trans men and women in Waltham Forest. Draft research report. Sigma Research, September 2009

## **Waltham Forest - The Place**

### **Physical Environment**

Open spaces and the physical environment have particular roles to play with respect to encouraging healthy lifestyles. In an urban area with little access to countryside they represent one of the few places for outdoor exercise and relaxation. Of particular significance are the:

- Regional Parks for longer walks, horse-riding and cycling.
- Local parks and open spaces for general exercise, informal sport and children's play.
- Playing Fields for organised sports.
- Allotments for exercise and healthy food.

### **Local Picture**

With 31% of the land area consisting of open space, Waltham Forest is a very green borough. It is in a unique position of being surrounded by open land and countryside of Epping Forest and the Lea Valley, which run the length of the eastern and western boundaries respectively.

Large proportions of the borough are designated as either Green Belt or Metropolitan Open Land, affording them a high degree of protection. Other open spaces within the borough are also given varying degrees of protection through planning policies contained within the Unitary Development Plan. There are a series of smaller local open spaces including Outdoor Sports Facilities, Parks and Gardens, and Allotments which together occupy significant areas, further emphasising the open character of the borough and the availability of land for recreational uses. The borough is unusual in that it has no Metropolitan or District Parks, however, it is recognised that the two Regional Parks (Epping Forest and Lee Valley Regional Park) also serve metropolitan, district and local functions for residents of the borough and beyond.

Overall, the borough is well served for public open space; however, a relatively small proportion (just over 7%) of the borough is deficient in terms of access to open space. See Figure 1. A significantly larger proportion of the borough is deficient in access to local play facilities. See Figure 2.

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<sup>13</sup> Waltham Forest LGBT Matters. The needs and experiences of lesbians, gay men, bisexual and trans men and women in Waltham Forest. Draft research report. Sigma Research, September 2009

Figure 1: Open spaces

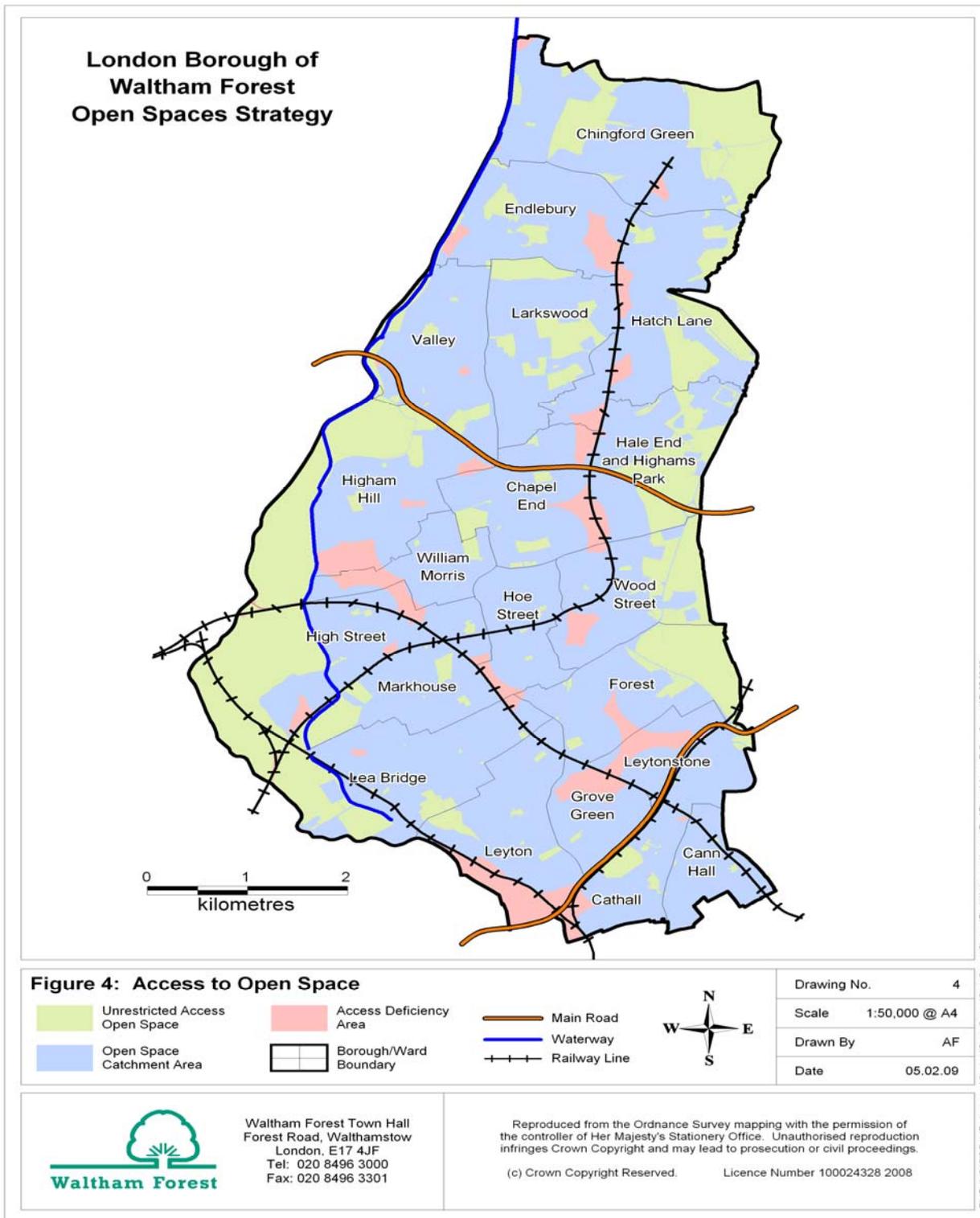
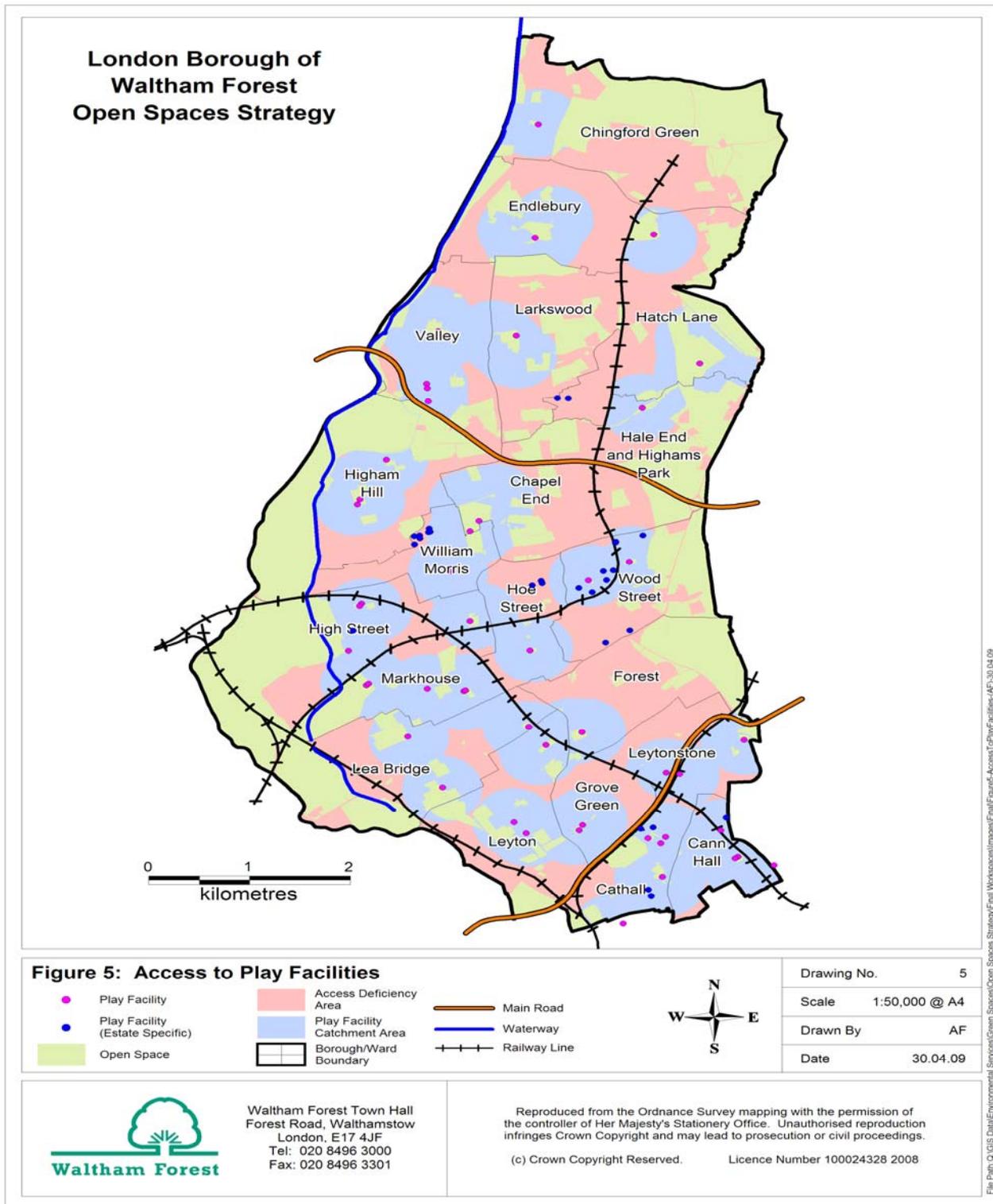


Figure 2: Access to local play facilities



While the borough offers a large number of allotments (2,354 plots provided over 39 sites) there is a substantial waiting list of over 500 people waiting for plots to become vacant.

Survey work undertaken in the lead-up to the Open Space Strategy (OSS) has indicated that those from African, Caribbean and Asian communities are under-represented among park users and that some women and residents over 50 years old do not use parks because they are concerned about their safety. Measures

are proposed in the OSS to address these issues as well as providing better facilities for people with disabilities and for children and families.

**What is being done locally to improve open spaces?**

The borough has an Open Space Strategy with an action plan which outlines the borough's plans to improve open spaces. In addition, the Council commissioned a Green Gym Project will deliver practical nature conservation projects across the borough that engages the voluntary participation of local people in the enhancement of biodiversity within their parks. These projects aim to improve the physical health and mental well being of participants as well as supporting volunteers to gain new skills and experiences and increasing an awareness of biodiversity and nature conservation.

The Green Gym Project is expected to:

- Improve health and wellbeing of participants.
  
- Sustain involvement of participants.
  
- Enhance skills development of participants.
  
- Enhance nature conservation features in parks and development of habitat.
  
- Increase areas for wildlife.
  
- Integrate nature conservation management into the ongoing maintenance and management of parks.

# Section 3

improving health and well being



## ■ The wider determinants of health and health inequalities

- Spatial Planning
- Deprivation
- Education
- Housing
- Crime
- Active Travel

## ■ Residents' Views of Waltham Forest

## **Wider Determinants of Health and Health Inequalities**

Over the last twenty years or so, health has come to be seen as a resource for everyday life that helps people realise their aspirations, to satisfy their needs, and to cope with their environment. Our view of health therefore must move from a focus on individual responsibility for healthy choices and medical interventions to cure disease to a whole system that creates an environment making it possible to be healthy and make healthy choices. The social determinants of health - those conditions in which people are born, grow, live, work and age - combine to create health and ill health and are dependent on the quality of housing, education, employment, and a nurturing environment in childhood, for example. They are shaped by policy decisions, which are mostly responsible for inequities in health - the unfair and avoidable differences in health status seen within and between groups of people.

Major changes proposed in the Health and Social Care Bill of 2011 are meant to be transformational, to bring about population health improvements that have not been possible in the old way of commissioning and delivering health and social care services separately. The coming together of new responsibilities for health in the local authority and GP commissioning of local health care services combine with the move of public health to the local authority and requirements for significant service cuts in local services to provide an opportunity to raise the priority for the prevention agenda.

These conditions combine to influence wellbeing and are dependent on education, employment, the quality of housing, and, most importantly, a nurturing environment in childhood. The negative influences associated with poverty are twofold:

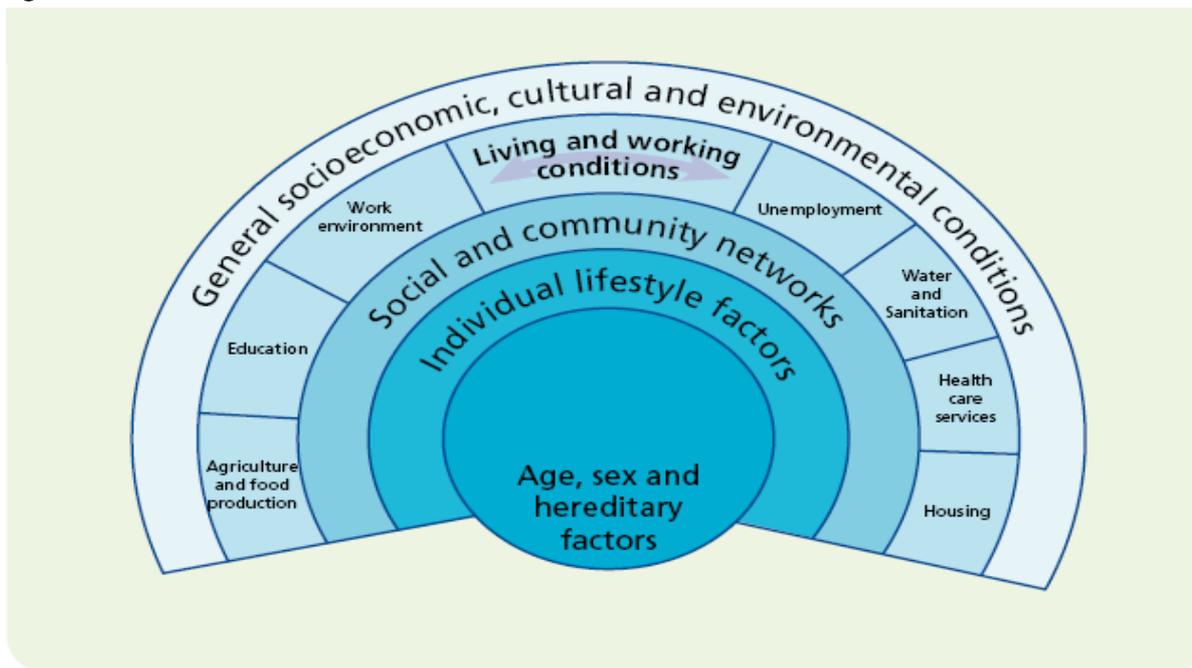
- People living in poverty are more likely to be exposed to conditions that are adverse to their health (crowded living conditions, unsafe neighbourhoods).
- People living in poor circumstances are more likely to be negatively affected by these adverse conditions.

This model<sup>14</sup> (Figure 1) proposes that genetic predisposition interacts with environmental influences and individual lifestyle behaviours to produce good or ill health, which is then mediated by healthcare services to restore good health where required.

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<sup>14</sup> Dahlgren, G. and Whitehead, M. 1991 Policies and Strategies to Promote Social Equity in Health Stockholm: Stockholm Institute of Future Studies

Figure 1: Influences on Health



Source: Dahlgren and Whitehead 1991

Inequities in health are related to social and economic policies that lead generally to better health for those with higher incomes and better education. Once societies reach the level of affluence found in developed countries, further improvements in absolute standards make little difference to improving health. Differences in health at that stage begin to reflect differences in income distribution or income inequality, sometimes known as relative poverty, within each country.<sup>15</sup>

Most determinants are included as domains in the Index of Multiple Deprivation and nearly all indicators of health and wellbeing are predicted by this index. However income and educational attainment are also good predictors as single indicators. The importance of income and education is also highlighted in this chapter (section 3.4).

Many of these “causes of the causes” of poor health & wellbeing, accounting for between 70 – 80% of improvement in life expectancy, can be influenced locally, mainly through the Borough and the partners acting in partnership.

A life course framework adds to the influences on health model to explain observations such as the way that the health of adults is influenced significantly by what they experienced during development both in the mother’s womb and in their early years. A life course framework makes a powerful case for investment in early years by providing an explanation for the persistence and worsening of inequalities by describing the ways in which health (both good and bad) is transmitted from generation to generation. It is “through economic, social and developmental processes, and the advantages and disadvantages are reinforced in adult life. A life course

<sup>15</sup>Commission on Social Determinants of Health, WHO

framework “focuses on the different elements of the experience of health, from the moment of conception through childhood and adolescence to adulthood and old age.”<sup>16</sup>

Sir Michael Marmot published *Fair Society Healthy Lives: a Review of Health Inequalities in England* in February 2010. Combining the determinants of health model and the life course framework, the review started with the premise that health inequalities result from wider social and economic inequalities. Important protective factors at key stages across the life course have the potential to protect against disadvantage and other risk factors. These protective factors include, for example, good early childhood development, building resilience, effective education and skills training and healthy work.<sup>17</sup>

The 2010/11 Annual Public Health report for Waltham Forest adopted *Making Health Everyone’s Business* as its theme and used the Ottawa Charter for Health Promotion as its organising framework.

The Charter recognised that health is not just the responsibility of the health sector, going beyond healthy lifestyles to well-being. Five key levels were proposed as the building blocks for health, including

- Build healthy public policy
- Create supportive environments
- Develop personal skills including information and coping strategies
- Strengthen community action including social support and networks
- Re-orient health services to increase prevention and access to health services

The discussion that follows focuses on the first two of these building blocks; i.e., healthy public policy and supportive environments. The remaining building blocks are discussed in the following chapters of the JSNA.

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<sup>16</sup> Graham H. C. Power. 2004. *Childhood Disadvantage and Adult Health: a life course framework*. HDA

<sup>17</sup> Fair society, healthy lives. 2010. *The Marmot Review. Strategic review of health inequalities in England post 2010*.

## **Spatial Planning and Health**

### **Executive Summary**

Good use of spatial planning offers opportunities to change the environment in which people make choices about their health, making it easier to choose the healthy option. The London Borough of Waltham Forest Spatial Planning Department and Public Health have formed an effective partnership to identify and implement these opportunities.

### **Recommendations**

- Raise the profile of work within the Council for joint working between spatial planning and public health to consolidate and expand areas of partnership, to develop healthy policies including food provision, betting shops and alcohol outlets, for example.
- .Adopt/develop simple health impact assessment format and process to assess impact of influences on health before implementation
- Use the Healthier Fairer Waltham Forest Board to raise the profile of health inequalities and prevention among the Health and Well being Board and the local authority

### **What is Spatial Planning?**

Spatial planning is a process of place shaping and delivery. It aims to:

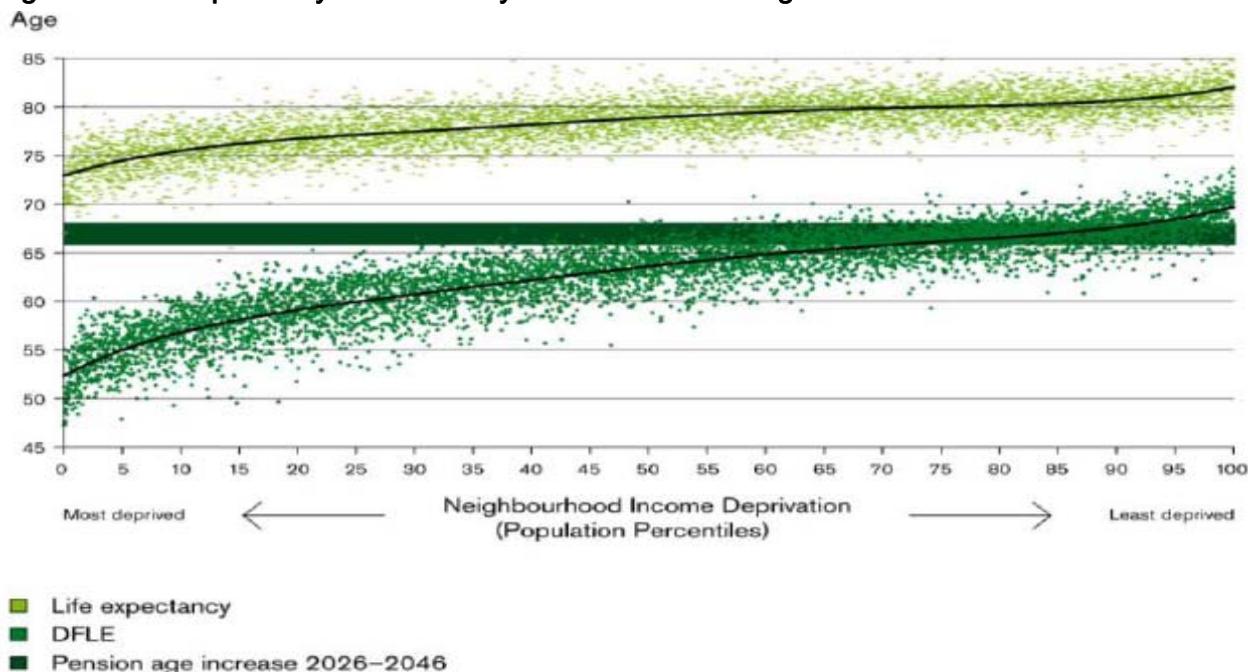
- Produce a vision for the future of places that responds to the local challenges and opportunities, and is based on evidence, a sense of local distinctiveness and community derived objectives, within the overall framework of national policy and regional strategies.
- Translate this vision into a set of priorities, programmes, policies, and land allocations together with the public sector resources to deliver them.
- Create a framework for private investment and regeneration that promotes economic, environmental and social well being for the area.
- Co-ordinate and deliver the public sector components of this vision with other agencies and processes [e.g. Local Area Agreements (LAAs)].
- Create a positive framework for action on climate change; and
- Contribute to the achievement of Sustainable Development.

Links between spatial planning and health include:

- High quality healthy environment is unlikely to emerge spontaneously and integrated decision making across a range of service areas is more likely to deliver real outcomes. Planning provides the opportunity through joined up actions to address some of the behavioural, social and environmental factors linked with health.
- As part of the remit of spatial planning, policy measures as different as they may be on housing, transport, economy, industry and commerce, built and natural environment, waste, pollution, water and energy must now take health into account.
- Planning decisions made through a spatial planning approach has greater capacity not only to overtly change environments, but also to create new environments which encourage people to lead healthier lives.

The Marmot Review of Health Inequalities in England in 2010 found that health inequalities that are preventable are unfair. There is a clear social gradient for mortality and morbidity where the poorer are sicker and die earlier. Mortality and morbidity, along with life expectancy and disability free life expectancy are influenced by the conditions in which one is born, lives and dies. The top curve in the graph in Figure 1 shows the relationship between neighbourhood income and life expectancy. The bottom curve shows the gradient in disability free life expectancy. The average difference between the richest and poorest neighbourhoods is 17 years. The social gradient in health means that everyone below the highest suffers some health inequality.

**Figure 1: Life Expectancy and Disability Free Years and Neighbourhood Income**



(Source: creating strong safe and prosperous communities through Local Spatial Planning. 2008. Communities and Local Government. London TSO)

The Marmot Report identified a convergence in policies aimed at improving health and wellbeing with those designed to advance sustainability and address climate change. For example, a well designed public realm

with high quality green open space will encourage physical exercise, improve mental health, increase biodiversity and help to mitigate the urban heat island effect. The case for delivering improvements to health and wellbeing through spatial planning policy should therefore be seen as part of the wider case for delivering sustainable communities.

Links between spatial planning and health date from rapid urbanisation in the nineteenth century, which created health and social problems that led to the passage of legislation promoting sanitary and healthy living conditions. As the burden of ill-health moved from communicable diseases to chronic diseases associated with unhealthy lifestyles in the twentieth century, attention moved away from the built environment to individual behaviours. However there is now strong evidence that the built environment continues to shape health outcomes. This is reflected in England in national plans to transition public health professionals back to local authorities.

### **Evidence of Effective Interventions**

Evidence is good for integrated appraisal in one statutory process including health, social and environmental considerations, with involvement through the whole plan, policy or project process, so that health objectives are integrated into the thinking from the outset.

The NHS London's Healthy Urban Development Unit (HUDU) planning development tool provides one effective approach. Integrating health into spatial planning is cost-effective. It needs to happen through consultation with communities. There are potentially very large gains to be obtained from effective integration of health and planning for whole-town infrastructure for walking and cycling and the retrofit of home zones that will often far outweigh the cost of incorporating health considerations early in the planning process.

Link spatial planning into the Joint Strategic Needs Assessment process to secure the long term well-being of communities. JSNAs to produce more location-specific profiles should enable a more targeted approach to planning interventions to help improve local health and well-being for issues such as access to quality primary care services, but also for issues such as access to fresh food, reducing obesity, and health links to deprivation, air and noise pollution.

The largest opportunity to make a difference in improving the health and well-being of people and communities lies at the local and neighbourhood (and ward) levels. The Sustainable Community Strategy will continue to play a crucial role in a corporate approach to local area planning. The local spatial planning approach, with its suite of planning documents, should continue to underpin the bringing together of different services to support integrated planning for places and spaces through the process of infrastructure planning and delivery.

At the development level, decisions made on individual development proposals support the delivery of key priorities and outcomes. The development management process offers opportunities for both the JSNA as health evidence and local NHS organisations to be influential in the outcome of decisions. Examples of

opportunities include in the master planning process, pre-application discussions, consultation on planning applications, and playing a role in delivery and implementation.

There is strong evidence that spatial planning for open space that is safe and easy to get to increases the amount that people exercise and that it improves mental health.

### **Local Initiatives**

Public Health and Spatial Planning LBWF worked over the last year to embed health policy in the local authority Core Strategy, including:

- Policy CS13 – promoting health and well being, improving access to health facilities, promoting higher levels of regular exercise, reducing the proliferation of any land use which reduces people’s ability to be healthy.
- Policy CS2 – improving housing quality and choice, seeks to ensure that residents live in high quality, well designed homes.
- Policy CS4 – maximising opportunities to deliver new and improved health services and facilities.
- Policy CS16 – providing more attractive and safer environments.

and in the Development Management Policies:

- Policy DM24 – resisting hot food takeaways where it results in over concentration and poses unacceptable risks of crime.
- Policy DM8 – providing satisfactory sunlight, daylight and well designed homes.

Since the Core Strategy was drafted, public health has provided evidence on health concerns of a fast food takeaway and a betting shop.

### **Supplementary Planning Documents**

LBWF was the first local authority to establish an SPD to manage hot food takeaways near schools to ensure residents have choice in range of food including healthy food options.

Proposed projects to improve public access to nature and increased opportunities for physical activities include Walthamstow Wetlands, Lee Valley Regional Park and Epping Forest improvements.

### **Evidence of Effectiveness**

Since introduction of the SPD for hot food takeaways in Waltham Forest within 400 metres of schools in 2009, there are 20 fewer fast food outlets in Waltham Forest.

Planning applications are being considered on their full merits including the impact on health outcomes – such as related to air/noise pollution, access to open/amenity spaces, community safety, climate change, access to social infrastructure, highway and traffic safety, employment implications etc.

The application of good urban design practices including the provision of adequate internal and external spaces etc is intended to create healthier living environments. LDF policies being implemented among other things to enhance the green infrastructure network, improve walkability, provide safe pedestrian friendly streets etc will encourage people to walk and cycle more for local shopping, school trips and leisure purposes thereby improving rates of physical exercise.

One study showed that in areas in England with more green spaces the gradient in deaths from circulatory disease by income deprivation is reduced. This suggests that the amount and the distribution of green space have great potential to reduce health inequalities.

### **Public Perspective**

A public consultation took place regarding the Hot Food Takeaway SPD and 304 responses were received. Of the total responses 88.8% of respondents supported the proposed SPD to limit Hot Food takeaways around schools.

Analysis of the responses included the following specific comments relating to the management of Hot Food Takeaway Shops in Waltham Forest:

- 56% of respondents identified Health (i.e. childhood obesity, proximity to schools & food quality).
- 56% of respondents identified Litter.
- 43% of respondents identified Proliferation of outlets.
- 10% of respondents identified Anti-social behaviour or crime.
- 9% of respondents specifically identified Lack of Retail diversity.
- 6.7% of respondents identified Road Safety; and
- 6% of respondents specifically identified Visual Amenity.

### **Priorities for the next 5 Years**

- Embed HIA into existing assessment processes in the local authority.
- Expanding access to green space.

Prioritise policies and interventions that both reduce health inequalities and mitigate climate change, by:

- Improving active travel across the social gradient.
- Improving good quality open and green spaces across the social gradient.
- Improving the quality of food in local areas across the social gradient.
- Improving the energy efficiency of housing across the social gradient.

Fully integrate the planning, transport, housing, environmental and health systems to address the social determinants of health in each locality.

Support locally developed and evidence-based community regeneration programmes that:

- Use spatial planning to remove barriers to community participation and action and reduce social isolation.
- Link JSNA and other assessment tools to develop a fuller understanding of areas.

Use [Healthy Places](#) resource, an online tool put together by a team from the National Heart Forum. This tool highlights how local authorities can use existing laws *"that have the potential to change local environments and encourage more active lifestyles and better diets"*.

Develop the table below with local examples of improving health outcomes through local planning.

**Table 3: Example of supporting health outcomes through local planning documents**

Potential Applications	JSNA core dataset contribution	Examples
<b>Core Strategy DPD</b> – Overall vision, strategic objectives for the area, a delivery strategy for achieving these objectives with locations for strategic development indicated on a key diagram; and arrangements for managing and monitoring delivery.		
- future reviews	Demography, Socio-environmental, services	Brent (2010) Wakefield (2009)
<b>Development Control DPD</b> – Topic-based policies and criteria against which planning applications for the development and use of land and buildings will be considered.		
- Standards of provision relating to a range of land uses - Assessment requirements for design and sustainability	Socio-environmental context, burdens of ill-health, access to health services, behaviour	South Cambridgeshire (2007) Brent (Preferred Option) Richmond (Pre-submission)
<b>Area Action Plan DPD</b> – Planning framework for areas/ neighbourhoods where significant change with a focus on implementation.		
- deliver planned growth areas - stimulate regeneration - protect areas - focus the delivery of area based regeneration initiatives	Demography, local area, socio-environmental context, employment, burdens of ill-health, access to health services, behaviour, user perspectives	Central Wakefield (2009)
<b>Supplementary Planning Documents</b> – Local planning authorities and other bodies to provide greater detail on the policies in development plan documents		
- Design standards	Demography, living arrangements, economic, transport, burdens of ill-health, behaviour	Salford (2008) Corby (2009)
- Planning obligations		Milton Keynes (2005) Sandwell (2009)
- Fast food takeaways		Waltham Forest (2009) Salford (2007)
<b>Statements of Community Involvement</b> – Identify and explain the process and methods for community and delivery stakeholder involvement through the different stages of plan preparation, including in pre-application and planning obligations.		
- future reviews	Demography, user perspectives	North Somerset (2007)

(Source: The Marmot Review: implications for Spatial Planning. The Marmot Review Team. Report authors: Ilaria Geddes, Jessica Allen, Matilda Allen, Lucy Morrisey)

## **Deprivation**

### **Executive Summary**

Poverty and education are the most important influences on health. According to the latest Indices of Deprivation (2010), Waltham Forest continues to experience increasing levels of deprivation with over a third of the population experiencing income deprivation. Around a fifth of households in the borough are workless. Just over a third of the borough's children are considered to live in poverty based upon median household income. Around a fifth of all school children take free school meals. Rates of Out-of-work Benefit claimants, lone parent benefit claimants and incapacity benefit claimants are higher in the borough than the London average.

Comparisons with the Indices of Deprivation 2007 and 2010 show that the ranking of relative deprivation has worsened in the borough. Only two wards in the borough (Chingford Green and Chapel End) have no output areas that dropped at least one band in their IMD ranking since 2007. Whilst this does not necessarily mean that the borough has become more deprived, it does mean that our position relative to other boroughs has slipped in most wards.

### **Deprivation, Income and Employment as an Influence on Health**

Deprivation and low income are the most significant influences on health, along with education. Levels of disposable income affect our ability to meet basic needs; the way we live, the quality of the home and work environment, and the ability of mothers to provide the kind of care they want for their children. The relationship between health and low income exists across almost all health indicators.<sup>18</sup> The outcomes associated with low family socioeconomic status include poor maternal nutrition, infant mortality, low birth weight, childhood injuries, child mortality, dental caries in children, malnutrition in children, infectious disease in children and adults, health care services use, chronic diseases in adulthood and excess mortality. The risk associated with poverty is two-fold:

- People living in poverty are more likely to be exposed to conditions that are adverse for development (e.g. crowded or slum living conditions, unsafe neighbourhoods, etc).
- People living in poverty are also more likely to be negatively affected by these adverse conditions.

### **Index of Multiple Deprivation 2010**

Waltham Forest continues to be one of the most deprived boroughs in England. In terms of the overall measure of multiple deprivation (IMD 2010) Waltham Forest ranks 15<sup>th</sup> most deprived among the 326 local authorities in England. Its position has declined from 25<sup>th</sup> in 2007.

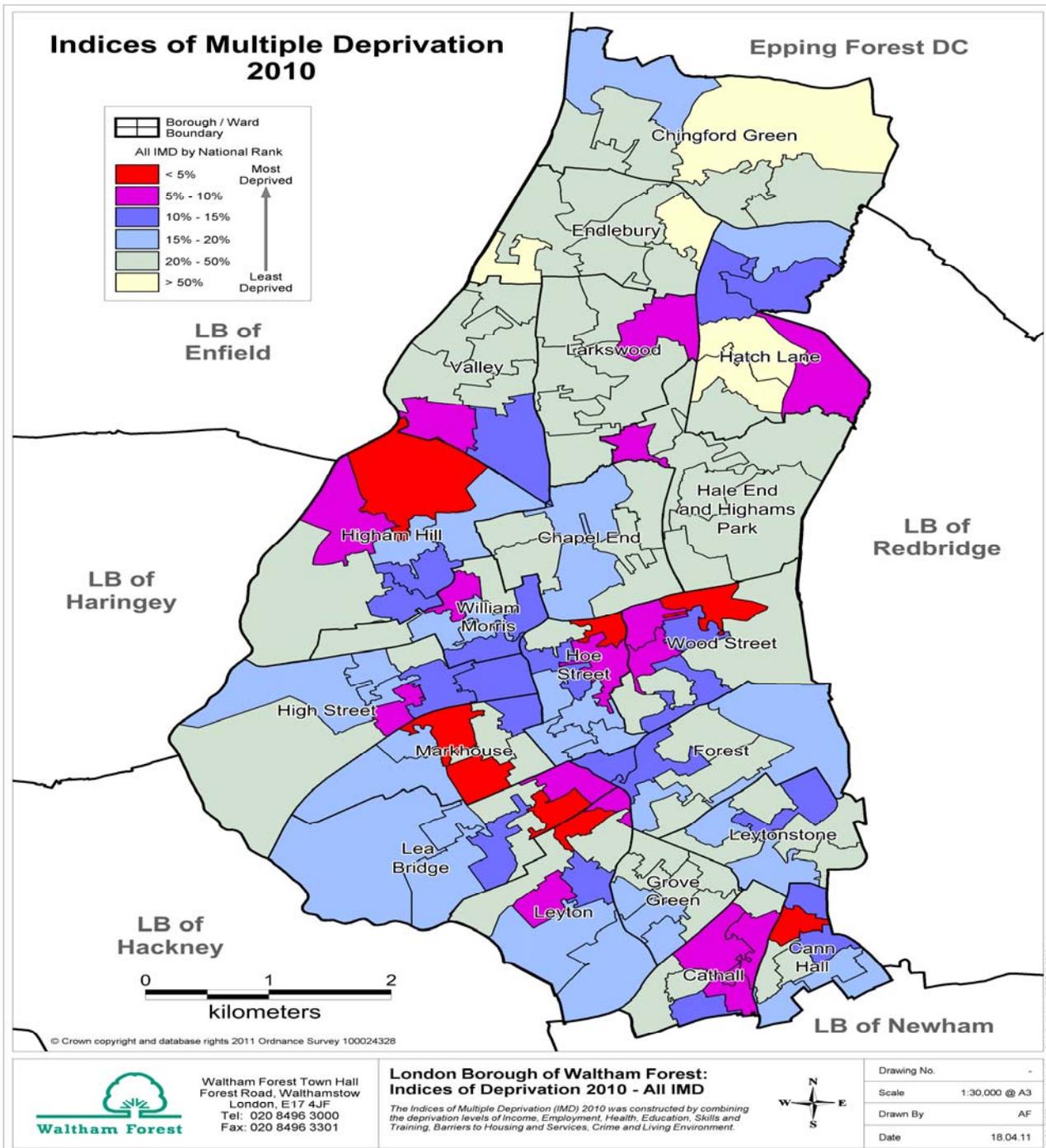
Out of 33 London boroughs, Waltham Forest is the 6<sup>th</sup> most deprived after Hackney, Newham, Tower Hamlets, Haringey and Islington.

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<sup>18</sup> London Health Observatory: [www.lho.org.uk/LHO\\_Topics/Health\\_Topics/Determinants\\_of\\_Health/Income.aspx](http://www.lho.org.uk/LHO_Topics/Health_Topics/Determinants_of_Health/Income.aspx)

The deprivation data show 53,038 people in Waltham Forest experience income deprivation and 16,580 people experience employment deprivation. Map 1 shows the varying levels of deprivation across the borough. Those output areas in red are amongst the 5% most deprived lower super output areas in England, whilst those in yellow are amongst the 50% least deprived. The middle and southern wards of the borough tend to contain the lower super output areas in the top three categories (red, purple and dark blue). This does not mean that pockets of deprivation do not exist in the North of the borough.<sup>19</sup>

Map 1



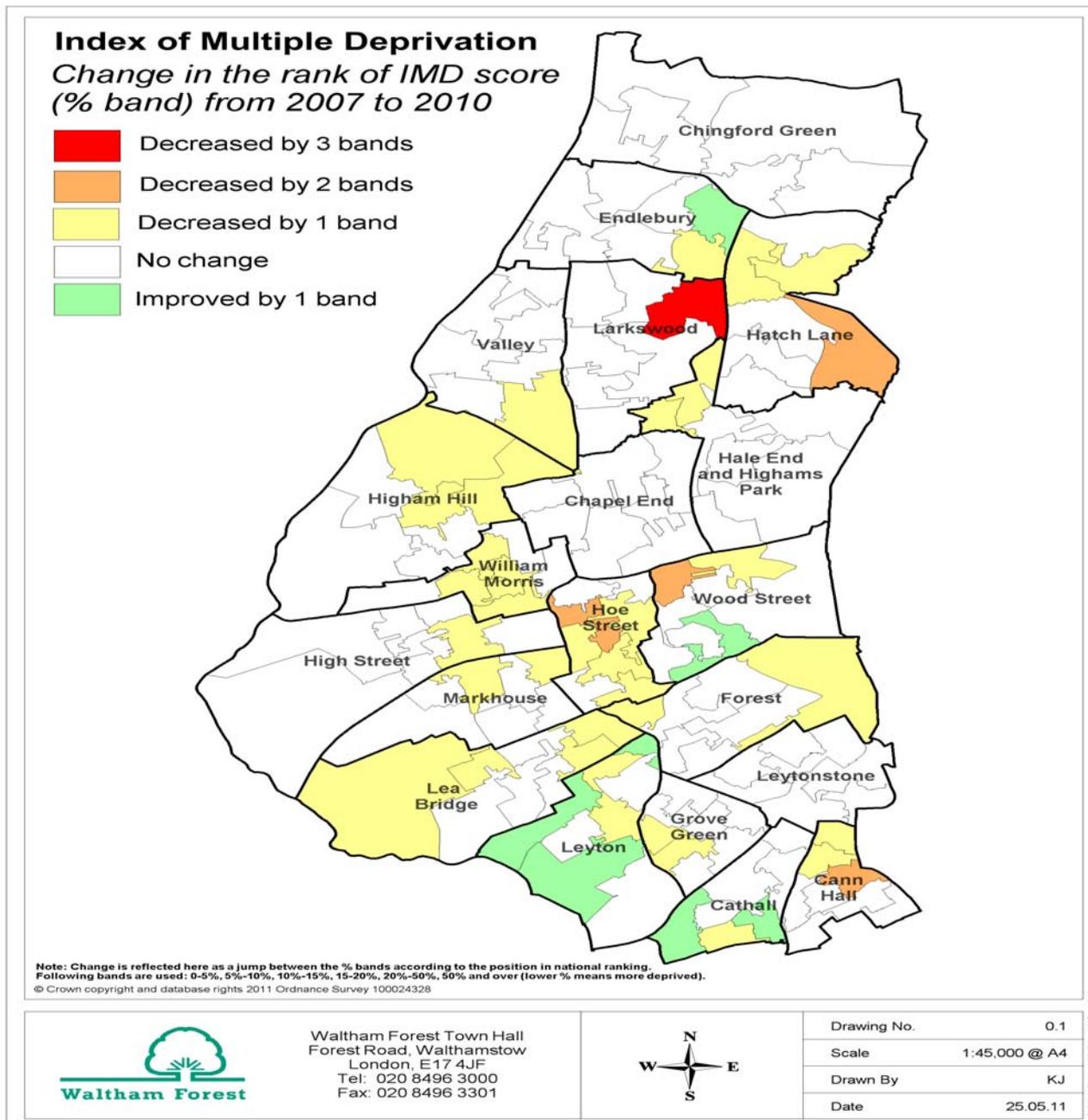
<sup>19</sup> Indices of Deprivation 2010, Department for Communities and Local Government

## Changes in Deprivation between 2007 and 2010

Map 2 shows the change in the rank of IMD score between 2007 and 2010, highlighting which parts of the borough have changed in terms of their relative deprivation since 2007.

Since 2007 only two wards in the borough (Chingford Green and Chapel End) have had no output areas that have dropped at least one band in their IMD ranking. It should be emphasised that this does not mean that these areas are not more deprived than they were in 2007, only that their rank compared to other areas has not worsened.

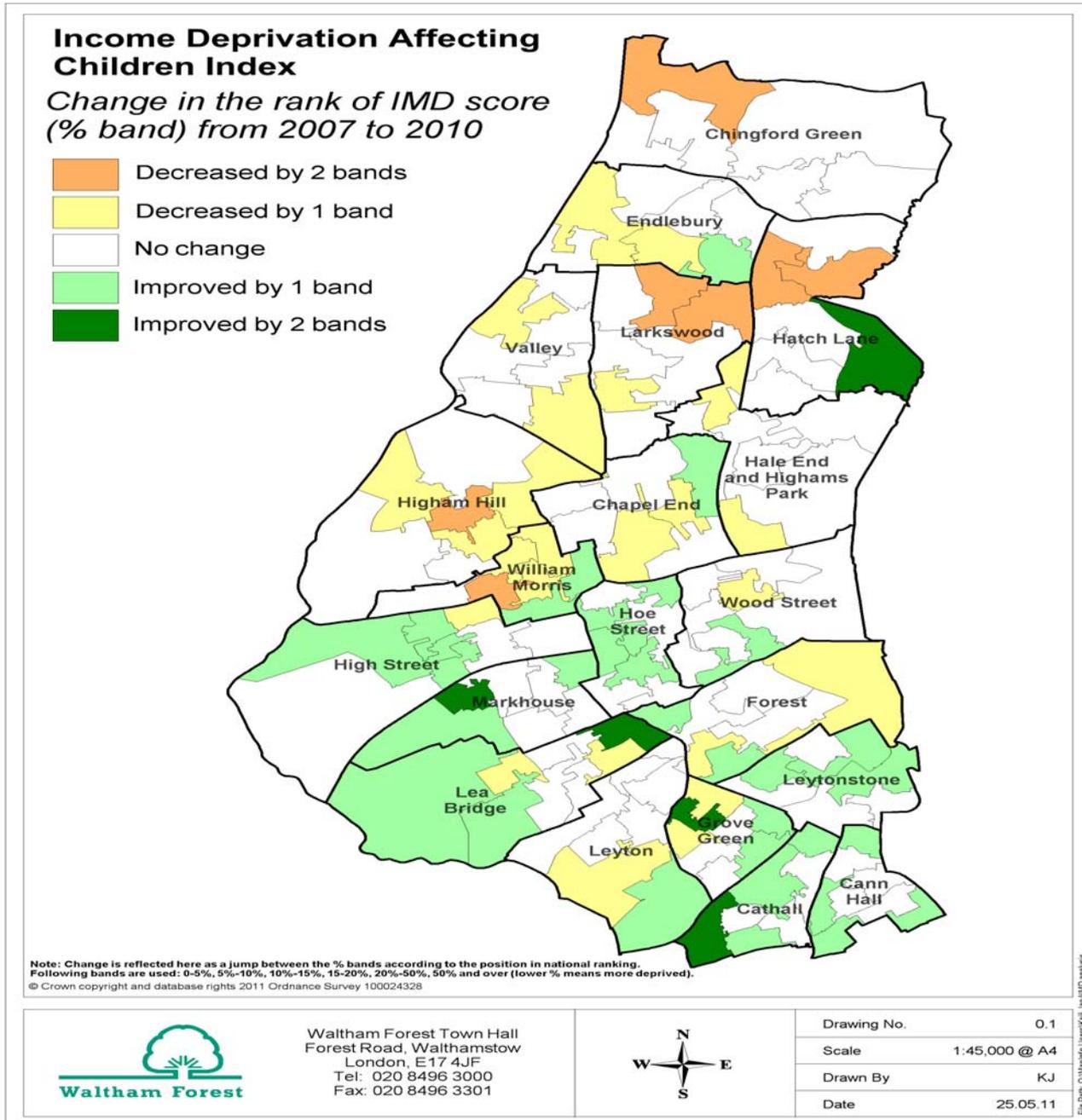
Map 2



## Income Deprivation Affecting children

Map 3 shows the change in the rank of IMD score between 2007 and 2010 for the IDACI (Income Deprivation affecting children index). It shows a somewhat more positive story than that for overall deprivation, although several wards in the north and middle of the borough have output areas that have dropped at least one ranking band. This is in contrast to the south of the borough, where every ward has at least one output area that has risen by one or two bands.

Map 3



## Children in Poverty

In 2008, the proportion of children considered to live in poverty in Waltham Forest was 34.2%; higher than both the London (30.8%) and national (20.9%) average. Children living in poverty is measured by whether they live

in families in receipt of out of work benefits or in receipt of in-work tax credits where their reported income is less than 60% of median income (before housing costs).

As of May 2010 the number of children (0 -18 year olds) living in out-of-work benefit households in Waltham Forest was 17,363. This includes 15,291 children aged 0 -15 years and 5,210 children aged 0 - 4 years.<sup>20</sup> The recent report published by Campaign to End Child Poverty places Waltham Forest among the 20 local authorities with the highest levels of child poverty across England. The report estimates that 35% of children in the borough were living in poverty as of 2010, compared with the average of one in five children (21.3%) across England.<sup>21</sup>

For more information on the Child Poverty Needs Assessment Toolkit please go to the following:

Link to the Child Poverty Needs Assessment Toolkit

<http://www.idea.gov.uk/idk/core/page.do?pagelD=22025996> <http://www.childpovertytoolkit.org.uk/>

Link to the Child Poverty Map of the UK report published by Campaign to End Child Poverty:

<http://endchildpoverty.org.uk/news/press-releases/child-poverty-map-of-britain/24/187>

### **Pupils Receiving Free School Meals**

In 2009, the number of pupils in receipt of free school meals in Waltham Forest was 4,779 (20.9%) in nursery and primary schools and 2,747 (19.8%) in secondary schools. More recent data from May 2011 suggest that the percentage of pupils in receipt of school meals has risen to 23.8% (though no breakdown between nursery/primary and secondary is available). The London and national averages are lower at 20.3% and 13.6% respectively for free school meal take-up in nursery and primary schools and 18.1% and 10.3% respectively in secondary schools.<sup>22</sup>

### **Child Poverty Strategy and Needs Assessment**

The Child Poverty Act 2010 placed a statutory obligation on local authorities to publish a needs assessment and child poverty strategy. Waltham Forest produced its Child Poverty Strategy in 2009, setting the Council's long-term strategic direction and the following key priorities:

1. Reduce the number of children living in workless households.
2. Reduce incidence of in-work poverty.

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<sup>20</sup> DWP Work and Pensions, HM Revenue and Customs (HMRC) administrative data.

<sup>21</sup> Child Poverty Map of the UK. Part 1: England. Campaign to End Child Poverty, March 2011.

<sup>22</sup> DCSF School Census through London Datastore.

3. Getting young people off to the best possible start in their education - raising aspirations and closing the educational attainment gap whilst raising standards for all.
4. Reducing housing related poverty.
5. Work closely with partners to tackle the causes and effects of child poverty.

An action plan was developed against these priorities to establish the short-term operational direction of the strategy (2009 – 2011). The changes to the political and economic landscape over the last two years have meant that it is necessary to refresh the strategy to reflect the current pressures in the borough and new priorities emerging from central government.

The child poverty needs assessment was refreshed in the summer of 2011, providing an updated evidence base and focusing increased attention on differences between wards, as much as regional and national differences. The needs assessment explored three elements of poverty:

- Mitigating the impact of poverty.
- The movement out of poverty.
- Breaking the cycle.

In terms of mitigating the impact of poverty, it was found that fragile family structure/resilience and low attainment and aspiration were the two new issues not previously addressed by the existing needs assessment. In terms of movement out of poverty, skills and training and sense of community were identified.

From autumn 2011 the strategy will be refreshed to take into account the pressures identified on families as identified in the child poverty needs assessment.

### **Child Poverty Innovation Pilot Project**

In 2009 the borough successfully bid for £1 million in funding from the Child Poverty Unit of the Department for Education to set-up 'More 4 U', a child poverty innovation pilot project<sup>23</sup>.

More 4 U had four key outcomes:

- To increase parental employment and access to services.

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<sup>23</sup> The schools and children's centres used for the pilot scheme were Woodside Primary school and children centre; Downsell Primary School and Snowberry children centre; Barclay Primary school and children's centre; Sybourn Primary school and children's centre; South Grove Primary School and Low Hall children's centre.

- Raise family income, including the improved take up of tax credits and benefit, including local authority administered benefits.
- Build capacity of communities to tackle poverty.
- Reduce intergenerational poverty by increasing educational attainment of vulnerable children, narrowing the gap.

The project provided holistic personalised support to families with children aged between 2 and 5 living in the catchment areas for five schools and children centres located in areas of high deprivation (Whitefield special school was also included). Running from March 2009 to March 2011, the project supported over 200 families; more than doubling the original target.

A review identified a number of wide-reaching findings, including that certain groups were more vulnerable to child poverty; including lone parents, families where either the child or primary carer had a disability or where the primary carer had a mental ill issue.

### **Workless families**

In 2009, Waltham Forest had 17,000 workless households, equivalent to about every fifth household in the borough (21.5%). About half of all the households work (49.2%) and about a third (29.3%) are considered mixed (household has both working and workless members). In total, about 23,000 people aged 16 to 64 and 15,000 children (0-15 year olds) live in workless households. This is equivalent to 14.9% of adults and 33.1% of children in the borough.<sup>24</sup>

### **Benefit claimants**

In August 2010, there were a total of 27,010 benefit claimants in Waltham Forest. This is the equivalent of 17.8% of the population aged 16-64. This compares with 14.5% in the London region and 14.3% in England.<sup>25</sup>

### **Out-of-work benefit claimants**

The out-of-work benefit count combines several types of benefits related with worklessness. In August 2010, the out-of-work benefit count in Waltham Forest was 23,770 or 15.7% of the working-age population (aged 16-64). This compares with 12.7% of population claiming out-of-work benefits in the London region and 12.0% in England.<sup>26</sup>

### **Lone parent benefit claimants**

In August 2010, the percentage of female lone parent benefit claimants in Waltham Forest was 6.0% of all females aged 16-64, compared with 4.6% in London and 3.4% in England. The percentage of male lone parent

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<sup>24</sup> Annual Population Survey (APS)

<sup>25</sup> Working Age Client Group, DWP through NOMIS

<sup>26</sup> Working Age Client Group, DWP through NOMIS

benefit claimants in Waltham Forest was 0.2% of males aged 16-64. In total there were 4,630 lone parent benefit claimants in the borough in August 2010.<sup>27</sup>

### **Incapacity benefit claimants**

In August 2010, the total number of incapacity benefit claimants in Waltham Forest was 9,950. This is equivalent to 6.6% of working-age population and compares with the London average of 5.9% and national average of 6.3%.<sup>28</sup>

### **Proposed changes to the benefits system**

The coalition government has proposed changes to the benefits system, which will be introduced under the Welfare Reform Bill 2011. Job seekers allowance, child tax benefit, housing benefit, income support and income related employment support allowance will be merged into one, known as Universal Credit. Whilst the idea is to simplify benefits payments to ensure that everyone is financially better off by working than not, there is much debate as to whether or not this move will further impoverish certain households in London.

A report from London Councils entitled "Making work pay in London under Universal Credit" claims that single parents and families with two or more children in London are likely to be worse off from an overhaul of the benefits system. It therefore seems plausible that these changes could further reduce the potential for reducing levels of deprivation in Waltham Forest.<sup>29</sup>

Integral to these reforms is the cap on housing benefit. The maximum LHA (Local Housing Allowance) from April 2011 is £400 per week for a 4 bedroom property or larger. According to research from London Councils, 82,000 households across the capital will be at risk of losing their homes due to these changes. A further impact of these reforms could be to push poorer families currently residing in expensive central London boroughs to cheaper suburban ones. Waltham Forest has one of the cheapest rental rates in London leading to the real possibility that the borough will absorb some of this exodus, putting further strain on borough resources.<sup>30</sup>

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<sup>27</sup> Working Age Client Group, DWP through NOMIS

<sup>28</sup> Working Age Client Group, DWP through NOMIS

<sup>29</sup> London Councils "Making Universal credit work in London"

<http://www.londoncouncils.gov.uk/news/current/pressdetail.htm?pk=1314>

<sup>30</sup> London Councils "The impact of housing benefit changes – research and briefing"

<http://www.londoncouncils.gov.uk/policylobbying/housing/benefit/landlordsurvey.htm>

## Education

### Executive Summary

Education, along with poverty, is the most important influence on health. The education indicator that is used to define the influence on health is the level of completed education in the population. Waltham Forest had a lower percentage of working-age residents with qualifications to NVQ Level 4 or above (degree and higher degree level qualification) (26%) than London (40%) and England (30%). The level of working age population who held no recognised qualifications in 2009 was 22%, compared to 11.8% for London and 12.1% for England.

At Key Stage 2 (pupils age 7 to 11) Waltham Forest had results that compare well to the England average. At Key Stage 4 improvements have been made in the percentage of pupils gaining 5+ A\*-C plus English and Maths GCSEs over the last 5 years though the borough is still at the lower end of the scale across London.

At A Level (Key Stage 5) results for Waltham Forest pupils are lower than they are for England as a whole.

National indicator data for the years 2005 to 2009 show that Waltham Forest has consistently lower levels of those not in employment, education or training (NEET) compared to either London or England.

Waltham Forest was well above the London average for the number of Entry Level 1 qualifications in literacy achieved in 2008-09 though much closer to the London average for numeracy.

The percentage of pupils at both primary and secondary school that had special educational needs (SEN) in 2010 was high at 27% and 28% compared to the London average of 20% and 23% respectively<sup>31</sup>.

### Education as an Influence on Health

Education offers opportunities for significant improvements in life expectancy and inequalities. While increases in education will take years to have an impact, the impact will affect peoples' lives for years. Education is linked to the ability to earn higher incomes, which in turn enables people to adopt healthier lifestyles such as never or quitting smoking. The Institute of Education recently published a report giving examples:

- 'for every 100,000 women enrolled in adult learning in the UK an estimated 116-134 cancers could be prevented because of greater take-up of cervical smear tests.'
- 'one more year of education has been shown to increase life expectancy in the US by as much as 1.7 years.'
- 'success or failure at school is strongly related to propensity to commit crime or engage in anti-social behaviour' and ' a 16 percentage point rise in those educated to degree level could save this country

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<sup>31</sup> Department of Education "In your Area" website - 2010 percentage of pupils with SEN, maintained primary and secondary schools without statements.

more than £1 billion annually in reduced crime costs.’

- ‘...when poor achievement is coupled with poor engagement (measured by truancy from school) the risk of ill health in adulthood multiplies by 4.5.’<sup>32</sup>

Over the twentieth century reductions in chronic disease and mortality did result from increasing numbers of UK citizens improving their education, jobs and income. Investment in education has much wider benefits than just increasing a country’s economic competitiveness.

It saves thousands of premature deaths. These findings from the Institute of Education and others suggest that increasing levels of education in Waltham Forest offer the potential to target disadvantaged groups to reduce the health gap.

### **Adult qualification/skills levels**

26% of the working age population (16-64 yrs old) in Waltham Forest are qualified to NVQ Level 4 or above (degree and higher degree level qualification). This compares poorly with London (40%) though is only marginally lower than the England average of 30%.

In 2009, 22% of the working age population held no recognised qualifications. This number was 11.8% for London and 12.1% for England. In absolute terms, there are an estimated 51,100 people in Waltham Forest with either no qualifications or NVQ at Level 1 (fewer than 5 GCSEs at grades A-C).<sup>33</sup>

### **Key Stage 2 results**

Waltham Forest’s Key Stage 2 (pupils aged 7 to 11) results are marginally higher than the England average. Pupils who meet Level 4 have achieved the level expected of most 11 year olds whilst those who meet Level 5 are achieving beyond the expected level.

The most recent data (2010) shows that the borough has a marginally higher percentage of pupils at Level 4 or above and Level 5 in both English (81% / 34% respectively) and Mathematics (82% / 34% respectively) than the England average. The averages for England are 80% / 33% in English and 79% / 34% in Mathematics.

A good overall percentage of local pupils attained Level 4 or above in English and in Maths by the end of primary school (75%). The average for England was 73%.

The expected progress made by Waltham Forest pupils at Key Stage 2 is also higher than the England average. 87% (English) and 84% (Mathematics) of pupils make at least expected progress between the end of Key Stage 1 (pupils aged 5 and 6) and the end of Key Stage 2, compared to 84% (English) and 83% (Mathematics) across England.<sup>34</sup>

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<sup>32</sup> Feinstein L, Budge D, et al., The Social and personal benefits of learning: a summary of key research findings October 2008. IOE

<sup>33</sup> Source: Annual Population survey through NOMIS, ONS

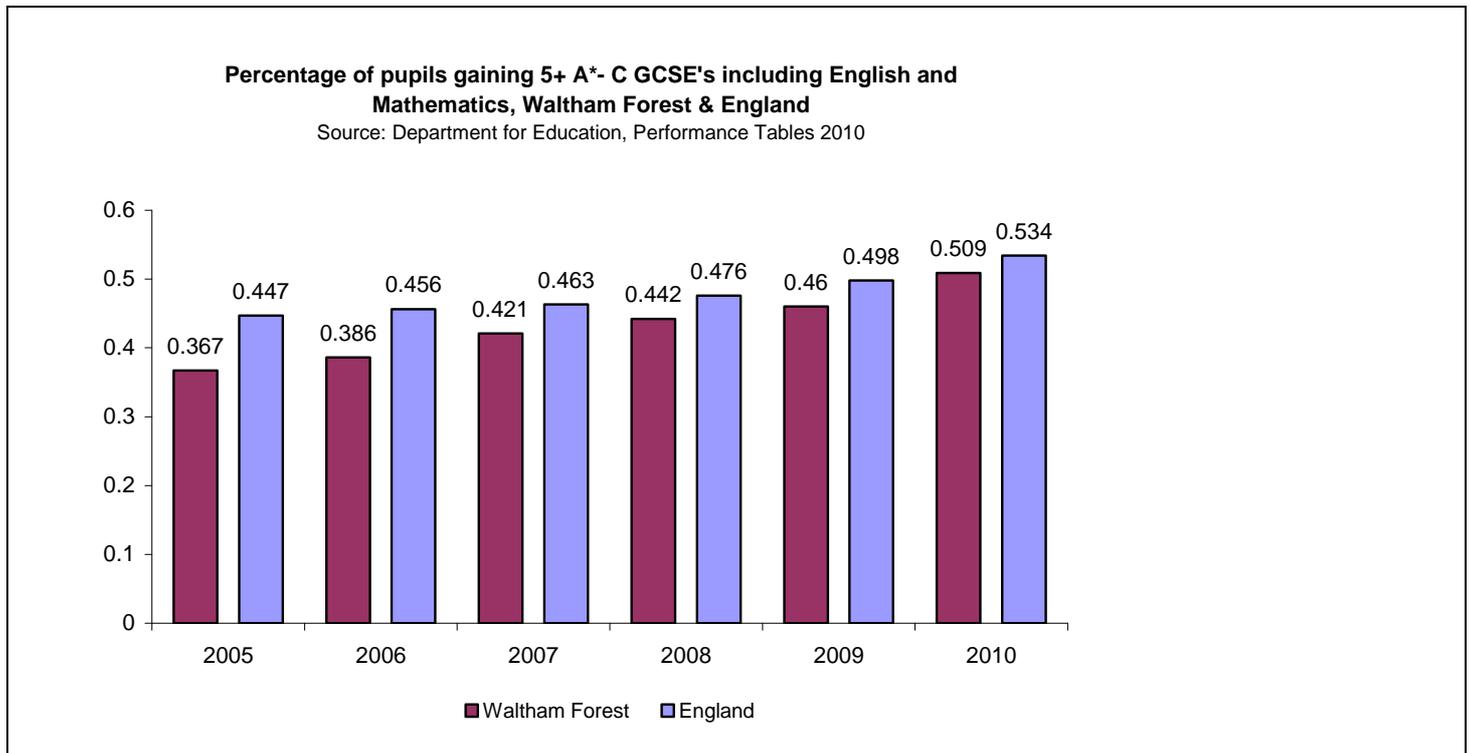
<sup>34</sup> Department for Education Performance Tables 2010

## GCSE / Key Stage 4 results

Waltham Forest is at the lower end of the scale across London regarding results at GCSE although large improvements have been made in the percentage of pupils gaining 5+ A\*-C GCSEs including English and Mathematics over the last 5 years. In 2010, 66.6% of all pupils at the end of Key Stage 4 (pupils aged 14 to 16) achieved 5 or more A\* - C grades at GCSE or equivalent, which means Waltham Forest has the 2<sup>nd</sup> lowest results across the 32 London boroughs<sup>35</sup>. The average in London is 77.8%.

Waltham Forest results for 5+ A\*-C GCSEs including English and Mathematics (50.9%) were lower than the London average (58%) in 2010. Waltham Forest ranks 5<sup>th</sup> lowest in London on this basis. When split by gender it is apparent that results for boys in Waltham Forest are some way behind girls at 46.8% vs. 55.4% respectively. The gender gap for Waltham Forest is in line with that between boys and girls on average nationally, 49.3% v 57.8%.

However there has been progress since 2005 as consistent improvements have been made in the percentage of pupils gaining 5+ A\*-C GCSEs including English and Mathematics. Moreover Waltham Forest has made notable progress in closing the gap with the England average.



Source: Department for Education Performance Tables 2010

## Progress between Key Stage 2 to Key Stage 4

Data on expected progress between Key Stage 2 (7 to 11) to Key Stage 4 (14 to 16) show that Waltham Forest fares marginally better than the England average and marginally worse than the London average.

In 2010, 73.4% of pupils made the expected progress in English compared to 74.6% in London and 69.9%

<sup>35</sup> No results are provided for the City of London

across England. For Maths the respective percentage of pupils making progress was 66.4% (Waltham Forest), 69.2% (London) and 62.5% (England).

### **GCE (A Level) / Key Stage 5 results**

Results at A Level / Key Stage 5 (pupils aged 16 to 18) are also lower in Waltham Forest than they are in England and London. For 2010, the average point score per pupil in Waltham Forest is 678.9 compared to 744.8 for England and 698.8 for London. The average point score provides a measure of the average number of A level equivalents studied and the grades achieved.

For example, a single grade "A" at GCE/A Level is worth 270 points, a grade "C" 210 points and a grade "E" 150 points. Since 2007 the average point score per pupil in Waltham Forest has risen from 643.4 to 678.9.<sup>36</sup>

### **Results at Level 2 and Level 3**

At NQF (National Qualifications Framework) Levels 2 and 3 Waltham Forest has results that are slightly above those of England but below those of London<sup>37</sup>. In 2010, 79.1% of Waltham Forest students had achieved a Level 2 qualification compared to 78.7% in England and 79.7% in London. At Level 3 the respective percentage of students achieving a qualification were 53.7% (Waltham Forest), 52% (England) and 56.2% (London).

### **Not in Employment, Education or Training (NEETs)**

The number of 16-18 year olds not in employment, education or training in Waltham Forest fluctuates on a monthly basis but in the year March 2010 to March 2011 varied between 267 (August 2010) and 348 (October 2010). Over the same period this represented between 3.8% and 4.8% of the 16-18 year old population of the borough.

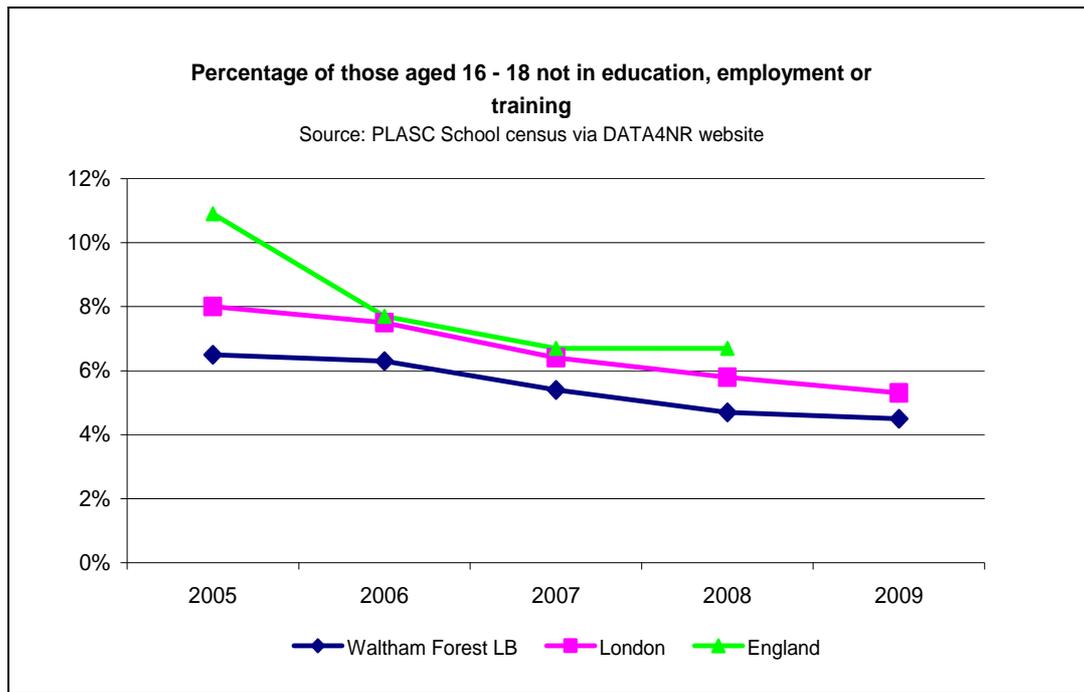
National indicator data for the years 2005 to 2009 show that Waltham Forest has consistently lower levels of those not in employment, education or training compared to either London or England. See Figure 1 below.

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<sup>36</sup> Department for Education Performance Tables 2010

<sup>37</sup> Level 2 qualifications include GCSE's at grades A\*-C and City & Guilds (Level 2) and various others whilst Level 3 qualifications include A Level's, City & Guilds (Level 3) and Advanced diplomas as well as various others.

**Figure 1**



Source: London Borough of Waltham Forest, Integrated Youth Support Management Information Report – January 2011 and Department for Education Pupil Annual School Level Census (PLASC) via Data4NR website

[http://www.places.communities.gov.uk/NewsPages/News\\_Documents/HubDownloadOct2010.xls](http://www.places.communities.gov.uk/NewsPages/News_Documents/HubDownloadOct2010.xls)

### Basic literacy and numeracy levels

Waltham Forest was well above the London average for the number of Entry Level 1 qualifications in literacy achieved in 2008-09, as shown in the table below. Level 1 qualifications for literacy include qualifications such as English for speakers of other languages (ESOL) and other entry-level certificates.

By comparison the number of Entry Level qualifications achieved in Waltham Forest for numeracy was much closer to the London average, 694 vs. 590.

**Figure 2: Literacy and numeracy levels**

Indicator	Latest data	Waltham Forest value	Waltham Forest rank (out of 33)	London average
NI161: No. of Entry level 1 qualifications in literacy (including ESOL) achieved	2008-09	2,510	3	1,480
NI162: No. of entry level qualifications in numeracy achieved	2008-09	694	12	590

Source: Skills Funding Agency Individualised Learner Record

## **What is being done locally to address education?**

### **Primary and Secondary school places**

The Council has a statutory duty to ensure that there are enough school places for every child in Waltham Forest who requires one. Since 2001, the birth rate in Waltham Forest has risen by 37%. This coupled with more families moving into the borough from other parts of London, the UK and abroad has led to Waltham Forest experiencing a high demand for primary school places. In order to meet the demand for school places, from September 2009 to September 2011 eight forms of entry of permanent primary places (240 places each year) have been provided. In addition to this, between 2007 and 2011, sixty additional primary classes (1,800 places) were set up across the borough. This pressure on primary school places is projected to continue and increase year on year, meaning that further permanent primary places and additional classes will be required in order to meet the future demand for school places. In a few years this pressure on primary school places will also be experienced in secondary schools and by 2014 we are projecting a demand for year 7 places in excess of the number of places available.

## **Housing**

### **Executive Summary**

As at 2010, over three quarters of the housing in the borough was held in the private sector (owner occupied or private rented). The remainder of housing was classified as social housing, half of which is owned by the local authority. Analysis from the GLA has shown that from 2004 to 2009 home ownership fell in the borough from 60% to 49%.

Data from LBWF Housing Services show that 30% of those of the housing waiting list were in overcrowded accommodation whilst the Waltham Forest Housing Needs and Market survey found that 20% of all borough households were under-occupied. Rates of those who were statutorily homeless are comparable to London as a whole and only 2 people were counted as rough sleepers in a count undertaken between October and November 2010.

### **Housing as an Influence on Health**

Housing quality is an important determinant of health and a marker for poverty. The condition of housing stock is a major influence on the borough's capacity to reduce inequality. Factors that create risks to health include the presence of lead, asbestos, radon, house dust mites, cockroaches and other infestations; extreme low or high temperatures and inadequate ventilation, inferior air quality, dampness/mould, cramped conditions and multiple family occupancy, among others. Health outcomes that may result from these conditions include asthma and TB.

### **Housing stock by tenure**

In 2010 the number of dwellings in Waltham Forest was 95,500 of which 78% were in private sector (owner occupied or private rented). Social housing accounted for 22% of dwellings, half of which (10,400) belong to the local authority and the other half (10,800) are run by Registered Social Landlords (RSL). RSLs are also sometimes called Registered Providers or Housing Associations.

### **Private Sector Housing Stock**

DCLG data used above does not provide a split between owner occupied and private rented sectors for local authorities. At the time of 2001 Census 59% of households in Waltham Forest owned their property and 16% rented privately. More recent figures suggest that the private rented sector has increased significantly since then. The Private sector housing stock conditions survey of 2011 shows that 32% of dwellings are privately rented (some 31,810) out of a total of 98,180 dwellings and 46% are owner-occupied. 36% of privately rented dwellings and 32% of owner-occupied dwellings do not meet the Decent Homes standard<sup>38</sup>.

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<sup>38</sup> Sources: Department for Communities and Local Government; 2001 Census; Private sector housing stock conditions survey 2011.

## What the Council is doing:

- Commissioned a new Housing Market and Needs Assessment to provide an up to date assessment of the housing needs of the borough and a solid evidence base for a new Housing Strategy for Waltham Forest.
- Under the 2011 – 15 Affordable Homes Programme have agreed a programme of development of over 900 homes, a significant proportion of which will be family sized homes (3 bed or bigger).
- Property Accreditation Scheme – Improving and monitoring housing conditions in the private sector.

Waltham Forest has launched an accreditation scheme to help landlords and tenants in the private sector. The process involves officers working in partnership with landlords to ensure their properties are safe, secure and sanitary. Unlike other accreditation schemes that assume all of a landlord's properties are up to a certain standard, this new scheme assesses and accredits each property individually. The Council also works in partnership with other London Boroughs on the London Landlord Accreditation Scheme which formally recognises 'good landlords' who provide tenants with good quality and safe accommodation.

- Houses in Multiple Occupation (HMO): As part of the Housing Act 2004 legislation, mandatory licensing has been introduced for all houses in multiple occupation that are:
  - Of three storeys or more
  - With five or more tenants (including children)
  - Belonging to two or more households

To obtain a licence, HMOs need to have adequate facilities, including safety and sanitation, and sufficient space for the number of people intended for housing. Licensing of HMOs is carried out by the LBWF Housing Standards team. We currently only have mandatory licensing scheme for high risk HMOs (as described above) but may expand this to other types of properties, or to a specific area, in the future.

- Home Improvements Agency (HIA): Papworth Trust Home Solutions deliver Home Improvement Agency (HIA) Services to vulnerable residents on behalf of Waltham Forest. They will act as a one-stop-shop where older, disabled and low-income families can go to for advice and support with a wide-range of housing related issues. This service is funded through Supporting People.

The HIA service includes:

- Support to apply for any available funding for adaptations and repairs.
- Obtaining quotes for repairs and adaptations.
- Handy person services for small jobs around the home and in the garden.
- Welfare benefits checks.

- Support to apply for grants for central heating / boilers to make homes more energy efficient.

GLA analysis of Annual Population Survey data shows that between 2004 and 2009 home ownership has fallen from 60% to 49% in Waltham Forest. This is a bigger fall than in London and the UK in the same time, where home ownership fell by 4 percentage points from 2004 to 2009. Of all households in Waltham Forest, 18% own their home outright and 31% have a mortgage or loan.

22% of Waltham Forest households rent a home from a social landlord including 11% renting from local authority and 11% from Housing Association. 32% rent from a private landlord. Private renting has increased from 13% in 2004 and 21% in 2009 in Waltham Forest. This is similar to London figures (20% private renting in 2009) but higher than in the UK (12%)<sup>39</sup>.

### **Local Authority housing stock**

All social housing must meet the Decent Homes Standard. In 2009 Waltham Forest had 39% of local authority dwellings below the Decent Home Standard. This compares to 31% of local authority owned dwellings in London falling below the bar.

A decent home must be in a reasonable state of repair, e.g. main building components should not need replacing or major repair because of their condition. It must have reasonably modern facilities and services (e.g. kitchen 20 years old or less, bathroom 30 years old or less). Also, it must have insulation and heating that provides reasonable degree of thermal comfort<sup>40</sup>.

### **What the Council is doing:**

- Developing a 5 year asset-management strategy with Ascham Homes for their stock.
- Continuing their programme of Decent Homes work within the borough which will see all of homes in Council ownership made 'Decent' by the end of March 2012.
- Preparing a new Housing Market and Needs Assessment and will be undertaking a review of their Allocations Policy, working towards putting in place a Local Tenancy Strategy for the borough.
- Have been successful in obtaining funding under the Local Authority New Build programme which will see 22 new homes directly developed by the Council on redundant land across the borough.

### **Housing waiting list**

There is significant demand for social rented housing in the borough. In 2009/10 there were 15,624 households on the local authority register; 81% of households required up to and including 2 bedrooms, 13% required 3

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<sup>39</sup> Focus on London 2011: Housing: A Growing City. GLA, 2011; Private sector housing stock conditions survey 2011

<sup>40</sup> Decent Homes Standard: <http://www.walthamforest.gov.uk/index/housing/planning-housing/pl-decenthomes.htm>

bedrooms and 6% required more than 3 bedrooms. By May 2011 the housing register had grown to 17,000 households (data on the types of properties sought are not yet available)<sup>41</sup>.

The data provided by LBWF Housing Services show that out of 18,400 households on the waiting list as at 1<sup>st</sup> April 2011, 5,623 (30%) are in overcrowded accommodation (one bedroom short) and 1,908 (10%) are in severely overcrowded accommodation (two or more bedrooms short)<sup>42</sup>.

### **Overcrowding and under-occupancy**

More recent data from the 2007 Waltham Forest Housing Needs and Market Survey shows that over-crowding affected 13% all existing households, while 20% were considered under-occupied.

The over-crowding was at much higher level in local authority housing (23%) and private rented sector (22.5%), while the under-occupation was more characteristic to the owner occupied households with no mortgage (48%)<sup>43</sup>.

### **What the Council is doing:**

- The restructuring of the borough's housing service in May 2011 saw the creation of the Residents' Support and Liaison Group, which focuses on delivering a holistic service to housing clients. The group includes a team addressing the housing needs of 16 and 17 year olds, and priorities include dealing with mental health issues and promoting sexual health and another that supports vulnerable, homeless households in temporary accommodation.
- A further team within the group is tasked with achieving the Council's priority of reducing by 50% the number of people on the waiting list living in overcrowded conditions, including those in private and social housing. Council officers are visiting all these people in order to discuss housing options which can include moves via the Council's Rent Deposit scheme, Low Cost Home Ownership schemes, sheltered housing or mutual exchange.
- Where broader problems, including health issues, are identified by any of the teams, council officers work in liaison with other partners such as Age UK, health services, fire service (for fire safety advice) and education services to address these issues in a holistic manner. Links are also being made with GPs, health visitors and Children's Centres to promote joint working in this area.
- Prioritised the development of family sized homes (3 bed+) in our Housing Strategy and emerging Core Strategy.

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<sup>41</sup> Department for Communities and Local Government through Neighbourhood Statistics

<sup>42</sup> London Borough of Waltham Forest, Housing Services.

<sup>43</sup> Waltham Forest Housing Needs and Market Survey – 2007. DCA 2008

- Have subscribed to the Seaside and Country Homes scheme to incentivise under-occupiers to move into a home more suited to their needs.
- Developing a garage strategy for the Council's garage sites and that development opportunities will be linked to reducing under-occupation working towards freeing up larger homes for overcrowded households.

### **Housing market and housing costs**

The recession resulted in a drop in home sales and property prices in Waltham Forest. The total number of housing sales in Waltham Forest has dropped to 2,000 in 2009 from the recent peak of 4,800 in 2006.

In 2009 the median house price in Waltham Forest was £212,000, which was less than the median house price in London at £250,000 and higher than median house price in England (£170,000).

The pre-recession house prices in Waltham Forest peaked in 2007 (£240,000). Since then the median house price in Waltham Forest has decreased by 12%, while the London average has dropped by 6% only<sup>44</sup>.

- In May 2011, the Council's Cabinet agreed guidance on the level of rent that may be charged on affordable rent homes funded through the HCA Affordable Homes framework.
- We are working with the East London Housing Partnership to develop an 'Affordability Calculator' for home seekers wishing to rent a new home under the Affordable Rent tenure.

### **Homeless and rough sleepers**

Homelessness data is related to the statutorily homeless (i.e. a household that meets the specific criteria of priority need set out in legislation and to whom a homelessness duty has been accepted by a local authority). Such households are rarely homeless in the literal sense of being without a roof over their heads but are more likely to be threatened with the loss of their current accommodation.

The 'priority need groups' include households with dependent children or a pregnant woman and people who are vulnerable in some way e.g. because of mental illness or physical disability.

During the 2009/10 financial year a total of 286 households were accepted as being homeless and in priority need in Waltham Forest. This corresponds to 3 households per 1,000, which is the same as the London average. The number of households that were eligible homeless but not in priority need was 610 in Waltham Forest.

35% of all households accepted as homeless and in priority need in Waltham Forest were Black or Black British, 25% were White and 18% were Asian or Asian British.

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<sup>44</sup> The Land Registry and Department of Communities and Local Government

In total 1,240 households in Waltham Forest were accommodated in temporary accommodation by the local authority as at 31 March 2010. This is 13 households per 1,000 compared to 12 per 1,000 in London.

Rough sleepers are people sleeping, about to bed down or actually bedded down in the open air, in buildings or other places not designed for habitation.

The autumn 2010 rough sleeping count and estimate was carried out between 1 October and 30 November 2010. Waltham Forest reported 2 rough sleepers counted in local authority area. The London Borough of Westminster had the highest number of rough sleepers (128), while the estimated total number of rough sleepers in London was 415<sup>45</sup>.

For more information about the housing issues in London please see the GLA report *Focus on London 2011: Housing: A Growing City* available on the London Datastore at:  
<http://data.london.gov.uk/datastore/applications/focus-london-housing>

### **What the Council is doing:**

LBWF have published a [Homelessness Prevention Strategy \(2007 – 12\)](#) and updated their Action Plan annually, focusing on a range of interventions including:

- Helping households to continue to live in their homes through promotion of the Mortgage Rescue Scheme and related schemes.
- Promote housing options and reduce homelessness through the Rent Deposit scheme.
- Negotiation with private sector landlords and lenders to facilitate hostel referral.
- Providing a support plan and follow-up for all Temporary Accommodation residents to include support with health, education, training and employment.

LBWF Housing Services participate in the East London Delivery Board, a multi agency sub group of the East London Housing Partnership established to deliver the action plan within the sub regional rough sleeping strategy No One Left Out in East London 2009 - 2013, published in December 2009.

London Street Rescue is working closely with LBWF, advising on assessment processes and working to improve referrals. As part of this work, LBWF has introduced regular, multi-disciplinary case conferences with key partners such as CDAT and mental health services, as well as developing enforcement work, to include joint working with the police and UKBA.

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<sup>45</sup> Department for Communities and Local Government

Research demonstrates that households in temporary accommodation have significantly more health problems than the general population; homeless children are twice as likely to be admitted to hospital for infectious diseases or accidents and have a higher incidence of behavioural problems. Homeless children and their mothers also have a significantly higher incidence of mental health problems.

It is also more difficult for families placed in temporary accommodation, especially if placed out of borough, to establish and/or maintain links with GPs, health visitors, schools etc.

LBWF has established a Support and Resettlement team working with people in temporary accommodation (TA). The team delivers tenancy sustainment and resettlement support via needs based support plans. The support enables clients placed in TA to access services and maintain a functioning home life while dealing with the transition of living in TA. The impact the team has had has been borne out in the reduced repeat homelessness applications made to the borough and the ability for those in TA to continue to receive essential services including health, education and welfare benefits. The team have also been able to identify and address resettlement needs and to facilitate support when they move to permanent accommodation. Partnership work has ensured that service users receive a complete service and data shared with health visitors, social services and education have resulted in clients accessing a continuous service. In 2010/11 28 households were supported by the TSRT to take up a 'change of life' plan to promote a better diet, healthy living & exercise.

## Crime

### Executive Summary

Recorded crimes decreased by 1% between 2009-2010 to 2010-11. Data up to the end of June 2011 show that Waltham Forest has the eleventh highest rate of crime within the Metropolitan Police Service, above the Metropolitan Police Service average.

Nearly one quarter of all crime in the borough is made up of just two offences; namely, other theft <sup>46</sup> (13%) and theft from a motor vehicle (10%). These represent the top two offences across the Metropolitan Police Service at 15% and 9% respectively.

In 2010/11 Waltham Forest had the 5<sup>th</sup> highest rate of DV per 1000 population when compared to other Metropolitan Police Service boroughs.

Home Office iQuanta data showed that as of the 31<sup>st</sup> March 2011 Waltham Forest had the 17<sup>th</sup> highest level of sexual offences within the Metropolitan Police Service and 8<sup>th</sup> highest when compared against its comparator group.

Data show that victims of crime in Waltham Forest

- Males have a slightly increased risk of victimisation for all crimes than females within Waltham Forest.
- The 20 – 34 age group has the most significant increased risk of victimisation within the borough.
- Females have an increased risk of becoming victims of domestic incidents and males for personal robbery.

An offender problem profile from July 2010 to 31<sup>st</sup> March 2011 identified the following key information in relation to who offends in Waltham Forest:

- Males aged 15 – 24 remain statistically significantly more likely to offend than any other age group, accounting for 46% of all males accused.
- 61% of all accused were unemployed, compared to 8.6% of the borough's estimated working age population who are either unemployed or on job seekers allowance.

High Street ward had the 21<sup>st</sup> highest volume of crime across all 625 wards in the Metropolitan Police Service. 25% of all borough crime occurred in just three wards namely High Street, Lea Bridge and Valley wards.

### Crime as an Influence on Health

The level of crime and fear of crime is one of the most commonly cited influences on people's quality of life. The same social and environmental factors that predict geographic variation in crime rates may also be relevant to

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<sup>46</sup> Other theft relates to theft of personal property outside the home, for example thefts of unattended property in the workplace and theft of property whilst at licensed premises, restaurant café or open space

explaining community variations in health and well-being. Crime is associated with social disorganisation, low social capital, relative deprivation and health inequalities.

Some of the most obvious links to health are the effects of personal violence and assault, which can have both mental and physical health consequences in the short and long term. In addition, crime rates affect people's sense of security and increases their experience of stress. Stress, in turn, causes hormonal levels to rise with potentially damaging health consequences.

Violence may entail physical injury, permanent disability and even death as well as often resulting in time off work and financial losses which can materially affect health.<sup>47</sup> In general, victims of violent crime experience deterioration in both their actual and perceived health; they have more chronic limitations on their physical functioning and increased medical consultation.<sup>48</sup>

There is growing recognition that crime is an indicator of collective well being and that areas with high crime rates also tend to exhibit higher mortality rates suggesting that crime and population health share the same origins<sup>49</sup>. Poverty and social inequality are two key factors in triggering violence, while social integration presents particular challenges for immigrants. Combined with feelings of being powerless to change their situation, these factors can all contribute to poor health outcomes by turning on a stress response elevating hormones that over the long term can lead to increased infections, diabetes, high blood pressure, heart attack, stroke, depression and aggression.<sup>50</sup>

As well as the immediate and direct impact of physical violence a range of long term health risks are associated with victimisation. Increased rates of cigarette smoking, alcohol and other substance abuse, health care neglect, risky sexual behaviour and sleeping and eating disorders are associated with physical and sexual assault.<sup>51</sup>

### **What are the Key Recommendations?**

- Develop a process with Domestic Violence (DV) services whereby they systematically record referrals received from health services and use of health services by victims as part of their case intake system.
- DV services must collect data that clearly shows the outcome of their services for victims.
- Secure agreement to pilot Project IRIS with GPs, to improve primary care response to patients who are experiencing domestic violence. The pilot study for Project IRIS found a cost/QALY of £2,450. Operating

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<sup>47</sup> Shapland et al. 1985:97

<sup>48</sup> Resnick et al, 1993: Shepherd and Farrington, 1993: Ullman and Siegal, 1996

<sup>49</sup> Kawachi et al, 1999

<sup>50</sup> Wilkinson, R and Marmot M. 2003. Social Determinants of Health the Solid Facts Second edition WHO

<sup>51</sup> Kilpatrick et al 1997

over 25 GP practices, Project IRIS generates a cost saving of £80 000 against a £50 000 investment.

- NHS ONEL to secure the inclusion of DV performance indicators in contracts with service providers.
- Health service commissioners (NHS ONEL) and health service providers to recognise cost of responding to DV locally and the important role they can play in the co-ordinated community response to DV.
- Health service commissioners (NHS ONEL) to recognise social and health care cost of responding to DV locally by involvement in the co-ordinated community response to DV and inclusion of DV indicators in contracts.
- Partnership to jointly commission and deliver coordinated training programme across the borough linking to a high profile DV awareness campaign with all partner agencies – a proposal to be submitted to Safety Net and the Local Safeguarding Children’s Board to secure partnership contribution towards this project.
- Children and Young People’s Service to consistently engage in MARAC process.
- Review DV pathway of referrals and Merlins from police to Children’s Services, health (school nursing and health visiting) and DV services.
- Review of all pathways to ensure that DV and other important violence against women issues are embedded.
- Action needs to be put in place to ensure that the Waltham Forest reputation for being at the forefront of response to Female Genital Mutilation (FGM) is sustained.

### **SafetyNet**

The Crime and Disorder Act 1998 was introduced to promote the practice of partnership working to reduce crime and disorder and placed a statutory duty on police and local authorities to develop and implement a strategy to tackle local problems. The responsible authorities are required to work in partnership with a range of other local, public (including the NHS), private, community and voluntary groups and with the community itself.

Section 5 of the Act imposes a duty on local authorities and the police in England to establish Community Safety Partnerships (CSPs) in their local areas. The CSP in Waltham Forest is known locally as SafetyNet and is the key vehicle for tackling crime, disorder and substance misuse issues in this borough. The development of CSPs recognises that both the causes of crime and disorder and the interventions required to deliver safer, more secure communities lie with a range of organisations, groups and individuals working in partnership. Crime reduction is not solely the responsibility of the police.

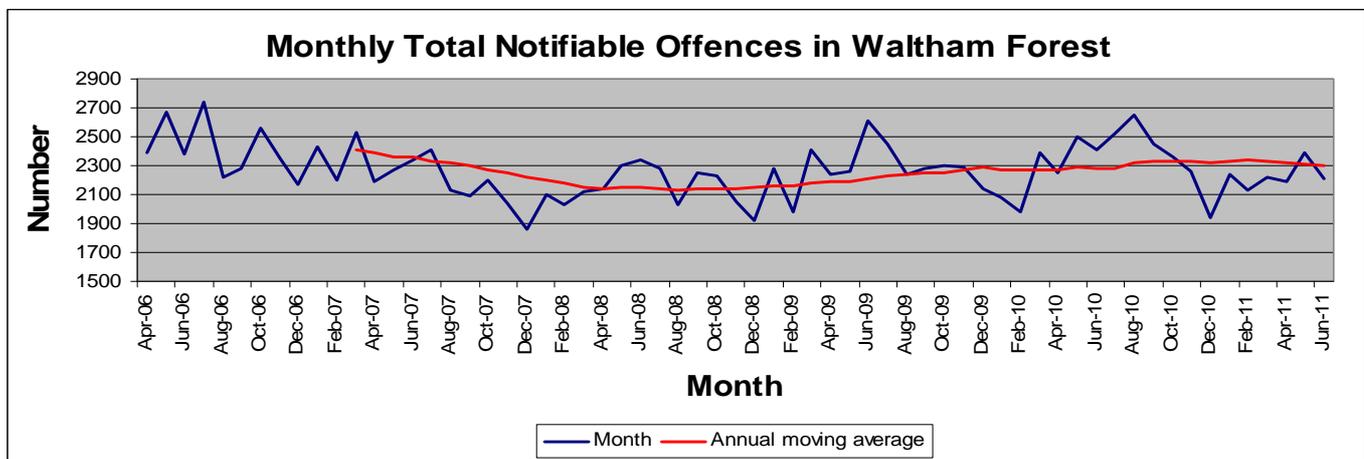
## Crime in Waltham Forest

From July 2010 to June 2011 there were 27,157 recorded crimes in Waltham Forest compared to 27,317 in the same period the previous year; a 1% reduction in crime, or 160 less offences.

On average 75 crimes occur per day in Waltham Forest. Data up to the end of June 2011 show that Waltham Forest currently has the eleventh highest rate of crime within the Metropolitan Police Service, which is above the Metropolitan Police Service average. The rate is second highest among the comparator group for Waltham Forest<sup>52</sup>.

Figure 1 shows the monthly number of all offences recorded in Waltham Forest (total notifiable offences) over the past five years and the annual moving average to identify long term trends. Of note June and July are the historical peak months for offending.

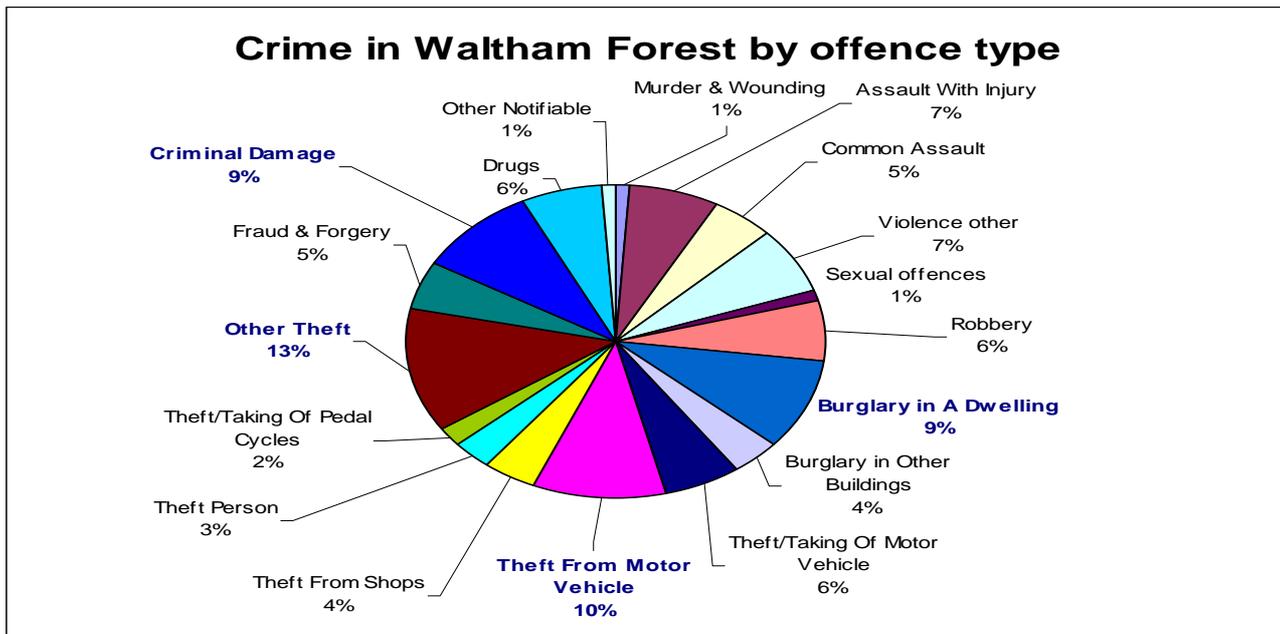
Figure 1



Crime can be split into a number of key offence categories. Figure 2 shows the breakdown of these offences for the period July 2010 to June 2011.

<sup>52</sup> These are Community Safety Partnerships in England and Wales with similar socio-economic and demographic crime factors

Figure 2



Nearly one quarter of all crime in the borough is made up of just two offences; namely, other theft<sup>53</sup> (13%) and theft from a motor vehicle (10%). These represent the top two offences across the Metropolitan Police Service at 15% and 9% respectively.

A Home Office study calculated the costs based upon the anticipation of crime, (e.g. defensive expenditure and insurance); the consequences of crime, (e.g. victim, property and health service costs) and finally response to crime, (e.g. the criminal justice system costs).<sup>54</sup> Although not all crime types can be costed in this way, it does provide a method of assessing the financial impact of some crimes to Waltham Forest. These calculations are based upon crime figures from July 2010 to June 2011 and 2003/04 costs, updated with the Treasury's GDP Deflator Index. Table 1 shows the estimated economic and social costs for crimes within Waltham Forest.

Table 1 Estimated Economic and Social Costs for Crimes in Waltham Forest

Offence category	Total estimated cost of crimes in Waltham Forest	Health Costs
Violence against the person	£63,986,220	£8,538,107
Sexual offences	£11,310,077	£339,734
Robbery	£13,918,525	£951,750
Burglary in a dwelling	£9,689,958	-
Theft	£10,291,297	-
Criminal damage	£2,496,424	-

Source: Dubourg & Hamed (2005), the Economic and Social Costs of Crime against individuals and Households 2003/04

<sup>53</sup> Other theft relates to theft of personal property outside the home, for example thefts of unattended property in the workplace and theft of property whilst at licensed premises, restaurant café or open space

<sup>54</sup> Dubourg & Hamed (2005), the Economic and Social Costs of Crime against individuals and Households 2003/04, Home Office

Costs to the health service can also be estimated; tackling crime in Waltham Forest is estimated to have cost the health service £10 million over the same period, of which £8.5m was spent on tackling violence against the person offences. This is likely to be a significant underestimation of the actual cost to the health service as the majority of crimes and in particular domestic violence and sexual violence crimes are underreported. Domestic violence offences make up over one third of violence against the person offences.

### **What are we doing?**

With effect from 2011 SafetyNet has restructured its current working arrangements away from a crime type focus to a problem oriented focus called '*risky people risky places*'. This approach ensures that resources are concentrated on tackling those most 'risky people', namely those who are at an increased risk of victimisation and those who are at an increased risk of re-offending and to those 'risky places' in the borough where disproportionate crime happens. Concentrating resources in this way should have the greatest impact upon reducing crime and Anti Social Behaviour in Waltham Forest.

One of the key Council Priorities and Commitments is to 'Improve the Safety of our community'. The two key actions that the Council has undertaken are to

- Find an effective solution to the gang problem.
- Reduce the level of crime and anti-social behaviour in the Borough.

### **Risky People**

Risky People include victims and offenders.

### **Victims**

Research and evidence from the British Crime Survey and police recorded crime figures show that victimisation is very uneven in nature. In fact 'victimisation is the best single predictor of victimisation'<sup>55</sup>. Understanding the nature and characteristics of the victims of crime and in particular those who are most likely to be repeat victims of crime should enable SafetyNet to develop the most effective strategies to reduce crime in Waltham Forest.

The latest victim problem profile covering the period July 2010 to 31<sup>st</sup> March 2011 found the following key facts in relation to victims:

- Males have a slightly increased risk of victimisation for all crimes than females within Waltham Forest.
- The 20 – 34 age group has the most significant increased risk of victimisation within the borough.
- Females have an increased risk of becoming victims of domestic incidents and males for personal robbery.
- Unemployed people have an increased risk of victimisation for domestic incidents and violence.
- Students/school children have an increased risk of victimisation for personal robbery.

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<sup>55</sup> Ken Pease – Repeat Victimisation Taking Stock

- Retired people have an increased risk of opportunistic acquisitive crime and more recently for burglary in a dwelling.
- London Ambulance Service data shows that most assault victims were males aged between 20-24 and dealt with on a Saturday evening.
- 14% of victims were shown to have been a repeat victim within the last 12 months.
- Most repeat victims were for domestic incidents.
- 84% of victims and witnesses were satisfied with their contact with the Criminal Justice System.

## **Offenders**

An offender problem profile from July 2010 to 31<sup>st</sup> March 2011 identified the following key information in relation to who offends in Waltham Forest:

- Males aged 15 – 24 remain statistically significantly more likely to offend than any other age group, accounting for 46% of all males accused.
- 61% of all accused were unemployed, compared to 8.6% of the borough's estimated working age population who are either unemployed or on job seekers allowance.
- Both unemployed male and female offenders were shown to be at an increased risk of offending when aged 20 -24. The crimes most committed by the unemployed are possession of cannabis and shoplifting.
- 14% of all accused were shown to be of A10 nationality, the majority of whom were Romanian or Polish, the crimes most significantly committed by the A10 community were shoplifting and burglary.
- Offenders do not travel far to commit crime, 74% of those accused of crimes in Waltham Forest were residents.
- Most crime (86%) is committed by just one offender.
- 4.5% (119) of crimes were committed by 1% (19) of accused offenders; each individual committed 5 or more crimes over this period.
- Drugs remain a significant driver in committing crime. 26% of people in Waltham Forest tested positive upon arrest, most people tested positive for cocaine.
- Alcohol is another key driver for crime. This is most apparent in violence against the person offences. Anecdotal evidence from treatment providers shows that alcohol misuse is increasing in prevalence.
- 2% of clients assessed by probation officers were classified as at high risk of re-conviction; 11% were considered at high risk of harm and thinking was shown as the greatest criminogenic need.
- Violence is the key crime committed by both first time entrants to the youth justice system and in terms of youth throughput data; like adult offenders "thinking" is the greatest criminogenic need.
- Criminal justice statistics show that victims and witnesses are more satisfied (84%) than the London average (81%); although this is improving it takes on average 75.6 days from charge to completion in comparison with a London average of 49.7 days.

## **Risky Places**

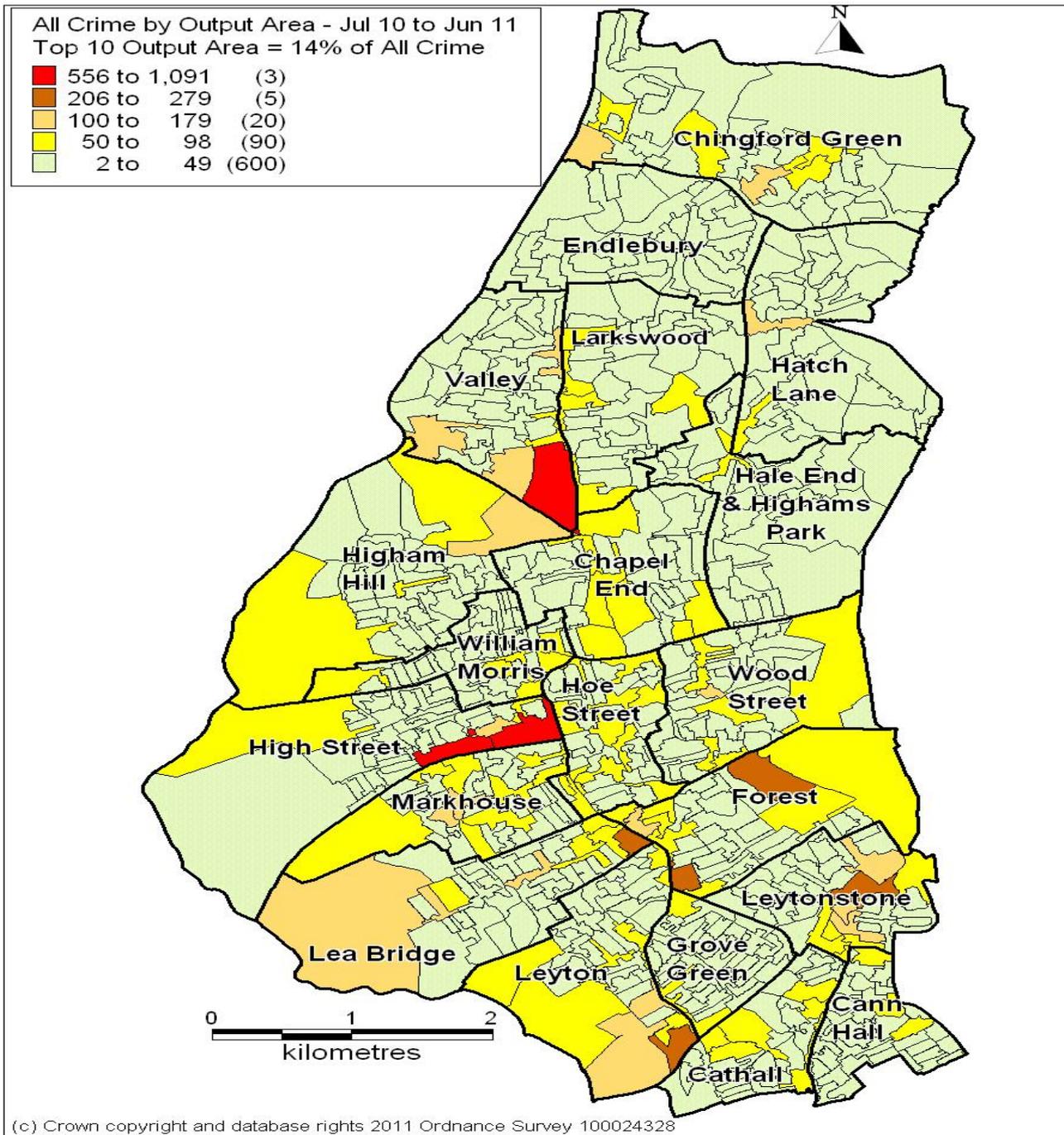
Crime is not uniformly distributed. Focusing on those areas with the greatest volumes of crime will have a greater impact upon reducing crime within Waltham Forest. The map in Figure 3 shows the breakdown of all crime reported in Waltham Forest from July 2010 to June 2011. This has been broken down to output area level<sup>56</sup>.

- High Street ward had the 21<sup>st</sup> highest volume of crime across all 625 wards in the Metropolitan Police Service. 25% of all borough crime occurred in just three wards namely High Street, Lea Bridge and Valley wards.
- Just four output areas account for 9.45% of all crime in Waltham Forest. If crime was reduced by 10% in these four areas, overall crime in the borough would fall by 1%.

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<sup>56</sup> A geographical area which contains approximately 125 households.

Figure 3



- Walthamstow Town centre remains the most 'risky place' in the borough, with other theft, theft from shoplifting and theft from the person accounting for half of all the crime in this area.
- 23% of Anti Social Behaviour (ASB) occurred in just 3 wards, Leyton (8%), High Street (8%) and Hoe Street (7%). The top 10 Computer Aided Despatch (CAD) grids accounted for 12% of all ASB incidents.
- The peak time for ASB incidents is from 18:00 to 20:59 hours accounting for 20% of all incidents and Sunday was the peak day.

- 56% of Waltham Forest residents stated that fear of crime affects their quality of life.

### **What more do we need to do?**

With reducing resources available to tackle crime and anti-social behaviour (ASB) in Waltham Forest and with the increased pressure of escalating crime levels due to the continuing economic recession and the forthcoming Olympic Games, it is imperative that resources remain targeted upon those most risky people and most risky places in Waltham Forest to maximise the opportunity and impact of reducing crime and ASB in the borough.

As crime can be shown to have a key impact upon health it is imperative that health services play a key role in the work of our Community Safety Partnership SafetyNet. This includes input into the programme boards that deliver the work of SafetyNet.

Some gaps include:-

- In terms of Prevent, a number of channel referrals have been referred previously to mental health services or have some kind of involvement from the health sector. The Department of Health are working with local health services to raise awareness of Prevent to increase the number of Channel referrals, and have identified two 'champions' in Waltham Forest. These champions have undertaken the WRAP (workshop to raise awareness on Prevent) train the trainer course, and work is to commence to deliver WRAP sessions to front line staff. However there is still a lack of NHS representation on the Channel Board and health senior management buy-in to the Prevent agenda.
- Lack of understanding/awareness of NHS involvement in supporting victims of hate crime.
- No referral pathways established to share information or to report hate crime.

### **Hate Crime, Domestic Violence (DV)**

#### **Executive Summary**

- In 2010/11 Waltham Forest had the 5<sup>th</sup> highest rate of DV per 1000 population when compared to other Metropolitan Police Service boroughs.
- Home Office iQuanta data showed that as of the 31<sup>st</sup> March 2011 Waltham Forest had the 17<sup>th</sup> highest level of sexual offences within the Metropolitan Police Service and 8<sup>th</sup> highest when compared against its comparator group.
- Waltham Forest has the sixth highest rate of prostitution related incidents recorded by the Metropolitan Police Service from August 2010 to June 2011.
- Waltham Forest has the sixth highest rate of prostitution related incidents recorded by the Metropolitan Police Service from August 2010 to June 2011. Prostitution incidents make up less than 1% of all

recorded Anti social behaviour incidents within Waltham Forest. Prostitution incidents are concentrated in Lea Bridge, Cathall and Forest and William Morris wards.

- Waltham Forest had the highest estimated number of maternities to women with FGM and percentage of all maternities to women with FGM (2001 – 2004) across the four ONHS Outer North east London boroughs (Barking & Dagenham, Havering, Redbridge and Waltham Forest).

## **Hate Crimes**

There is a growing body of evidence that confirms hate crime and hate related incidents can have a disproportionate physical and psychological impact on both victims and the wider community as compared to equivalent 'non hate' related crimes.

Research<sup>57</sup> found that racist victimisation often disproportionately impacts upon:

- Partner/spouse relationships
- Children
- Carrying out routine activities (e.g. shopping, socialising etc.)
- Victim's use of public space
- Feelings of insecurity
- Health and well-being

The latter point is particularly significant and is not exclusive to racist victimisation. Research into homophobic motivated crimes found that victims of hate crime often displayed symptoms of post-traumatic stress disorder that have been proven to last up to five years.<sup>58</sup>

In contrast, for comparable crimes without the 'hate' element, the same research found that victims usually experience a decrease in crime-related psychological problems within two years. The hate element makes a great deal of difference in fact; it makes this crime type unique.

Findings from the Pilkington Public Inquiry provided further evidence of the adverse impact that hate crime and targeted victimisation can have on victims and their family members' health and well being.

## **Waltham Forest Context**

Many of the support services provided to victims and witnesses of hate crime and hate related incidents in Waltham Forest are delivered by charities and local voluntary sector organisations. Listed below are some of the impacts they have identified whilst supporting clients:

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<sup>57</sup> Chahal & Julienne, 1999

<sup>58</sup> Herek, Cogan and Gillis, 2002

- **Physical health:** injuries sustained in an attack – ranging from minor to short-term hospital treatment. Chronic health-related symptoms relating to stress, sleep disturbance, eating disorders, increased substance or alcohol use.
- **Mental health:** all victims of serious crime are at risk of psychological trauma, but the problems associated with hate crimes can last longer than for 'random crimes'. In some cases, individuals may continue to experience high levels of stress and fear of crime.
- **Social isolation:** avoiding certain areas or activities, withdrawing from groups matching the perpetrators profile. Staying indoors for safety. Moving to live in a different area in order to feel safe. Not participating in community due to fear of repeat incidents.
- **Disrupted education:** This can be because of the emotional and physical impact, missing school – fear of going to school if the perpetrator also attends the same school. Lack of concentration and withdrawing from classroom exercises.
- **Financial loss:** many victims suffer financially, for example loss of earnings through sickness, additional cost for home security, relocating property, not using public transport (using taxi's or mini cabs),
- **Loss of confidence:** in the public authorities to deal effectively with incidents, loss of self-esteem, the law is not on their side.

A key action from the Reducing Victimisation Action Plan 2011/12 is to raise awareness of health service staff and the adverse impact of hate crime and hate related incidents. To start off this process hate crime information will be shared with the Communications Manager to distribute to NHS staff and to develop pathways for reporting and/or referral for support.

### **Gaps**

- Health representation on the Programme Board that will act as a Champion for Hate Crime similar to the Domestic Violence Lead.
- Lack of understanding/awareness of NHS involvement in support victims of hate crime.
- No referral pathways established to share information or to report.

### **Domestic Violence**

This section covers the issue of domestic violence and violence against women and girls. Domestic violence (DV hereafter) remains highly prevalent in the borough, where it has a significant impact on the health and wellbeing of victims and their children.

DV is:

*"Any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members, regardless of gender or sexuality. This includes issues of concern to black and minority ethnic (BME) communities such as so called 'honour based violence', female genital mutilation (FGM) and forced marriage."*

DV is a form of gender based violence. Although violence can affect people of both genders, research shows that women and girls are more likely than men and boys to experience all forms of gender-based violence. 89% of those suffering four or more incidents of domestic violence are women and victims in nearly 8 out of every 10 incidents of domestic violence are female.

This definition applies equality to girls and includes the following forms of violence:

- sexual violence, abuse and exploitation
- sexual harassment and bullying
- stalking
- trafficking and forced prostitution
- domestic violence
- female genital mutilation
- forced marriage
- crime committed in the name of "honour"

In 2010/11:

- There were 4,199 incidents of domestic violence reported to the police, accounting for 7% of all total notifiable offences recorded in Waltham Forest.
- There were 1,858 DV offences recorded - a 0.1% reduction from the previous year, compared with a 6.1% reduction across the Metropolitan Police Service (MPS) and a 2.9% reduction across the North East London area.
- The DV sanction detection rate of 46.2% (target 47%) compared with 49.3% across the MPS and 48.3% in the North East London area.
- The DV arrest rate of 80.6% (target 77%) compared with 82.3% across the MPS and 83.1% across the North East London area.
- There were no domestic violence homicides in 2010/11. There haven't been any for a number of years (DV homicides - 2003/4 2, 2004/5 3, 2005/6 1).

In 2010/11 Waltham Forest had the fifth highest rate of DV per 1000 population when compared to other Metropolitan Police Service boroughs. In comparison Waltham Forest had the 9<sup>th</sup> highest rate in 2009/10.

Data from the Waltham Forest Multi Agency Risk Assessment Conference (MARAC) show that for 2010/11:

- 200 cases were dealt with.
- 28 were repeat victims over this period, which equates to a repeat victimisation rate of 14%.
- 239 children related to these cases.
- 109 were from black and minority ethnic communities.
- There was none from the LGBT communities.
- In 45 of the cases the victim had a registered disability.
- 20 were male victims.

53% of children subject to the child protection conference process in Waltham Forest live in families affected by domestic violence. A recent review of the Waltham Forest MARAC by Co-ordinated Action Against Domestic Abuse (CAADA) highlighted the inconsistent attendance and inappropriate representation of health services as an issue.

### **DV ready reckoner results**

The ready reckoner provides an estimate of the incidents of DV, sexual violence and stalking, for the local female population. These estimates can be used to help inform commissioning of services to meet unmet and previously unrecognised need.

<b>Borough</b>	<b>Female population*</b>	<b>Estimate for area**</b>
Waltham Forest	112093	DV 5,268 Sexual Assault 4,708 Stalking 9,324
Havering	116291	DV 5,466 Sexual Assault 4,884 Stalking 9,673
Redbridge	122786	DV 5,771 Sexual Assault 5157 Stalking 10,213
Barking and Dagenham	85876	DV 4,036 Sexual Assault 3,607 Stalking 7,143

\*Population data taken from 2001 Census (is total female population and not broken down to 16 – 59 age group).

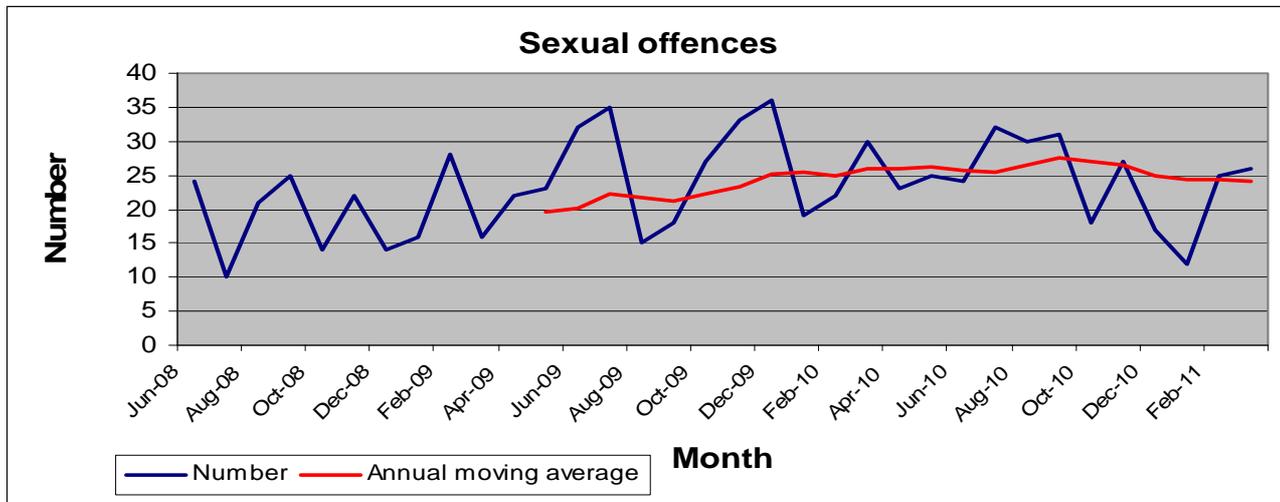
\*\*Figures are an estimate of number of women and girls who have been a victim in the past year

### **Sexual Violence**

Figure 4 show the number of sexual offences from June 2008 to February 2011, along with a rolling average from April 2009. Home Office iQuanta data showed that as of the 31<sup>st</sup> March 2011 Waltham Forest had the 17<sup>th</sup> highest level of sexual offences within the Metropolitan Police Service and 8<sup>th</sup> highest when compared

against its comparator group. (Community Safety Partnerships in England with similar socio economic, demographic and crime factors as Waltham Forest).<sup>59</sup>

**Figure 4 Number of sexual offences in Waltham Forest by month, June 09 – February 11, with rolling averages**



Sexual violence offences account for less than 1% of all reported crimes within Waltham Forest. There were 235 recorded serious sexual violence offences in Waltham Forest over 2010/11, that is a 0.4% reduction compared with the previous year. In comparison there was a 7.2% increase for the North East area and a 7.5% increase across the Metropolitan Police Service.

A sanctioned detection rate was achieved of 14%. In comparison 21% was achieved across North East Area and 21.6% across the Metropolitan Police Service. Data up to February 2011 show that there were 24.6:100 offences brought to justice to crime ratio for serious sexual offences (Tier 1) against a target of 26:100, which is below the average of 32.7 for the most similar areas.

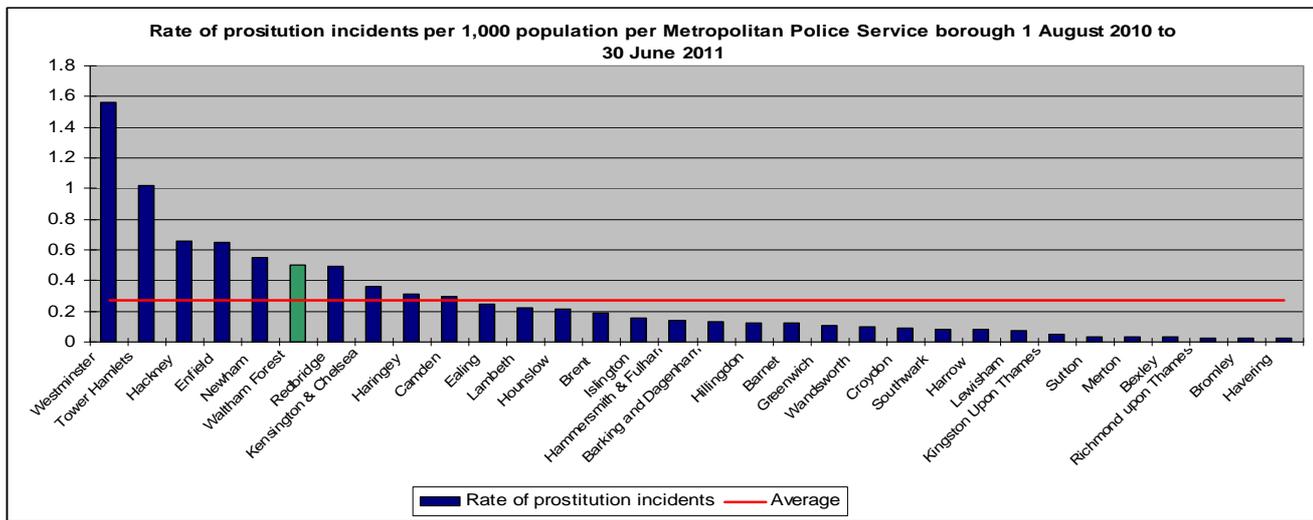
### Prostitution

Waltham Forest has the sixth highest rate of prostitution related incidents recorded by the Metropolitan Police Service from August 2010 to June 2011. The National Standards of Incident Recording were changed with effect from August 2010 therefore no long term data can be compared. This is above the MPS average and equates to a rate of 0.5 incidents per 1,000 population i.e. 113 incidents.

Prostitution incidents make up less than 1% of all recorded Anti social behaviour incidents within Waltham Forest. Prostitution incidents are concentrated in specific wards of the borough namely: - 41 incidents (36%) were in Lea Bridge ward, 12 incidents (11%) in Cathall ward and 8 incidents (7%) in both Forest and William Morris wards. Figure 5 describes the rates of prostitution in the Metropolitan Police Service area between August 2010 and June 2011.

<sup>59</sup> Dudley; Sefton, Barnet, Southend on Sea; Enfield; Hastings; Wolverhampton; Croydon; Greenwich; Lewisham; Ealing; Haringey; Brent and Slough.

**Figure 5 Rates of prostitution in the MPS area**



**Trafficking**

Between 1<sup>st</sup> April and 13<sup>th</sup> September 2009 a total of 12 classifications of trafficking were recorded on Metropolitan Police Service systems; from 1<sup>st</sup> April 2010 to 13<sup>th</sup> September 2010, 43 offences were recorded. There have been 8 convictions for trafficking for sexual exploitation since April 2010. A further 4 trafficking cases are currently with the Crown Prosecution Service for decision on charging. This is believed to be more due to the enhanced focus of SCD9<sup>60</sup> rather than an increase in sex trafficking. This will be monitored by the Human Trafficking and London Olympic Games Network. There is little intelligence available on the scale of trafficking for sexual exploitation within Waltham Forest.

**Female Genital Mutilation (FGM)**

It is acknowledged that it is very difficult to obtain accurate figures on the prevalence of female genital mutilation in the local community. Table 2 below shows the estimated number of maternities to women with FGM and percentage of all maternities to women with FGM (2001 – 2004).<sup>61</sup> Waltham Forest had the highest estimated number of maternities throughout the period.

**Table 2: Estimated number of maternities to women with FGM and percentage of all maternities to women with FGM (2001 – 2004)**

Area	2001 Number	%	2002 Number	%	2003 Number	%	2004 Number	%	Total Number
Waltham Forest	128	3.68	143	4.03	174	4.66	189	4.82	635
Barking & Dagenham	82	3.42	100	4.15	122	4.74	167	6.8	471
Redbridge	103	3.33	114	3.56	125	3.73	156	4.51	498
Havering	6	0.26	8	0.36	15	0.64	17	0.67	47

<sup>60</sup> SCD9 – Specialist Crime Directorate within the Metropolitan Police Service with responsibility for Human Exploitation and Organised Crime.

<sup>61</sup> Forward (2007) A Statistical Study to Estimate the Prevalence of Female Genital Mutilation in England and Wales Summary Report

Action needs to be put in place to ensure that the Waltham Forest reputation for being at the forefront of response to Female Genital Mutilation is sustained.

### **What are the effective interventions?**

NICE guidance for effective DV interventions is in early stages of development.

The borough's response to domestic violence is shaped by the following documents:

- Call to end violence against women and girls – Coalition strategy and action plan – 2011.
- The way forward – Mayors strategy to end violence against women and girls March 2010.
- Dept of Health Taskforce on the health aspects of violence against women and children – March 2010.
- Together we can end violence against women and girls – HM Government 2009.

Saving lives, saving money: MARACs and high risk domestic abuse CAADA 2010, shows that each high risk case of DV discussed at the MARAC costs £20K per victim. It is estimated that MARACs deal with around 10% of the total of all DV reported incidents. These are the most serious and high risk cases and should be seen as the “tip of the iceberg”.

This means that the 200 high risk cases of DV discussed at the MARAC in the borough for 2010/11 cost the borough £4 million and health services £1 million (visits to GP, A&E, prescriptions and other health services such as sexual and mental health). The costs for the other three NHS ONEL boroughs are:

- Redbridge: £3.4 million and health services £850,000.
- Barking and Dagenham: £5.3 million and health services £1.3 million.
- Havering: £2.2 million and health services £505,000.

Using an independently verified analysis, MARACs save at least £6,100 of these costs per victim. The net return on investment for the health service is 533%.<sup>62</sup>

Evidence shows that DV advocates benefit victims of domestic violence. For women and families living with severe domestic violence, MARACs and Independent Domestic Violence Advisors (IDVAs) offer an effective solution. Almost two thirds of women living with high risk abuse report that it stops following intensive, multi-agency support coordinated by an IDVA.

The pilot study for Project IRIS (identification, referral, improving safety) in East London found a cost/QALY of £2,450. This is well within the NICE guidelines for cost effectiveness with a threshold of £20,000-£30,000 per

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<sup>62</sup> Saving lives, saving money: MARACs and high risk domestic abuse CAADA 2010.

quality adjusted life year (QALY). Project IRIS operating across 25 GP practices at an initial set up of £50, 000 will generate savings to the NHS of £80,000.

The estimated cost of domestic violence (not including the human and emotional costs) pro rated by population to Waltham Forest is £26 million. The hidden cost to NHS in Waltham Forest in responding to DV (its immediate and the long term impact) is estimated to be £7.8 million a year. This figure includes the costs of visits to GPs and A&E, treatment for injuries, use of ambulances, prescriptions, and referral to services for treatment, mental health and rehabilitation.<sup>63</sup>

In comparison to other boroughs across Outer North East London, the costs are:

- Redbridge cost of DV is £29.9 million, the hidden costs to NHS is £9 million.
- Barking and Dagenham cost of DV is £19.1 million, the hidden costs to NHS is £5.7 million.
- Havering cost of DV is £23.8 million, the hidden costs to NHS is £7.1 million.

As part of the European Daphne Fund Waltham Forest, Newham and Lewisham have received two years funding to work with Lithuania to deliver the HEART programme. HEART is designed to support both vulnerable young men and women and improve the relationships they have with both peers and prospective partners. The primary focus will be on reducing the risk of young women either committing or being subject to serious violence, particularly gang related and sexual violence, with a view to reducing victimisation and crime levels. It will consist of three strands:

1. Guidance for young people.
2. Helpline to signpost services available.
3. Mentoring scheme to provide 1-1 support to those most at risk.

The programmes are designed to be challenging, interactive, participatory and engaging, empowering young people to make informed life choices.

### **What is being done locally to address domestic violence?**

The DV services in the borough work together to help deliver a co-ordinated community response model which:

1. Increases survivor safety
2. Holds perpetrators accountable for their behaviour
3. Challenges the social tolerance of domestic violence.

For 2010/11 the Community Safety Team had four different Violence Against Women and Girls commissioned services in the borough. This includes:

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<sup>63</sup> The Cost of Domestic Violence: by local authority, Trust for London and the Henry Smith Charity (2011)

1. A contract with Victim Support to provide 1 Independent Domestic Violence Advocate - £36K (also supplemented with £20,000 grant from Ministry of Justice to fund an IDVA for 6 months working with Victim Support).
2. A contract with Report IT the East London Community Law Service to provide legal and advocacy support to victims and witnesses of DV and hate crime £79,056.
3. Two contracts for counselling with Ashiana – sexual violence counselling and support groups £35K and Domestic Violence service £62,000.

Work is being undertaken to commission a new more holistic DV service provision for the borough which will replace these current contracts. The aim is for a more accessible and coordinated service. This contract is mainly funded through the Voluntary Sector Commissioning Fund and topped up with the Community Safety Budget.

Domestic Violence is a key priority for the Waltham Forest Council and despite reductions across the Voluntary Sector Commissioning budget the funding available for DV remained the same. A significant area of concern is despite the wealth of evidence demonstrating the impact upon health and children these areas do not contribute to the commissioning process. Victim Support and Waltham Forest Council will receive £10,000 each over the next four years (total value £80K) towards further IDVA provision, which will result in Waltham Forest now having 2.5 IDVAs as recommended by CAADA to support a monthly MARAC in Waltham Forest.

Despite the high prevalence of DV, large numbers of victims experiencing DV are not being identified by health professionals such as GPs, A&E staff or midwives. DV services in Waltham Forest have not been systematically recording referrals to their services from health professionals. Anecdotal discussion with service providers has found that despite a lack of referral data, only occasional referrals are made to them by health services. This is a concern given the prevalence of DV, the health impact of DV and research such as The British Crime Survey finding that that 47% of violent injuries to women are caused by DV. No referrals have been received from GPs to DV services in 2010/11, with only 3 referrals made to the MARAC from health services.

Work is now underway with DV services in the borough to record and report all health referrals on a monthly basis. A review of health engagement with the MARAC has been conducted and issues regarding representation are now being addressed at a strategic level with the support from NHS Outer North East London.

### **Sexual Violence**

The East London Rape Crisis Centre opened in November 2010 and provides an essential service to residents of the borough (along with Hackney, Havering, Newham, Redbridge, and Tower Hamlets). The

service provides vital counselling and long term support for both men and women for those aged 14 and over who have been raped or sexually abused.

Currently the service has three service users from Waltham Forest - two accessing counselling and one accessing both counselling and advocacy. It is expected that referrals will gradually increase as awareness of the service grows. Initial low take up of the service is expected as it is a new service and the sensitive and complex nature of disclosure and help seeking in cases of rape and sexual assault. An engagement and publicity campaign is underway to raise awareness locally of the service.

Waltham Forest enjoyed a reputation for delivering first class services to girls and women who have been affected by female genital mutilation, through the pioneering work by the African Well Women's Clinic. However, this service has temporarily ceased due to key staff leaving. Commissioners are working towards establishing an appropriate service model for the borough.

### **What evidence is there that we are making a difference?**

There has not been a DV homicide in the borough since 2005/6.

The MARAC repeat victimisation rate<sup>64</sup> for 2010//11 is 14%; and 16% for the year to date. This is the repeat incident rate of high risk cases of domestic violence discussed at the MARAC. The percentage is the reduction of repeat victimisation for those domestic violence cases reviewed by a MARAC.

National research has clearly evidenced the positive impact of IDVAS and MARACs in addressing high risk DV. Using an independently verified analysis, MARACs save at least £6,100 of these costs per victim. The net return on investment for the health service is 533%<sup>65</sup>. For women and families living with severe DV, MARACs and Independent Domestic Violence Advisors (IDVAs) offer a real solution. Almost two thirds of women living with high risk abuse report that it stops following intensive, multi-agency support coordinated by an IDVA.

The data monitoring available from contracted DV services working in the borough does not show any outcomes. This is disappointing as we have no local data available to show the positive impact these services are having on the lives of victims in reducing harm and repeat victimisation.

### **What is the perspective of the public on support available to them?**

Women survivors of DV who had received support from Refuge were consulted as part of the development of NHS Barking & Dagenham's domestic violence and violence against women and children strategy. Although this was not conducted with local women in the borough it provides relevant feedback on survivors' views of how health services can help victims of DV.

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<sup>64</sup>[www.auditcommission.gov.uk/localgov/audit/nis/Pages/NI032repeatincidentsofdomesticviolencecasesreviewedatmarac.aspx](http://www.auditcommission.gov.uk/localgov/audit/nis/Pages/NI032repeatincidentsofdomesticviolencecasesreviewedatmarac.aspx) for a detailed explanation of domestic violence repeat victimisation rate.

<sup>65</sup> Saving lives, saving money: MARACs and high risk domestic abuse CAADA 2010

The women felt that health services can and must play an important role in responding to domestic violence – both for women and their children.

The women recommended that the health agency response to DV should include prevention and early intervention. They also recommended that training on domestic violence is vital so that women experiencing domestic violence can be confident that they will receive a consistent and professional response if they choose to disclose what is happening to them.

Above all, the health service response should be collaborative in approach and recognise that health services need to work with partner agencies to ensure that all the needs of DV victims are addressed. It is vital that partners from across the community work together in order to properly support women who experience violence.

Feedback from our commissioned service which provides legal and advocacy support to victims and witnesses of domestic violence and hate crime showed that 100% of clients who completed a survey reported an increase in confidence in the local response to tackling hate crime. 100% also reported improvements in their perceptions of community safety.

### **What more do we need to know?**

- Outcome monitoring framework to be agreed and implemented by all DV services commissioned in the borough.
- Details from children's social care on the number of cases of DV they deal with (where DV is the primary reason for referral or a background factor).
- In spite of repeated attempts by Public Health to obtain acute data on records of admissions to hospital in respect of DV, this has not proved possible, given that DV is not part of the clinical coding set in secondary care and therefore cannot be isolated from the electronic record.
- Referrals from health services including GPs to DV services are extremely low. We need to obtain regular information from DV services on health referrals, and work to capture information from victims of DV on their use of health services to evidence local need.
- Feedback and perspectives of local service users on how our services are supporting victims and improvements they think are needed.
- Data sets across services on incidents and concerns regarding DV, forced marriage, honour based violence and female genital mutilation.

- Intelligence on the incidence and nature of prostitution, sexual violence and trafficking in the borough.

### **What are the priorities for improvement over the next 5 years?**

- Ensuring appropriate agencies and representatives attend the MARAC.
- MARAC data is collated appropriately and sufficiently to understand the needs of the victims and to align services accordingly.
- Recommendations are implemented from the CAADA MARAC quality assurance review.
- Improve our datasets and intelligence locally on DV and other forms of VAWG. Most of the data which informs our decisions about DV commissioning is based upon police data and the services we commission. There is a key gap in terms of health and social care data which needs to be addressed, to develop a comprehensive dataset to clearly evidence high level of unmet need.
- Develop joint commissioning opportunities for DV/VAWG services to improve service provision and coordination (namely with health).
- Engage GPs in the coordinated response to DV, to improve practice, generate referrals and pilot Project IRIS locally.
- Commission and implement dedicated DV services working alongside A&E and midwifery services in Whipps Cross hospital.
- Implement a series of DV key performance indicators into the contracts of health service providers to help support the mainstreaming of the response to DV within health.
- Identify and secure funding for the continual professional development and training for front line workers across the partnership so they are able to respond appropriately to concerns of DV.
- Work with SafetyNet to identify issues with how DV cases are handled at the magistrates' court to improve support provided to victims.
- Deliver a high profile local DV awareness campaign, to inform the public about services and to support professionals to make referrals (currently there are no such publicity materials available even though it is an important element of any coordinated community response to DV).
- The Mayor of London has funded the East London Rape Crisis Centre to March 2012. Consideration needs to be given to future commissioning of this essential service if this funding ceases. This is expected

to be approximately £30 000 per year from each borough.

- Monitor prostitution activities across the borough to inform planning for Olympics – including health service data.
- Evidencing the high level of unmet need in the borough for DV services is difficult with the current data set.
- Health services need to improve their response to DV through jointly commissioning services and developing staff to identify and respond to patients experiencing DV.
- Data collected on incidents of DV and other forms of violence against women and girls needs to be improved across the partnership.
- The terms of reference (including membership of the MARAC steering group) needs to be reviewed to ensure leadership and commitment from all services.
- Specialist support needs to be secure for children and young people affected by DV – Children’s Social Care – family intervention with fathers - A coordinated programme of awareness raising, prevention and early intervention needs to be considered alongside interventions to tackle perpetrators.

## Active Travel

### Executive Summary

Transport choices affect the health and wellbeing of individuals and populations. This chapter considers active travel, (cycling and walking) as an effective and realistic way of increasing physical activity. Based on current trends, it has been estimated that nearly 60% of the UK population could be obese by 2050<sup>66</sup>. Current Department of Health (DH) advice is that adults should accumulate at least 150 minutes (2½ hours) of moderate intensity activity per week<sup>67</sup> and that under 16s should achieve a total of at least 60 minutes a day. Recommended levels of activity can be achieved in one session or through shorter bouts of activity of at least 10 minutes each.<sup>68</sup>

Across England, only 2% of trips are currently cycled<sup>69</sup>. In 2009-2010, cycle mode share for Inner and Outer London was 2.9% and 1.5% respectively and 2.1% for Londoners overall<sup>70</sup>. By way of comparison, 26% of journeys in the Netherlands are made by bicycle, with 19% in Denmark, and 10% in Germany<sup>71</sup>. In Greater Copenhagen, 36% of commute trips are currently made by bicycle.<sup>72</sup>

At 0.8%, Waltham Forest currently has a low cycle mode share.<sup>73</sup> Transport for London (TfL) analysis for the north London sub-region<sup>74</sup> shows that only 5 % of the total potential in outer London is actually cycled, compared to 14 % of that for central London

### What is active travel?

Active travel is non-motorised transport involving human physical effort. Cycling and walking are the most common forms of active travel (although other modes, such as push scooters and roller-skating also offer opportunities for active travel, particularly among young people). Public transport may appear to be an inactive mode, but using public transport often involves walking or cycling to and from transport stops and interchanges.

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<sup>66</sup> Government Office for Science (Foresight). 'Tackling Obesities: Future Choices' (2007)

<<http://www.bis.gov.uk/assets/bispartners/foresight/docs/obesity/17.pdf>> [retrieved on 22 August, 2011] (p 34)

<sup>67</sup> or 75 minutes of vigorous intensity activity spread across the week or combinations of both.

<sup>68</sup> Chief Medical Officers. 'Start active, stay active: a report on physical activity from the four home countries' Chief Medical Officers (July 2011) <[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_128209](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_128209)> [Retrieved on 22 August, 2011].

<sup>69</sup> Department for Transport/Department of Health. 'Active Travel Strategy' (2010)

<<http://www2.dft.gov.uk/pgr/sustainable/cycling/activetravelstrategy/pdf/activetravelstrategy.pdf> > [retrieved 22 August, 2011]

<sup>70</sup> Transport for London. 'Travel in London 3' (2010) <http://www.tfl.gov.uk/assets/downloads/corporate/travel-in-london-report-3.pdf> [Retrieved 23 August, 2011]

<sup>71</sup> Department for Transport/Department of Health. Op cit.

<sup>72</sup> City of Copenhagen. 'Green Urban Mobility' (2011).

<http://www.kk.dk/sitecore/content/Subsites/CityOfCopenhagen/SubsiteFrontpage/LivingInCopenhagen/CityAndTraffic.aspx> [Retrieved on 29 August, 2011]

<sup>73</sup> Waltham Forest Council. Draft Local Implementation Plan (Waltham Forest) (2011).

<sup>74</sup> Transport for London. Sub regional transport plan: North (2011). <http://boroughs.tfl.gov.uk/documents/general/north-london-sub-regional-transport-plan.pdf> [Retrieved 18 August, 2011]

Department for Transport (DfT) research has found that most people consider distances of up to a mile walkable and trips of up to 5 miles (8km) cycleable. Where trip distance exceeds a mile (about 1.6km), only a small proportion of people will regularly walk. As a result, car trips of up to 5 miles can be reasonably targeted for active travel.<sup>75</sup>

While countries with the highest levels of active travel generally have the lowest obesity rates<sup>76 77</sup>, medical evidence from across the world links time spent in cars as passenger or driver to an increased risk of weight gain, as calorific expenditure is reduced.<sup>78, 79</sup>

### **Cycling and Walking**

Physical activity can significantly reduce a person's risk of many diseases and extend their life expectancy<sup>80</sup> - physically active adults have a 20-30% reduced risk of premature death<sup>81</sup>. There is also increasing evidence linking physical activity with mental wellbeing<sup>82</sup>. It is estimated that only 40% of men and 28% of women in England currently achieve this recommended level of physical activity<sup>83</sup>. Moderate activity includes cycling and brisk walking, which offer the opportunity to incorporate exercise into daily routines at no or low cost, so they have a potentially important role in helping to address obesity. As a host borough of the London 2012 Olympic Games and Paralympic Games, Waltham Forest has a unique opportunity to create a lasting legacy of active travel through improved infrastructure and public realm, supportive policies and promotion.

As well as increasing physical activity, interventions to increase active travel have other potential health, social, economic and environmental co-benefits including reduced local air pollution, greenhouse gas emissions and

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<sup>75</sup> Department of Health/Department for Transport. 'Active Travel Strategy' (2010).

<http://www2.dft.gov.uk/pgr/sustainable/cycling/activetravelstrategy/pdf/activetravelstrategy.pdf> [Retrieved on 19 August, 2011].

<sup>76</sup> Bassett, D., Pucher, J., Buehler, R., Thompson, D., Crouter, S., 'Walking, cycling, and obesity rates in Europe, North America and Australia.' *Journal of Physical Activity and Health*, 5: (2008) 795-814.

<sup>77</sup> Davis, A., Valsecchi, C., Fergusson, M. 'Unfit for purpose: How car use fuels climate change and obesity,' London: Institute for European Environmental Policy. (2007)

<http://www.yale.edu/transportationoptions/choicematters/documents/UnfitforPurposeCarUseObesityandClimateChange.pdf> [Retrieved 19 August, 2011]

<sup>78</sup> Davis, Adrian. 'Essential evidence on a page – No 7: Weight gain and car use'. (2009) [retrieved on 13 June 2011]

[http://www.bristol.gov.uk/ccm/cms-service/stream/asset/?asset\\_id=29542007](http://www.bristol.gov.uk/ccm/cms-service/stream/asset/?asset_id=29542007)

<sup>79</sup> Ewing, R, Schmid, T, Killingsworth R, Zlot A, Raudenbush S; 'Relationship Between Urban Sprawl and Physical Activity, Obesity, and Morbidity; .*American Journal of Health Promotion* 18 (September/October 2003).

[http://www.activelivingresearch.org/alr/files/AJHP\\_8\\_Ewing.pdf](http://www.activelivingresearch.org/alr/files/AJHP_8_Ewing.pdf) [Retrieved 19 August, 2011]

<sup>80</sup> *ibid*

<sup>81</sup> Department of Health. At least five a week. Evidence on the impact of physical activity and its relationship to health. A report from the Chief Medical Officer, London DH 2004.

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4080994](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4080994) [Retrieved on 22 August, 2011].

<sup>82</sup> Royal College of Psychiatrists. 'Physical Activity and Mental Health' (2009)

<http://www.rcpsych.ac.uk/mentalhealthinfoforall/treatments/physicalactivity.aspx> [Retrieved 6 August, 2011]

<sup>83</sup> Department for Health 'Health Survey for England - 2008: Physical activity and fitness' (2009)

<http://www.ic.nhs.uk/pubs/hse08physicalactivity> [Retrieved on 19 August, 2011]

noise, increased social interaction, low cost access to local services and employment. Evidence from the UK and elsewhere has demonstrated that coordinated implementation of a number of complementary policies and infrastructural measures are key to increasing cycling and walking. Incentives to travel actively (promotion and high quality infrastructure) are significantly more effective if aligned with disincentives to travel by car (including the reallocation of road space to cycling, walking and public transport)<sup>84,85,86</sup>.

### **What is the local picture?**

In recent decades the distance travelled by car in England has increased,<sup>87</sup> while trips by walking and cycling have been in long-term decline.

Across England, only 2% of trips are currently cycled<sup>88</sup>. In 2009-2010, cycle mode share for Inner and Outer London was 2.9% and 1.5% respectively and 2.1% for Londoners overall<sup>89</sup>. By way of comparison, 26% of journeys in the Netherlands are made by bicycle, with 19% in Denmark, and 10% in Germany<sup>90</sup>. In Greater Copenhagen, 36% of commute trips are currently made by bicycle.<sup>91</sup>

At 0.8%, Waltham Forest currently has a low cycle mode share.<sup>92</sup> Transport for London (TfL) analysis for the north London sub-region<sup>93</sup> shows that only 5 % of the total potential in outer London is actually cycled, compared to 14 % of that for central London.<sup>94</sup> The Mayor of London is seeking to effect a London-wide

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<sup>84</sup> Pucher, J, Dill, J, Handy, S; 'Infrastructure, programs, and policies to increase bicycling: An international review', *Preventive Medicine* 50 (2010) <[http://policy.rutgers.edu/faculty/pucher/Pucher\\_Dill\\_Handy10.pdf](http://policy.rutgers.edu/faculty/pucher/Pucher_Dill_Handy10.pdf)> [retrieved on 22 August, 2011]

<sup>85</sup> Jones T, Pooley C, Chisholm A, Horton D, Scheldeman G. 'Understanding walking and cycling: interim findings from a multi-method approach to investigate household decision making in relation to short journeys in urban areas' (2010). [http://www.lec.lancs.ac.uk/research/society\\_and\\_environment/cycling/WCTR\\_TJ\\_July\\_2010.pdf](http://www.lec.lancs.ac.uk/research/society_and_environment/cycling/WCTR_TJ_July_2010.pdf) [retrieved on 22 August, 2011]

<sup>86</sup> Department of Health. 'Active Travel Strategy' (2010) <<http://www2.dft.gov.uk/pgr/sustainable/cycling/activetravelstrategy/pdf/activetravelstrategy.pdf>> [retrieved on 22 August, 2011]

<sup>87</sup> Department for Transport. 'Reported Road Casualties in Great Britain: Quarterly Provisional Estimates Q1 2011: Statistical Release' (August 2011) <<http://assets.dft.gov.uk/statistics/releases/road-accidents-and-safety-quarterly-estimates-q1-2011/road-accidents-and-safety-quarterly-estimates-q1-2011.pdf>> [Retrieved 4 August, 2011]

<sup>88</sup> Department for Transport/Department of Health. 'Active Travel Strategy' (2010) <<http://www2.dft.gov.uk/pgr/sustainable/cycling/activetravelstrategy/pdf/activetravelstrategy.pdf>> [retrieved 22 August, 2011]

<sup>89</sup> Transport for London. 'Travel in London 3' (2010) <http://www.tfl.gov.uk/assets/downloads/corporate/travel-in-london-report-3.pdf> [Retrieved 23 August, 2011]

<sup>90</sup> Department for Transport/Department of Health. Op cit.

<sup>91</sup> City of Copenhagen. Green Urban Mobility' (2011). <http://www.kk.dk/sitecore/content/Subsites/CityOfCopenhagen/SubsiteFrontpage/LivingInCopenhagen/CityAndTraffic.aspx> [Retrieved on 29 August, 2011]

<sup>92</sup> Waltham Forest Council. Draft Local Implementation Plan (Waltham Forest) (2011).

<sup>93</sup> Transport for London. Sub regional transport plan: North (2011). <http://boroughs.tfl.gov.uk/documents/general/north-london-sub-regional-transport-plan.pdf> [Retrieved 18 August, 2011]

<sup>94</sup> Transport for London. 'Analysis of Cycling Potential Policy Analysis: Research Report' (Dec 2010)

cycling revolution. Targets include increasing the number of cycling trips to 5% of trips by 2026. Waltham Forest has set its own targets to increase cycling mode share: 2% by 2013, and 6% by 2025. Transport for London has identified Walthamstow Town Centre and the surrounding area as having high cycling potential<sup>95</sup>.

The number of walking trips has also been in decline in England, although the overall distance walked has changed little, indicating that people are making fewer, but longer, walking journeys.<sup>96</sup> In London, walking is an important mode of travel, with 21% of journeys made on foot.<sup>97</sup> 32.4% of trips within Waltham Forest are made on foot<sup>98</sup>. This is slightly higher than the Outer London average of 29%, but less than the neighbouring Olympic boroughs of Hackney (36.8%) and Newham (37.8%). While there is no London-wide target, TfL seeks to increase London's walk mode share to 24%, and Waltham Forest council's target is to achieve 34% walk mode share by 2013 and 37% by 2025. These targets reflect current and proposed schemes to improve walking routes, the urban realm, smarter travel initiatives and Olympic legacy schemes that promote active lifestyles.

The Council recognises that making provision for cycling and walking more convenient and pleasant can help to encourage a shift from the private car and contribute to improving health. Cycle infrastructure is being improved as part of the Council's 2012 "street scene" improvements programme (a public realm programme supported by Olympic Delivery Authority funding). This includes new segregated cycle (and pedestrian) provision at Ruckholt Bridge and along Whipps Cross Road (to Bush Road) which will help to make the Olympic Park and Stratford city centre more accessible by bicycle and on foot, increasing access to jobs, services, shopping and leisure. Public realm improvements in Leytonstone High Road and Wood Street are enhancing the environment for pedestrians, for example through high quality pavements, tree planting and improved lighting. The Council promotes school and workplace travel planning<sup>99</sup>, is installing cycle parking in new urban schemes and requires developers to provide cycle parking facilities in all new developments. In addition, it is prioritising measures to address cyclist and pedestrian accident hotspots (such as Lea Bridge Road and Forest Road) and exploring the introduction 20mph zones in all residential roads in the borough.

There are 23 miles of cycle lanes on main roads and 20 miles of quiet cycle routes along residential roads and through green spaces. However, as in other parts of London, accommodating cycling alongside traffic and car parking has compromised the quality of some infrastructure (for example most on-road cycle lanes are advisory and blocked by parked cars in the evenings and at weekends). Some cycle lanes are narrow and - at

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<http://www.tfl.gov.uk/assets/downloads/roadusers/Cycling/analysis-of-cycling-potential.pdf.pdf> [Retrieved 30 August, 2011]

<sup>95</sup> Transport for London. Sub regional transport plan: North (2011). <http://boroughs.tfl.gov.uk/documents/general/north-london-sub-regional-transport-plan.pdf> [Retrieved 18 August, 2011]

<sup>96</sup> Department for Transport/Department of Health. Active Travel Strategy (2010) <http://www2.dft.gov.uk/pgr/sustainable/cycling/activetravelstrategy/pdf/activetravelstrategy.pdf> [retrieved 22 August, 2011]

<sup>97</sup> Transport for London. Travel in London 3 (2011), TfL, London.

<sup>98</sup> Transport for London. Travel in London 3

<sup>99</sup> A travel plan is a strategy and package of measures to reduce drive alone car use

between 1.2-1.5m wide - do not comply with best practice guidelines.<sup>100</sup> However, width increases to 2m (recommended by the DfT and TfL) in parts of High Road Leytonstone.

Traffic speeds can discourage cycling and walking among both adults and children. Specific data on speeding is not available for Waltham Forest. However, across Great Britain, 46% of cars exceeded the speed limit on 30 mph roads in 2010. On 40 mph roads, 23% of cars exceed the speed limit.<sup>101</sup>

Waltham Forest is in the lowest quartile for child Killed and Seriously Injured (KSIs), and the third quartile for cyclist and pedestrian KSIs respectively.<sup>102</sup> Accidents involving cyclists and pedestrians respectively accounted for 7% and 17% of all accidents in the borough for the baseline year of 2006-2008. The Council aims to reduce these by at least 33% by 2020.

Waltham Forest has some excellent off-road walking and cycling routes (for example along the Lee Valley Park). These are being enhanced to encourage sustainable access to the Olympic Park and provide attractive traffic-free routes south to the River Thames and north to Enfield, Hertford and Ware.

They are a valuable resource, enabling novice cyclists to try cycling and build confidence, providing opportunities for families to walk and cycle together without fear of traffic, and short cuts to workplaces in Enfield's industrial estates.

45% of households in Waltham Forest do not own a car;<sup>103</sup> interventions and policies to increase active travel and widen travel choices have the potential to directly benefit a significant proportion of the population. In addition, fewer cars and more pedestrians and cyclists can make the roads safer for all users.<sup>104</sup> The currently relatively low car ownership is an opportunity to influence travel habits in favour of walking and cycling, supported by public transport and car clubs.

### **What are the effective interventions?**

Combinations of interventions (land use and transport policies, street/road design and infrastructure) which facilitate cycling and walking and actively restrain car use are most effective at increasing active travel. In

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<sup>100</sup> Department of Transport. Design Manual for Roads and Bridges Volume 5 Section 2 (Feb 2005)

<http://www.dft.gov.uk/ha/standards/dmrb/vol5/section2/ta9105.pdf> [Retrieved 29 August, 2011]

<sup>101</sup> DfT. Vehicle Speeds Statistics: Free Flow Vehicle Speeds in Great Britain 2010. (June 2011).

<http://assets.dft.gov.uk/statistics/releases/free-flow-vehicle-speeds-2010/free-flow-vehicle-speeds-2010.pdf> [Retrieved 29 August, 2011]

<sup>102</sup> TfL. Benchmarking data for London boroughs (Oct 2010).

[http://boroughs.tfl.gov.uk/documents/borough\\_information/spending\\_plans/lip-benchmarking-tool-v1.3.xls](http://boroughs.tfl.gov.uk/documents/borough_information/spending_plans/lip-benchmarking-tool-v1.3.xls) [Retrieved 31 August, 2011]

<sup>103</sup> Transport for London. Developing a Sub-regional Transport Plan: Interim report on challenges & opportunities (North London). February 2010. <http://boroughs.tfl.gov.uk/documents/general/north-london-challenges-opportunities-v2.pdf> p26 [Retrieved 18 August, 2011]

<sup>104</sup> Department of Health. 'Active Travel Strategy' (2010)

<http://www2.dft.gov.uk/pgr/sustainable/cycling/activetravelstrategy/pdf/activetravelstrategy.pdf>

[retrieved on 22 August, 2011]

2008, the National Institute for Health and Clinical Excellence (NICE) published the first national, evidence based recommendations on how to improve the physical environment to encourage physical activity.<sup>105</sup> It recommends that local authorities:

- Ensure planning applications for new developments prioritize the need for people (including those whose mobility is impaired) to be physically active as a routine part of their daily life.
- Ensure pedestrians, cyclists and users of other modes of transport that involve physical activity are given the highest priority when developing or maintaining streets and roads (including reallocating road space to walking and cycling, and reducing road capacity for traffic).
- Plan and provide a comprehensive network of routes for walking, cycling and using other modes of transport involving physical activity.
- Ensure public open spaces and public paths can be reached on foot, by bicycle and using other modes of transport involving physical activity.

DfT and CHIT guidance for urban planners stresses the need to design high streets, residential and non-trunk roads as “social spaces”, putting pedestrians and cyclists firmly at the top of the road user hierarchy.<sup>106</sup> <sup>107</sup>

Studies of walking and cycling in the UK and abroad recommend a mix of incentives to travel actively and measures which render car use less attractive for local trips:

*..... Whilst getting in a car is the quickest and easiest option for most people, only those most dedicated to walking and cycling will do so regularly. Thus policies to promote walking and cycling are likely to have limited impact unless they are linked to a broader set of transport policies that actively restrict car use and elevate the convenience and status of walking and cycling within towns and cities.*<sup>108</sup>

*... key to the success of cycling policies in the Netherlands, Denmark and Germany is the coordinated implementation of [a] multi-faceted, mutually reinforcing set of policies ..... these countries implement far more of the pro-bike measures [and] they greatly reinforce their overall impact with highly restrictive policies that make car use less convenient as well as more expensive. It is precisely that double-barrelled combination of ‘carrot’ and ‘stick’ policies that make cycling so irresistible.*<sup>109</sup>

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<sup>105</sup> on creating built or natural environments that encourage and support physical activity

<sup>106</sup> Department for Transport. ‘Manual for Streets’ (2007); <http://www2.dft.gov.uk/pgr/sustainable/manforstreets/pdfmanforstreets.pdf> [retrieved on 22 August, 2011]

<sup>107</sup> Chartered Institution of Highways and Transportation (CIHT). ‘Manual for Streets 2: Wider application of the principles’ (2010) (p 7) CHIT, London

<sup>108</sup> Jones T, Pooley C, Chisholm A, Horton D, Scheldeman G. ‘Understanding walking and cycling: interim findings from a multi-method approach to investigate household decision making in relation to short journeys in urban areas’ (2010). [http://www.lec.lancs.ac.uk/research/society\\_and\\_environment/cycling/WCTR\\_TJ\\_July\\_2010.pdf](http://www.lec.lancs.ac.uk/research/society_and_environment/cycling/WCTR_TJ_July_2010.pdf)

<sup>109</sup> Pucher, John and Buehler, Ralph (2008) ‘Making Cycling Irresistible: Lessons from The Netherlands, Denmark and Germany’, *Transport Reviews*, 28:4, 495 — 528 <http://policy.rutgers.edu/faculty/pucher/irresistible.pdf>

A large body of evidence, including recent TfL studies<sup>110,111</sup> shows that fear of traffic is the most significant and widespread barrier to cycling and walking, so speed and volume of traffic must be addressed if active travel is to be increased. TfL advises that to maintain cycling by existing frequent cyclists and to encourage infrequent and non-cyclists to take up cycling, “practical measures to increase safety and improve the provision of facilities will be the most effective”.<sup>112</sup> These findings are echoed in council staff surveys and surveys of employees at other workplaces in Waltham Forest. Further, TfL identifies ease of use of car in Outer London as an obstacle to take up of active modes.<sup>113</sup>

Researchers undertaking an ongoing academic study of four English cities<sup>114</sup> conclude that the biggest steps that could be taken to encourage more people to cycle would be to create more segregated cycle lanes along main roads, restrict traffic speed and the availability of parking in urban centres, and introduce strict liability legislation to protect more vulnerable road users.

The importance of supportive infrastructure for walking and cycling has been emphasised:

*...for walking [this] includes removal of barriers and parked vehicles on pavements, better maintenance... For most potential cyclists the key requirement seems to be the reduction of road danger when cycling through a combination of slower motor traffic speed in city centres and the provision of dedicated cycle routes that are segregated from traffic where necessary (e.g. along faster and busier arterial routes).....*<sup>115</sup>

Smarter travel<sup>116</sup> interventions, such as the UK Sustainable Travel Demonstration Towns, have also been successful. Supported by the Department for Transport, these towns implemented a programme of measures (from 2004 to 2009) to increase the use of sustainable modes and reduce drive alone car use, involving a

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<sup>110</sup> Transport for London. ‘Analysis of Cycling Potential Policy Analysis: Research Report’ (Dec 2010)

<http://www.tfl.gov.uk/assets/downloads/roadusers/Cycling/analysis-of-cycling-potential.pdf>

[Retrieved 30 August, 2011]

<sup>111</sup> Transport for London. Delivering the benefits of cycling in Outer London (Feb 2010)

<http://www.tfl.gov.uk/assets/downloads/businessandpartners/benefits-of-cycling-report.pdf>

[Retrieved 31 August, 2011]

<sup>112</sup> Transport for London. ‘Analysis of Cycling Potential Policy Analysis: Research Report’ (Dec 2010)

<http://www.tfl.gov.uk/assets/downloads/roadusers/Cycling/analysis-of-cycling-potential.pdf>

[Retrieved 30 August, 2011]

<sup>113</sup> Transport for London. Op cit.

<sup>114</sup> Understanding Walking and Cycling: research collaboration between Lancaster University, the University of Leeds and Oxford Brookes University:

<sup>115</sup> Jones et al, op cit p 22

<sup>116</sup>. Smarter travel interventions seek to provide better information, increase opportunities for people to reduce car use, and make alternatives more attractive. They include

- workplace, school and personalised travel plans;
- travel awareness campaigns, and public transport information and marketing;
- car clubs and car sharing schemes;
- teleworking, teleconferencing and home shopping

combination of both 'hard' (infrastructure etc) and 'smarter choices' measures. Taken together the three towns have achieved the following.<sup>117</sup>

- Car driver trips per resident fell by an average of 9%.
- Cycle trips per resident increased by 26–30%.
- Walking trips per resident increased by 10–13%.<sup>118</sup>

One of the most important overall findings was that on average nearly half of all car trips within the towns could be replaced by cycling, walking and public transport.

DfT and independent evaluations concluded that the programme was very successful in reducing travel by car, and increasing the use of other modes. It also suggests that the programme offered very high value for money. Implied benefit-cost ratio (after including environmental, consumer benefit, and health impacts) is very high, probably of the order of 20 or higher<sup>119</sup>.

### **What is being done locally to support active travel?**

Through its land use planning policy and practice, the Council is seeking to increase the walkability and cycleability of the built environment in and around all new developments and to reduce the dominance of the private car. The Council is currently updating development policies and guidance for the period until 2026, and writing its Local Implementation Plan (LIP) which sets out transport investment priorities for the next three years. Both initiatives seek to increase sustainable active travel by prioritising cycling, walking and public transport over private vehicle use.

For example, revised council planning policy promotes new development close to public transport facilities, requires developers to ensure access by active modes, and has minimum cycle parking and maximum car parking standards. Where possible, the Council also seeking to retrofit facilities (eg through public realm improvements and targeted grants for workplace cycle parking). In addition, the Council's transport planning team regularly consults with TfL, local residents, businesses and other stakeholders (such as the WF Cycling Campaign) to inform decision making on issues affecting pedestrians and cyclists, and to raise public awareness of active travel options, via events such as the Tour de Waltham Forest, Car Free Day and the Green Fayre.

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<sup>117</sup> Department of Health. 'Active Travel Strategy' (2010)

<http://www2.dft.gov.uk/pgr/sustainable/cycling/activetravelstrategy/pdf/activetravelstrategy.pdf>

[retrieved on 22 August, 2011]

<sup>118</sup> These results should be seen in the context of a national decline in bus use, cycling and walking during the same period.

<sup>119</sup> Department of Health. 'Active Travel Strategy' (2010)

<http://www2.dft.gov.uk/pgr/sustainable/cycling/activetravelstrategy/pdf/activetravelstrategy.pdf>

[retrieved on 22 August, 2011] p22

Waltham Forest Council has long been committed to providing quality cycling infrastructure. The Council has built three large cycle sheds with smartcard access at key rail and underground stations. It is constantly adding to cycle parking facilities across the borough – installing at least 250 stands (500 spaces) over the next three years.

The Council funds cycle training in schools (Year 6), free one to one adult cycle training for residents and those who work or study in the borough. It also runs a bicycle recycling centre which acts as a hub for local cyclists, and sells refurbished bicycles at low cost and hosts cycle maintenance classes.

With Sustrans and TfL, the Council is improving greenways<sup>120</sup> through the borough to the main Olympic Park. Other public realm improvements under way for the Olympic Games are expected to catalyse a significant increase in walking as a main mode of travel in the short term. It is expected that there will be some shift to cycling for slightly longer trips as facilities improve and cycling is normalized across London.

Other Council initiatives supporting active travel include:

- Introducing improved crossing points, wider footways and speed tables to improve the environment for pedestrians.
- Improved signposting for pedestrians and cyclists.
- Public events, guided rides and walks (e.g. Tour de Waltham Forest).
- Improving the permeability of residential roads by allowing contra-flow cycling on one-way streets, wherever feasible.
- Plans to enhance cycle parking facilities at stations such as Blackhorse Road and Wood Street.
- Work with TfL, Sustrans and other agencies to ensure easy access to the Cycle Superhighways (CSH) in neighbouring boroughs and the London Cycle Network.
- Work with TfL and neighbouring boroughs to extend the cycle hire scheme beyond the Olympic Park to Waltham Forest.
- Provision of cycle parking, implementation of workplace travel plans and engagement with local businesses and the NHS to increase active and sustainable commuting within the borough.

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<sup>120</sup> A greenway is a publicly accessible linear space linking parks and other areas (eg through an urban area). They are typically vehicle-free

- As the borough's largest employer, the Council is also taking measures to increase cycling and walking among its own workforce, eg through the promotion of pool bikes, reducing business miles, a programme of healthy walks for staff, and car parking charges for senior staff.

### **What evidence is there that we are making a difference?**

The Council holds a large cycling event annually (Tour de Waltham Forest), and there has seen a gradual increase in participants in the four years that it has been running, with over 200 in 2011. The Council's Sport team run a successful programme of health walks, and numbers of participants, and requests for walk leader training, have increased significantly in recent years. As the borough's largest employer, the Council has conducted staff surveys in 2007 and 2010 to assess how its employees travel to work, and how active modes might be encouraged. Cycling has increased from 3% to 9% over this three-year period, and walking from 8% to 9%. School and workplace travel plans in Waltham Forest have also shown increases in walking and cycling over time.

### **What is the perspective of the public on support available to them for active travel?**

The Council has a Transport Liaison Group, which includes a wide range of local stakeholders, including the Waltham Forest Cycling Campaign (WFCC). The WFCC has regular meetings with the Council's portfolio holder for Transport and the Environment and with council officers. In 2009 WFCC published a project report, *Movers and Shakers*, in which it reported on the results of a survey of local cyclists, assessed conditions for cycling in the borough and made proposals for improvement.<sup>121</sup>

Discussions with the public at sustainable transport events, in schools and workplaces in the borough confirm research that, as in the rest of England, that the main barrier to cycling in Waltham Forest is fear of traffic. Cyclists and pedestrians experience higher rates of injury than motorists.<sup>122</sup> However, there is increasing evidence of a "safety in numbers" effect: that increasing the number of cyclists reduces the risk of injury (Jacobsen, 2003<sup>123 124</sup>).

On balance, the health benefits of cycling far outweigh the safety risks involved. Research suggests that safety risks are outweighed by the health benefits by a factor of around twenty to one. There is one cyclist death per 33 m km of cycling, while being sedentary presents a much greater risk. Over 50,000 people die in the UK each year as a result of coronary heart disease related to insufficient physical activity, compared to around 100 cyclists killed on the road annually.<sup>125</sup>

<sup>121</sup> WFCC *Movers and Shakers* (2009) [http://www.wfcycling.org.uk/documents/movers\\_shakers\\_web.pdf](http://www.wfcycling.org.uk/documents/movers_shakers_web.pdf) [Retrieved 29 August, 2011]

<sup>122</sup> National Audit Office: *Improving road safety for pedestrians and cyclists in Great Britain* (2009)

<sup>123</sup> Jacobsen PL. Safety in numbers: more walkers and bicyclists, safer walking and bicycling

*Injury Prevention* 2003 9 (3), p. 205 <http://www.ncbi.nlm.nih.gov/pubmed/12966006> [Retrieved 31 August, 2011]

<sup>124</sup> Robinson DL. Safety in numbers in Australia: more walkers and bicyclists, safer walking and bicycling.

*Health Promotion Journal of Australia*. 2005 Apr;16 (1):47-51. <http://www.ncbi.nlm.nih.gov/pubmed/16389930> [Retrieved 31 August, 2011]

<sup>125</sup> Department for Transport/Department of Health. *Active Travel Strategy* (2010)

<http://www2.dft.gov.uk/pgr/sustainable/cycling/activetravelstrategy/pdf/activetravelstrategy.pdf>

Nationally, studies have shown that there is broad public support for measures to promote active travel. The vast majority of adults agree that everyone should be encouraged to walk to help their health (97%), help the environment (94%) and to ease congestion (92%)<sup>126</sup>.

More needs to be done to demonstrate the economic benefits of walking and cycling to local businesses, which often overestimate the importance of car borne trade and actively oppose measures that improve the local environment for active travellers. In fact, DfT research shows that pedestrians and cyclists can spend at least as much in town centres as those travelling by car (and often more as they tend to visit more frequently), so facilitating access by pedestrians and cyclists is likely to encourage local growth<sup>127, 128</sup>.

### **What more do we need to know?**

There is a large and growing body of evidence about what works in promoting active travel. However, further quantitative and qualitative data on barriers to walking and cycling in Waltham Forest is required. This could include:

- Asking local residents (for example via questionnaires and on street interviews) what would encourage them to walk and cycle.
- Consulting residents about specific local barriers and perceived safety hotspots.
- Cycle counts.
- Walking audits.

The Council plan to develop a walking strategy and revise its existing cycling strategy and this is likely to reveal further local knowledge gaps.

### **What are the priorities for improvement over the next 5 years?**

- The Council recognizes that it needs to increase its efforts to tackle barriers to cycling and walking in the borough. TfL has summarised key barriers and measures to increase cycling in Outer London<sup>129, 130</sup>. Many, but not all, are also relevant to improving the environment for walking. These are listed in Figure 1 below and will be key areas for action by the Council over the next five years.

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[retrieved 22 August, 2011]

<sup>126</sup> ONS Omnibus Survey, 2002 cited in Department of Health. 'Active Travel Strategy' (2010)

<http://www2.dft.gov.uk/pgr/sustainable/cycling/activetravelstrategy/pdf/activetravelstrategy.pdf>

[retrieved on 22 August, 2011], p44

<sup>127</sup> DfT. 'Local Sustainable Transport Fund: Frequently Asked Questions' <http://assets.dft.gov.uk/publications/adobepdf-165237/1stffaq.pdf> [Retrieved 31 August, 2011]

<sup>128</sup> DfT. Creating Growth, Cutting Carbon: Making Sustainable Local Transport Happen (Jan 2011)

<http://www2.dft.gov.uk/pgr/regional/sustainabletransport/pdf/whitepaper.pdf> [Retrieved 31 August, 2011]

<sup>129</sup> Transport for London. Delivering the benefits of cycling in Outer London (Feb 2010)

<http://www.tfl.gov.uk/assets/downloads/businessandpartners/benefits-of-cycling-report.pdf> [Retrieved 31 August, 2011]

**Figure 1: Transport for London: Barriers to Cycling in Outer London**

Attitudinal barriers for individuals	Physical barriers	Barriers to delivery
Fear of traffic and feelings of vulnerability, particularly when undertaking unfamiliar journeys	High traffic speeds	Lack of political support – especially where cycling levels are low – not perceived as a mainstream solution
Convenience of the car	Severance, eg major roads and lack of permeability	Perceived lack of funding
Individual not sure if cycling is for them	Lack of cycle parking/cycle facilities at key locations	Lack of adequately trained and experienced staff within the borough
Cycling perceived as incompatible with busy, complicated lifestyles		

Attitudinal barriers	Physical barriers	Barriers to local delivery	
Smarter travel	Innovative infrastructure	Partnership working and mainstreaming cycling	Political commitment
Personalised travel planning	Improved permeability	Integrating cycling across all LIP categories	Boroughs leading the way through travel planning
Workplace and school travel planning	Crossing points	Use support available from other organisations	Borough leaders/members as cycle champions
Led rides	Network of quiet routes	Mainstreaming cycling across borough council and partners	Improved evaluation and monitoring of cycling initiatives
Awareness campaigns, local cycle events	Improved wayfinding	Partnership working with PCTs, workplaces, schools, local cycling groups and police	
Targeted cycle training	Traffic restraint and speed reduction measures		
Changing perceptions of cycling with non-cyclists	Provision of cycle facilities		
	Provision of secure cycle parking		

Source: Delivering the benefits of cycling in outer London (TfL, Feb 2010)

- In the short to medium term, the Council will seek to protect, improve and enhance its cycle network through the implementation of the Greenways schemes and through improvements to existing routes. It will seek greater co-operation with organisations such as Sustrans and the London Cycle Campaign to identify new routes (eg from Banbury Reservoir running through Walthamstow Wetlands to Forest Road) and improve the cycleability of the wider road network.
- As major generators of traffic and its negative impacts, the Council and other large public and private sector employers in the borough are encouraged to develop business travel policies which promote active, green travel and set the standard for other organisations within the borough. These are also cost saving measures. Local authority staff and NHS professionals can act as influential role models for their patients and the wider community. NHS Waltham Forest and Whipps Cross both have workplace travel plans and are promoting active travel to their staff and other stakeholders via participation in the

<sup>130</sup> Transport for London. 'Sub regional transport plan: North' (2011). <http://boroughs.tfl.gov.uk/documents/general/north-london-sub-regional-transport-plan.pdf> [Retrieved 18 August, 2011]

- Develop walking strategy and update cycling strategy.
- Write sustainable transport supplementary planning document with detailed guidance for developers, to ensure that opportunities for active travel are built into future development.
- More segregated cycle lanes on busy roads such as Whipps Cross.
- Increasing awareness of the benefits of cycling and walking to the local economy, and in strengthening communities.
- As part of the implementation of the borough's LIP, we will be monitoring progress against targets and indicators on an on-going basis. Where targets are not on track, we will analyse causes and evaluate options for improving our performance.

## Residents' Views on the London Borough of Waltham Forest

### Overview

In 2011 Westco Trading ran a public opinion survey for the London Borough of Waltham Forest. The survey was based on 502 telephone interviews with Waltham Forest residents aged 16+ and the data was weighted by the gender, age, work status and ethnic profile of the borough. The following themes were investigated by the research:

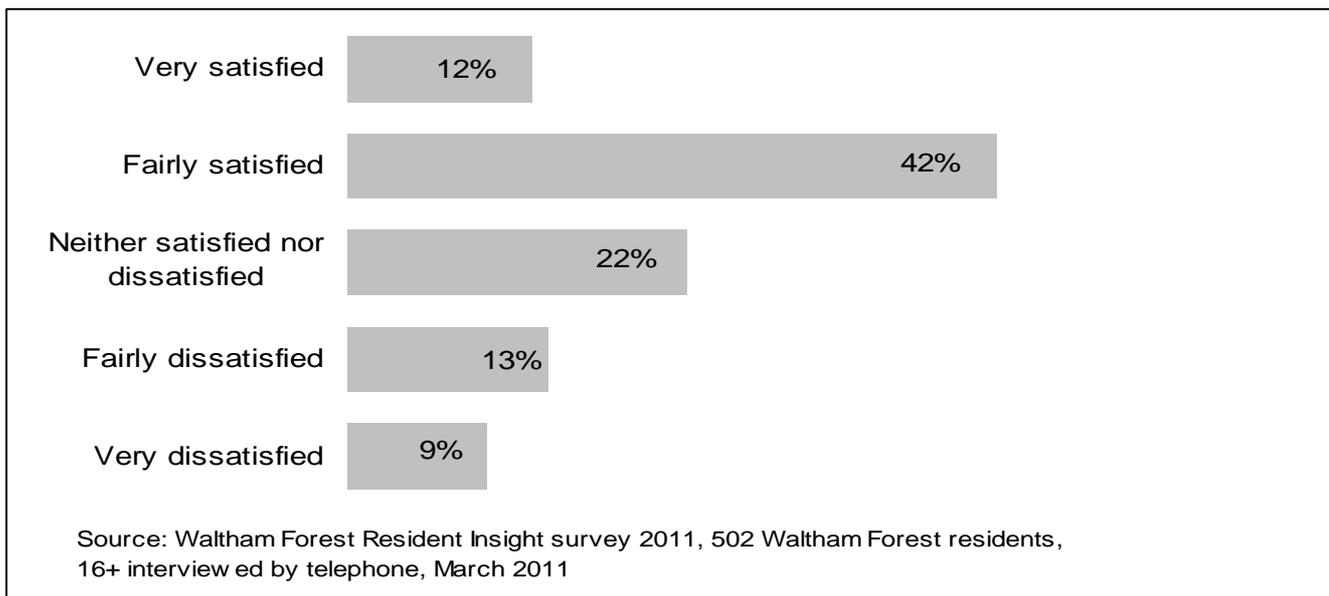
- Council reputation
- Looking after the local area and people
- Keeping residents informed
- Crime and anti-social behaviour
- Expectations of council services
- Customer care
- The local area
- The Olympics

### Council reputation

54% of residents were satisfied (12% very satisfied, 42% fairly satisfied) with the way the council is running the borough whilst 24% of residents are dissatisfied (9% very dissatisfied, 13% fairly dissatisfied). A further 22% are neither satisfied nor dissatisfied.

Levels of net satisfaction (fairly or very satisfied) vary notably by resident characteristics. Amongst the more satisfied residents are those aged 16-29 and those who either rent privately or from the council.

**Figure 1 – How satisfied or dissatisfied are you with the way Waltham Forest Council is running the borough?**



### Expectations of council services

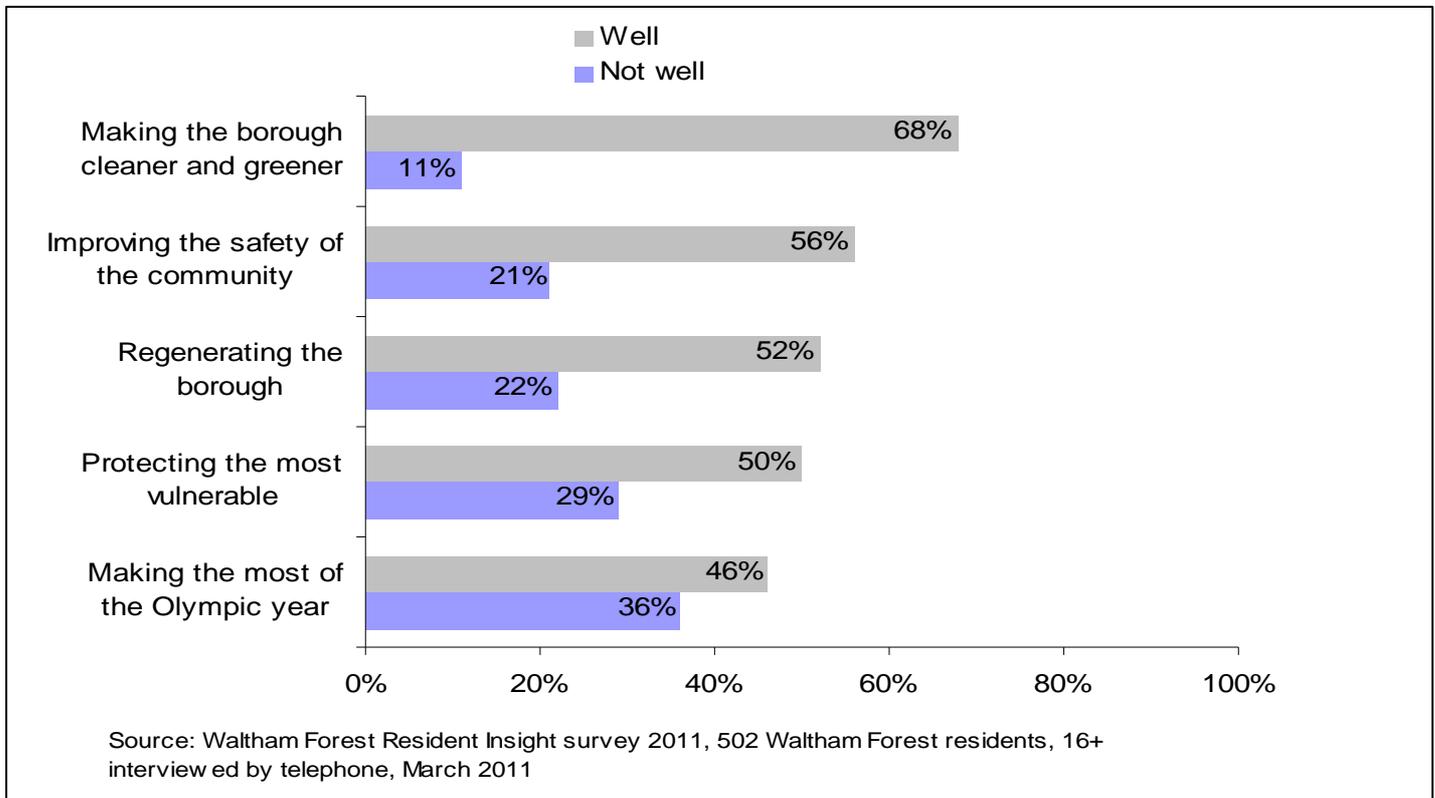
When taking into account current levels of council tax and government spending almost 9 in 10 residents (87%) said they expected council services to be of good quality all or most of the time.

When then asked if they felt the council performed well most or all of the time two in five residents (41%) agreed. There is therefore a large gap between expectations and the level of service residents feel they get.

## Looking after the local area and people

Residents were asked how well they felt the council achieved a number of initiatives ranging from making the borough cleaner and greener to making the most of the Olympic year. Figure 2 illustrates the results and shows that over two thirds of residents (68%) feel that the council is making the borough cleaner and greener. By contrast just under half (46%) feel the council is making the most of the Olympic year.

Figure 2 – How well, if at all, does the Council achieve the following?



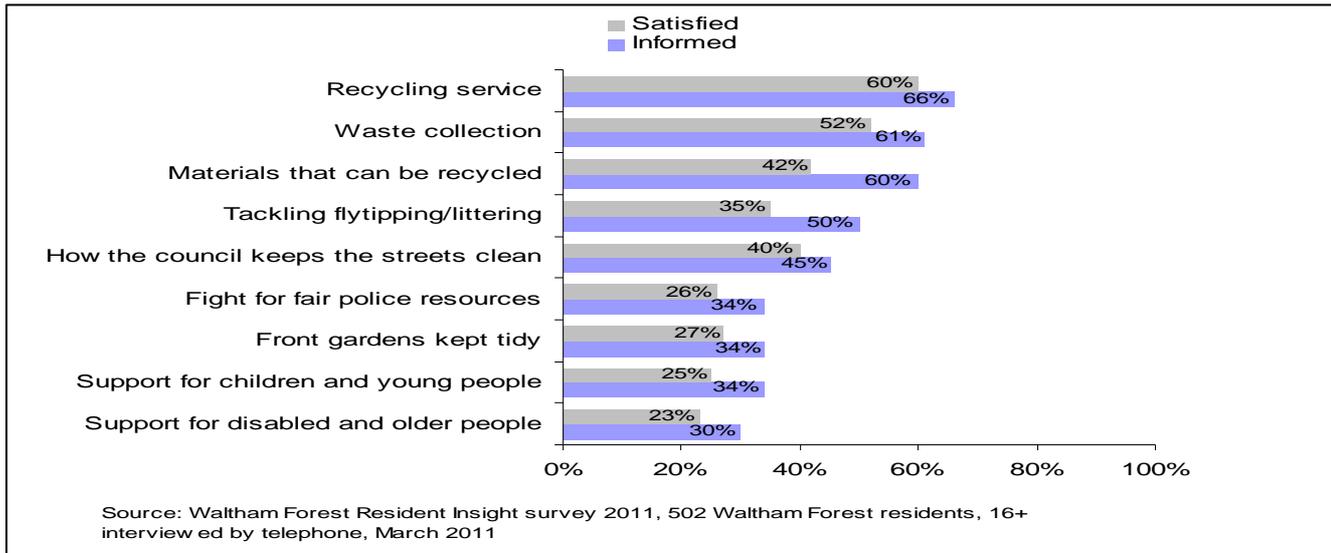
## Customer Care

A third of those surveyed had contacted the council over the last two to three years. Of these, two thirds said that the council had given them the service or information they wanted at the point of first contact. 3 in 5 (59%) were satisfied with the way the council handled their enquiry though fewer (45%) were satisfied with the outcome of their enquiry.

## Keeping residents informed

Overall, half of residents (51%) feel well informed about the services and benefits the council provides. There is also a strong relationship between how informed residents are about different council services and their levels of satisfaction with those services as shown in Figure 3 below. Whilst two-thirds (66%) of residents felt informed about the recycling service, 6 out of every 10 (60%) also felt satisfied with that service. A third (30%) of residents felt informed about support for disabled and older people and less than a quarter (23%) felt satisfied with that support.

**Figure 3 – Which, if any, of the following are you kept well informed about? And thinking of the same list which, if any, are you satisfied with?**

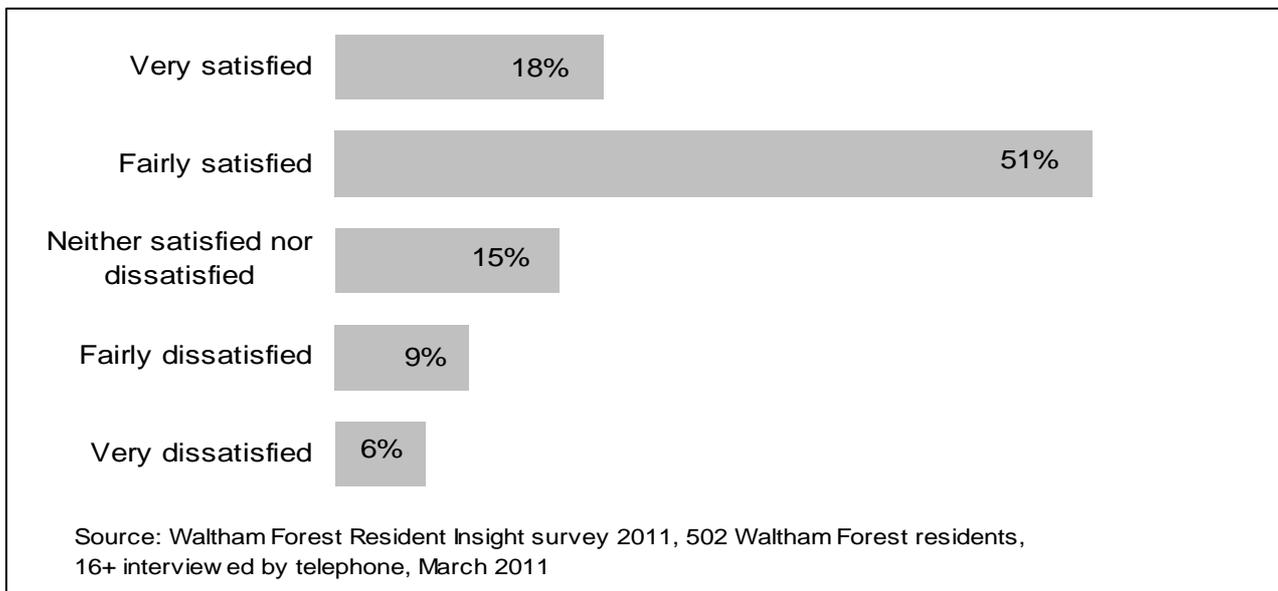


**The Local Area**

Figure 4 shows that most residents are satisfied living in Waltham Forest. The overall net satisfaction (the percentage of those satisfied minus the percentage of those dissatisfied) is 54%.

However, levels of satisfaction vary greatly by group. Amongst those most satisfied are men, older residents (aged 65 and over), those not working full-time and those living in the north of the borough rather than the centre or south of the borough.

**Figure 4 – How satisfied or dissatisfied are you with this area as a place to live?**

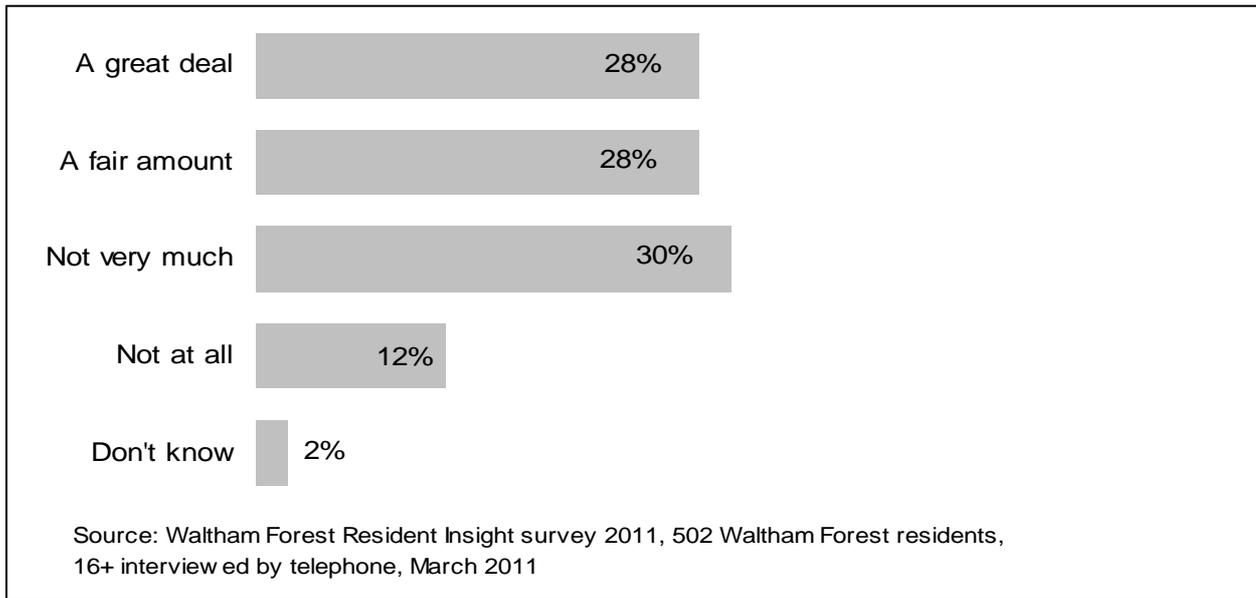


**Crime and Anti-Social Behaviour**

The fear of crime is a notable concern of residents in Waltham Forest with around 3 in 5 (56%) saying that it affects their quality of life. Women, those who have a disability and those not working full-time are most likely to feel affected by fear of crime. Those living in the North of the borough are more concerned about home

burglary than those in the centre or south whilst those in the centre are more concerned about drug related crime.

**Figure 5 – How much do you feel that your quality of life is affected by fear of crime?**



### **The Olympics**

Almost 7 in 10 (68%) of residents said they would like to have a ticket to see the Olympic and Paralympic Games, though only a quarter (24%) think it will be easy for them to get a ticket.

Just under half of the residents (48%) felt the Olympics would benefit their local area although a third (30%) disagreed with this.

In terms of priorities for improvement as a result of the Olympics they were identified as:

- Opportunities for young people (89%).
- Opportunities and support for businesses (85%).
- Quality of streets and the local environment/surroundings (83%).
- Community spirit or relations (80%).

# Section 4

## lifestyle risk factors



- Alcohol
- Drugs
- Tobacco use
- Obesity

## Lifestyle Risk Factor

Dahlgren and Whitehead's influences on health model proposes that outcomes for health are influenced by a combination of genetic predisposition interacting with environmental influences and individual lifestyle behaviours, which is then mediated by health care services to restore health where required. The effect of lifestyle behaviours on health outcomes can be substantial; for example, men who smoke and are obese lose 13.7 years of life expectancy, while females lose 13.3 years.<sup>131</sup> (See Table 1)

**Table 1: Years Lost Due to Unhealthy Behaviours**

(life expectancy lost in years compared to normal weight non-smoker, 40 years old)

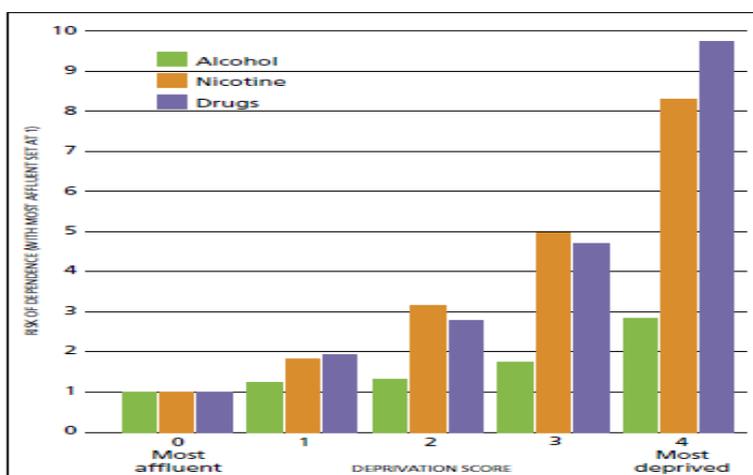
Risk Factor	Male	Female
Normal weight, non-smoking	-	-
Overweight, non-smoking	3.1	3.3
Obese, non-smoking	6.7	7.2
Obese, smoking	13.7	13.3

Lifestyle behaviours are laid down across the life course, starting during pregnancy. Alcohol, smoking, diet and exercise are the main lifestyle behaviour risk factors that influence development of the biggest killers—cardiovascular disease, cancer and respiratory disease—in Waltham Forest.

Data from the World Health Organisation (WHO) atlas of heart disease and stroke estimates that tobacco use, alcohol, obesity, low fruit and vegetable intake and physical inactivity account for 36% of the burden of disease across the globe.

Figure 1 below demonstrates the relationship between cigarette smoking, alcohol dependence and substance misuse with social and economic disadvantage.<sup>132</sup>

**Figure 1**



<sup>131</sup> Goals for the Common Good: Exploring the Impact of Education Goals for the Common Good: Exploring the Impact of Education 2009. A joint publication of the American Human Development Project and United Way.

<sup>132</sup> Wilkinson, R and Marmot M. 2003. Social Determinants of Health the Solid Facts. Second edition. WHO

## **Alcohol**

### **Executive Summary**

- Safe, Sensible, Social. The next steps in the National Alcohol Strategy (2007) sets out the agenda on alcohol misuse.
- Excessive drinking has a huge economic burden on society and it is estimated that the financial burden of alcohol misuse was around £2.7 billion in 2006/07 to the NHS alone
- The World Health Organisation (WHO) divides alcohol misuse disorders into three categories including Hazardous drinking; Harmful drinking; Alcohol dependence
- Waltham Forest QIPP plan identifies alcohol as one of the priority areas under the Staying Healthy prevention agenda. It sets out to reduce alcohol harm.
- Rate of alcohol related hospital admissions in 2009/10 was higher than London and England averages. It is predicted to increase over the coming years.
- Alcohol specific hospital admissions for under 18s in Waltham Forest is higher than the London average
- The wards with the most alcohol related incidents for under 18s between April 2008 and August 2009 included Chapel End, Hale End and Highams Park
- NICE recommends screening, brief advice and extended brief intervention for people who may be at risk of misusing alcohol
- Commissioners have made significant progress for implementing last year's Alcohol JSNA recommendations.

### **Recommendations**

- Develop alcohol health needs assessment and the recommendations will inform commissioners on alcohol services redesign.
- Refresh the current Waltham Forest Alcohol Strategy and set up an implementation group to drive the strategy
- Review the current Direct Enhanced Service (DES) for identification and brief advice in primary care. Consideration should be given to extending the DES to cover all at-risk groups, possibly via a Local Enhanced Service (LES).

- Training frontline staff (GP practices, Housing, Job Centre Plus, Education, Probation service, Youth centres and voluntary sector agencies) to identify and refer people misusing alcohol to appropriate services.
- Population level awareness raising and social marketing targeted at groups at risk of hazardous or harmful drinking. This includes health promotion in pub settings.
- Examine the potential to use local authority powers to limit proliferation of alcohol outlets. For example, local licensing departments can take into account the links between the availability of alcohol and alcohol related harm when considering a licence application. This includes, for example, the number of alcohol outlets in a given area and times when it is on sale and the potential links to local crime and disorder and alcohol-related illnesses and deaths.
- Ensure that alcohol treatment and management services are reviewed and follow NICE guidance, particularly given that the NHS Health Checks and any additional work in accident and emergency and the wider sector may increase referrals
- Improve collection and information sharing across the partnership which is key to monitoring impact and effectiveness of interventions and to identify groups for targeted interventions.

## What is Alcohol Misuse?

The World Health Organisation (WHO) divides alcohol misuse disorders into three categories<sup>133</sup>:

**Hazardous drinking (also referred to as increased risk drinking):** individuals drinking above recognised “sensible” levels but not yet experiencing harm. “Hazardous” limits are defined as the consumption of 22-50 units per week for men, and 15-35 units for women.

**Harmful drinking (also referred to as higher risk drinking):** individuals drinking above recommended levels for sensible drinking and experiencing physical and/or mental harm. The weekly consumption associated with harmful drinking is of more than 50 units per week for men and of more than 35 units for women. Individuals categorised as Harmful drinkers have not yet developed alcohol dependence.

**Alcohol dependence:** individuals drinking above sensible levels, experiencing an increased drive to use alcohol and difficulty controlling its use. Dependent drinking can be sub-divided into two categories; “moderate” dependence and severe dependence, traditionally known as “chronic alcoholism”. Dependence can be

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<sup>133</sup> Adapted from County Durham and Darlington Alcohol Health Need Assessment 2011:

[http://www.darlington.gov.uk/dar\\_public/documents/Community%20Services/Community%20Safety%20Partnership/safercommunities/Alcohol%20Health%20Needs%20Assessment%20Final%20WB.pdf](http://www.darlington.gov.uk/dar_public/documents/Community%20Services/Community%20Safety%20Partnership/safercommunities/Alcohol%20Health%20Needs%20Assessment%20Final%20WB.pdf)

measured by an Alcohol Use Disorder Identification Test (AUDIT) and a Severity of Alcohol Dependence Questionnaire (SAD-Q).

The term binge drinking used also to describe consumption of at least twice the daily recommended amount of alcohol in a single drinking session (8 or more units for men and 6 or more units for women).

### **Local Picture - Adults**

Safe, Sensible, Social, The next steps in the National Alcohol Strategy (2007)<sup>134</sup>, sets out the agenda on alcohol misuse. Drinking beyond the recommended daily allowance and particularly binge drinking can put people at an increased risk of developing a number of diseases including cancer, liver disease, mental health problems and stroke. Consequences of excessive drinking have a huge economic burden on society and it is estimated that the financial burden of alcohol misuse was around £2.7 billion in 2006/07 to the NHS alone. This includes Accident and Emergency attendances, hospital admissions and costs to primary care.<sup>135</sup> An additional cost involves the societal impact on alcohol related crime and disorder, violence, employment and the economy. A Department of Health analysis of data on alcohol related deaths shows that inequalities increase as areas of high deprivation have a 45% higher alcohol related death rate than areas with lower deprivation.<sup>136</sup>

Figure 1 shows an overall upward trend in alcohol related admissions in Waltham Forests and its comparators (England, London and Croydon). The rates in Waltham Forest in 2009/10 are higher than the other areas. Waltham Forest rates are predicted to increase over the coming years and are likely to be higher than the England average. See Figure 2.

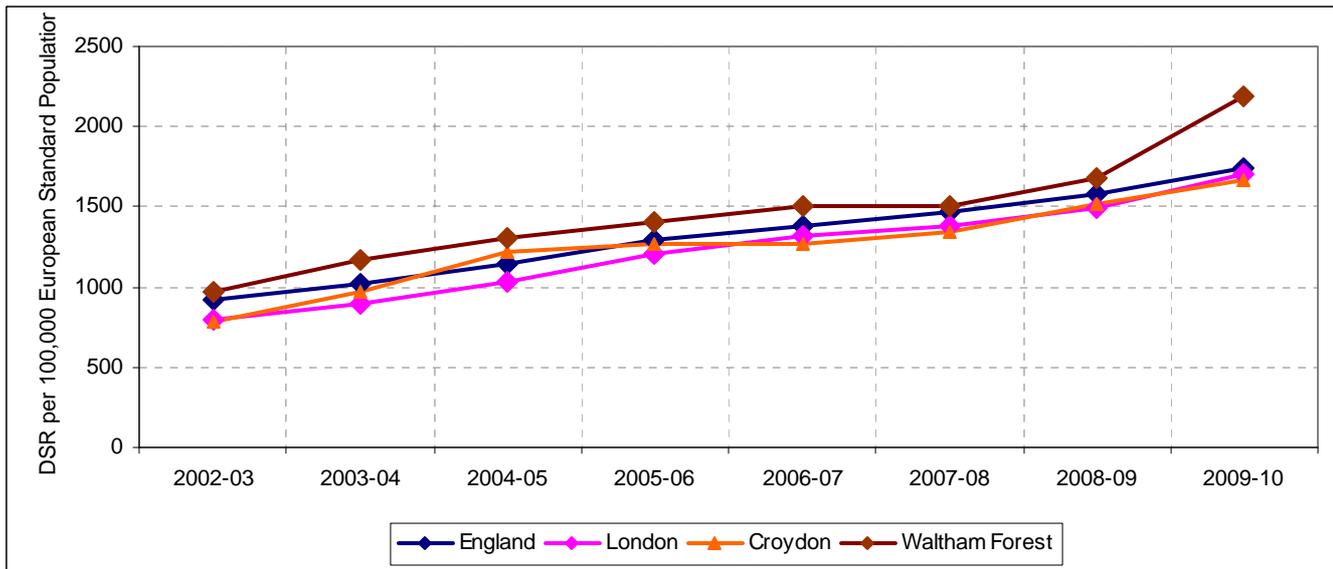
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<sup>134</sup> Safe, Sensible, Social. The next steps in the National Alcohol Strategy, Department of Health, Home Office, Department for Education and Skills, Department for Culture, Media and Sport, 2007

<sup>135</sup> The cost of alcohol-related harm to the NHS in England, Department of Health. 2008.

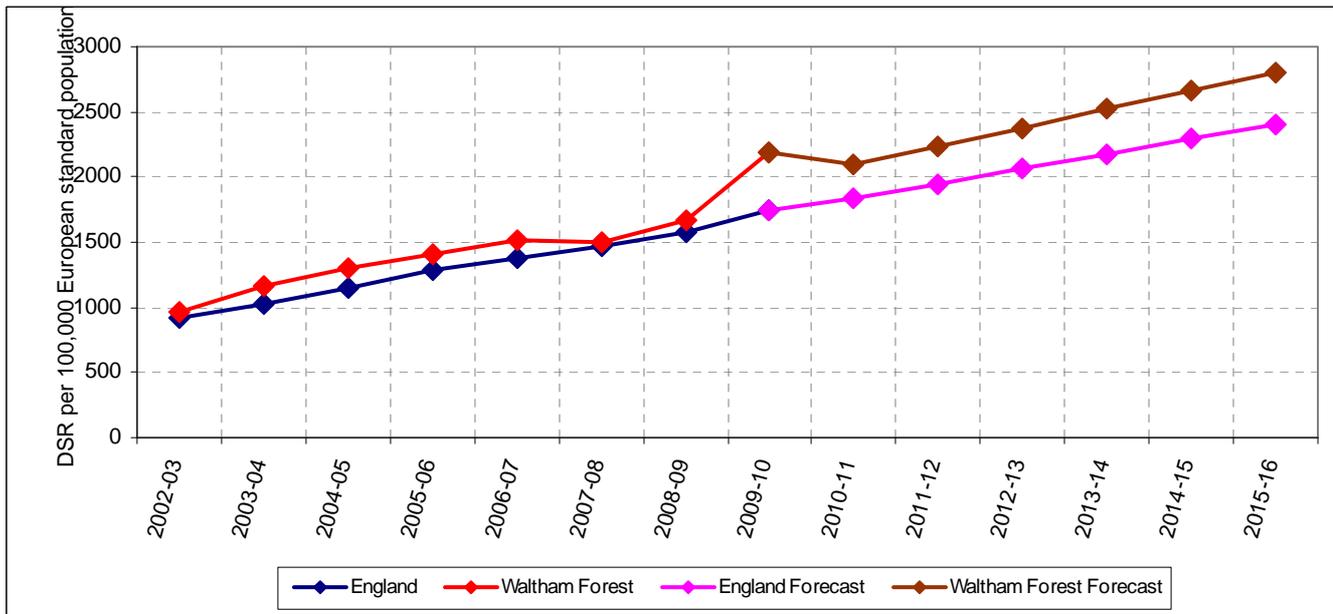
<sup>136</sup> Safe. Sensible. Social. The next steps in the National Alcohol Strategy, Department of Health, Home Office, Department for Education and Skills, Department for Culture, Media and Sport, 2007

Figure 1: Alcohol Related Hospital Admissions, Waltham Forest, 2002/3 -2009/10



Source: North West Public Health Observatory

Figure 2: Alcohol Related Hospital Admissions, Waltham Forest, 2002/3 -2009/10



Source: North West Public Health Observatory and Waltham Forest Public Health Estimates

Generally, Waltham Forest is doing worse than the London average in all the indicators listed below apart from Alcohol specific mortality<sup>137</sup>. The national average and the national ranking are given, where 1 is the best performing local authority and 326<sup>th</sup> is the worst. See Table 1.

<sup>137</sup> Local alcohol profiles for England accessed at: <http://www.nwph.net/alcohol/lape/index.htm>

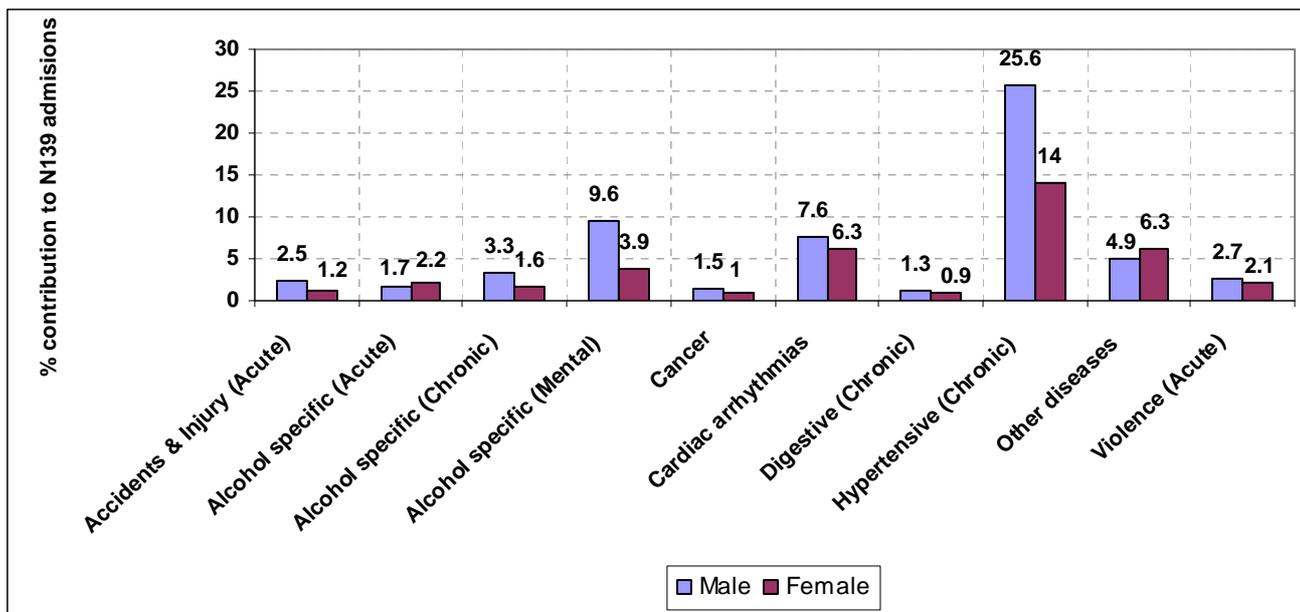
**Table 1: Alcohol related indicators**

No.	Indicator	Populations	Waltham Forest	London Average	England Rank
2	Alcohol specific hospital admission	Male (per 100,000), 2008/09	401.8	379.1	211
		Female (per 100,000), 2008/09	174.6	142.3	176
		Under 18s (per 100,000), 2006/07 – 2008/09	43.6	39.3	108
3	Alcohol attributable hospital admission	Male (per 100,000) 2008/09	1432.3	1291.4	245
		Female (per 100,000) 2006-08	810.4	672.9	241
4	Alcohol specific mortality	Male (per 100,000) 2008/09	10.6	11.3	153
		Female (per 100,000) 2006-08	2.6	3.8	42
5	Alcohol attributable recorded crimes	Male/female, (per 1,000), 2009/10	15	12.2	316
6	Alcohol related violent crimes	Adult Male/female, (per 1,000), 2009/10	9.8	8.5	303
7	Binge drinking (% - synthetic estimate) (2007-08)	Male/female, (per 1,000), 2009/10	14.3	14.3	29

Source: The North West Public Health Observatory on behalf of the Public Health Observatories in England

Figure 3 shows that male admissions outnumber female admissions in their contribution to NI39. For both male and female admissions, hypertensive diseases, cardiac arrhythmias and mental and behavioural disorders are generally the conditions that contribute the most toward NI39.

Figure 3: N139 (Alcohol related admissions) by cause and gender, Waltham Forest, 2008/09



Source: The North West Public Health Observatory on behalf of the Public Health Observatories in England

### Local Picture - Young people

According to a TellUs4 national survey (2009), only 31% of children and young people in Waltham Forest had had an alcoholic drink over the previous weekend compared to 42% nationally.

Alcohol specific hospital admissions for under 18s in Waltham Forest are higher than the London average (see table 1). The wards with the most alcohol related incidents for under 18s between April 2008 and August 2009 included Chapel End (14%) and Hale End and Highams Park (9% each), with regular referrals into specialist treatment from these areas. From 2001, young people aged 18 and under accounted for approximately 6% of all alcohol related incidents dealt with by the London Ambulance Service in Waltham Forest.<sup>138</sup>

### Patterns of drinking

Table 2 provides an indication of the number of young people and their pattern of drinking based on a prevalence model tool. An estimated 62% of 16-17 year olds were estimated to have consumed alcohol in the last week, while 36% of 15-16 year olds were regular drinkers, equating to an estimated 3369 and 1945, respectively.

Table 2: Estimated number of young people and their pattern of drinking

Consumed alcohol in last week	Waltham Forest	'Regular drinkers'	Waltham Forest
12-13 yr olds 14%	710		
14-15 yr olds 33%	1778	11-12 yr olds 7%	352
16-17 yr olds 62%	3369	15-16 yr olds 36%	1945

Source: Young people's substance misuse needs assessment 2010<sup>139</sup>

<sup>138</sup> Young people's substance misuse needs assessment. 2010. London Borough of Waltham Forest.

<sup>139</sup> Young people's substance misuse needs assessment. 2010. London Borough of Waltham Forest.

## **Treatment**

In total 80 young people were recorded in specialist treatment in 2008/09 for substance misuse, including 69 under 18s and 11 18/19 year olds. Alcohol was the primary substance for 33% of the young people in treatment.

The White British ethnic group continues to be the largest group accessing treatment. There is significant under representation of young people from Black and Asian backgrounds compared to school population numbers in these groups.

## **Hospital admissions**

For under 18s, there were nearly twice as many female hospital admissions than males in 2008. This is consistent with the young people substance misuse service referrals where all alcohol presentations were female.

## **What are effective interventions?**

The harm minimisation approach accepts that alcohol use occurs and does not aim to eliminate the use of alcohol but rather, to reduce harm which may result from its use. A combination of interventions is required to reduce alcohol related harm. Population level interventions will reduce the aggregated level of alcohol consumed and therefore lower the whole population risk of alcohol related harm, preventing people from drinking harmful amounts of alcohol in the first place. Individual level interventions are required to raise awareness of potential risks or harm at an early stage to support changes in behaviour. NICE guidance published in June 2010 provides a basis for action with 12 recommendations outlined to reduce alcohol related harm.<sup>140</sup> The recommendations for practice include:

- Resources for providing screening and a brief intervention.
- Supporting children and young people aged 10 to 15 years who are thought to be at risk from use of alcohol.
- Screening and extended brief interventions with young people aged 16 and 17 years thought to be at risk from alcohol use.
- Screening, brief advice and extended brief intervention for adults and appropriate referral to specialist services for all who may be alcohol dependent.

Screening and a brief intervention can be provided in a number of settings using specific tools for example in GP practices, pharmacies, and youth centres<sup>141</sup>. There is evidence that screening in an Accident and

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<sup>140</sup> Alcohol-use disorders: Preventing harmful drinking. National Institute for Health and Clinical Excellence (NICE) 2010.

<sup>141</sup> Luqman T et al. Cost-Effectiveness of an Opportunistic Screening Programme and Brief Intervention for Excessive Alcohol Use in Primary Care. PLOS One available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2682644/pdf/pone.0005696.pdf>

Emergency setting is shown to be effective.<sup>142</sup> Increased provision should be made available in Tier 2, 3 and 4 structured alcohol treatment services to respond to screening and identification of those requiring treatment.

Alongside this, NICE<sup>143</sup> has also developed a set of three guidance documents focused on addressing alcohol related problems:

- Alcohol use disorders: preventing the development of hazardous and harmful drinking.
- Alcohol use disorders: Diagnosis and clinical management of alcohol-related physical complications.
- Alcohol use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence.

The NHS Health Check<sup>144</sup> programme is a preventative programme which is intended to help people stay healthy for longer. Everyone who has a NHS Health Check, regardless of their risk score, should be given lifestyle advice including alcohol brief advice and intervention. This will help motivate them and support the necessary lifestyle changes to manage their risk.

There is need to have a comprehensive alcohol health needs assessment. The recommendations will inform the alcohol strategy action plan. There is a need to have an Alcohol Implementation Group to drive the strategy.

### **What is being done locally to address alcohol misuse?**

Reducing the harm that alcohol causes to health is part of the plan set out in the Government's new Public Health Strategy 'Healthy Lives, Healthy People', published in November 2010. Changing adult behaviour could result in saving the NHS the £2.7 billion cost of alcohol abuse. There is a continued focus on supporting behaviour change and targeting the areas with worst outcomes so that the health of the poorest will improve fastest. Structural changes to the NHS will see the move of Public Health services into local authority by April 2013, but the emphasis on reducing alcohol related harm remains a high priority.

Waltham Forest QIPP plan identifies alcohol as one of the priority areas under the Staying Healthy prevention agenda. It sets out to reduce alcohol harm.

The Waltham Forest Alcohol Strategy (2009-2012) sets out the overarching strategic aim to minimise the health harm, violence and antisocial behaviour associated with alcohol, while ensuring that people are able to

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<sup>142</sup> D'Onofrio G, Degutis L C. Preventive care in the emergency department. Screening and brief intervention for alcohol problems in the emergency department: a systematic review. *Academic Emergency Medicine* 2002; 9(6): 627-638

<sup>143</sup> NICE Guidance: <http://guidance.nice.org.uk/CG/Wave17/1>

<sup>144</sup> Putting Prevention First NHS Health Check: Vascular Risk Assessment and Management Best Practice Guidance, 2009

enjoy alcohol safely and responsibly.<sup>145</sup> The strategy focuses on reducing alcohol-related crime, antisocial behaviour and alcohol related harm while raising awareness of sensible drinking.

A local Alcohol steering group progresses the work on Alcohol in Waltham Forest. There is a need to target those most at risk, under-represented groups and treatment-naïve individuals by addressing early identification and barriers to accessing treatment services.

Under a GP practice DES (Directed Enhanced Service) on Alcohol, practices are required to provide screening and brief interventions on alcohol for new registrants. This has been implemented in Waltham Forest and will need to be monitored to evaluate the uptake and impact of screening.

For those with substance misuse problems, specialist services commissioned include open access services for drug and alcohol users with referral to more structured interventions, outreach services providing information, advice and referral to services, specialist structured intervention, counselling services for BME groups with specialist outreach work, crisis intervention, community detoxification and residential rehabilitation and young people's substance misuse services.

Training in screening and brief interventions has been made available to organisations. The Supporting People Team in the local authority has already had training.

There are a range of specialist alcohol treatment services for adults and young people, including a Tier 4 services commissioned in Waltham Forest which links into the Drugs services provided under the umbrella of substance misuse services. Turning Point Waltham Forest is funded by the local authority to provide open access, drop in information, advice; and outreach service to Drug and Alcohol service users.

A group has been established to monitor frequent users of A&E services to develop management plans for users with alcohol and dual diagnosis to reduce attendances.

Going the Distance is an employment and skills project implemented in Waltham Forest, which supports people who have had drug or alcohol problems and offenders who have used drugs to get back into work. The project provides support and access to voluntary work, short courses, job applications and improving skills in this area.

### **WOSUP (Weekend Opening Service User Project)**

It is a new social club for people with drug and alcohol problems. It is run by volunteers who have experienced the problems themselves; the club provides much needed support at weekends for people in drug and alcohol treatment and recovery services.

As well as providing a social club 'WOSUP' also provides an opportunity for those who are in treatment or have finished their treatment to volunteer to help run the club themselves and get involved in supporting others."

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<sup>145</sup> Waltham Forest Alcohol Harm Reduction Strategy. London Borough of Waltham Forest and NHS Waltham Forest. 2009-2012

Organisers hope the club will help improve the self esteem of volunteers, develop their skills and give them experience which can help them back into work or training.

### **Evidence that we are making a difference**

Commissioners have made significant progress around alcohol service delivery for Waltham Forest. Alcohol specific mortality for both men and women is lower than the London average. For women Waltham Forest ranked 42 out of 326 local authorities in England. However alcohol related hospital admissions continue to rise and we have demonstrated significantly worse than the London average on some alcohol measure indicators.

### **Progress since last year's Alcohol JSNA**

<b>Recommendations JSNA 2011-12</b>	<b>Progress</b>
Enhance data collection and information sharing across the partnership which is key to monitoring impact and effectiveness of interventions and to identify groups for targeted interventions.	Regular data collected and contract monitoring occurring across the partnership. Alcohol data entered on The National Alcohol Treatment Monitoring System (NATMS) by each provider.
An assessment using the audit template for NICE guidance (Alcohol-use disorders: Preventing harmful drinking) should be undertaken to highlight areas that need to be addressed in Waltham Forest.	Partnership assessment audit tool recently completed with the Deputy Regional Manager (Kevin Driscoll – NTA).
Increase the number of GPs providing Alcohol screening, brief interventions and referral to specialist services. Data on uptake and referral can be used to identify practices that are under referring to specialist services for targeted work.	A number of GPs signed up to the LES and supervised consumption (shared carer).
Address the under-representation of young people from Black and Asian backgrounds into young people's treatment services	Young people under 18 are seen by Children and Family services
All potential referrers to specialist services should be made aware of the potential under referral of people from BME groups, women and older people. The 'White other' group which includes Eastern Europeans may present initially as mental health cases or accidents where screening should establish the potential contribution of alcohol to the attendance.	QALB delivers an outreach service, which targets women, Eastern European and BME Groups. Alcohol targets set to achieve this.
Primary care commissioning team, public health and GP commissioning boards need to emphasise the importance of delivering brief interventions in alcohol in primary care and encourage maximum sign up for the Alcohol-enhanced service	Further work to be developed in this. This will be embedded in the 2012-13 JSNA for review.
Mainstream screening and brief interventions for alcohol in existing services that may come into contact with people who would benefit from referral to specialist treatment services	Frontline staff in WX hospital already trained. Training to be rolled out to community GPs.

Recommendations JSNA 2011-12	Progress
Population level awareness raising and social marketing targeted at groups at risk of hazardous or harmful drinking	QALB has given a series of presentations across the borough, distributing leaflets at known hotspots.
Develop a pathway for screening and referral of patients attending A&E to identify patients with alcohol issues who would benefit from referral to treatment services	Pathway in place. Alcohol Liaison Nurse appointed and in role from August 2011.
A referral pathway needs to be developed from the London Ambulance Service (LAS) and the Clinical Decision Unit and key wards for identification and appropriate referral	Outstanding – This will be embedded in the 2012-13 JSNA for review
Examine potential to use local authority powers to limit proliferation of alcohol outlets. For example, local licensing departments can take into account the links between the availability of alcohol and alcohol-related harm when considering a licence application. This includes, for example, the number of alcohol outlets in a given area and times when it is on sale and the potential links to local crime and disorder and alcohol-related illnesses and deaths.	No evidence of any work being undertaken in this area – to be explored within the alcohol strategy Steering Group.

### **What is the perspective of the public on support available to them?**

WOSUP is a new social club for people with drug and alcohol problems run by volunteers, who have experienced the problems themselves. The club provides much needed support at weekends for people in drug and alcohol treatment and recovery services. As well as providing a social club, WOSUP also provides an opportunity for those who are in treatment or have finished their treatment to volunteer to help run the club themselves and get involved in supporting others. Organisers hope the club will help improve the self esteem of volunteers, develop their skills and give them experience which can help them back into work or training.

### **What more do we need to know?**

- Waltham Forest has the highest rate of alcohol related hospital admissions as compared to England and London averages.
- Alcohol specific hospital admissions for under-18s in Waltham Forest are higher than the London average.
- The White British ethnic group continues to be the largest group accessing treatment. There is significant under representation of young people from Black and Asian backgrounds compared to school population numbers in these groups.
- There is a direct enhanced service (DES) for identification and brief advice in primary care. This service provides screening and brief interventions on alcohol for new registrants but does not include other registered populations who may be at risk of alcohol misuse.

- There is no Waltham Forest Alcohol health needs assessment.
- There is a need to revise the Waltham Forest Alcohol Strategy.
- Recent analysis of alcohol related hospital admissions has highlighted that there is no clear pathway for those who access emergency treatment in hospital due to alcohol but are not admitted, to be referred to specialist services where appropriate.
- Clear pathways are also required for patients who are admitted due to alcohol so they can be referred to specialist treatment services.
- Enhancing pathways to mainstream screening and appropriate referral for alcohol within existing services such as Accident and Emergency, other health and social care settings, voluntary and community services is required. The GP DES which provides screening and brief interventions is only for new patients registering at practices; therefore strategies to screen in other settings are required and is recommended by NICE.

## **What are the priorities for improvement over the next 5 years?**

### **Key insight**

#### **Population Needs**

- Develop alcohol health needs assessment and the recommendations will inform commissioners on alcohol services redesign.
- Refresh the current Waltham Forest Alcohol Strategy and set up an implementation group to drive the strategy.

#### **Prevention and Early Intervention**

- Review the current Direct Enhanced Service (DES) for identification and brief advice in primary care. Consideration should be given to extending the DES to cover all at-risk groups, possibly via a Local enhanced service (LES).
- Population level awareness raising and social marketing targeted at groups at risk of hazardous or harmful drinking. This includes health promotion in pub settings.

#### **Training and Development**

- Training Frontline staff (GP practices, Housing, Job Centre Plus, Education, Probation service, Youth centres and voluntary sector agencies) to identify and refer people misusing alcohol to appropriate services.

### **Stakeholders Collaboration**

- Examine the potential to use Local Authority powers to limit proliferation of alcohol outlets. For example, local licensing departments can take into account the links between the availability of alcohol and alcohol related harm when considering a licence application. This includes, for example, the number of alcohol outlets in a given area and times when it is on sale and the potential links to local crime and disorder and alcohol-related illnesses and deaths.

### **Treatment and Management**

- Ensure that alcohol treatment and management services are reviewed and follow NICE guidance, particularly given that the NHS Health Checks and any additional work in accident and emergency and the wider sector may increase referrals

### **Data**

- Improve collection and information sharing across the partnership which is key to monitoring impact and effectiveness of interventions and to identify groups for targeted interventions.

## **Drugs**

### **Executive Summary**

The estimated number of problematic drug users in the borough is 1622 (1013 using opiates, 1217 using crack), a decrease on previous years estimates. We estimate our penetration rate with structured treatment into this group is 58.5%.

Changes to the local drug using population in light of a steady migration of Eastern Europeans into the borough has resulted in more clients from this community accessing treatment for alcohol and cocaine misuse. There is also an increase in the number of people from South Asian communities accessing services for alcohol and cocaine problems.

A service user and carer strategy was finalised in 2010/11 and service user groups are running in all treatment services which enables feedback to be gathered. Survey data for both service users and carers highlighted a number of important areas such as: more holistic 'wraparound' support services, staff skills and experience, improvement in BBV and sexual health provision, and more focus on families and carers. Commissioners need to address service user views within the treatment plans and in making commissioning decisions. There has been a steady decline in drug related deaths since 2008 however Waltham Forest has experienced proportionately more drug related deaths than its neighbouring boroughs. More robust data collection is required for a better informed analysis and determination of gaps or unmet need.

Waltham Forest has a high prevalence of hepatitis C. Performance of BBV services for drug users, particularly vaccination for hepatitis B and testing for hepatitis C has been poor despite significant attention to this important area of health need. Commissioners and providers need to refocus on improving rates of uptake of BBV interventions. Improvement plans will be implemented with immediate effect.

### **Recommendations**

Some of our recommendations last year were not fully achieved and these are again highlighted in this years' JSNA.

- Drugs are a key driver for committing crime and as such it is essential that adequate drug treatment and aftercare provision is commissioned and available.
- Such provision needs to ensure that aftercare is seen as a key component of treatment provision with the key aim of reducing representations of clients.
- A seamless transition for clients needs to exist between treatment services particularly in relation to the sharing of client information.
- Better understanding of the needs around those with dual diagnosis of drugs and alcohol and mental health issues.

- Confidential enquiry group needs to be established to review drug related deaths to see how they could have been prevented and learn any lessons from deaths occurring locally. This may be combined with a suicide prevention group locally.
- Develop plan to increase numbers of crack users engaging in treatment from tier 2 upwards. Review crack treatment provision against best practice, promote services widely to target groups.
- The level of testing for Hepatitis C is very low and needs to be significantly improved therefore tighter data recording and reporting processes is needed within services to be robustly monitored by commissioners.
- Ensure systems are in place to support clients post-treatment to prevent relapse and decrease re-presentation rates.
- Young People/adult treatment transitional arrangement plans to be developed based on NTA guidance.
- Pathways into tier 4 to be revisited to ensure that current arrangements are inclusive for all clients from all commissioned services to access.
- Increase the 'penetration rate', targeting treatment naïve potential service users, injectors, poly-drug and alcohol users, and those in contact with the Drug Intervention Programme.
- Ensure links between GPs, specialist services and commissioners are maintained and developed further.
- Improve BBV services across the whole treatment system especially rates to testing and vaccination.
- Form stronger links with Assessment and care management and Adult social care commissioners to develop a partnership wide approach that ensures staff has the appropriate skills and knowledge:- to effectively screen, early identification of childcare/parenting needs, advice and information and signposting and referral to safeguarding team or children and young people services.
- Once needs are identified in relation to parenting or childcare the Common Assessment Framework to be used to ensure relevant service are made available to meet the identified needs. However where child protection concerns are identified referrals are to be sent directly to children's Social Care referral and assessment service.

### **What is Drugs Misuse?**

The World Health Organisation defines the misuse of drug or alcohol as the use of a substance for a purpose not consistent with legal or medical guidelines. It can also be defined as a pattern of substance use that

increases the risk of harmful consequences for the user. Some would limit the consequences to physical and mental health (as in harmful use); some would also include social consequences.<sup>146</sup>

An estimated 328,767 people between the ages of 15-64 are thought to be problem drug users in the UK (2006/07).<sup>147</sup> Problem drug users are defined as those using opiates such as heroin and/or crack cocaine, categorised as Class A drugs. It costs the government around £1.2 billion a year to tackle drug use in England and costs society an estimated £15 billion a year (2003-2004 estimate).<sup>148</sup> Of the costs to society, 90% is attributable to drug related criminal offences such as theft and burglary. In 2008, the Government introduced a new 10-year Drug Strategy (Protecting Families and Communities), which aims to reduce the harm caused by drugs to society. London has the highest rate of problem drug users in the UK with a rate of 14.2 per 1000 aged 15-64 followed by the North West region with a rate of 12.28 per 1000.

### Local Picture – Adults

The Waltham Forest Drug Action Team completed an Adult Substance Misuse Needs Assessment 2010/11 in January 2011. According to the most recent ‘Glasgow estimates’ Sweep 5 report conducted in 2008/2009, Waltham Forest was estimated to have 1,622 problematic drug (Crack and opiate) users (PDUs) in the year 2008/2009, a reduction from 1877 since the last calculation in 2007.

In 2009/2010 643 PDUS were engaged in effective treatment, and 882 of all adult drug users engaged in effective treatment.<sup>149</sup> Table 1 shows the estimated drugs users in Waltham Forest.

**Table 1: Estimated Drug Users in Waltham Forest in 2008/2009**

Waltham Forest	
Category	Estimate
PDUs	1622
Crack	1217
Opiates	1,013

There has been a gradually rising split between males/females accessing treatment 75 males/25 females. In 2009/2010 the gender profile followed a similar trend with 77% of users engaged in treatment being male and 23% female. The largest ethnic group engaging in treatment was White British (44%) aged between 20-44 years (57%). The BME breakdown remains fairly consistent to previous years with approximately 40% of all clients engaged in effective treatment.<sup>150</sup>

### Drug Related Deaths

The number of drug related deaths peaked locally in 2000 where there were 7 deaths, but since then the

<sup>146</sup> Lexicon of alcohol and drug terms, World Health Organization, Geneva 1994

<sup>147</sup> National and regional estimates of the prevalence of opiate use and/or crack cocaine use 2006/07: a summary of key findings. Home Office. Research Report 9. 2008.

<sup>148</sup> Tackling problem drug use. Report by the Comptroller and Auditor General. National Audit Office. 2010

<sup>149</sup> Estimates of the Prevalence of Opiate Use and/or Crack Cocaine Use, 2008/09: Sweep 5 report, University of Glasgow

<sup>150</sup> Waltham Forest Substance Misuse Needs Assessment 2010/2011

number of deaths has decreased. The numbers of Drug Related Deaths in Waltham Forest are falling; this is a higher rate than its neighbouring boroughs of Havering, Barking & Dagenham and Redbridge.

There is a need to establish local mechanisms to allow for effective and efficient communication and rapid response to drug related deaths when appropriate. The partnership is without a confidential inquiries panel/lead and will seek to establish this as a priority in 2011/2012, supporting the collection of robust data and communications.

### **Harm Reduction**

Policies, programmes, services and actions aimed at reducing drug-related harm to individuals, children and families, and the wider community should be incorporated into Harm Reduction strategies. Waltham Forest is currently developing a Harm Reduction strategy and this should be completed and actions taken forward in 2011/12. Harm reduction should include actions to reduce the number of drug-related deaths and extent of health damage, including that related to HIV, Hepatitis B (HBV), Hepatitis C (HCV) and Tuberculosis (TB) by prevention and treatment.

### **Blood Borne Viruses**

Injecting drug users have a high risk of contracting blood-borne virus infections, particularly hepatitis C. The Health Protection Agency (HPA) estimated for 2006<sup>151</sup> that almost half of current injecting drug users have contracted hepatitis C infection.<sup>152</sup> Blood-borne virus (BBV) infections can cause chronic poor health and can lead to serious disease and to premature death. Minimising the risk of BBV transmission is a key public health issue, both in protecting the health of this vulnerable group and in protecting the wider population.

### **Needle and Syringe Programme**

in terms of harm reduction and reducing BBV syringe/needle exchange services are vital. CDAT coordinates the boroughs needle/syringe exchange provision. There are currently 11 pharmacies participating in the needle exchange programme in Walthamstow and 6 pharmacies that provide supervised consumption. Geographical mapping of where opiate users live and where supervised consumption services located has identified that there are areas where there is a need for supervised consumption services such as Higham Hill which has no nearby pharmacies providing this service. There are a high proportion of Opiate users in Higham Hill and Chapel End wards hence there is need to have this programme in these areas.

### **Hepatitis C**

The HPA estimated local Hepatitis C Virus (HCV) prevalence that placed each Drug Action Team into a HCV prevalence band (low, medium, or high). These estimates are based on HCV prevalence data from the Unlinked Anonymous survey which monitors blood borne infection levels amongst users in contact with specialist services since 1990. The prevalence of Hep C in injecting drug users between 2005-2007 in England

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<sup>151</sup> "Shooting Up" – Infections among injecting drug users in the United Kingdom. 2005. Health Protection Agency, An update: October 2006"

<sup>152</sup> Reducing drug related harm: an action plan. 2007. Department of Health and National Treatment Agency.

was 44% amongst those who injected in the last year. Waltham Forest is categorised in the 'HIGH' group for prevalence of HCV together with 24 other boroughs in London, which means that over 50% of those who injected in the last year were HCV positive.<sup>153</sup> Modelling from the HPA estimates that 55% of the number of IVDUs (443) would have HCV. The total infected population is estimated to be 1,139 people, including those who are ex-users and as well as those who do not use intravenous injections.<sup>154</sup>

### **Substance Misusing Parents**

Access to treatment and support services appropriate for this group needs to be improved. Current pathways into children services from tier 3 treatment need to be clarified and revised. Better links to joint working arrangements need to be forged with children centres. Training for treatment service staff on what children's services are available to clients, will enable workers to provide a more holistic package of care to these clients.

### **Drug Related Offending**

#### **Police Data**

Drugs offences make up 6% of all total notifiable offences. However it should be noted that drugs offences recorded by the police is not an indication of the level of drug related problems in an area but is more an indication of the number of police operations undertaken to tackle drugs. There were 1,674 drugs offences recorded by police in Waltham Forest between July 2010 to June 2011. This is a 22% reduction from the same period last year. Three wards in the borough accounted for 29% of all drugs recorded offences in the borough. With High Street ward accounting for 11%; Forest and Cathall wards accounting for 7.5% each. These three wards are in the top 25% of all wards when compared across the Metropolitan Police Service.

#### **Probation**

Data was obtained from probation via their OASys assessment database. OASys assessments provide a means of helping to identify influencing factors relating to offending. Offenders are categories as having different needs which influence their criminal behaviour. Drugs are identified as one such criminogenic need. From July 2010 to June 2011 29% of clients identified drugs as a criminogenic need.

### **Drug Intervention Programme**

The Drug Intervention Programme (DIP) was introduced in April 2003 with the aim of developing and integrating measures for directing adult drug-misusing offenders into drug treatment and reducing offending behaviour. As Waltham Forest is a DIP intensive borough this requires compulsory class A drug testing upon arrest for trigger offences<sup>155</sup>.

DIP data from the London Analyst Support Site has been analysed to show all those being tested upon arrest at Chingford Police Station and also where Waltham Forest resident arrestees were tested across London.

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<sup>153</sup> Hepatitis C in London Health Protection Agency 2009

<sup>154</sup> Hepatitis C prevalence modelling template available at: <http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/HepatitisC/>

<sup>155</sup> Trigger offences are primarily offences related to acquisitive crime, they include; theft, robbery, burglary, aggravated burglary, theft of a motor vehicle, handling stolen goods, going equipped for stealing, possession and supply of controlled drugs, fraud and begging.

The data for Waltham Forest residents tested upon arrest across London between July 2010 to March 2011 revealed where they travelled to offend:-

- 59% Waltham Forest
- 10% Redbridge
- 6% Newham

Of note 85% of those Waltham Forest residents were arrested either in the borough or surrounding boroughs. Unfortunately non London boroughs are not included.

In contrast looking at the borough of residence of people who are tested upon arrest at Chingford Police Station reveals who is committing crime within Waltham Forest :-

- 58% Waltham Forest
- 12% Newham
- 5% Haringey
- 4% Redbridge
- 3% Enfield
- 3% Hackney
- 3% Essex

This tallies with accused data which shows that people travel relatively short distances to commit crimes. Interestingly it shows that our offenders go to Redbridge to offend but Redbridge offenders do not come here to commit trigger offences.

The table below looks at the top three offences for those being tested upon arrest within Waltham Forest, to identify if there are any different offending patterns that attract offenders to Waltham Forest.

Borough of Residence	1st	2nd	3rd
Waltham Forest	Theft (39%)	Burglary (18%)	Robbery (9%)
Newham	Theft (47%)	Burglary (16%)	Robbery (13%)
Haringey	Theft (54%)	Burglary (12%)	Robbery (12%)
Redbridge	Theft (49%)	Possession Class A (9%)	Fraud (9%)

The top three offences are the same for the other boroughs, with the exception of Redbridge. 26% of people tested positive for Class A drugs upon arrest in Waltham Forest.

This is the breakdown of class A drugs for those testing positive:-

- Cocaine 11%;
- Both cocaine and opiates 9%; and
- Opiates 5%.

28% of Waltham Forest residents tested positive for class A drugs upon arrest, this is broken down as:-

- Cocaine 13%;
- Both cocaine and opiates 9%; and
- Opiates 6%.

Of note, Within Waltham Forest, proportions of males and females who tested positive were very similar with 25% for females compared with 26% for males.

In respect of ethnic appearance of those testing positive; 64% were of White European appearance, compared with only 20% of those of African Caribbean appearance. For White European, African Caribbean and Asian arrestees, the main drug that they tested positive for was cocaine.

25-34 was the peak age for people to test positive, accounting for 42% of all those testing positive.

The offences committed with the greatest percentage of people testing positive on arrest were:-

- drugs 48%;
- theft 31%; and
- handling stolen goods 30%.

Despite increasing acquisitive crime levels across the borough, the proportion of people testing positive upon arrest remains stable.

### **London Ambulance Service Drugs Overdose Data**

London Ambulance Service data in relation to drugs overdoses for the period July 2010 to June 2011 found that of the 673 recorded drugs overdoses. Only 2% were related to either cocaine (4) or heroin (9).

### **Local Picture - Young People**

The Waltham Forest Young People's Substance Misuse Needs Assessment, January 2011 and the Young People's Specialist Substance Misuse Treatment Plan 2011/12 recorded that 74 young people were in specialist treatment in 2009/10, of which 62 were under 18 and 12 were 18/19 year olds. This is a decrease of 6 from 80 in 2008/09. 18 and 19 year olds in treatment equate to 16% of clients, an increase from 13% in 2008/09. 54% of young people entering treatment are under 16, a decrease from 63% the previous year. However, 15 year olds still remain the largest group entering treatment (36%).

More young women are in treatment than young men, 68% as against 32%. This is an increase from 57% in 2008/09. Young women in general were presenting with more multiple needs such as e.g. LAC (Looked After

Children), NEET (Not in Education Employment or Training), Self Harm, offending, pregnant etc. Waltham Forest has more young women coming back into treatment than the regional average.

The largest proportion of these under 18 in treatment were white, 51% in 2009/10, followed by Dual Heritage young people at 18% and Black or Black British at 16%.

Dual Heritage and young people are significantly over represented as they make up 9% of the school population. In comparison Asian young people are significantly under represented, with only 7% in treatment.

45% of young people under 18 entering treatment in 2009/10 are using cannabis and alcohol combined.

Young people entering treatment in 2009/10 for heroin or crack use have increased from 6% to 12%. Young people entering treatment for heroin/crack use is significantly higher than our statistical neighbours. 40% of referrals from April to December 2010 were known to a CAMHS Service. Of those who engaged in treatment from April to December 2010, 60% had mental health concerns and 39% child protection concerns.

Young people exiting treatment either drug free or with occasional use has increased to 62% compared to 37% in 2008/09. However unplanned and unknown exits still remain relatively high. There are higher unplanned exits amongst cannabis and alcohol users accessing a psychosocial intervention. Young people from Black or Black British and Dual Heritage backgrounds are more likely to exit treatment in an unplanned way compared to White young people.

The top four offences committed by first time entrants to the Youth Offending Service from July 2010 to March 2011 was violence 23%, theft/handling 18%, drugs 15% and robbery 15%.

The priorities for substances misuse for 2011/12 are as follows:

- To develop a systematic approach to identifying and supporting the substance misuse needs of children in care and care leavers and those on the edge of care through early identification and increased engagement.
- To increase the engagement with young people in contact with the criminal justice system and reduce offending by addressing their substance misuse.
- To build a partnership with the gang prevention programme to ensure that young people and families have access to support for substance related needs.
- To develop pathways with teams providing family support to ensure access to family based interventions that address identified need.

- To strengthen joint work with CAMHS to ensure effective interventions for young people with dual diagnosis.
- To continue to capacity build with front line workers to increase confidence, improve early identification and engagement with young people to prevent escalation of use and harm relating to drug and alcohol use.

### **What are the effective interventions?**

Substance misuse impacts all aspects of society, and as stated in the National Drug Strategy 2010, *“From the crime in local neighbourhoods, through families forced apart by dependency, to the corrupting effect of international organised crime, drugs have a profound and negative effect on communities, families and individuals”*.

A new national Drug strategy was published in 2010. *Reducing Demand, Restricting Supply, Building Recovery, Supporting People to Live a Drug Free Life*.

The main headlines of the new strategy in relation to drug and alcohol treatment are:

- Building recovery in communities.
- Recovery is an individual, person-centred journey.
- Built on the recovery capital available to individuals.
- In a system that is locally led and locally owned.
- Where all services are outcome focused.
- Delivered using a ‘whole systems’ approach.
- An inspirational recovery orientated workforce.
- Supported by recovery networks.
- Keeping children safe and rebuilding families.
- To enable reintegration into communities.
- Tackling housing needs.
- Helping people find sustained employment.

Other key documents and guidance are:

- Models of Care Update 2006 for the treatment of adult drug misusers is the national framework for the commissioning and provision of drug treatment services in England.
- Drug Misuse and Dependence: UK Guidelines on Clinical Management is the national clinical guidelines for clinicians providing pharmacological interventions for drug misusers as a component of drug misuse treatment.

- Reducing Drug-Related Harm: An Action Plan. This plan was published by the Department of Health in May 2007 to set out the broad streams of action to be taken in England to enhance harm reduction activities within drug treatment services.
- Hepatitis C Action Plan. Hepatitis C as a public health issues was highlighted in 2002 with the publication of the Government's Hepatitis C Strategy for England. The Hepatitis C Action Plan, published by the Department of Health in 2004, is based on best practice, serves as a broad framework for implementation of the Hepatitis C Strategy for England.
- NICE guidance on needle exchange and syringe programmes. This guidance provides recommendations for good practice, based on the best available evidence of effectiveness, including cost effectiveness.
- Health Protection Agency Shooting Up reports focus solely on infections among injecting drug users in the UK. This report focus on the current prevalence of the main viral infections (hepatitis A, B, C and HIV) and bacterial infections (staphylococcus aureus infections, group A streptococcal infections and clostridial infections) as well as making recommendations.
- The Safer Injecting Briefing (DrugScope, 1999) guidance covers areas such as the evidence based for promoting safer injecting, routes of administration, vein damage, and transmission of blood-borne viruses and providing comprehensive services to tackle unsafe injecting practices.
- NICE has produced a number of guidance reports on hepatitis C.

### **What evidence is there that we are making a difference?**

The new 10-year government strategy aims to get problem drug users into effective treatment, to reduce drug related offences and re-integrate into society to reduce harm to families and communities.<sup>156</sup>

The key local priorities for 2011/12 in the Drug Treatment Plan<sup>157</sup> include:

- Improve take up of BBV interventions and data across treatment system.
- Improve access to treatment from tier 1 agencies.
- Develop the 'recovery agenda' locally.
- Work with providers to improve, clarify and develop care pathways.

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<sup>156</sup> 2010 Drug Strategy consultation document

<sup>157</sup> Waltham Forest Drug treatment Plan 2011/12

- Improve access and engagement in Tier 3 services of service users who only access community and pharmacy-based needle exchange schemes.

There is a 4 tier model of service available in Waltham Forest which includes:

- Tier one – Provision of drug-related information and advice, screening and referral for specialised drug treatment.
- Tier two - Triage assessment and referral into structured, local treatment systems, harm-minimising interventions, brief interventions for specific target groups and aftercare support and outreach services.
- Tier three – Community-based specialised drug assessment, coordinated care planned treatment and drug specialist liaison.
- Tier four - Residential specialised drug treatment.

Outreach work is undertaken to increase the number of problematic drug users to access treatment.

The latest performance reports from the National Treatment Agency which outline our final performance for 2010 showed that Waltham Forest have met our PDU (VSB14/N140) target for 2010/11. The PDU target for 2010-11 as 726 and final performance figure was 731.

Needle Exchange services have been set up in 7 Pharmacies in the borough and 1 Needle Exchange service being provided for young people.

For young people, there are services that provide the full range of interventions based on the National Treatment Agency framework.

### Progress since last year's JSNA

Recommendations from JSNA 2011-12	Progress since last year's JSNA
Better understanding of the needs around those with dual diagnosis of drugs and alcohol and mental health issues.	NELFT has a draft Dual Diagnosis Strategy.
Confidential enquiry group needs to be established to review drug related deaths to see how they could have been prevented and learn any lessons from deaths occurring locally. This may be combined with a suicide prevention group locally.	In the process of being established.
Complete the Drugs Harm Reduction Strategy and action plan taken forward across the partnership.	Drugs Harm Reductions Strategy is in development along with the action plan.
Monitor delivery of a higher target for those accessing treatment with reduced resources in 2011/12.	Providers' targets have been stretched and these continue to be monitored through monthly contract monitoring meetings.
Implement the of BBV pathways partnership-wide	Providers will meet and device a pathway for BBV.

Recommendations from JSNA 2011-12	Progress since last year's JSNA
Commission satellite clinics for testing for blood-borne viruses to increase uptake.	BBV Nurse will be providing satellite clinics.
Increase Needle Exchange and Supervised Consumption services in areas where there are high proportions of Opiate users.	11 Community Pharmacies and 2 Treatment Providers providing Needle Exchange services and 6 Community Pharmacies providing Supervised Consumption service.
Target outreach by police and treatment services in areas where drug related offences take place to reduce offending in these areas and get drug users to access treatment services.	QALB Outreach has been working closely with PCSO for information regarding "hotspots" QALB work closely with DIP team, however more work needs to be done with PCSO/ Police regarding offending. Work in progress.
Review the impact of reduced funding for young people's substance misuse services and commission appropriate services based on needs beyond March 2011.	Additional funding identified through Community Safety, therefore impact was minimal. Funding available for 2012/13 has not been released.
Improve identification of young people with substance misuse problems as there are young people with problems not accessing services (based on those in treatment and estimated regular users).	Partnership agreement and pathway protocol written and reviewed between 722 and Youth Offending Service (YOS). 722 now attends YOS management board and high risk panel meetings. 722 and TYSS representation on Health Strategy Group for Children in Care. TYSS on NEET tracking group for children in care under the age of 18, which identifies additional needs.
Address the apparent under representation of young people from Asian backgrounds into young people's treatment services.	The number of young people from Asian backgrounds in treatment has increased from 6.56% to 12.5% from 2009/10 to 2010/11.
Develop a multi-agency strategic plan for reducing drug-related deaths this should include a confidential inquiries panel/lead.	This is outstanding. To be developed by the Harm Reduction Steering Group.

### **What is the perspective of the public on support available to them?**

A service user and carer strategy was finalised in 2010/11 and service user groups are running in all treatment services which enables feedback to be gathered. Survey data for both service users and carers highlighted a number of important areas such as: more holistic 'wraparound' support services, staff skills and experience, improvement in BBV and sexual health provision, and more focus on families and carers. Commissioners need to address service user views within the treatment plans and in making commissioning decisions.

The commissioning team are particularly keen to work with providers and service users to develop peer support/mentoring to enhance the long term aftercare and support that can be offered to treatment service users. Furthermore commissioners are keen to involve service users more closely in devising and scrutinising meaningful quality indicators.

### **What more do we need to know?**

Rates of successful residential rehabilitation completion for Waltham Forest clients have improved in 2009/2010. 65% of clients who commenced primary treatment completed successfully and 80% of clients who commenced secondary treatment completed successfully compared to a completion rate below 50% and frequent drop outs in 2008/2009. This assessment highlighted the need for more robust aftercare in the community once the client has completed residential treatment. This includes providing an aftercare package consisting of housing, ETE and possible volunteering opportunities within the treatment system. The needs

assessment highlighted a need to ensure the need for inpatient detoxification is met by way of ensuring adequate capacity and reducing costs where possible.

The Partnership has continuously invested in this agenda over the years and prides itself on achieving local targets. The shared care scheme includes 50 participating GPs (42% of all GPs within the borough) supported by appropriate contractual arrangements. In 2011/2012 the Partnership are committed to increasing the number of clients engaging in the scheme but recognise the need for better data recording to support clinical handover from the prescribing service to the individual GPs.

### **Recovery and Reintegration**

We have ensured our local treatment systems become more recovery, outcomes and abstinent focussed and ensure our treatment system is integrated with support services that will optimise treatment gains.

The Aftercare and Recovery pilot commissioned will focus on building recovery capacity and support client's continued abstinence and recovery in line with the new national drug strategy.

The provision of a robust Aftercare and ETE will provide employment, training and education opportunities and address housing issues to reduce the rate of re-presentation to services.

Community provision such as mutual aid and peer support/mentoring.

W.S.O.U.P Service User led weekend service provision.

### **In-patient Detox**

Community Care Funding Applications for Tier 4 continue to be submitted to Commissioners by Providers. These are assessed based on the criteria and demonstration that the client has engaged with community based treatment prior to and is motivated for In-patient detox.

### **Integrated Care Pathway**

This has improved inter-agency working.

### **Data recording – GP Shared Care**

A new target has been agreed for 2011-12 and data is recorded/monitored through monthly submissions for contract monitoring meetings.

### **What are the priorities for improvement over the next 5 years?**

- Increasing referrals from mainstream services such as GP practices has been challenging for adult services. Referrals from GPs were only 2% of all those referred into specialist services in 2008/09. This is an area where Provider needs to promote their services so that there is an increase in referral from GPs.

- The number of pharmacies providing supervised consumption is not meeting the needs of opiate users. Expressions of interest from pharmacies have been sought and training is being developed to increase services, particularly in areas where there are a high numbers of opiate users. There are no Needle Exchange services in Hingham Hill and Chapel End wards where there are high proportion of Opiate users.
- As per the recommendations in the Harm Reduction Strategy: Partnership Audit tool, a Confidential Enquiries lead is required and a Drug Related Deaths (DRD) review group needs to be established to learn any lessons from deaths and prevent future deaths.
- The needs assessment suggests that estimates of Class A drug use by young people in Youth Offending Teams and Children in Care is not being routinely identified.
- There will be a reduction in funding for young people's specialist treatment services of 38%.
- There may be underrepresentation of Asian backgrounds in treatment and referral of Asian young people.

## **Tobacco**

### **Executive Summary**

Smoking prevalence has declined across the country through the influence of policy and effective interventions for smokers. The causal effect of smoking on health is well established in the literature. This chapter considers what that means for the health of the population, how it compares to other areas, and what is being done to address the following issues:

- 19.3% estimated prevalence in the general population aged 16+.
- 24% estimated prevalence in people aged 40-74 attending a health check.
- Smoking attributable hospital admissions third highest in London for 2009-10.
- Smoking is the leading cause of health inequality.

The provision of Stop Smoking Services is only part of the story for tackling tobacco use and its effects. The local authority and the NHS have distinct roles to play in not only preventing tobacco use, but also to detect smoking related harm earlier.

### **Recommendations**

- Invest in prevention and health promotion strategies to improve knowledge of tobacco related harm locally, and to divert young people from tobacco use.
- Embed tobacco control messages in the local education curriculum developed with input from pupils, community and health leaders.
- Improve implementation of the NHS Health Checks programme for cardiovascular risk.
- Increase investigation of unexplained coughs with aggressive focus in high need areas.
- Increase identification of smokers at the healthcare interface, refer to NHS Stop Smoking Services and develop individualised patient plans to screen for and treat smoking related conditions.
- Develop multi-agency schemes to support smoke free homes initiatives.
- Increase enforcement activities against recent and established legislation.
- Commission Stop Smoking Services to meet the needs of high risk and high need smokers.
- Tobacco Control Alliance members to contribute to the development of referral and treatment pathways to ensure services are accessible to all, including places of work, recreational areas and for residents with limited mobility.

## What is Tobacco?

Tobacco is a green leafy plant grown in warm climates. Tobacco products are made mainly of tobacco leaf with the intention to be smoked, sucked, chewed or snuffed. All products contain the highly addictive psychoactive ingredient, nicotine<sup>158</sup>. The most common method of consuming tobacco is through cigarette smoking.

Cigarettes are made of chopped tobacco plants rolled in paper. Cigarettes contain chemical additives to assist with storage and to make the smoke more palatable to consumers. When the additives are burned, combustion creates new chemical products. The smoke from tobacco cigarettes consists of particles and gas. The particles in smoke are made up of nicotine, tar, benzene and benzo (a) pyrene. The gas part of cigarette smoke includes carbon monoxide, ammonia, formaldehyde, and hydrogen cyanide<sup>159</sup>. Benzene and benzo (a) pyrene are environmental hazards and are known to cause cancer. In total, there are over 4,000 chemicals in cigarette smoke, of which 60 are known to cause cancer.

Worldwide, tobacco kills nearly 6 million people a year. The majority of these deaths are in tobacco users and ex-users, but almost 10% of these deaths are in people exposed to second hand smoke. The World Health Organisation estimates that tobacco will cause over 8 million deaths a year by 2030<sup>160</sup>. Tobacco is the leading risk factor for long term conditions, mainly cancer, cardiovascular disease and respiratory disease. Diseases categorised as smoking attributable by the London Health Observatory are:

- Cancers of: Lip, Oral Cavity, Pharynx, Oesophagus, Stomach, Pancreas, Larynx, Trachea, Lung, Bronchus, Cervix Uteri, Kidney and Renal, Pelvis, Urinary, Bladder, Acute Myeloid Leukaemia.
- Cardiovascular diseases: Ischemic Heart Disease, Other Heart Disease, Cerebrovascular Disease (stroke), Atherosclerosis, Aortic Aneurysm, and other arterial diseases.
- Respiratory diseases, Pneumonia, Influenza, Bronchitis, Emphysema, Chronic Airway Obstruction.
- Diseases of the digestive system such as stomach ulcer, duodenal ulcer, Crohn's Disease, Periodontal Disease.
- Other diseases such as age related cataracts, hip fractures, and spontaneous abortion.

In England, tobacco use is the greatest cause of health inequality, affecting most those who live in the greatest areas of deprivation due to high use and poor health. Tobacco related illness costs the NHS £2.7 billion per year. This cost does not include the costs to social care and business resulting from long term sickness and disability.

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<sup>158</sup> WHO 2011 Health Topic Tobacco

<sup>159</sup> ASH Factsheet What's in a cigarette? July 2009

<sup>160</sup> WHO Factsheet No. 339 Tobacco. July 2011

## The Local Picture

The estimated smoking prevalence for Waltham Forest is 19.3% for the general population aged 16 and above<sup>161</sup>. This is lower than the estimated prevalence for England (21%). Preliminary results from the local NHS Health Checks programme indicate an estimated prevalence of 24% for those aged 40 to 74 who received an opportunistic health check from their GP. Opportunistic health checks have been provided to people visiting their GPs for other health reasons from late 2008.

The smoking prevalence in England has declined over the past 10 years from 28% (1998) to 21% (2008). This equates to approximately 8 million current smokers, half of which will die prematurely if they continue to smoke<sup>162</sup>. Certain groups are more likely to smoke than others. People who have jobs in the Routine and Manual sector are more likely to smoke (prevalence fell from 31% to 29% for this group) and are more likely to find it difficult to stop. Disadvantaged and vulnerable communities may also experience higher rates of smoking and difficulties in stopping.

Compared to England for the timeframe between 2007 and 2009, deaths due to conditions attributable to smoking, including lung cancer, heart disease and stroke, are generally poor although not statistically different nationally. The greatest concern for Waltham Forest is the rate of smoking-attributable hospital admissions. The rate of admissions in 2009-10 was 1753.8 per 100,000 population aged 35 and over. Waltham Forest is ranked 3<sup>rd</sup> highest in London for this indicator, which is higher than statistical comparators Greenwich and Croydon, and higher than the other PCTs in Outer North East London (See Figure 1). The rate of smoking-attributable hospital admissions is calculated using current smoking prevalence and the rate of ex-smokers. Due to some uncertainty of the smoking prevalence locally, the national estimated prevalence of 21% was used to calculate the provisional rate of admissions for 2010-11. The result shows that the rate could be much higher than previously reported. The rates are high across the borough, with significantly higher rates of admission in areas of high deprivation (See Figure 2). Smoking attributable hospital admissions accounted for 7.5% of all hospital admissions for adults aged 35 and over. This is an increase from the year before at 6.8%.

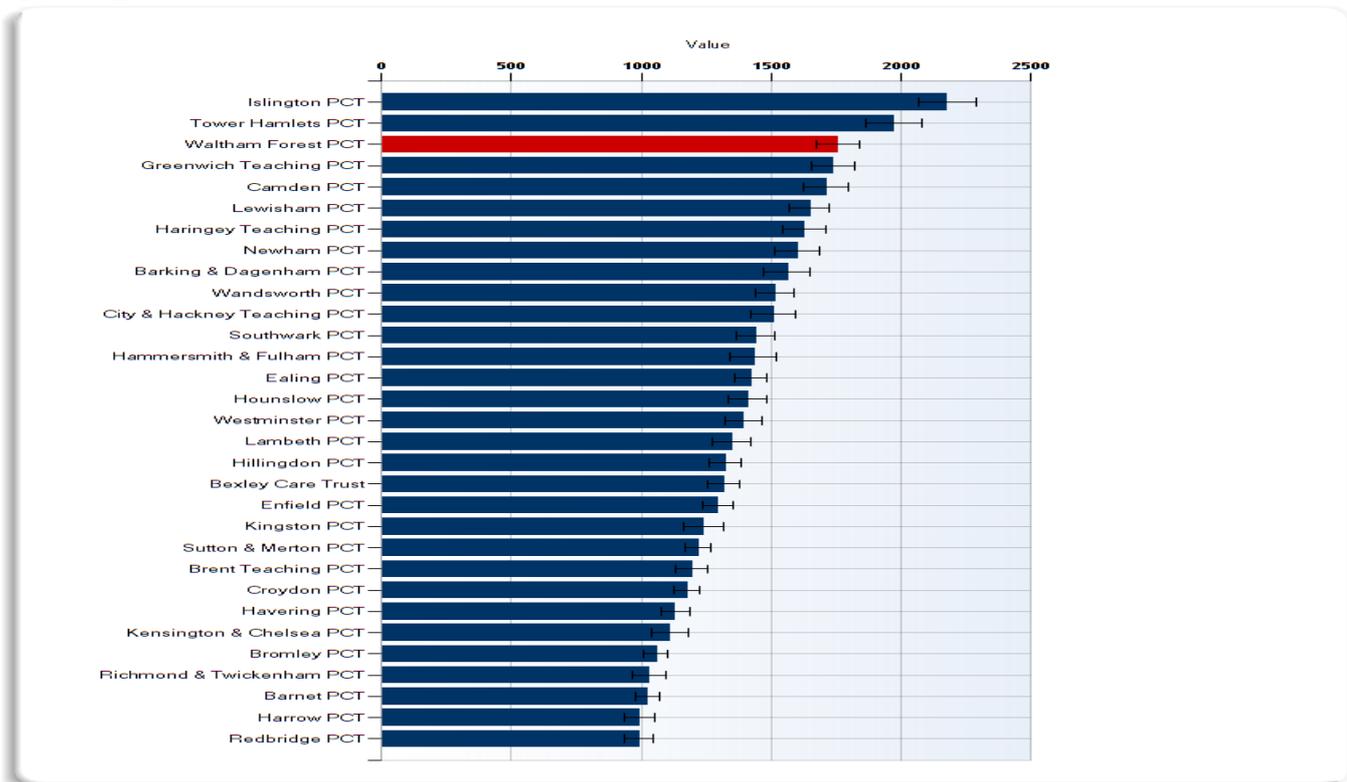
The wards with the highest rate of admissions are characterised by a high risk population, with some of the greatest concentrations of people employed in the Routine and Manual industry, who traditionally have higher rates of smoking compared to other occupations. The areas are also characterised by high need, with high levels of deprivation, an indicator of poor health outcomes.

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<sup>161</sup> London Health Observatory Tobacco Control Profile 2011

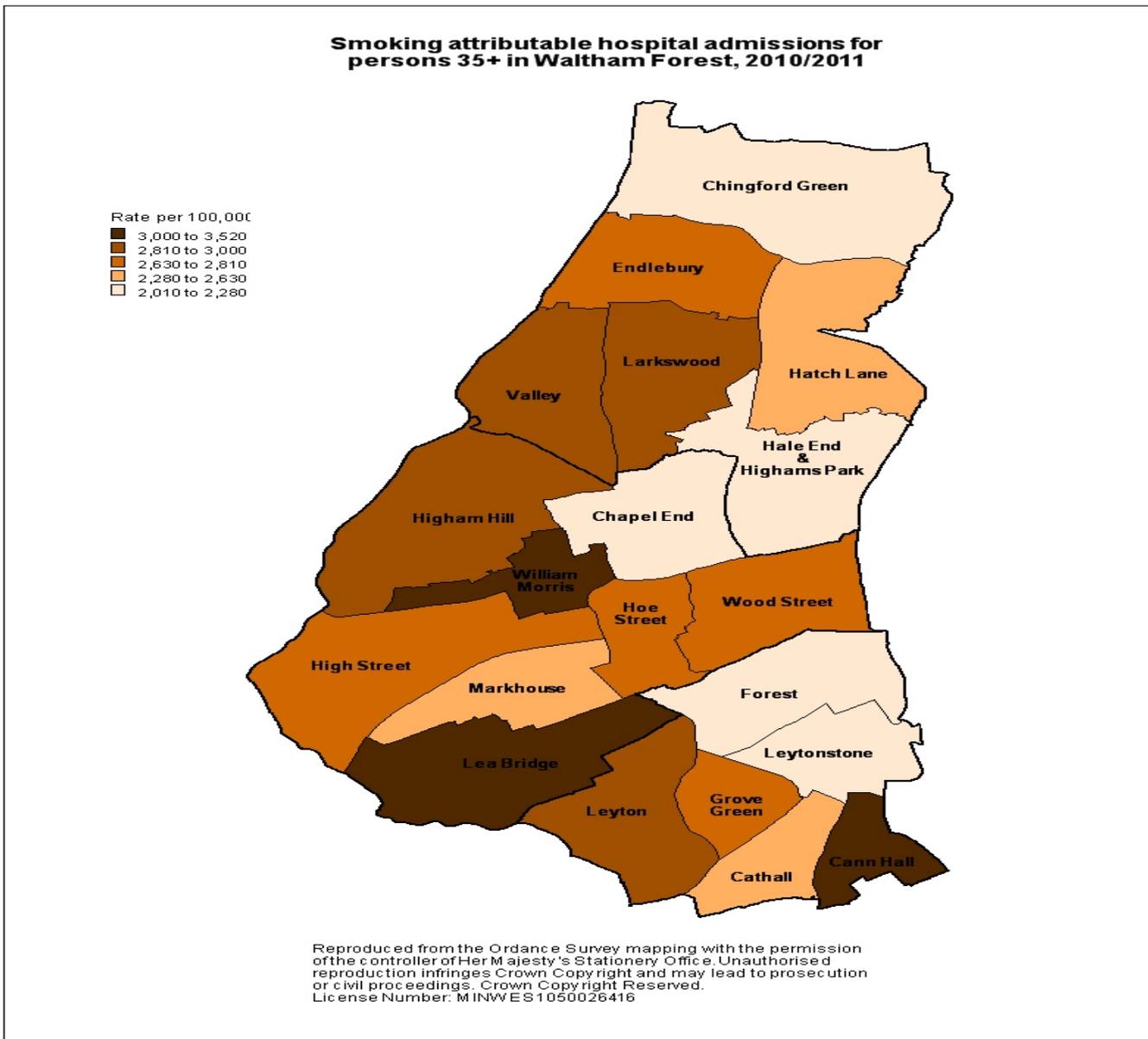
<sup>162</sup> A Smoke Free Future. Department of Health 01 February 2010

Figure 1: Directly age-standardised rate of smoking attributable hospital admissions per 100,000 population aged 35 years and over



Source: London Health Observatory Local Tobacco Control Profile 2011

Figure 2: Smoking attributable hospital admissions for persons 35+ in Waltham Forest 2010/11



### Effective Interventions

Based on national recommendations and the international evidence base, reducing the harm caused by tobacco should be achieved using a multi-sector approach. The ten year strategy for England has been published. Entitled *A Smokefree Future (2010)*, it describes the ten-year agenda to end tobacco related harm through three key objectives:

1. To stop the inflow of young people recruited as smokers: reduce the smoking rate among 11–15-year-olds to 1% or less, and the rate among 16–17-year-olds to 8% by 2020.
2. To motivate and assist every smoker to quit: reduce adult smoking rates to 10% or less, and halve smoking rates for routine and manual workers, among pregnant women and in the most disadvantaged areas by 2020.

3. To protect our families and communities from tobacco-related harm: aspiring to increase to two-thirds the proportion of homes where parents smoke but that are entirely smokefree indoors by 2020.

Effective interventions for reducing the number of young people who smoke include bans on advertising to reduce the appeal and supply of tobacco to young people, and making tobacco products less affordable. Protecting families and communities from tobacco-related harm includes reducing exposure to second hand smoke in the home. Evidence shows that children born in areas of high deprivation are more likely to have mothers who smoke in addition to greater exposure to second hand smoke throughout childhood, increasing their risk of developing long term conditions.

Clinical outcomes for smoking attributable diseases are improved when smokers quit even after diagnosis. A range of national clinical guidelines and protocols recommend smoking cessation. These include guidelines for heart disease, stroke, and chronic obstructive pulmonary disease (COPD) to name a few.

Encouraging more people to quit with the aim of meeting the 10 year targets for smoking prevalence requires a pro-active and effective smoking cessation programme. Nationally, smoking cessation programmes are NHS services delivered to local populations by trained professionals. It is an evidence based programme that uses behaviour modification techniques supported by pharmacotherapy (prescribed drugs) or nicotine replacement therapy (NRT) such as patches or gum. Treatment programmes typically last 6 to 9 weeks, focussing on achieving 4 weeks of abstinence. Evidence shows that people who abstain from smoking for 4 weeks are more likely to stay stopped, and begin to realise better health outcomes. NICE Guidance recommends that services treat 5% of the estimated smoking population, aiming for a minimum 35% successful quitter rate at 4 weeks validated by carbon monoxide measurement. Some service users may require ongoing support after successfully meeting the 4 week target<sup>163</sup>. Social marketing techniques are proven to encourage more people to access stop smoking services, and should be applied appropriately to high risk and hard to reach groups.

The national strategy estimates that successful implementation of the strategy will result in net savings for the NHS between £1.5 billion and £2.4 billion. The estimated net savings to society as a whole, including the NHS, could be as high as £15 billion for that 10 year period (2010-2020).

### **What is being done to locally address this issue?**

The NHS Stop Smoking Services are well established in the borough, and have been in operation for over 6 years. Over that time the service has performed well, maintaining a position within the top ten London PCTs for high rates of successful quitters. The Service leads on social marketing campaigns, and has delivered several face to face events to engage with the community, and have successfully worked with mosques,

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<sup>163</sup> NICE public health guidance 10

Smoking cessation services in primary care, pharmacies, local authorities and workplaces, particularly for manual working groups, pregnant women and hard to reach communities

schools and local businesses to assist smokers to quit. The number of service users began to reduce in 2009/10, with a dramatic decrease in numbers in 2010/11, despite active local campaigns. Referrals from a range of sources including the national help line also decreased significantly. As a result, only 2% of the estimated number of adult smokers successfully quit in 2010/11. Actions to increase activity included setting up electronic referral systems for GP practices to facilitate access to the service, and implementing the new national training standards for all Stop Smoking Advisors. The Choose and Book system for referring practice patients into the service has resulted in steady levels of referring, and ensured that patients were contacted within 5 days of referral. Nearly 30% of community stop smoking advisors in Waltham Forest completed the first phase of the national programme operated by the National Centre for Smoking Cessation and Training (NCSCT), and 30% of that cohort have gone on to complete the second phase of the training by the summer of 2011. New service providers took over the Waltham Forest Stop Smoking Service in May 2011 working against a service specification that addresses target groups and high risk smokers.

### **Prevention**

The local Trading Standards team are active in enforcing tobacco related legislation. Regular test purchases are performed across the borough to establish the amount of underage sales that happen locally. In 2008/09 and 2009/10, 5% of test purchases resulted in an underage sale. In 2010/11, the team increased the volume of test purchases, resulting in 19% of tests resulting in underage sales. This is 3% higher than the national average of 15% reported in the Local Government Survey on Tobacco published in 2009. This increase in activity is representative of the local authority's determination to discover the true extent of underage sales and take remedial action. National legislation that bans the sale of tobacco from vending machines will come into force on 01<sup>st</sup> October 2011. The local Trading Standards team confirm that there are very few tobacco vending machines in the borough, and are working with the locations that have them to ensure the legislation is enforced.

The local NHS Stop Smoking Services are engaged with the local community to distribute information on the harm caused by smoking through maintaining a presence at local events and in the local media. National campaigns are supported by the Stop Smoking Services. National No Smoking Day in March 2011 was an opportunity for a range of lifestyle and physical activity services to demonstrate alternatives to smoking in an event in the Walthamstow Town Square.

### **Primary Care**

Local GP practices are ideally placed to identify people who smoke, and provide brief advice on tobacco harm and how to access help to stop. Referrals into the local stop smoking service have increased over the past year, and are more stable across the course of the year. The number of trained Stop Smoking Advisors in primary care has also increased. More practices are trying different techniques to encourage their registered patients to access the stop smoking services.

## **Secondary Care**

A dedicated Stop Smoking Clinic was re-established in Whipps Cross Hospital in 2010/11, and operates once a week in the Out Patient's department. The cardiology department at the hospital is working closely with specialists in the Stop Smoking Service to establish more robust pathways into smoking cessation for their patients.

## **Community Services**

The NHS Stop Smoking Service contracts a wide range of community practitioners in Pharmacies and Community Specialist Services to work as trained advisors for the communities they serve. In addition, the service operates four drop-in clinics where smokers can receive weekly support without appointment. As a result, the service can cater for the majority of the languages spoken locally such as Polish and Urdu. Services are available somewhere in the borough from 8am to 8pm.

## **Social Services**

The local authority has established a resource hub in Leyton for carers to receive information and services in one place. A further three hubs are predicted to open in the following year and are ideally placed to offer stop smoking services to hard reach groups such as carers.

## **Public Perspective**

The national Statistics on Smoking: England 2010 reports the following key findings:

- In adults aged 16 and over (2008/09)
  - 67% of smokers reported the desire to quit
  - 75% of smokers reported making quit attempts in the past
  - 69% of adults do not allow smoking in the home
  - 81% of respondents agreed with the smoking ban in public places
  
- In pupils aged 11 to 15
  - 36% of pupils who were regular smokers reported a desire to quit
  - 34% pupils think it's OK to smoke (compared to 54% in 1999)
  
- 66% of all current and ex-smokers started smoking before the age of 18.

## **What more do we need to know?**

National level data suggests that many adults understand the risks of smoking to health. The decrease in stop smoking service users, high volume of underage tobacco sales and uncertainty of local prevalence indicates that more local level data is required provide greater insights into the needs of Waltham Forest residents and tobacco control.

Recommendations for future needs assessments include

- Drill down into hospital admission data to help understand need and expenditure.

- A comprehensive local survey to improve smoking prevalence estimates, attitudes to smoking and health and local needs.
- Systematic engagement with residents regarding tobacco issues.

### **Priorities for the next 5 years**

The Local Authority and the NHS are working hard to reduce the burden of tobacco use in their areas, although more needs to be done to work collaboratively and with residents to refine local needs and aggressively tackle this preventable cause of health inequality. The recently formed Tobacco Control Alliance will work with stakeholders to ensure the implementation of the following priorities:

1. Local level implementation of the national tobacco control strategy.
  - a. Dedicated enforcement of all legislation to reduce smoking uptake by young people and increase engagement to support healthy decision making regarding tobacco use.
  - b. Reduce local smoking prevalence to 10% and halve the rates of high prevalence groups.
  - c. Implement and monitor compliance to smoke free homes.
2. Multi-sector collaboration to reduce smoking-attributable hospital admissions.

## **Obesity**

### **Executive Summary**

Obesity in Waltham Forest continues to be on the increase. Data from the National Child Measurement Programme (NCMP) show that underweight children need support. Some of our recommendations last year were not fully achieved and these are again highlighted in this years' JSNA. One key recommendation last year was to ensure that our commissioned Weight Management Service meets NICE Guidelines and best practice. This is still in the process of being redesigned due to lack of resources. However, we have increased the alternative for physical activity outside leisure centres with the introduction of our community Fit Club. Work relating to limiting the proliferation of Fast Food outlets and reducing health inequalities continues. Our long term vision is to provide an environment that enables all our residents to make healthy food choices, to stay physically active and to maintain a healthy weight. The work we do to prevent obesity in pre-school children is crucial to achieving this since prevention is more effective than management. The strategy document, Healthy Weight – Achieving a Healthy Weight for All in Waltham Forest is a local approach that provides a public health framework to tackle obesity among adults and children in Waltham Forest.

### **Recommendations**

- 1) Ensure adequate provision by building on the 'Go for It 'and 'Why Weight' Programmes.
  - a) Design and implement appropriate multi-component interventions for all target groups which include: healthy eating, physical activity and behavioural change. This has been shown to be a predictor of success in tackling obesity. Ensure pathway in place to cover tiers 1 – 3 based on NICE guidance for adults and children.
  - b) Set up programmes that are 10-12 weeks.
  - c) Cater for the working parents.
  - d) Introduce a screening tool to assess readiness to change to ensure that only motivated people are recruited to the service.
- 2) Commission pharmacists to offer weight reduction programmes based on NICE guidance and signpost to other services.
- 3) Pilot the Healthy Living Pharmacies scheme to deliver services such as weight reduction, stopping smoking, emergency hormonal contraception, Chlamydia screening, advice on alcohol and medication reviews.
- 4) Ensure adequate resources are allocated to the current weight management services so that the service meets NICE guidelines and best practice.

- 5) Ensure that work relating to limiting the proliferation of fast food outlets are reducing health inequalities and is embedded in new and emerging planning policies of the local authority.
- 6) Continue sustainable school based interventions to prevent overweight and obesity in partnership with relevant agencies. Parental family involvement should continue to be actively facilitated. This should include increasing the take-up of nutritional school meals with a focus on those eligible for free school meals.
- 7) Develop the localised Healthy Schools programme to ensure the Food in Schools work is sustained and there is consistent and accessible health and wellbeing support for pupils, their parents/carers and schools across the borough.
- 8) Continue dietetic input into children's centres to ensure consistent, easily accessible advice is available to parents/ carers around weaning age and beyond.
- 9) Ensure that resources are available to support children and parents/carers who are identified as being underweight following the NCMP.
- 10) Repeat the User satisfaction survey for 2010/2011 dietetic group education programmes.
- 11) With the change in funding for school sport and monitoring more competitions should be developed to enable participation by young people in schools.

### **What is Obesity?**

Obesity is caused by an imbalance between 'energy in' (calories consumed) and 'energy out' (calories expended by the body and through physical activity). Healthy decisions, however, are influenced by broader social and environmental factors. The Foresight<sup>164</sup> report identifies four headings under which these factors can be allocated. These are

- Human biology.
- Culture and individual psychology.
- The food environment.
- The physical environment.

**Table 1: WHO Classification of obesity**

<u>Classification</u>	<u>BMI (kg/m<sup>2</sup>)</u>	<u>Risk of co-morbidities</u>
Underweight	<18.5	Low*
Healthy weight	18.5-24.8	Average
Overweight	25-29.9	Increased

<sup>164</sup> Foresight (2008) Tackling Obesities: Future Choices, Government Office for Science

Obesity, class I	30-34.9	Moderate
Obesity, class II	35-39.9	Severe
Obesity, class III	>40	Very Severe

In England almost two thirds of adults and a third of children are either overweight or obese and without effective action this could rise to almost nine in ten adults and two thirds of children by 2050.<sup>165</sup> Overweight and obesity increase the risk of a wide range of diseases and illnesses, including coronary heart disease and stroke, type 2 diabetes, high blood pressure, metabolic syndrome, osteoarthritis and some cancers. Obesity poses a threat to the health and wellbeing of the population, as well as a huge financial burden on both the NHS and the wider economy.

## Physical Activity

### What is physical activity?

Physical activity includes all forms of activity, such as everyday walking or cycling to get from A to B, active play, work-related activity, active recreation (such as working out in a gym), dancing, gardening or playing active games, as well as organized and competitive.<sup>166</sup>

Physical inactivity is the fourth leading risk factor for global mortality accounting for 6% of deaths globally. This is followed by high blood pressure (13%), tobacco use (9%) and high blood glucose (6%). Overweight and obesity are responsible for 5% of global mortality. The World Health Organisation also highlighted that there is a clear causal relationship between the amount of physical activity people do and all-cause mortality.<sup>167</sup>

### Who is most at risk?

The people who are least active are those at greatest risk of ill health. Increasing the activity levels of adults who are not meeting the recommendations is important and will produce the greatest reduction in chronic disease.

According to research, some sectors of the population are at considerably higher risk of developing obesity, with an associated increase in the incidence and prevalence of related co-morbidities. These groups are:

- Children, for genetic and/or environmental reasons from families where one or both parents are overweight or obese
- Individuals from particular Black Minority Ethnic (BME) groups
  - Children who are Asian are 4x more likely to be obese than those who are white.

<sup>165</sup> DH(2008) Healthy Weight Healthy Lives: A cross Government Strategy for England, DH London

<sup>166</sup> DH (2011) Start Active, Stay Active, A report on Physical activity for health from the four home countries' Chief Medical Officers

<sup>167</sup> World Health Organisation(2010) Global Recommendations on Physical Activity for health

- Indian men – 41% centrally obese compared to 28% of men in the general population.
- Women – in 1999 obesity among Black Caribbean women was 50% higher than the national average, and 25% higher among Pakistani women.
- People living on a low income where, for example 14% of women in social class 1 are obese compared with 28% in social class V.
- People who stop smoking.
- Older people: Increasing age is associated with increasing prevalence in obesity up to the age of 64 years, when a decline in the prevalence begins.

Certain points in life have also been found to be associated with weight gain: pregnancy, menopause and smoking cessation (NICE 2006).<sup>168</sup>

More recently, people who use mental health services, in particular those with a diagnosis of schizophrenia or bipolar disorder, have been identified as being at increased risk of greater levels of obesity and associated conditions, such as heart disease and diabetes (DH 2006).<sup>169</sup> In addition to the groups listed above, it is important to also consider the needs of those disadvantaged groups for whom barriers to accessing services are known to exist, including: people with mental health problems, people with a disability and people for whom English is not their first language.

A link has been established between breastfeeding and obesity in later life. Research suggests that children who are breastfed are less likely to be overweight or obese as they grow up and so should form part of a wider consideration of the issues to do with obesity.

There is evidence that weaning earlier than current recommendations leads to rapid weight gain in infancy which may in turn increase the risk of child obesity.<sup>170</sup> Early weaning has also been found to be associated with increased weight and body fat at age 7 years.<sup>171</sup>

## **Local Picture**

### **Adults – Obesity**

Estimates suggest that adult obesity in Waltham Forest is 25% compared to Croydon 23.5%, Enfield 23.2%,

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<sup>168</sup> NICE (2006) Obesity: Full guideline – section 3 Prevention –evidence statements & reviews, NICE

<sup>169</sup> DH (2006) Choosing Health: Supporting the physical health needs of people with severe mental illness, DH, London

<sup>170</sup> Sloan S, et al (2007) Early weaning is related to weight and weight gain in infancy, Child:care, health and development, 34,1,59-64

<sup>171</sup> Wilson AC, et al (1998), Relation of infant diet to childhood health: seven year follow up of cohort of children in Dundee infant feeding study, BMJ,316,21-25

Greenwich 23.4% and 24.2% for England. The 2009-2010 Quality and Outcomes Framework (QoF) data show that Waltham Forest had a diabetes prevalence in adults of 5.9% compared to Croydon 5.6%, Enfield 6.2%, Greenwich 4.9%, London 5.3% and the average in England of 5.4%.<sup>172</sup>

### **Adults – Physical Activity**

In the period 2007-2009, 7% of adults in Waltham Forest participated in sport and active recreation – defined as equivalent to 30 minutes on 5 or more days per week. Comparing with our statistical comparators and England, the percentage of adults who take part in regular moderate intensity sport and recreation in Greenwich was 9.5%, Enfield 7.5%, Croydon 7.4% in 2007-2009 compared to the average of 11.2% in England.<sup>173</sup>

### **Children – Obesity**

The recorded obesity rate in children in Waltham Forest increased between 2008-2009 and 2009-2010 in Reception pupils from 9.9% to 10.9%. The national average increased from 9.6% to 9.8%. In the same period, the obesity rate in Year 6 pupils increased from 20.6% to 21%, the national average increased from 18.3% to 18.7%. The percentage of children obese in London in 2009-2010 was Reception 11.6% and Year 6 21.8%.<sup>174</sup>

The recorded obesity rate in Croydon remained the same between 2008-2009 and 2009-2010 in Reception pupils at 11.1%. In the same period, the obesity rate in Year 6 pupils increased from 21.3% to 22.1%.<sup>175</sup>

The recorded obesity rate in Greenwich increased between 2008-2009 and 2009-2010 in Reception pupils from 12% to 13.2%. In the same period, the obesity rate in Year 6 pupils decreased from 22.9% to 21.5%.<sup>176</sup>

The recorded obesity rate in Enfield decreased between 2008-2009 and 2009-2010 in Reception pupils from 13.5% to 13%. In the same period, the obesity rate in Year 6 pupils decreased from 22.9% to 22.5%.

### **Children – Physical Activity**

In 2009/10, the School Sports Survey examined participation in three hours high quality PE and out of school sports, as the Public Service Agreement (PSA) indicator was already being achieved for 2 hours of such sports.

In that same year the proportion of pupils participating in at least three hours of high quality PE and out of hours school sport in a typical week in Waltham Forest was 84.% compared to the national average of 82% and our statistical comparators Croydon 79.0%, Greenwich 79.0%, and Enfield 81.0%.<sup>177</sup>

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<sup>172</sup> Child Health Profile (2011), Waltham Forest, [www.chimat.org.uk](http://www.chimat.org.uk)

<sup>173</sup> Child Health Profile(2011),Waltham Forest, [www.chimat.org.uk](http://www.chimat.org.uk)

<sup>174</sup> Child Health Profile (2011), Waltham Forest, [www.chimat.org.uk](http://www.chimat.org.uk)

<sup>175</sup> Child Health Profile (2001) Waltham Forest, [www.chimat.org.uk](http://www.chimat.org.uk)

<sup>176</sup> Child Health Profile (2011) Waltham Forest, [www.chimat.org.uk](http://www.chimat.org.uk)

<sup>177</sup> Child Health Profile (2011), Waltham Forest, [www.chimat.org.uk](http://www.chimat.org.uk)

## Underweight

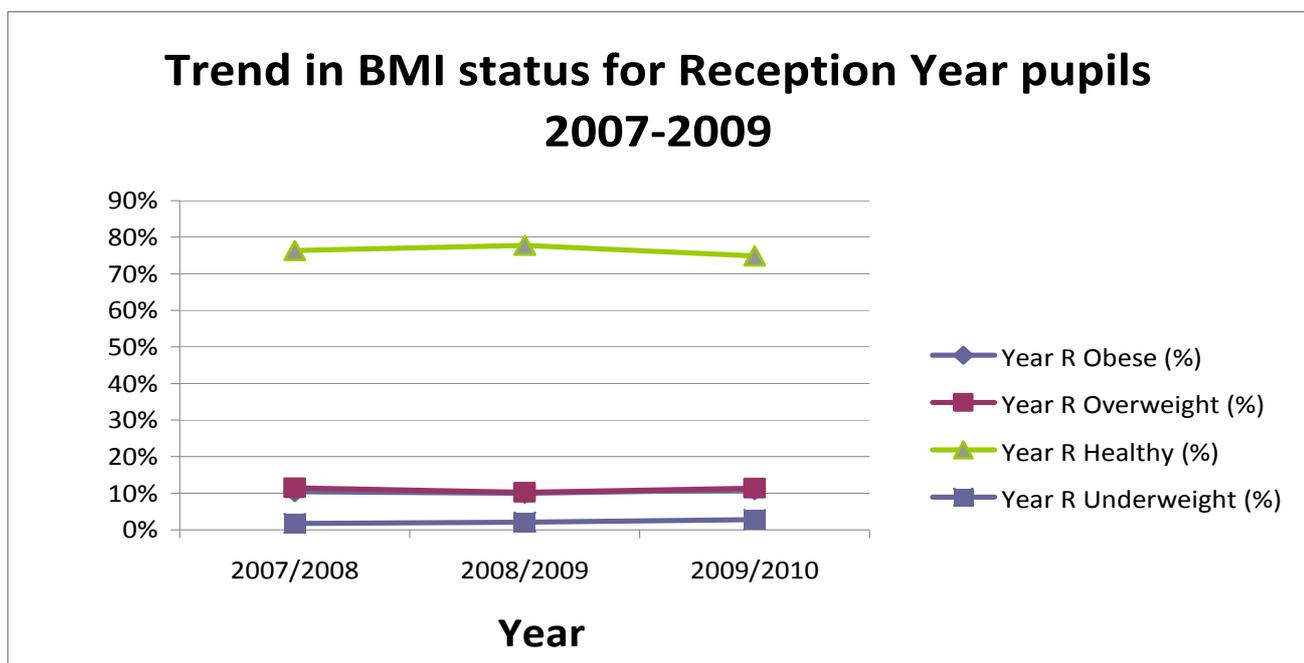
Being underweight is not the same as being thin or slender. Some children have a naturally slight build and maintain this with a well-balanced diet and physical activity. This is normal and healthy. There are several possible reasons for being underweight:-

- not consuming enough food
- an underlying illness
- stress,
- obsessive exercise
- lack of interest in eating
- or a sudden growth spurt

Children in the poorest households are twice as likely to be underweight as those in the least poor households. Children living in rural areas are more likely to be underweight than those living in urban areas.<sup>178</sup>

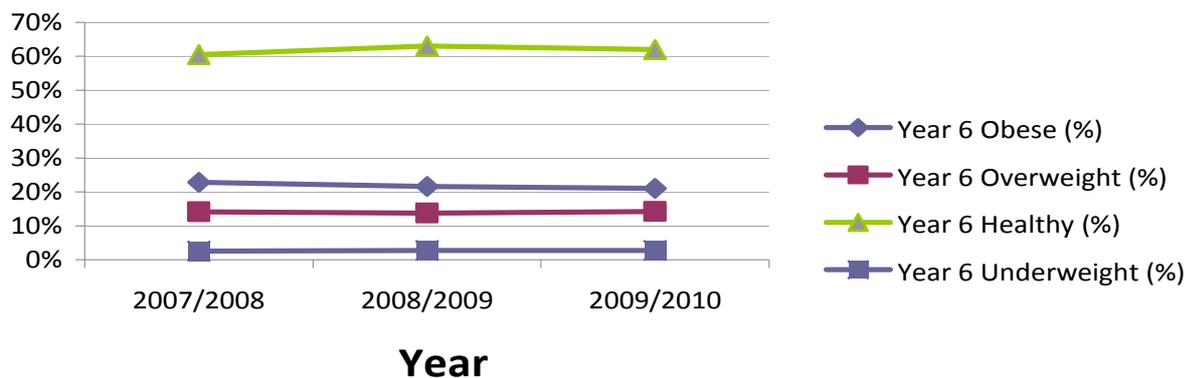
The recorded underweight rate in children in Waltham Forest increased for the Reception year 2008-2009 from 2.13% to 2.8%. There was no change of 2.8% for the same period for year 6.

Although under weight children are in the minority they should also been seen as a priority in Waltham Forest. The graphs below show the Trend in BMI status for Reception Year pupils from 2007 – 2009.



<sup>178</sup> WHO (2001), Global Health Observation [http://www.who.int/gho/mdg/poverty\\_hunger/situation\\_trends\\_underweight/en/index.html](http://www.who.int/gho/mdg/poverty_hunger/situation_trends_underweight/en/index.html)

## Trend in BMI status for Year Six pupils 2007-2009



### What are the effective interventions?

The increase in the number of overweight and obese children and adults has been documented in a number of significant reports and Government White Papers.

- The policy issues raised have been translated into national delivery plans, National Service Frameworks and toolkits. These documents are designed to help partners to develop and support local action. They include:
  - ‘Choosing Health White Paper’ and subsequent delivery plans, Delivering Choosing Health: Making Healthier Choices Easier’; Choosing a Better Diet: A Food and Health Action Plan; and ‘Choosing Activity: A Physical Activity Action Plan’ (2005).
  - Lightening the Load: Tackling Overweight and Obesity – A Toolkit for Developing Local Strategies to Tackle Overweight and Obesity in Children and Adults’ (National Heart Forum, Faculty of Public health and the NHS 2007).
  - National Service Framework for Children, Young People and Maternity Services, Standards 1, 2, and 3 (November 2006).
  - Maternity Matters: Choice, Access and Continuity of Care in a Safe Service (April 2007).
  - Physical Activity and the Environment (National Institute for Health and Clinical Excellence (NICE), 2008).
  - Healthy Weight, Healthy Lives: A cross Government Strategy for England (January 2008).
  - Let’s Get Moving - A new physical activity care pathway for the NHS: Commissioning Guidance (September 2009).

The new White Paper *Healthy Lives, Healthy People: Our strategy for public health in England (2010)* highlighted Healthy Living Pharmacies (HLPs) in Portsmouth. These HLPs proactively promote a healthy living ethos and work closely with local GPs and other health and social care professionals. HLPs have to demonstrate consistent, high-quality delivery of range of services such as weight management, stopping smoking, emergency hormonal contraception, Chlamydia screening, advice on alcohol and reviews of the use of their medicines.<sup>179</sup>

In addition NICE has produced:

- *Clinical Guidance Number 43: Obesity: the Prevention, Identification, Assessment and Management of overweight and Obesity in Adults and Children (November 2006)*
- *NICE Dietary interventions and physical activity interventions for weight management before, during and after pregnancy (July 2010)*
- *NICE guidance on promoting and creating built or natural environments that encourage and support physical activity.*

### **What is being done locally to address this issue?**

Our long term vision is to provide an environment that enables all our residents to make healthy food choices, to stay physically active and to maintain a healthy weight across their lives.

We will use the opportunity of the 2012 Olympic and Paralympic Games and its legacy to achieve a maximum momentum for this aim.

We have reintroduced free swimming for Under 18s in school holidays and at all times for over 60s and are working with partners and voluntary sector organisations to sustain activity including seated aerobic classes, healthy walks, recreational jogging and cycling. We have developed sport specific development groups to create a legacy for the future and are working with local organizations and sports clubs to build capacity through training more coaches and providing more equipment to enable increased participation and opportunity.

Some primary and secondary school are opened throughout the summer holidays providing sport and art cultural activities.

### **Challenges Locally**

Achieving change on levels of obesity is clearly a long-term challenge and interventions must be sustainable.

- Partnership commitment and communication given the breath of the strategy.
- Given the financial constraints within the PCT and Local Authority keeping it high on the agenda will be a challenge.

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<sup>179</sup> DH (2010) *Healthy Lives, Healthy People: Our strategy for Public Health in England*, Department of Health

- NHS reforms.
- Funding and Staffing constraints.
- Sustainability.
- Having a robust structure of accountability for the implementation of the strategy.

### **What is the perspective of the public on support available to them?**

The Nutrition and Dietetics Service of Waltham Forest undertook a patient survey of all their group education programmes. The survey involved patients who completed any programmes between Dec 2008 and Dec 2009.

These programmes included

- Why Weight?
- Go For It!
- Teen Why Weight?
- X-pert

The results of this survey highlighted that 36% of service users are British and 23% are Black Caribbean. 71% of responders said that the programme they attended helped them start to make changes to their lifestyle.

### **What evidence is there that we are making a difference?**

The Change for Children team continues to work with schools with positive outcomes. Our schools:

- Provide healthy lunches which meet the government food and nutrient-based standards. These promote health and wellbeing including maintaining a healthy weight.
- Year 6 obesity prevalence in Waltham Forest has demonstrated a downward trend since the National Child Measurement Programme commenced in 2006/07 (-2.7%), with the exception of the 2010 results where a 0.4% increase occurred.
- 89% of schools have achieved Healthy School Status and 100% are engaged with the programme. Healthy eating and physical activity are two key themes of this award. Schools evidence a whole school approach including leadership, policies, curriculum, and environment including school food & physical activity provision, pupil and parent engagement and linking with local services.

The scale of the problem demands that a population approach is taken to tackle obesity. The issue of obesity, physical activity and healthy eating are already integral to a wide range of local strategies, for example

- ONEL Breast Feeding strategy
- NHS Waltham Forest Healthy Child programme 0-5 years
- Waltham Forest Health Inequalities Strategy
- Action Plans on Coronary Heart Disease, Diabetes, Cancer, Mental Health all highlight the importance of preventing and managing obesity and promoting healthy lifestyles and physical activity

- Joint Strategic Needs Assessment
- Children and Young People Plan
- Change for Children Service Plan
- Waltham Forest Local Development Framework Core Strategy
- Waltham Forest's Health Inequalities Strategy
- Waltham Forest Hot Food Takeaway Supplementary Planning Document
- Waltham Forest Catering School Meal Strategy
- Nutritional Guidelines for 0-5 years

The council considers the provision of high quality, safe and accessible open spaces within the Borough as essential to ensuring opportunities for physical activity in order to promote healthy living and preventing illness. Areas of quantity, quality or access deficiency should be reduced and where possible eliminated and new public spaces provided. The council will also support and cultivate the provision of innovative opportunities for sport and recreation for all sections and age groups of the community.<sup>180</sup> This includes the provision of free swimming during school holidays for under 18s and at all times for 60 plus residents.

Waltham Forest council has planning policies in place which seek to reduce the proliferation of Hot Food Takeaways, particularly near schools as a means of combating their known adverse impact on community health.

The Change for Children team support schools to achieve all 5 outcomes of the Every Child Matters agenda and to meet criteria for the Healthy Schools programme. Established in 2006, the Food in Schools programme sits within the Change for Children Team. The aim of the programme is to work with key partners and all schools in the borough to ensure healthier food is provided and promoted as part of a whole school approach. The programme is managed by the Food in Schools Programme Manager and co-delivered with the Food in Schools Dietician. Activities include providing expert advice to schools on food and nutrition, offering training opportunities for school staff, including school nurses, working with parents and pupils to promote healthy eating and the benefits of school meals, supporting schools with meeting the standards for food and drinks served across the whole school day and working with schools to develop food policies. The contract for this service ceases at the end of March 2012 and it is unclear how schools will be supported after this time.

The Waltham Forest Catering School Meals Strategy focuses on increasing the number of children and young people benefitting from having nutritious school meals.

The Nutrition and Dietetic Service has a SLA with the London Borough of Waltham Forest to provide health promotion advice and activities within their 17 children's centres until the end of March 2012. The consultation

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<sup>180</sup> Waltham Forest LDF Core Strategy 2011

'A future for children centres – a public consultation on what we do next' has ended, and the outcome of this may alter future service provision.

An Obesity Health Needs Assessment has been undertaken which identified gaps in the services and unmet health needs. A healthy weight care pathway for both adults and children, incorporating weight management and specialist programmes has been developed alongside exercise on referral to offer primary and secondary prevention services.

Feedback received from parents/carers following the National Child Measurement Programme and the obesity needs assessment highlighted that the commissioned Weight Management Services is not flexible in meeting the needs of the working parent /carer.

### **What are the priorities for improvement over the next 5 years?**

Our long term vision is to reduce obesity and support residents to achieve a healthy weight. The work we do to prevent obesity in pre-school children is crucial to achieving this since prevention is more effective than management. An ONEL sector wider breastfeeding strategy has been developed and breastfeeding is incorporated into the Healthy Weight Strategy Action plan. (*Please refer to the section on Maternal and Child health section for more information on Breastfeeding*).

The strategy document, Healthy Weight – Achieving a Healthy Weight for All in Waltham Forest is a local approach that provides a public health framework to tackle obesity among adults and children in Waltham Forest.

Our priorities are as follows:-

- Increase participation in physical activity by creating social, cultural and physical environments that supports and encourage active lifestyles.
- To promote healthy eating by increasing the availability of and access to healthy food choices & reducing the availability of and access to food that are high in fat, sugar and salt including promoting taking nutritious school meals.
- To provide consistent, evidence based information, education and advice on how to maintain a healthy weight.
- To provide consistent, evidence based advice, support and treatment for people who are overweight or obese and their families.
- To create healthy organisations that support and encourage active lifestyles and healthy eating.

# Section 5

children and young people



■ Maternal and Child Health

## Maternal & Child Health

### Executive Summary

#### Demographics

- Increase in births at Whipps Cross – 27% increase from 2006/07 to 2010/11.

Waltham Forest is doing well on:

- Breastfeeding initiation – within the top 25% in the country (2009/10).
- Smoking in pregnancy – lower than London and England.
- Healthy Schools Scheme – 100% of schools engaged with programme.
- Diabetes, and epilepsy emergency hospital admissions for <18 year olds – lower than London and the Outer North East London boroughs.
- Lower respiratory tract infections emergency hospital admissions for < 18 year olds – lower than London.
- Accident and Emergency attendances for <5 year olds – lower than London and England.
- Elective hospital admissions for 0-4, 5-10 and 10-14 year olds – lower than London.

Waltham Forest has some challenges around:

- Infant mortality – equal to England rate but higher than London.
- Still births, perinatal mortality, low birth weight – higher than London and England.
- Early booking to maternity services (by 12 weeks gestation) – below the local target of 88% in 2010/11.
- Healthy Start Vitamins uptake for women and babies – lower than London and England.
- Prevalence of Breastfeeding at 6-8 weeks – below local target of 72%.
- Childhood immunisations coverage – below local targets and World Health Organisation (WHO) target of 95%.
- Oral Health – higher percentage with decayed, missing or filled teeth (dmft) than England.
- Human Papilloma Virus (HPV) vaccination programme coverage – lower than London and England.
- Child Well-being index – rank below England average.
- Child and Adolescent Mental Health Service– numbers of children and young people accessing services are larger in the higher tier of services (tier 4) and lower numbers in tier 2 and 3 where the reverse would have been expected.
- Gastrointestinal emergency admissions for persons <5 years old – higher than London but lower than England.
- Asthma emergency hospital admissions for <18 year olds – higher than London and England.
- Injury related hospital admissions for <18 year olds – higher than London and England.
- Elective hospital admissions for 15-19 year olds - higher than London.
- Teenage Pregnancy – higher than London and England.
- Looked After Children – rate of children in care is higher than national average.

Additionally:

- Young Carers – Numbers accessing specialist provisions and known to local authority is lower than estimated numbers of young carers in the borough.
- Domestic Violence - In 2009/10 there were 524 episodes of domestic violence involving 417 children and young people reported to the Councils' children's services.

## **Recommendations**

1. Build on joint health inequalities strategy to address infant mortality and child wellbeing.

## **Data**

2. Improve the Maternity data system in Whipps Cross University Hospital to provide robust data and improve monitoring and accurate reporting of Key Performance Indicators.
3. Commissioners should use the standard CAMHS data monitoring framework as the basis for contract specifications.<sup>181</sup> Local indicators should be added where required to ensure this meets local requirements. The data framework should be used for benchmarking.
4. Review data recording systems already used for recording data on children with disabilities and establish a central system for recording this data.
5. Embed Health Equity Audits across all Children's Services.
6. Review data on Vitamin D deficiency in the borough.
7. Improve early identification of, and data collection on, young carers.
8. Improve data collection and analysis around domestic violence in order to improve targeting services.
9. Improve information sharing (using agreed protocols) on adults who pose a risk to children around domestic violence.

## **Quality**

10. Plans to implement the new Infectious Disease Programme Standards are required as standards need to be implemented by March 2012.
11. Localise national guidelines for the Healthy Child Programme for children and young people aged 5 – 19 years.

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<sup>181</sup> Commissioning Support for London (CSL) and National CAMHS Support Service Standard Data Monitoring Framework. 2010

12. Update local nutritional guidelines 0-5 years and raise awareness amongst all relevant health professionals.
13. Implement the action plans developed from the detailed Antenatal and Newborn Screening programme audits, including undertaking an annual survey of women's experiences of Antenatal Screening Programmes to inform service improvement.
14. Disabled Children - Improve parental experiences of services for disabled children.
15. Develop outcomes focused measures for commissioning Maternal and Child Health services.
16. Strengthen needs assessments including assessment of needs of the person cared-for in order to develop a whole family approach to support young carers.
17. Develop formal reporting mechanisms for senior managers and the LSCB to receive reports on outcomes for young carers.

## **Service**

18. Develop a strategy that covers pregnancy through childhood to 18 years and action plan to include recommendations from the report Early Intervention: The Next Steps and other key documents. Ensure identified gaps are delivered and make investment where necessary to achieve objectives of strategy.
19. Increase the uptake of Children and Women's Healthy Start vitamins by implementing good practice that has worked in other areas e.g. training for health professionals, improving access by increasing the number of distribution points, developing a policy and publicity materials.
20. With the increase in births at Whipps Cross, build on the significant work ongoing in Maternity to further meet needs and improve the quality of services for women and babies. Include expanding the "In my shoes" focus groups to take into account the needs of women delivering e.g. women from the White Other Ethnic Group and women who were born outside the UK who constitute a high percentage of women giving birth.
21. Develop an Oral Health Strategy for children and young people up to the age of 18 in the borough based on an assessment of needs.
22. Commission the proposed school based Child Oral Health Programme by Queen Mary's which will offer fluoride varnish amongst other initiatives to improve oral health.

23. Review local data on emergency hospital admissions for asthma to look at coding issues that may be evident in the data and put appropriate actions in place to reduce admissions including education programmes for children and their families who attend accident and emergency for Asthma to reduce re-attendance if appropriate.

24. To increase childhood immunisations coverage:

- During transition and changes, ensure the sustainability of a coordinated immunisations programme between primary care, child health and other partners.
- Commissioners should make an investment to set up GP payments for immunisations based on the RiO Child Health Information system which should improve the coverage reported.
- Commissioners should invest in a Local Enhanced Service (LES) to incentivise GP practices to reach 95% coverage.
- Staff completing a Health Assessment for Looked After Children should ensure immunisations uptake is complete for each LAC in the borough to 95%.

25. To improve CAMHS services:

- Commissioners and providers should monitor the implementation of the new CAMHS model which has been developed to ensure it delivers an improved service for children and young people. Delivery of the Emotional Health and Wellbeing Strategy should be monitored together with the areas of the NHS Operating Framework for 2011/12 which has direct relevance to improving children's mental health and well-being.
- Improve CAMHS needs assessment by undertaking an ONEL wide needs assessment and develop an integrated strategy.
- Data within specialist CAMHS service needs to be improved. Providers should regularly review and audit data to ensure the quality and integrity of the data. The recording of outcomes and ethnicity should be improved in order to monitor effectiveness as well as identify inequalities in access to deliver targeted services to high risk groups.
- Commissioners and providers should use the CAMHS Comprehensive Workforce Planning Tool to support developing a good workforce model for Waltham Forest. Within this, specialist CAMHS services support to tier 1 universal services to develop skills for early identification and

appropriate referral where necessary should be monitored necessary.

- Commissioners and providers should review the provisions at Transition from CAMHS to Adult Mental Health Services (AMHS) for young people and implement recommendations.

26. Develop a children's mental health strategy that takes the CAMHS work across the four boroughs that use North East London Foundation Trust mental health services as a starting point to include prevention and early diagnosis.
27. Ensure progress to deliver a quality Health Visiting service to meet the needs including continuing efforts to deliver increased 1 year health reviews coverage, while maintaining 2 year reviews. The Health Visiting service should also expand in line with the Health Visitor Implementation plan 2011–2015.
28. Review the Best Start in Life (BSiL) pilot to align maternal and early childhood services and expand as appropriate ensuring sustainability.
29. Develop the Unicef Baby Friendly 7-step plan initiative in the community, align commissioning to the breastfeeding commissioning guidance tool and deliver the ONEL wide Breastfeeding Strategy.
30. Embed childhood prevention work in frontline staff work e.g. GPs, Children's Centre's, Midwifery, Health Visiting, School Nurses to includes areas such as increasing awareness of importance of immunisations and breastfeeding.
31. Once the results of the Children's Centre consultation are published and proposals are finalised, monitor Children's Centre activity to ensure they are meeting the needs and any risks are minimised.
32. Sustain and expand the Family Nurse Partnership programme and embed into the Health Visiting service.
33. Increase the number of CAF assessments completed, broadening the range of practitioners using CAF. Supporting professionals through provision of training and support to complete CAF process should increase numbers. Health professionals and others should ensure the CAF process is embedded in normal practice for staff in different services.
34. Implement recommendations following the recent Ofsted/CQC safeguarding inspections in Waltham Forest.

35. Disabled and Looked After Children – review and develop strategy to improve services (e.g., provision of therapies) and experience of parents.
36. Review adequacy of therapy provision such as Physiotherapy and Speech and Language Therapy for Waltham Forest Children and Young People with disabilities. Through increased investment, ensure Occupational Therapy services meet the needs of Waltham Forest Children.
37. Review the Healthy Schools Programme with a view to continuing best practice beyond March 2012.
38. Improve awareness of the range of services available for young carers.
39. Work with voluntary sector providers to increase take-up of carers' assessments and services among hidden carers.
40. Enhance transition support for young carers, as they transition from Children and Young People's Services to Adult Social Care.
41. Enable young carers aged 16 and over to access education, employment and training opportunities.
42. Work with schools and the local community to raise awareness of the needs of young carers and promote a culture where young carers feel comfortable to come forward to access support services.
43. Develop a consultation and engagement plan with young carers.
44. Commission a domestic violence service that offers therapeutic interventions including counselling and practical support for perpetrators to cease their violent and /or controlling behaviour, and support, counselling and advice to victims including children and young people affected.
45. Ensure victims and witnesses of domestic violence and sexual violence, including children and young people are adequately protected and supported.
46. Strengthen coordination of multiagency partnership working to protect children at risk of domestic abuse.

### **Looked After Children Recommendations**

1. Develop a Strategy for Looked After Children in Waltham Forest.
2. Undertake audit using the Looked After Children guidance audit tool published in 2010.
3. Develop the market for residential placements in order to improve the range and quality of local provision to meet individual needs particularly those with complex needs.

4. Collaborate with our sub-regional partners in order to broaden provision of semi-independent accommodation and short breaks.
5. Ensure personal education plans (PEP) are developed for each child and used by all professionals involved in the child's education.
6. Improve information sharing between professionals and agencies around the educational needs of looked after children including needs around transition to secondary and new schools.
7. Prioritise careers guidance for 14–19 year olds by appropriate teams.
8. Ensure looked after children with disabilities have access to specialist occupational therapy and social work support that provide routes into health and specialist care.
9. Strengthen corporate parenting including the role of lead members, and independent reviews of children's care plans in accordance with statutory guidance.
10. Develop and implementing robust pathway plans for children leaving care to ensure they develop skills for independent living.
11. Enhance social work support for looked after children in the criminal justice system.
12. Develop a recruitment and retention strategy for foster carers in order to increase the number of in-house foster carers.
13. Reviewing and streamlining adoption processes in order to increase adoption rates.
14. Improve transition support in order to facilitate the transition from children to adult services.
15. Embed 'team around the child' and multi-agency working in order to provide effective care especially around complex cases.
16. Improve access to specialist services such as CAMHS in order to improve the health and well-being of looked after children, and ensure services are sensitive to the individual needs of each child paying particular attention to the issue of diversity and its implications in terms of improved outcomes.

## **Maternal and Child Health**

The Marmot review proposed steps to reach a fair society and reduce the inequalities gap that exists between groups of people.<sup>182</sup> Giving every child the best start in life was given the highest priority. Action to reduce health inequalities must start before birth and be followed through the life of the child to improve adult outcomes. Reducing the risk factors for poor pregnancy outcomes for example can significantly reduce the number of infant deaths, disabilities and potential long term conditions related to prematurity and low birth weight.

Risk factors for poor health outcomes include low birth weight, smoking and alcohol consumption in pregnancy, poor nutrition, infection, gestational diabetes, maternal obesity, late booking for antenatal care, multiple births, low socioeconomic status and teenage pregnancy.

## **Maternal Health**

Maternal health refers to the health of women during pregnancy, childbirth and the post partum period. It includes issues such as family planning, birth outcomes; recovery from child birth; newborn care; nutrition and breast feeding. Risk factors for poor maternal health include obesity, alcohol, drug and substance misuse, smoking, homelessness, mental ill health, teenage pregnancy, domestic violence, and sexually transmitted infection. Women with low-income, low level of education, previously ill women and multiparous women are more at risk of developing complications during child birth and after delivery.

## **Demographics of Women Giving Birth in Waltham Forest**

There were 4,765 births for women who were either registered with a GP in Waltham Forest or living in Waltham Forest and not registered with any GP in 2011/12. Of these, 8.1% were not residents of Waltham Forest but were registered with a GP in the area and hence the responsibility of Waltham Forest. The number of births has increased by 222 since 2009/10 (4.9% increase). Among those who were the responsibility of Waltham Forest, 31% were first pregnancies and 28% were second pregnancies. The general fertility rate has increased from 64.8 per 1000 females aged 15-44 in 2001 to 87.4 per 1000 in 2009 and has been consistently higher than the England (63.8 per 1000) and London (69.3 per 1000) averages. However, between 2008 to 2009 there was no change.

According to a report in 2010, there was a 15% increase in the number of mothers delivering at Whipps Cross Hospital from 2005/06 to 2009/10.<sup>183</sup>

- Women giving birth in Waltham Forest in 2010-2011 were mostly from deprivation quintiles 4 (34.82%) and 5 (52.98%). These are the two lowest deprivation groups totalling 87.8% of births. There has been a decrease from 95% in 2009/10.

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<sup>182</sup> Fair society, healthy lives. 2010. The Marmot Review. Strategic review of health inequalities in England post 2010

<sup>183</sup> Trends in births and adverse birth outcomes in ONEL. 2010. Peter Congdon. Report for ONEL Public Health Network.

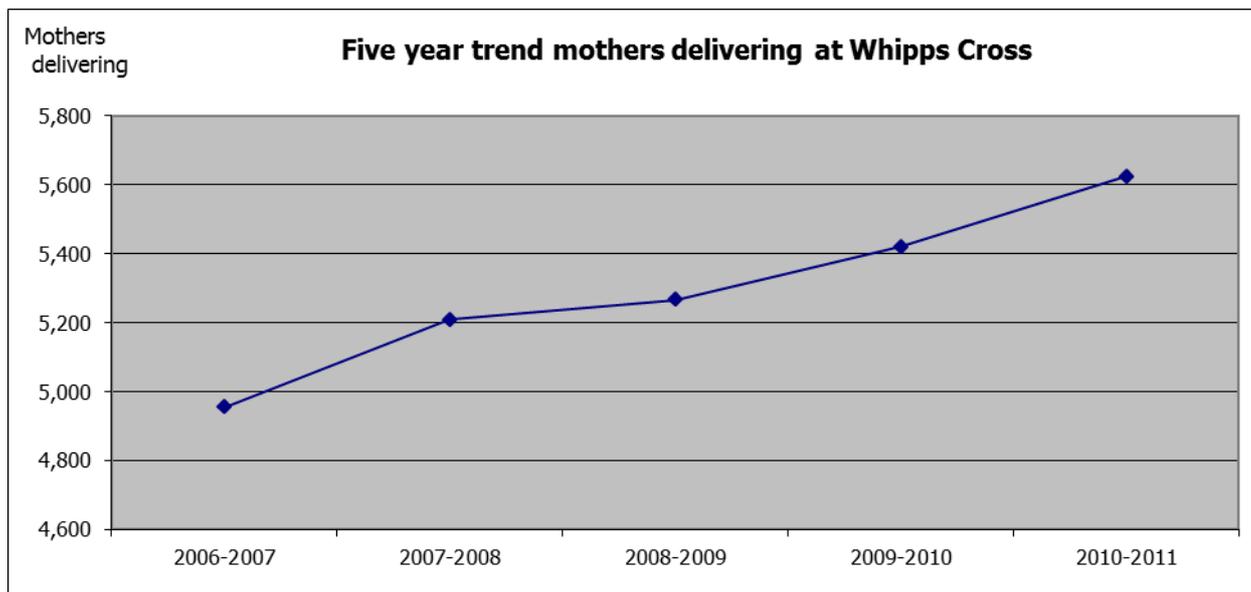
- 43% of women delivering in Waltham Forest during 2010-2011 were White (White British, White Irish and Other White ethnicities), followed by Asian women who made up 24.9% of those delivering. This compares very closely with 2009/10. 17% of births were to women from the Black ethnic group.
- 22.5% of Waltham Forest women delivering were categorised as White Other. These are women who do not fall in the White British, White Irish, White and Black African, White and Asian or White and Black Caribbean groups. This group would include the Eastern European and other White ethnic backgrounds.
- The second highest ethnic group was White British (19.8%) followed by Pakistani (13.8%) and Black African (10.5%).
- 58.3% of women delivering were aged 25-34 years old.
- Further analysis of the White Other ethnic group based on age showed that the 25 – 29 age group had the highest number of births (35.5%) followed by 30 - 34s (29.9%). In the White British group, the 30 – 34 age group had the highest number (29.9%) followed by the 35 – 39 age group (27.4%).
- Residents of Walthamstow accounted for 43% of the deliveries, while Leyton/Leytonstone constituted 40% of the deliveries and Chingford 16%.
- The largest proportion of deliveries in 2010/11 were from Lea Bridge (6.9%), Hoe Street (5.9%), High Street (5.7%), Grove Green (5.6%) and Markhouse (5.5%) wards.

### **Whipps Cross University Hospital Births**

Whipps Cross Hospital serves women who live in or are the responsibility of Waltham Forest but also women who come from elsewhere. Table 1 shows the trends in the number of births at Whipps Cross maternity from 2006/07 to 2010/11. These include Waltham Forest women as well as women from other areas.

- There has been a 13.5% increase in births from 2006/07 to 2010/11 from 4,955 to 5,624.
- There has been a 27% increase in twin births from 2006/07 to 2010/11.

**Table 1**



Source: Whipps Cross University Hospital Information Department

### **Maternal Mortality**

Maternal deaths measure the death of a woman during pregnancy or within 42 days of delivery, spontaneous abortion or termination, provided the death is associated with the pregnancy or its treatment.

Maternal mortality for under 20 years olds and 15-44 year old women delivering in Waltham Forest was lower (0 per 100,000) than for London (0.65 per 100,000) and England (0.45 per 100,000) during 2007-2009. This was also lower than the Outer North East London boroughs (Redbridge, Barking and Dagenham, Waltham Forest and Havering) average which was 0.98 per 100,000 deaths. There were no maternal deaths in Waltham Forest from 2006-2008.

From April 2008 to August 2010, there have been 7 maternal deaths in Waltham Forest which are then reviewed to establish whether they are Direct or Indirect deaths. Direct deaths are defined as those related to obstetric complications during pregnancy, labour or puerperium (6 weeks) or resulting from any treatment received, whereas indirect deaths are those associated with a disorder the effect of which is exacerbated by pregnancy.

### **Live Births**

- Live births have increased progressively in Waltham Forest from 2001-2010 from 3,510 in 2001 to 4640 in 2010.
- In 2009, 60.3% of mothers giving birth were born outside the UK. This was the highest percentage compared to our statistical neighbours of Croydon (47.2%), Greenwich (52.7%) and Enfield (58.4%) as well as London (55.2%) and England (25.4%).
- Between 2002-2006, the percentage increase in Waltham Forest was higher (7.43%) than NE London (6.55%), London (6.33%) and England (5.29%).

- Walthamstow had the largest proportion of live births by 3 year averages from 2007 -2009 (6,527) followed by Leyton/Leytonstone (4,384) and Chingford (2,511).
- Lea Bridge ward had the highest number of live births by 3 year average (2007 – 2009) followed by High Street ward and Leyton ward.

### **Women’s Experiences of Maternity Services**

In the Health Care Commission survey of women’s experiences of maternity services (2007), Whipps Cross attained a “Fair Performing” rating whereas all other North East London sector hospitals were given a rating of “Least Well” performing (Barking Havering and Redbridge, Barts and the Royal London, Newham General Hospital and Homerton Foundation Hospital Trust). Overall Whipps Cross scored below average in the questions relating to whether women were informed, counselled and supported to ensure they have a positive maternity experience (Whipps Cross score 2.63, national average score 3) and questions around whether there were practices in place to help ensure a high quality and effective maternity service (Whipps Cross score 2.88, national average score 3).<sup>184</sup>

### **Infant Mortality and Perinatal Mortality**

Infant mortality describes the death of a baby under the age of 1 year whereas perinatal mortality describes the death of a neonate/infant up to 28 days of life. Infant mortality, along with life expectancy, is used as a marker of health and health inequalities for nations. The risk factors associated with infant mortality include infants being put to sleep on their stomach, smoking during pregnancy, sharing a bed with parents, low birthweight/prematurity, mothers born outside the UK, teenage mothers, babies registered by the mother alone, births amongst those who are in routine and manual jobs.<sup>185</sup>

- Infant mortality remained higher than London and England from 1991-1993 (9 per 1000 live births) to 2006-2008 (5.4 per 1000 live births), except in 1995-1996 when it dipped below the England 3 year average rate.
- Infant mortality in Waltham Forest in 2007 – 2009 was 4.7 per 1,000 live births which fell from 5.4 in 2006 – 2008 and now equals the England average, but is still higher than the London average (4.4 per 1,000). In 2007-2009 Waltham Forest ranked 15<sup>th</sup> highest in London out of 33 boroughs for infant mortality which up from 9<sup>th</sup> in 2006-2008.
- There were a total of 22 deaths in children less than 1 year old in 2009; approximately 32% were due to congenital abnormalities or extreme prematurity/low birth weight and 50% were due to perinatal conditions.

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<sup>184</sup> Health Care Commission Survey of women’s experiences 2007. Whipps Cross score available at:

[http://2009ratings.cqc.org.uk/\\_db/\\_documents/RGCScoredAssessment.pdf](http://2009ratings.cqc.org.uk/_db/_documents/RGCScoredAssessment.pdf)

<sup>185</sup> Implementation plan for reducing health inequalities in infant Mortality: A Good practice Guide. Department of Health, DCSF. 2007.

- Pooled data for infant deaths 2006-2009 show deaths due to perinatal conditions made up 38.5% of deaths, followed by deaths related to congenital conditions (17.6%).
- Perinatal mortality in Waltham Forest was 9.2 per 1000 births from 2007-2009. This is higher than London (8 per 1000) and England (7.6 per 1000) and placing Waltham Forest 7<sup>th</sup> out of 31 boroughs.

### **Still Births**

- In 2007-2009, Waltham Forest had a still birth rate of 7 per 1000 live births, higher than London (5.8 per 1000) and England (5.1 per 1000). Waltham Forest's ranking increased from 7<sup>th</sup> highest in 2006-2008 to 4<sup>th</sup> highest in London in 2007-2009.
- There were a total of 33 still births in 2009.

### **Low Birth Weight and Very Low Birth Weight Babies**

Having a low birth weight baby (weighing < 2500grams) is strongly associated with deprivation, poor maternal health, lack of antenatal care, belonging to a black and ethnic minority group and smoking during pregnancy. The latest data published from the Office of National Statistics (ONS) shows that babies born under 2.5kg were over five times more likely to die suddenly and unexpectedly than those of normal birth weight.

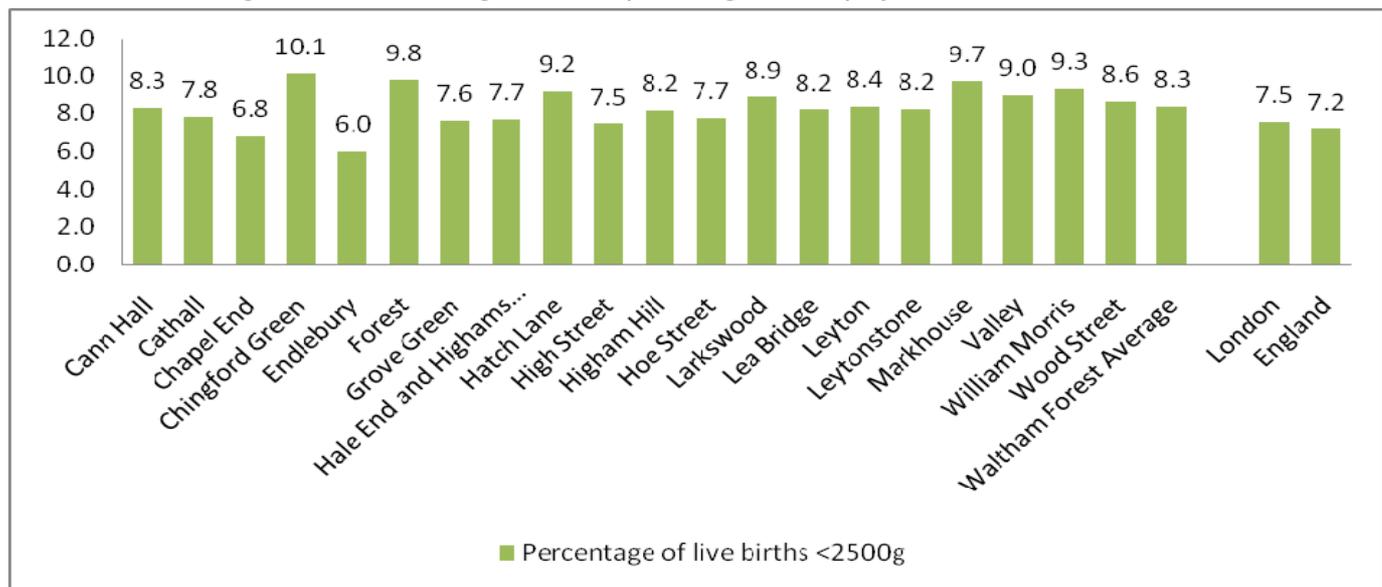
- Waltham Forest had highest rate of low birth weight babies (8.3%) compared to Outer North East London boroughs (7.5%), London (7.9%) and England and Wales (7.5) in 2009 and was ranked 10<sup>th</sup> highest in London. (See table 3). Waltham Forest was also ranked 16<sup>th</sup> in London in 2009 for high rate of very low birth (<1500 grams) weight babies as a percentage of all live and still births. The percentage of low birth weight babies in 2009 is now the same as in 2007.
- In 2007-2009 the percentage of low birth weight babies was quite similar across the 3 localities: Chingford 8.5%, Leyton/Leytonstone 8.4% and Walthamstow 8.3% born with low birth weight. Table 2 shows the percentage by ward.
- The ward with the highest percentage of low birth weight babies was Chingford Green where 10.1% were born with a low birth weight followed by Forest ward with 9.8%. Although Chingford Green had the highest percentage, this was not significant (based 95% confidence intervals).
- Forest and Markhouse ward had a significantly higher percentage of low birth weight babies than the London average.

**Table 2: Low Birth Weight babies as a percentage of all live and still births, and all maternal ages, 2005-2009**

	2005 (%)	2006 (%)	2007 (%)	2008 (%)	2009 (%)
Waltham Forest	9.4	9.6	8.3	9.5	8.3
London	8.7	8.3	7.9	7.9	7.9
England and Wales	7.9	7.9	7.5	7.5	7.5
Waltham Forest ranking out of 33 London Boroughs	7	3	12	3	10

Source: Compendium of Clinical and Health Indicators December 2010

**Table 3: Percentage of low birth weight babies (<2500 grammes) by ward 2007-2009**



Source: London Health Observatory<sup>186</sup>

## Protective Factors for Birth Outcomes

### 12-Week Booking

In Whipps Cross Hospital, 78.5% of pregnant women booked and attended their first antenatal appointment by 12 weeks gestation, below the target of 88% in 2010/11. This has improved from 72.3% in 2009/10. Data on women booking late in 2009/10 shows that there are higher numbers of Asian women booking late.

### Stop Smoking in Pregnancy

In 2010/11, 6.6% (273) of mothers were still smokers at delivery. This is slightly higher than 2009/10 where 4.5% of mothers were still smokers at time of delivery.

Smoking in pregnancy is lower than Greenwich (10.8%), Croydon (9.1%) and London (6.5%), England (13.5%) and the ONEL borough average (9.4%).

<sup>186</sup> Number and Percentage of Births with Low Birth Weight, Ward Level, 2006-2008 and 2007-2009. London Health Observatory. Available at: <http://www.lho.org.uk/ViewResource.aspx?id=16895>

## Healthy Start Vitamins

Healthy Start is a UK-wide government scheme to improve the health of low-income pregnant women and families on benefits and tax credits. Women who are at least 10 weeks pregnant and families with children under four years old qualify for Healthy Start if the family is getting Income Support, Income-based Jobseeker's Allowance, Income-related Employment and Support Allowance, or Child Tax Credit. Vouchers can be spent on milk, plain fresh or frozen fruit and vegetables and infant formula milk. Additionally, beneficiaries receive vitamin coupons which can be swapped for Healthy Start Vitamins locally.

Healthy Start vitamins contain the appropriate amount of recommended vitamins A, C and D for children aged from six months to four years, and folic acid and vitamins C and D for pregnant and breastfeeding women.

Table 4 shows Healthy Start scheme uptake for the different elements. This is based on those eligible and based on claims for reimbursement from areas. In 2010/11, Waltham Forest had similar uptake for the scheme as London and England but higher than its statistical neighbours. In terms of Children's vitamin drops, uptake is poor across the country. Waltham Forest had lower uptake (0.9%) than London (1.5%) and England (1.8%). Women's vitamin tablets uptake is poor across the country and Waltham Forest had lower rates than London (1.1%) and England (2.5%)

Table 4: Healthy Start scheme uptake

Area	2010/11 (%)		
	Healthy Start Scheme uptake	Children's drops uptake	Women's Tablets uptake
Waltham Forest	80.1	0.9	0.3
Enfield	81.0	0.0	0.0
Croydon	75.2	1.4	1.3
Greenwich	78.2	0.0	0.0
London	79.5	1.5	1.1
England	80.1	1.8	2.5

Source: Department of Health, Healthy Start quarterly statistics

## Antenatal and Newborn Screening

There are six antenatal and newborn screening programmes. Below is some key data on the screening programmes.

- Down's Syndrome screening uptake was 43.8% compared to a London average of 70.2% in 2008/09. The rate in Waltham Forest increased from 43.8% in 2008/09 to 59.9% in 2009/10.
- Infectious Diseases screening in 2008/2009, uptake was 94.6% for HIV, 94.8% for Hep B, 97.9% for Syphilis and 95% for Rubella, similar to London uptake figures.

- Fetal anomaly scan uptake was 74.5% in 2008/09 and increased to 95.1% in 2009/10.
- Newborn Hearing Screening uptake by 4 weeks of age was 92.3% compared to a standard target of 95% in 2009/10.
- Newborn bloodspot screening standard 3, Waltham Forest had 93.3% of samples taken within 5-8 days in 2008/09 and 93.5% in 2009/10, lower than the core target of 95%.<sup>187</sup>
- Sickle Cell and Thalassaemia disease: Although progress has been made on improving data, there is no data available on uptake for the full year.

## **0 - 5 year olds**

### **Breastfeeding**

Breastfeeding initiation is recorded at maternity units before babies leave the hospital.

Breastfeeding initiation increased from 79.01% in 2005/06 to 89.2% in 2010/11. This is the highest that it has been since recording began in 2003/04. In 2009/10, Waltham Forest was in the top 25% of the country for breastfeeding initiation.

Breastfeeding is also measured at the 6-8 week baby health review where the prevalence of breastfeeding reduces dramatically.

- In 2010/11, 96.4% of those who were due a 6-8 week check had breastfeeding status recorded (RiO data as at April 2011), up from 90.8% in 2009/10 (coverage).
- 66.1% of those due a check in 2010/11 were either fully or partially breastfed (prevalence), up from 62.6% in 2009/10.

Breastfeeding prevalence at 6-8 weeks is below the local vital signs target of 72%. Analysis by GP practices of babies (RiO data as at May 2011) showed that the prevalence of breastfeeding in those registered with a Chingford GP was lower (59.2%) than that of Walthamstow (72.7%) and Leyton/Leytonstone GP localities (67.4%). The prevalence increased slightly in all 3 localities from 2009/10 (Walthamstow – 64.7%, Leyton/Leytonstone – 63.1%, Chingford - 55.7%) and Walthamstow only has reached the prevalence target of 72% in 2010/11.

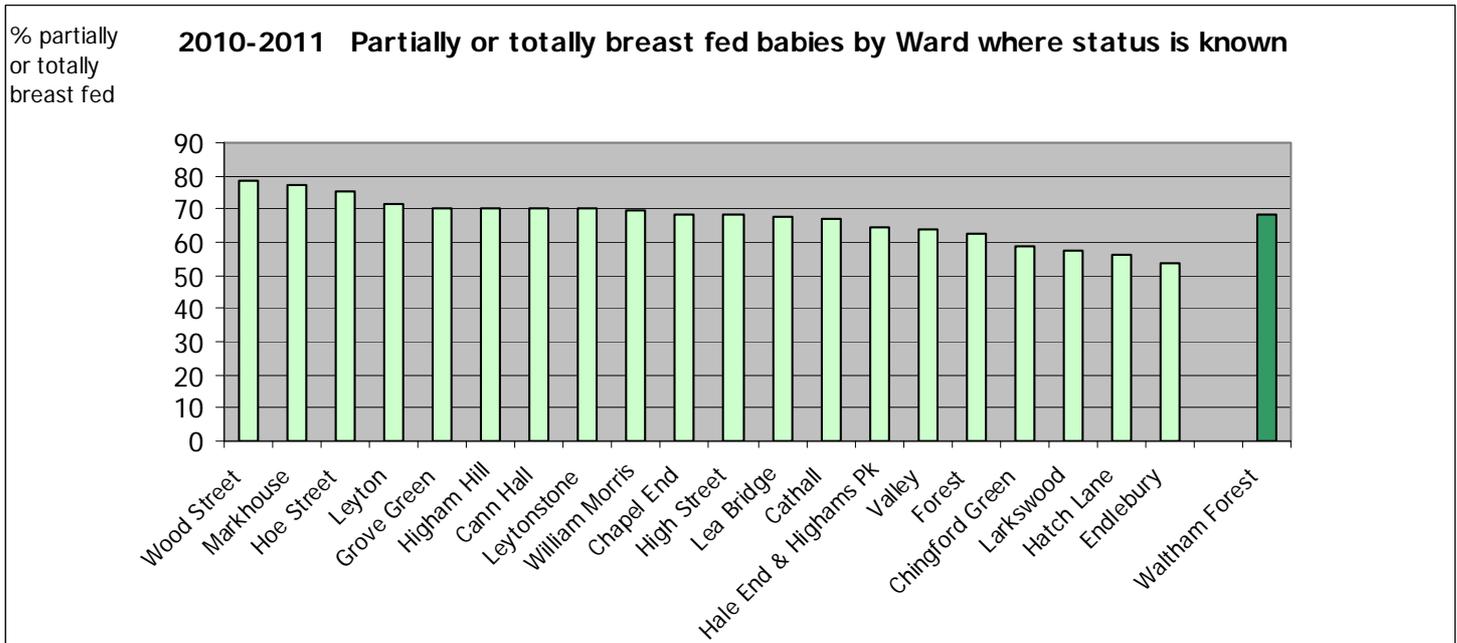
The wards with the highest prevalence of breastfeeding at 6-8 weeks based on where babies are registered with a GP include Wood Street (78.8%), Markhouse (77.2%) and Hoe Street (75.4%). The wards with the lowest prevalence of breastfeeding include Endelbury (53.7%), Hatch Lane (56.4%), Larkwood (57.4%).and Chingford Green (58.6%) (See Table 5)

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<sup>187</sup> London Annual Antenatal Screening Report 2008/09 and Newborn Bloodspot Screening report available at:

<http://www.screening.nhs.uk/london>

**Table 5: Prevalence of breastfeeding at 6-8 weeks 2010/11 by ward**



Source: RiO data extract as at 18<sup>th</sup> May 2011

Ethnicity analysis of babies breastfeeding status at 6-8 weeks in 2010/11 using the 16 ethnic census categories showed the ethnic groups with the highest breastfeeding prevalence were Black African (87.3%), Indian (81.1%), Black Other (78.2%) and Asian Other (76.8%). The ethnic groups with the lowest prevalence of breastfeeding were White and Black African Caribbean (50.7%), White British (57.8%) and Pakistani (64%). The Chinese and White Irish group had very low prevalence (44.4% and 57.1%) but the numbers of babies in these groups were very small.

Based on the 4 broad ethnic groups (White, Black, Asian, Other) the highest prevalence is seen in the Black ethnic group (83.2%) and the lowest is seen in the White ethnic group (62.6%). There was however a large group where the ethnicity of babies was unknown (24.5%) therefore caution should be placed on interpretation of data.

### Immunisations

Immunisation protects children against diseases that can kill or cause serious long-term ill health. Inequalities in immunisation uptake persist among poorer families. Table 6 shows that performance from 2008/09 through to 2010/11 has either been maintained or improved in Waltham Forest in 2010/11. They all however fall below the local Vital Signs targets, England averages and are below the 95% WHO target. Immunisations coverage has been improving in Waltham Forest and for all 6 indicators, performance has improved from 2008/09 through to 2010/11.

**Table 6: Proportion of children who complete immunisation by recommended ages**

	Age 1 Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib) - (DTaP/IPV/Hib)- 3Doses	Age 2 Haemophilus influenza type b (Hib), meningitis C (MenC) - (Hib/MenC)	Aged 2 measles, mumps and rubella (MMR)	Aged 2 Pneumococcal infection (PCV) - (PCV booster)	Age 5 Diphtheria, Tetanus, Polio, Pertussis (DTaP/IPV) - pre- school booster	Aged 5 measles, mumps and rubella (MMR2)
Waltham Forest 08/09	88%	78.7%	83.5%	75.4%	65.7%	72.4%
Waltham Forest 09/10	90.5%	84.8%	84.0%	81.1%	80.9%	80%
Waltham Forest 10/11 (provisional)	91%	89.4%	87.0%	85.4%	82.1%	80.7%
London 10/11	90.7%	84.9%	83.8%	82.4%	74.7%	76.6%
England 10/11	94.2%	91.6%	89.1%	89.3%	85.9%	84.2%

Source: RiO Child Health Information system COVER data

### Oral Health

WHO (2003) defined Oral health as the ability to be able to eat, speak, and socialise without active disease, discomfort or embarrassment. Oral health promotion is the activities delivered to ensure that populations are supported in maintaining good oral health. Oral health promotion is also a fundamental aspect of the pursuit of general health and wellbeing.

A local oral health survey undertaken during 2008/09 for 3-4 year olds living in Waltham Forest collected information on decayed, missing, and filled teeth (DMFT). 524, 3-4year olds took part in the survey. The prevalence of decay in the three to four year old children was 22.7% with a mean of 1.0 decayed tooth.<sup>188</sup> 2.5% of the children had at least one missing tooth due to dental decay and 41.9% of the 3-4 year olds had never been to the dentists. The survey also indicated that 7% of the parents/carers reported that their child had experienced dental pain. It highlighted that in Waltham Forest there is a significant number of 3-4 year olds experiencing early onset of dental decay that was not being treated, and a substantial number of 3-4 year olds not attending regular dental check ups.

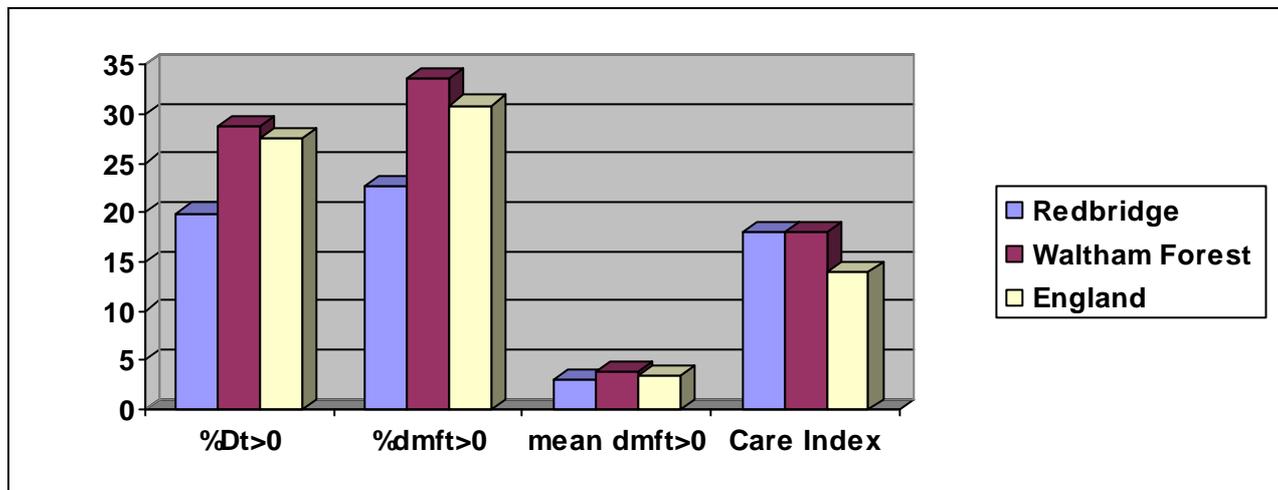
<sup>188</sup> Marcenes W. et al. Oral health in Waltham Forest: Children aged 3-4 years. Report of the Dental Health Survey in 2008/2009.

Comparing the dental status of three to four year-old children living in Waltham Forest with UK averages reported in the Child Dental Health Survey in 2003 shows that three to four year-old children in Waltham Forest had better oral health than national averages. A significantly higher proportion of Asian three to four years (24.2%) children in Waltham Forest experienced an oral health related impact compared to White (17.8%).

Regionally, Waltham Forest is ranked 11<sup>th</sup> among 28 London Primary Care Trusts for under 5 year olds with Decayed Missing of Filled Teeth (1.8 mean dmft). Compared to Croydon (1.3 mean dmft) and Enfield (1.2 mean dmft), Waltham Forest's rate was the highest.<sup>189</sup>

The 2007/2008 national oral health survey examined 1,737 (63% of sample) children aged 5 years old in Waltham Forest of this 33.6% had DMF>0 with a mean of 3.84 decay, missing or filled teeth. Decayed teeth made up the highest component at 28.8% of the DMF value and although Waltham Forest had a <sup>190</sup>care index of 18%. This indicates that the 5 year olds are receiving dental care but they are also experiencing dental disease early, highlighting a need for early interventions that will support the reduction of the early onset of dental disease in our younger population.

The only other Outer North East London Borough which took part in the 2007/8 survey is Redbridge and the diagram below illustrates the findings for both boroughs.



Source: ChiMat website

## Children and Young People 5-19 year olds

### Child Wellbeing

The child wellbeing index in 2007 for Waltham Forest was 227, ranking Waltham Forest 324<sup>th</sup> out of 354 areas

<sup>189</sup> ChiMat web site August 2010

<sup>190</sup> Care index is the value of children that had dental treatment or in the process of receiving dental treatment.

in England (1 is the best and 354 is the worst in England).<sup>191</sup> Within this index, Waltham Forest ranked poorly for material well being, health and disability, education, crime, housing, environment and children in need.

### **Immunisations**

For Human Papilloma Virus (HPV) uptake, Waltham Forest reached 64.8% for completion of the vaccination (3 doses), which was lower than England (80.1%) and London (73.8%) average in 2009/10.

### **Teenage Pregnancy**

Teenage pregnancy rates for 15-17 year old females were higher than that for London and England from 1998 to 2009 (London was only slightly higher than Waltham Forest in 2004). Overall from 1998 to 2009, the rate in Waltham Forest declined from 56 per thousand in 1998 to 55 (provisional) per thousand (the lowest rate was 48 per 1000 in 2004). The national target is to reduce teenage pregnancy by 50% by 2010 from the 1998 baseline; Waltham Forest only achieved a 1.8% reduction up until 2009. Please refer to the Sexual Health section of the JSNA for more information on Teenage Pregnancy.

### **Family Nurse Partnership (FNP)**

The FNP is a preventive programme for young first time mothers. It offers intensive and structured home visiting, delivered by specially trained nurses (Family Nurses), from early pregnancy until the child is two. FNP has three aims: to improve pregnancy outcomes, child health and development and parents' economic self-sufficiency. The programme also supports reducing repeat conceptions to teenager mothers. Waltham Forest is implementing the FNP programme as a wave 3 pilot.

Data as at March 2011 has shown that:

- 79 young first time mothers were enrolled with 77.2% of clients active within the programme.
- Out of 56 first time mothers who had a breastfeeding status recorded at time of giving birth, 82.1% initiated breastfeeding. This was higher than other wave 3 pilot sites where only 59.6% had initiated breastfeeding.
- Out of 46 young mothers with babies reaching 6 months of age, 80.4% had a subsequent pregnancy which is lower than other wave 3 sites (85%).
- Out of 29 young mothers with babies reaching 6 months of age and a hospitalisations status recorded, there were no babies hospitalised due to ingestion or injury.

### **Children with Special Needs**

An estimate of the number of disabled children nationally is said to be between 3% and 5.4%.<sup>192</sup> Applying these national estimates to the Waltham Forest population estimates suggests that there are between 1,794 and 3,229 children and young people experiencing some form of disability in the borough. The annual school

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<sup>191</sup> Local Index of Child Well-being 2009. Department for Communities and Local Government.

<http://www.communities.gov.uk/publications/communities/childwellbeing2009>

<sup>192</sup> ChitMat website available at:

[http://atlas.chimat.org.uk/QuickProfileView.asp?GeographyTypeID=13&GeographyID=\\_5NC&ThemeID=57&ProfileID=5&lastGeogTypeID=13&btnProfile.x=14&btnProfile.y=11](http://atlas.chimat.org.uk/QuickProfileView.asp?GeographyTypeID=13&GeographyID=_5NC&ThemeID=57&ProfileID=5&lastGeogTypeID=13&btnProfile.x=14&btnProfile.y=11)

census (2010) shows that 23% of pupils have special educational needs with 11% on School Action, 9% with School Action Plus and 3% who are Statemented. 1,418 children and young people have a statement of Special Educational Needs (SEN) in the borough as at June 2010. As at May 2011, the figure has reduced to 1,373 children and young people. Around 57% of children and young people with a statement of Special Educational Needs attend mainstream schools.

- Of those with a statement of Special Educational Needs, 23.6% had Speech, Language and communication needs followed by Autistic spectrum disorders (20%) and Behavioural, Emotional and Social Difficulties and Moderate Learning Disability with both around 13% in each group as at May 2011.
- Compared to data from June 2010, the percentage of children and young people with Speech, Language and Communication needs has increase slightly from 22% to 23.6% and the percentage with Behavioural, Emotional and Social Difficulties and Moderate Learning Disability has reduced from around 15% to 13%.
- Based on 2010 data, for children with a Statement of Special Educational Needs (SEN), 44.4% live in Walthamstow, 24.5% in Leyton/Leytonstone and 26% in Chingford. Around 5.2% of those with a statement of SEN live outside the borough.

### Children with Mental Health Needs

ONS mid year estimates for 2009 and data from the most recent ONS survey for 5-16 year olds show national prevalence for conduct disorders (5.3%), emotional disorders (4.3%), being hyperactive (1.4%) and less common disorders (1.3%).<sup>193</sup> These prevalence rates apply only to this age band. Table 7 applies these percentages to the under 18 population in Waltham Forest to provide an estimate of number of children with specific disorders.

**Table 7**

	Number
<b>Conduct Disorders (5.3%)</b>	1,843
<b>Emotional Disorders (4.3%)</b>	1,176
<b>Being Hyperactive (1.4%)</b>	477
<b>Less Common Disorders (1.3%)</b>	413

Source: ChiMat website

<sup>193</sup> ChiMat website available at:

<http://www.atlas.chimat.org.uk/QuickProfileView.asp?GeographyTypeID=27&GeographyID=CAM91&ThemeID=57&ProfileID=6&lastGeogTypeID=27&btnProfile.x=8&btnProfile.y=10>

The 1996 publication 'Treating Children Well' provides an estimate of the number of children and young people who may experience mental health problems appropriate to a response from CAMHS at Tiers 1, 2, 3 and 4.<sup>194</sup> For the population aged 17 and under in Waltham Forest this would equate to

	Number
<b>Tier 1 (15%)</b>	8,152
<b>Tier 2 (7%)</b>	2,804
<b>Tier 3 (1.85%)</b>	1,005
<b>Tier 4 (0.075 %)</b>	41

Source: ChiMat website

A Child and Adolescent Mental Health (CAMHS) needs assessment carried out in 2011 in Waltham Forest found that the numbers at each CAMHS service tier in 2008/09 and 2009/10 are larger in the higher tier of services (tier 4) and lower number in tier 2 and 3 where the reverse would have been expected (See Table 8). The number of children and young people in specialist CAMHS services has also increased from 2008/09 to 2009/10.

**Table 8: Children accessing specialist CAMHS services at each tier (2008/2009 and 2009/10)**

	2008/2009	2009/2010
<b>Tier 2</b>	135	42
<b>Tier 3</b>	785	1125
<b>Tier 4</b>	874	1176
<b>Total</b>	<b>1792</b>	<b>2723</b>

Source: Specialist CAMHS data

For children with a higher level of mental health needs, emergency admissions rate for inpatients (0-17 years) with mental health disorders > 3 days duration was 5.2 per 100,000 between 2007-2010. The rate was lower than London (6.7 per 100,000), England (7.4 per 100,000) and the same as Enfield and Greenwich. Out of 17 London boroughs where data was published, Waltham Forest ranked 6<sup>th</sup> lowest.

### **Learning Disabilities and Mental Health**

Estimation of the population prevalence of learning disability is problematic and should be treated with caution. One study estimated that 2% of the total population has a learning disability.<sup>195</sup> Further estimates are available for age related prevalence as follows; 5 to 9 years (0.96%), 10 to 14 years (2.26%) and 15 to 19 years (2.67%). The estimated total number of children with specific disorders in Waltham Forest is shown in Table 9.

<sup>194</sup> Kurtz Z. Treating Children Well London: Mental Health Foundation, 1996

<sup>195</sup> Emerson E, Hatton C. Estimating the Current Need/Demand for Supports for People with Learning Disabilities in England. Lancaster: Institute for Health Research, Lancaster University, 2004

**Table 9: Estimated total number of children with a learning disability and Mental Health Problems**

	learning disability	Mental health problem associated with learning disability
<u>Ages 5 to 9 (2009)</u>	134	52
<u>Ages 10 to 14 (2009)</u>	285	115
<u>Ages 15 to 19 (2009)</u>	356	145

Source: ChiMat data atlas

These age-specific rates reflect the increasing identification of children with mild learning disabilities with age. On the basis of a 40% prevalence of mental health problems associated with learning disability, (the Foundation for People with Learning Disabilities publication<sup>196</sup> "Count Us In"), Table 9 shows the number of children with mental health problems which might be expected in Waltham Forest by age.

### **Looked After Children's Health**

The term Looked After Children (LAC) refers to any children or young people who are subject to care orders and those who are voluntarily accommodated by the local authority. This could be placements with other family, friends or foster carers. Looked after children are at an increased risk of poor outcomes.

### **Profile of looked after children in Waltham Forest (as at 31<sup>st</sup> March 2011)<sup>197</sup>**

- There were 310 looked after children on 31<sup>st</sup> March 2011 which is lower than the same time in 2010.
- The majority are male (54%).
- There were 90 children looked after continuously for 2.5 years of which 73.6% were living in the same placement for at least 2 years. This is higher than the England (68.6%) and London (69.9%).

### **Why Children Come into Care**

55% of the children entering care in 2010/11 did so due to abuse or neglect, 14% due to family dysfunction and 13% due to family in acute stress. 8% were due to a disability.

<sup>196</sup> The report of the committee of inquiry into meeting the mental health needs of young people with learning disabilities. Count Us In. The Foundation for People with Learning Disabilities. Update, Volume 4, Issue 8.

<sup>197</sup> Department for Education (DfE): Children Looked After by Local Authorities in England (including adoption and care leavers) - year ending 31 March 2011. <http://www.education.gov.uk/rsgateway/DB/SFR/s001026/index.shtml>

## **Age**

36% of children entering care in 2010-11 were aged between 10-15, 27% were aged 16 years and above, 19% were aged between 5 and 9 years old and 4% of children entering care in the period were under 1.

## **Ethnicity**

40% of children entering care in 2010-11 were white, 26% were of black or black British ethnic background, 20% were of mixed heritage and 8% were Asian. Further breakdown of this data is required to facilitate more sophisticated analysis and intervention.

Based on the number of children looked after by the local authority continuously for at least 12 months as at 31<sup>st</sup> March for the corresponding year:

- 89% of LAC in Waltham Forest had an annual health review in 2009 which was higher than England (85.4%) but was slightly lower than London (90%). In 2011, this has decreased to 80% which is lower than England (84.3%) and London (90.2%).
- 86% of LAC had their teeth checked by a dentist in 2009 which was similar to England (86%) but lower than London (90%) average. This has reduced to 73.3% in 2011 which is lower than England (82.4%) and London (87.3%).
- In 2009, only 77% had up to date immunisations which was lower than England (83.9%) and London (84%). This has increased to 93.3% in 2011 which is higher than England (79%) and London (81.4%).
- In terms of developmental assessments of children aged 5 or under, 85.7% had an assessment, which was higher than England (76.4%) but lower than London (94.8%).
- In 2011, 8.4% of Waltham Forests LAC were convicted or subject to a final warning or reprimand during the year. This is higher than London (6.1%) but similar to England (7.3%).
- 8.1% were identified as having a substance misuse problem during the year which was higher than England (4.3%) and London (5.6%).

The local children in care population has remained relatively stable over the past few years; rising from 325 in 2007-08 to 340 in 2008- 2010. While 102 children left care in 2010/11, 90 children entered care during the same period.

The rate of children in care per 10,000 of children and young people is 56, which is lower than the national average of 59 and has reduced from 62/10,000 in 2010. Unaccompanied asylum seekers made up 6.5% of the children in care as at 31<sup>st</sup> March 2011.

## **Health**

The average score for looked after children at 31<sup>st</sup> March 2011 for whom a Strengths and Difficulties Questionnaire (SDQ) was completed was 77% compared to the London average of 79% and England average of 69%. The average score per child was 20.1 which is higher than England (13.9) and London (13.5). An SDQ score is required for those children aged 4 to 16 who had been looked after continuously for at least twelve months at the 31 March. A higher score indicates a higher level of need.

## **Adoption of Looked After Children**

Nationally there has been a fall in the number of children being placed for adoption over the past few years – this relates to the time taken, not numbers of children. In 2007/8, 60% of children were successfully placed for adoption within 12 months of the decision being made for adoption. This rose to 75% the following year and fell sharply to 47% in 2009/10. In 2010/11 this has increased to 69.2%. This performance is below the rate of adoption across England at 74% and London at 71.5% over the same period. For the year ending 31<sup>st</sup> March 2011, 9% of looked after children were adopted during the year which is lower than England average (11%).

## **Placement location**

195 (63%) looked after children are placed outside of Waltham Forest, while 77 (32%) are placed within the borough (The placement of 5% were unknown). Waltham Forest had 255 children who were the responsibility of other local authorities placed in Waltham Forest

## **Education of Looked After Children**

33% of Waltham Forest Looked after children achieved a Level 4 in English in 2009/10 compared to 73% in 2008/09. The number of looked after children reaching Level 4 in Maths has remained consistently below both the national level and that of similar areas. In 2008 only 33% of our looked after children achieved a Level 4 in Maths; this rose to 55% in 2008/09 and it fell back to 33% in 2009/10. At the same time performance across England remained relatively steady.

The proportion of looked after children achieving 5 grades A-C at GCSE has progressed from 8% in 2007/08 to 22% in 2009/10. Based on children who have been looked after continuously for at least 12 months in 2010/11, 32.1% achieved 5 A\* - C grades at level 4 (GCSE) which was slightly higher than England (31.2%) and London (30.6%).<sup>198</sup>

## **Education, employment and training needs of care leavers**

In 2008/9 65% of Waltham Forest care leavers were in some form of education, training or employment by the time of their 19<sup>th</sup> birthday. By 2010/11 the picture had declined to only 44% of care leavers being in some form of training, education and employment on their 19<sup>th</sup> birthday. This is lower than England (61%) and London (66%).

## **Young Carers**

Statistical data collated in 2010 by the Greater London Authority estimates that there are about 673 young

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<sup>198</sup> Department for Education statistical release:

<http://media.education.gov.uk/assets/files/xls/la%20level%20tables%20sfr302011.xls#Table LA1!A1>

carers in Waltham Forest. Based on a national occurrence rate of 3% of population, similar areas compare as follows:

**Table 11: Estimated number of young carers by selected boroughs<sup>199</sup>**

	Waltham Forest	Redbridge	Haringey	Newham	Hackney
Population	224,294	256,030	236,248	265,688	229,036
Approximate number of young carers	673	768	709	797	687

However data on young carers in the borough is weak with only 70-90 young people accessing our specialist provision for young carers each year.

### **Domestic Violence**

Helping the most vulnerable in the community including those affected by domestic violence is one of the Council’s priorities. Waltham Forest Council has adopted the Government’s definition of domestic namely: *“Any incident of threatening behaviour, violence or abuse (psychological, sexual, financial or emotional) between adults who are or have been intimate partners or family members, regardless of gender or sexuality”* The definition covers specific issues relating to black, Asian, minority ethnic and refugee communities such as ‘honour based violence’ (HBV) female genital mutilation and forced marriage (FM) also known as harmful practices.

The Violence Against Women and Girls and The Way Forward Strategies set out a range of measures to prevent, tackle perpetrators and improve access to support as well as strengthen the rights of victims and witnesses.

In view of the sensitivities around domestic violence, there is significant under –reporting of domestic violence incidents. At a national level, domestic violence claims the lives of two women each week and thirty men a year.

Nationally, more children than women are affected by domestic violence, even when they may not be the primary victims. At least 750, 000 children a year witness domestic violence.<sup>200</sup>

- In 2009/10 there were 524<sup>201</sup> episodes of domestic violence involving 417 children and young people reported to the Councils’ children’s services.

<sup>199</sup> [www.dcsf.gov.uk/everychildmatters/](http://www.dcsf.gov.uk/everychildmatters/)

<sup>200</sup> Department of Health (2002) Women’s Mental Health – Into the Mainstream Strategic Development of Mental Health Care for Women

<sup>201</sup> Further analysis of this data needs to be undertaken to understand the nature of the abuse and consistency in the application of the definition: “Any incident of threatening behaviour, violence or abuse (psychological, sexual, financial or emotional) between adults who are or have been intimate partners or family members, regardless of gender or sexuality”

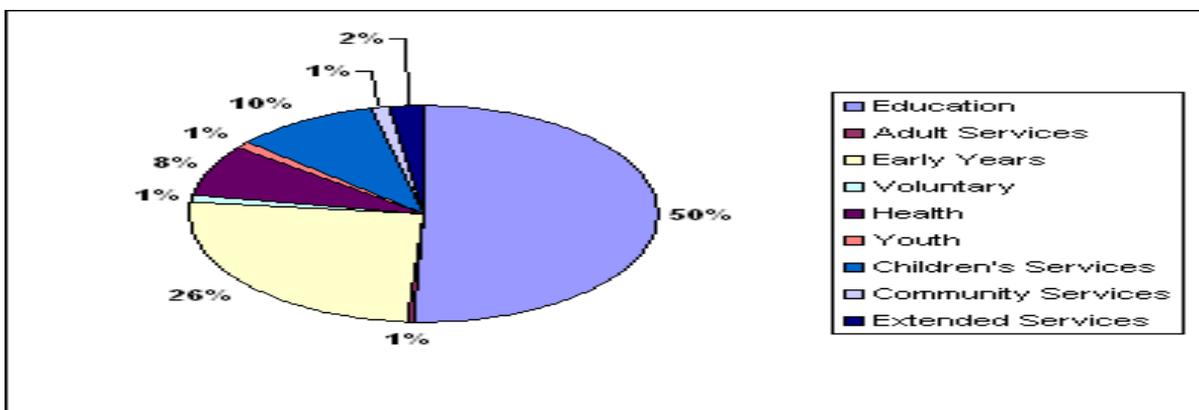
- In 2010/11 there were 522 episodes of domestic violence involving 411 children and young people reported.
- 53% of children subject to child protection processes in Waltham Forest live in families affected by domestic violence.
- Of the 90 children entering care in 2010, 49 (54%) did so due to emotional abuse or neglect in particular witnessing domestic violence. Children who witness domestic violence are more likely to develop behavioural difficulties, emotional and mental ill-health in adulthood.

### Common Assessment Framework (CAF)

The Common Assessment Framework (CAF) is designed to assess children’s needs, and to help professionals to understand those needs and work together to meet them. It consists of a common process of assessment, a standard form and a pre-assessment checklist to decide whether common assessment would be useful. It is designed to offer a holistic, shared assessment of the child and their situation which reduces duplication and enables early intervention working across services.

Between June 2010 and May 2011 a total of 420 CAFs were completed; a 78% increase in comparison to the previous year completed numbers (236).<sup>202</sup>

Table 12: Percentage of CAF completed from May 2009 – August 2011 by service area



Although there has been an upward trend in the completion of CAF forms, there are services that do not readily use the CAF process to engage other partner agencies working with the child. For example only 8% of all CAFs completed between May 2009 and August 2011 were from health.

The newly formed Early Intervention service in the council has put CAF at the heart of its strategy and ethos and aims to enhance and broaden support for those practitioners undertaking CAF assessments. It is anticipated that this will serve to build on the improvements made to date.

<sup>202</sup> Report on the audit of CAF assessments in Waltham Forest 2010/11. Children and Young People Services. London Borough of Waltham Forest.

## **View of Children and Young People (TellUs survey 2009/10)**

### **Emotional Health of Children (National Indicator –NI50)**

Tellus4 was a major online survey which asked children aged between 10-15 in England how they view their lives and how good local authorities are at providing children's services. The Tellus4 survey was carried out across the country in schools and gave some indication of the views of young people. It is important to capture the view of Children and Young people.

In 2009/10, of those children who took part in the survey, 86% said that they worry. This is higher than Greenwich (83%) and Croydon (82%) and equal to Enfield.

In 2009/10 TellUs survey, 50.6% of children who undertook the survey answered yes to having one or more good friends and being able to speak to their friends, parents or another adult. This has reduced from 60.7% in 2008/09 and is slightly lower than Enfield (53%), Croydon (51.6%) and Greenwich (52.3%).

### **Healthy Schools**

Healthy Schools is a joint Department of Health (DH) and Department for Children, Schools and Families (DCSF) initiative which promotes the link between good health, behaviour and achievement. It supports creating healthier children and young people who do better in learning and life. The core themes are Personal, Social & Health Education, Healthy Eating, Physical Activity and Emotional Health & Wellbeing.

In Waltham Forest, the Change for Children Team has supported 100% of schools to engage with the National Health Schools Programme which requires schools to achieve certain core standards. Ofsted reports have shown that 98.3% of schools in Waltham Forest have been judged as 'Good' or 'Outstanding' for Healthy Lifestyles.

### **Emergency Hospital Admissions**

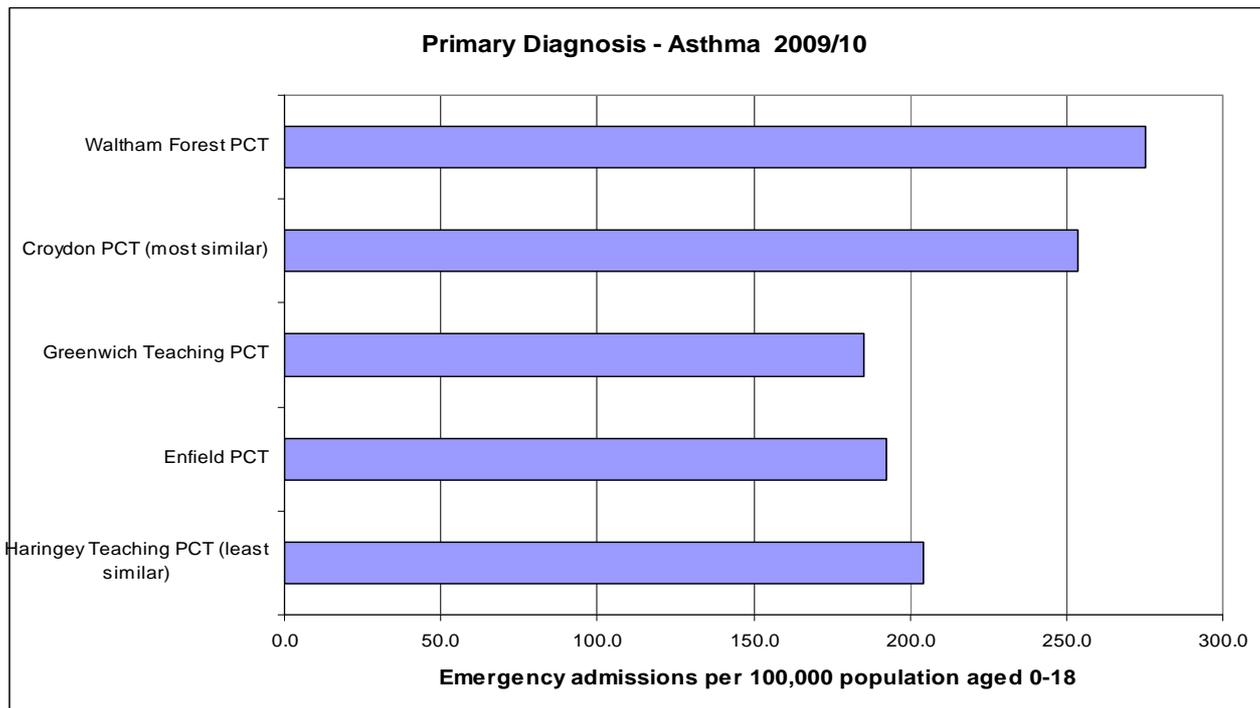
Waltham Forest had a lower rate of

- Diabetes admissions in persons aged 18 years and under at 29.8 per 100,000 compared to London (58.8 per 100,000) and ONEL average (56.4 per 100,000) in 2009/10. Waltham Forest also has the lowest rate amongst its statistical neighbours of Enfield (59.6), Croydon (51.0) and Greenwich (48.1). The rate in Waltham Forest has also reduced from 35.7 per 100,000 in 2008/09 and is now ranked 3<sup>rd</sup> lowest in London.
- Lower respiratory tract infections admissions for persons aged 15 and under at 160.8 per 100,000 compared to London (218.4 per 100,000) in 2007/08. This was however higher than the ONEL (137.2 per 100,000) average. Ranking was 25<sup>th</sup> highest out of 31 boroughs.
- Epilepsy admissions in persons aged 18 and under at 66.6 per 100,000 compared to London (70.4 per 100,000) and ONEL (73.5 per 100,000) and ranked 14<sup>th</sup> highest in London in 2009/10. This was lower than Enfield (105.6 per 100,000) but higher than Croydon (46.3 per 100,000) and Greenwich (48.1 per 100,000).

Waltham Forest had a higher

- Gastrointestinal admissions for persons aged under 5 years and in 2009-2010 at 784.9 per 100,000 population and ranked 4<sup>th</sup> highest in London. Waltham Forest has higher rates than London (520.7 per 100,000) and its statistical neighbours but lower than England (1273.4 per 100,000).<sup>203</sup> This is however lower than 2008/09 where the rate was 873.4 per 100,000.
- Asthma admissions in persons aged 17 years and under at 275.2 per 100,000 persons aged 18 years and under, compared to the rates in London (226.2 per 100,000) and ONEL (220.5 per 100,000) ranking Waltham Forest 6<sup>th</sup> highest in London in 2009/10. Waltham Forest had higher rates than Croydon, Greenwich and Enfield (see Table 10). Some caution may need to be place on this data as local information suggests there may be hospital coding issues where children under 5 years old with viral wheeze may be coded as an Asthma Admission.
- Number of emergency hospital admissions per patient aged 17 years and under for sickle cell disease (2007/08 -2009/10) at 4.1 compared to London (2.8) and England (2.8). This was also higher than Enfield (2.3), Croydon (2.9) and Greenwich (2.2).

**Table 10: Asthma Emergency admissions per 100,000 population aged 0-18 years (2009/10)**



Source: ChiMat Disease Management Tool<sup>204</sup>

<sup>203</sup> Compendium of Clinical Health Indicators. Indirect age and sex standardised rate (standardised to 2006-2007).

<sup>204</sup> ChiMat Disease Management Information Toolkit available at <http://atlas.chimat.org.uk/IAS/dmit> (Registration and NHS data access required)

## **Profile of Emergency Hospital Admissions**

- Emergency hospital admissions in 2009/10 were lower in Waltham Forest among 0-4 year olds (472.7 per 100,000) compared to London (655.1 per 100,000) and England (474.1 per 100,000). It was also lowest among Waltham Forest's statistical neighbours of Croydon, Greenwich and Enfield both in 2008/2009 and 2009/2010. Waltham Forest ranked 30<sup>th</sup> out of 31 London Boroughs for the 0-4 age group (2009/10).
- Emergency admissions were the 2<sup>nd</sup> highest in London out of 31 boroughs for both the 5-9 years and the 10-14 year old age group at 54.1 per 1000 and 49.1 per 1000 respectively.
- Waltham Forest also ranked 7<sup>th</sup> highest in London for the 15-19 year old age group for emergency admissions.

Analysis of emergency hospital admissions (under 19 years) pooled for 2009/10 and 2010/11 shows:

- Around 53.8% of admissions are for the 0-4 age group, followed by the 5-9 age group (18.3%).
- The wards with the highest percentage of admissions were Markhouse (6.2% of admissions) followed by Higham Hill and Leyton which made up 5.9% of admissions each.
- 7.8% of admissions had an unknown postcode or were outside of Waltham Forest.
- Using the International Classification of Disease (ICD) 18.8% were classified as Symptoms, Signs, Abnormality, 16.4% were Respiratory related and 15.9% were classified as Injury, Poisoning, and External.
- The highest rate of emergency hospital admissions per 1,000 GP registered population under 19 years was Walthamstow (67.7 per 1,000) followed by Leyton/Leytonstone (66.4 per 1,000) and Chingford had the lowest rate at 54.6 per 1,000 (SUS data and Exeter GP registered population).

## **Emergency Hospital Admissions due to Injury**

Waltham Forest's under 18s injury related hospital admissions rate of 1473.6 per 100,000 is higher than London (1229.7 per 100,000) and England (1443.2 per 100,000).

## **Emergency Hospital Admissions due to self-harm**

Hospital admissions for self-harm has increased over recent years with admissions of young females being much higher than admissions for males. With links to other mental health conditions such as depression, the emotional causes of self-harm may require psychological assessment and treatment.

Waltham Forest ranked 11<sup>th</sup> in London for Emergency Hospital Admissions rates for self-harm (0-18 years) with a rate of 95.5 per 100,000 for 2007-2009. This is higher than London (83.0 per 100,000) but lower than England (137.8 per 100,000).

### **Unscheduled Care**

Information from the Waltham Forest Unscheduled Care Strategy 2010-2015<sup>205</sup> shows that:

- In 2009 under 18s from Waltham Forest experienced 11,662 admissions to hospital (all providers). Of these 4,437 (38%) were unplanned. There are 3 broad groups particularly important in underlying factors for Emergency Bed Days (EBDs) – Respiratory and thoracic (33%), Gastrointestinal and Feeding problems (14%) and Orthopaedics (10%).

These cover a wide range of conditions but abdominal pain, feeding problems, wheezing and chest infections and orthopaedic surgery are particularly prominent.

- In 2009, around 36% of calls to GP out of hours services were for children and young people.
- In terms of usage of the Emergency Urgent Care Centre at Whipps Cross in 2009, 27% were under 18 years (total attendance all ages - 36,811).
- Nearly one third of all the Accident and Emergency attendances for Waltham Forest patients were for children but the conversion rate to admission is only 18%.

### **Elective Admissions**

Waltham Forest had the 4<sup>th</sup> lowest admission rate (45.8 per 100,000) for elective procedures among 0-4 year olds, 5<sup>th</sup> lowest for 5-9 year olds (41.1 per 100,000) and 6<sup>th</sup> lowest for 10-14 year olds (36.3 per 100,000) out of 31 London Boroughs in 2009/10. However, the rates for 15-19 year olds was ranked 9<sup>th</sup> highest in London (54.3 per 100,000) and higher than the statistical neighbours of Croydon (42.8 per 100,000), Enfield (53.1 per 100,000) and Greenwich (46.8 per 100,000).

### **Road Traffic Accidents**

The percentage change in the number of children (under 16 years) Killed or Seriously Injured (KSI) during each calendar year is compared to the previous year and the percentage change using a 3 year rolling average is used to indicate performance. A positive percentage change indicates good performance whereas a negative percentage change indicates a poorer performance.

Waltham Forest showed reduced numbers of children Killed or Seriously Injured from 1998-2000 to 2002-2004. This trend reversed over the next three-year average to show an increase (percentage change of -

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<sup>205</sup> Waltham Forest Unscheduled Care Strategy. 2010 - 2015. NHS Waltham Forest (2010)

15.9%). It improved in the following 3 year average (5.9% percentage change) and then worsened again in 2005-2007 average (-6.3% change).<sup>206</sup>

- The 3 year average for 2007-2009 (17% change) ranked Waltham Forest 12<sup>th</sup> out of 33 boroughs where 33 is the worst and 1 is the best in London. Waltham Forest was ranked higher and therefore better than Croydon (28<sup>th</sup>) and Greenwich (16<sup>th</sup>) although Enfield was ranked 9<sup>th</sup> (statistical comparators).

### **Review of recommendations from 2010/11 JSNA**

A number of recommendations within the 2010/11 JSNA have not been fully achieved. Progress may have been affected by the changes in the government and the effect of policy change on the NHS and local authority. The past year has seen many changes but as this settles, the recommendations should be taken forward by partners.

Some of the successes and progress based on the recommendations in last year's JSNA include:

- Development of a pilot to align maternal and early childhood services and implement best practice through partnership working between Midwifery, Health Visiting, Children's Centres and GPs.
- Significant changes in the organisation of midwifery services into geographically located teams with specific teams to better cater to the needs of vulnerable women and home births.
- Launch of the localised Healthy Child Programme guidance (0-5 years).
- Detailed audit of all Antenatal and Newborn Screening programmes in Waltham Forest undertaken with action plans.
- Appointment of an Antenatal and Newborn Screening Coordinator and an Infectious diseases Midwife to improve the screening programme.
- Increasing childhood immunisations coverage from 2009/10 to 2010/11 in all 6 indicators.
- Teenage Pregnancy evaluation completed.
- CAMHS needs assessment initiated.
- An evaluation on Sex and Relationship Education (SRE) service undertaken.
- Service review of Occupational Therapy completed.

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<sup>206</sup> Children Killed or Seriously Injured data available at: [www.dft.gov.uk/pgr/statistics/datatablespublications/accidents](http://www.dft.gov.uk/pgr/statistics/datatablespublications/accidents)

Where recommendations have not been fully achieved, these have been reviewed against their relevance this year and included again where the need is still relevant.

### **Evidence Base for interventions and what is being done locally**

The national guidance and policy drivers for work on improving maternal, child and young people's health highlight areas that will improve the health of these groups.

The *National Service Framework for Children, Young People and Maternity Services* (NSF) published in 2004 sets out a ten-year programme to stimulate long-term and sustained improvement in children's health and well-being. There are a set of 11 standards which describe what should be achieved for Children, Young People and Maternity Services to improve health outcomes.

In 2004, the Every Child Matters document sets out the 5 outcomes that all children and young people should enjoy. These are to:

- Be healthy
- Stay Safe
- Enjoy and Achieve
- Make a positive contribution
- Achieve economic well-being

The Marmot review made recommendations for reducing inequalities and improving the outcomes for children.

These are to:

- Reduce inequalities in the early development of physical and emotional health, and cognitive, linguistic, and social skills.
- Ensure high quality maternity services, parenting programmes, childcare and early years education to meet need across the social gradient.
- Build the resilience and well-being of young children across the social gradient.

Early Intervention is a key driver for commissioning services. Early Intervention can be defined as consisting of:

*'multidisciplinary services provided for children from birth to five years of age to promote child health and wellbeing, enhance emerging competencies, minimize developmental delays, remediate existing or emerging disabilities, prevent functional deterioration and promote adaptive parenting and overall family functioning. These goals are accomplished by individualized developmental, educational and therapeutic services for children provided in conjunction with mutually planned support for their families.'*<sup>207</sup>

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<sup>207</sup> Shonkoff, J.P. and Meisels, S.J. (eds) (2000) *Handbook of early intervention*, second edn, Cambridge: Cambridge University Press. Slade, Z., Coulter, A. and Joyce, L. (2009)

Early intervention can be taken to mean action taken early in life or action taken early in the onset or at the diagnosis of impairment. The following provides examples of evidence to support early intervention taken from the report *Early Intervention: The Next Steps*.<sup>208</sup>

- A child's development score at just 22 months can serve as an accurate predictor of educational outcomes at 26 years.
- Some 54 per cent of the incidence of depression in women and 58 per cent of suicide attempts by women have been attributed to adverse childhood experiences, according to a study in the US.
- An authoritative study of boys assessed by nurses at age 3 as being 'at risk' found that they had two and a half times as many criminal convictions as the group deemed not to be at risk at age 21. Moreover, in the at-risk group, 55 per cent of the convictions were for violent offences, compared to 18 per cent for those who were deemed not to be at risk.

The report details interventions from the literature shown to improve outcomes for children and families. The NICE guidelines, *Pregnancy and complex social factors* address the service provision for those pregnant women who may have additional needs.<sup>209</sup> It specifically identifies:

- Women who misuse substances (alcohol and/or drugs).
- Women who are recent migrants, asylum seekers or refugees, or who have difficulty reading or speaking English.
- Young women aged under 20 years.
- Women who experience domestic abuse.

There are a number of other NICE guidelines that provide evidence for improving maternal and child health such as *Maternal and Child Nutrition*, *Antenatal Care*<sup>210</sup>, *Antenatal and postnatal mental health*<sup>211</sup>. Reviewing practice against NICE guidelines should be the first step in identifying gaps locally and prioritising these for action.

### **Infant Mortality**

A good practice guide produced by the Department of Health to reduce infant mortality set out 7 key areas

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<sup>208</sup> Allen, G. *Early Intervention: The Next Steps*. An Independent Report to Her Majesty's Government. 2011

<sup>209</sup> National Institute for Health and Clinical Excellence. *Pregnancy and complex social factors: A model for service provision for pregnant women with complex needs*. NICE. 2010.

<sup>210</sup> *Maternal and Child Nutrition*. 2008. NICE Public Health Guidance PH11

<sup>211</sup> *Antenatal and postnatal mental health*. 2007. NICE Clinical Guidance CG45.

shown to contribute to reducing the gap in infant mortality between the routine and manual (R&M) groups and the population as a whole (Public Services Agreement target).<sup>212</sup> These included

- Promoting early antenatal booking amongst disadvantaged groups.
- Reducing the prevalence of obesity in R&M group by 23% to current levels.
- Reducing smoking in pregnancy.
- Reducing Sudden Unexpected Deaths in Infancy (SUDI) by reducing sharing a bed with babies or putting baby to sleep on its front.
- Reducing teenage pregnancy rates.
- Meeting the child poverty target.
- Reducing overcrowding in R&M groups.

In terms of reducing inequalities in infant mortality, other areas which could have an impact are support to breastfeed, infant screening, immunisations and provision of high quality primary care, midwifery, obstetric, neonatal and health visitor care.

The Reducing Infant Mortality programme in Hackney identified key areas which contributed to reducing the high infant mortality rates. These include

- Named midwife (improving continuity of care) 24/7 service and visits taking place in women's homes. Results were that: No DNAs reported for service, 80% initiated breastfeeding, reduced readmissions (<28 days).
- Children's Centre Midwives in targeted areas 1:1 care in pregnancy for most vulnerable women, support with breastfeeding.
- Midwife working with particular GP practice that was already providing tailored services for refugees, asylum seekers, homeless people and vulnerable groups.

### **Low Birth Weight**

Birth weight is a key determinant of infant mortality and is associated with premature birth and factors affecting fetal growth during pregnancy, such as maternal smoking. The latest data published by the Office of National Statistics (ONS) shows that babies born under 2.5kg were over five times more likely to die suddenly and unexpectedly than those of normal birth weight.

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<sup>212</sup> Implementation plan for reducing health inequalities in infant mortality. 2007. Department of Health.

In 2009, the unexpected infant death rate for babies born with low birthweight was 1.67 deaths per 1,000 live births compared with a rate of 0.30 deaths per 1,000 live births for babies born with a normal birthweight (2,500 grams and over) in England.<sup>213</sup> Low birth weight may be caused by a short gestation, retarded intrauterine growth or a combination of both. Similarly to reducing the risk of infant mortality, evidence suggests effective smoking cessation interventions reduce the prevalence of low birth weight and increase birth weights among pregnant women who quit.

Among nutritional interventions, there is evidence that calcium supplementation reduces premature birth rates and the incidence of low birth weight, especially in women at risk for hypertensive disorders.<sup>214</sup>

### **Local work to address Infant Mortality, Still Births, Low Birth Weight**

There has been increased investment in maternity services since 2008 so that babies can have the best start in life. There has been progress to increase the number of women who have a booking appointment with a health professional before 12 weeks of pregnancy, by making women aware of direct access to midwifery and importance of early booking through free pregnancy testing and direct referral to midwifery from community pharmacy, for example.

A number of factors may have an influence on joining up efforts to tackle the multiple risk factors and the social determinants of health, including.

- The Maternity data system has been a problem and is identified as a risk. Information is not easily accessible to better understand the needs and risk factors for pregnant women for targeted intervention.
- A review of maternity services in mid-2010 revealed the need to modernise the service. The review proposed integrating the service into the community to provide a seamless service between Midwifery, Health Visiting, Primary Care and Children's Centre's for women and their families.
- The Family Nurse Partnership Programme pilot is only funded for a limited period of time i.e. not embedded in services.

A pilot called 'Best Start in Life' is being developed to align maternal and early childhood services. This includes Midwifery, Health Visiting Children's Centres and GP practices. Health Visitors and Midwifery services are moving to a geographical model to improve the quality of the services, improve partnership and bringing essential services closer to where women live.

### **Antenatal and Newborn Screening**

The UK National Screening Committee (UKNSC) provides standards and guidelines for all national screening programmes so that they provide a high quality screening service. Evidence for screening and policies,

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<sup>213</sup> Statistical Bulletin. Office of National Statistics. August 2011. Available at: <http://www.statistics.gov.uk/pdfdir/uinfmort0811.pdf>

<sup>214</sup> Bull J, et al. Prevention of low birth weight: assessing the effectiveness of smoking cessation and nutritional interventions: evidence briefing. Health Development Agency 2003

standards and protocols relating to the screening programme can be found at UKNSC website.<sup>215</sup> The screening relating to the antenatal and newborn period includes:

1. Fetal Anomaly Screening
2. Infectious Diseases Screening
3. Newborn Hearing Screening Programme
4. Newborn Bloodspot Screening Programme
5. Newborn Physical Examination Screening Programme
6. Sickle Cell and Thalassaemia Screening Programme

New standards have been published in 2011 for the Infectious Diseases Screening Programme which will need to be implemented by March 2012.

### **Local work on Antenatal and Newborn Screening**

A detailed audit of the entire Antenatal and Newborn screening programmes has taken place in Waltham Forest. Recommendations and an action plan for all 6 screening programmes have been developed and are now being implemented through the re-establishment of the screening steering group and subgroups for each programme. A full time Antenatal Screening Coordinator and an Infectious Diseases Midwife are now in post to support coordination of the programme as recommended by the National Screening Committee to provide a quality service. A survey of women's experiences of Antenatal and Newborn Screening Programme locally is required annually to engage with mothers and improve the service provided. The data system in Maternity continues to be a problem as data is not readily available and some data needs to be counted manually for reporting.

The Antenatal and Newborn Screening Programmes are one of the QIPP indicators and a new ONEL wide Public Health lead group has been established to continue improvements in this area across the sector.

### **Breastfeeding**

To improve breastfeeding prevalence NICE Public Health Guidance<sup>216</sup> and the Breastfeeding Commissioning toolkit<sup>217</sup> identify a multi-faceted approach and coordinated programme of interventions across different settings to increase breastfeeding rates to include:

- Implementing Unicef Baby Friendly Initiative status in acute settings and implementing the 7 point plan for communities as part of a strategy.
- Activities to raise awareness of the benefits of and how to overcome the barriers to breastfeeding e.g. developing a breastfeeding friendly businesses scheme to encourage mothers to breastfeed when out of the home.

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<sup>215</sup> UK National Screening Programme Committee website: [www.screening.nhs.uk](http://www.screening.nhs.uk)

<sup>216</sup> Maternal and Child Nutrition. 2008. NICE Public Health Guidance PH11

<sup>217</sup> Commissioning local breastfeeding support services. 2009. Department of Health.

- Training for health professionals using Unicef Baby Friendly training as a minimum.
- Comprehensive breastfeeding peer-support programmes.
- Joint working between health professionals and peer supporters.
- Education and information for pregnant women on how to breastfeed, followed by proactive support during the postnatal period.

### **Local work on Breastfeeding**

Training for Health Care Professionals such as Health Visitors and Nursery Nurses and breastfeeding peer supporter training has taken place previously in the borough to improve knowledge and skills. There is however, no rolling programme of training provided and coordination of volunteers and service provisions. Performance on breastfeeding initiation is good with Waltham Forest ranked in the top 25% of the country in 2009/10. The coverage of breastfeeding at 6-8 week has improved from 2008/09 and 2009/10 but prevalence of breastfeeding is lower than the 72% target.

Whipps Cross Hospital is pursuing Unicef Baby Friendly Initiative accreditation. A North East London wide Breastfeeding strategy has been developed, the recommendations of which are being prioritised for action to improve breastfeeding rates.

Waltham Forest does not have a continuous programme of training for peer supporters and health care professionals to support women to breastfeed. A breastfeeding coordinator to work between acute, community and voluntary sector is not in place. The 7-step community plan is not being implemented in Waltham Forest. The community level activities require better coordination and peer supporters require improved supervision and support so that they continue to support women once trained.

The reasons for the drop between breastfeeding initiation prevalence and the 6-8 week check needs to be explored. Implementing the actions and recommendations of the ONEL Breastfeeding strategy will support improvements. Interventions should also be targeted in areas where breastfeeding rates are low based on data presented.

### **Immunisations**

NICE guidelines published in 2009 highlighted steps required to reduce the differences in the uptake of immunisations. The 6 key areas are:

1. Adopting a multifaceted, coordinated programme across different settings to increase timely immunisation among groups with low or partial uptake.

2. Information systems - Robust information systems for recording immunisations and the accurate transfer of data from GP to Child Health.
3. Training - Ensure all staff involved in immunisation services are appropriately trained. Training should be regularly updated and comply with the minimum standard for immunisations training.
4. Contribution of nurseries, schools, colleges of further education to ensure identification of unimmunised children and young people and systems for making sure children are up to date and encouraging high uptake.
5. Targeting groups at risk of not being fully immunised using different methods.
6. Hepatitis B immunisation for infants – ensuring identified person responsible for coordinating the local hepatitis B vaccination programme for babies at risk of hepatitis B infection. The person should also be responsible for scheduling and follow-up to ensure babies at risk are vaccinated at the right time.

### **Local work on Immunisations**

An intensive programme of work to improve immunisations uptake has been taking place since 2009/10 as childhood immunisations was one of NHS London's top priorities for improvement. Although immunisations coverage has increased from 2008/2009 to 2010/11 it is still below target.

One of the key issues identified are data gaps between the Child Health Information System RiO (used to report coverage) and GP IT systems (used for payment). Although practices would be paid for high coverage, when compared to the RiO data system and COVER reporting (which is reported earlier than payments data) the GP practice coverage may be lower and thereby decreasing the borough's coverage.

NHS Enfield has successfully been able to link payment to GPs with the RiO system and thereby increase the accuracy of RiO in comparison to the GP IT systems. Waltham Forest should also adopt this process by working with GP practices. Initial investment may be required to set up the systems to enable this process to take place.

The frequency and completeness with which data from GP systems is transferred to the RiO information system also varies in the borough.

Some GP practices send data electronically or on paper records which then need to be manually input into RiO. A new GP upload tool has been developed and is currently being piloted in Lewisham.

Based on the findings from the pilot Waltham Forest should invest in implementing the GP upload tool as this will mean data will electronically be uploaded into RiO which will save time and standardise processes. Using this method it is envisaged that coverage may also increase as process will be simplified.

Immunisations awareness-raising should be embedded in existing activities such as community outreach programmes.

NHS Tower Hamlets is one of the best performing areas for childhood immunisations in London. In England currently GPs are paid for reaching 90% immunisations coverage, but to reach 95% WHO recommended coverage has been very challenging. NHS Tower Hamlets set up a Local Enhanced Service (LES) to incentivise GP practices to reach 95% immunisations coverage for their childhood population and are now performing well in London.

## **Oral Health**

The Department of Health and NICE have provided guidance around how to promote good oral health and steps needed to reach this<sup>218, 219</sup> The recommendations seek to:

- To prevent oral diseases through community based interventions.
- To reduce inequalities in oral health by addressing the social determinants of oral diseases.
- To improve the use of oral health services.

NICE guidance (2007) also recommends that the delivery of individual-level interventions and programmes should include selecting interventions that motivate and support people to understand the short, medium and longer-term consequences of their health-related behaviour for themselves and others.

Evidence shows that tooth decay in young children can be reduced by breastfeeding, not adding sugar during weaning, adopting a low sugar diet,<sup>220</sup> regular tooth brushing with fluoride toothpaste, application of fluoride varnish,<sup>221</sup> and provision of sugar-free medicines.

Tower Hamlets in East London continued to commission a programme to deliver the national intervention “Brushing for Life”. Packs contained fluoride toothpaste, toothbrush, and leaflets that had key oral health messages for children aged 8 months and 2 years.

Halton and St Helen PCT commissioned a programme where all children attending their dentist were offered fluoride varnish 3 times a year and all children aged between 3 and 11 years were sent a toothbrush and tube of fluoride toothpaste twice a year. A three-year epidemiological cohort study was commissioned by the PCT to measure the effectiveness of the interventions, which started in 2007/08. The initial findings after two years

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<sup>218</sup> Department of Health and British Association for the Study of Community Dentistry, Delivering Better Oral Health: An evidence-based toolkit for prevention. 2007: London.

<sup>219</sup> Dental recall. Recall interval between routine dental examinations. 2004, National Institute for Clinical Excellence, Dental Recall. NICE: London.

<sup>220</sup> Hinds K, Gregory JR. National Diet and Nutrition Survey; children aged 1.5 to 4.5 years. London: The Stationery Office. 1995.

<sup>221</sup> Marinho VC, Higgins JP, Sheiham A, Logan S, Fluoride toothpastes for preventing dental caries in children and adolescents. *Cochrane Database of Systematic Reviews*. 2003. Issue 2. No CD002278 DOI: 10.1002/14651858.

indicate that there has been a substantial improvement in child dental health, with an 18 percent reduction in the levels of active decay in the five-year-old population.<sup>222</sup>

In Salford, a new dental service has been commissioned, with a link dental practice for every Children's Centre in Salford. The link practice dental nurses provide outreach preventative sessions for families. The cost-effectiveness of the services is currently being evaluated.

An Oral Health Strategy for children and young up to the age of 18 years should be developed based on an assessment of needs in the borough. In Waltham Forest, presently there are no defined interventions being delivered for the 5-15 age group. The oral health team in the borough should link in with professionals already working with this age group to look at where pathways could be established. A briefing paper on Oral Health Promotion has been developed which details further areas which need to be reviewed as part of developing the strategy and services available.<sup>223</sup>

### **Healthy Start Vitamins**

A number of local initiatives in different areas have increased the uptake of Healthy Start Vitamins for both women and babies.

NHS Westminster reviewed their uptake, availability and access to Healthy Start Vitamins. Gaps identified included women not knowing where to get Healthy Start Vitamins, professionals not knowing where to signpost women and some distribution centres not stocking both types of vitamins. To improve uptake, NHS Westminster:

- Established a steering group of professionals to support improvements.
- A programme of awareness raising sessions undertaken for professionals including Health Visiting, Midwifery, Children's Centre and Dentist staff.
- Local policies developed to support staff to promote the vitamins and identify those at risk of vitamin D deficiency as well as providing treatment guidelines.
- Monitoring and evaluation process implemented.

Additionally, NHS Bolton established a process where all registered health professionals (Midwives, Health Visitors, Dieticians and Staff Nurses who had contact with pregnant women and children carry vitamins and distribute to women. East Sussex Community Health Services produced leaflets which were used to promote the vitamins across the borough including pharmacies and libraries.

### **Children's Centres**

There are 17 Children's Centres in the borough providing easier access to a variety of advice and support services for parents and carers from pregnancy through to when a child goes to nursery at a primary school. The centres have a particular focus on reaching vulnerable groups who may be on low income, teenage

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<sup>222</sup> NHS North West. A guide for commissioners of children's, young people's and maternal health and wellbeing services. 2011

<sup>223</sup> Briefing paper on Oral Health Promotion in Waltham Forest and Redbridge. Community Dental Service. 2011

parents, ethnic minorities, families with disabled children and single parents, among others. At the July 2011, there were 15,181 registered children. This has increased by 1,404 children since 2010.

There has been a Children's Centre Consultation undertaken around changing the model of delivery for the centres in Waltham Forest. The proposed hub and spoke model seeks to assign 6 main hubs in Waltham Forest with the rest of the children's centre's becoming spokes.

The results of these consultations will have an impact on how Children's Centres will work in the future in Waltham Forest and the health input into them.

In terms of children registered with a Children's Centres, data shows 82.1% of children (under 5 years) from quintile 5 (the most deprived), 76.4% of quintile 4, 63.7% of quintile 3 and 32% of children from quintile 2 (least deprived) are registered. From April 2010-March 2011, of those registered with a Children's Centre, the percentage of those reached are higher from quintiles 5 (54%), followed by quintile 4 (47.9%), and 3 (41.9) than from quintile 2 (16%). This is a positive change from 2009/10 where the highest percentage of children reached from any quintile was highest in quintile 2 despite the need to target those in the most deprived groups.

A total of 13,387 Children were reached in 2010/11 and a total of 87,603 contacts were made (counts each time a child visits a centre). Ward analysis shows of those who live in each ward, the highest percentage of children reached from a ward was in Cathall where 82.5% of children from that ward were reached (Based on Mayhew population count 2010 as the denominator). This was followed by Leyton with 74.8% of children from this ward being re Cathall and Leyton are one of the most deprived wards in Waltham Forest and hence this shows Children's Centres are targeting the most deprived in the borough. Higham Hill is also one of the most deprived wards but only 45.2% of children from this ward were reached. Using ward based analysis Children's Centre's should target wards where the reach is lowest, particularly amongst the most deprived wards. This may involve outreach work to these areas as engagement with Children's Centres is low.

There is a need to establish monitoring for the local Healthy Child Programme (0-5 years) including identifying the key performance metrics. The Healthy Child Programme 5-19 years Department of Health guidelines need to be localised.

The Healthy Child Programme is led by health visitors. Monitoring the implementation of universal Health Reviews at 1 year and improving uptake of further reviews at 2 year and 3-5 years is needed.

The numbers of Health Visitor have dropped in recent years nationally and regionally. A report in 2010 showed that Waltham Forest Health Visitor caseloads were on average around 707 children, higher than the average of 507 based on 7 other statistical neighbouring boroughs. The analysis did not include Health Visitors delivering additional services such as those based in Children's Centre's. The previous model for

Midwifery was similar to that of health visiting where there were generic Midwives and those based in Children's Centres providing additional support to women with additional needs. This model has now changed and all midwives and health visitors who were providing services in Children's Centres are in the universal workforce. With the new community based midwifery model, there will be midwifery teams based in certain children's centres which will improve partnership working and women's experiences of services.

### **Children with Special Needs**

The Specialist Children's Services is based at Wood Street Health Centre. For instances where professional have concerns about a child, there is one point of referral to the team. Referrals are then forwarded to appropriate teams i.e. Speech and Language Therapy, Occupational Health etc. Where there are multiple concerns about a child's development, Multidisciplinary Team (MDT) meetings (Team around the Child) are set up to provide the opportunity for all professional to come together to agree a care plan for the family. Interventions are then put in place to assess and support the child.

There is no central location where all data on disabled children is stored and easily accessible. There has been a voluntary register which is not representative of the majority of children and young people with disabilities. Service providers hold data on different IT systems, making it difficult to know how many disabled children there are in the borough.

An Occupational Therapy (OT) service review undertaken in June 2011, highlights the referrals coming into the Health OT service have doubled since 2009.<sup>224</sup> This is based on comparing referrals between October 2008 – March 2009 (6 month period) where there were 182 referrals and January – June 2011 where there were 375. The report also highlights the low staffing levels (2 WTE OTs) has resulted in waiting time for children needing OT therapy remaining high. For example as at June 2011, 148 children were on the OT waiting list with the longest waiting time being 45 weeks for a Health Review. The referral criteria for health OT has been recently revised to provide a service for children aged 0-7 years only (with certain exceptions). There are a large number of children who would benefit for OT service over age 7, such as children with neurological problems. There are a number of recommendations which need to be taken into account when commissioning the OT service to ensure the service meets the needs.

National Indicator NI54 Parental experiences of services for disabled children (2009/10), Waltham Forest scored poorly on family support experiences in assessments of disabled children (score of 15 out of 100, participation experiences in Education (42), feedback experiences to parents in terms of health (13), education (21) and family support (13).

### **Child and Adolescent Mental Health**

Child & Adolescent Mental Health Services (CAMHS) commissioned under NELFT (North East London

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<sup>224</sup> N. Patel and C. Wood. Service Review on the Waltham Forest Children's Occupational Therapy Team. London Borough of Waltham Forest and ONEL Community services. June 2011.

Foundation Trust) offer support to children and young people who are experiencing emotional, behavioural or mental health difficulties. This operates under a national 4 Tier system based on varying levels of need.

- Tier 1 – Delivered through Educational Psychology Service and universal services supported by training, consultation and support from CAMHS professionals.
- Tier 2 – Primary Care Mental Health Workers work with all local schools to support children and families using evidence-based group interventions, they also provide training for staff. A new tier 2 triage system operates as the single referral pathway into the tier 3 service but also provides short evidence-based interventions and if appropriate signposting to appropriate support within the community. The Targeted Mental Health in Schools services (TAMHS) ceased in March 2011.
- Tier 3 – Child and Family Consultation Service (CFMS) linking health, education, social care and tier 3 substance misuse services. Tier 3 services are offered in schools via community clinics and also in reach to acute e.g. the Parent Infant Mental Health Service linked to Special Care Baby Unit and Maternity Services (works with parents and under 3s to address attachment difficulties to prevent complex mental health problems when the babies and toddlers become older).
- Tier 4 – Acute inpatient and high dependency services

There has been extensive work in Waltham Forest to redesign CAMHS services. This involved partners in Primary Care Trust as well as Provider services. Based on data analysis, a tier 2 specification has been developed which should deliver a better service for children and young people with mental health needs. Data showed a higher number of children and young people being seen in tier 3 and 4 while there were lower numbers in tier 2. The opposite should be expected based on national estimates of prevalence i.e. higher numbers in tier 2 than in 3 or 4.

An Emotional Health and Wellbeing Strategy has also been developed in Waltham Forest which will provide a framework for improving the Emotional Health and Wellbeing of children and young people in Waltham Forest. The implementation of the strategy and the new model of working for CAMHS will need to be monitored to show evidence of effectiveness in delivering better services for the target group.

Gaps that have been identified in Waltham Forest are that the, data quality in CAMHS services needs to be improved and Transition from CAMHS to Adult Mental Health Services needs to be reviewed.

### **Healthy Schools**

The Change for Children team who manage the local Healthy Schools Programme has ensured 100% engagement with schools in Waltham Forest. They work in partnership with the PCT and have developed a range of interventions to engage and support schools in addressing local health priorities. Some of the achievements in the past year include development and dissemination of a culturally sensitive parents' booklet

to support discussions in the home around sex and relationships, and concise guidance on sex and relationship education for children and young people with learning difficulties/disabilities.

Waltham Forest has been identified as an area which demonstrates good practice both at school and at the local authority level with regards to wellbeing and the Healthy Schools Programme. Targets set nationally have been consistently met and exceeded.

The government continues to support Healthy Schools but as a school-led localised programme. Hence funding for this has been cut and the programme is at risk beyond March 2012. The programme should be reviewed with a view to continue this best practice beyond March 2012.

### **Management of chronic conditions (asthma, diabetes and epilepsy)**

ChiMat (Child and Maternal Observatory) has developed a Disease Management Information toolkit for the conditions Asthma, Diabetes and Epilepsy. Using this tool commissioners and providers can easily compare performance on a number of indicators such as emergency hospital admissions, average length of stay, emergency bed days etc. Using this tool for Asthma Table 13 has been produced below. This shows with better management of Asthma, if Waltham Forest had the same emergency admission rates per 100,000 0-18 year olds as England, there would be a potential saving of £18,226 and similarly if rates were the same as the top 5% in the country there is a potential saving of £68,213.

**Table 13: Asthma Disease Management Tool – Potential cost savings**

	<b>Waltham Forest PCT</b>	<b>England</b>	<b>Top 25%</b>	<b>Top 5%</b>
Admissions per 100,000 population aged 0-18	275.25	230.18	148.14	106.57
Cost per admission	£709	£709	£709	£709
Total cost per 100,000 population aged 0-18	£195,149	£163,197	£105,031	£75,561
Potential cost savings per 100,000 population aged 0-18		<b>£31,953</b>	<b>£90,118</b>	<b>£119,588</b>
Potential cost savings - PCT Population aged 0-18		<b>£18,226</b>	<b>£51,403</b>	<b>£68,213</b>

Source: ChiMat data atlas

There is evidence that educational intervention for children who have attended the accident and emergency department for asthma lowers the risk of the need for future emergency visits and hospital admissions.<sup>225</sup> Local

<sup>225</sup> Boyd M, Lasserson TJ, McKean MC, Gibson PG, Ducharme FM, Haby M. Interventions for educating children who are at risk of asthma-related emergency department attendance. Cochrane Database of Systematic Reviews 2009, Issue 2. Art. No.: CD001290. DOI: 10.1002/14651858.CD001290.pub2.

information suggests there may be some coding issues when children present (i.e. those presenting with viral wheeze may be coded as wheeze), therefore after review of local data, appropriate interventions can be put in place.

### **Looked After Children**

There are challenges around sufficiency of local provision particularly suitable residential accommodation for those with complex needs. Unit costs of foster placements are high, foster care recruitment is below target and there is an urgent need to increase the proportion of in-house foster carers and sustain the increase in the use of Special Guardianship Orders.

To improve stability of placements, a joint health education and children's social care operational placement stability task group was established in 2010 to review on a monthly basis the reasons for each child's move, the risk of any further moves and to recommend and implement changes to practice which support the stability of placements.

Consistent with NICE<sup>226</sup> and SCIE guidance there is a virtual school head appointed who works with schools, head teachers and governors to improve educational attainment of looked after children.

There are sound advocacy, independent visiting and children's' rights services, and through a range of groups such as young advisors, children in care council, youth funding panel and voices in partnership, looked after children are enabled to take part in planning and decision making about services that affect them.

There is a need for more local, personalised and better targeted provision for at risk groups such as those disabled, those who have exhausted their appeal rights, first time parents, those missing from care, looked after children who are known to youth offending service and newly arrived unaccompanied asylum seeking children. The interface between social care and health around the needs of children looked after needs to be strengthened particularly links with GPs, children's mental health, A & E attendance and access to sexual health and emotional and psychological counselling.

In Waltham Forest, the aspiration is that looked after children achieve educational, health and social care outcomes similar to their peers whether their care plan is to remain in care or to be returned to their family.

### **Young Carers**

The London Borough of Waltham Forest (LBWF) aspires is to deliver the vision of the National Carers Strategy (2008) to protect children and young people from inappropriate caring and ensure that they have the support they need to learn, develop and thrive; to enjoy positive childhoods and to achieve against all the Every Child Matters outcomes.<sup>227</sup> A joint carers strategy is in place which includes young carers.

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<sup>226</sup> NICE (2010) Promoting the quality of life of looked after children and young people. Available at: <http://www.nice.org.uk/PH28>

<sup>227</sup> Carers at the heart of 21st century families and communities: a caring system on your side, a life on your own (2008), Department of Health

Consistent with this and the over-arching ambition as set out in the Children and Young People Plan (2009-12) to protect, promote and respect the rights of every single child and young person in Waltham Forest, LBWF will continue to provide designated provision for young carers that cater to their additional needs alongside high quality universal services for all children and young people, recognising that young carers do not want to be stigmatised.

The Council's well-established designated community-based young carers service provides advice, information and a range of leisure, social and educational activities.

These offer not only a break from caring responsibilities but also access to health, counselling, career guidance, trips, club days and peer support to improve the quality of life and outcomes of young carers. Around 90 young carers access this service each year and a strong alignment with the council's youth support service means young carers accessing this provision are able to access additional services.

Awareness of services available and one to one support for young carers needs to be improved. Young carers have also fed back that services in general need to be more accessible and should continue after they are 18 years of age. They have also asked for extra education support, continuity of support workers and additional leisure activities.

### **Domestic Violence**

Assessments of risk to children affected by domestic violence are a critical part of safeguarding practice in Waltham Forest. Effective processes exist for the identification and referral for assessment of children affected by domestic violence. Multi-Agency Public Protection Arrangement (MAPPA) processes are used to manage adults who pose a risk to the community. Multi-agency risk assessment conferences (MARAC) also take place regularly. However, there is limited provision for women affected by domestic violence and there are no programmes in place to support children and young people affected by domestic violence and help perpetrators to desist from their violent and/or controlling behaviours. Consistent with Waltham Forest's commitment to prevention and early intervention, the priority is to focus on reducing reoffending, re-victimisation and the impact of domestic violence on children and young people by commissioning a domestic violence service, protecting and supporting victims and witnesses, improving data collection and information sharing and strengthening multiagency partnership working.

A recent report by CAADA titled 'Saving money saving lives' found that of all domestic violence cases, high risk domestic violence accounted for the greatest cost to agencies such as the police, local authorities and the health service at approximately £20,000 per high risk victim. Focusing on these high risk victims through a MARAC process found that for every £1 spent on MARACs £6 of public money can be saved annually. Therefore MARACs would only need to be successful in 16% of cases to pay for themselves.<sup>228</sup>

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<sup>228</sup> Co-ordinated action against domestic abuse – (CAADA) is a national charity supporting a strong multi-agency response to domestic abuse. Their work focuses on saving lives and saving public money.

## Strategy and Commissioning

Maternity and Child Health was a priority in 2010-11 Waltham Forest Commissioning Strategic Plan, to be measured through reducing the prevalence of obesity in Year 6 children to be no more than 21%, with a vision to reducing levels to 20.6% by 2013/14.

The NHS Operating Framework (2011/12) set out key areas in relation to Maternal and Child Health to improve the outcomes for this group. Maintaining quality improvements to maternal and child health through:

- Developing and expanding the existing Health Visiting Service in response to the Health Visitor Implementation Plan 2011/15 - A Call to Action.
- Sustaining and expanding the Family Nurse Partnership.
- Implementing the national Mental Health Strategy (No Health without Mental Health) to improve mental health and well-being.
- Safeguarding Children (in line with the Munro Review of child protection).
- Promote improvements in the oral health of children.

Areas for improvement should include:

- Focusing on particular groups with specific needs including disabled children, palliative care, and child and adolescent mental health services (CAMHS), looked after children and families with multiple problems.
- Ensuring processes are in place to identify women and girls who may be victims of violence or abuse with suitable care pathways in place.

The Waltham Forest Children and Young People's Plan 2010-2013 prioritises improving Physical and Mental Wellbeing, and improving sexual health and reducing teenage conceptions through programmes such as the Family Nurse Partnership (supporting young mothers and their families with first pregnancies), pharmacies supporting early booking to midwifery and provision of free Emergency Hormonal Contraception, launching a young people's website for information on contraceptive and sexual health.<sup>229</sup>

Key areas where outcomes are worse for Waltham Forest include Infant Mortality, Still Births, Low Birth Weight, high Teenage Pregnancy rates, higher emergency hospital admission rates for 5-19 year olds than England and London averages, higher asthma admissions, ranked amongst the lowest using the child wellbeing index (324 out of 354 in England), drop in breastfeeding rates at 6-8 weeks, oral health, emergency admissions due to self harm.

## Early Intervention

*Early Interventions: The next steps*, emphasises some of the most effective interventions as well as

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<sup>229</sup> 'Your rights, your future' – Waltham Forest's Children and Young People Plan 2010-13. London Borough of Waltham Forest available at: <http://www.walthamforest.gov.uk/cypp.htm>

highlighting the cost effectiveness of the interventions (See diagram 1). These range from universal services such as Health Visiting to targeted interventions such as the Triple P parent-child programme.

Diagram 1: Effective intervention examples by age



With national work suggested by the report, Waltham Forest should begin to review and align service provisions with recommendations from this report and based on evidence of effectiveness.

### Expenditure on Community Health Services

In 2008/09 data shows that Waltham Forest spent £142.90 on community health services per head of population aged 0-17 years. This was higher than Enfield (£121.02), Croydon (£122.69) but lower than Greenwich (£230.26). Out of 24 London boroughs where information was available, Waltham Forest ranked 11<sup>th</sup> highest.

### Children and Young People

Other issues related to children and young people and maternal health are available in the following sections of the JSNA.

- Obesity
- Drugs
- Alcohol
- Tobacco
- Deprivation/Child Poverty
- Domestic Violence
- Sexual Health

# Section 6

working age adults



## ■ Cardiovascular Disease (CVD)

- Coronary Heart Disease (CHD)
- Stroke
- Heart Failure
- Hypertension
- Atrial Fibrillation

## ■ Ambulatory Care Sensitive Conditions

- Diabetes
- Respiratory Diseases
  - Chronic Obstructive Pulmonary Disease (COPD)
  - Asthma

## ■ Cancer

## ■ Mental Health

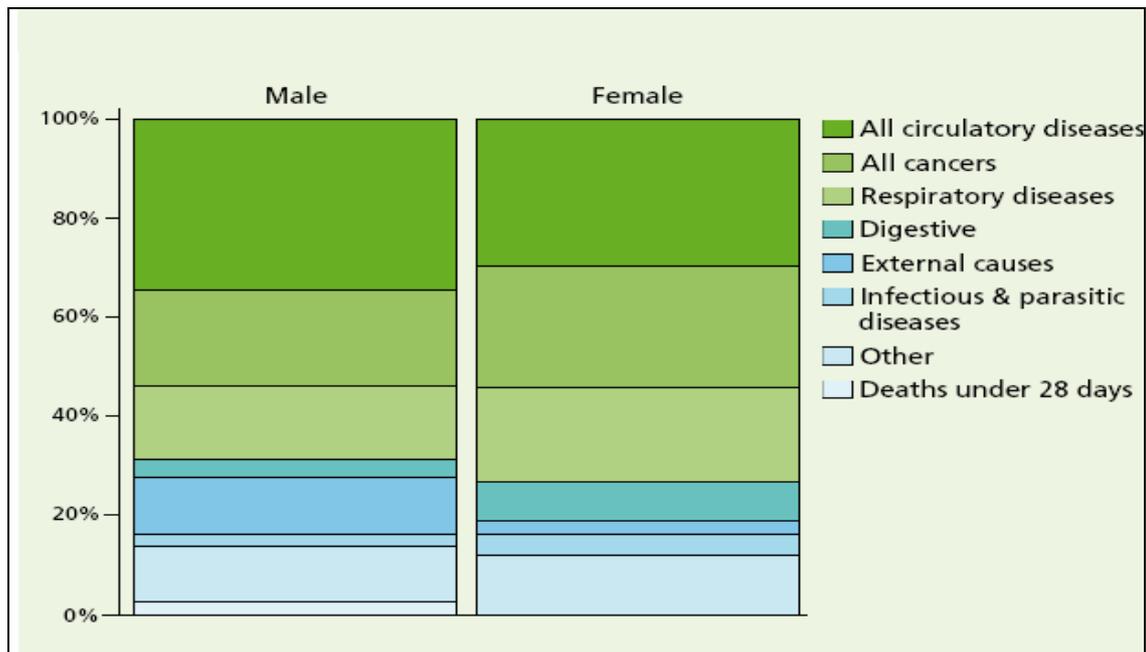
## ■ Learning Disabilities

## The Biggest Killers in Waltham Forest and Health Inequalities

The Health Inequality tool produced by the London Health Observatory shows the causes of death which are driving local health inequalities, with breakdowns by gender. The tool also models the impact evidence-based interventions can have on local health inequality gaps.

Figure 1 shows the main groups of conditions which contribute to the life expectancy gap in Waltham Forest. In both men and women, more than half (around 53%) of the gap is due to cardiovascular diseases and cancers. Respiratory diseases are the other major contributor to lower life expectancy in Waltham Forest.

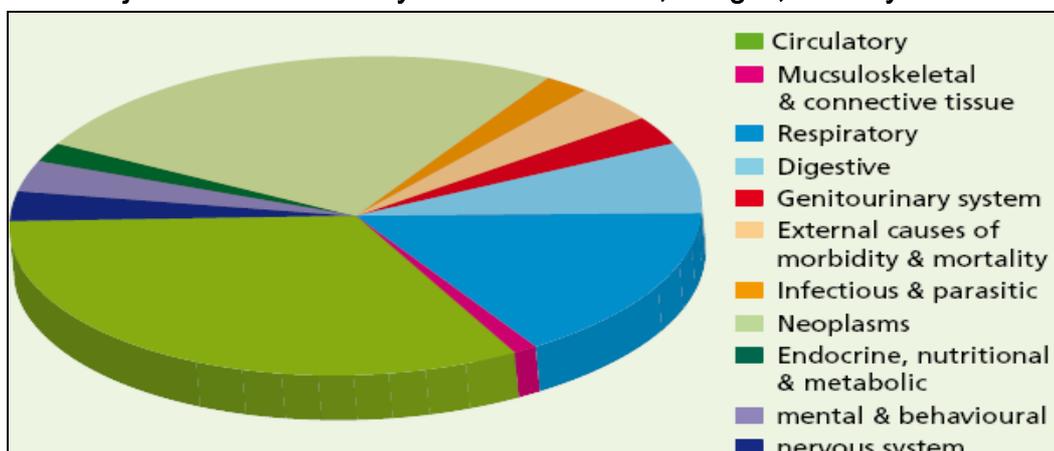
**Figure 1: Breakdown of life expectancy gap between the most deprived quintile (MDQ) of Waltham Forest LB and the England average by cause of death**



Source: London Health Observatory

Figure 2 shows the proportions of causes of death by disease groups. As with the contributors to the life expectancy gap, the largest contributors are circulatory disease, cancers, and respiratory disease.

**Figure 2: Major causes of mortality in Waltham Forest, all ages, 28+ days 2007**



Source: ONS VS Table 3 November 2008

Figure 3 illustrates the inequalities in life expectancy in terms of the east-west divide across London. Travelling east from Notting Hill Gate, each tube stop represents nearly a half year of life expectancy lost for a total of about 8 years.

Figure 3: Years of life expectancy lost from west to east London

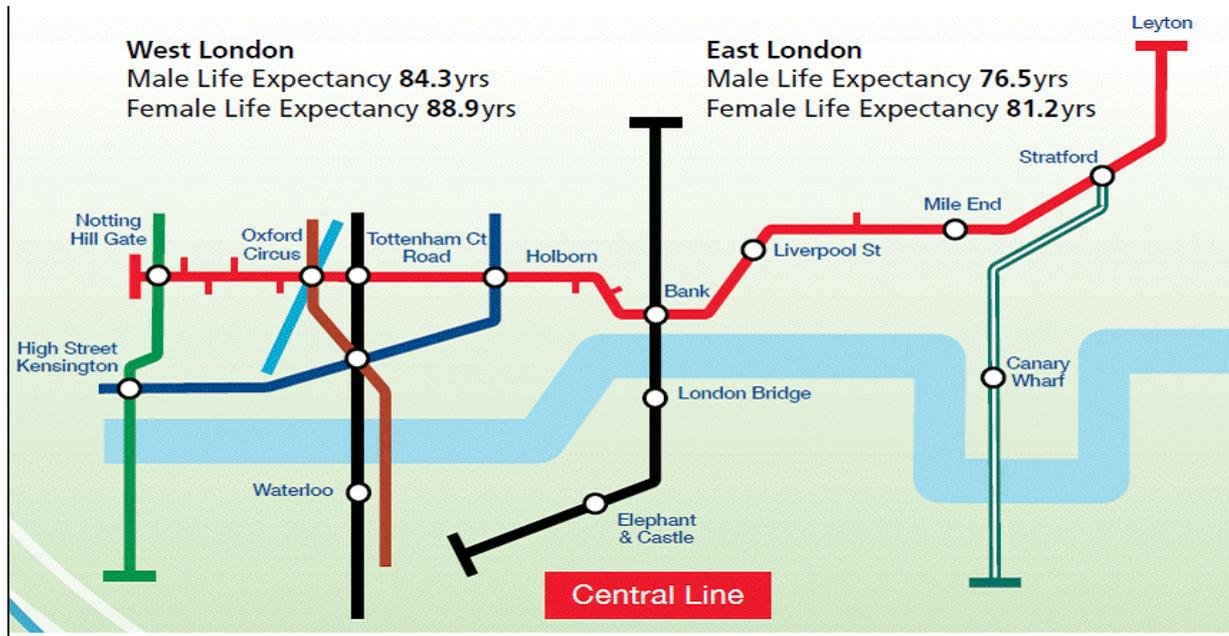
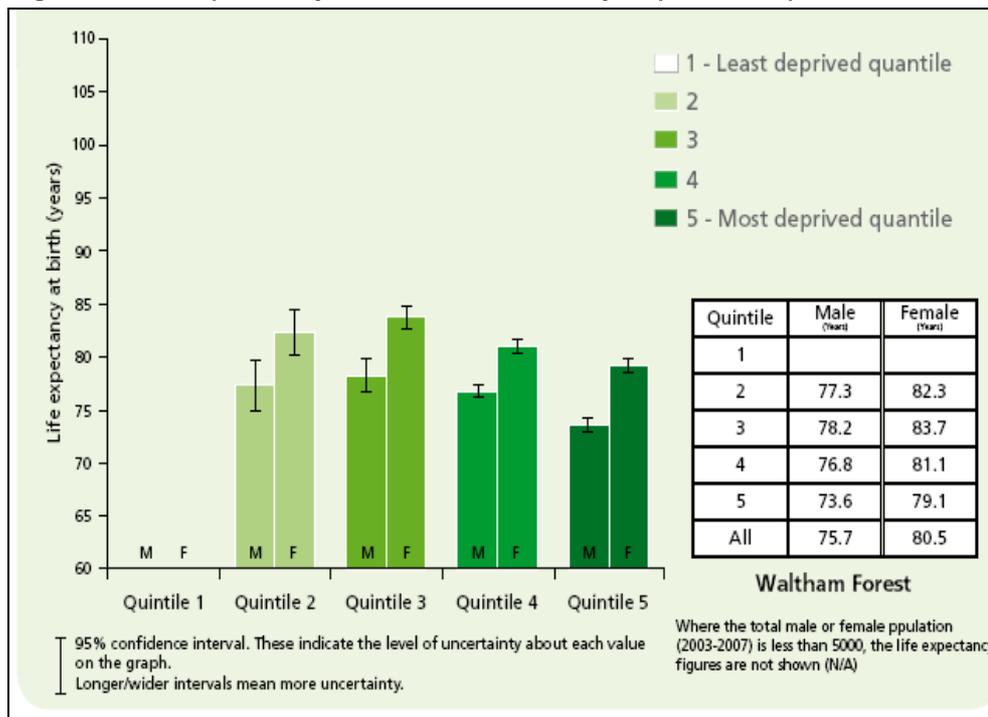


Figure 4 shows life expectancy at birth across the deprivation quintiles (each quintile is 20%), clearly showing the association between life expectancy and deprivation.

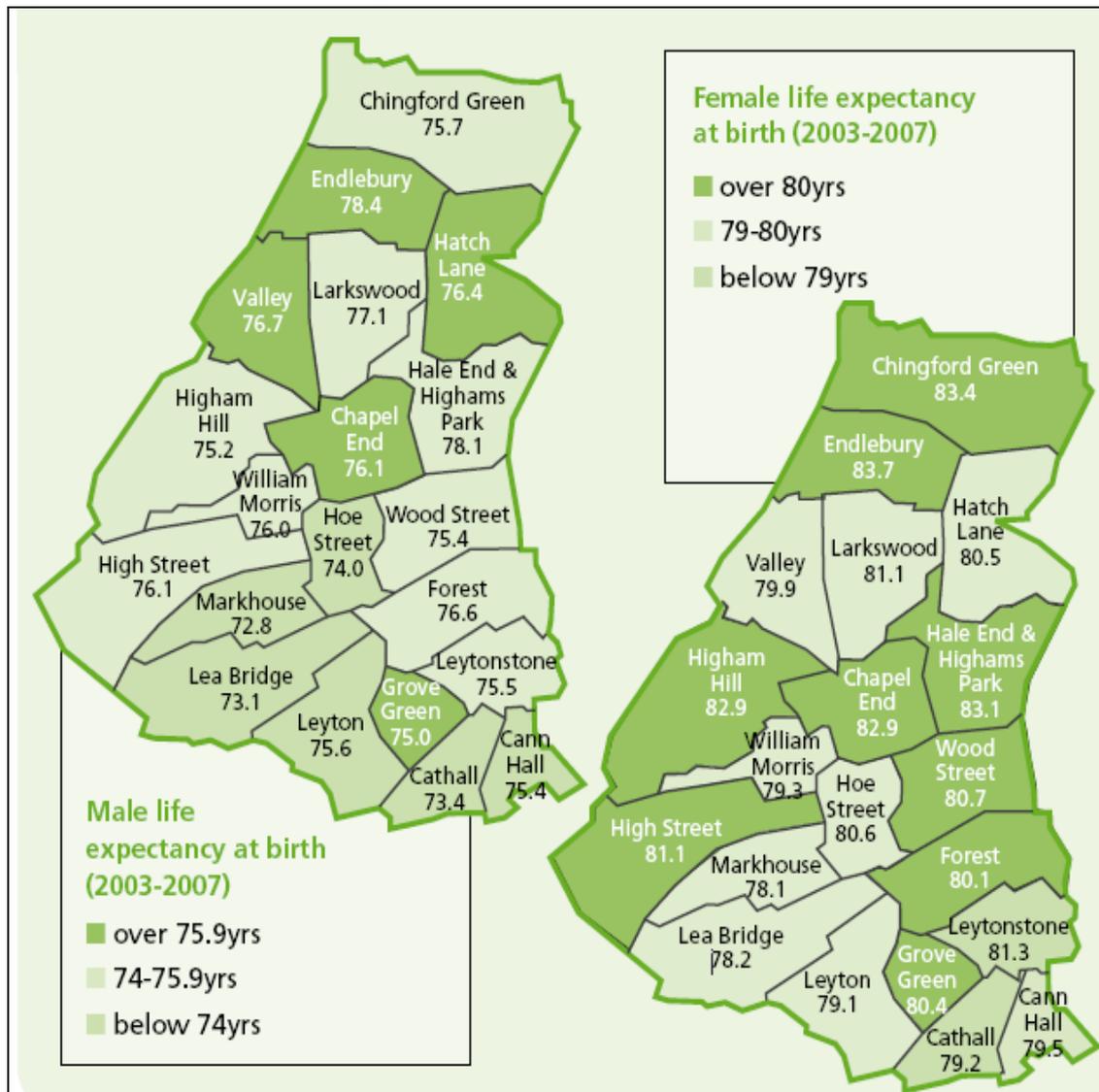
Figure 4 Life expectancy in Waltham Forest by deprivation quintile



Life expectancy at birth across the borough, reflecting the levels of socio-economic prosperity, ranges from 83.4 years in Chingford Green to 78.1 years in Markhouse for females (2003-2007). For males, the range is from 78.4 years in Endlebury to 72.8 years in Markhouse. Life expectancy at birth by ward and gender is shown in Figure 5.

The PCT's ambition is to increase life expectancy at time of birth by 2 years by 2013, and narrow the gap between the population groups across the different levels of deprivation.

**Figure 5: Life expectancy by gender and ward**



## **Cardiovascular Disease (CVD)**

### **Executive Summary**

CVD is the biggest killer in the London Borough of Waltham Forest and causes 27% of premature deaths (75 years and under). It is the main contributor for health inequalities between Waltham Forest and England. The borough has a higher burden of lifestyle risk factors for circulatory disease which includes smoking, physical inactivity, higher level of alcohol intake, unhealthy eating and obesity. Up to 19 in every 100 deaths from Coronary Heart Disease (CHD) are associated with smoking. Socio-economic deprivation is strongly associated with CVD prevalence and outcomes. There are significantly higher death rates in the most deprived wards compared to other parts of the borough. The premature (under 75 years) death rate for women in Waltham Forest is 56% higher than the national rate for Coronary Heart Disease, and is 4<sup>th</sup> highest out of all London boroughs. As the local population ages, increasing demands will be made on health and social care needs. It is predicted that the highest increase in population over the next 20 years will be for men and women over the age of 50 with an estimated increase of 34% from 57,900 to 79,100 people.

### **Recommendations**

#### **Data**

- Use Health Analytics to obtain timely data to plan and monitor equity and quality of NHS Health Checks delivery, Atrial Fibrillation, heart failure and TIA/stroke care pathways.
- Undertake an in-depth analysis of exception reporting related to CVD to plan appropriate interventions.
- Undertake an audit of patients readmitted for cardiac surgical interventions to assess the management of underlying conditions and risk factors.
- Establish a process to combine health and social care data for effective and efficient use of resources to deliver specific services.

#### **Quality**

- Develop a joint cardiovascular strategy to align with national and London policy/guidance underpinned by local needs and service gaps.
- Implement NHS Health Checks with particular emphasis on areas of high mortality and deprivation as a priority with a 6months review to assess the model of service delivery.
- Improve AF care pathway to promote proactive case finding, identify and appropriately manage high risk patients to improve prescribing of anticoagulants adhering to NICE guidance.
- Proactive detection of undiagnosed patients with high blood pressure and improve the percentage of people with controlled blood pressure using targeted outreach work based on actual/estimated ratio in primary care.

- Reduce variation in quality of primary care in CVD by supporting selected practices through benchmarking practices and continuing to support selected practices through practice visits.
- Develop a robust plan for education and training of primary care clinicians (sharing best practice that exists within the borough) on a regular basis on identified priorities.
- Invest in the development of stroke specific Early Supported Discharge service that incorporates all NICE recommendations, ONEL stroke quality standards and includes the provision of 6 month post discharge review in appropriate settings.
- Develop and agree a local model for improving end of life care pathway for heart failure in partnership with key stakeholders.

### **Services**

- Implement and monitor the community based specialist HF service combined with appropriate publicity and agreed process of monitoring of referrals to maximise effectiveness of this service.
- Tailor long-term support services that assist stroke survivors and their carers to improve confidence, mobility and independence.
- Produce a care record book to ensure continuity of care for people suffered with TIA/stroke using Camden best practice model.
- Provide support and contribute to the ONEL QIPP integrated care model related to CVD to reduce high impact users i.e. Heart Failure and CHD.
- Invest in targeted innovative culturally appropriate social marketing to raise public awareness of early signs/symptoms of heart disease, TIA/stroke, AF and hypertension to encourage seeking early treatment.
- Use the findings of the qualitative research undertaken among high risk communities in July 2011 on CVD prevention to inform the above recommendation.
- Develop innovative outreach work using community champions to deliver culturally appropriate messages on CVD to hard to reach communities.
- Continue to designate smoking as a priority in reducing prevalence to achieve NHS and Local Area Agreement targets whilst reducing inequalities.

- Work with relevant leads to develop a co-ordinated programme of personalised advice and support services to encourage quit smoking, promote physical activity and sensible drinking and reducing overweight/obesity based on assessed needs.

## Introduction

Cardiovascular disease (CVD), also called circulatory disease, describes a group of diseases which are caused by blockage or rupture of blood vessels. CVD embraces a range of conditions including atherosclerosis (blocked arteries), high blood pressure (hypertension), atrial fibrillation (AF), cerebro-vascular disease (stroke), aortic aneurysm (ballooning of the main artery) and peripheral vascular disease (PVD), which usually involves blockage of the blood supply to the legs<sup>230</sup>. CVD is the number one killer and the main cause of premature deaths nationally and locally<sup>231,232</sup>. It is also the main contributor to the health inequality gap between Waltham Forest and England accounting for 34% of the life expectancy gap for men compared to 29% for women<sup>233</sup>. Socio-economic deprivation is strongly associated with CVD prevalence and outcomes. Hypertension is one of the most important predictive risk factors in the development of CVD particularly Coronary Heart Disease (CHD) and stroke. Atrial Fibrillation and Type 2 Diabetes (T2D) are also well known risk factors.

The two most important causes of CVD death are coronary (ischaemic) heart disease (CHD) and stroke. The precursors of these include angina (chest pain) and hypertension (high blood pressure). The main risk factors for CHD and stroke are high blood lipid levels, smoking, obesity, hypertension, diabetes, physical inactivity and high alcohol intake<sup>234</sup>. People aged over 65 years are most at risk, but strokes and heart attacks can affect people of any age, including children<sup>1</sup>. Some ethnic groups such as South Asians and the Black African and Black Caribbean groups have a higher risk due to a genetic predisposition towards some of the key risk factors such as diabetes and hypertension.

## Local Picture

Increasing numbers of older people over the next decades will mean more complex health and social care needs. There will be a significant increase in the numbers of people with long-term limiting illnesses such as cardiovascular disease and diabetes. Data indicate that females survive longer and outnumber males from the age of 65 onwards in the local population. This has implications as older women are more at risk of poverty, given shorter employment histories and pension contributions.

By 2031 42% of all people aged over 50 are projected to be of minority ethnic background. This has significant implications for the health and social care economy as these groups are at a greater risk of developing CVD compared to the general population.

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<sup>230</sup> [http://www.lho.org.uk/LHO\\_Topics/Health\\_Topics/Diseases/Cardiovascular.aspx](http://www.lho.org.uk/LHO_Topics/Health_Topics/Diseases/Cardiovascular.aspx) (accessed 16thSept10)

<sup>231</sup> <http://www.nhs.uk/conditions/Cardiovascular-disease/Pages/Introduction.aspx>

<sup>232</sup> ONS mortality data (2008)

<sup>233</sup> [http://www.lho.org.uk/LHO\\_Topics/Analytic\\_Tools/HealthInequalitiesInterventionToolkit.aspx](http://www.lho.org.uk/LHO_Topics/Analytic_Tools/HealthInequalitiesInterventionToolkit.aspx)

<sup>234</sup> J Mackay, G Mensah, Atlas of Heart Disease and Stroke. 2004 World Health Organization. Geneva.

- CVD accounts for nearly one third of all deaths in Waltham Forest and 27% of premature deaths<sup>235</sup>.
- Waltham Forest experiences a significantly higher premature death rate than England and London.
- Waltham Forest has a higher burden of main lifestyle risk factors for circulatory disease which includes smoking, physical inactivity, higher level of alcohol intake, unhealthy eating and obesity. Waltham Forest experienced 40 % decline in CVD death rate from the baseline (1995 -1997), although the rate of decline during the same period is significantly lower than London and national rates.
- CHD related premature death rate in Waltham Forest is 28% higher than national rate and is the 9<sup>th</sup> highest rate out of all London boroughs. It is important to note that female death rate is 56% higher than the national rate and is the 4<sup>th</sup> highest across London.
- Premature death rate (DSR Persons <75 years) for Acute Myocardial Infarction (AMI) is also significantly higher than the national rate 27.7 vs 16.3/100,000 for 2007-2009 within LBWF.
- Premature death rate for stroke in Waltham Forest was significantly higher than the rate reported for England in 2009 (DSR per 100,000 Persons <75: England - 11.87; London – 12.41; Waltham Forest – 17.20).<sup>236</sup>
- Lower rate of detection of most CVDs including CHD, TIA/stroke, hypertension, atrial fibrillation (AF) and heart failure across the borough (compared to estimated number) in 2009/10 is an important public health concern:
  - Only 49% of CHD is detected and is significantly lower than the national detection rate of 61%.
  - Only 50% of TIA/stroke are detected locally and was almost half of the rate of England.
- Stroke related emergency admission rate is 155.6 PER 100,000 a significantly higher rate than the 104.2observed nationally.

## Specific Conditions

### Coronary Heart disease (CHD)

CHD is a condition where the arteries of the heart muscle become narrowed and blocked, starving it of oxygen. CHD manifests as angina and heart attack. CHD accounts for the majority of circulatory diseases and is the single most common cause of premature death in the UK<sup>237</sup>. The main risk factors for CHD and circulatory

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<sup>235</sup> NCHOD. Clin Comp web site accessed 27.09.2010

<sup>236</sup> NCHOD

<sup>237</sup> UK coronary heart disease statistics 2009-10: G30UK stats factsheet 0210

[www.bhf.org.uk/plugins/PublicationsSearchResults/](http://www.bhf.org.uk/plugins/PublicationsSearchResults/)

disease are smoking and obesity and higher levels of disease are associated with areas of deprivation<sup>238</sup>. It is estimated that about 5% of deaths from CHD in males and 6% of deaths from CHD in females are due to obesity<sup>239</sup>. Up to 19 in every 100 deaths from CHD are associated with smoking<sup>240</sup>. Although light to moderate alcohol consumption may actually reduce the risk of CHD as compared with total abstinence, excessive alcohol consumption has been associated with an increased risk of CHD<sup>241</sup>. Hypertension is one of the most important predictive risk factors in the development of CHD<sup>242</sup>.

### Local Picture of CHD

The incidence of CHD is higher amongst men, the elderly and in the more deprived areas. Based on GP Registers, there are 5885 CHD patients with a prevalence of 2.2% (QoF 2009/10).

**Table 1: Actual prevalence (QoF 09/10) of CHD in NHS Waltham Forest by localities**

Waltham Forest	Number	%
Chingford	1,795	2.9%
Leyton Leytonstone	1,877	1.8%
Walthamstow	2,213	2.1%
Waltham Forest	5,885	2.2%

There is a wide variation in the prevalence across practices, ranging from 0.3% to 4.8%. Detected prevalence across the borough (3.4%) is lower than the national prevalence of 3.8%. Patients with CHD who are not diagnosed are more likely to suffer disease progression and premature death.

The premature death rate in Waltham Forest as a result of CHD is higher than the national average for both males and females (50.6 vs 39.5, 2007 - 2009). There has been a decline in the premature deaths due to CHD over the past 16 years in both sexes. The rate of decline is however slower than London and national rates.

CHD mortality is not distributed evenly across Waltham Forest where the more deprived wards experience higher mortality. The death rate in both Grove Green and Lea Bridge wards were more than 50% higher than the national rate.

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<sup>238</sup> Patel KCR, Bhopal The Epidemic of Coronary Heart Disease in South Asian Populations: Causes and Consequences: South Asian Health Foundation, ISBN: 0-9546712-0-1  
<http://www.sahf.org.uk/uploads/docs/files/21.pdf>

<sup>239</sup> National Heart Forum, 2009.

<sup>240</sup> National Heart Forum, 2002.

<sup>241</sup> Poikolainen, 1998.

<sup>242</sup> (Wilson et al., 1998).

## **Mortality for Acute Myocardial Infarction (AMI)**

Waltham Forest ranked fourth highest in London for the Standardised Mortality Rate for both males and females. In 2009-10, the premature death rate significantly higher locally compared to the national rate (27.72 and 16.3 per 100,000 population respectively).

## **QOF performance 2010/11 provisional**

PCT targets have been achieved for all the CHD related QOF indicators. However, there is wide variation across practices. Higher exception rates reported by some practices also influence clinical outcomes for some groups of patients. The outlier practices need to be supported to improve quality of care and reduce inequalities. Work is already underway through the Waltham Forest CVD Board to visit and support practices to reduce variation.

## **Local Progress**

A rapid access chest pain clinic is run at Whipps Cross University Hospital where GPs could refer patients directly to avoid the delay in treatment. Development of evidence based user friendly referral protocols and increased awareness among GPs combined with public awareness of symptoms of heart disease are likely to improve efficiency and outcomes.

## **Emergency Admissions Rate for CHD**

The emergency (or non-elective) admission rate for CHD in Waltham Forest in 2008/09 was 253.8 per 100,000 which was significantly higher compared to the national rate of 205.3. Proactive targeting of people with more than 20% risk of CVD for appropriate management and public awareness of early symptoms of CHD are not only be effective in reducing these rates but also in improving the quality of life of affected people.

## **Surgical Procedures for CHD**

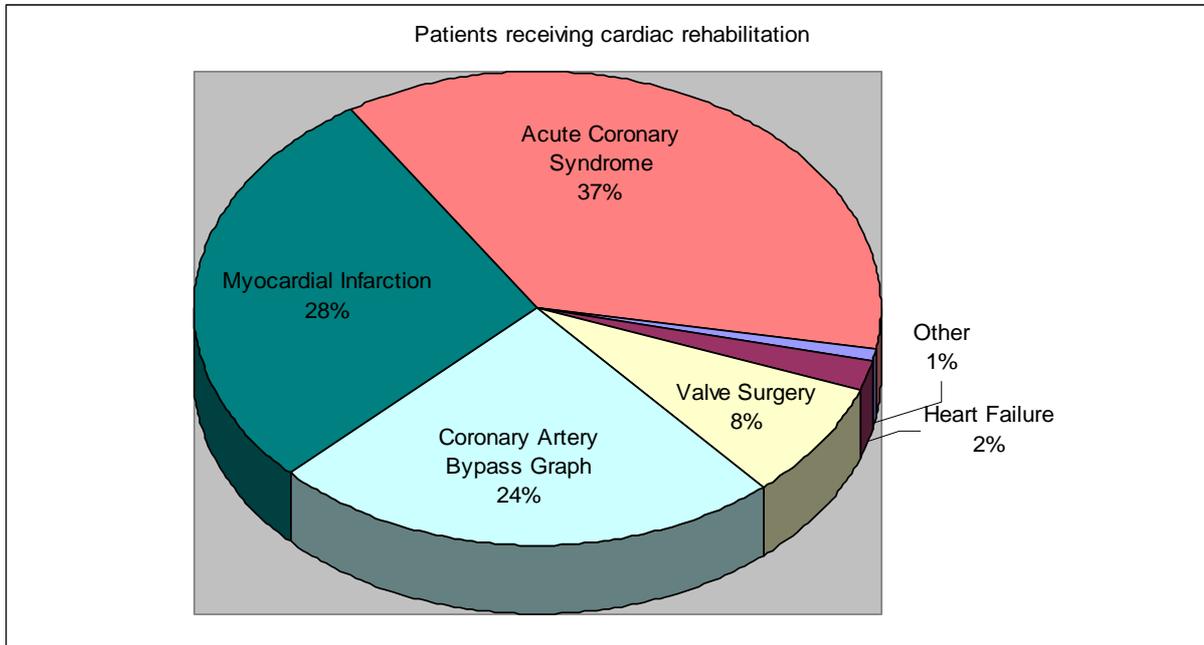
Heart conditions that are too complex to manage through lifestyle change and condition management require surgical procedures. The main two interventions for treating heart disease are Coronary Artery Bypass Grafts (CABGs) and angioplasty, which is also known as a Percutaneous Coronary Intervention (PCI). Complex cases in which one or more arteries are blocked are commonly treated using CABG, rather than a PCI, which is a less invasive procedure. The ratio of PCI to CABG was lowest in Waltham Forest, compared to London and NE London rates. Waltham Forest had the highest CABG rates in all of London with a DSR of 50, nearly double the rate for London as a whole. The PCI to CABG ratio was 1.8 to 1 in Waltham Forest, 4 to 1 in London and was 2.7 to 1 in England, indicating that more patients have complex cases compared to national rates.

## **Cardiac Rehabilitation**

Cardiac rehabilitation is a set of services that enables people with coronary heart disease to have the best possible help (physical, psychological and social) to preserve or resume their optimal functioning in society. Cardiac Rehabilitation including psychological and/or educational interventions reduces mortality and secondary events. Cardiac rehabilitation is highly cost effective. The National Service Framework (NSF) for Coronary Heart Disease states that more than 85% of patients discharged after Myocardial Infarction should be offered rehabilitation. Waltham Forest residents benefit from a dynamic cardiac rehabilitation service that

operates through Whipps Cross University Hospital and provides a range of specialist exercise programmes. The breakdown of the case load is shown in Figure 1. Patients are contacted within 48 hours of receiving the referral from the specialist tertiary centres. All clients are invited to the Phase 3 programme within 6 weeks post surgery, 4 weeks after a Myocardial Infarction, and 2 weeks after a PCI (angioplasty).

**Figure 1**



Patients with Acute Coronary Syndrome, Myocardial Infarction and CABG are the most common types of patients participating in the programme. Approximately 50 patients have received home based programmes. The service currently accepts patients with varying levels of Heart Failure. Numbers are limited as this client group require greater vigilance during exercise sessions. The service would need to expand its staffing and resources to enable the greater vigilance required of this group of patients with heart failure.

### **Evidence based interventions**

- The evidence relating to good management of CHD in terms of outcomes for individuals are well established in the National Service Framework for CHD and if implemented can reduce the risk of death from this disease and improve quality of life for patients.
- Studies have shown that if lifestyle targets for primary prevention of CHD are met, approximately 75,000 CHD events would be prevented per year nationally, with the greatest gain coming from reduced blood pressure levels<sup>243</sup>. Therefore, reducing hypertension (elevated blood pressure) is a prime prevention target for reducing CHD.

<sup>243</sup> Gemmell et al., Potential population impact of the UK government strategy for reducing the burden of coronary heart disease in England: comparing primary and secondary prevention strategies BMJ Quality & Safety 2006

- In England and Wales, there were 68,230 fewer CHD deaths in 2000 compared with 1981. Fifty-eight percent of the decline has been attributed to reduction in risk factors, particularly a fall in smoking prevalence and the balance to medical and surgical treatments. Eleven percent of the decrease in mortality was due to secondary prevention, the treatment of risk factors in those who already had CHD. Only 4% was attributable to angioplasty and coronary artery bypass surgery.<sup>244,245</sup>
- Published economic modelling for vascular risk assessment is cost effective with a quality adjusted life year (QALY) of around £3000.

## Stroke

A stroke occurs when the blood supply to a part of the brain is suddenly cut off. This may be due to a blockage in a blood vessel or when a blood vessel in the brain bursts, spilling blood into the spaces surrounding the brain cells. This can leave lasting damage, affecting mobility, cognition, sight or communication<sup>246</sup>.

A transient ischaemic attack (TIA) is a minor stroke lasting less than 24 hours, which is often an important warning sign of a more serious stroke, heart attack or other vascular event. The risk of stroke in the first 24 hours after TIA is higher than the risk of a heart attack after an episode of chest pain.<sup>247</sup>

The risk of stroke increases with age but the most important risk factor amenable to intervention is hypertension. Other important risk factors include a previous TIA, atrial fibrillation, diabetes, smoking, obesity, poor diet (including high salt intake) and high alcohol intake.<sup>248</sup>

People aged over 65 years are those most at risk. There is also a higher risk of stroke for people in the Black African and Black Caribbean ethnic groups due to a genetic predisposition towards some of the key risk factors such as hypertension and diabetes. Stroke rates for this group are twice that for Whites. On average Black people experience their first stroke at 61 years, while White people about twelve years later at aged 73.<sup>249</sup>

## Stroke: the local picture

People in Waltham Forest are estimated to have 370 strokes per year<sup>250,251</sup>. In 2009/10, the prevalence for stroke/TIA in Waltham Forest was 0.9% compared to the national prevalence of 1.7%. Detected prevalence is

<sup>244</sup> Unal B Critchley J A & S Capewell Explaining the decline in coronary heart disease in England and Wales between 1981 and 2000. *Circulation* 2004;109(9):1101-7

<sup>245</sup> Kelly M P & S Capewell *Relative contribution of changes in risk factors and treatment to the reduction in coronary heart disease mortality*. Health Development Agency, London 2005

<sup>246</sup> Department of Health (2007), National Stroke Strategy ([www.dh.gov.uk/stroke](http://www.dh.gov.uk/stroke))

<sup>247</sup> Department of Health. Improving Stroke Services: A guide for commissioners, Gateway reference 7418: December 2006

<sup>248</sup> Stroke Risk Factors: American Heart Association, <http://www.startchallenge.org/presenter.jhtml?identifier=4716>

<sup>249</sup> Balarajan R. Ethnic differences in mortality from of blood pressure with special reference to socioeconischaemic heart disease and cerebrovascular disease in imic status in a rural south Indian community. *J EpideEngland & Wales. Br Med J* 1991; 302: 560–564.

<sup>250</sup> ASSET for Commissioners Version 2.00b Sep 2009 ([www.dh.gov.uk/stroke/ASSET](http://www.dh.gov.uk/stroke/ASSET))

almost half of the modelled prevalence of 1.7% in Waltham Forest. Prevalence varies from 0.3% to 2.7% across practices.

**Table 2: Actual prevalence (QoF 09/10) of TIA/stroke in NHS Waltham Forest by Clinical Commissioning Groups (CCGs)**

CCG	Number	Prevalence
Chingford	837	1.3%
Leyton Leytonstone	715	0.7%
Walthamstow	907	0.9%
Waltham Forest	2,459	0.9%

A high level of under detection of stroke/TIA is a significant unmet need. Given the high level of deprivation and a higher percentage of Black Caribbean, Black African and South Asians in Waltham Forest, one would expect a higher prevalence. Focus groups with local communities that discussed CVD prevention in July 2011 highlighted that the high risk groups were not only unaware of the term TIA or mini-stroke but also have not heard of the signs or symptoms of TIA.

However, most of them were aware of symptoms and early signs of stroke through the 'FAST' campaign. The estimated number of people living with moderate or severe disability following a stroke in 2010 is between 878 and 960<sup>252</sup>, which demonstrates long term impacts on the quality of life for those affected and their families and also on the social care budget.

Stroke is the third biggest killer in England and the main cause of adult disability. A similar picture exists in Waltham Forest. In 2007 - 2009, the directly standardised mortality rate in persons under 75 years for was 18.3 per 100,000 population, which was significantly higher than the rate reported for England (12.8).

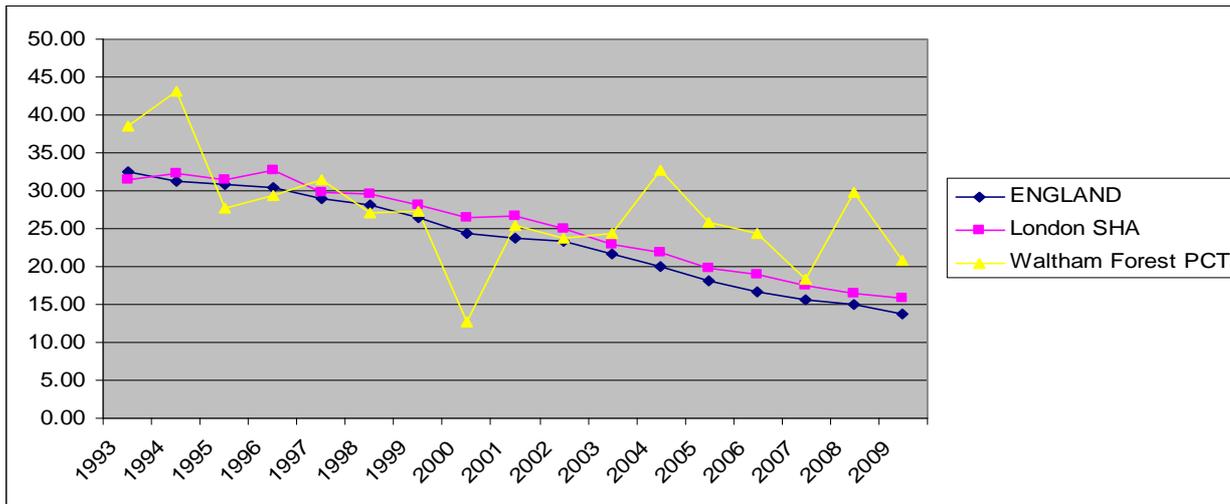
Figures 2 and 3 show an overall downward trend in the mortality rates reported from 1993 to 2009 for England and London. Small numbers make it difficult to establish a trend in Waltham Forest, although it is generally going down.

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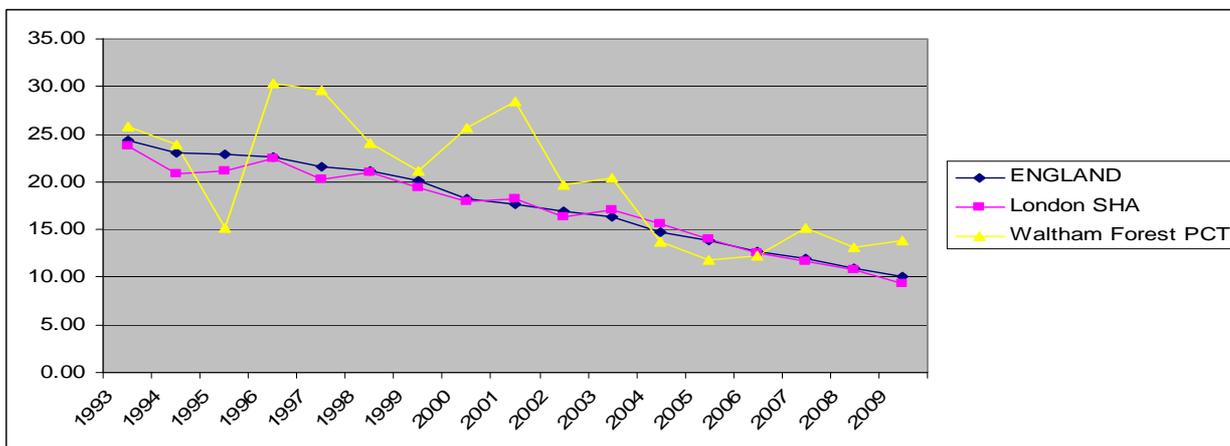
<sup>251</sup> Incidence and Case Fatality rates of stroke subtypes in a multiethnic population: the South London Stroke Register" Wolfe e al. J Neurol Neurosurg Psychiatry 202;72:211-216. Cited in Ref.4).

<sup>252</sup> Projecting Older People Population Information System and Projecting Adult Needs and Services Information System 2010 (based on the General Household Survey 2007)

**Figure 2: Stroke related Mortality among men 1993-2009**



**Figure 3: Stroke related Mortality among Women 1993-2009**



**Primary Care Service Provision related to Stroke in Waltham Forest**

The quality of care a patient receives in primary care has a direct impact on his/her risk of developing another stroke or cardiovascular event. Approximately 25% of people who recover from their first stroke will have another stroke within five years. The risk of having a second stroke is greatest within 30 days of the first one. A third of recurrent strokes take place within two years of the first stroke. Recurrent strokes are a major contributor to disability and death. The risk of severe functional restriction or death increases with each stroke recurrence<sup>253</sup>. Therefore secondary prevention interventions following a stroke event are crucial to prevent further events. A number of QOF indicators are in place to monitor the quality of these interventions delivered through primary care.

**Emergency Admissions for Stroke**

Stroke related emergency admissions rate in WF is 155.6 a significantly higher rate than the 104.2 observed nationally. Effective interventions such as detection and management of high risk groups for CVD and proactive referral of suspected TIA to well equipped TIA Clinic at Whipps Cross University Hospital for timely

<sup>253</sup> Stroke Education Ltd, <http://www.stroke-education.com/info/StrokeInfo.do>

management need to be strengthened within the borough through the CVD board and multi-stakeholder partnership. These are significant partially met needs locally.

### **Stroke Rehabilitation in Waltham Forest**

Rehabilitation services following a stroke is an evidence based intervention that improves the quality of life and reduces mortality due to stroke. Local stroke rehabilitation for many patients begins in secondary care on an inpatient basis. Waltham Forest stroke care specialists participate in a sector wide initiative to maintain and raise rehabilitation standards, ensuring that residents who have had a stroke receive inpatient rehabilitation that meets 17 quality of care indicators. The Waltham Forest service performs extremely well against these indicators<sup>254</sup>, ensuring that patients will:

- Have access to a specialist inpatient rehabilitation unit with specialist multi-disciplinary teams.
- Are assessed by all relevant members of the rehabilitation team including Occupational Therapists, Speech and Language Therapists, and receive psychological assessment.
- Be involved in negotiating their rehabilitation goals and receive a copy of the goals within 5 days of admission.
- Receive appropriate seating, posture and position advice within 24 hours of admission to the stroke unit.
- Be allocated a named key or support worker within 7 days of admission.
- Offered a minimum of 45 minutes active therapy for a minimum 5 days a week if appropriate.
- Have a joint care plan on discharge from hospital.

### **Early Supported Discharge**

Early Supported Discharge (ESD) is proven to improve outcomes in stroke survivors. QIPP evidence supports the development of ESD services as recommended interventions to improve quality and cost-effectiveness. A community stroke rehabilitation team currently operates through the acute stroke unit at Whipps Cross University Hospital to support stroke survivors immediately following discharge from hospital. The service is being redeveloped with plans to enhance it to provide full Early Supported Discharge and appropriate 6 month follow-up. This will include a Community Clinical Nurse Specialist and project management support. Long term support is also required following initial home or community based rehabilitation. Estimates for the people with long terms conditions due to stroke indicate a high level of need.

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<sup>254</sup> North East London Rehab Quality Report, June 2011

**Table 3: No of people predicted to have a longstanding health condition caused by a stroke**

	2010	2015	2020	2025	2030
No. (aged 18+) predicted to have stroke	878	923	961	1012	1080

Source: Projecting Adult Needs and Services and Projecting Older People Population Information Systems, 31 Aug 2011

### **Care Quality Commission Review on Stroke**

The Care Quality Commission (CQC) review of stroke services in WF in 2010 identified areas that are undertaken well in Waltham Forest, and those in need of improvement. The performance was rated good in a number of areas which include: involving stroke survivors and carers in planning and developing services, the range of services and information provided, and helping people to choose the services they want. The review of progress after people have left hospital scored higher than average. The categories “care and support after TIA” (mini-stroke) also scored well.<sup>255</sup> The review identified the following areas that need to be improved:

- Managing the transfer home.
- Providing care and support for carers.
- Meeting individuals’ needs.
- Helping people to stay healthy after their stroke.

In response to the CQC review, the CVD Board in Waltham Forest established a sub-group to develop an action plan to address the identified areas for improvement. The sub-group consisted of public health, clinical leads, Local Authority and Whipps Cross University Hospital. The action plan agreed by the CVD Board is currently in progress and monitored through the CVD Board.

### **Support to stroke survivors and carers**

Stroke survivors and their carers now benefit from a dedicated stroke care co-ordinator in the community funded through the reablement funding of the LBWF, and dedicated support for carers through the resource hubs, the first of which opened in Leyton in July 2011. Two more resource hubs will be established in other two localities in early 2012 to provide easy access to all residents of the borough.

### **Evidence based interventions**

There is considerable scope for preventing strokes by addressing the key risk factors such as smoking, hypertension and excessive salt consumption.

The ASSET tool of the Department of Health (DoH) estimates the impact of management of risk factors including blood pressure, cholesterol, arrhythmia and smoking cessation on prevention of strokes/TIA. For Waltham Forest the tool gives the following results per annum:

- 34 strokes prevented by keeping hypertension to below 140mmHg systolic BP.

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<sup>255</sup> Supporting life after stroke – Waltham Forest 2011

- 25 strokes prevented through prescribing Warfarin to patients with atrial fibrillation.
- 16 strokes prevented through prescribing statins for all people with over 20% risk of CVD in 10 years.
- 7 strokes prevented through smoking cessation for all smokers who have suffered a stroke or TIA.

For both stroke and heart disease, action to tackle the underlying socio-economic determinants of health could help to reduce overall death rates and disease burden and to narrow the inequalities gap.

The National Stroke Strategy sets out a framework of quality markers for raising the quality of stroke prevention, treatment; care and support over the next decades. The key features of the strategy are summarised below:

1. Awareness: action to improve public and professional awareness of stroke symptoms.
2. Preventing stroke: supporting healthier lifestyles and taking action to tackle vascular risk, for example hypertension, atrial fibrillation and high cholesterol.
3. Involvement: involving people with stroke as informed partners in care planning and planning and evaluation of local services, including those with communication and/or physical disabilities.
4. Acting on the warnings: since TIAs are a clear warning sign that a further stroke may occur and the time window for action is very short a system that responds quickly to people who have had a TIA is required.
5. Stroke as a medical emergency: planning to ensure that everyone who could benefit from urgent care is transferred to an acute stroke centre that provides 24-hour access to scans and specialist stroke care.
6. Stroke unit quality: stroke unit care is the single biggest factor that can improve a person's outcomes following a stroke.
7. Rehabilitation and community support: intensive rehabilitation immediately after stroke, operating across the seven-day week, can limit disability and improve recovery<sup>256</sup>.
8. Participation: assistance to overcome physical, communication and psychological barriers to engage and participate in community activities helps people to lead more autonomous lives and move on after stroke, across the range of community services – housing, education, leisure, transport, employment.

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<sup>256</sup> National stroke strategy, DOH, 2009

9. Workforce: people with stroke need to be treated by a skilled and competent workforce.
10. Service improvement: this new vision for stroke care demands services working together in networks, looking across all aspects of the care pathway; regular local and national audit will also drive improvements in stroke care.
11. NICE guideline on stroke covers interventions in the acute stage of a stroke ('acute stroke') or TIAs. Most of the evidence considered relates to interventions in the first 48 hours after onset of symptoms, although some interventions up to two weeks are covered.

Health care for London identified stroke as a top priority for action. The goal of this project is to achieve a step change in the quality of stroke care in London by creating a stroke care system that ensures every Londoner receives the same high quality of care. The acute stroke service comprises three key service lots defined as follows:

- Hyper-acute stroke units (HASU) provide the immediate response to a stroke, where the patient is stabilised and receives primary intervention, and where length of stay is typically no longer than 72 hours.
- Stroke units (SU) provide multi-therapy rehabilitation and ongoing medical supervision following a patient's hyper-acute stabilisation, where length of stay varies and will last until the patient is well enough for discharge from an acute inpatient setting.
- Stroke centre is a combined HASU / SU, all HASUs are expected to also have an SU. TIA services provide rapid diagnostic assessment and access to a specialist within 24 hours for high risk patients following a TIA, and within seven days for low risk.

## Heart Failure (HF)

Heart failure is a clinical syndrome caused by a reduction in the heart's ability to pump blood around the body. The prognosis is poor and survival rates are worse than, for example, breast and prostate cancer, with a high risk of sudden death. Up to 40% of patients die within the first year of diagnosis. Most cases of heart failure in the UK are due to CHD and about a third result from hypertensive heart disease.<sup>257</sup>

### Heart Failure: the Local Picture

Table 4: Actual prevalence (QoF 09/10) of HF in NHS Waltham Forest by CCGs

CCG	Number	prevalence
Chingford	445	0.7%
Leyton/Leytonstone	445	0.4%
Walthamstow	553	0.5%
Waltham Forest	1443	0.5%

<sup>257</sup> Pushing the boundaries, improving services for patients with heart failure, Commission for Healthcare Audit and Inspection 2007

The NSF for Coronary Heart Disease identifies the following aims for Heart failure treatment:

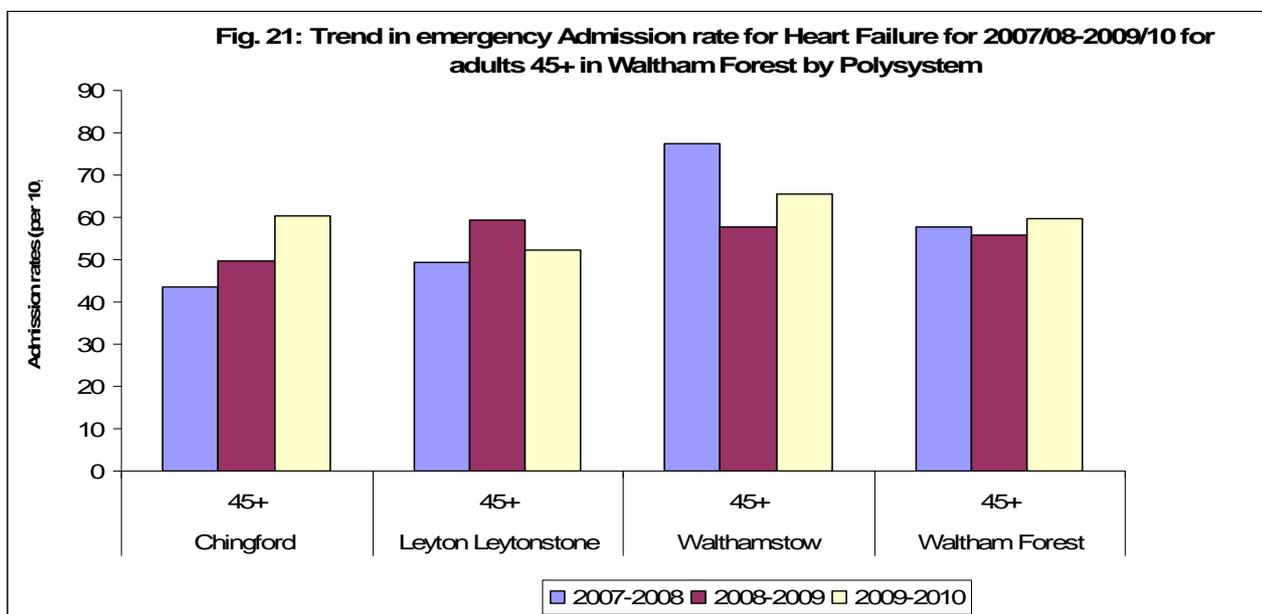
- Help people with heart failure to live longer and achieve a better quality of life.
- Help people with unresponsive heart failure and other malignant presentations of coronary heart disease receive appropriate palliative care support.

Evidence suggests that minority ethnic patients are more likely to have hypertension as a cause of their heart failure whilst the white patients are more likely to have CHD as a cause often accompanied by obesity and diabetes mellitus<sup>258</sup>. This is relevant for Waltham Forest because of the higher percentage of Black and Asian ethnic groups.

### Heart Failure related admissions

It is important to note that rates of emergency admissions related to heart failure in Waltham Forest were higher than the national rates in both 2007/08 and 2008/09. Heart Failure emergency admissions increased in Waltham Forest between those two years. Although having a young population, Walthamstow had the highest rate of admissions relating to heart failure since 2007/08. This may be associated with the relatively higher level of deprivation.

**Figure 4: Trend in emergency admission rate for Heart Failure for 2007/08 – 2009/10 for adults 45+ in Waltham Forest by CCG**



Repeated admissions of same patients incur high cost and affect the quality of life of patients who are affected. The likely reasons are gaps in the quality of primary care and/or lack of community based specialist heart

<sup>258</sup> Developing a strategy for hypertension. HDA (2005).

failure service. This is an area for service development in order to shift care from acute to community/primary care and should be considered a priority for future commissioning.

### **Evidence of effectiveness**

There is strong evidence that community based heart failure specialist service with consultant supported multidisciplinary team (MDT) can reduce emergency re-admissions by 30%, reduce mortality rates by 25% and optimise effective management of heart failure. Evidence also shows that specialised, dedicated heart failure nurses in the community can improve health outcomes for patients with heart failure and reduce emergency admissions to hospital.<sup>259, 260</sup>

A number of studies including a recent systematic review found that a self-management program for patients with heart failure decreases both all-cause hospital readmissions and readmissions due to heart failure<sup>261</sup>.

### **Progress made in heart failure service delivery since the previous JSNA**

Significant achievements have been made since highlighting the unmet need in HF care pathway in last year's the JSNA (2010). These are stated below:

- Consensus reached through a stakeholder consultative workshop on prioritising the service development needs underpinned by unmet needs, evidence of effectiveness and past clinical experience.
- Funding secured through the Re-ablement Grant of the London Borough of Waltham Forest and the service specification signed off by the Waltham Forest CVD Board to establish a community based HF specialist service. This in turn will provide care closer to home, provide step down care to reduce length of stay, shift outpatient activity into the community and reduce emergency readmissions and A&E attendance reflecting productivity, efficiency and effectiveness. The service is expected to go live in November 2011.
- Introducing Serum Natriuretic Peptides (Serum NP) for suspected heart failure patients to rule out other causes to align with recent NICE Guidance on HF<sup>262</sup>. This is expected to reduce the number of

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<sup>259</sup> Blue, L Lang E, McMurray, JJV, Davie AP, McDonagh, TA, Murdoch DR, et al. Randomised controlled trial of specialist nurse intervention in heart failure [www.bmj.com/content/323/7315/715.full.pdf](http://www.bmj.com/content/323/7315/715.full.pdf)

<sup>260</sup> Akosah KO, Schaper AM, Havlik P, Barnhart S, Devine S. Improving Care for Patients With Chronic Heart Failure in the Community: The Importance of a Disease Management Program.  
<http://chestjournal.chestpubs.org/content/122/3/906.full>

<sup>261</sup> Effects of self-management intervention on health outcomes of patients with heart failure: a systematic review of randomized controlled trials, Jovicic J, A, Holroyd-Leduc JM, Straus SE.  
<http://www.biomedcentral.com/content/pdf/1471-2261-6-43.pdf>

<sup>33</sup> Joint Health Surveys Unit. 2004. *Health Survey for England 2003. Volume 2 Risk Factors for Cardiovascular Disease*. London: The Stationery Office

<sup>262</sup> NICE Guidance on Heart Failure (2010).

Echocardiograms (ECHOs) performed by about 45%<sup>263</sup>. The service is expected to go live in November 2011.

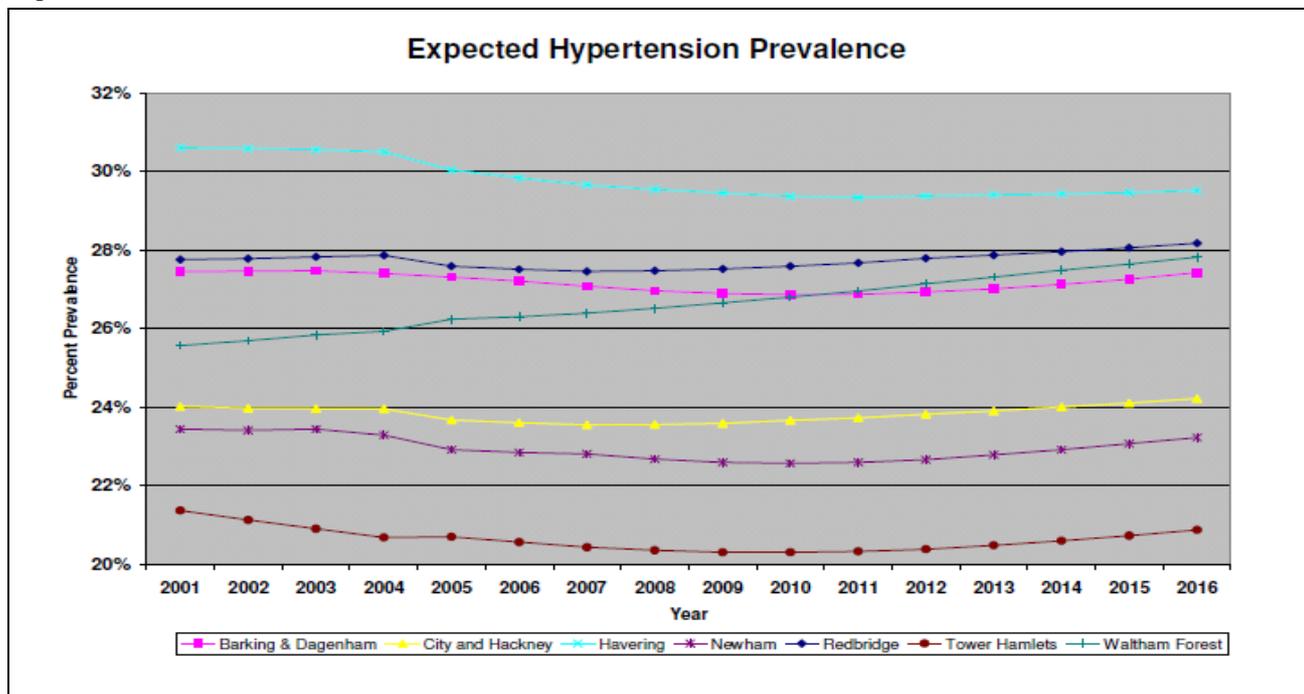
## Hypertension

Hypertension is the most common cardiovascular condition nationally and locally. It is the single biggest risk factor for stroke. It also plays a significant role in heart attacks. It can be prevented and successfully treated but only if it is diagnosed and managed appropriately. The Health Survey for England found that Black Africans and Black Caribbean have above average prevalence of hypertension compared with the general population<sup>264</sup>.

### Hypertension: the local picture

Using the model developed by the Association of Public Health Observatories (APHO), the projected trend for prevalence of hypertension from 2001-16 across the NE London sector, by PCT, is shown in Figure.5<sup>265</sup>. The prevalence in Waltham Forest is predicted to range from 25.6% to 27.8%.

Figure 5



Recorded prevalence of hypertension in Waltham Forest according to QOF 2009/10 is 10.9% with 29,850 registered patients in GP registers. The prevalence ranged from 3.1% to 18.4%. Chingford, with the highest percentage of older people, had the highest rate among the three localities. Recorded prevalence in the borough reflects only 50% of the modeled prevalence for Waltham Forest compared to 55% for England.

<sup>263</sup> One Year Evaluation of introduction of BNP in GP Practices in Northamptonshire (2008)

<sup>264</sup> Health Survey for England 2004

<sup>265</sup> Estimates are based on two separate models derived from the Health Survey for England (HSE). These estimates have been produced for APHO by collaboration between the Yorkshire and Humber and Eastern Region Public Health Observatories and Doncaster PCT

Hypertension is also linked to diabetes, which is more prevalent among ethnic minorities. Further, McPherson et al estimates found that 14% of deaths from CHD are attributable to blood pressure above 140/90. However, good management can produce large reductions in Coronary Heart Disease as well as stroke. Additionally adequate control of hypertension is important to prevent the other consequences such as heart failure, aortic aneurysm and peripheral vascular disease and chronic renal failure<sup>266</sup>. As mentioned previously, keeping hypertension to a level below 140mmHg systolic BP could prevent 34 strokes in Waltham Forest per annum.

### **Atrial Fibrillation**

Atrial fibrillation (AF) is the term used for a common type of irregular heartbeat and is an important risk factor in stroke, accounting for 14% of all strokes. The annual risk of stroke is five to six times greater in AF patients than in people with a normal heart rhythm. Early treatment of AF with Warfarin, an anticoagulant, reduces risk of stroke by 50-70%.

The prevalence of AF in Waltham Forest is 0.7% (1,955 patients in GP registers) with a range of 0.1% to 2.5%. This prevalence is lower than the national recorded prevalence resulting in AF going untreated in the population.

**Table 5: Actual prevalence (QoF 09/10) of AF in NHS Waltham Forest by CCGs**

CCG	Number	Prevalence
Chingford	842	1.3%
Leyton Leytonstone	475	0.5%
Walthamstow	638	0.6%
Waltham Forest	1,955	0.7%

Last year's JSNA identified that improved detection and management of patients with AF was a key factor in reducing the burden of stroke in the borough. Detection and treatment of AF in primary care is a published QIPP case study identified as a highly recommended intervention by their peer review process<sup>267</sup>. The programme recommends that opportunistic screening for pulse palpitations of patients over the age of 65, and subsequent treatment using anticoagulation supported by the GRASP tool. A proportion of Waltham Forest residents experience stroke and atrial fibrillation at a younger age, and GP recommend pulse checks to all adults over the age 40 to ensure optimal screening results.

### **Evidence based interventions**

In order to prevent AF related strokes, the recommended course of action is to initiate anticoagulation therapy. When this therapy is appropriately used and monitored, it is highly effective, lowering stroke risk by about two thirds. However, despite the clear benefits of Warfarin and the presence of guidelines for its use and

<sup>266</sup> Easing the pressure: tackling hypertension: Hypertension: public health burden (HDA 2005)

<sup>267</sup> Atrial Fibrillation – detection and optimal therapy in primary care. NHS Stroke Improvement Programme, November 2009.

management in stroke prevention, current data indicate that the management of AF is still suboptimal, with many of those receiving anticoagulation not consistently in the optimal therapeutic range.

Recent clinical trials have supported a relationship between anticoagulant control and benefit of anticoagulation, with the longer time spent in therapeutic range reducing the chance of embolic stroke. Patients receiving oral anticoagulation are at risk of under-anticoagulation, which can result in thrombosis, and over anticoagulation which can result in haemorrhage, both of which can be fatal. The risk of haemorrhage whilst on long-term anticoagulation varies between 1-15% per year, with the risk of death rising with increasing international normalised ratio (INR).<sup>268</sup>

### **Local progress: Atrial fibrillation pilot in Waltham Forest**

A nurse-led community pilot was developed and implemented with assistance from the North East London Cardiac and Stroke Network. An Arrhythmia Nurse Specialist was recruited to operate the clinics with clinical supervision by a specialist consultant cardiologist. The nurse specialist identified patients through co-ordinating with local GPs to review AF registers for appropriate patients and to generate referrals.

Patients attending a clinic received a full history and examination by specialist arrhythmia nurse, ECG recording and analysis, access to 24-hour, 72-hour and 7 day ambulatory monitoring, echocardiography, phlebotomy and a close link with anti-coagulation services. The Nurse Specialist was further supported through the use of the GRASP tool, an IT system developed to help monitor patients on anticoagulation treatment to optimise patient management. Over the past year, the pilot saw 133 patients, of those that were diagnosed with AF, 41 received anticoagulation treatments.

The evidence indicates that stroke patients with AF have longer hospital stays than any other strokes. Uniquely it also is an eminently preventable cause of stroke with a simple highly effective treatment. Appropriate anti-coagulation of all patients with recognised AF would prevent approximately 4,500 strokes per year and prevent 3,000 deaths.<sup>269</sup>

It is evident from the recorded prevalence of AF that detection occurs at a lower rate than would be expected. The recorded prevalence is currently at 0.7%, compared to a recorded prevalence of 1.4% for England. Although the prevalence has remained the same over the past 3 years, the actual number of residents diagnosed with AF has increased from 1,782 in 2006/07 to 1,955 in 2009/10.

### **Evidence of effectiveness**

- The treatment of AF with Warfarin reduces risk of stroke by 50-70%.

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<sup>268</sup>Heart and Stroke Improvement; Atrial fibrillation in primary care: making an impact on stroke prevention: National priority project final summaries October 2009 [www.improvement.nhs.uk](http://www.improvement.nhs.uk)

<sup>269</sup> Atrial Fibrillation Action Plan for NE London, NE London cardiac & stroke network 2010.

- The estimated total cost of maintaining one patient on Warfarin for one year, including monitoring, is £383.
- The cost per stroke due to AF is estimated to be £44,000 in the first year after stroke occurrence<sup>33</sup>.

Current anti-coagulant management of AF is sub-optimal. NICE estimate that 46% of patients that should be on Warfarin are not on Warfarin in Waltham Forest:

- 630 is the estimated additional number requiring Warfarin according to NICE guidance.
- 25 strokes would be prevented if fully compliant with NICE guidance for prescribing Warfarin to patients with atrial fibrillation.

### **Supporting people with cardiovascular disease - what is being done locally to address this issue?**

Cardiovascular disease (CVD) is the main cause of long term disability in adults. The needs and support required varies depending on the needs of the individual. The London Borough of Waltham Forest works with local groups to provide a range of support for people living with CVD and for those who provide their daily care needs, paid and unpaid. *POhWER* is an advocacy organisation that provides information and advice to help people plan, choose and manage their care needs. Age UK, the Stroke Association and range of local community groups offer services to help people live at home, facilitate rehabilitation and support independence. There are financial planning support services available for people who have been assessed as needing help and decide to pay for their own care and services or have Personal Budgets available to them. These services provide advice and information on how to plan and spend money to achieve the outcomes residents with care needs require.

The local authority has prioritised the needs of people who care for others through the development of single access resource hubs. The hubs will be open in four areas support carers to access independent information, advice and advocacy support, provide emotional support and training to enhance the general wellbeing and independence of carers. Many of the services mentioned above are accessible through the hubs.

### **Priorities for the next 5 years: gaps and challenges**

1. Ensure NHS Health Checks are implemented with a robust call/recall function.
2. Under-detection of CHD, TIA/stroke, hypertension, atrial fibrillation and heart failure is an unmet need across GP practices in Waltham Forest.
3. Variation in quality of care for CVD reflected through QOF performance and high exception reporting in certain practices warrants further analysis of exception reporting and appropriate interventions.
4. Under utilisation of the rapid access chest pain clinic at Whipps Cross University Hospital together with inappropriate referrals. The service will benefit from tightening referral criteria and clarification of what constitutes an appropriate referral.

5. Inequity in access to Percutaneous coronary intervention for Waltham Forest residents overall and particularly for women.

6. Stroke – No local stroke awareness campaign locally.

- TIA clinic at Whipps Cross University Hospital is under utilised.
- Only 19% of stroke patients treated at Whipps Cross University Hospital receive the bundle of care (9 quality indicators Related to stroke).
- Length of stay for stroke patients at Whipps Cross University Hospital is above the national and London averages.
- No early supported discharge team for specialist stroke rehabilitation in the community.

7. Heart Failure-

- Variation in QOF performance across practices.
- Need to strengthen self management programmes on HF in the community.

8. Close the inequality relating to heart disease and stroke related mortality and admissions related to deprivation.

9. CVD is grouped as 'Low spend and poor outcomes' under Programme Budget Management Analysis (PBMA) group.

### **Challenges**

- High level of deprivation and cultural diversity remain as big challenges in providing equity in access to services in primary, secondary and community care.
- Language appears to be a barrier in communicating with health care professionals particularly among unregistered recent migrants.
- Higher level of CVD risk factors (smoking, obesity, physical inactivity).
- High level of under detection of CHD, Stroke, Hypertension, atrial fibrillation and heart failure compared to modelled prevalence.
- High level of exception reporting in primary care relating to CVD.
- High level of readmissions for heart failure.

## **Priorities for improvement over the next 5 years**

The NHS Waltham Forest Commissioning Strategic Plan aims to achieving an 8% improvement in the rate of early deaths due to CVD by 2013, in order to reduce the rate to 59.1 per 100,000. This would contribute to reducing health inequalities in Waltham Forest.

## **Ambulatory Care Sensitive Conditions**

An ambulatory care-sensitive condition (ACSC) is one where admission to hospital is potentially avoidable through good quality primary and preventive care. Most chronic conditions such as asthma, diabetes, and COPD are considered ACSCs. Detecting ACSCs early when there is a possibility of cure or of management in the community could delay not only hospital admissions but also mortality.

As well as treatment, ambulatory care also includes preventive measures such as screening and the management of risk factors such as cholesterol and blood pressure. When patients are admitted to hospital for treatment of an ACS condition, this can be thought of as an avoidable hospital admission or failure in primary care delivery. Rates of ACSC admissions are therefore often used as a measure of the quality of primary care in a local area.

The North East Public Health Observatory classified the ACSCs into three categories:

- 1. Chronic conditions**, i.e. those long term conditions for which rate of progression and incidence as acute episodes requiring hospital admission can be reduced by effective primary and community care (e.g., asthma, chronic obstructive pulmonary disease, congestive heart failure, angina, hypertension, diabetes, musculo-skeletal disorders such as rheumatoid arthritis, anaemia and nutritional deficiencies)
- 2. Acute aggravated conditions**, i.e., those where failure to provide timely and efficacious primary care interventions aggravate the condition and thus produce the need for hospital admission (e.g., cellulitis, convulsions and epilepsy, dental conditions, ear-nose-throat infections, gangrene, gastroenteritis, pelvic inflammatory disease, perforated/bleeding ulcer, pyelonephritis)
- 3. Immunisable conditions** i.e., those where immunisation can prevent the onset of the condition and hence the need for a hospital admission (e.g., influenza, pertussis, rheumatic fever, tetanus and the range of conditions for which we usually provide population wide vaccination programmes)<sup>270</sup>.

The ambulatory care sensitive conditions discussed in the 2012/13 JSNA include diabetes and respiratory diseases chronic obstructive pulmonary disease and asthma.

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<sup>270</sup> Gray, A. 2009. Ambulatory Care Sensitive Conditions: a note for commissioners workshop 22/9/200. North East Public Health Observatory

## **Diabetes**

### **Executive Summary**

Diabetes is one of the most significant long-term conditions in Waltham Forest, which can lead to a number of other serious conditions such as heart disease, stroke and kidney disease. As the diverse population in Waltham Forest ages, the local health system needs to have the capacity and flexibility to prevent, detect and treat diabetes and its associated health outcomes.

### **Recommendations**

- Implement the Healthcare for London model for diabetes care.
- Commission more dynamic community programmes that address modifiable risk factors, such as physical activity and diet and encourage more local uptake.
- Improve integration between specialist diabetes services and primary care, using more community based locations where appropriate.
- Ensure Stop Smoking Services are accessible to all diabetes patients through active identification of smokers and referral into the NHS Stop Smoking Services.
- Expedite the diabetes care planning plot and the accreditation process to embed best practice across all GP practices.
- Develop a diabetes care strategy with a clear pathway between prevention, primary care, community care and secondary care. Undertake a demand and capacity analysis to plan and strengthen the capacity of the Tier 3 diabetes care.
- Provide a well planned training programme for primary care staff using the identified training needs as part of the accreditation process.
- Reduce variation in quality of care on diabetes detection, monitoring and control and work with the Health Promoting GP Practice scheme, targeting selected practices to reduce variation particularly relating to HbA1c, cholesterol measures.
- Address poor uptake of the structured education programme as a priority using focus group discussion feedback and in collaboration with the local authority to ensure all people with newly-diagnosed diabetes are offered access to these services within three months of diagnosis.
- Address risks urgently in the DRSS care pathway to improve the service to meet national quality standards to prevent avoidable blindness and any serious untoward incident.

- Explore screening of high risk groups for diabetes in selected wards using innovative approaches.
- Establish links with all risk factor (obesity) and co-morbidities (CVD) pathways to provide a well integrated service to patients with diabetes.
- Maximise NHS health checks to detect diabetes early, including those with impaired glucose tolerance.
- Undertake further analysis of exception reporting to improve quality of care and reduce variation.
- Engage and involve patients and carers more to promote self management of diabetes and prevent complications.
- Use Health Analytics to ensure robust data collection and audit process to ensure clinical assurance, patient satisfaction and improved outcomes.
- Improve the provision of psychological support for patients with diabetes

### **What is Diabetes?**

Diabetes mellitus is a condition in which the amount of glucose in the blood is too high because the body cannot use it properly. There are two main forms of diabetes: Type 1 diabetes occurs when the pancreas produces no insulin. Type 2 diabetes develops when the pancreas does not produce enough insulin. Type 2 is the more common in the population and accounts for around 90% of cases of diabetes<sup>271</sup>.

More than 500,000 who have Type 2 diabetes are not aware of it. It is estimated that by 2025 there will be more than four million people with diabetes in the UK. Most of these cases will be Type 2 diabetes, attributable to an ageing population, changing ethnic mix and rapidly rising numbers of overweight and obesity. Recent estimates show that 10% of NHS spending goes on diabetes – that is £9 billion a year or £1 million an hour<sup>272,273</sup>.

### **Why is diabetes important?**

Poor control of diabetes can, in the short term, result in diabetic ketoacidosis, and a potentially fatal medical emergency. In the longer term, poor diabetic control increases the risk of complications such as heart attacks, stroke, blindness, kidney failure and amputation. Studies have shown that good diabetes control is associated with a reduced risk of these complications developing. On average diabetes reduces life expectancy by more than fifteen years for someone with Type 1 diabetes and up to ten years for Type 2.

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<sup>271</sup> Harris M.I. Definition and Classification of Diabetes Mellitus and the Criteria for Diagnosis. In, *Diabetes Mellitus, a Fundamental and Clinical text*. 3<sup>rd</sup> Edition. LeRith D., Taylor S.I. and Olefsky J.M. Eds. Lippincott Williams and Wilkins, USA, 2004. P. 457-462

<sup>272</sup> Diabetes UK (2008), A report from Diabetes UK, October 2008: Diabetes. Beware the silent assassin.

<sup>273</sup> APHO Diabetes Prevalence Model Findings for England, Yorkshire and Humber, Public Health Observatory; [www.yhpho.org.uk](http://www.yhpho.org.uk)

Around half of people with diabetes have cardiovascular or other types of complications at diagnosis, suggesting that they already have had the condition for up to 10 years. Undiagnosed diabetes, presenting as an acute emergency, contributes to the need for unscheduled emergency care and acute admission. Diabetes related accident and emergency (A&E) attendances and hospital admissions have huge implications on the local health and social care economy<sup>274</sup>.

### **Risk factors for diabetes**

Diabetes is most prevalent among those who are overweight or obese, physically inactive and who have a family history. People of South Asian origin are up to six times more likely, and those of Black African-Caribbean origin up to five times more likely, to develop diabetes compared to white people. Data suggests that 20% of the South Asian community and 17 % of the Black African and Caribbean community living in the UK have Type 2 diabetes in contrast to 3% of the general population. For those with diabetes morbidity is also much higher, especially heart disease (2-3 times higher in South Asians), renal failure (4 times higher in Asians) and stroke (3 times higher in African-Caribbeans)<sup>275</sup>.

Socio-economic deprivation is also associated with increased risk of diabetes, with the most deprived people at two and a half times greater risk<sup>4</sup> and the risk increases with age in both sexes. These are particularly relevant to Waltham Forest, considering its ethnic mix, high level of deprivation and higher level of physical inactivity and overweight/obesity.

Lifestyle behaviours such as physical inactivity and smoking increase the risk of developing type 2 diabetes and the risk of diabetic complications<sup>276</sup>.

### **Local picture**

In Waltham Forest, diabetes is a significant long term condition both in respect of prevalence and associated morbidity and mortality. Current diabetes prevalence is estimated at 5.8% but it is predicted to rise to over 10% by 2030 due to changes in social demographics. The local population is expected to increase from 224,880 to 245,800 by 2031. Growth will be highest for the over 50s: an estimated increase of 37% from 57,900 to 79,100 people<sup>277</sup>. In addition, it is predicted that by 2031, 42% of people over the age of 50 will be of ethnic minority origin<sup>278</sup> - both are major predictors for diabetes.

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<sup>274</sup> Diabetes Guide for London, HealthCare for London, <http://www.healthcareforlondon.nhs.uk/assets/A4diabetesHfL.pdf>

<sup>275</sup> Diabetes UK (2006), Diabetes and the disadvantaged: reducing health inequalities in the UK; World Diabetes Day 14 November 2006, A report by the All Parliamentary Group for Diabetes and Diabetes UK, [http://www.diabetes.org.uk/Documents/Reports/Diabetes\\_disadvantaged\\_Nov2006.pdf](http://www.diabetes.org.uk/Documents/Reports/Diabetes_disadvantaged_Nov2006.pdf)

<sup>276</sup> Bazzano, L A., Serdula, ML, Prevention of Type 2 Diabetes by Diet and Lifestyle Modification, J Am Coll Nutr 2005 24: 310-319 <http://www.jacn.org/cgi/reprint/24/5/310>

<sup>277</sup> GLA 2010, 2009 Round Demographic Projections

<sup>278</sup> GLA Round Ethnic Group Projections (Revised), August 2010.

In 2009, Waltham Forest PCT had the 8th highest diabetes-related mortality rate of all London PCTs. The incidence of major limb amputations was higher in Waltham Forest compared to statistical comparators in 2007/08 and 2008/09.

The modelled prevalence of diabetes for England, London and for Waltham Forest in 2010 is 7.4%, 7.5% and 8% (13,681 patients) respectively. It is predicted that by 2030, national, London and Waltham Forest prevalence will go up to 9.5%, 10.1% and 10.6% (19,530) respectively<sup>279</sup>.

### **Registered prevalence of diabetes in Waltham Forest (2008/09 and 2009/10)**

As of end March 2009, there were 11,607 people with diabetes (both Type 1 and Type 2) in all 46 GP Practice registers in Waltham Forest. This number increased to 12,233 in 2009/10. This equals to a prevalence of 5.6% and 5.9% respectively and higher than the prevalence recorded nationally and in London<sup>280</sup> during both years.

**Table 1: Prevalence of diabetes in three GP Commissioning Boards**

	QoF list size at Jan 2010 (age 17+)	Diabetes register	% prevalence (17+ denominator)
Chingford	48,970	2,536	5.2%
Leyton Leytonstone	80,059	4,791	6.0%
Walthamstow	79,997	4,906	6.1%
All	209,026	12,233	5.9%

The highest prevalence was observed in Walthamstow 6.1% with Leyton Leytonstone reporting 6.0%. and Chingford 5.2%.

### **Breakdown of type of diabetes in Waltham Forest**

Specific numbers of patients with Type 1 and Type 2 diabetes are not reported routinely through QMAS data. Therefore data available from the National Diabetes Audit (NDA) 2009/10 were used to present the proportion of Type 1 and Type 2. The NDA receives information on patients with diabetes from both GP practices and secondary care providers. The table below shows where patients identified by secondary care are not found on the primary care diabetes register. The figures are only for data relating to the 45 practices (out of 46) participating in the NDA and explains the discrepancy in the number 12,233 reported above for 2009/10 and 12,128 in Table 2.

<sup>279</sup> APHO Diabetes Prevalence Model, <http://www.yhpho.org.uk/resource/view.aspx?RID=81090>

<sup>280</sup> QMAS database data as at year ends. Copyright © 2007; 2008; 2009; 2010 The Health and Social Care Information Centre, Prescribing Support Unit.

**Table 2: Diabetes registrations by type for Waltham Forest PCT**

	<b>NDA Registrations</b>
	<b>Total number of registrations</b>
<b>Type 1</b>	849
<b>Type 2</b>	10,924
<b>All Diabetes *</b>	12,128

\*All Diabetes include MODY, other specified and unspecified

This indicates that Type 1 Diabetes represents 7% of the total population with diabetes registered in Waltham Forest.

### **Level of detection of diabetes**

The Association of Public Health Observatories (APHO) diabetes prevalence model<sup>281</sup> predicts the expected number (diagnosed and undiagnosed) of people aged 16 years and above with diabetes based on the age, sex, ethnicity and deprivation of the population in Waltham Forest.

The projected rise in prevalence of Type 1 and Type 2 Diabetes will have a major impact on demand on diabetes services within Waltham Forest. It may also result in an increase in the number of diabetes related complications which impact on health and social care economy.

### **Mortality**

The estimated percentage of deaths attributable to diabetes among people aged 20 - 79 in Waltham Forest was 14.6%, which was higher than London (13.5%) and national (11.6%) rates. Data for Mortality from Diabetes in persons of all ages (Directly Standardised Rate) showed that Waltham Forest ranked 4<sup>th</sup> highest in London in 2007-2009<sup>282</sup>.

### **Diabetes Prevention**

Studies have shown that lifestyle interventions, particularly those targeted at reducing obesity can prevent or delay Type 2 diabetes<sup>283</sup>. Within Waltham Forest, there is no specific diabetes prevention programme. However, there are population health improvement programmes such as increasing physical activity, healthy eating and reducing overweight and obesity, which all contribute towards diabetes prevention.

### **Screening for diabetes**

There is no systematic screening programme in Waltham Forest for Type 1 or Type 2 Diabetes. Screening is performed at GP Practices based on need or through opportunistic assessment using the NHS Health Check Programme or as part of registering new patients to the practice.

<sup>281</sup> APHO Diabetes Prevalence Model Findings for England, Yorkshire and Humber, Public Health Observatory; [www.yhpho.org.uk](http://www.yhpho.org.uk)

<sup>282</sup> NCHOD

<sup>283</sup> NEW England Journal of Medicine article

Establishing diabetes risk register to monitor those who may be at risk of developing diabetes in the future will enable appropriate follow up of those identified at risk.

## What is being done locally to address these issues?

### Management of Type 2 diabetes in Waltham Forest

Type 2 diabetes patients are more likely to be mainly managed by primary care. A number of quality and outcome (QOF) indicators are in place under General Medical Services (GMC) contract. QOF provides financial incentives for GP practices to achieve targets in a number of domains including clinical care. This data can be used to provide information on a number of indicators of clinical outcomes in people with diabetes. Tool developed by Diabetes Health Intelligence and Yorkshire and Humber Public Health Observatory<sup>284</sup> allows diabetes care intermediate outcomes in Waltham Forest to be compared with national, regional or the 'Blue Group'. Waltham Forest falls within the 'Blue Group' which has a young population with average deprivation and slightly higher than average population from Black and Asian ethnic groups.

This tool also provides a guide as to the scale of change required to move the PCT to a position of entering the half of trusts with the highest percentage of patients with diabetes meeting the given outcome, if they are not already in this position. The third similarly gives the change required to move the PCT into the top 25% of trusts.

### Control of blood glucose in diabetes

According to 2009/10 data, percentage of diabetics achieving HbA1c of 7% or less on the QOF register in NHS Waltham Forest was 54.6%. This equates to 5,524 out of 10,124 people on the register. This ranks the PCT as the 68<sup>th</sup> highest percentage of people with diabetes with HbA1c of 7% or less nationally.

It is important to note that performance on HbA1c, ranked NHS Waltham Forest in the top 50% of trusts in England. However, our achievement for HbA1c of 7% or less is lower than those of the top 25% of trusts in England. In order to achieve a percentage to enter the highest 25% of trusts, the PCT would need to increase the number of people with diabetes with an HbA1c of 7% or less by a further 243, assuming a static total register size.

**Table 3: People with diabetes with HbA1c of 7% or less**

	Waltham Forest HbA1c ≤ 7%	England: HbA1c ≤ 7%	Blue diabetes cluster group: HbA1c ≤ 7%	London SHA: HbA1c ≤ 7%
PCT which cuts off the lowest 25% of outcomes		50.9%	50.2%	48.6%
Average (Median)		53.7%	53.7%	52.9%

<sup>284</sup> APHO Diabetes Prevalence Model Findings for England, Yorkshire and Humber, Public Health Observatory; [www.yhpho.org.uk](http://www.yhpho.org.uk)

<b>PCT which cuts off the highest 25% of outcomes</b>		57.0%	56.7%	55.9%
<b>NHS Waltham Forest</b>	54.6%	68 out of 152	9 out of 19	11 out of 31
<b>NHS Croydon</b>	53.3%	82 out of 152	13 out of 19	15 out of 31
<b>NHS Enfield</b>	59.1%	17 out of 152	1 out of 19	2 out of 31
<b>NHS Greenwich</b>	44.6%	151 out of 152	19 out of 19	31 out of 31

\* Note for ranking data, a value of 1 indicates the PCT has the highest value in England/diabetes cluster group/SHA

### Control of blood pressure in diabetes

The percentage of patients with blood pressure less than 145/85 on the QOF register in NHS Waltham Forest is 82%. This equates to 9,255 out of 11,293 people on the register. This ranks the trust as the 28th highest percentage of people with diabetes with blood pressure less than 145/85 nationally. It is encouraging to note that the percentage of people with diabetes with blood pressure less than 145/85 in NHS Waltham Forest is in the top 50% of trusts in England.

**Table 4: People with diabetes with blood pressure less than 145/85**

	<b>Waltham Forest Blood pressure ≤ 145/85</b>	<b>England: Blood pressure ≤ 145/85</b>	<b>Blue diabetes cluster group: Blood pressure ≤ 145/85</b>	<b>London SHA: Blood pressure ≤ 145/85</b>
<b>PCT which cuts off the lowest 25% of outcomes</b>		79.7%	78.9%	79.3%
<b>Average (Median)</b>		80.7%	80.3%	81.0%
<b>PCT which cuts off the highest 25% of outcomes</b>		81.6%	81.6%	81.7%
<b>NHS Waltham Forest</b>	82.0%	28 out of 152	1 out of 19	5 out of 31
<b>NHS Croydon</b>	79.7%	114 out of 152	12 out of 19	22 out of 31
<b>NHS Enfield</b>	78.5%	137 out of 152	16 out of 19	27 out of 31
<b>NHS Greenwich</b>	79.3%	123 out of 152	14 out of 19	24 out of 31

\* Note for ranking data, a value of 1 indicates the PCT has the highest value in England/diabetes cluster group/SHA.

## Control of cholesterol in diabetes

The percentage of people with diabetes, with cholesterol lower than 5mmol/l on the QOF register in NHS Waltham Forest was 80.2%. This equates to 8,680 out of 10,817 people on the register. This ranks the trust as the 134<sup>th</sup> highest percentage of people with diabetes with cholesterol lower than 5 nationally.

The percentages of people with diabetes with cholesterol lower than 5 in NHS Waltham Forest are in the bottom 50% of trusts in England. In order to achieve a percentage equivalent to that of the median (average) trust the PCT would need to increase the number of people with diabetes with cholesterol lower than 5 by a further 314, assuming a static total register size.

In order to achieve a percentage to enter the highest 25% of trusts, the PCT would need to increase the number of people with diabetes with cholesterol lower than 5 by a further 443, assuming a static total register size. The number needed to achieve that of the median (average) trust Waltham Forest would need to increase the number by a further 489 including exceptions.

**Table 5: People with diabetes with cholesterol < 5 including exceptions (QOF 2009/10)**

	PCT: Cholesterol $\leq$ 5	England: cholesterol $\leq$ 5	Blue diabetes cluster group: cholesterol $\leq$ 5	London SHA: cholesterol $\leq$ 5
PCT which cuts off the lowest 25% of outcomes		73.9%	72.0%	72.1%
Average (Median)		75.0%	73.5%	74.0%
PCT which cuts off the highest 25% of outcomes		76.3%	74.9%	75.4%
NHS Waltham Forest	71.0%	149 out of 152	17 out of 19	29 out of 31
NHS Greenwich	69.8%	151 out of 152	19 out of 19	15 out of 31
NHS Enfield				
NHS Croydon				

\* Note for ranking data, a value of 1 indicates the PCT has the highest value in England/diabetes cluster group/SHA.

## Other Conditions Related to Diabetes

People with diabetes are twice as likely to have depression as the general population and clinical depression and people with depression are more likely to neglect their diabetes self-care, have worse physical symptoms, worse glycaemic control, increased risk of complications and have two to five times increased mortality. In addition, diabetics with depression have significantly higher medical costs than those without depression. Mental health treatments such as psychological treatments and antidepressants can improve depression outcomes. GP registers for depression among patients with CHD and/or diabetes indicate that the number of

CHD and/or diabetes patients with depression increased from 12,787 in 2009/10 to 13,713 in 2010/11 (provisional figure), an increase of 7.2%.

Diabetes related foot care contributes to significant amounts of hospital stays. In Waltham Forest, diabetic foot disease accounted for 5,257 nights in hospital. The incidence of major amputations between April 2007 and March 2010 was 0.86 per 1,000 adults with diabetes, close to the national average of 1.08 per 1,000. During the same time period, the incidence of minor amputations was significantly lower statistically than the national average: 0.97 per 1,000 adults with diabetes compared to 1.64 per 1,000 in England<sup>285</sup>.

### NICE recommended Diabetes care processes in Waltham Forest (2009/10)

NICE recommends that all patients aged 12 years and over should receive all of nine care processes (CPs). This core annual review 'bundle' have been identified as having the greatest impact on reducing complications and hospital admissions. The results from the National Diabetes Audit for Waltham Forest 2009/10 indicate that only 52.5% of patients with diagnosed diabetes are receiving all 9 care processes.

These CPs include Weight, Blood Pressure, HbA1c, Urine Albumin Creatinine Ratio (UACR), Serum Creatinine, Serum Cholesterol and assessment of Eyes, Feet, and Smoking. National Diabetes Audit<sup>286</sup> reports on the percentage of people registered with diabetes who received the nine CPs of diabetes care for each PCT. Table 6 shows how Waltham Forest compares with all PCTs in England.

**Table 6: % of patients receiving NICE recommended care processes (CP) by CP type in Waltham Forest compared to national rates**

Care Process recorded (2009/10)	Waltham Forest	Change since 2008-9	Median score across all PCTs	National Quartile ranking	RAG score
HbA1c*	88.2%	↓-1.5%	92.3%	4	Yellow
BMI	90.2%	↓-0.4%	90.0%	2	Green
Blood Pressure	94.2%	↓-0.3%	95.0%	3	Green
Urinary Albumin	75.4%	↑3.00%	75.0%	2	Yellow
Blood Creatinine	90.4%	↓-1.1%	92.7%	4	Green
Cholesterol	90.1%	↓-0.4%	91.4%	4	Green
Eye Screening	78.3%	↑0.6%	78.8%	3	Yellow
Foot Exam	83.7%	↓1.7%	83.8%	3	Yellow
Smoking review	82.4%	↑2.7%	86.6%	4	Yellow
All Care process**	52.4%	↑3.4%	52.5%	3	Red

Applies to all ages

RAG (Red-Amber-Green) Score Key

\*\* People registered with diabetes receiving all nine processes of care



<sup>285</sup> National Diabetes Information Service, Yorkshire and the Humber Public Health Observatory 2011

<sup>286</sup> National Diabetes Audit 2009/10

## **Quality of Care across Waltham Forest**

Tables 1-3 above compare the diabetes QOF performance in Waltham Forest across practices. The mean for QOF indicator on control of blood pressure (DM12) in Waltham Forest was 82.10 with a Standard Deviation (SD) of 7.2. Five practices did not meet the QOF target of 70% with exceptions. Twenty two practices achieved the mean and eight practices were 1 SD below the mean.<sup>17</sup>

A similar pattern is observed for HbA1c  $\leq 7$  g/dl and Cholesterol  $\leq 5$ mmol/l as shown in Tables 3 and 5.

### **Exception reporting of QOF data**

When reviewing a practice's achievement on any given measure some patients may be excluded from calculation, so-called 'exception' patients. Valid reasons for exception include, the treatment was clinically inappropriate; the patient did not attend or refused treatment, or the patient was only recently diagnosed or registered with the practice<sup>287</sup>. However, further analysis on profile of patients who are exception reported is needed in order to plan appropriate interventions.

### **Morbidity associated with diabetes complications**

The complications of diabetes are the final outcomes of care. Of all aspects of diabetes they have the greatest costs to the patient and the health service. Achievement of treatment targets reduces the risk of developing complications. Apart from Diabetic Ketoacidosis (DKA) in Type 1 diabetes, which is an immediate consequence of treatment failure, the other complications arise only after many years of exposure to high blood glucose, blood pressure and high cholesterol. The prevalence of complications has been assessed by determining which patients with diabetes identified in the NDA have had relevant admissions recorded in the Hospital Episodes Statistics database (HES). Data submitted to the NDA from practice and outpatients units are linked to data from the HES. The complication prevalence rate in Figure 1 is based on an admission to hospital with one of the listed conditions at any time in the last 5 years, for patients with diabetes from Waltham Forest.

### **Emergency admission rates for diabetic ketoacidosis and coma**

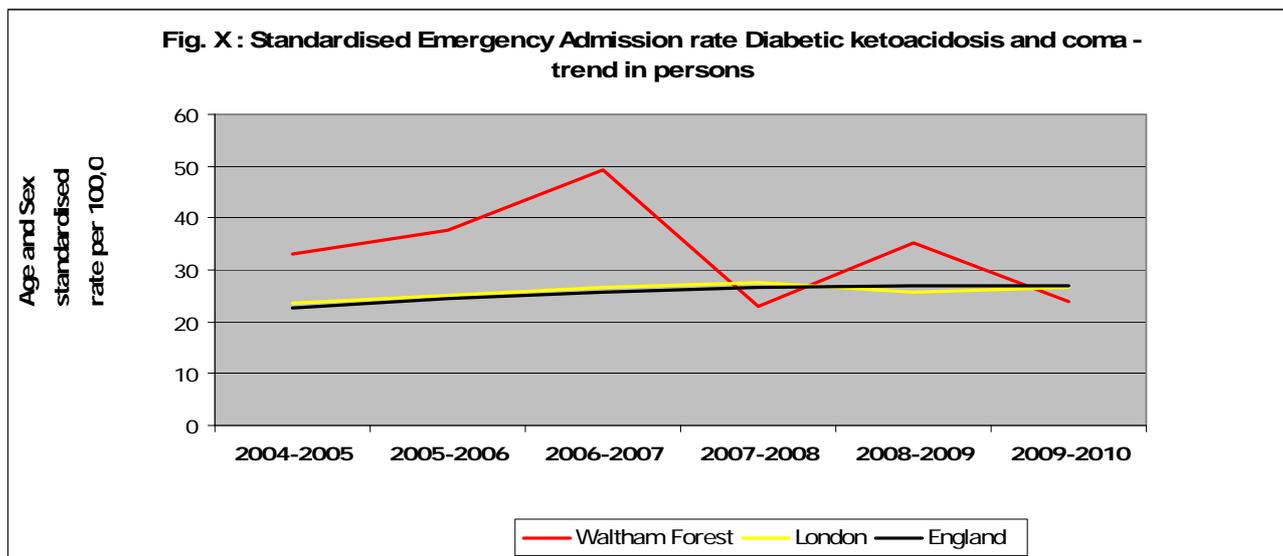
It is important to note that age and sex standardised emergency admission rates for diabetic ketoacidosis and coma in Waltham Forest are lower than for England, London and statistical comparators except for Enfield (23.9 vs 21.03 per 10,000). The reduction from 2008/09 to 2009/10 is more marked in Waltham Forest.

As shown in Figure 1, there is a clear downward trend in the admission rates in Waltham Forest although there is slightly upward trend nationally and in London. Fluctuations observed in Waltham Forest are likely to be due to a smaller sample size.

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<sup>287</sup> QMAS Guidance

Figure 1



### Diabetes related foot complications in Waltham Forest

According to NICE guidelines, 20-40% diabetes patients have neuropathy and 20-40% have peripheral vascular disease. Approximately 5% develop a foot ulcer in any year and amputation rates are 0.5%<sup>288</sup>. 15% of patients with diabetes will develop a foot ulcer in their lifetime and at any one time, it is estimated that 1.4% will have a foot ulcer<sup>289</sup>.

The incidence of major amputations in Waltham Forest is currently below the national average. Diabetes foot care audit<sup>290</sup> indicates that there have been 13.3 episodes of care per 1,000 adults with diabetes with foot complications each year which is significantly lower than the national rate of 17.6 per 1,000. However, the average number of nights spent in hospital for each episode of care was 11.3 nights, above the national average of 10.5 nights.

### Hypertension

Hypertension is another term for consistent high blood pressure. There is evidence that there is increased prevalence of diabetes in patients with hypertension, with one large study showing those with hypertension are 2.5 times more likely to develop diabetes than those with normal blood pressure<sup>291</sup>. Diabetes is known to increase the risk of hypertension. Estimates of hypertension prevalence in diabetes patients have ranged from 35%<sup>292</sup> to over 70%<sup>293</sup>, depending on the populations studied and the definition of hypertension used.

<sup>288</sup>NICE, Type 2 Diabetes. Prevention and management of foot problems. 2004.

<sup>289</sup> Edmonds, M., Diabetic foot ulcers: practical treatment recommendations. *Drugs*, 2006. 66(7): p. 913-29.

<sup>290</sup> NICE, Type 2 Diabetes. Prevention and management of foot problems. 2004.

<sup>291</sup> Gress TW et al. The atherosclerosis risk in communities S. Hypertension and antihypertensive therapy as risk factors for type 2 diabetes mellitus. *N Engl J Med*. 2000. 342 (13): 905-912.

<sup>292</sup> Hypertension in Diabetes Study (HDS): I. Prevalence of hypertension in newly presenting type 2 diabetic patients and the association with risk factors for cardiovascular and diabetic complications. *J Hypertens*, 1993. 11(3): 309-17

<sup>293</sup> Colhoun, H.M., et al., The scope for cardiovascular disease risk factor intervention among people with diabetes mellitus in England: a population-based analysis from the Health Surveys for England 1991-94. *Diabet Med*, 1999. 16(1): 35-40

## **Microalbuminuria**

Microalbuminuria or proteinuria is the presence of protein in urine and indicates how well the kidneys are functioning. Poor kidney function is a common progressive condition. Microalbuminuria or proteinuria is present in 12% of type 2 diabetes patients at diagnosis. Approximately 25% of type 2 diabetes patients have microalbuminuria<sup>294</sup>, which equates to 3000 patients in Waltham Forest.

## **Diabetes and Mental Health**

People with diabetes are twice as likely to have depression as the general population and clinical depression and people with depression are more likely to neglect their diabetes self-care, have worse physical symptoms, worse glycaemic control, increased risk of complications and have two to five times increased mortality.

In addition, diabetics with depression have significantly higher medical costs than those without depression. Mental health treatments such as psychological treatments and antidepressants can improve depression outcomes. There are two QOF indicators relating to depression in patients with diabetes (see mental health section).

## **Structured education for patients with diabetes**

Patient education and empowerment is crucial for self management of diabetes. Waltham Forest has adopted XPERT model that meets NICE criteria for structured education. This service is provided by Diabetes Specialist Nurses (DSNs) and 40 patients participated during 2010. For the first 9 months in 2011/12, 20 people attended. There is a need to identify reasons for inadequate uptake of this service, as well as to provide psychological support for adults.

## **Diabetes Retinal Screening Service (DRSS)**

The aim of screening for diabetic retinopathy (eye disease) is to decrease the incidence of blindness in the local community. The national screening committee requires an annual retinopathy screen for all patients with diabetes aged over 12.

A central call-recall register is in place to ensure that all patients who have diabetes are identified and appropriately invited for screening. This needs close working with primary care so that the list of patients is updated on a regular cycle.

All recorded diabetics within the Waltham Forest area must be screened (photographed) by the screening service yearly unless formally excluded (under hospital care or unable to screen or treat). The National Screening Programme requires that patients are put on very strict timelines for screening, grading images, clinic appointments and treatment. The Screening service is delivered in three centres across the borough. Patients are photographed in the community at 3 sites; Comely Bank, Langthorne and Chingway, and results are checked and validated by specialist ophthalmologists at Whipps Cross Hospital. If further investigation or treatment is required patients are seen at Whipps Cross.

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<sup>294</sup> Summaries, C.K. Diabetes Type 1 and 2 – screening / managing renal disease. . [cited 14.04.09]; Available from: [http://cks.library.nhs.uk/clinical\\_knowledge/clinical\\_topics/previous\\_version/diabetes\\_renal\\_disease.pdf](http://cks.library.nhs.uk/clinical_knowledge/clinical_topics/previous_version/diabetes_renal_disease.pdf).

Issues within the current service that involve risk include multiple providers (call/recall, IT, and screening and follow-up by ophthalmology) and lack of a failsafe system.

## **Evidence of effective interventions**

### **Diabetes Guide for London**

Diabetes was selected as the focus of the first long-term conditions project of the Healthcare for London programme because of the major impact this illness has on individuals and on local communities. The new model of care described in the London Guide for Diabetes as part of Health Care for London, provides the framework for delivering a world class diabetes service for Londoners, which reflects guidance from the Department of Health.

The principles underlying the model of care are:

- Early detection and identification.
- Individuals with diabetes at the centre of their care.
- Care planning and self management.
- Integration of care.
- Quality assurance, evaluation and monitoring.
- Targeting high risk population.

Early intervention is essential for good long-term outcomes for diabetes. In addition to the NHS Health Checks programme, identifying people with high risk of diabetes requires:

- Case finding of those at high risk of diabetes particularly when using NHS services.
- Innovative approaches for hard to reach communities, particularly relevant to Waltham Forest.

The model emphasises the need to develop self management skills, involving patients in planning their own care and how to manage their own condition in order to improve clinical outcomes. It further identifies the need to developing new skills among patients and clinicians and bringing about a cultural change to provide integrated and seamless care across the care pathway. Robust monitoring and rigorous evaluation of care pathway and education programme to ensure that effective diabetic care is delivered for those at highest risk and where substantive inequalities exist.

### **Levels of Care**

The diabetes model is based on four tiers of care provided in three settings: primary, community and hospital.

Around 80% of care should be provided in primary or community setting.

- **Tier 1** provider status requires:
  - A complete and up to date diabetes register.
  - A fully-trained diseases register co-ordinator for each practice.
  - Competence in delivering essential diabetes care.

- **Tier 2** provider status requires:
  - Care should be defined locally, but will include essential and enhanced diabetes care including:
    - Treatment escalation – e.g. insulin initiation in people with type 2 diabetes.
    - Structured education programmes for patients and carers.
- **Tier 3**
  - Will include consultant-led specialist care and advice in a community-based setting for patients with complex needs.
  - community settings should be chosen where there is definite added value in terms of:
    - quality of the care that can be provided.
    - Improved access to services.
- **Tier 4**
  - will include specialist care and advice provided in a hospital based setting for patients with complex needs.
  - Led with a multi-disciplinary team approach including medical consultant and diabetes specialist nurse/nurse consultant.

### **Applicability of London model to Waltham Forest**

To apply this model to local population will require:

- Up skilling primary care staff.
- Support to practices from Tier 3 service.
- PCT buy-in to fulfil training and ongoing personal development needs.
- Healthcare professionals to ensure collaborative care planning.

It is expected that all GP practices will achieve Tier 1 status by 2011/12, with appropriate support and training from the intermediate diabetes team and acute providers - and that a proportion of practices have reached Tier 2 services.

A benchmarking exercise was undertaken in October 2010 across practices (using a validated tool<sup>295</sup>) in order to understand training needs and capacity development needs in primary care to implement London Diabetes Model in Waltham Forest. Work is now underway to accredit practices using robust criteria to improve quality of service and reduce variation across practices.

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<sup>295</sup> Tool developed by Public Health NHS Waltham Forest, using the Lambeth & Southwark Diabetes Network (2006) & Wandsworth PCT tool, with slight modifications by the Waltham Forest Diabetes network (2010)

This model once in place is expected to reduce acute episodes through more proactive management of diabetes in a primary and community setting through personalised care planning and improved education of patients. Personalised care planning involves patients with long term chronic conditions setting agreed goals together with their clinicians who monitor progress towards the agreed goals. Named contacts within the practice are also identified and all information is gathered on a template guiding the clinician through the process<sup>296</sup>.

The current pilot on Year of Care (YOC) on care planning when completed will corroborate already existing evidence that care planning:

- Improves better understanding among patients about their condition and are more confident about playing their part in the management of their condition.
- Reduces the use of emergency services.
- Reduces the costs of disease management.

### **NICE Quality Standards for Diabetes (2011)**

In July 2011, NICE published a Quality standard for diabetes <sup>297</sup> which supports the existing NSF and provides an authoritative definition of good quality care. NICE quality standards enable the following to happen:

- Health and social care professionals can make decisions about care based on the latest evidence and best practice.
- Patients can understand what service they can expect from their health and social care providers.
- NHS trusts can quickly and easily examine the clinical performance of their organisation and assess the standards of care they provide.
- Commissioners to be confident that the services they commission are high quality and cost-effective.

**Standard 1:** people with diabetes and/or their carers receive a structured educational programme that fulfils the nationally agreed criteria, from the time of diagnosis, with annual review and access to ongoing education.

**Standard 2:** people with diabetes receive personalised advice on nutrition and physical activity from an appropriately trained healthcare professional or as part of a structured education programme.

**Standard 3:** people with diabetes participate in annual care planning which leads to documented agreed goals and an action plan.

**Standard 4:** People with diabetes agree with their healthcare professional a documented personalised HbA1c target, usually between 48 mmol/mol and 58 mmol/mol (6.5% and 7.5%), and receive an ongoing review of treatment to minimise hypoglycaemia.

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<sup>296</sup> NHS Northshire and Humber. Delivering Healthy Ambitions Better for Less: Long Term Conditions Personalised Care Planning. <http://www.healthyambitions.co.uk/Uploads/BetterForLess/BETTER%20FOR%20LESS%20personalised%20care%20planning.pdf>

<sup>297</sup> NICE Quality standards for diabetes 2011

**Standard 5:** People with diabetes agree with their healthcare professional to start, review and stop medications to lower blood glucose, blood pressure and blood lipids in accordance with NICE guidelines.

**Standard 6:** Trained healthcare professionals initiate and manage therapy with insulin within a structured programme that includes dose titration by the person with diabetes.

**Standard 7:** people with diabetes receive an annual assessment of the risk and presence of the complications of diabetes, and these are managed appropriately.

## **Type 1 Diabetes Mellitus (Type 1 Diabetes)**

### **Diagnosis and management**

Diagnosis of Type 1 Diabetes is more likely to occur in a hospital setting following a patient presenting with the consequences of undiagnosed diabetes e.g. dehydration, weight loss, diabetic ketoacidosis. Type 1 Diabetes patients are usually managed by the acute trusts. GPs see Type 1 Diabetes patients for insulin dose adjustment or for insulin and needle prescriptions.

Every child newly diagnosed with type 1 diabetes should be evaluated and cared for by a diabetes team (consisting of a paediatrician with a particular interest in diabetes, a nurse educator, a dietician, and a mental health professional) qualified to provide up-to-date adolescent-specific education and support<sup>298</sup>.

Nurses dedicated to communicating basic specialised diabetes education skills are required for adolescents. They require management skills within a context that addresses family dynamics and issues facing the whole family.

It is essential that substantial educational material (necessary for basic management, often referred to as "survival skills") be conveyed to a family of a child with Type 1 Diabetes:

- Immediately after the initial diagnosis.
- Studies suggest that to be effective, educational interventions need to be ongoing.
- Frequent telephone contact, and both in-person care and telephone availability have been demonstrated to improve HbA1c.

### **Other services and screening for Type 1 Diabetes**

Children with Type 1 Diabetes need to be referred for the following services in order to maximise outcomes related to this condition.

1. Medical nutrition therapy by a registered dietician
  - As part of initial team education and on referral, as needed
  - Generally requires a series of sessions over the initial 3 months after diagnosis, then at least annually, with young children requiring more frequent re-evaluations

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<sup>298</sup> HfL & BUPA Report on Diabetes 2010

2. Diabetes nurse educator
  - As part of initial team education, or referral as needed at diagnosis; generally requires a series of sessions during the initial three months of diagnosis, then at least annual re-education
3. Behavioural specialist
4. Depression screening annually for children  $\geq 10$  years of age, with referral as indicated:
5. Annual screening for microalbuminuria should be initiated once the child is 10 years of age and has had diabetes for 5 years; more frequent testing is indicated if values are increasing.
  - Fasting lipid profile should be performed at the time of diagnosis (after glucose control has been established). If values fall within the accepted risk levels (measurement should be repeated every 5 years).
  - The first ophthalmologic examination should be obtained once the child is 12 years of age and has had diabetes for 3–5 years. After the initial examination, annual routine follow-up is generally recommended.
  - Annual foot exams should begin at puberty.

### **Barriers to managing Type 1 Diabetes among children**

A number of factors such as presence of repeated episodes of diabetic ketoacidosis, other health problems (e.g. asthma), poor school attendance, learning disabilities, and emotional and behavioural disorders and depression are barriers to adhere to treatment regime for diabetes.

Certain family characteristics have been identified as risk factors for poor diabetes control. These include a single-parent home, chronic physical or mental health problems in a parent or other close family member (including substance abuse,) a recent major life change for the parent (e.g. loss of a job or a death in the family), complex child care arrangements, and health/cultural/religious beliefs that make it difficult for the family to follow current diabetes treatment plans. Therefore early evaluation of family barriers to comply with treatment plan is essential to avoid inadequate control of diabetes.

Working with the patient and family, develop an exercise plan and support package including strategies to measure blood glucose levels, manage hypoglycaemia, adjust carbohydrate intake and insulin doses will enable adequate control of diabetes.

### **Transition from childhood to adolescence - Type 1 Diabetes**

Attention to such issues as family dynamics, developmental stages and physiologic differences related to sexual maturity are all essential in developing and implementing an optimal diabetes regimen in adolescents.

Targets of education need to be adjusted to the age and developmental stage of the patient with diabetes and must include the parent or caregiver<sup>299</sup>.

The goal should be a gradual transition toward independence in management through adolescence. Adult supervision remains important throughout the transition.

Many of the demands of self-care for diabetes interfere with the adolescent's drive for independence and peer acceptance. Peer pressure may generate strong conflicts. In this age-group, there is a struggle for independence from parents and other adults that is often manifested as suboptimal adherence to diabetes care. Evidence shows that adolescents whose parents exercise supervision in the management of diabetes have better metabolic control.

Adults with Type 1 diabetes are more frequently under the care of specialists at Whipps Cross University Hospital although they may see their GP for insulin dose adjustments and prescriptions. Type 1 diabetes patients also receive care from the community diabetes services if required.

Many of the demands of self-care for diabetes interfere with the adolescent's drive for independence and peer acceptance. Peer pressure may generate strong conflicts. In this age-group, there is a struggle for independence from parents and other adults that is often manifested as suboptimal adherence to diabetes care. Evidence shows that adolescents whose parents exercise supervision in the management of diabetes have better metabolic control.

### **What is being done locally to address this issue?**

The Waltham Forest Diabetes Network, local clinical leadership and commissioners will improve care through the implementation of the Diabetes Guide for London service model and improving or implementing a range of services. This model once in place is expected to reduce acute episodes through more proactive management of diabetes in a primary and community setting through personalised care planning and improved education of patients. A pilot to implement the Year of Care model in 2010/11 provided information on some of the barriers to care planning experienced by patients and clinicians.

### **Prevention Services**

Services to improve physical activity and reduce obesity are available across Waltham Forest. The NHS works with the local authority to provide specialist exercise on referral services for secondary prevention of diabetes. They also work in partnership to provide exercise opportunities to young people and those over the age of 55 who would not normally exercise. A service to improve healthy eating entitled Why Weight uses a whole family approach to tackling weight issues through diet.

### **Primary Care Services**

Local GP practices are monitored on achievement against the 9 care processes through the Quality and Outcomes Framework. The Clinical Commissioning Group agreed to adopt a process of accreditation based

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<sup>299</sup> BUPA diabetes

on the Diabetes Guide for London. A local review identified high levels of variation in achievement across practices in all parts of the borough. The review also revealed high levels of patients excluded from the Quality and Outcomes Framework mechanism. Reductions in variation and exceptions are fundamental to improving management of patients within primary care.

### **Secondary Care Services**

Specialist outpatient and inpatient services have been commissioned to provide care for children and adults with Type 1 diabetes, women with diabetes who become pregnant and who develop gestational diabetes, patients with Type 2 diabetes that have difficulties managing their condition or have established complications. Other specialist services include foot care, renal services, and diagnosis and treatment of diabetes related eye conditions.

### **Community Care Statement**

A specialist community service was commissioned in 2008 to provide specialist care for high need patients outside of hospital. Other services include footcare, diet services, and a diabetes nurse specialist service. Structured patient education is available for Type 1 patients through the BERTIE course and for Type 2 patients using the XPERT patient programme and from 2011 the Conversation Map programme. Both courses are delivered by the community Diabetes Nurse Specialists Nurses and dietician.

Footcare services are provided across Outer North East London and receive over 100 referrals a week for diabetic and non-diabetic foot care needs. Twenty two podiatrists and three podiatry assistants provide sessions in community clinics, hospital wards and in patients homes.

A review of community services revealed that there is a need to increase the provision of Diabetes Nurse Specialists from 2 to 5 nurses per 250,000 population and the number of dieticians to from 3 to 4 per 250,000 population as recommended by national guidance.

The Diabetes Retinal Screening Service provides screening facilities in three locations in the community, with referral pathways into specialist care for high need patients. Assessments of the patient pathway demonstrate the need to improve information sharing across primary, community and secondary care services to ensure the best possible service for residents with reduced risk of duplicate or missed appointments.

### **What evidence is there that we are making a difference?**

#### **Primary Care**

In patients who have been diagnosed with diabetes, we know that in 2009/10<sup>300</sup>

- 54.6% of patients had a recorded blood glucose level at or under 7%
- 82% of patients had controlled blood pressure
- 71% of patients had controlled cholesterol levels

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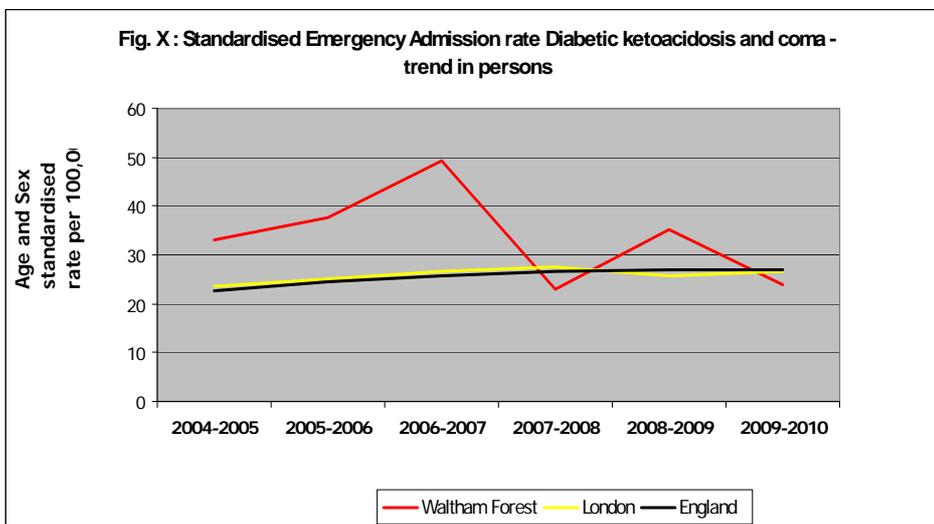
<sup>300</sup> QMAS 2009;2010 The Health and Social Care Information Centre, Prescribing Support Unit.

It is important to note that in blood glucose under 7 and controlled blood pressure, NHS Waltham Forest is ranked in the top 50% of trusts nationally. However, there are more patients with uncontrolled blood glucose levels compared to our statistical comparators. The achievement against controlled cholesterol levels places Waltham Forest in the lowest 50% of trusts nationally. In order to reach the highest 25% of trusts in these three care processes, practices would need to increase the number of people with diabetes with controlled blood sugar by 243 people, and with controlled cholesterol by 443.

## Secondary Care

Figure 2 demonstrates that the age and sex standardised emergency admission rates for diabetic ketoacidosis and coma in Waltham Forest is lower than that for England and London, with a decrease below national and London rates in 2008/09.

Figure 2



## What is the Public Perspective?

The chart below (provided by the Yorkshire and Humber Diabetes Community Health Profile) demonstrates the patient experience in 2006. This data refers to all patients with a long term condition, not just diabetes. It is important to note the low levels of patients reporting attendance at education for their conditions. The NICE Technology Appraisal for diabetes patient education models describes education as a fundamental part of diabetes care that provides the skill and knowledge for individuals to manage their day to day care needs. Additionally, the discussion of goals and the number of patients who definitely received enough support is lower than national averages, indicating a need for the local health sector to improve patient participation in their care needs.

Participants in focus group discussions in October 2010 were not aware of the existence of structured education programmes, but stated that they would welcome the opportunity to attend one. A number of focus group participants expressed the view that diabetes treatment is a process directed by healthcare professionals rather than involving self management. Views of diabetes as being a 'fatal' condition were also

expressed. There was little awareness on this condition and what HbA1c was. Participants expressed their keen interest in attending education sessions if these are held in community centres.<sup>301</sup>

## **What more do we need to know?**

### **Challenges**

- Variation in the quality of diabetes care in primary care
- Gaps in the provision of diabetic retinal screening to meet national quality standards
- Poor uptake of existing structured education programme
- Inadequacy in provision of culturally appropriate structured education programmes
- Lack of a well integrated diabetic care pathway across primary, community and acute care
- Gaps in diabetic care for housebound patients
- Psychological support continues to be variable across the localities
- Financial constraints

### **Meeting the Challenges (Progress)**

1. An active local Diabetes Network is in place in Waltham Forest, with multidisciplinary interagency representation including patient representation and the London Borough of Waltham Forest.
2. A Responsible Officer for Planned Care is leading the diabetes agenda locally supported by a Clinical Director and a GP clinical lead on diabetes has been appointed to provide clinical leadership and support the improvement of outcomes for Diabetes.
3. The work is underway to implement the Healthcare for London (HfL) model on diabetes to improve quality of care and reduce variation to meet local needs.
4. High level of detection of diabetes compared to estimated numbers 73% in Waltham Forest.
5. The Year of Care (YOC) care planning pilot is in progress to improve clinical and patient outcomes of diabetes in active consultation with patients.
6. The work is underway to establish a robust system to undertake NHS health checks which will enhance case findings of diabetes.

## **What are the priorities for the next 5 years?**

The prevention and management of diabetes is a key feature of the NHS Waltham Forest vision of better health closer to home for all residents. This will be achieved through joint working across the healthcare economy to:

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<sup>301</sup> Report of the Focus Group Discussions, Public Health Directorate, NHS Waltham Forest October 2010.

1. Ensure 85% of diabetic patients have cholesterol levels below 5mmol/l by 2013 to reduce the risk of first and secondary cardiovascular events within this population.
2. Move delivery of diabetes care from acute settings into community settings closer to home within the next three years.
3. Provide psychological support to all diabetic patients who require it.
4. Support young people moving from children's services to adult care (transition period).

## **Respiratory Diseases**

### **Chronic Obstructive Pulmonary Disease (COPD) and Asthma**

#### **Executive Summary**

Respiratory disease is the third main cause of death in Waltham Forest and contributes to health inequality in the borough. Chronic Obstructive Pulmonary Disease (COPD) is a progressive and debilitating respiratory disease that is a leading cause of health inequality in men in Waltham Forest, particularly from areas of high deprivation. Asthma is a long term respiratory condition that can be debilitating in some individuals, and in Waltham Forest, people with asthma are 62% more likely to die from the disease compared to asthma sufferers in the rest of England. Both diseases result in high levels of hospital admissions. COPD and Asthma are clinically different diseases but share similar risk factors, notably smoking and exposure to second-hand smoke. It is estimated that 95% of COPD cases in the borough are attributable to smoking. Deprivation is a key factor in poor health outcomes for both asthma and COPD.

#### **Recommendations**

1. Improve local intelligence of asthma and COPD incorporating tobacco use and public engagement.
2. Invest in prevention and health promotion awareness interventions to improve knowledge of tobacco related harm and local services, particularly targeting the at risk populations.
3. Commissioners should develop early awareness campaigns for COPD and expanding access with the COPD Pilot to improve patients care.
4. Improve housing quality to prevent respiratory conditions and improve outcomes for those with the diseases.
5. Explore possibility of including smoking status in the Whipps Cross Hospital discharge forms so patients who smoke can be referred to smoking services.
6. Reduce exposure to second hand smoke in the home through joint local authority and NHS initiatives.
7. Improve the quality of life for COPD patients and reduce hospital admissions through reviewing current:
  - i. Stop smoking services.
  - ii. Physical activity programmes.

#### **What is Chronic Obstructive Pulmonary Disease (COPD)?**

COPD is the common term for obstruction of the airways, causing breathing difficulties and subsequently mobility problems. Chronic bronchitis and emphysema are conditions which come under the umbrella term COPD.

The most common cause of COPD is smoking. Nationally, smoking causes 80% of all COPD cases. Environmental and genetic factors can account for some cases<sup>302</sup>. COPD is more common in areas of high deprivation, and is more common in men. People with COPD often have other diseases that share tobacco smoking as a risk factor heart disease and lung cancer are the most common<sup>303</sup>.

An estimated 3 million people have COPD in the UK, of which 2 million is undiagnosed<sup>304</sup>. The National Institute for Clinical Excellence (NICE) recommends that in patients over the age of 35 who have a risk factor (generally smoking) and who present with exertional breathlessness, chronic cough, regular sputum production, frequent winter 'bronchitis' or wheeze, COPD should be considered as a diagnosis. There is no single diagnostic test. A diagnosis of COPD may be made if the patient meets all of the following criteria: >35 years of age; history of exposure (smoking and/or occupational factors); typical symptoms; absence of clinical features of asthma; presence of airway obstruction measured by spirometry.

## **What is the local picture?**

### **Risk Factors**

- Estimated smoking prevalence for the general population is currently 19.3%, although higher than the national prevalence in previous years.
- Local practice level data indicates the smoking prevalence for those aged over 40 is 24%, higher than the national average and higher than modelled prevalence for that age group.
- Waltham Forest has areas of high deprivation.

### **Prevalence and Mortality**

- The LHP toolkit gave a prevalence of 4.07% for 16+ persons in Waltham Forest in 2010.
- COPD specialists estimate that 95% of COPD cases locally are attributable to smoking.
- There were 2,520 patients living with COPD in primary care in 2009/10.
- The LHP toolkit predicts that Waltham Forest will have 7,663 persons aged 16+ with COPD by 2020. Gives for 16+ persons WF 2020.
- High levels of variation exist in recorded prevalence across practices in similar geographic areas.
- Chingford had the highest recorded prevalence of 1.2% in 2009/10. The lowest was in Leyton Leytonstone (0.7%). The recorded prevalence in Walthamstow was 0.9%. Walthamstow had the best

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<sup>302</sup> Health and Safety Executive COPD Causes <http://www.hse.gov.uk/copd/causes.htm>

<sup>303</sup> NCE Clinical Guideline 101 Chronic Obstructive Pulmonary Disease 2010

<sup>304</sup> Clinical Knowledge Summaries November 2010

rate of detection compared to the estimated prevalence.

- Deaths due to COPD are more common in men from deprived areas (see Figure 1).
- In 2009 the directly age standardised rate (DSR) for COPD mortality in Waltham Forest men was 50.10, (All ages) significantly higher than the England rate of 31.74 and representative of the increasing gap in mortality for local men compared with national figures (See Figure 2).
- In 2009 the directly age standardised rate (DSR) for COPD mortality in Waltham Forest women was 16.79, (All ages) lower than the England (20.45) and London (17.62) rates.

Figure 1

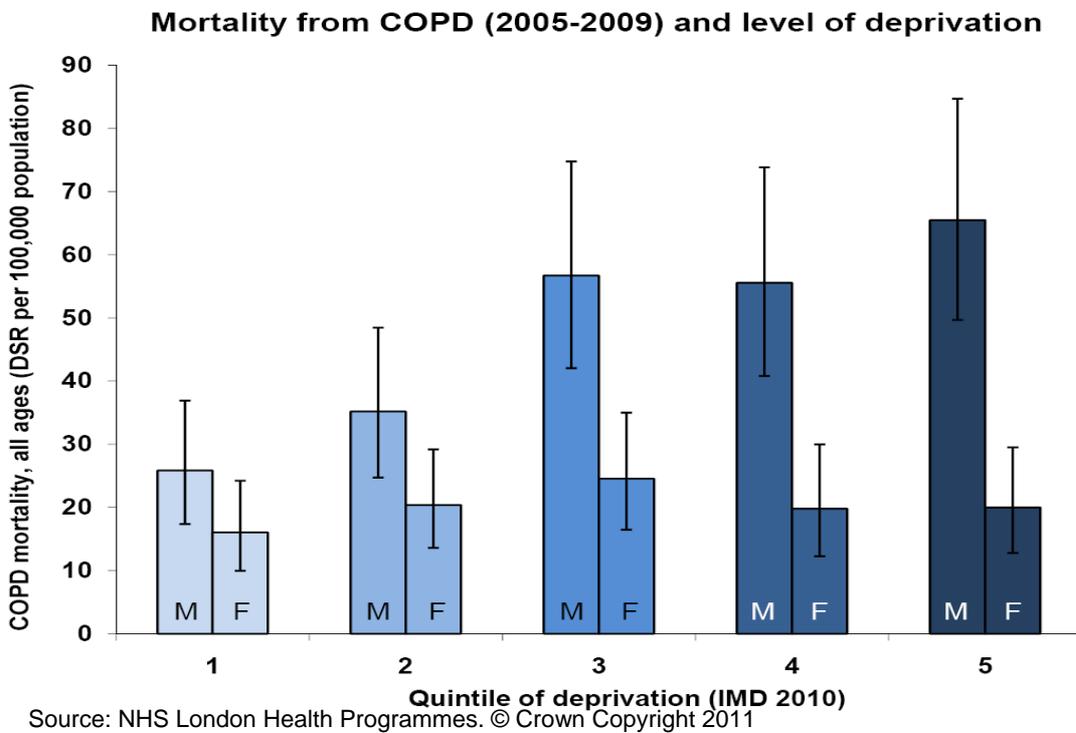
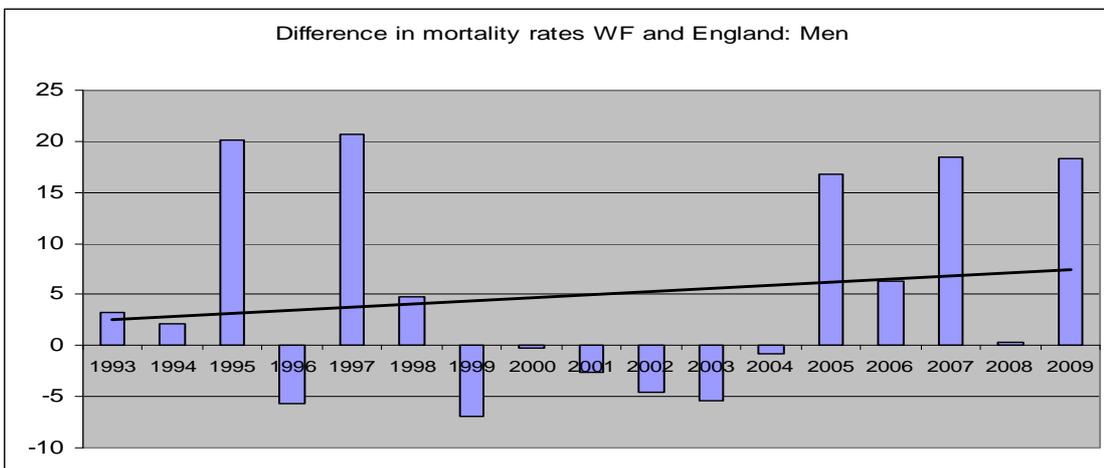


Figure 2



### **What are the effective interventions?**

COPD is the most common reason for emergency hospital admission due to respiratory disease. COPD accounts for high numbers of total bed-days per year. COPD patients have high readmission rates following first time hospital admissions (30% within three months). COPD is one of the most costly inpatient conditions treated by the NHS, accounting for over £800 million in direct expenditure, mostly in hospital care. Indirect costs are also high due to lost working days (24 million days a year). There is little information available on indirect costs of carers time, although it is estimated that 90% patients live at home, 39% receive personal care at home, paid or unpaid.

The updated NICE Guideline on COPD recommends prevention, early diagnosis, consistent therapy and pulmonary rehabilitation (the provision of education, psychological support, and nutritional advice) is available to all that need it.

Stopping smoking is the most important treatment for smokers with COPD<sup>305</sup> as it slows the decline in FEV<sub>1</sub>, subsequently improving symptoms and survival. NICE Guidance also recommends that Stop Smoking support is offered to everyone, regardless of age and health status, to reduce the prevalence of COPD<sup>306</sup>, 80% of which is due to exposure to tobacco smoke.

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<sup>305</sup> van der Meer RM, Wagena E, Ostelo RWJG, Jacobs AJE, van Schayck OP. Smoking cessation for chronic obstructive pulmonary disease. Cochrane Database of Systematic Reviews 2001, Issue 1. Art. No.: CD002999. DOI: 10.1002/14651858.CD002999.

<sup>306</sup> NICE Clinical Guidance CG101 Chronic Obstructive Pulmonary Disease

## Asthma

### What is Asthma?

Asthma is a chronic disorder of the airways, caused primarily by inflammatory processes and constriction of the smooth muscle in airway walls (bronchoconstriction). It is characterised by airflow obstruction and increased responsiveness of the airways to various stimuli. Symptoms include recurring episodes of wheezing, breathlessness, chest tightness and coughing. Typical asthma symptoms tend to be variable, intermittent and worse at night. Asthma is commonly triggered by viral respiratory infections, exercise, smoke, cold and allergens such as pollen, mould, animal fur and the house dust mite<sup>307</sup>.

Evidence suggests 1,400 people die from asthma/year in the UK. About a third of deaths (34%) occur in people under age of 65<sup>308</sup>.

### Local Picture

- Waltham Forest had a higher rate (179.0/100,000) of asthma admissions than London (147.1) and England (139.0). The rate for Waltham Forest was highest among our statistical neighbours Greenwich (104.4) and Enfield (131.9)<sup>309</sup>.
- Deaths due to Asthma are 62% higher in Waltham Forest than England for all age groups. This is higher (162) than SMRs for peer PCTs Croydon (128) and Enfield (64)<sup>310</sup>.
- Waltham Forest has the lowest (4.7) percentage of patients with Asthma condition as compared to England (5.9) and London (4.8) averages<sup>311</sup>.
- By locality, the highest percentage of patients with asthma conditions is in Chingford (5.4%), then Leyton-Leytonstone (4.4%) and Walthamstow (4.7%).

Figure 1 illustrates that admission rates due to asthma were significantly higher in Higham Hill, Valley, Hoe Street, Hatch Lane and Lea Bridge as compared to Waltham Forest average. This need to be interpreted with caution because it was not standardised (not adjusted for potential explanatory variables such as age and gender that can interrupt the rate).

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<sup>307</sup> NICE 2012: NICE technology appraisal guidance: <http://www.nice.org.uk/nicemedia/pdf/TA138Guidance.pdf>

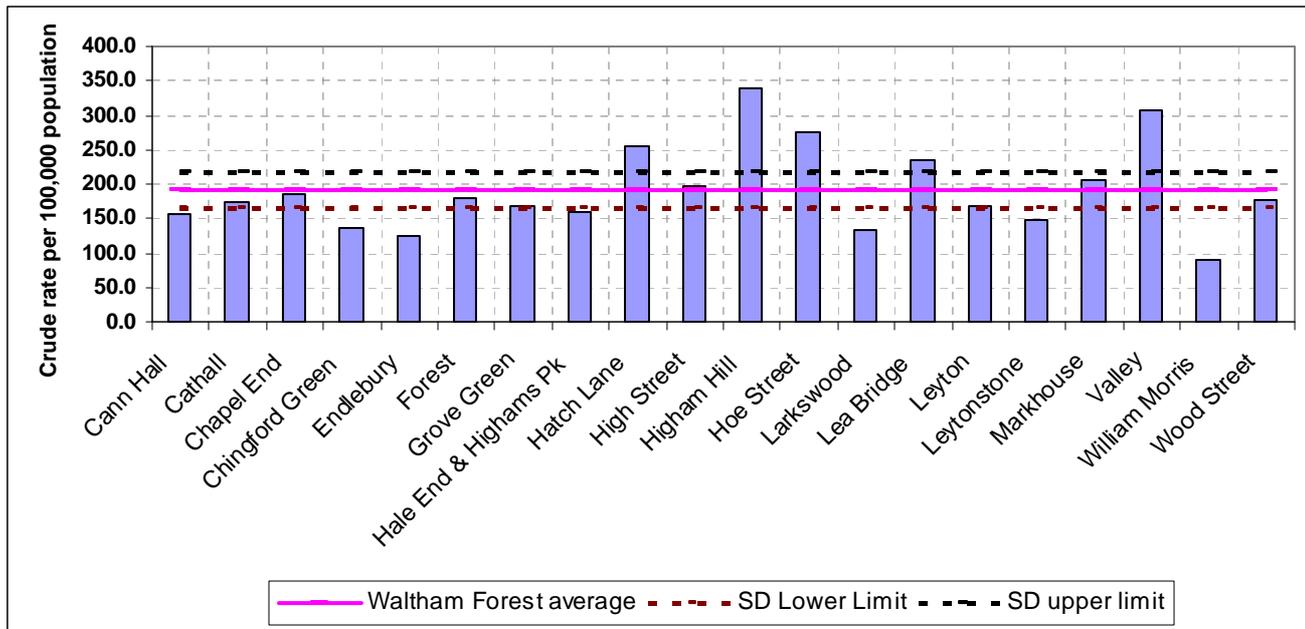
<sup>308</sup> British Thoracic Society 2008 revised 2011

<sup>309</sup> The NHS Information Centre for health and social care (2007-2009)

<sup>310</sup> The NHS Information Centre for health and social care(2007-2009)

<sup>311</sup> QOF 2009/10

Figure 1: Asthma hospital admission by wards in Waltham Forest, 2008/09-2010/11 pooled



Source: SUS ODBC query run August 2011, 5NC; Exeter GP registered population April 2009, April 2010, April 2011

### Evidence and Strategy and Commissioning

Diagnosis, pharmacological and non-pharmacological management and patients' education are the cornerstones of asthma control<sup>312</sup>.

Diagnosis is based on the presence of series of factors for both children and adults, alongside serious considerations of alternative diagnosis. Spirometry and reversibility testing are also recommended. There is evidence of limited effectiveness of prevention interventions such as allergens avoidance; breastfeeding; tobacco smoke; house dust mites; air pollutions. However smoking cessation, weight reduction and allergen avoidance if appropriate are recommended<sup>313</sup> Immunotherapy can be considered where a clinically significant and pharmacological management of asthma should be governed by 'The Stepwise Approach' <sup>314</sup>

### Progress in COPD and Asthma

- Waltham Forest GPs, community specialists, and acute providers are working together to improve patient care and reduce hospital admissions through co-ordinating pathways and increasing the provision of specialist clinics for COPD patients. Work streams include increasing the provision of spirometry to support diagnosis, training for health professionals, and working with locally available technology to improve the patient journey. These activities are consistent with a range of quality and productivity initiatives that have been recommended nationally as cost-effective<sup>315</sup>.

<sup>312</sup> The British Thoracic Society and SIGN (2008) revised 2011: <http://www.sign.ac.uk/pdf/qrg101.pdf>

<sup>312</sup> British Society for Allergy and Clinical Immunology: [www.bsaci.org](http://www.bsaci.org).

<sup>314</sup> The British Thoracic Society and SIGN (2008) revised 2011: <http://www.sign.ac.uk/pdf/qrg101.pdf>

<sup>315</sup> Quality and Improvement Case Studies, NHS Evidence 2011 <http://www.evidence.nhs.uk/qjpp>

- A community based COPD specialist service provides treatments and pulmonary rehabilitation.
- Access to Stop Smoking Services remains well provisioned. Adding the service to Choose and Book has increased referrals from GPs.
- Data improvement projects for COPD have been designed to facilitate patient management.

#### **What more do we need to know?**

- Greater understanding of risk factors and outcomes at ward level to improve commissioning of targeted services
- The needs of people with COPD and Asthma from their perspective

#### **Priorities for the next 5 Years**

- Poor detection rates hinder the ability to develop effective strategies to reduce the burden COPD and Asthma. Reduce the gap between modelled and recorded prevalence is a priority.
- Reduce variation in service provision and levels of care across the borough for primary care and specialist community services.

## **Cancer**

### **Executive Summary**

- Cancer is the second most common cause of death and accounted for nearly 25% of all deaths in the borough in 2007-09.
- The leading cause of cancer mortality in the borough is lung, breast and colorectal cancers, accounting for over 40% of the cancer deaths.
- Incidence rate for all cancer all ages is lower than England average apart from male lung cancer, female oesophageal cancer and both male and female stomach cancer.
- Mortality for all cancers in all ages is lower than the England and the London average but male lung cancer and both male and female stomach cancer mortality is higher than England average.
- On average 717 people in Waltham Forest are diagnosed with cancer each year - 67% of these cases were in people aged less than 75 years.
- Under 75 mortality rate from cancer is higher than London and England average.
- Cancer survival is still one of the poorest in the country.
- Breast and bowel cancer screening coverage has improved 10/11 but declined in cervical screening programme.

### **Recommendations**

- Funding community outreach to increase population awareness of cancer symptoms and uptake of cancer screening programmes.
- Reducing delay in secondary care through implementing of integrated cancer systems.
- Develop a programme of action to ensure successful implementation of HPV testing in 2012/13.
- Implement age extension for bowel and breast screening programme.
- Build on the partnership working with NELCN and Whipps Cross University Hospital to continue offering GP training sessions to increase early cancer diagnoses. This needs an allocated budget.

- GPs to routinely discuss screening with eligible patients to help improve uptake of the cancer screening programmes.
- Work closely with NELCN to improve cancer survival rates by implementing the London Strategy for early diagnosis locally.
- Use insights gained from the older people's pilot to inform future commissioning to meet the needs of older people with a diagnosis of cancer.
- Embed significant event audits and after death analysis of cancer cases in GP practices by including it in the GP appraisals.
- Develop a programme to implement locally the Healthcare for London cancer case for change priorities and the new model of care aimed at improving the quality of care given to cancer patients in London.
- Increase awareness of cancer risk factors, symptoms and screening programmes in Waltham Forest by sustaining the NAEDI project. This will entail:
  - Provision of further funds to ensure the continuity of the NAEDI project after April 2012.
  - Working closely with LBWF to embed cancer prevention in front line work.
  - Sustain community outreach to provide culturally and linguistically appropriate cancer awareness in targeted venues.
- Continue to monitor and address the low uptake of screening among younger women in the 25-49 year old age group and among minority ethnic women. Commissioners to finance a targeted promotion work to increase coverage in these groups.
- Implement familial breast screening surveillance in 2012- commissioners to ensure a contract and funding for this activity which incorporates funding for MRI is in place.

## **What is Cancer?**

Cancer is a term used to describe a group of diseases that affect different parts of the body. Other terms used are neoplastic disease or malignancy. Cancer accounts for nearly 30% of all deaths among men and 25% of deaths among women in England every year.<sup>316</sup> Cancer remains a high priority in Waltham Forest as the second most common cause of death. Between 2007 and 2009 cancer accounted for nearly 25% of all deaths in the borough<sup>317</sup>.

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<sup>316</sup> London Health Observatory (LHO); Mortality from all cancers (directly age standardised rate per 100,000 population, persons under 75 years) by local deprivation quintile. Metadata. Available at

[http://www.lho.org.uk/Download/Public/16127/1/Stratified\\_cancers\\_under%2075s%20MetaData.doc](http://www.lho.org.uk/Download/Public/16127/1/Stratified_cancers_under%2075s%20MetaData.doc) . Accessed 5/7/2011

<sup>317</sup> National Centre for Health outcome and development (NCHOD); compendium of indicators.

## Cancer Risk factors

Cancer risk factors can be divided in to two broad categories:

- 1) Fixed risk factors - these are factors that one can not control. They include:
  - Age: ageing is the primary factor for the development of cancer, for example 85 percent of breast cancer cases occur in women 50 years of age and above<sup>318</sup>.
  - Gender: certain types of cancer e.g. Prostate cancer is gender specific.
  - Family history: research shows that there is an inherited predisposition to cancer for people with family history of cancer. Women who have a family history of breast or ovarian cancer are at a higher risk for breast cancer than those who lack such a history<sup>319</sup>.
- 2) Modifiable factors - these are factors that one can change as they are related to life style choices.
- 3) Smoking: smoking causes 9 out of 10 lung cancer cases<sup>320</sup>. The Waltham Forest estimated smoking prevalence in the general population aged 16+ is 19.3% and 24% in people aged 40-74 attending a health check.
  - The death rate from smoking per 100,000 population is 263.3, one of the highest in England<sup>321</sup>.
  - Obesity: Research has shown that many types of cancer are more common in people who are overweight or obese<sup>322</sup>. Waltham Forest adult obesity rate (model based estimates) is 20.2% which is higher than London (18.4%) but lower than England (23.6%).
  - Lack of exercise: regular physical exercise has been shown to reduce the risk of breast cancer. A physical activity survey by sport England in 2007-2008 highlighted Waltham Forest's residents have lower levels of physical activity; only 15.5% of residents aged 16 years and over participate in 30 minutes of moderately intense physical activities 3 times a week compared to 16.4% in England and 16.5% in London<sup>323</sup>.

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<sup>318</sup> Breast cancer UK, <http://www.breastcancercampaign.org/breastcancer/6/> accessed September 2010

<sup>320</sup> Cancer research UK <http://www.cancerhelp.org.uk/type/lung-cancer/about/lung-cancer-risks-and-causes> Accessed Sept 2010

<sup>321</sup> Department of Health *Smoking Kills: a white paper on tobacco*. London: The Stationery Office, 1998.

<sup>322</sup> Cancer research UK <http://info.cancerresearchuk.org/healthyliving/obesityandweight/index.htm?gclid=CLPI8v6T-KMCFQIB4wod5Va9IA> Accessed Sept 2010

<sup>323</sup>

- Diet: generally a diet rich in fruit and vegetables, high in fibre and low in red meat, processed foods and sugar will contribute to a protective effect against lots of diseases including breast cancer, bowel cancer etc.
- Alcohol consumption is associated with an increased risk of oral, esophageal, breast, and other cancers. Six percent of cancer deaths in the UK are caused by alcohol and all of these deaths could be avoided<sup>324</sup>.
- Other lifestyle and environmental factors known to affect cancer risk include certain sexually transmitted diseases (such as those conveyed by the human Papilloma virus (HPV), exposure to radiation from the sun or from tanning beds and certain occupational and chemical exposures.

The vast majority of cancer risk factors are environmental or lifestyle-related; leading to the claim that cancer is a largely preventable disease<sup>325</sup>.

## Local Picture

### Cancer Incidence

On average 717 people are diagnosed with cancer each year in Waltham Forest. Between 2006 and 2008 there were 2,151 cancer cases diagnosed, 67% of these cases were in people aged less than 75 years. Females accounted for more cases (1,125) compared men (1,026)<sup>326</sup>.

Waltham Forest's directly standardised incidence rate (DSR) for all cancers in all ages is lower than the England and the London average.

However this is not the case for Lung cancer; the DSR for male (61.4) is above England male average (57.39). Similarly the DSR for oesophageal cancer in females is higher than England average. DSR for stomach cancer is higher than the England average in both males and females. See Figure 1 below.

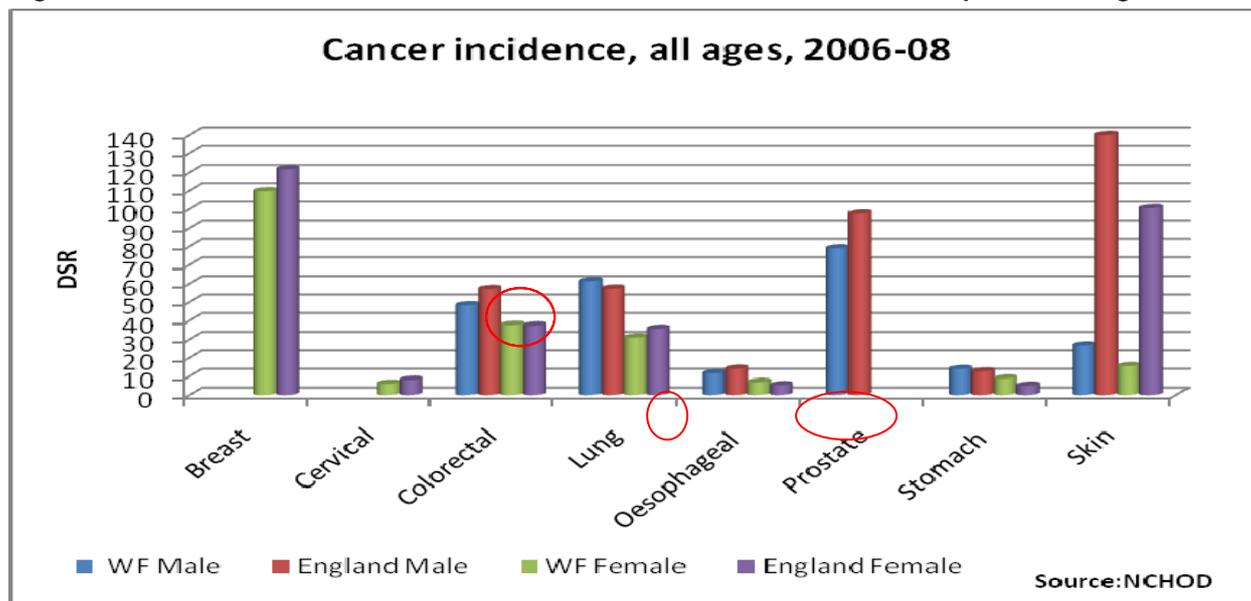
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<sup>324</sup> Doll, R. and R. Peto, *Epidemiology of Cancer*. Oxford Textbook of Medicine, ed. D. Warrell, et al. 2003, Oxford: OUP.

<sup>325</sup> Danaei G, Vander Hoorn S, Lopez AD, Murray CJ, Ezzati M (2005). "Causes of cancer in the world: comparative risk assessment of nine behavioural and environmental risk factors". *Lancet* 366 (9499): 1784–93. doi:10.1016/S0140-6736(05)67725-2. PMID 16298215.

<sup>326</sup> National Centre for Health outcome and development (NCHOD); compendium of indicators

Figure 1: Waltham Forest cancer incidence rate for male and female compared to England average



### Mortality

Cancer accounts for nearly 30% of all deaths among men in England and nearly 25% of deaths among women every year<sup>327</sup>. Between 2007 and 2009 there were 1,102 cancer deaths in the borough. Of these 546 were in males and 556 in female. 54% of these deaths were in people under 75 years old (premature deaths).

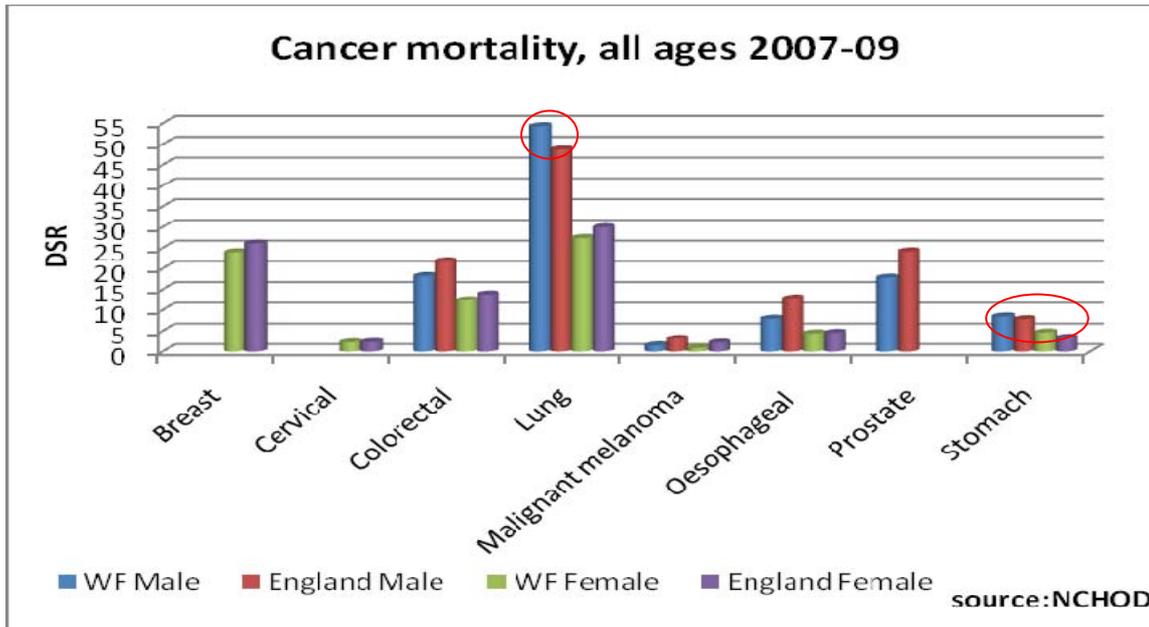
Cancer mortality in Waltham Forest has been declining. Between 1999 (DSR 213) and 2009 (DSR168) there was a 78% reduction in the age standardised mortality rate. In the period 2007-09 Waltham Forest's mortality rate for all ages was higher than the London average for both men and women but below England average. But for premature deaths (under 75 years) Waltham Forest rates are higher than London and England average.

In the same period (2007-09) Waltham Forest's male lung mortality rate (DSR 54.32) was higher than the England average (DSR 48.74) and both male and female mortality rates for stomach cancer respectively (DSR 8.44 and 4.64) are higher than the England average for male (DSR 7.80) and female (DSR 3.33), see Figure 2 below.

The leading cause of cancer mortality in the borough is lung, which combined with breast and colorectal cancers accounts for over 40% of the cancer deaths.

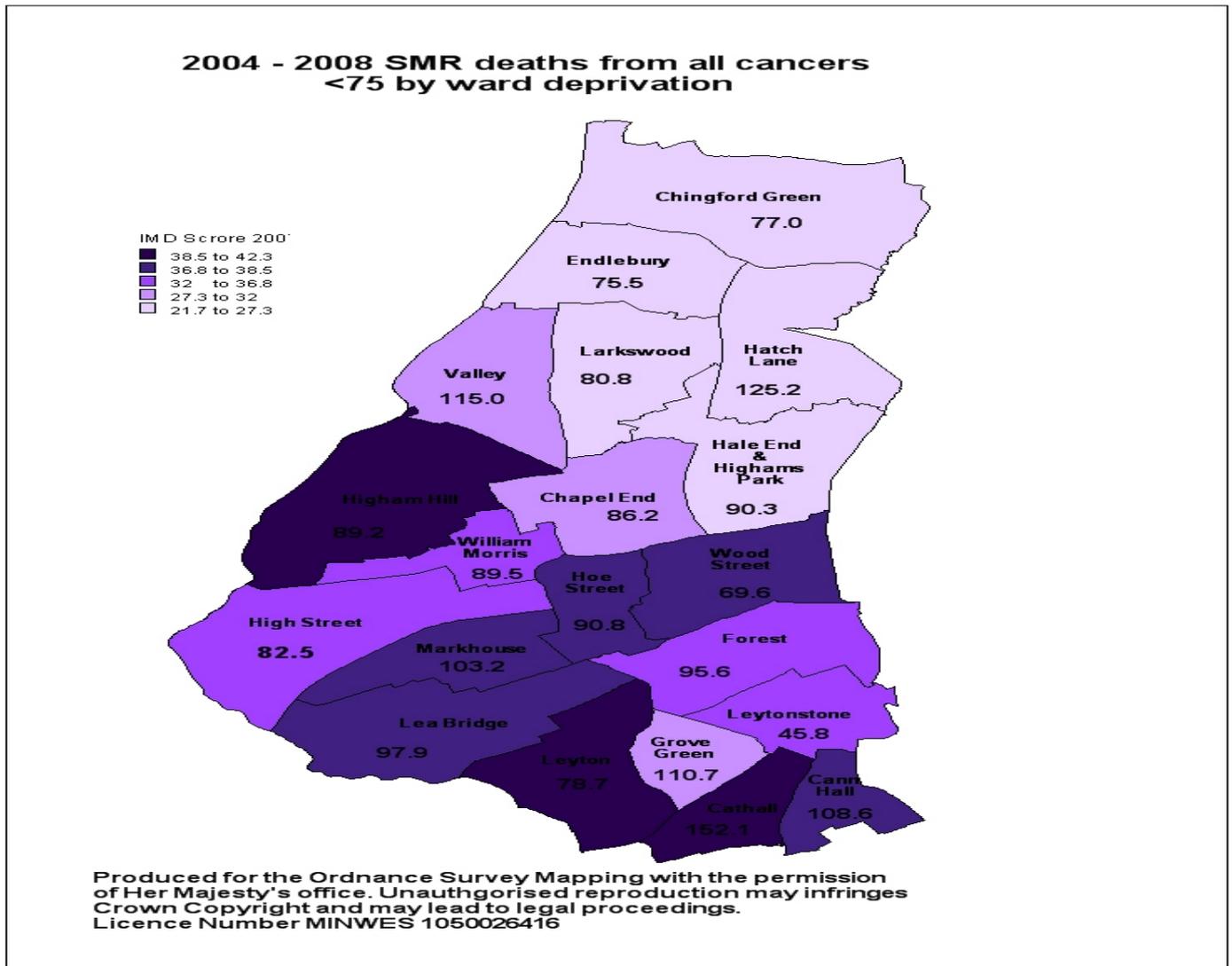
<sup>327</sup> London Health Observatory (LHO); Mortality from all cancers (directly age standardised rate per 100,000 population, persons under 75 years) by local deprivation quintile. Metadata. Available at [http://www.lho.org.uk/Download/Public/16127/1/Stratified\\_cancers\\_under%2075s%20MetaData.doc](http://www.lho.org.uk/Download/Public/16127/1/Stratified_cancers_under%2075s%20MetaData.doc) . Accessed 5/7/2011

Figure 2: Waltham Forest cancer mortality rate for male and female compared to the England average



Cancer mortality at ward level appears to be is mainly driven by age and deprivation. The north of the borough is less deprived compared to the middle and south of the borough (see Figure 3 below), Hatch lane ward in the North has the second highest standardized mortality ratio (SMR) 125.2 in the borough and this is likely to be driven by the older age of the population living there. In the south Cathall ward has the highest SMR (152.1) in the borough and this is likely to be driven by the high levels of deprivation.

Figure 3: Map of Waltham Forest borough showing standardised Mortality ratio by deprivation



### Survival

Nationally cancer survival rates are improving for most cancers, although the improvement is not reflected in all cancers; for some cancers survival rates are static or even declining slightly. The variation in trends between cancers is the result of a number of factors, including differences in screening, diagnostic tests, advanced stage at diagnosis, and delays in diagnosis and treatment<sup>328</sup>.

Waltham Forest's cancer survival for the leading causes of cancer deaths (breast, lung and colorectal) is still one of the poorest in London. Big differences exist in one and five year's cancer survival between Waltham Forest and best PCT in London. Waltham Forest survival rates are still lower than our statistical comparators Croydon PCT, Greenwich PCT and Enfield PCT. See Table 1 below.

<sup>328</sup> The King's Fund ; how to improve cancer survival ; available at:

<http://www.statistics.gov.uk/CCI/nugget.asp?ID=861&Pos=2&ColRank=1&Rank=144> accessed 08/08/2011

Table 1: One and 5 year relative survival rates from breast, colorectal and lung cancers, Waltham Forest compared to PCT statistical comparators and London best PCT

Organisation Name	1 year survival (%)			5 years survival (%)		
	Breast	Colorectal	Lung	Breast	Colorectal	Lung
Waltham Forest	93.57 4 <sup>th</sup> lowest in London	68.97 4 <sup>th</sup> lowest in London	27.04 6 <sup>th</sup> lowest in London	77.03 5 <sup>th</sup> lowest in London	36.73 lowest in London	4.38 lowest in London
Greenwich Teaching PCT	94.44	73.3	28.24	84.36	45.48	7.23
Enfield PCT	94.59	73.23	30.89	82.24	45.37	7.34
Croydon PCT	95.71	78.28	34.97	85.73	56.38	6.94
Best PCT in London	98.95 (Hammersmith & Fulham)	82.69 (Camden)	43.49 (Kensington & Chelsea)	89.5 (Kingston PCT)	63.72 (Kensington & Chelsea)	20.31 (Kensington & Chelsea)

Source: CCT People diagnosed in 2006-8 (one year), and 2002-4 (5 year).

The key drivers for the poor survival in Waltham Forest are poor awareness of cancer symptoms by the general population, advanced stage at diagnosis and delay in diagnosis. As part of the national early awareness and diagnosis initiative Waltham forest is addressing these issues.

### Resources and Investment

The most recent data on PCT expenditure from Department of health; 2009-10 show Waltham Forest PCT spend on cancer per 100,000 population was £9.7 million. When compared to the expenditure of our statistical comparators, Waltham Forest expenditure was the lowest. See Table 2 below.

Table 2: 2009-10 PCT national index scores and rankings for cancers and tumours

PCT	Spend per 100K population (£m) (Unified weighted population)	Ranking (highest investment first)	Index*
Waltham Forest	9.7	118	0.71
Greenwich	11.2	45	0.83
Croydon	10.6	84	0.78
Enfield	10.3	98	0.76

Source: DH Programme Budgeting Tool v1.00.

\*For example Waltham Forest's cancer budget was 71% of that of the highest spending PCT in England

Although over all expenditure on cancer has increased over the years, most of the spending has been in secondary care and our cancer outcomes are poor - higher premature mortality than London and England average and one of poorest cancer survival rates in the country.

As discussed in earlier section the key drivers for poor cancer outcomes in the borough are poor awareness of cancer symptoms by the general population and delay in diagnosis. This would suggest reviewing our overall spending to ensure adequate resources for investment in cancer prevention, early awareness and detection work streams.

## **Cancer Screening Programmes**

### **Breast Screening**

The Waltham Forest provisional breast screening coverage for 2010/11 for women aged 53-70 years is 70.05%, which meets the national minimum target of 70% and marks a 0.6% improvement from the previous year's coverage. Waltham Forest's coverage is below the England average of 75.9% but above the London average of 67.5%.

The coverage data for 50-70 year olds is lower at 65%. In 2010/11 uptake at practice level for 50-70 year olds was also variable with a range of 48.6% - 73.9% and four practices out of 47 (8.5%) achieved the recommended threshold of 70%.

This suggests there are screening inequalities, probably driven by factors related to the locality and residents' age. There is a need to engage further with both primary care staff and the general population to raise awareness of the importance of breast screening. Targeted outreach work with younger women will be needed to engage this age group to take up breast screening.

### **Cervical Screening**

Provisional data for 2010/11 show that Waltham Forest's coverage of 76.92% for women aged 25-64 years which is below the national target of 80%. Analysis of coverage across age groups shows that coverage has been declining in all age groups but most dramatically in the youngest age group (25-49), whose coverage is 76.04% compared to 80.04% in the 50-64 year old coverage. Only 14 practices out of 47 (30%) achieved the national target of 80% coverage.

Coverage at practice level ranged from 89.68% to 66.23%. This variation in coverage is also reflected in the consortia coverage levels, Chingford which has the older population has 82.05% and Leyton / Leytonstone which has a younger population has the lowest coverage of 74.9%. There is need to continue to monitor and address the low uptake of screening among younger women in the 25-49 age group and among women from minority ethnic groups. Although the coverage has declined slightly (0.6%), it is worth noting that the demand for cervical screening is increasing as more women are eligible. Between 2008 and 2010 there has been a 12% increase in eligible women from 67,447 to 75,421. Local initiatives should be undertaken by the PCT to seek to identify the underlying reasons for the decline in coverage.

Recently the government has changed the national two weeks turnaround time target on screens from 100% to 98%. In 2010/11 on average 93.7% women received their cervical screening results in two weeks.

The colposcopy units at Whipps Cross hospital have performed above the national minimum standard of 90% waiting time for the assessment of all referrals within 8 weeks, and referrals for moderately / severely dyskaryotic smears within 4 weeks. However, the proportion of women who did not attend for moderately / severely dyskaryotic appointments was 13.0%, slightly higher than the England and London averages of 10.6% and 12.6% respectively.

### **Bowel Screening**

Bowel cancer screening uptake has been improving over the years from 36.86% in 2007 when the project was rolled out to 44.18% in 2010/11. In 2010/11 practice level bowel screening uptake ranged from 58.98% to 15% which reflects the variation in screening uptake in the borough.

Although national data is not available, Waltham Forest's uptake (44.18%) when compared to the other outer north east London PCTs is above Barking and Dagenham but lower than Redbridge and Havering.

### **Age Extension**

#### **Bowel Screening (70 to 74 years old)**

Currently people aged 60 - 69 years are eligible for the national bowel screening programme. Age extension will increase the age range from 60 – 74 years.

Age extension 'roll out' began in April 2010. The age extension roll out at each Screening Centre is controlled by the National Office and London Quality Assurance Reference Centre (QARC). The requirements for implementing age extension are:

- The PCT has completed 2 years of screening i.e. they are in the recall phase.
- The Screening Centre has demonstrated that they have the capacity to provide the age extended service along with the existing workload in screening and diagnostic service.
- The Hub has the capacity to deal with the increased administrative and laboratory work and the necessary space.

In Waltham Forest age extension was due to roll out in 2011/12 but since bowel screening is commissioned as a sector across North East London some sections of the sector do not meet the criteria and London QARC has advised that age extension be postponed until 2012/13.

#### **Breast Screening (47-49 & 71-74 year olds)**

Currently people aged 50 - 70 years are eligible for the national breast screening programme. Age extension will increase the age range from 47 – 74 years.

Breast screening age extension for the Central and East London breast Screening Service (CELBSS) was planned to start in 2011 but this has been postponed until 2012 as CELBSS is not meeting some of the qualifying criteria (regarding screen to assessment times).

### **Familial Breast Cancer**

The majority of breast occurs as isolated cases, however about 20-30% is 'familial' of which a minority (15-20%) is caused by mutations in breast cancer genes such as *BRCA1* and *BRCA2*, which are associated with high risks of breast cancer.

Women with a first degree relative (mother, father, sister, brother, daughter and son) with breast cancer are twice as likely to develop breast cancer themselves and the risk of breast cancer increases with increasing family history. Surveillance of familial breast cancer aims at detecting breast cancer early and has been demonstrated to improve mortality and morbidity<sup>329</sup>

Cancer Reform Strategy, 2009 recommends that:

- Women who are at increased risk of breast cancer (e.g. those with a family history) should be offered risk assessment and extra surveillance, using the existing NHS Breast Screening Programme for follow up.
- All women who are currently unaffected with breast cancer but who are concerned about their risk of breast cancer because of a family history should have access to appropriate information, risk assessment and surveillance.

The National Screening Office has requested Breast Screening Units to undertake breast screening surveillance for women at high risk of breast cancer from 2012 and have also agreed a protocol for the surveillance of this group. The London Screening Improvement Board has agreed the London Guidance for the screening of women at increased risk of breast cancer.

### **HPV Triage Testing**

Following the results of a pilot study to test the effectiveness of Human Papilloma virus (HPV) triage testing in the effective management of low grade abnormal cytology, the NHS Cervical Screening Programme (NHSCSP) has agreed to start rolling out HPV testing in 2011/12. This programme will be incorporated within the cervical screening programme. Women identified with low-grade abnormal sample results – borderline or mild dyskaryosis are tested for the high risk HPV strain. If found positive, they would be referred to the colposcopy service, and if negative, they would be returned to the routine recall programme. This test will also be used to ascertain whether women who had treatment have indeed been cured. It is expected that this

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<sup>329</sup> London Specialised Commissioning Group. Familial Breast Cancer Risk Assessment and Surveillance in London.2011

approach will lead to major cost savings, as it will “minimise unnecessary surveillance, while maintaining excellent diagnostic and treatment services.”<sup>330</sup>

### Effective interventions

Overall, the most plausible drivers for improved cancer survival appear to be diagnosis at an early stage, including through effective screening programmes, access to optimal treatment and improvements in the management of older people<sup>331</sup>. Waltham Forest is in the process of implementing initiatives addressing these areas.

<b>Prevention</b>	Improved outcomes in cancer can be achieved by tackling cancer risk factors such as smoking, obesity, physical inactivity and excessive alcohol consumption. It is estimated that about a third of cancers could be prevented by eating a healthy diet, being physically active and maintaining a healthy weight <sup>332</sup> .
<b>Screening</b>	<ul style="list-style-type: none"> <li>• Targeted outreach, health promotion and cancer awareness has been shown to be effective in increasing screening uptake:</li> <li>• Provision of culturally and linguistically appropriate cancer awareness in targeted venues like grocery shops<sup>333</sup>.</li> <li>• Provision of tailored print intervention (newsletter/booklet) and telephone counselling<sup>334</sup>.</li> <li>• Active follow up of DNAs through telephone calls, text messaging, letters offering second time appointments or recommending screening when eligible persons attend clinics<sup>335</sup>.</li> <li>• Client reminders, particularly telephone calls<sup>336</sup>.</li> <li>• Provision of flexible appointment times to meet client needs and easy means to change appointments<sup>337</sup>.</li> </ul>

<sup>330</sup> NHS Cervical Screening Programme Annual Review 2010

<sup>331</sup> The King’s Fund ; how to improve cancer survival ; available at:

<http://www.statistics.gov.uk/CCI/nugget.asp?ID=861&Pos=2&ColRank=1&Rank=144> accessed 08/08/2011

<sup>332</sup> World cancer research fund -stopping cancer before it starts, <http://www.wcrf-uk.org/> accessed 3/09/2010

<sup>333</sup> Sadler GR, Thomas AG, Yen JY, Dhanjal SK, Ko CM, Tran CH, Wang K: Cancer education program based in Asian grocery stores. *Journal of Cancer Education* 2000, 15:173-177. [PubMed Abstract](#) | [Publisher Full Text](#)

<sup>334</sup> Rimer B, Halabi S, Skinner C, Lipkus I, Strigo T, Kaplan E, Samsa G. Effects of a mammography decision-making intervention at 12 and 24 months. *Am J Prev Med.* 2002; 22:247–257. [[PubMed](#)]

<sup>335</sup> Approaches to improving breast screening uptake: evidence and experience from Tower Hamlets; KW Eilbert, K Carroll, J Peach, S Khatoun, I Basnett and N McCulloch; *British Journal of Cancer* 101(S2), S64 – S67 (2009)

<sup>336</sup> Interventions to increase the uptake of Cancer Screening: Guideline recommendations; M Brouwers, C De Vito, A Carol, J Carroll, M Cotterchio, M Dobbins, B Lent, C Levitt, N Lewis, S E McGregor, L Paszat, C Rand and N Wathen; *Cancer Care Ontario*; 26 March 2009

<sup>337</sup> Why Islington women do not attend for breast screening; Dr Edwina Affie; 29th September 2009; Cancer Inequalities Workshop

<b>Early diagnosis in primary care</b>	<p>NICE guidelines on reduction of delayed or missed diagnostic opportunities in Primary Care include:</p> <ul style="list-style-type: none"> <li>• CG27 June 2005 Referral for suspected cancer – access to specialist advice.</li> <li>• CG24 February 2005 Lung cancer: diagnosis and treatment – offer urgent referral for smokers / ex-smokers with specific symptoms not resolved within 3 weeks.</li> </ul>
<b>Population awareness cancer risk factors and symptoms</b>	<ul style="list-style-type: none"> <li>• The Healthy Communities programme supports community volunteers to work in partnership with primary care staff and other specialist cancer service providers, in both statutory and voluntary sectors, to lead improvement locally. Community members and professionals are taught to use improvement tools to identify what can be changed to make an improvement, and then to measure that improvement. Outcomes include not only improvement in a specific topic area, but benefits to the individual volunteers and to the community itself<sup>338</sup>.</li> </ul>

### What is being done locally?

The national Cancer Strategy<sup>339</sup> published in 2011 sets out a range of actions to improve cancer outcomes, including:

- diagnosing cancer earlier;
- helping people to live healthier lives to reduce preventable cancers;
- screening more people;
- introducing new screening programmes; and
- making sure that all patients have access to the best possible treatment, care and support.

In Waltham Forest the PCT in partnership with other partners is working to align the cancer service delivery with the recommendations in the cancer strategy.

### Prevention

#### National Awareness and Early Diagnosis Initiative (NAEDI project)

Waltham Forest PCT won a bid to carry out a cancer awareness project for breast, bowel and lung cancer which is part of the National Awareness and Early Detection Initiative (NAEDI). The aim of the project is to raise population awareness of cancer signs and symptoms, leading to earlier presentation and diagnosis of lung, bowel and breast cancer. After consultation with the local population we have developed awareness resources including posters, leaflets and symptom checker cards. We used several channels of communications including local newspapers, adverts on buses and bus shelters, and distribution of these resources in libraries, GP surgeries, local grocery shops, faith centres and community groups.

<sup>338</sup> Lyon D, Knowles J, Slater B and R Kennedy Improving the early presentation of cancer symptoms in disadvantaged communities: putting local people in control

<sup>339</sup> Department of Health; Improving Outcomes: A Strategy for Cancer, 2011

## **Community Services**

As part of NAEDI project the PCT has commissioned a community organisation, to recruit and train local health champions to raise cancer awareness in their communities and faith groups.

The public health team in partnership with GP practices is running a series of bowel screening education sessions in targeted practices to:

- Raise awareness of the bowel cancer signs and symptoms.
- Give information on how to use the kit and increase the number of people completing the test kit.

## **Colorectal Community Service**

The Colorectal Service sees and treats patients suffering from colorectal symptoms quickly within the community. The service treats patients with lower GI problems, Inflammatory Bowel Disease, and those requiring colorectal surgery.

- The service aims to:
  - offer a rapid service within the community to patients with colorectal symptoms,
  - offer a fast track to Whipps Cross University Hospital for patients requiring treatment within acute care,
  - reduce waiting times for colorectal services

## **Primary Care**

Selected GP practices are undertaking cancer audits that aim to help GPs evaluate their cancer referral patterns; identify delays in primary care and overall improvement in early diagnosis. The PCT is also running GP education sessions on improving use of the 2 weeks referral pathway for suspected cancers.

The PCT and North East London Cancer Network (NELCN) have provided GPs with their practices' cancer profiles, recently published by the National Cancer Information Network (NCIN). The profiles provide analysis of referrals made for patients with suspected and diagnosed cancer through the Two Week Wait routine and emergency routes. They also include practice level cancer incidence rates and screening coverage. Their purpose is to support reflection on referral patterns with a view to improving early diagnosis and survival for people with cancer.

## **Secondary Care**

Whipps Cross hospital has now installed the Somerset IT system that will enhance data collection and sharing. Whipps Cross clinicians have supported the development of NAEDI campaign and GP education sessions.

## **Social Services**

The London borough of Waltham Forest social care provides various services that support people suffering from cancer and their families/carers. This includes:

- Information and Advice Service.
- Individual Advocacy Service.
- Day Opportunities Service (Generic).

- Wellbeing Programme.

Further mapping of cancer survivorship services is required to identify services available in the community and any gaps that might exist.

### **Risks to local delivery**

With the current restructuring of the NHS the main risk to service delivery is financial constraints and loss of staff through redundancy. The merging of Whipps Cross with other hospitals will also influence how services are commissioned and delivered in the future.

### **Evidence that we are making a difference**

From last year's JSNA we have achieved the following:

- Commissioned community organisation to carry out targeted cancer awareness sessions in the community.
- In partnership with clinicians and local communities the PCT has developed awareness materials for bowel, lung and breast cancer and the social marketing campaign is being implemented.
- As part of the NAEDI project the PCT has commissioned comprehensive research through focus group discussions in the borough.
- Implementation of the NAEDI project is underway and we have carried out various publicity events to raise awareness of cancer symptoms.
- The PCT in partnership with NELCN has been selected as one of the pilot sites for improving cancer treatment assessment and support for Older People with a diagnosis of cancer.
- Whipps Cross Hospital has implemented the Somerset IT system to help improve data collection.
- The provisional data for 2010/11 shows the PCT has achieved national targets in breast screening coverage.
- The PCT is taking part in the national GP cancer audit and plan to run refresher GP education sessions on the two weeks referral pathway.
- The Whipps Cross breast screening unit has been refurbished and now has two digital mammography machines, in line with national guidelines.
- The vacant specialist cytology nurse post that supports GP practices with cytology issues has been filled.

## **User feedback**

A recent feedback from focus group discussions held this year among the Pakistani community showed that<sup>340</sup>:

- Cancer is still a taboo, viewed as a 'death sentence', some stigma is attached to it and it is not openly discussed.
- Bowel screening is embarrassing and people who cannot read the instructions on using the kit would be embarrassed to ask family members to translate it for them.
- Generally visiting the doctor was viewed negatively because of the necessary association with ill health. The immediate response was that going to the doctor was to be avoided because the less you see the doctor the healthier you are. Some linked going to the GP with bringing on or exacerbating illness. There is the use of herbal medicines as an alternative to visiting the GP in many cases and there was general agreement that if you could look after it yourself it was better than going to a GP.

This gives some pointers to why some people may delay seeking medical help when they have concerns, which contributes to late diagnosis and poor cancer survival.

## **What more do we need to know?**

1. Staging data - still gaps exist especially in recording of stage of diagnosis.
2. Underlying reasons for decline in cervical screening coverage.
3. Impact of NAEDI project on early diagnosis.
4. Numbers of women that will need to be included in familial breast cancer surveillance both from January 2012 and on an ongoing basis.

## **Priorities for the next 5 years**

1. Specific data requirements to be stipulated in provider contracts.
2. Allocate budget for GP training sessions on early cancer diagnosis.
3. Implement London strategy for early diagnosis locally which entails:
  - Funding community outreach to increase population awareness of cancer symptoms and uptake of cancer screening programmes.
  - Increasing GPs access to diagnosis.

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<sup>340</sup> Forster, NHS Waltham Forest Qualitative research –awareness and early diagnosis of breast and bowel cancer

- Reducing delay in secondary care through implementing of integrated cancer systems.
4. Ensure significant event audits and after death analysis of cancer cases in GP practices are embedded in the GP appraisals.
  5. Cervical screening coverage has gone down commissioners to finance a targeted promotion work to promote cervical screening and follow up of women who don't attend their appointments.
  6. Develop a programme of action to ensure successful implementation of HPV testing in 2012/13.
  7. Implement age extension for bowel and breast screening programme.
  8. Implement familial breast screening surveillance in 2012- commissioners need to put in place a contract and funding for this activity to continue and this incorporates funding for MRI.

### **Key insights**

- Cancer is the second most common cause of death and accounted for nearly 25% of all deaths in the borough in 2007-09.
- The leading cause of cancer mortality in the borough is lung, breast and colorectal cancers.
- Incidence rate and mortality rate for all cancer, all ages is lower than England average apart from:
  - Incidence rate for male lung cancer, oesophageal cancer and both male and female stomach cancer.
  - Mortality rate for male lung cancer and both male and female stomach cancer.
- Under 75 mortality rate from cancer (premature cancer death) is higher than London and England average.
- Cancer survival in the borough is still one of the poorest in the country.
- Bowel and breast screening coverage improved but cervical screening coverage declined in 2010/11.

There are a number of challenges in reducing cancer morbidity, mortality and increasing survival. These include:

- Increasing screening coverage / uptake in the breast bowel and cervical cancer screening programmes.

- Tackling lifestyle-related cancer risk factors particularly smoking, obesity, physical inactivity and excessive alcohol consumption.
- Addressing factors that contribute to late presentation for diagnosis and limited awareness of cancer symptoms amongst front line clinicians.
- Implementing age extension for both bowel and breast screening programmes.

## Mental Health

### Executive Summary

- Waltham Forest (WF) has high levels of risk factors for mental illness some of which include high level of deprivation, higher percentage of certain Black and ethnic minority groups and low employment rates.
- In any given week, approximately 18% of adults in Waltham Forest will have a mental health problem, which is not statistically different to the London average of 16%<sup>341</sup>. It is estimated that about 50 per cent may require treatment<sup>342</sup>
- CMDs also known as neurotic disorders are more common and cause marked emotional distress and interfere with daily function, but do not usually affect insight or cognition. In contrast severe mental health illness (SMI) also known as psychosis is less common and produces disturbances in thinking and perception severe enough to distort perception of reality.

### Recommendations

#### Data

- Use Health Analytics to improve data collection, reporting and monitoring of mental health services, throughout the care pathway particularly at the primary care and community level.
- Analyse demographic data of patients who are on primary care mental health registers (serious mental health conditions) to develop targeted and integrated interventions across primary, community and acute care in order to improve quality of effectiveness.

#### Quality

- Further explore differences in service use by BME groups to examine underlying health inequalities related to above average use of acute care (health equity audit).
- Work in partnership with LBWF and the voluntary sector particularly in addressing wider determinants such as education, employment and housing.
- Undertake awareness raising campaign underpinned by knowledge, attitudes and experience of service users and carers to target services more effectively. This should include outreach work aimed at specific groups.

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<sup>341</sup> London Mental Health Score Card January 2011

<sup>342</sup> Psychiatric Morbidity Survey, 2000

- Train service providers at all levels on ethnic diversity and mental health is a key requirement.
- Undertake qualitative data collection with regard to A&E attendance to plan appropriate interventions.
- Establish screening of high risk groups for CMD and SMI to improve early detection and appropriate management particularly among patients with COPD and heart failure.
- Implement the pilot on London Model for Long Term Mental Health Conditions.
- Redesign care pathways for schizophrenia, depression and dementia to align with national policy/ guidance through wider stakeholder consultation and clinical leadership to address under detection and higher dependency on acute care.
- Undertake full analysis of secondary care services' performance and capacity for, Value for Money, Quality, Access and Levers for change.
- Plan and implement interventions to improve clinical outcomes of patients with SMI with co morbid physical illness.
- Agree a plan to address the high admission rates among African and African Caribbean people, which is also a national priority.
- Develop a mental wellbeing strategy for Waltham Forest with the emphasis on wellbeing before they develop mental health problems.
- Improve access to employment for people with mental health problems. This requires initiatives to change the attitudes of employers and making the support systems designed to help people into paid work more accessible and flexible.
- Work in partnership with PCT CVD Board in order to prevent vascular dementia in Waltham Forest.

### **Services**

- Deliver culturally appropriate mental health promotion to raise awareness of available services and to reduce stigma aimed at hard to reach and disadvantaged groups.
- Education and training for primary care professionals about the importance of improved detection of depression among people with CHD and/or diabetes as this impacts on self management and clinical outcomes.

- Work with schools, community groups and other appropriate settings to change the attitudes towards mental health problems and to reduce the stigma associated with mental illness.
- Provide mental health training for service providers who come in contact with high risk groups e.g. those working in benefits advice, Job Centre Plus, counselling.

### **Common mental health disorders (CMDs)**

- An estimated 30,000 people have CMDs in Waltham Forest.
- Compared to the London average Waltham Forest has a similar prevalence estimate for common mental health disorders (CMD) <sup>1</sup>.
- The prevalence estimate for CMDs among 16 - 74 aged is 154 per 1000 which is not different from London. The largest proportion is estimated to be in Walthamstow.
- Mixed anxiety and depressive disorder is estimated to be the most prevalent CMD in Waltham Forest
- 11% of the adult population in Waltham Forest are estimated to have depression, which is similar to London and higher than England which is 8%.
- It is of concern that the acute care use reflected by Finished Consultation Episodes (FCE) rates for CMD from 2008/09 to 2009/10 was markedly higher within Waltham Forest than the national rates and show a clear upward trend from 2008/09 to 2010/11.

### **Severe Mental Illness (SMI)**

- The 2009/10 SMI register for Waltham Forest showed 2,699 people with schizophrenia, bipolar disorder and other psychoses registered with GPs.
- This amounts to a prevalence of 1%, higher than national and ONEL prevalence; and is expected to be even higher as some currently treated at NELFT are not known to the primary care system.
- It incurs a huge cost to the local health and social care economy as WF has the highest admission rates through A&E for mental health reasons in London (08/09 and 09/10).
- There are stark inequalities with BME groups and older people experiencing significantly higher standardised emergency admission rates (198.5) compared to their White counterparts – 103.1 /1000.
- Inequalities exist by locality and gender as well reflected by rates of admission rates for schizophrenia in 2009-2010 which were higher in males 150.2/1000) vs 98.9/1000 for females.
- Leyton Leytonstone recorded the highest rate (180.6/1000).

- Organic brain disorders (dementia).
- Cost of dementia inpatient admissions was five times higher in 08/09 than the average for other London PCT.

### **Quality of primary care & service users' views**

- The actual prevalence of depression among diabetics on GP registers in 2009/10 was 6.2%, compared to 7.7% in London and 10.9% in England.
- 92% of patients with depression have had the severity of their depression assessed.
- The 2009/10 QoF performance for SMI in Waltham Forest (MH9) with a review recorded in the preceding 15 months was 93.6%, higher than the London average of 91.2%.
- However, the exception rates for depression among diabetes and/or CHD, SMI and dementia are higher than national, London and ONEL sector with wide variation across practices.
- Joint prevention strategy across NHS WF and LBWF has identified mental health as key priorities for commissioning and action plan is in place.
- Focus group discussions conducted in Waltham Forest (2010) among service users, majority of who were BME groups confirmed that their socio-economic issues and culture and belief systems contributed to stigmatisation that prevented people from seeking support early from services.
- They expected 'talking therapy' services to be more accessible to them.

### **What is Mental Health?**

Mental health problems range from common disorders like anxiety and depression to far more severe but less common conditions, such as schizophrenia<sup>343</sup>. Mental health conditions are of considerable public health significance being the single largest source of burden of disease in the UK. Good mental health is a key factor in successful psychological and social functioning, and poor mental health is associated with poor socio-economic status, poor education, poor opportunities for employment, and a host of inequalities, some of which fall under the umbrella term 'social exclusion'<sup>344</sup>. Physical and mental health are closely linked; poor physical health may increase the likelihood of developing poor mental health, and poor mental health may increase risks of developing or not recovering from serious physical health problems.

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<sup>343</sup> McManus S., Meltzer H., et al. Adult Psychiatric Morbidity in England, 2007: Results of a Household Survey. The Health and Social care Information Centre, Social Care Statistics, 2009.

<sup>344</sup> Martin Knapp, David McDaid et al. Mental Health Policy and Practice Across Europe. Open University, 2007.

Mental health problems can be divided as follows:

### **Common mental health disorders (CMD)**

CMDs also known as neurotic disorders are conditions that cause marked emotional distress and interfere with daily function, but do not usually affect insight or cognition. They include problems such as depression and anxiety disorders such as panic disorder, obsessive compulsive disorder, phobias, post traumatic stress disorders, health anxiety, body dysmorphic disorder, generalised anxiety disorders. CMDs can be effectively treated with medication and/or psychological therapies.

### **Severe and enduring mental health problems**

**Severe mental health disorders** also known as psychosis are disorders that produce disturbances in thinking and perception severe enough to distort perception of reality. These include conditions such as schizophrenia and bipolar affective disorders (manic depression).

**Personality disorder** is defined as 'an enduring pattern of inner experience and behaviours that deviates markedly from the expectation of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time and leads to distress or impairment'.

**Organic brain disorders** are due to structural abnormalities of the brain and include conditions such as Alzheimer's disease.

### **Why is it important?**

Mental illness account for a greater number of disability adjusted life years (a measure of the overall burden of disease), than other major condition such as cancers, circulatory and respiratory diseases<sup>345</sup>. Reducing the prevalence of Common Mental Disorders (CMD) is a major challenge because despite evidence for effective treatment, there seems to have been little impact on reducing prevalence<sup>346</sup>.

### **What are the major risk factors for mental ill health?**

The key risk factors for mental health include:

- Deprivation- Adults from disadvantaged backgrounds are more likely to suffer mental health disorders than the rest of the population<sup>347</sup>.
- Poor housing -poor housing can lead to both poor mental and poor physical health.

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<sup>345</sup> No health without public mental health the case for action, Royal College of Psychiatrists position statement PS4/2010, www.rcpsych.ac.uk

<sup>346</sup> World Health Organisation (WHO) 2005. Mental Health: Facing the Challenges, Building Solutions. Report from the WHO European Ministerial Conference

<sup>347</sup> Hamburg D. and Sartorius N. Mental Health and Behaviour: Selected Perspectives. World Health Organisation. Cambridge University Press, 1989.

- Unemployment- it is an identified risk factor for developing mental illness<sup>348</sup>.
- [Alcohol and drug abuse](#) can both cause and exacerbate preexisting mental health problems. Substance abuse can serve as a trigger for latent emotional conditions. Chronic heavy drinkers are more likely to suffer from depression, anxiety, serious cognitive impairment and psychosis<sup>349</sup>.
- Lack of connection to a primary caretaker during childhood leading to lifelong repercussions.
- Serious trauma, death of a parent, hospitalization, tragic accidents and other devastating events, particularly during early childhood.
- Chronic or disabling illness leading to isolation from other people, denying them necessary social support of friends and family.
- [Medication side effects](#) particularly in the elderly who generally take multiple medications, creating the potential for problematic drug interactions affecting mental health.

### **Groups at risk of poor mental health**

1. People at particular life stages including:
  - Antenatal and postnatal women.
  - Older people are at risk of poor mental health, and
  - Young people (teenagers).
2. Other groups are at risk of suffering poor mental health regardless of their life stage.
  - People with long term conditions and chronic disease.
  - People experiencing mental illness.
  - People with learning disabilities are a particularly vulnerable group within society.
  - Carers.
  - BME groups.
  - Offenders and ex-prisoners.
  - People dependent on drugs and alcohol.
  - Gay and bisexual people.

### **Impact of Mental health conditions on individuals, populations and health and social care**

Schizophrenia and bipolar disorders fall within the top 30 leading causes of years of life lost due to disability globally. These conditions reduce the chance of employability and independent living of people who are affected and their families. In addition, they experience worse physical health and reduced life expectancy

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<sup>348</sup> Broking J.I., Ritter S. A. H. A text book of Psychiatric and Mental health Nursing. Churchill Livingstone, 2002. p.280

<sup>349</sup> World health Organisation, 2005. Mental health, Facing the Challenges, Building Solutions: Report of the WHO European Ministerial Conference. P. 67

compared to the general population<sup>350</sup> as patients with schizophrenia have increased relative risk for obesity, hypertension, congestive heart failure while patients with affective psychoses have increased risk for diabetes<sup>351, 352</sup>. Therefore these conditions incur huge cost to the health and social care economy<sup>353, 354</sup>. People suffering from mental ill health are at higher risk of committing suicide and having commonly occurring physical co-morbidities<sup>1, 355</sup>. In addition these conditions substantially impose negative emotional, social and economic burdens on those who are affected, their families, carers, and society as a whole<sup>356</sup>. Presence of a mental health disorder is one of the main contributors to health inequalities experienced by specific groups.

## What is the local picture?

### Socioeconomic determinants and lifestyle behaviours (Risk Environment)

Waltham Forest has high levels of risk factors for mental illness. These include high levels of deprivation which is increasing. Waltham Forest has lower employment rates compared to London and England and a larger proportion of Job seekers allowance claimants than London average of (2010). See Table 1 below.

Though the proportion of mental health incapacity benefit claimants in Waltham Forest is below London and national average, proportion of mental health incapacity benefit claimants in 9 out of 20 wards in Waltham Forest (2008/09) is still higher than London and national average.

**Table 1: Headline Labour Market Indicators 2010**

	Waltham Forest		London
	N	%	%
Working age population (16-64 years)	153,300		
Economically active	115,600	73.9%	74.7%
Economically Inactive	40,200	26.1%	25.3%
Employment & Support Allowance/Incapacity benefit claimants	9,900	6.5%	5.8%

<sup>350</sup> De Hert M, Dekker JM, Wood D, et al. (2009) Cardiovascular disease and diabetes in people with severe mental illness position statement from the European Psychiatric Association (EPA), supported by the European Association for the Study of Diabetes (EASD) and the European Society of Cardiology (ESC). *Eur Psychiatry* 24: 412–424

<sup>351</sup> Leucht S, Burkard T, Henderson J, Maj M, Sartorius N: Physical Illness and Schizophrenia. A Review of the literature. *Acta Psychiatrica Scand.* 2007. 116(5): p. 317-33.

<sup>352</sup> Weber NS, Cowan DN, Millikan AM and Niebuhr DW (2009) Psychiatric and general medical conditions co morbid with schizophrenia in the National Hospital Discharge Survey. *Psychiatry Serv* 60: 1059–1067

<sup>353</sup> Carney CP, Jones L, Woolson RF, Medical Co morbidity in Women and Men with Schizophrenia: A Population-Based Controlled Study, *Journal of General Internal Medicine* 2006;21(11):1133–1137

<sup>354</sup> Kilbourne A M, Post E P. et al. Improving Medical Psychiatric Outcomes Among Individuals with Bipolar Disorder: A Randomized Controlled Trial. *Psychiatric Services.* 2008:Volume 59: 760-768

<sup>355</sup> World Health Organisation (WHO) 2003. The Mental health Context: Mental health Policy and Service Guidance Package.

<sup>356</sup> United Teates Printing Office, 2001. Congressional Report: Proceedings and Debates of the 107<sup>th</sup> Congress First Session. Vol 147, Part 15. p. 20899.

Employed	101,000	64.5%	68.1%
JSA (June 2011)	9,193	6.1%	4.2%
Unemployed (model based)	13,000	11.4%	8.7%
Wanting a job	7,600	4.9%	6.4%
Not wanting a job	32,600	21.1%	18.9%

Source: NOMIS Labour Market Profile for Waltham Forest, 2010. NOMIS website 15.07.2011

The proportion of adults using secondary mental health services and known to be in paid employment in 2008/2009 within Waltham Forest was 2.8% which is below the national average of 3.4% and slightly above the London average of 2.5%.

## **Burden of mental health disorders in Waltham Forest**

### **Mental Illness Needs Index (MINI)**

The MINI provides an estimate of mental health issues relative to England and includes admissions related to mental health conditions. The MINI score for Waltham Forest is 1.33 indicating there will be about 30% higher need for mental illness in Waltham Forest than England. The MINI score across the borough ranges from 0.8 to 1.8. Fifteen out of the 20 Wards in Waltham Forest have a score above that of England.

### **Prevalence of mental health conditions in Waltham Forest**

Determining the prevalence of mental health problems remains a challenge. Information on the use of mental health services especially for common mental health problems cannot be relied upon entirely as many people with a mental health problem do not consult a health professional. Only data available at present for depression among people with diabetes &/or CHD. Therefore prevalence estimates have been calculated applying the Annual Psychiatric Morbidity Survey (APMS) 2007, data to specific age groups of WF current population.

Compared to the London average Waltham Forest has a similar prevalence estimate for common mental health disorders (CMD). Therefore prevalence estimates are used to describe the local need related to other conditions. It should be noted that all estimates are based on studies with differing findings, and a range of expert opinions. All these figures should therefore be taken as broad planning assumptions, rather than certain counts.

The prevalence estimate for CMDs for 16-74 yrs is 154 per 1000 and the largest proportion is estimated to be in Walthamstow. Mixed anxiety and depressive disorder is the most common CMD in WF and constituted above 50% of all CMDs in WF; females had higher rates than males; prevalence peaked among 25-34 and 45-54 among females and 16-24 and 45-54 years for males. 11% of the adult population have depression, compared to 11% in London, and 8% in England. The prevalence of generalised anxiety disorder in men, is estimated to be higher in Waltham Forest (3.4%) compared to London (2.6%). Similarly, prevalence estimates

of depressive episodes, all phobias and obsessive compulsive disorder are higher in Waltham Forest than in London.

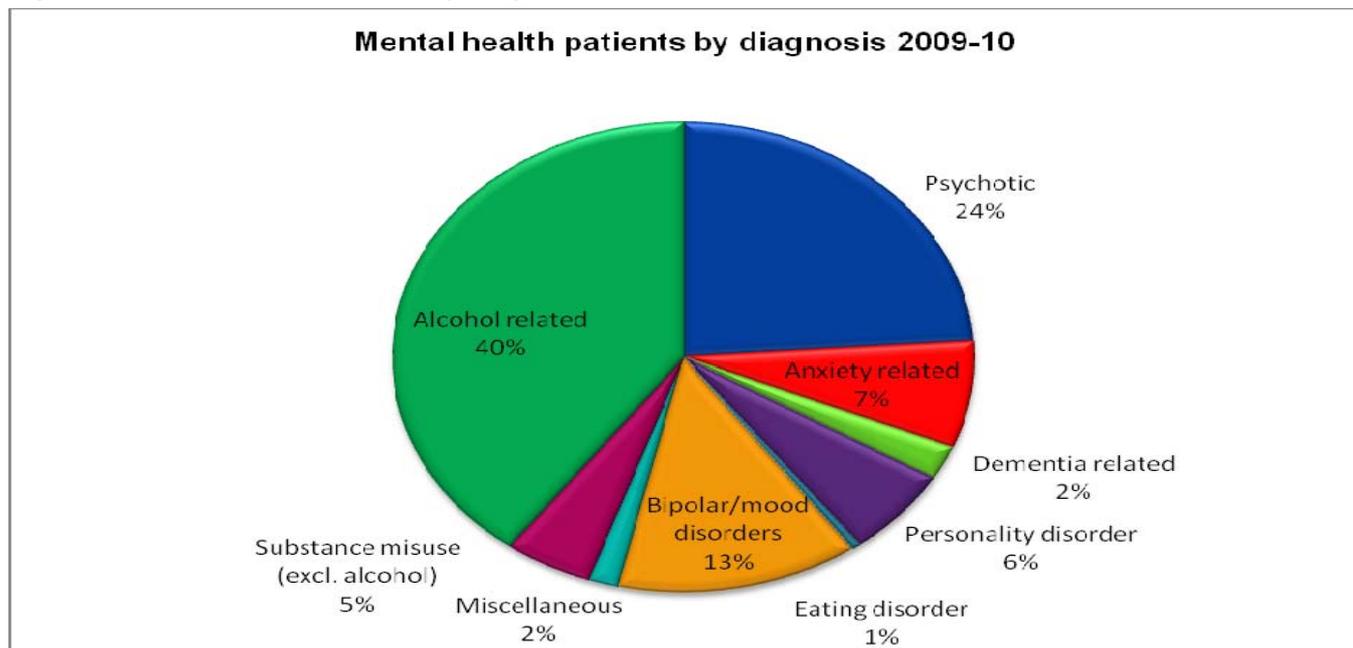
### Reported prevalence of depression among people with diabetes and/or CHD

GP registers for depression among patients with CHD and/or diabetes indicate that the number of CHD and/or diabetes patients with depression increased from 12,787 in 2009/10 to 13,713 in 2010/11 (this is a provisional figure) which is 7.2% increase. This is likely to be due to better detection in 2010/11.

### Prevalence of Mental Disorders in Waltham Forest by Diagnosis at discharge

Another proxy measure that can be used to get an indication of detected mental health conditions is diagnosis at discharge of acute admissions within all providers. Figure 1 shows the proportion of mental health conditions to all acute providers by diagnosis at discharge<sup>357</sup> in 2009/10. Of all mental health conditions psychotic illness and bipolar/mood disorders was the most frequent diagnosis followed by anxiety related disorders and personality disorders<sup>32</sup>. Reflected demand of SMI is likely to be due to inadequate access to appropriate primary or community service provided locally. There is anecdotal evidence that GP registered SMI lists do not reflect all patients treated by NELFT. Examining those patients not registered in primary care will be useful to commission appropriate services closer to home.

Figure 1: Mental health patients by diagnosis



### Primary care mental health services

An estimated 91% of people with mental health problems are cared for entirely within primary care.

The Quality and Outcomes Framework (QOF), requires GPs to monitor and assess the mental health of their patients and to provide high quality care in line with NICE guidance and to meet QOF targets.

Table 2 provides a summary of three QOF achievements in Waltham Forest with exceptions. Of 46 practices, 41 achieved the target for both DEP1 and DEP2. For DEP 3 indicator only 32 practices achieved the target of

<sup>357</sup> London mental health A&E data for Waltham Forest PCT, CSL (2010)

90% for all indicators. In 2010/11 there has been approximately 11% increase in DEP 1, 5% increase in DEP2 and 3% decrease in DEP3. There is need for improvement in follow up for defaulters to reduce variation across practices. Patients not receiving regular review are likely to end up in acute care.

Table 3 shows QOF achievement by locality in 09/10 and 10/11. Leyton/ Leytonstone and Walthamstow achieved the 90% target for DEP1 and Chingford did not in both years. DEP 2 target was achieved by Chingford and Leyton/Leytonstone while Walthamstow did not achieve for both years. For DEP 3 all the localities did not achieve the 90% target in 10/11 with Walthamstow being significantly lower than the other two localities.

**Table 2: Waltham Forest QOF performance for depression among patients with CHD and /or diabetes (2010/11) provisional data**

Indicator	PCT range (%) 09/10 & PCT value in brackets		No of practices achieving the target		PCT range (%) 2010/11		No of practices achieving the target
	Range with exceptions	Range without exceptions	with exceptions	without exceptions	with exceptions	without exceptions	with exceptions
DEP1: % of patients on the diabetes register & /or the CHD register for whom case finding for depression has been undertaken on one occasion previous 15M	76.6 - 99.05 (90.4)	72.9 - 99.1* (87.5)	37	22	68.19 –99.54 (90.58)	65.89 – 98.80 (88.05)	41
DEP2: % (among those patients with a new diagnosis of depression, recorded between the preceding 01/Apr-31/March) who had an assessment of severity	56.5 - 100.0 (92.9)		39	0	53.85 - 100.0* (91.68)	N/A	41
DEP3: % who have had a further assessment of severity 5-12 wks after the initial assessment of severity (DEP2)	8.3 - 100.0 (86.1)		33	0	17.86 - 100.0* (79.52)	N/A	32

- Range excludes one practice

**Table 3: Depression in CHD/Diabetes QoF locality achievement in 2009/10 and provisional 2010/11**

Dep1 (screening)				Dep2 (new diagnosis assessment)			Dep3 ( new diagnosis further assessment of severity 5-12 wks after 1 <sup>st</sup> assessment)		
CCG	QoF target	% 09/10	% 10/11	QOF target	% 09/10	% 10/11	QoF target	% 09/10	% 10/11
Chingford	90%	88.28	86.63	90%	95.40	95.00	90%	89.44	89.64
Leyton Leytonstone	90%	91.50	91.05	90%	96.03	92.02	90%	92.56	86.51
Walthamstow	90%	90.70	92.44	90%	89.01	89.44	90%	78.29	67.36
Waltham Forest	90%	90.41	90.58	90%	92.90	91.68	90%	86.07	79.52

#### **Rate of exceptions for QOF performance on depression in CHD &/or diabetes**

Exception reporting rate for the above indicator in Waltham Forest is not significantly different from national and London rates but slightly higher than ONEL. Chingford had the highest rate compared to other two localities. Chingford had the highest rate among three clinical commissioning groups (CCGs).

#### **Emergency admissions related to CMD**

The four year average for finished consultation episodes (FCE) in Waltham Forest for all CMD by age group from 2007/08 to 2010/11 are benchmarked against England for 4 year average rate/100,000 persons. Waltham Forest's rate was almost twice the rate that for England 47.9 vs 88.5.

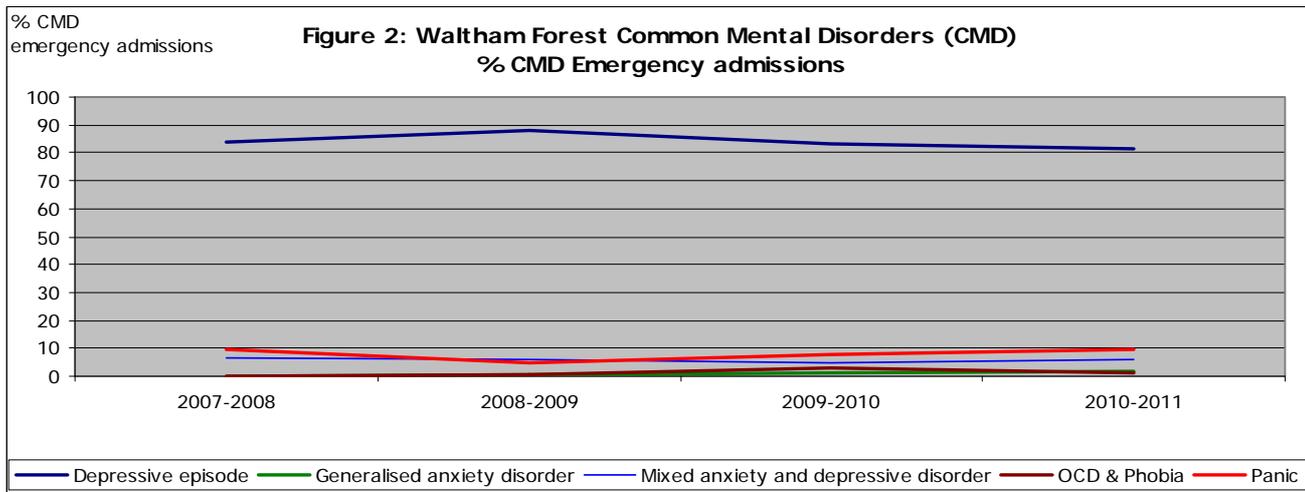
#### **The trend in emergency admissions related to CMD**

The trend in emergency admissions for CMD in Waltham Forest 2007/08 - 2010/11 (Figure 2) shows that depressive episodes (approx 84%) and panic attacks are the most common conditions resulting in emergency admissions consistently across all years with an upward trend from 2008/09. It is important to note that the depression was not the most common condition indicated by prevalence estimates for CMDs. Under-detection of depression in primary care is likely to be partly responsible for higher admissions.

Current QOF indicator requires GPs to screen only those with diabetes and CHD. Evidence shows that people with COPD and heart failure have higher rates of depression. Further, certain other high risk groups including marginalised groups, older people are have a higher predisposition to develop depression. Hence

screening of these groups for timely detection and management is likely to reduce these admissions.

**Figure 2**



**GP registered prevalence of SMI in Waltham Forest**

The actual prevalence of schizophrenia, bipolar affective disorder and other psychoses in Waltham Forest in 2009/10 was 1%, similar to London rate but higher than rates reported for England, and outer north east London sector which were 0.8% each<sup>358</sup>. The total number of patients diagnosed as having any of the psychotic conditions referred above was 2,699, which is an increase of 135 compared to previous year. The APMS identified a need for continued focus on improving early intervention and support for people with a first episode of psychosis to improve clinical outcomes.

**Table 4: GP registered SMI Numbers and % (QOF data 2008-10)**

Level	QOF 2008/09		QOF 2009/10	
	No. with SMI	Prevalence (%)	No. with SMI	Prevalence (%)
England	406,075	0.7	424,223	0.8
London	78,719	0.9	83,405	1.0
NE London	15,908	0.9	16,927	0.9
Outer NE London	5,874	0.8	7,557	0.8
NHS Waltham Forest	2,564	1.0	2,699	1.0

**Primary care QoF performance (QOF 2010/11)**

Waltham Forest achievement of MH9 (92.46%) has declined slightly compared to 2009/10 achievements (93.6%) Table 5 below summarises the QoF achievement of MH6 and MH9 in Waltham Forest in 2010/11. 46

<sup>358</sup> QMAS database - 2008-2009 data as at end of June 2009. The Health and Social Care Information Centre, Prescribing Support Unit.

practices achieved MH 6 and 44 practices achieved MH 9 with exceptions. Without exceptions, 46 practices achieved MH 6 and 13 practices achieved MH 9 which is an improvement compared to last year.

**Table 5: Summary of MH6 and MH9 QoF achievements in Waltham Forest (10/11) provisional data**

Indicator	QOF target	PCT range (%) 09/10 – PCT average in brackets)		No. of practices achieving the target		PCT range (%) 10/11		No. of practices achieving the target	
		with exceptions	without exceptions	with exceptions	without exceptions	with exceptions	without exceptions	with exceptions	without exceptions
MH6: % of patients on the register who have a comprehensive care plan documented in the records agreed between individuals, their family and/or carers as appropriate	50%	60.0-100.0 (89.9)	33.3-100.0 (82.1)	46	43	58.06-100.0 (88.8)	53.73-100.0 (83.01)	46	46
MH9: % of patients with schizophrenia, bipolar affective disorder and other psychoses with a review recorded in the preceding 15M (there should be evidence that the patient has been offered age, gender & health status appropriate routine health promotion and prevention advice.	90%	75.0-100.0 (94.2)	33.3 - 100.0(85.8)	43	12	76.9 - 100.0 (92.46)	66.67 - 100.0 (84.96)	44	13

Source: QMAS web site provisional data (run: 09.06.2011. Data of 06.04.2011 & 20.06.2011

Table 6 shows mental health QoF achievement in GP localities. Over all the 2010/11 achievement had marked improvements apart from MH9 and MH5 (lithium) where there was a slight decline. There were variations in achievements across the borough but Leyton/Leytonstone had the best achievement in MH9, MH4 and MH5 while Chingford had the best achievement in MH7 and Walthamstow in MH6. When compared with the national target Waltham forest has achieved the national QoF target apart from MH5 where Chingford did not achieve the 90% target in both years.

**Table 6: Mental health QoF locality achievements in 2009/10 and 10/11(provisional)**

MH9 (review)				MH6 (care plan)			MH7 (non attend follow-up)		
Locality	QoF target	% 09/10	% 10/11	QoF target	% 09/10	% 10/11	QoF target	% 09/10	% 10/11
Chingford	90%	93.35	91.57	50%	87.75	87.36	90%	94.44	98.77
Leyton Leytonstone	90%	94.12	92.87	50%	86.64	86.73	90%	91.14	94.87
Walthamstow	90%	93.09	92.40	50%	91.50	91.77	90%	85.19	88.52
All	90%	93.58	92.46	50%	88.81	88.88	90%	90.32	94.55

### **Exceptions reporting rate**

The exception reporting rate for SMI in Waltham Forest in 2009/10 was 7% and lower than national and London rates but slightly higher than the ONEL average. Chingford had the highest rate of 9.96% with lowest being in Leyton/Leytonstone at 5.21%.

### **Emergency admissions for severe mental illness**

The trend in admission rates for schizophrenia and delusional disorders shows an upward trend with a slight dip in 2009/10. The rate observed in 2010/11 is four times the rate reported in 2007/08 and markedly higher than 2009/10. This indicates a clear need for redesign of this care pathway to ensure early detection and appropriate management of patients, understand the capacity for early intervention service and Crisis Intervention Team against the current demand.

Previous work undertaken on unscheduled care to identify hot spots with higher A& E attendance and targeted intervention aimed at these postcodes is likely to achieve reductions in this costly use of acute care.

### **Adults and older people in contact with secondary care mental health services**

Number of people in contact with adult and older people secondary care mental health services, excluding inpatient services in 2008/09 was 3306.6 per 100,000 population. This is markedly higher than London rate of 2734.5. However, rates for Crisis Resolution Home Treatment (CRHT) caseload and 'Early Intervention for Psychosis' (EIP) service caseload during 2009/10 were not different from London, 23.6 and 52.0 per 100,000 weighted population<sup>1</sup>.

Further, there are markedly higher admission rates experienced by people with SMI in Waltham Forest. This may be due to a number of factors including a low threshold for admission, or inadequate access to primary or community care services. Therefore this care pathway needs to be reviewed in order to identify gaps in the current care pathway against NICE guidance and best practice models to prioritise service development opportunities to promote quality, reduce variation and improve efficiency.

## **Perinatal mental health**

The risk for women of developing mental health problems in the perinatal period is linked to deprivation, domestic violence, substance misuse, unemployment, newly arrived refugee and asylum seekers.

In 2009/10 Waltham Forest had 4542 maternities and it is suggested that around 10% of women on average (454) will develop post natal depression and 5% (227) will present with more serious mental health issues which may involve self harm or harm to their baby<sup>359</sup>.

## **Suicide and undetermined injury**

The mortality rate for suicide for the 3 years 2007-09 in Waltham Forest was 3.73 per 100,000, lower than London's 4.39 per 100,000 and England's 5.76 per 100,000<sup>360</sup>. All three regions have shown a marked decline compared to 2005-07 rates. Between 2007 and 2009 there were 24 recorded suicides in the borough - 19 in males and 5 in females.

The combined mortality statistics for both suicide and undetermined injuries<sup>14</sup> also shows that overall the rates for Waltham Forest (5.80) are lower than London (7.04) and England (7.85) in the years 2007-09.

In the same period (2007-09) there is a slight decline in the mortality rate for London and England but an increase in Waltham Forest compared to the rates in 2005-07 (Eng (7.89); London (7.49); Waltham Forest (5.21)<sup>14</sup>.

Newham PCT has been commissioned to undertake an annual suicide audit for the Outer North East London Cluster including Waltham Forest.

## **Joint working with the London Borough of Waltham Forest**

The Joint Prevention Strategy developed in 2010 makes particular emphasis on SMI and dementia.

A joint dementia strategy with action plan was developed in 2010. This will be updated in response to recent changes to the national policy.

## **What are the effective interventions?**

### **National Mental Health Strategy**

A new Mental Health Strategy - *No Health without Mental Health* was launched earlier this year (2011)<sup>361</sup>. The strategy sets out six shared objectives to improve the mental health and well-being of the nation, and to improve outcomes for people with mental health problems through high quality services. See table below for the six shared objectives and local action needed to implement the strategy locally. There is need to develop a programme to ensure the actions are implemented locally.

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<sup>359</sup> Waltham Forest Perinatal Mental health Liaison Services report to scrutiny sub-committee, 7<sup>th</sup> January 2009.

<sup>360</sup> Source: © Compendium of Clinical and Health Indicators (March 2011)

<sup>361</sup> Department of health (DoH), 2011.No health without mental health- a new mental health strategy.

	Six Shared Objectives	Actions
1	More people will have good mental health	Prioritise MH in the new Health and Wellbeing Boards
2	More people with mental health problems will recover	Embedding Recovery- Making sure all services and through out the patient pathway have a focus on recovery
3	More people with mental health problems will have good physical health	Reduce health risk behaviour for people with mental illness by improving access to services aimed at improving health: <ul style="list-style-type: none"> <li>• smoking cessation</li> <li>• Weight management</li> <li>• Support to overcome alcohol &amp; drug misuse</li> <li>• physical activities</li> </ul>
4	More people will have a positive experience of care and support	Develop patient centred services and strong user involvement in developing /redesigning services
5	Fewer people will suffer avoidable harm	Reduce self harm and suicide in the borough and improve management of risk, appropriate sharing of information and learning lessons from serious incidents
6	Fewer people will experience stigma and discrimination	Improving public attitudes and reducing the institutionalised discrimination

### Long term mental health conditions (London Model)

The London model of care for long term mental health conditions aims to support and promote wellbeing and recovery through improvements in the quality and delivery of services and improved access to mental health interventions when required. This is due to the distinct challenges with regard to mental health faced by London compared to the rest of the country. These include:

- High levels of deprivation.
- Higher prevalence of psychosis and a higher proportion of mental health admissions.
- Higher than average numbers of people with complex needs including refugees, asylum seekers and people with dual diagnosis of mental illness and drug or alcohol problems.
- Higher spend per head on mental health services with wide variation between different localities.

The principles of the proposed London model of care for long term mental health conditions include<sup>362</sup>:

**Recovery:** to promote and support recovery and to enable those who no longer need specialist services to control the planning and delivery of their own care.

**Appropriate care setting:** to increase the numbers of people whose support is appropriately managed within primary care through the introduction of 'shared care'. This would free up capacity in specialist secondary mental health services to enable quicker access for those who need it.

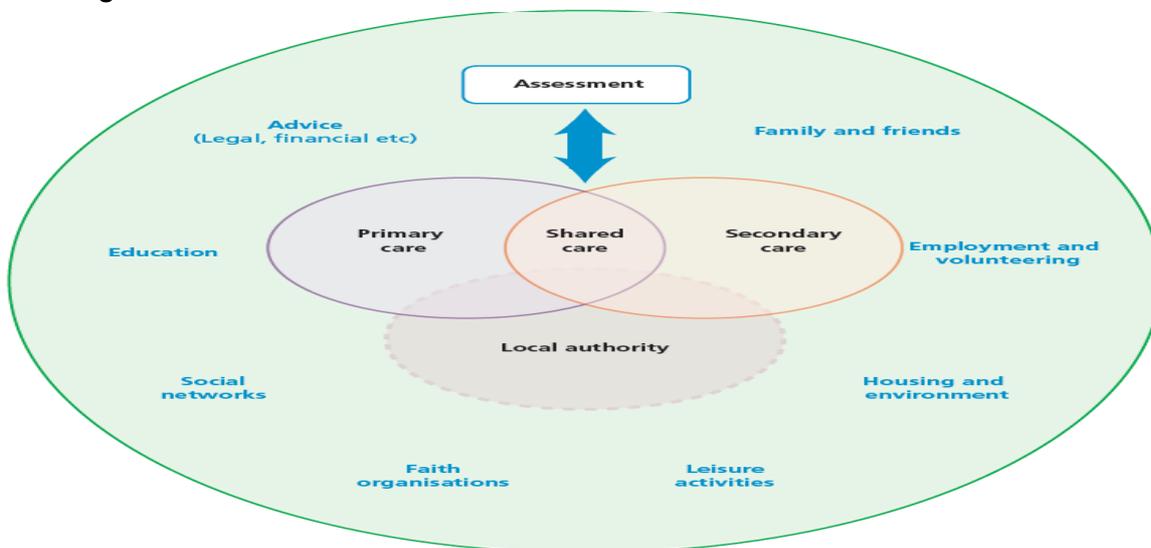
<sup>362</sup> NHS London health programmes: Mental health model of care for London. 2011

**Shared care:** describes a transfer of clinical responsibility to primary care with the support and collaboration of secondary care. By improving the competence and capacity of primary care services, the model is designed to ensure that other health problems, such as physical health, are not neglected.

Moreover, a 'navigator' role is proposed to facilitate access to services available to support people with a range of other issues such as employment and housing, which may well be integral to their recovery.

**Partnership working:** Improved and effective communication and partnership working underpins the model. By working in partnership, it is envisaged that the expertise of the individual, their family members, friends and carers, and a range of relevant professionals, can be harnessed to develop the most appropriate plan for their care.

**Figure 3: Long term mental health conditions London model of care**



### **Strategic vision and approach**

The Mental Health Outcome identified by the Waltham Forest Commissioning Strategic Plan (CSP)<sup>363</sup> is: “The percentage of patients (cared for by GPs) with schizophrenia, bipolar affective disorder and other psychosis with a review recording in the preceding 15 months. The review should be evidence that the patient has been offered routine health promotion and prevention advise appropriate to their age, gender and health status” (MH 09 QOF Indicator).

NHS Waltham Forest has set a Five Year Improvement Trajectory for patients for the above indicator:

- 2008/09 - 91.63%
- 2009/10 - 92.43%
- 2010/11 - 93.13%
- 2011/12 - 94.00%
- 2012/13 - 95.00%

<sup>363</sup> WF CSP

It is important to note that the trajectory for 2010/11 (93.13%) has been already achieved (93.58).

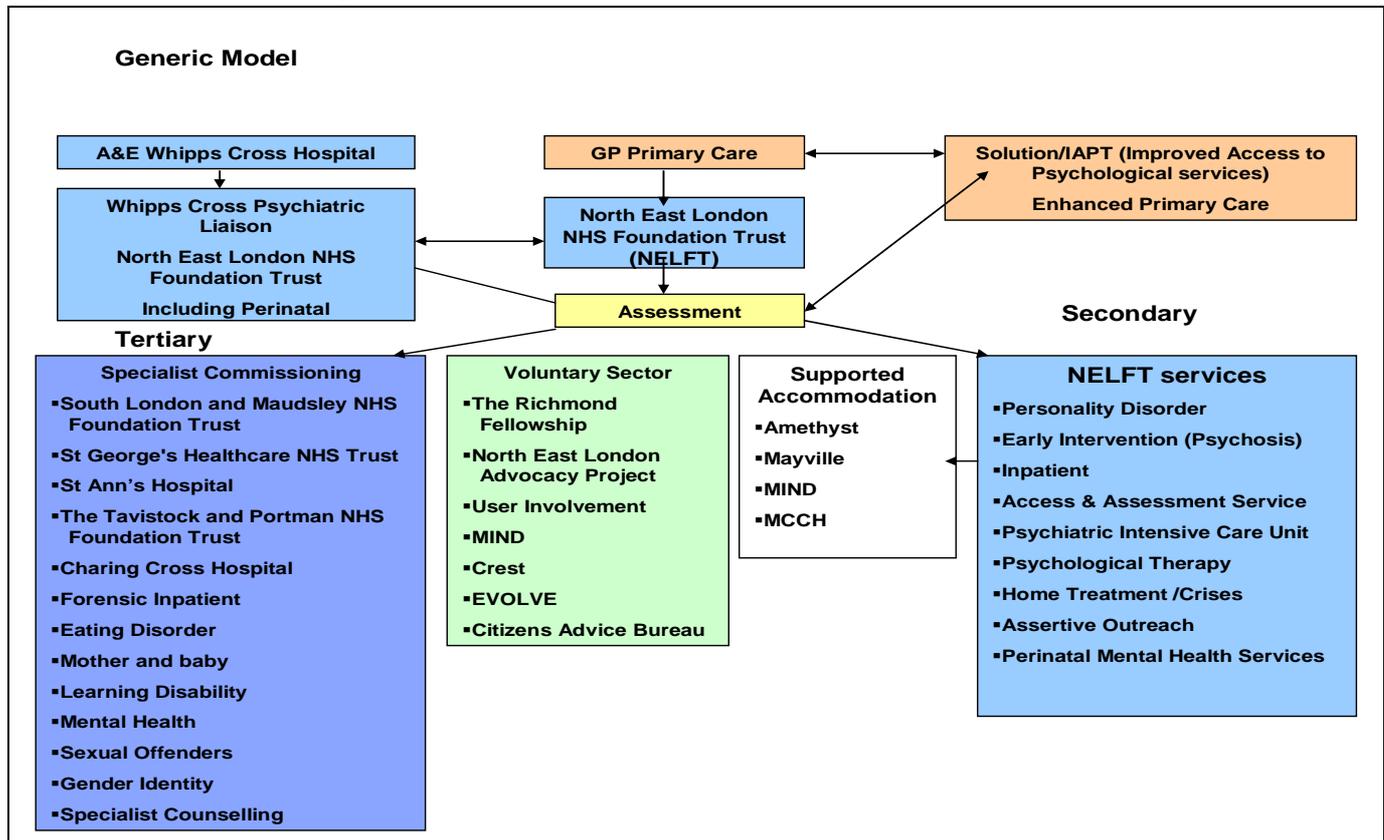
The CSP recommended undertaking full analysis of secondary care services' performance and capacity for value for Money, Quality and Access to inform commissioning priorities with care pathways. It is timely to undertake this analysis.

This is particularly important as the current allocation of resources for mental health in Waltham Forest is mainly within secondary care. Expenditure is around £41,626 million compared to primary care investment of only £1.7 million. This expenditure in primary care is disproportionate to the number of people who access primary care mental health services.

**What is being done locally to address this issue?**

Currently mental health services are being commissioned from a number of providers as shown in the Figure 4 below.

**Figure 4: Current service provision on mental health**



**Community Services**

**Improving Access to Psychological Therapies (IAPT) programme**

The Improving Access to Psychological Therapies (IAPT) programme aims to improve access to psychological therapies, especially relating to people with depression and anxiety disorders.

It also aims to promote a more person-centred approach to therapy and provide NICE recommended therapies. One of the treatments they recommend is Cognitive Behavioural Therapy (CBT). This treatment was

developed from the idea that the way an individual feels is related to the thoughts and belief systems held, and by the individual's behaviour. Based on its clinical efficacy, CBT is the preferred method of therapy within the IAPT programme.

Early Intervention Team and Crisis Resolution team are in place.

### **Solutions IAPT' service**

Aims to provide access to NICE recommended psychological therapies using a stepped care approach in the treatment of mild to moderate depression and anxiety disorders. The route of referral to the service is by self and GP referrals. The service is open to all residents of Waltham Forest registered with a local GP and accepts referrals from anyone from the ages 18 upwards. Referrals are not accepted from those who are already in secondary care services.

The step care approach has two components high and low intensity interventions. Low intensity interventions have a duration of a maximum of 4 hours and focus on these interventions: guided self help, psycho education groups, behavioural activation groups, relaxation groups, bibliotherapy, and computerised CBT.

High intensity interventions are at two levels step 3a up to 8 hours and step 3b up to a maximum of 20 hours of therapy. The therapeutic modalities offered are CBT, Interpersonal Psychotherapy, Dynamic Interpersonal Therapy and Behavioural Couples Therapy but the predominant therapy modality is CBT.

### **EVOLVE**

Community Bridge Building – works with adults aged 18 – 64 years whose mental health difficulties are being treated and managed within Primary Care. The aim of the project is to reduce the risk of social isolation by working with people to help them engage with a meaningful activity or opportunity within their mainstream community. All the relevant life domains are covered and include education, volunteering, employment, sports, arts and community including faith.

All work undertaken has a person-centred focus and has a time boundary whereby the risk of dependency is minimised. Evolve ensures that people from the BME communities are encouraged to access the project and has use of Language Line.

Clients can be referred by their GP, a member of the Primary Care Psychological Practitioners Team or can submit a self-referral.

### **Social care service provision**

The London borough of Waltham Forest social care provides various services that promote wellbeing and support people with mental health problems and their families/carers. This includes:

- Information and Advice Service.
- Individual Advocacy Service.
- Independent Mental Capacity Advocacy (IMCA) Service.

- Waltham Forest Carers Support Groups.
- Learning Disabilities Advocacy Service - Transition (18 -24) & Adults.
- Employment and Support and Health and Wellbeing LD.
- Dementia Support.
- Samaritans of Waltham Forest.

### **Developments in mental health in Waltham Forest**

- A Joint Mental Health Partnership will be established to provide the strategic direction for delivering the mental health agenda locally including multi-stakeholder partnership with clinical leadership, commissioning, and LBWF.
- One of the responsibilities will be to develop local mental health commissioning strategy to align with national and London policies/guidance underpinned by the JSNA.
- Joint prevention strategy across NHS WF and LBWF has identified mental health as a key priority for commissioning.
- Patient and service user engagement has been strengthened by undertaking focus group discussions among high risk groups.

## **Learning Disabilities**

### **Executive Summary**

People with learning disabilities are among the most vulnerable and socially excluded people in Waltham Forest. They are more likely to:

- Have poorer physical and mental health.
- Have difficulties in accessing health care.
- Be at risk of abuse and suffer discrimination.
- Need support to access housing and employment.
- Be at a greater risk of ending up in prison.

There are an estimated 4,046 people with learning disabilities resident in Waltham Forest. Of these, 864 have moderate/severe learning disabilities and 65 have challenging behaviours. Also, 741 people are currently receiving services from the Community Learning Disability Team.

There is a forecast of an increase in the prevalence of people with learning disabilities over the next 10-15 years, with the highest increase being among those with the most severe learning disabilities. In addition, there is a forecast of an increase in the number of young people with learning disabilities entering transition that will require services.

Data recording in both health and social care are not consistent and this makes it difficult to estimate the number of people with learning disabilities in Waltham Forest who have a specific diagnosis or type of learning disability (i.e. complex needs, including behavioural issues, mental health condition, dual diagnosis and complex physical needs) to enable commissioners to map future needs and plan accordingly.

Health and Social Care commissioners require robust data in order to provide a more holistic knowledge and understanding of the current and the future trends of the learning disability population in Waltham Forest.

The following are the Strategic priorities for the Learning Disabilities Service:

- Personalisation - Access to good information, advocacy and person centered planning, choice and control of access to self directed support and individualised budget.
- Supporting Carers.
- Transition into adult life.
- Safeguarding and Community Safety.
- Housing and employment support.

- Good Health.
- Reducing the number of out of borough placements and increasing the opportunity of accessing housing and support locally.

### **Recommendations**

- To commission services in line with the expected increase in the prevalence of people with learning disabilities over the next 10-15 years.
- To continue to commission the Learning Disabilities Direct Enhanced Service (DES) and to ensure that practices are offering high-quality health checks to those who are eligible. To also consider alternative methods of delivering health checks to people with learning disabilities who are registered at practices that have not signed up to the DES.
- To continue to stimulate the local market to ensure that more respite provision is available locally to meet the needs of people with challenging behaviour and autism.
- To understand the demand for and the costs of specialist services to ensure that service provision is delivering value for money.
- To map Out of Borough Placements with specific focus on people with challenging behaviour; people in high –cost placement; people with mental health needs; and people with complex needs.
- To work closer with GPs to improve health outcomes for people with learning disability.
- To work with wider voluntary sector providers to create volunteering opportunities and support people with learning disabilities to get into employments.

### **What are Learning Disabilities?**

A 'learning disability includes the presence of a significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence) with a reduced ability to cope independently (impaired social functioning); which started before adulthood with lasting effect on development'. This definition includes people with autism who also have learning disabilities, but not those with a higher level of autistic spectrum disorder who may be of an average or even above average intelligence, such as some people with Asperger's syndrome. (Valuing People (2001).

This definition encompasses people with a broad range of disabilities. The presence of a low intelligent quotient, for example an IQ below 70, is not, or in itself a sufficient reason for deciding whether an individual should be provided with additional health and social care support.

The World Health Organisation also defines learning disabilities as 'a state of arrested or incomplete development of mind'. Somebody with a learning disability is also said to have 'significant impairment of intellectual functioning'. The presence of a low intelligence quotient [IQ] below 70 is one of several indicators of

learning disability, and 'significant impairment of adaptive/social functioning'. This means that the person will have difficulties understanding, learning and remembering new things, and in generalising any learning to new situations. The term learning disability does not include all those who have a 'learning difficulty' which is more broadly defined in education legislation<sup>364</sup>.

People with learning disability have a range of development needs. Learning disability affects the way a person learns and copes with new things in any area of life. It means it is harder for the person to learn, understand and communicate when compared to other people and it may also mean the individual is more vulnerable to exploitation and abuse. In addition, there may be other needs because of physical disabilities and or sensory impairments.

Due to the wide range of possible needs, people can be assessed with mild, moderate, severe and profound/complex disabilities. The difference between these assessments is the level of help that they need with their daily living.

## **What is the local picture?**

### **Prevalence of learning disabilities**

It is difficult to estimate the number of people with learning disabilities in England. Statistics that are collected tend to relate to the numbers of adults receiving services. Many adults, especially those with mild learning disabilities are not users of specialist learning disability services.

Emerson and Hatton<sup>365</sup> have produced estimates looking at the prevalence of learning disabilities within England using the locally held learning disability registers of 24 Councils with Social Service responsibilities. Using their estimates, the national prevalence is 2% for learning disability.

### **Increasing prevalence**

Factors that are likely to lead to an increase in the prevalence rates for adults with learning disabilities over the next two decades are:

- An increase in proportion of younger English adults who belong to Bangladeshi and Pakistani communities.
- South Asian minority ethnic communities (as evidence suggests a two to three-fold increase in severe learning disability).
- Increase in the survival rates among young people with severe and complex disabilities.
- Reduction in the mortality rate among older adults with learning disabilities.

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<sup>364</sup> DOH (2001) Valuing people: a new strategy for learning disability for the 21st century

<sup>365</sup> Emerson E and Hatton c (2008) 'People with Learning Disabilities in England' Centre for Disability Research

The Department of Health website provides a source of information based on independent research and Census figures (2001) [www.pansi.org.uk](http://www.pansi.org.uk). The site provides an estimate of the number of people in Waltham Forest affected by different level of learning disabilities.

<b>Age 18+</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>
LD Waltham Forest Baseline	4,046	4,050	4,063	4,068	4,080
Severe Learning Disability	215	217	221	229	236
Moderate/Severe Learning Disability	864	878	898	932	962
Challenging Behaviour	65	66	67	68	69
Autism Spectrum	1,464	1,472	1,485	1,510	1,531
Down's Syndrome	91	92	93	94	95
Down's Syndrome & Dementia	3	4	4	4	4
People with Learning Disability living with a parent	320	320	322	334	345

Source: PANSI 2011

### **Age profile**

The largest number of People with Learning Disabilities (PLD) in Waltham Forest are aged between 25 - 54 (See Figure 6.20), indicating a future increase of older people with Learning Disabilities. An increase in age related illness such as dementia in the next 10 to 20 years can therefore be predicted.

The percentage of PLD over the age of 65 of the older population in Waltham Forest is 0.3%. This is predicted to increase by 1.5% by 2015 and to double by 2020<sup>366</sup> due to increase in life expectancy among PLD. Given these improvements, it is estimated that over a third of all people with learning disabilities will be over 50 years of age by 2020<sup>367</sup>.

### **Diversity**

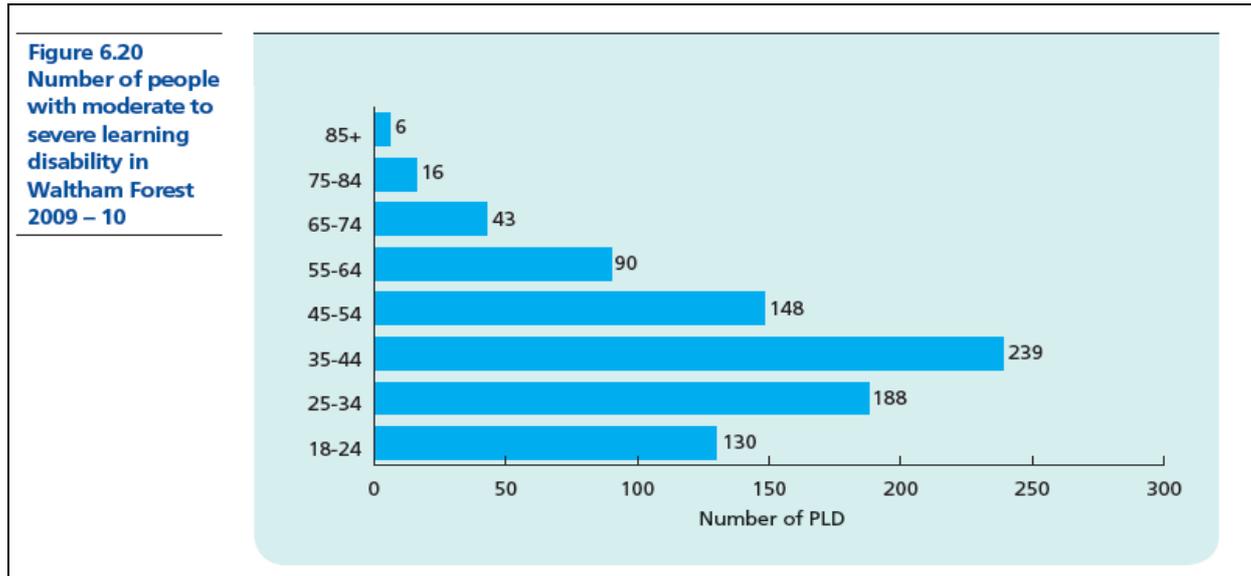
Leyton /Leytonstone (39%) and Walthamstow (38%) have a higher number of PLD from BME groups compared to Chingford (20%). This data is from the DES for GP health checks and 44% of PLD who received health checks were from BME groups.

There were 561 with learning disabilities aged 18+ years recorded on GP practices' QOF registers in 2010/11.

<sup>366</sup> Janicki M P & Dalton, A J (2000) Prevalence of dementia and the impact on intellectual disability services "Mental Retardation 38, 277-288

<sup>367</sup> McConkey, R., Mulvany, F. and Barron, S. (2006) Adult persons with an intellectual disability on the island of Ireland. Journal of Intellectual Disability Research, 50, 227-236

The number of people with learning disability (PLD) with moderate to severe learning disabilities in Waltham Forest is estimated to be 864. This figure is projected to rise to 962 by 2015<sup>368</sup>.



Source: QoF 2009/2010

GP practices' records of prevalence of learning disabilities) shows that the largest number of PLD is in Walthamstow (434), followed by Leyton/Leytonstone (344) and Chingford (87).

### Transition

The number of PLD turning 18 shows a decrease by year 2010 – 36; 2011 – 29; 2012 -22; 2013 -16; and 2014 – 10 (source: children with disability services in Waltham Forest), These data are based on children who are known to the services and may not reflect the true picture. Predictions are based on available and reasonable information, but cannot be absolutely precise, as individual and family needs change over time.

### Mortality

Nationally, respiratory disease accounts for 46% to 52% of deaths among PLD, which is higher than that of the general population between 15% and 17%. It is the highest cause of death among PLD. People with Down's syndrome are particularly at risk because they have a predisposition to lung abnormalities, a poor immune system and a tendency to breathe through their mouth.

CHD is the second most common cause of death among PLD. PLD are more likely to develop hypertension and obesity and they also suffer from lack of exercise, all of which increase the risk of Ischaemic heart disease (14%-20%). Between 40 and 50% of people with Down's syndrome is affected by congenital heart defects. In Waltham Forest 6% of those who had the annual health checks were found to have heart disease.

Smoking rates among PLD have been reported to be comparable to those in the general population or even higher. Smoking is higher among people with mild/moderate learning disabilities and this is mostly among

<sup>368</sup> Office of National Statistics 2011

those who live in private households<sup>369</sup>.

### **Long-term conditions among PLD**

PLD experience a higher prevalence of health conditions/risk factors compared to the general population. For example:

- Obesity - 1 in 3 PLD.
- CHD - 2nd most common cause of death.
- Respiratory disease - 3 times higher than the general population.
- Dementia - 4 times higher than the general population.
- Epilepsy - 20 times more common among PLD.
- Sudden unexplained death in epilepsy - 5 times more common in PLD than in others with epilepsy.

Other major health problems among PLD include:

- Sensory impairment.
- Osteoporosis.
- Hypothyroidism (particularly in Down's syndrome).
- Mental Illness and Challenging Behaviours and early onset of dementia.
- Poor oral health.
- Gastrointestinal disorders (e.g. gastro-oesophageal reflux disease).
- Cancer (particularly gastrointestinal cancers).

Annual health checks for people with learning disabilities were introduced in 2008 as part of a Directed Enhanced Service (DES) In Waltham Forest. Of the 49 practices, 40 practices signed up and are trained to carry out annual health checks.

Out of the estimated numbers of 864 PLD in Waltham Forest, 468 PLD attended the annual health checks. The breakdown of numbers of PLD with long-term conditions by the GP Commissioning Boards is given in Figure 6.21 below.

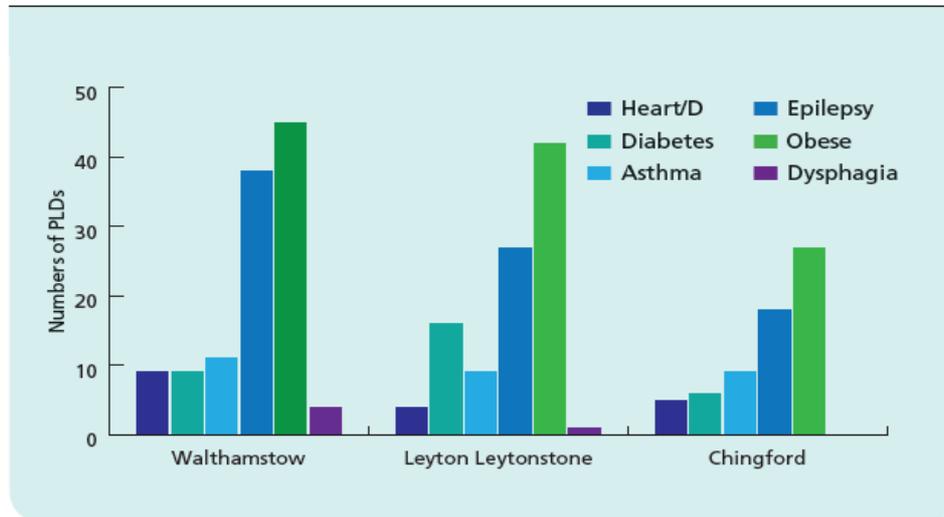
Walthamstow has more cases of heart disease than Leyton/Leytonstone and Chingford. This analysis must be treated with caution as it is only based on those PLD who attended the annual health check.

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<sup>369</sup> Background evidence for the DRC's formal investigation into health inequalities, 2006

**Figure 6.21**  
**Number of PLD by**  
**disease**

Source: Data from G.P records in Waltham Forest (2010)



About one person in three with a learning disability is obese compared to one in five of the general population. 80% of this group of people do less physical exercise than is recommended<sup>370</sup>. 35% of those who had health check in Waltham Forest fall into the obese category, which increases the risk of circulatory disease, Type 2 diabetes and cancer.

PLD are at a higher risk of developing diabetes than the wider population. The DES found 9% of the PLD to have diabetes in Waltham Forest.

The local DES found out that 8% of PLD suffer from asthma while other respiratory diseases were not recorded. Asthma appears to be relatively the same in all localities.

PLD have a much higher risk of developing epilepsy, particularly if they have severe learning disabilities. Nearly one in four (22%) have epilepsy compared with 1% of the general population. This figure is in line with the Waltham Forest findings. Of those who had the annual health check 22% were found to have epilepsy. Epilepsy is higher in Walthamstow.

PLD have a higher risk of developing dementia compared to the general population, with a significantly increased risk for people with Down's syndrome and at a much earlier age. About 20% of people with a learning disability have Down's syndrome, Dementia prevalence rates have been estimated at ten (with some studies as high as 25) in 100 people at 40 years of age, 36 in 100 people at 50 years and 50 - 65 people in 100 at age 60+. For those who have learning disabilities and do not have Down's syndrome, the prevalence rate is increased over the general population but at lower percentages than PDL with Down's syndrome. This approaches a level that is 4 times as great as the general population<sup>371</sup>. Waltham Forest has 92 people with Down's syndrome, 29 of those are between the ages of 45-64 and out the 29, 5 suffer from dementia.

<sup>370</sup> Equal Treatment: Closing the Gap Interim Report, Disability Rights Commission

<sup>371</sup> Hutchinson N (2008) People with Learning Disability and Dementia

Of the PLD who had the annual health check in Waltham Forest, 35% were having care provided by older carers. Given that PLD are living longer and most require more than 50 hours a week of care, plans will be required for a number of PLD who may need their care provided by paid carers in future.

### **Challenging behaviour**

People with all levels of learning disability and complex needs may display challenging behaviour. Emerson et al<sup>372</sup> found that people identified as having challenging behaviour were more likely to have additional health and social care needs such as restricted mobility (24%), visual impairment (15%), not fully continent (38%) or a need for assistance when washing (70%). Findings in the studies of prevalence in challenging behaviour in people with learning disability vary widely, reporting rates of between 5.7%<sup>373</sup> and 14%<sup>374</sup>. The overall prevalence increases with age during childhood, reaches a peak during the age range of between 15 - 34 years and then declines. The Office of National Statistics<sup>375</sup> estimates that 4% of PLD between the ages of 18 and 64 in England have challenging behaviour. PLD with challenging behaviour in Waltham Forest is 4.2% of those between ages 18 and 64 and this is similar to that of England. Prevalence across age groups is fairly equal, with the exception of a small increase between 25 to 44 years.

### **Complex health needs**

People who have a learning disability and Complex Health Needs are diverse. In Waltham Forest 4% of PLD fall into the complex needs category.

### **What are the effective interventions?**

There are several government policies and service development frameworks that influence attitudes and services for people with learning disabilities. These policies and frameworks focus on promoting and delivery advocacy, employment support, person-centred planning, quality of life, effective transitions from children to adult services, improved support for families and partnership working to improve the lives of people with learning disabilities. A few of the policy drivers are summarised below.

**Valuing People (DH:2001)** – The White Paper sets out the Government’s commitment to improving the life chances of people with learning disabilities, through close partnership working to enable people with learning disabilities to live full and active lives.

**Valuing People Now (DH:2009)** – retained the principle outlined in Valuing People that people with learning disabilities are people first, and re-emphasised the need for agencies to work together to achieve the best outcomes for people with learning disabilities.

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<sup>372</sup> Emerson E and Hatton C (2008) ‘People with Learning Disabilities in England’, Centre for Disability Research

<sup>373</sup> Qureshi, H. & Alborz, A. (1992) Epidemiology of challenging behaviour. *Mental Handicap Research*, 5, 130-145

<sup>374</sup> Borthwick-Duffy, S. A. (1994) Prevalence of destructive behaviours. In *Destructive Behaviour in Developmental Disabilities: Diagnosis and Treatment* (eds T. Thompson & D. B. Gray), pp. 3–23. Thousand Oaks, CA: Sage.

<sup>375</sup> Office of National Statistics 2009

**Valuing Employment Now (2009)** – sets out the government’s strategy to improve employment opportunities for people with learning disabilities.

**Our Health, Our Care, Our Say (DH: 2006)** – sets out the Government’s’ idea for the future direction of health and social care community services.

**Health Care for All (2008)** – the report of the independent inquiry into Death by Indifference concluded that people with learning disabilities appear to receive less effective care than they are entitled to, with evidence of a significant level of avoidable suffering and a high likelihood that deaths are occurring that could be avoided. A total of 10 recommendations were made, all of which were accepted by the Department of Health and Valuing People Now.

**Six Lives (2009) Ombudsman Report** – the report of the Health Ombudsman into the cases highlighted in Death by Indifference highlighted some significant and distressing failures in health and social care services, leading to situations where people with learning disabilities experienced prolonged suffering and inappropriate care.

**The Autism Act 2009 and Fulfilling and Rewarding Lives** – sets a clear framework for all mainstream services across the public sector to work together for adults with autism.

The key themes and national priorities for people with learning disabilities are as follows:

**Personalisation:** to ensure that people have real choice and control over their lives and the services they receive.

**Meaningful Day Opportunities:** to ensure that people are included in their communities with a focus on increased independence and being in paid work.

**Fair Access to Health:** to ensure that people have full and equal access to good quality healthcare for both physical and mental well being from NHS.

**Access to housing:** to ensure that people have options for housing and with a focus on home ownership and tenancies.

**Make change happen:** to ensure that partnership boards are more effective in delivering policies.

### **What is being done locally to address this issue?**

**Prevention and Access to Universal Services:** Preventive services focus on providing information, advice and advocacy support to people with learning disabilities to enable them to enjoy independent living.

Waltham Forest commissioned Learning Disabilities Advocacy Service through a collaborative arrangement. The services commissioned included one to one advocacy, complex and high support professional advocacy, service users inclusion service (People First), Learning Disability Experience and Service Users Forum.

Waltham Forest also provides an advocacy support to young people (18-24) going through transition; these services empower young people through person-centred planning, independent and healthy living activities, community participation and development of friendships and relationships.

**Supporting Carers:** Support for carers is a key part of support for vulnerable people. Support for carers also enables carers to continue with their lives, families, work and contribution to their community. Carers are able to access a range of services including low level preventive services to empower and enable them to have breaks.

**Short Break (respite) Services:** are available to people with learning disability through the Council's in-house respite care service and from independent providers. Respite care describes separate periods of care for people with learning disability if they, or their carer, need a short-term break. Respite care can also be provided in an emergency such as illness.

**Self Directed Support:** Self Directed Support is seen as being at the centre of personalisation. It is about giving people who use care and support services more choice and control over the support services they require. It enables people to take control of their own individual budget from which to commission and procure the care and support they feel will meet their individual needs.

People with Learning Disabilities also have access to Support Planning and Brokerage Services that will support them to set the outcomes they wish to achieve and plan how to spend their individualised budget. The service also supports individuals to arrange the services they require through a support broker.

**Community Learning Disability Team:** is a multi-disciplinary and multi-agency team that include a range of professionals (including consultant psychiatrist, community learning disability nurse, social worker, welfare rights officer, physiotherapist, occupational therapist, speech and language therapist, clinical psychologist and administrative support) and act as the gate-keeper to services for adults with a learning disability living in Waltham Forest. In 2010/11, 109 individuals were supported by the community learning disability nurses.

**Supporting People:** funds housing support services, housing support services are intended to help people live independently in their own homes and provide early intervention and preventive services e.g. to prevent homelessness. These services are not intended to provide care services or to maintain people in their own homes by doing things for them.

**Supported Living:** Supported living offers people with learning disability the opportunity to live in their own home in the community and to lead active, socially inclusive lives. The support is designed individually, with the active participation of the person to be supported and those who know them best. It focuses on what people can do, provides support for things people cannot do, and creates opportunities for people to learn how to do things they want to do.

Most importantly supported living offers choices to people about where they live; who they live with, if anyone; what support is required and who offers it. Supported living has the potential to ensure that each individual's needs wishes and aspirations are met in a way, which suits them, and the lifestyle they want to lead. Approximately, 90 service users are currently been supported in Supported Housing in Waltham Forest.

**Day Opportunities:** Day Opportunities services are available for people with learning disabilities through the Joint Community Day Services. The services comprise of Day Services for Asian Women, Supported Employment Project and Sidmouth House (activities based centre). Day Opportunities services are also available from 247 Markhouse Road for people with Learning Disabilities. There is also a voluntary sector organisation that provides Day Opportunities namely Ellingham Employment services. It provides employment opportunities for people with Learning Disabilities. Opportunities available include coaching, life skills and volunteering opportunities, all these contribute towards improving the health and wellbeing of people with learning disabilities.

**Residential/Nursing Care:** The policy drive at both national and local level is to move away from residential care provision for people with learning disabilities. In Waltham Forest a considerable percentage of service users are still placed in residential care, the total number of both in and out of borough placements is 205. This represents approximately 37% of people receiving services from the Community Mental Health Team.

One of our strategic priorities is to reduce the use of residential care and the strategic approach will be outlined in the commissioning strategy for people with learning disabilities which will be produced shortly.

All the block residential care contracts have been converted into spot contracts. In addition, three residential care homes are been remodelled into supported living using the Individual Service Fund model.

**Equalities:** It is broadly recognised that people with learning disabilities experience inequality in service provision and social outcomes when compared with people without learning disabilities. They also experience poor health, risk of early death and significant discrimination in accessing health care facilities, diagnosis and treatment as highlighted in the March 2007 Mencap report, '*Death by indifference*'. The report accused the health services of institutional discrimination that led to people with a learning disability receiving worse health care than non-disabled people.

Waltham Forest embraces the principles of equality and celebrates the diversity of Waltham Forest's communities. Waltham Forest therefore will:

- Monitor performance against local population to ensure that policies and work practices meet the needs of the different communities.
- Reduce barriers to services in terms of gender, disabilities, race, religion, sexuality and age.
- Monitor service delivery to ensure equal access for all people requiring services.
- Monitor take up of services.
- Train staff to recognise diversity, promote equality and inclusiveness.

An Equality Impact Assessment will be carried out as part of the development of the Learning Disability Commissioning Strategy.

**Safeguarding:** Waltham Forest and all partner agencies aim to protect and promote individual rights, independence and well being. This also includes an assurance that vulnerable people are safe and are safeguarded against abuse, neglect, discrimination and poor treatment. And, that they are treated with dignity, respect and enjoy a high quality of life. The Safeguarding process is detailed in the Safeguarding Operational Guidance Manual. The manual outlines the roles and responsibilities of care management, commissioners, providers and other agencies.

#### **What evidence is there that we are making a difference?**

The impact of service provision for people with learning difficulties is measured against a number of key targets and indicators. Key national-level indicators include:

- National Indicator 145:- Adults with learning disabilities in settled accommodation.
- National Indicator 146: - Adults with learning disabilities in employment.

In 2010/11 performance data showed only 204 of adults with learning disabilities in settled accommodation out of the recorded data on Framework (social care database). During the same period, only 79 adults with learning disabilities were in employment, this figure represents approximately 13% of those known to the Community Learning Disability Team. 42 out of the 47 GP practices have a Quality and Outcome Framework Learning Disabilities register. The same number have also signed up to the Learning Disabilities DES that requires practices to offer annual health checks to people with learning disabilities that are known to Adult Social Care and Health Service. In 2010/11, 408 out of 780 people with Learning Disabilities who registered on GP registers received a health check, this is approximately 52%. There are specific issues with data recording and authenticity of some of the data as there are either under or over estimation of data due to the fact that data were not routinely and accurately updated or cleansed.

The table below shows the type and number of people with learning disabilities who received services in 2010/11.

Service Type	Number of people
Community Nurses	109
OT	49
Home Care (brokerage)	22
Residential Care (out of borough)	111
Residential Care (in borough)	94
Day Opportunities (In-House)	145
Day Opportunities (Spots)	46
Supported Living Accommodation (in borough)	90
Supported Living Accommodation(out of borough)	9
Floating Support	60
Direct payment/Individual Budget	102

Sources of Data: The data has been collated from various sources, these include LP12 Review reports; activities returns for NI145 and 146; Finance database; service area records; and GP registers.

### **What is the perspective of the public on support available to them?**

Learning Disability Partnership provides a platform for a regular dialogue with people with learning disabilities and their carers to inform the board about their experiences and to discuss issues they face in accessing services. It is also a local forum to enable users and carers to have a say and for commissioners to gain insights into their needs and aspirations.

### **What more do we need to know?**

Waltham Forest signed up to the Learning Disabilities and Self Assessment Framework which requires all providers to evidence how they identify and effectively engage with people with learning disabilities and where there are poor performance to demonstrate how they will improve. This is independently validated by NHS London.

The Self Assessment Framework outlines four main Top Targets and Key Objectives to be assessed. These include:

- 1) People who are or who were formerly in NHS provided long term care have settled accommodation that reflect their Person-Centre Plans and there is a system in place to ensure minimum annual review.
- 2) Health and Social Care commissioners are working closely with local Partnership Boards, statutory organisations and other partners to address the health inequalities faced by people with learning disabilities.
- 3) People with learning disabilities who are in services that the NHS commissions or provides are safe.
- 4) Progress is being made in developing local services for those needing more help with their health.

Every year the NHS holds local events to assess the experiences of people with learning disabilities and their carers. The outcomes of these events inform the performance of Waltham Forest on the four top key targets and objectives areas. These are submitted to NHS London who validate and confirm the local scoring.

In 2010, Waltham Forest scored one RED and three AMBERS; the RED score was due to one person still living in a long stay NHS bed. However, in 2011, the scoring has improved to one GREEN and three AMBERS. This shows that Waltham Forest still has areas that need improvement as shown in the chart below.

TARGET	2010 VALIDATED OUTCOME	2011 VALIDATED OUTCOME
TARGET 1	RED	GREEN
TARGET 2	AMBER	AMBER
TARGET 3	AMBER	AMBER
TARGET 4	AMBER	AMBER

### What are the priorities for improvement over the next 5 years?

Estimates suggest that the prevalence of people with learning disabilities will increase in the next few years; this is driven by three main factors (Emerson and Hatton 2004):

- The increase in proportion of younger adults who belong to South Asian communities, as these communities have a higher prevalence of severe learning disabilities.
- Increased survival rates among young people with severe and complex disabilities.
- Increased longevity among adults with learning disabilities, due to improvements in medical care and reduced mortality.

With this in mind, the priorities for the next 5 years include;

- To commission services in line with the expected increase in prevalence of people with learning difficulties over the next five years.
- Improve the quality of primary care learning disability register, ensuring that there are systems in place to ensure services are reasonably adjusted to meet the health needs of people with complex needs.
- To ensure that all the Key Targets and Objectives in the Self Assessment Framework are met and to ensure that there is continued improvement in services for people with learning disabilities.
- To help people with learning disabilities to understand personalisation and individualised budget, how to spend their budgets and what choice and control mean to them.
- Partnership working to address health inequalities and engaging with people with learning disabilities who have complex needs and involving them in making choices about their health.
- Encourage uptake of annual health checks and improve access to screening services and other services in line with Valuing People, Six Lives and Health Care for All recommendation.
- Strengthen partnership working and develop closer relationship with the voluntary sector to promote health and the wellbeing of PLD.
- Develop services to meet the needs of people with learning disabilities locally.
- Develop better well co-ordinated systems to plan for young people going through transition to adult services.

# Section 7

## sexual health and infectious diseases



- Sexual Health
- Tuberculosis (TB)

## **Sexual Health**

### **Executive Summary**

Sexual health is influenced by a number of factors including sexual behaviour and attitudes. Unprotected sex, sometimes influenced by excessive drug and alcohol use are risk factors for sexual ill-health.

There are high rates of Sexually Transmitted Infections (STIs), HIV and late HIV diagnoses in Waltham Forest. This could be linked to lack of sustained health promotion and prevention interventions; and inadequate HIV testing initiatives. Waltham Forest has high rates of abortion and repeat abortions. This indicates high rates of unprotected sex and suggests lack of awareness of, or inadequate contraception services. Waltham Forest has lower rates of GP prescribed Long Acting Reversible Contraception (LARC) compared to London and England.

Community sexual and reproductive health clinics are not equitably located within the borough; and the locations are not necessarily linked to need. As with other parts of the country, teenage pregnancy rates in Waltham Forest are associated with deprivation - areas with high deprivation generally have high rates of teenage pregnancy. Teenage pregnancy rates in Waltham Forest are falling but remain higher than London and England rates. Higham Hill, Lea Bridge, Cathall and Leyton are among the 20% of wards with the highest teenage pregnancy rates. Young people in Waltham Forest have identified a number of barriers to accessing sexual health and contraception services, including service location, opening times.

### **Recommendations**

1. The Waltham Forest Young People's Plan should consider strategies to tackle teenage pregnancy alongside child poverty and low educational attainment with particular emphasis on areas with the highest rates.
2. Develop evidence based sexual health promotion / prevention activities to raise awareness of risk factors for STIs, HIV and unwanted pregnancy, and services available to help reduce STI rates.
3. Develop systems to publicise Emergency Hormonal Contraception (EHC) pharmacies and increase the provision of LARC through outreach, to increase access to young people. Put systems in place to systematically record LARC and EHC use in all services in order to assess the impact of increasing LARC on EHC use.
4. Address barriers to young people's access to primary care sexual health provision in order to increase uptake of Chlamydia screening and other sexual health services in primary care to reduce the over reliance on outreach.
5. Review the closure of young people's sexual health clinics to ensure that young people's access to services is not compromised.

6. Set up point of care testing (POCT) service for diagnosing HIV infection (i.e. providing comprehensive HIV counselling and screening for HIV infection, at the point at which an individual accesses healthcare, such as primary care and non-traditional settings including the voluntary sector).
7. Plan for the future of Sex and Relationships Education (SRE) provision in the borough post March 2012, as the Healthy Schools Programme (which includes SRE provision) will end in March 2012.

## **What is Sexual Health?**

According to the World Health Organisation:

*“Sexual health is a state of physical, mental and social well-being in relation to sexuality. It requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence.”<sup>376</sup>*

Sexual health is influenced by a number of factors including sexual behaviour and attitudes. Sexual ill-health includes the problems of sexually transmitted infections (STIs) and human immunodeficiency virus (HIV), unintended pregnancy and abortion, and infertility, among others.

STIs and HIV are a significant public health concern; and can cause a range of illnesses which may lead to premature death. Unwanted pregnancy has a significant impact on individuals, especially young people; and termination can have long-term physical and psychological effects, leading to further health problems in the future. Teenage pregnancy often leads to poor health and social outcomes for the mother and baby.

## **Risk Factors**

- Unprotected sex is the major risk factor for the transmission of STIs. Risky behaviours such as frequent or excessive alcohol and drug use are associated with unprotected sex.
- In the UK those at higher risk of unprotected sex and STIs are young people, men who have sex with men, and Black Africans.
- Teenage conceptions are often associated with high levels of deprivation.
- Injection drug users are also at high-risk for some STIs, through the sharing of needles.

## **Local Picture**

### **STIs**

Waltham Forest has high rates of acute STI diagnoses – the highest within the outer north east London sector – and higher than the London average. The highest rates of STIs in Waltham Forest continue to be in Chlamydia, with the lowest rates in Syphilis. In 2010 there were 1362.8 acute STI diagnoses per 100,000 population in Waltham Forest compared to an average of 1196.0 in London.

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<sup>376</sup> [http://www.who.int/topics/sexual\\_health/en/](http://www.who.int/topics/sexual_health/en/)

The current indicator measured for Chlamydia is the percentage of the population of young people aged 15 – 24 tested. The 2010/11 Vital Signs Indicator (VSI) was to test 35% of all 15 – 24 year olds in healthcare and non healthcare settings, excluding genito urinary medicine (GUM) activity. In outer north east London Waltham Forest and Barking & Dagenham achieved the 35% target; Redbridge (34.6%) narrowly missed while Havering (20.6) achieved well below the target.

There will be a new indicator from 2012/13 around Positivity. The National Chlamydia Screening Programme recommends a focus on achieving a diagnostic rate of between 2,400/100,000 and 3,000/100,000 (2.4% to 3.0%) in 2011/12, in readiness for the introduction of these new outcome measures in 2012/13 (anticipated to be set at a minimum of 2,400/100,000). In 2010/11 the positivity rate for Waltham Forest was 3.5%, which would meet the new positivity target.

It is recommended that 60% of Chlamydia tests are performed by core services (GPs, Pharmacies, Community Sexual and Reproductive Health clinics) and 40% by outreach. However, in 2010/11 over 80% of the tests in Waltham Forest were performed through outreach, with less than 20% through core services. The challenge is to increase the number of screens through core services.

## **HIV/AIDS**

Overall the main route of HIV infection in Waltham Forest is heterosexual sex. However, amongst males, sex between men is the main route of infection.

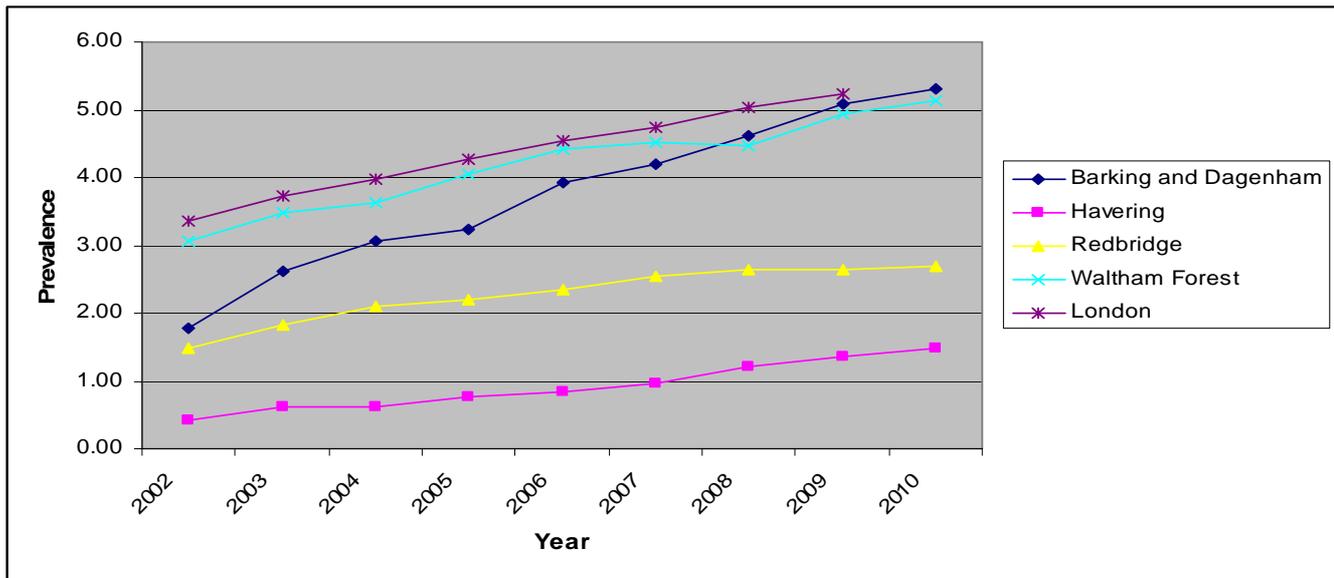
The prevalence of HIV in Waltham Forest is highest among Black Africans. There are variations in the ethnicities of numbers of people diagnosed with HIV in Waltham Forest. Amongst males, the majority are Whites but amongst females Black Africans are the majority.

Almost half (49%) of persons living with HIV in Waltham Forest in 2009 were from the E17 area. This has implications for the targeting of prevention interventions.

Figure 1 sets out the trends in prevalence of people living with HIV within the Outer North East London sector. The prevalence in all the PCTs has been rising throughout that period, in line with London and national trends. However, rates in outer north east London PCTs are below London rates. Waltham Forest had the highest rate within the sector initially but since 2008 rates in Barking and Dagenham have become higher.

In terms of numbers, there were 433 people aged 15 – 59 years living with HIV in Waltham Forest in 2002. By 2010 this had risen to 753, and increase of 74%.

**Figure 1: Prevalence (rate per 1,000 population) of diagnosed HIV among persons aged 15 to 59 years, 2002 to 2010**



Source: HPA

Late diagnosis of HIV infection results in significantly increased morbidity and early mortality, as well as the risk of unknowingly transmitting infection, all of which are preventable.<sup>377</sup> Late diagnosis was previously defined as having a CD4 count of less than 200/mm<sup>3</sup> within three months of diagnosis. This is now classified as very late diagnosis, while late diagnosis is now defined as CD4 count less than 350/mm<sup>3</sup>.

The NHS London target for late HIV diagnosis is for each PCT to reduce its late diagnoses to 15% by 2010/11. In 2009, the percentage of newly diagnosed HIV cases with CD4 cell count less than 200/mm<sup>3</sup> at time of diagnosis was 34.1% among residents of Waltham Forest compared to 26.4% in London and 29.6% in England.<sup>378</sup> Of the 91 newly diagnosed HIV cases at Whipps Cross University Hospital in 2009/10, 70% had CD4 cell count less than 350/mm<sup>3</sup>.

## Abortions

Table 1 provides some abortion data for 2009. Waltham Forest recorded the highest number of abortions for women aged 15 – 44 in outer north east London. However, when converted into rates Barking and Dagenham had the highest rates per 1,000 women. All the Outer North East London PCTs had a greater percentage of NHS funded abortions compared to London. Waltham Forest had a higher percentage of repeat abortions in women under 25 years compared to London.

<sup>377</sup>MedRASH (2008) Sex and our city

<sup>378</sup> Sexual Health Balanced Scorecard (<http://www.apho.org.uk/default.aspx?RID=74115&TYPE=FILES>)

Table 1: 2009 abortion data

Area	Abortion rate per 1,000 resident women aged 15-44yrs	Number of abortions	% of NHS funded abortions by 10 weeks gestation	% repeat abortions in women aged under 25yrs
London	26	41062	77	32
Barking & Dagenham	40	1438	83	25
Havering	25	972	83	35
Redbridge	28	1396	82	33
Waltham Forest	36	1596	79	35

Source: The NHS Information Centre

### Teenage Pregnancy

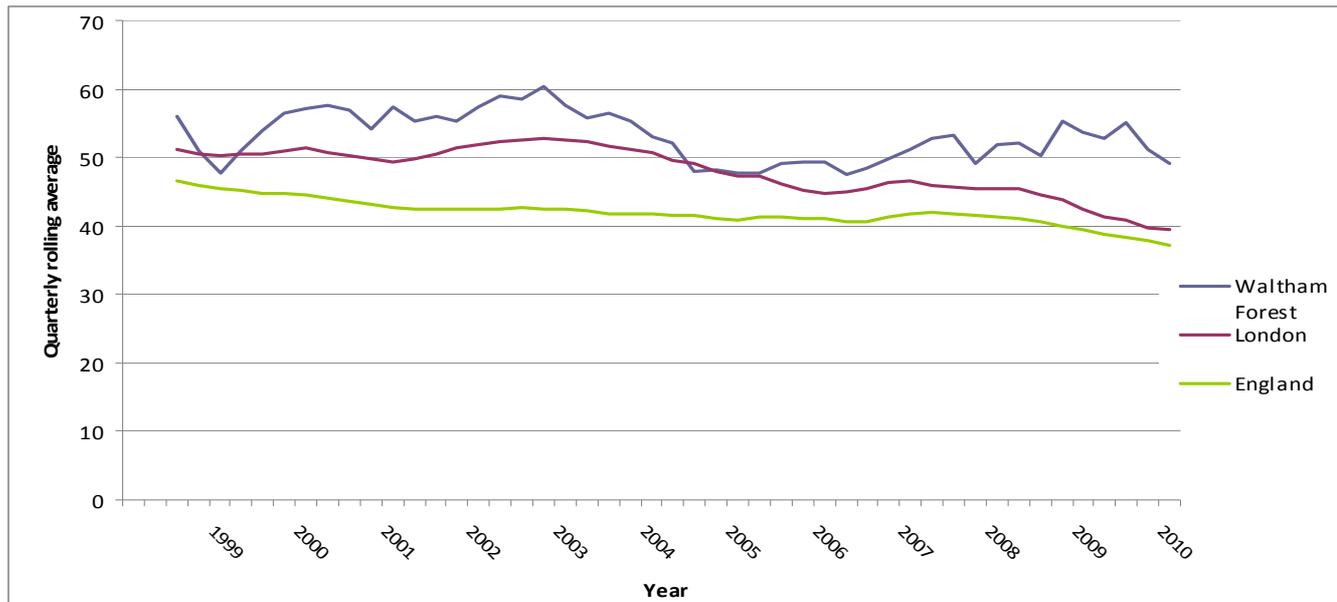
There was an average of 206 teenage pregnancies a year in Waltham Forest between 1998 and 2009. The highest during this period was 231 conceptions in 2003 and the lowest was 191 in 2004 and 2006.

The teenage pregnancy rate in Waltham Forest remains higher than London and England. Waltham Forest's teenage pregnancy rate only fell slightly from 56 conceptions per 1000 in 1998 to 49.2 per thousand in the second quarter of 2010. This compares to a reduction from 51.5 to 39.4 per 1,000 in London and 46.6 to 37.2 per 1,000 in England during the same period.

Figure 2 shows trends in teenage conception rates between 1998 and the second quarter of 2010. There was a 2% reduction in teenage pregnancy rates in Waltham Forest between 1998 and 2009 compared to 18% reduction in England and 20% in London. Full year figures for 2010 are not yet available but it is unlikely that the 50% reduction by 2010, set by the national Strategy, will be achieved.

The latest available data show that there were 85 conceptions in Waltham Forest from January to June 2010, compared to 109 during the same period in 2009.

**Figure 2: Quarterly under-18 conception rates per 1,000 females aged 15 – 17, 1998 to second Quarter 2010 (Rolling quarterly average)**



Source: ONS

Due to small numbers, ward level teenage conception rates are generally published by combining three years' data. The rates for 14 of the 20 wards in Waltham Forest fell in 2006 - 2008 compared to 2005 - 2007, with Leytonstone recording almost 50% reduction during this period. Higham Hill and Lea Bridge continue to have the highest teenage conception rates in the borough.

Four wards in Waltham Forest were among the 20% of wards in England with the highest rates (at least 53.1 conceptions per 1,000 women aged 15-17) in 2006 – 2008. They are Higham Hill, Lea Bridge, Cathall and Leyton.

### Teenage Abortions

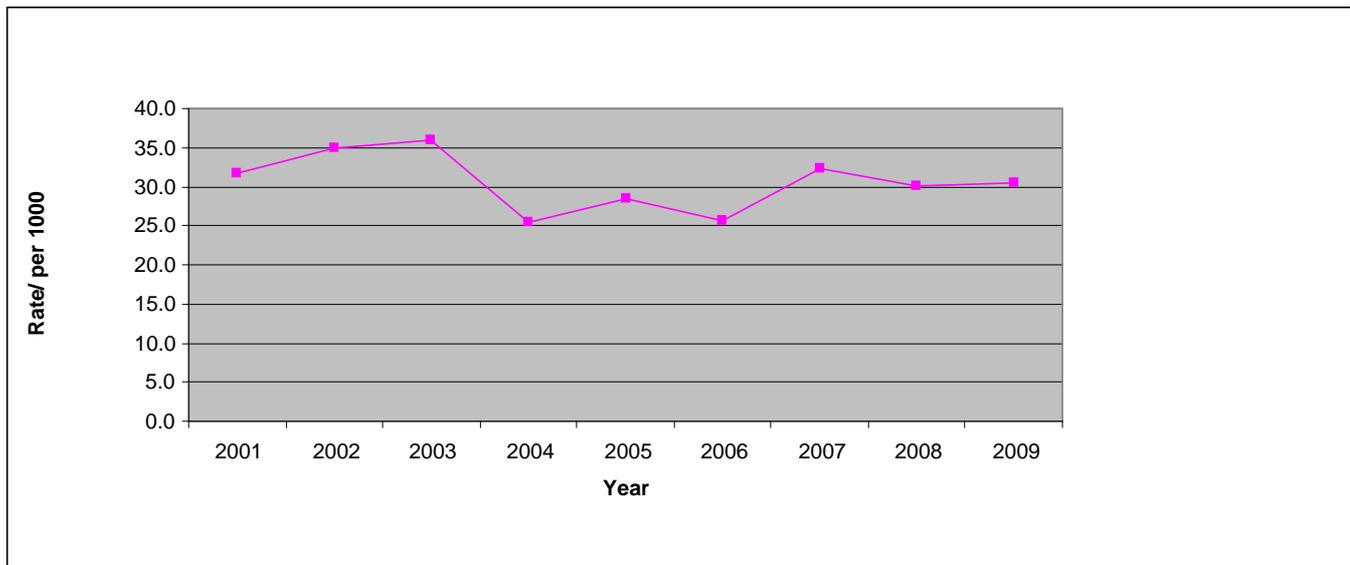
The percentage of abortion in teenagers aged under 19 in Waltham Forest in 2009 was similar to London (17.3% vs. 17.4% in London) but significantly higher than England.<sup>379</sup>

In 2010/11 the main abortion service provider for Waltham Forest residents performed 1,793 abortions in total. Eight percent (145) were for under 18s. This compares to 9% in Barking & Dagenham and 13% in Havering.

The rate of teenage abortions in Waltham Forest has fallen slightly between 2001 and 2009 as shown in Figure 3.

<sup>379</sup> Sexual Health Balanced Scorecard (<http://www.apho.org.uk/default.aspx?RID=74107&TYPE=FILES>)

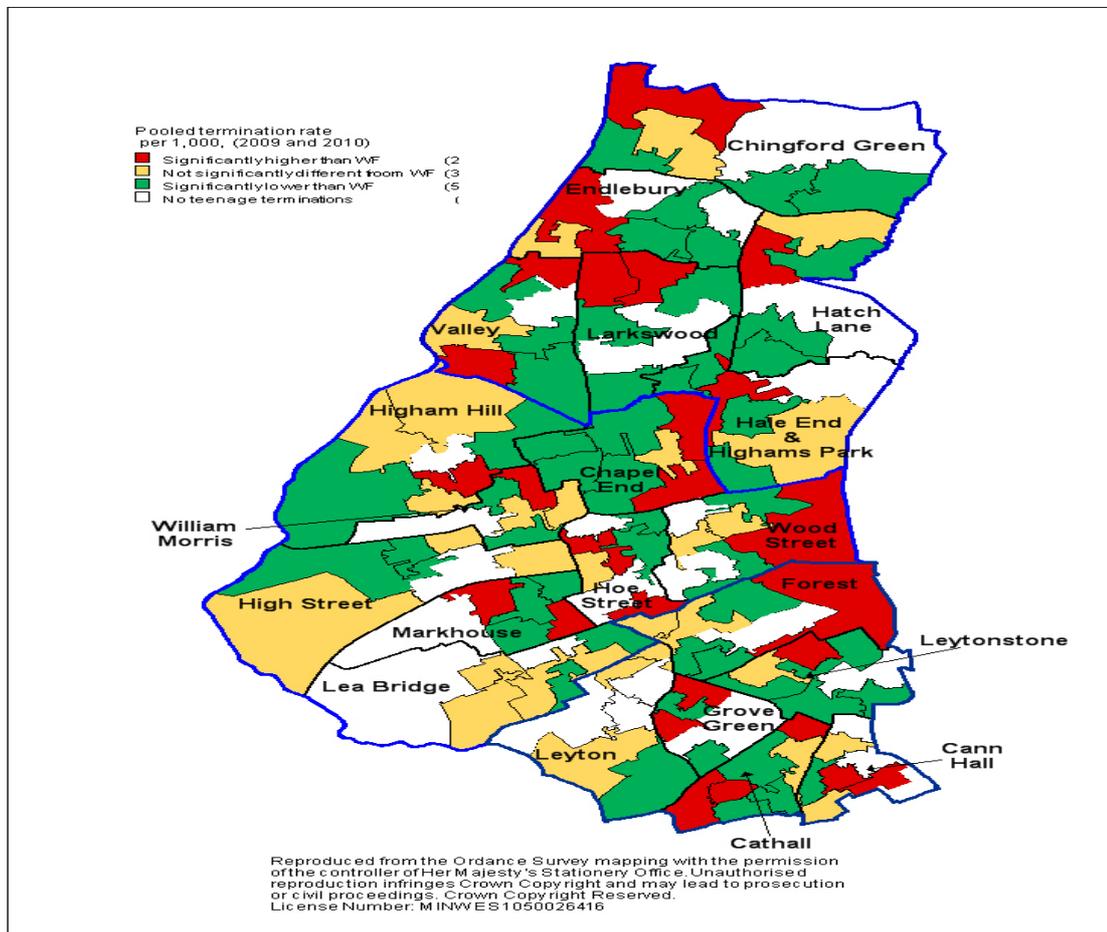
Figure 3: Teenage abortion trends (Rate per 1,000 female population 15-17 years)



Source: NCHOD

Teenage abortions, like conceptions, are not evenly distributed across the borough. 2010/11 data show that Cathall, Cann Hall, Grove Green and Leyton wards (all in the sought) had abortion rates significantly above the borough average. However, there are pockets of areas with higher rates right across the borough, as shown in Figure 4. This is useful for planning targeted interventions.

Figure 4: Teenage Termination rates by LSOA 2009/10



## Contraception

Long-acting reversible contraception (LARC) is effective in preventing unwanted pregnancies. In 2009/10 the rate of GP prescribed LARC per 1,000 registered female population aged 15 – 44 in Waltham Forest was 22.4 compared to 25.0 in London and 46.9 in England. Rates of prescribing in the neighbouring outer north east London PCTs were all higher than Waltham Forest – ranging from 26.8 in Redbridge to 40.3 in Barking and Dagenham.<sup>380</sup>

It is important to see this in the context of all prescriptions of LARC, as Waltham Forest has a very active LARC service within Contraception and Sexual Health Service, which prescribes more LARC than GP practices.

Analyses of LARC prescribing data show a cumulative increase of 21% in Waltham Forest from 2007/08 to 2010/11, compared to an increase of 19% in London during the same period. The other three outer north east London PCTs recorded higher percentage increases than Waltham Forest.

## What are effective interventions?

The benefits of preventing an STI extend beyond the individual as onward transmission to other people is also prevented. The following interventions have been found to improve sexual health. These are based on NICE guidance<sup>381,382,383,384</sup>, research commissioned by Department of Health and other national policy documents on sexual health.

**Table 2: Evidence base for effective sexual health interventions**

Work area	Interventions
Contraception and abortion services	<ul style="list-style-type: none"><li>• Increasing uptake of Long Acting Reversible Contraception (LARC)</li><li>• Access to services that provide information and choice on full the range of contraceptive methods</li><li>• Reducing delays in obtaining abortion</li></ul>
Screening	Screening strategies targeting high risk populations such as pregnant women for HIV and young women for Chlamydia are cost saving, leading to early treatment, averting cost of complications (such as infertility) and onward transmission. Cost saving measures include: <ul style="list-style-type: none"><li>• Antenatal screening for HIV in high-risk women</li><li>• Antenatal syphilis screening</li><li>• Chlamydia screening for young people and groups at high risk</li></ul>

<sup>380</sup> Sexual Health Balanced Scorecard (<http://www.apho.org.uk/default.aspx?RID=74107&TYPE=FILES>)

<sup>381</sup> NICE (2005) Long acting reversible contraception. Clinical guideline

<sup>382</sup> NICE (2011) Increasing the uptake of HIV testing among black African in England

<sup>383</sup> NICE (2011) Increasing the uptake of HIV testing among men who have sex with men

<sup>384</sup> NICE (2007) Prevention of sexually transmitted infections and under-18 conceptions

Work area	Interventions
Treatment interventions and service organisations / delivery for STIs and HIV	<p>Comprehensive and accessible STI treatment services are cost saving; and partner notification and highly active antiretroviral therapy (HAART) are cost effective. Measures include:</p> <ul style="list-style-type: none"> <li>• STI treatment services in groups at high risk</li> <li>• Partner notification</li> <li>• Access to services with very short / no waiting times</li> <li>• Antiretroviral treatment for HIV</li> <li>• Routine HIV testing for STI clinic attendees</li> <li>• Reduce late and undiagnosed HIV through the provision of testing in a range of settings</li> <li>• Improve understanding and awareness of barriers to HIV testing particularly in affected communities</li> <li>• Reduce HIV related stigma</li> <li>• Ensure integrated HIV service to meet the needs of those living with HIV/AIDS</li> </ul>
Health promotion and disease prevention	<p>A range of interventions aimed at preventing HIV and promoting sexual health are cost –saving and are most cost-effective when targeted at high – risk group. Measures include:</p> <ul style="list-style-type: none"> <li>• Free condom provision for medium and high risk groups</li> <li>• Outreach programmes for high risk, hard-to-reach groups</li> <li>• Provision of HIV risk reduction messages in gay bars</li> <li>• Needle exchange provision for injecting drug users</li> <li>• High quality integrated SRE</li> </ul>
HIV prevention interventions specifically targeting men who have sex with men (MSM)	<ul style="list-style-type: none"> <li>• Risk reduction education</li> <li>• Safer sex skills training sessions / cognitive behavioural interventions, peer leader interventions</li> <li>• Interpersonal skills training</li> <li>• Peer support</li> <li>• Group and community level interventions</li> <li>• Multiple delivery methods</li> <li>• Interventions targeting minority MSM and younger populations</li> <li>• Increasing uptake of HIV testing through <ul style="list-style-type: none"> <li>○ Assessing local need, developing a strategy and planning services accordingly</li> <li>○ Promoting HIV testing among men who have sex with men</li> <li>○ Offering and recommending an HIV test for all men who attend specialist sexual health services</li> <li>○ Offering and recommending HIV test to all men who register with a GP practice</li> <li>○ Providing rapid point-of-care tests</li> </ul> </li> </ul>
HIV prevention interventions specifically targeting African Communities	<ul style="list-style-type: none"> <li>• Health promotion HIV risk reduction interventions specifically targeting African communities</li> <li>• Targeting interventions at different black communities that include culture specific materials to support health promotion interventions</li> <li>• Interventions designed specifically to target African females using gender- or culture- specific materials and delivered by females</li> <li>• Knowledge / skills building and interpersonal skills training</li> <li>• Using role-playing to teach negotiation skills for female groups</li> </ul>

	<ul style="list-style-type: none"> <li>• Skills training in condom use and negotiation of safer sex for female groups</li> <li>• Increasing uptake of HIV testing through <ul style="list-style-type: none"> <li>○ Community engagement</li> <li>○ Assessing local need, developing a strategy and planning services accordingly</li> <li>○ Promoting HIV testing for black African communities</li> <li>○ Reducing barriers to HIV testing</li> <li>○ Offering and recommending HIV test in healthcare settings</li> <li>○ Ensuring clear referral pathways for people with positive and negative HIV test results</li> </ul> </li> </ul>
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### **What is being done locally address sexual ill-health?**

Our aim is to ensure that Integrated Sexual and Reproductive Health services meet the sexual health needs of Waltham Forest residents and improve health outcomes by providing quality and holistic services in the right place, at the right time, by the right people and at the right cost.

Commissioners are considering commissioning some sexual health services sector-wide to increase efficiency and value for money. Areas being considered include abortion services and Chlamydia screening.

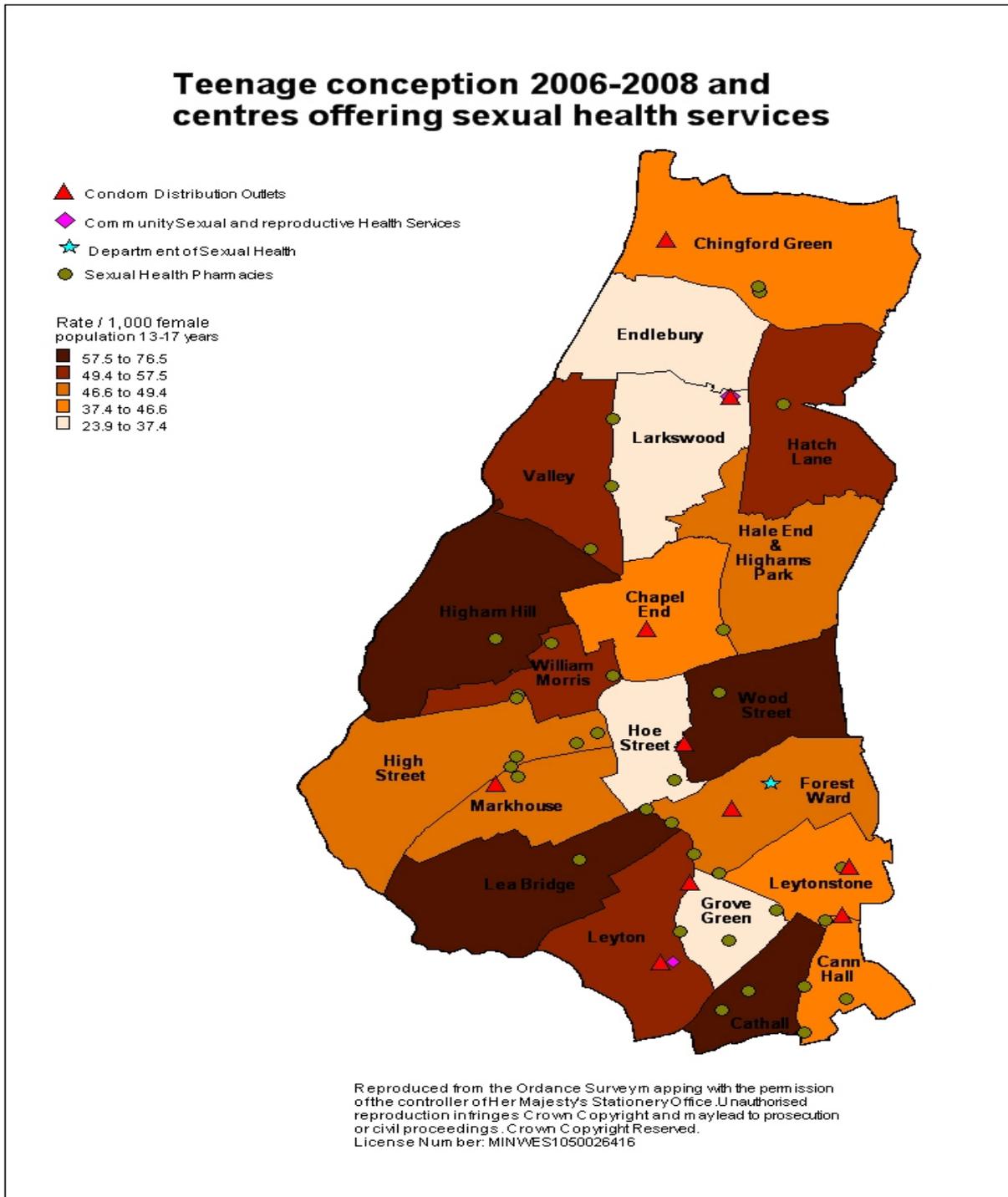
Delivery of sexual health services in Waltham Forest occurs in primary care, secondary care and community services. Our sexual health services cover the following areas:

- STI and HIV testing, diagnoses and treatment.
- Care and support for people living with HIV.
- HIV prevention programme delivered across London.
- Family planning, including LARC provision.
- Emergency Hormonal Contraception (EHC) provision in pharmacies.
- Sex and Relationships Education in schools.
- Teenage pregnancy prevention work with young people.
- Condom distribution scheme for young people.
- Abortion services.

In addition to clinic-based services, there are some outreach services targeting young people and some high risk groups such Looked After Children, especially in Chlamydia screening and teenage pregnancy prevention. The vast majority of our Chlamydia screening is provided by the voluntary sector.

Figure 5 shows the locations of the different sexual health services in the borough.

Figure 5: Location of sexual health services in Waltham Forest



In 2010/11, of the 5321 attendances to the Department of Sexual Health at Whipps Cross University Hospital, 2072 (39%) were aged under 25.

There are some concerns about the lack of sexual and reproductive health services in the middle of the borough (Walthamstow area) following the closure of community sexual health clinics due to service restructure. However, nearly half of all the pharmacies that provide EHC in the borough are located in that area. This might suggest a lack of awareness of the EHC provision in pharmacies.

This area has high rates of HIV and teenage pregnancy. However, data from the Community Sexual and Reproductive Health service show that over half of clinic attendances between January and June 2011 came from that area.

This suggests that lack of services in the area alone does not explain the high rates of HIV and teenage pregnancy. Other explanations need to be explored in order to address this.

Another area of concern is the cessation of the Teenage Pregnancy Team following the end of the teenage pregnancy grant in March 2011, despite the borough's high rates of teenage pregnancy. Teenage pregnancy work is now integrated into the work of the targeted Youth Support Service's generic Opportunity and Development Workers. The teenage pregnancy strategy has recently been evaluated and recommendations will be taken forward.

Table 3 provides a summary of best practice in reducing teenage conceptions and what happens in Waltham Forest.

**Table 3: Summary of best practice in reducing teenage conceptions**

Best practice	What happens in Waltham Forest
Effective sex and relationship education helps young people gain the skills to handle the pressure to have sex as well as equips them with the knowledge and skills to avoid unwanted pregnancies and STIs	The Christopher Winter Project, which trains teachers to deliver SRE, has been rolled out in a number of schools in Waltham Forest. Youth Support workers and TPT staff have been trained to deliver the project. The vast majority of the young people who took part in the survey for this report had some knowledge of contraception and positive attitude towards contraception. Most of them reported that this was gained from school. Almost all of them thought that getting pregnant under 18 years was not a good idea.
Easy access to young people-oriented contraceptive and sexual health services	The SRE that is delivered in Waltham Forest schools incorporates a focus on increasing access to services. However, about 30% of the students who took part in the survey as part of this evaluation were not aware of the location of young people's sexual health services. This may be due to the fact that all the young people's clinics provided by the ONEL CS community sexual health and gynaecology service have been centralised to the Oliver Road hub. The CFC Team have developed a DVD in consultation with young people, which highlights the services available. This will help raise awareness and improve access. The Teenage Pregnancy Team routinely provides information about services to young people. However, changes in service configurations are not always communicated in a timely manner.
Appropriate method(s) of assessment and evaluation being built into PSHE programmes ensures effective outcomes	Support is provided to schools through training and promotion of the SRE Core Curriculum for London which includes assessment. However, there are still improvements to be made in this area. The Healthy Schools whole school review provides a mechanism for monitoring and evaluating policies and programmes in PSHE.

<b>Best practice</b>	<b>What happens in Waltham Forest</b>
The most effective SRE programmes use trained teachers/facilitators, include content that is specific to reducing risk and involve interactive and participatory techniques	Most schools in Waltham Forest use PSHE co-ordinators or assistant coordinators to deliver PSHE including SRE lessons. The 6 <sup>th</sup> Forms use 'generic' tutors to deliver PSHE, and this generates negative comments from students
The use of small group work, focused on skills and attitudes (rather than knowledge) is effective in reducing sexual risk behaviour	The PSHE departmental reviews undertaken by CFC highlighted many examples of excellent lesson plans with varied activities, including group work
Provide one to one advice on how to prevent unwanted pregnancies, covering all methods of reversible contraception including LARC. This should include vulnerable young women such as those from disadvantaged backgrounds, those who are in or leaving care, and those who have low educational attainment	<p>This is provided by clinicians at the young people's sexual health clinics, the teenage pregnancy link nurse, the Teenage Pregnancy Team and Opportunity and Development Workers. The abortion service offers advice and fitting of LARC to all women who undergo termination of pregnancy. The condom distribution scheme in Waltham Forest has not been very effective in getting young people registered to receive free condoms. Waltham Forest has recently signed up to the pan London scheme, which would help improve access.</p> <p>There is a gap in terms of outreach to young women who are in or leaving care. This is currently being addressed.</p>
Regularly visit vulnerable women aged under 18 who are pregnant or who are already mothers and support them towards preventing unwanted pregnancies	<p>The teenage pregnancy team members regularly visit young mothers on their caseloads from all backgrounds but there is a gap in terms of those in care. The Family Nurse Partnership also works with pregnant mothers from all over the borough. However not all teenage mothers are eligible for FNP support and a pathway has now been developed for those who are not eligible.</p> <p>A lot of effort went into getting the FNP and TPT to work more collaboratively but there was a lack joined up work. This is being resolved to ensure that all partner agencies work more collaboratively.</p>
Where appropriate, refer young women aged under 18 who are pregnant or who are already mothers to relevant agencies, including services that support reintegration into education and work	The Teenage Pregnancy Team had a reintegration officer who supported young mothers towards reintegration. The team also had a connexions worker specifically targeting young fathers. With the team being wound down, these roles have been picked up by Opportunity and Development Workers
Youth development programmes – focusing on personal development including self confidence and self-esteem	The Youth Support Service had generic youth workers and Connexions workers who work with young people on various issues including personal development. The new team is being trained on specific issues to deal with the target group such as housing, benefits, etc

Best practice	What happens in Waltham Forest
Address the underlying risk factors such as low educational attainment, low aspirations, lack of engagement in learning post-16 and poverty	<p>These are part of the Waltham Forest Joint Inequalities Strategy. The action plan for the strategy is being developed and includes specific actions to:</p> <ul style="list-style-type: none"> <li>• identify and support young people at risk of failing in school</li> <li>• work with the families of young people at risk of gang affiliation</li> <li>• support young people and long term unemployed into work</li> </ul>

Waltham Forest is currently shadowing the London sexual health tariffs with the aim of adopting the new tariffs when they go live. This will enable equity of access to integrated sexual health services and ensure that services provided are coded and costed appropriately.

### **Evidence that we are making a difference**

Since the last JSNA there has been progress in the performance of the Community Sexual and Reproductive Health Service. The service was under-performing, which led to an action plan developed and monitored jointly by the PCT and service provider to address the under-performance, with very good outcome. The service has improved significantly and performance is currently above plan.

The service is working towards a fully integrated service model, providing both STI and contraception care in the same clinics. There are also plans for the service to move to level 2 sexual health provision. The service has developed its IT system to ensure it can meet the London sexual health tariff data requirements.

### **What is the public perspective the sexual health services?**

#### **Summary of NELNET HIV outpatients' survey, July 2010**

- Patients were generally satisfied with the service they received from Whipps Cross University Hospital and would recommend to friends.
- A quarter of respondents (6/24) said they needed an interpreter but this was not offered.
- 66% (27/41) of respondents strongly agreed that they were treated with dignity and respect.
- 82% (32/39) agreed or strongly agreed that they were given enough privacy and could speak confidentially while booking in at the reception.

#### **Summary of Waltham Forest LINKs' consultation with young African people**

Waltham Forest LINKs consulted 162 young African people living in Waltham Forest between July 2009 to January 2010 about their sexual health awareness and local sexual health services.

- There was very little knowledge of sexual health services among the cohort.
- The most common services identified by the young people were those provided by GPs.

- The young people favoured targeted workshops or seminars followed by easy-to-read information leaflets as the best ways of enhancing their knowledge.
- The young African people expressed a need for services that address Female Genital Mutilation and cervical screening.
- There was a need for increased outreach to women who do not speak English.
- Sexual health services, for example HIV services, should include counselling to help young people come to terms with diagnoses.
- HIV services should have links with other services such as housing, benefits and immigration advice.

### **Summary of Young Advisors' experiences during visits to community sexual health clinic**

There were issues with reception/front-of-house but generally once the young people saw a health professional, the experience was very good. For example:

*"Had good service inside – nurse took an interest and cared about feelings. Gave good advice about counselling, abortion and contraception. Also tried to ask a few times if it was me rather than my friend that was pregnant".*

*"Nurse was polite and made us feel comfortable"*

Some of the front-of-house issues were:

- The times changed for the youth drop-in centre and nobody was told.
- Service abrupt but not rude. *'Need someone who was really nice, that you would feel comfortable talking to.'*
- It felt like an inconvenience that we asked to go to a confidential room.
- Waited at reception for a while as nobody was there, staff didn't come for 5 minutes.
- Opening hours should be more suitable for young people as they are mainly during school times.

These issues have been discussed with the provider and are being addressed. The Young Advisors will return in six months to check progress.

## **Survey of Young People**

As part of the teenage pregnancy strategy evaluation in Waltham Forest, a sample of school children in years 9, 10 and 11 completed questionnaires to elicit their knowledge and attitudes to contraception; awareness of services and their views on the quality of SRE in schools. This included telephone interviews with teenage mothers. Some of the responses are summarised below.

Most of the respondents indicated that they obtained knowledge of contraception from SRE in school/college. The following barriers to young people's access to sexual health and contraception services were identified:

- *Clinics near gangs – "like Oliver Road and Beaumont"*
- *Not enough services*
- *"Some GPs can act as a barrier"*
- *Location, opening times restrict access*
- *Not enough advertising*

Service location was the most mentioned, and the reasons were mainly either the locations were too far, or they were scared to go to those locations.

Suggestions for improving young people's access to sexual health and contraception service were:

- More outreach and one to one.
- More young people's clinics.
- More accessible locations.
- GPs not to be judgemental.

## **What more do we need to know?**

- Systematic collection of LARC and EHC data from all services to identify any inequalities in access and target groups with poorer access.
- An understanding of the barriers to young people accessing sexual and reproductive health services, e.g. Chlamydia screening, in primary care.
- An understanding of the most efficient way(s) of implementing HIV testing in Waltham Forest in order to reduce the rate of late diagnoses.

## **What are the priorities for improvement over the next 5 years?**

### **Key insights**

- As with other parts of the country, teenage pregnancy rates in Waltham Forest are associated with deprivation - areas with high deprivation generally have high rates of teenage pregnancy.

- Young people in Waltham Forest have identified some barriers to accessing sexual health and contraception services.
- Community sexual and reproductive health clinics are not equitably located within the borough and the locations are not necessarily linked to need.
- There are high rates of late HIV diagnoses in Waltham Forest. This could be linked to lack of sustained health promotion and prevention interventions; and inadequate HIV testing initiatives
- Waltham Forest has high rates of abortion and repeat abortions. This indicates high rates of unprotected sex and suggests lack of awareness of, or inadequate contraception services.

## **Tuberculosis (TB)**

### **Executive Summary**

TB continues to be an area of concern in Waltham Forest. Some of our recommendations last year were not fully achieved and these are again highlighted in this year's JSNA. One key recommendation last year dealt with people who have no recourse to public funds. By working closely with the commissioners and the TB team at Whipps Cross University Hospital we were able to have systems in place for treating people with no recourse to public funds. This has enabled us to ensure adherence to TB therapy. Another recommendation last year was for a TB strategy to be developed. The Waltham Forest TB Prevention Strategy is presently being developed and will be completed following the publication of the London TB Plan in autumn 2011.

The Public Health directorate is committed to continue working with TB alert and the council to raise TB awareness in Waltham Forest.

### **Our Vision**

- To reduce the risk of people being newly infected with TB.
- Provide high quality treatment and care for all people with TB in Waltham Forest.

### **Recommendations**

- TB is a multi-sector problem that demands a multi-agency approach to its prevention and control. Health service providers, local authority departments and third sector organisations must establish a joined up approach to TB prevention and rate reduction in Waltham Forest.
- To control transmission of TB within Waltham Forest the provision of effective outreach services into appropriate at risk groups who have complex health and social needs is recommended.
- Awareness strategies need to be targeted at the most affected communities in the borough i.e. Black African, Pakistani and Indian communities. Homeless people and people with substance abuse problems also need to be targeted.
- All HIV positive clients should be offered TB testing.
- TB Alert, the UK's national TB charity, is the Department of Health's lead partner in delivering TB awareness raising objectives. Professionals with access to communities affected by TB should utilise the multi-lingual and contextually specific resources available from TB Alert as part of *The Truth About TB* programme<sup>385</sup>.

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<sup>385</sup> <http://www.thetruthabouttb.org/>

- Ensure that effective components of TB management and control are implemented locally including: early diagnosis and treatment, contact tracing and BCG immunisation and access to GP registration for hard to reach and vulnerable people.
- TB awareness and TB Health Promotion should be included in commissioning plans. Consideration should be given to elements of the TB service that could be provided outside of the hospital setting e.g. contact chemoprophylaxis, treatment adherence services (such as Directly Observed Treatment (DOT)).
- Commission third sector organisations and other primary care groups to provide outreach work, in order to improve health outcomes. To achieve this Waltham Forest should work closely with TB Alert as part of *The Truth About TB* programme, which is working to build TB knowledge and capacity in key third sector organisations.

### **What is Tuberculosis?**

Tuberculosis (TB) is a serious, but preventable, infectious illness. In almost all cases TB can be cured, but only if the full course of treatment is taken as prescribed for a minimum of 6 months. There were 7,970 new TB cases in England in 2008. They were mainly concentrated in major cities including Bradford, Birmingham, Leicester, Manchester and London. 42% of cases in England are reported in London – a rate of 44.3 cases per 100,000 members of the public<sup>386</sup>. Any region, territory or country with a rate of 40/100,000 or higher is considered to have a high incidence of tuberculosis, according to World Health Organisation standards<sup>387</sup>.

TB infection is caused by *mycobacterium tuberculosis*, and is transmitted when someone breathes in the bacteria, coughed/sneezed into the air by someone with infectious TB in the lungs or throat. While anyone can get TB, it is closely associated with overcrowding and poverty. It is a treatable illness, although in recent years there has been an increase in drug resistant strains. Raising awareness is the first action to help bring the illness under control.

Prevention of TB requires a good level of accurate knowledge among the general public, especially affected communities, about the illness and the service available.

As TB is closely linked with over-crowding, poverty and other social problems, it can be seen as an indicator of inequality. Owing to the wider determinants of health that affect TB rates, the prevention of TB is also dependent on acceptable standards of living for people in a local area, including good quality housing and living conditions.

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<sup>386</sup> Miles I (2010), Tuberculosis 1: exploring the challenges facing its control and how to reduce its spread, Nursing Times.net, [www.nursingtimes.net](http://www.nursingtimes.net), date accessed 07/09/2010

<sup>387</sup><http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/Tuberculosis/EpidemiologicalData/TBWorldwideData/tbepiWhoTable1>

Effective case finding and management to consistent and high clinical standards is essential to TB control. Treatment default is associated with relapses and development of drug resistant TB, which is harder to treat and puts a far greater financial burden on the NHS. It can also be difficult to ensure that people complete their six month course of treatment and do not pose a risk of infection to others. If left untreated, each person with active TB disease will infect on average between 10 and 15 people every year<sup>388</sup>.

### **Who is most at risk?**

The groups at higher risk of contracting TB are:

- Newly arrived people from countries with high rates of TB.
- People living with HIV.
- People who are immunosuppressed.
- People with a history of drug use.
- Prison/ex-prison population.
- Homeless people.
- People living in unhealthy and overcrowded conditions.
- Refugees.
- Certain BME communities.
- People with occupational exposure. <sup>389</sup>

### **Local Picture**

The rate of new cases of TB in Waltham Forest is higher than the regional and national averages. In 2009 there were 47.68 new cases per 100,000 members of the general public in Waltham Forest. This is compared to London's regional rate of 44.4 and England national rate of 16.9 in 2009<sup>390</sup>. In 2007 the rate in Waltham Forest was 41.83 per 100,000.

In the 2001 census overcrowding in Waltham Forest was 16%, affecting 14,408 households. This was compared to London at 17.3% and England and Wales at 7%<sup>391</sup>. The majority of TB cases are concentrated in the southern part of the borough where there are high levels of domestic overcrowding and poverty. The most overcrowded ward at the 2001 census was Cathall at 25.7%.

Tuberculosis incidence increased by 10% or more in Barnet in North Central London, Waltham Forest in the North East and Hounslow in the North West, Bexley in the South East, and Kingston and Wandsworth in the South West (but small numbers in some PCTs mean year on year fluctuations should be interpreted with caution).<sup>392</sup>

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<sup>388</sup> <http://www.who.int/mediacentre/factsheets/fs104/en/>

<sup>389</sup> TB Alert 2010, The Truth About TB, [www.tbalert.org](http://www.tbalert.org), date accessed 7/09/2010

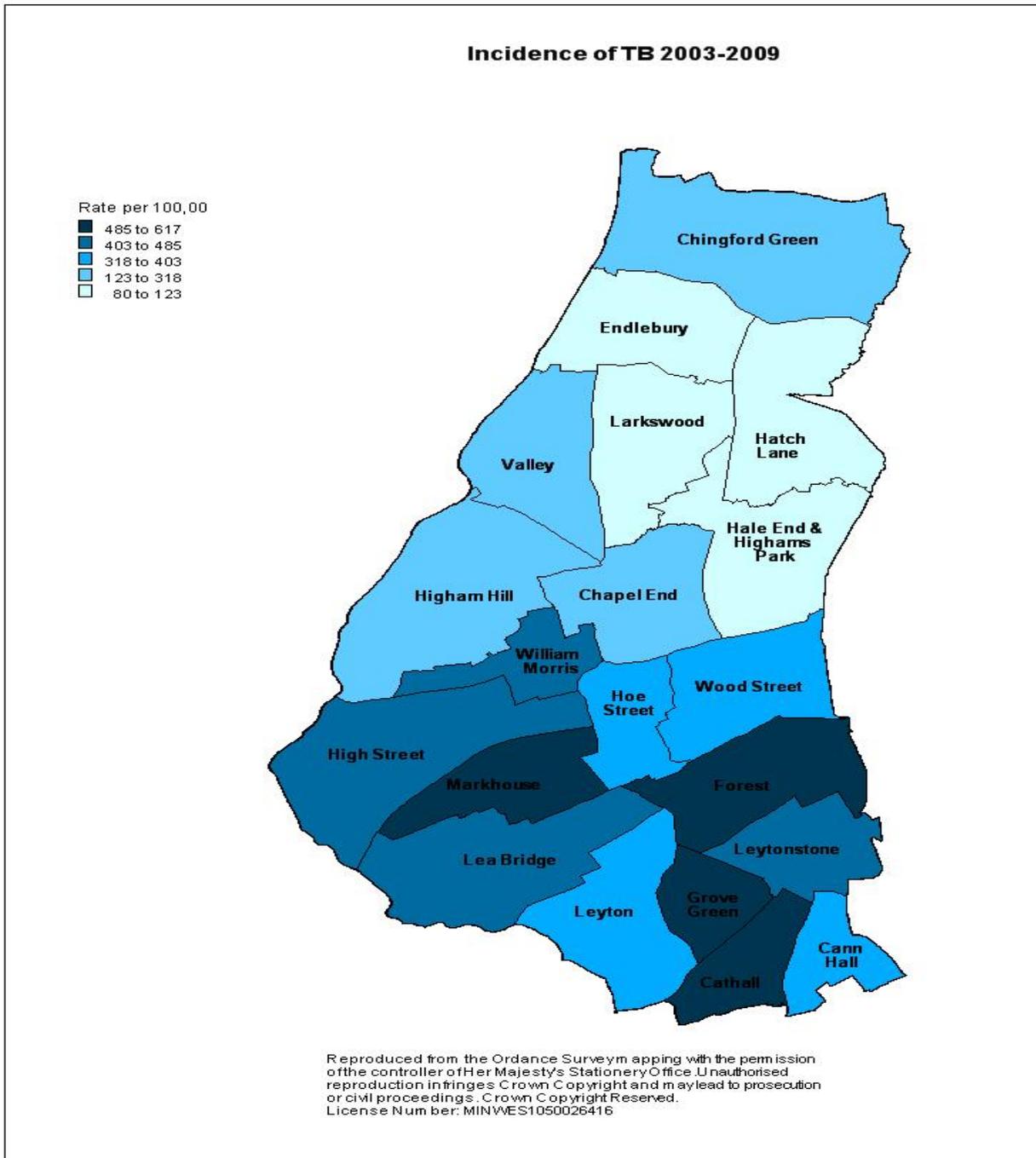
<sup>390</sup> Health Protection Agency, TB Surveillance, North East London TB Network, October 2009, [www.hpa.org.uk](http://www.hpa.org.uk)

<sup>391</sup> ONS Census 2001

<sup>392</sup> HPA (2011) Tuberculosis in London 2010, Annual report on Tuberculosis Surveillance in London, HPA

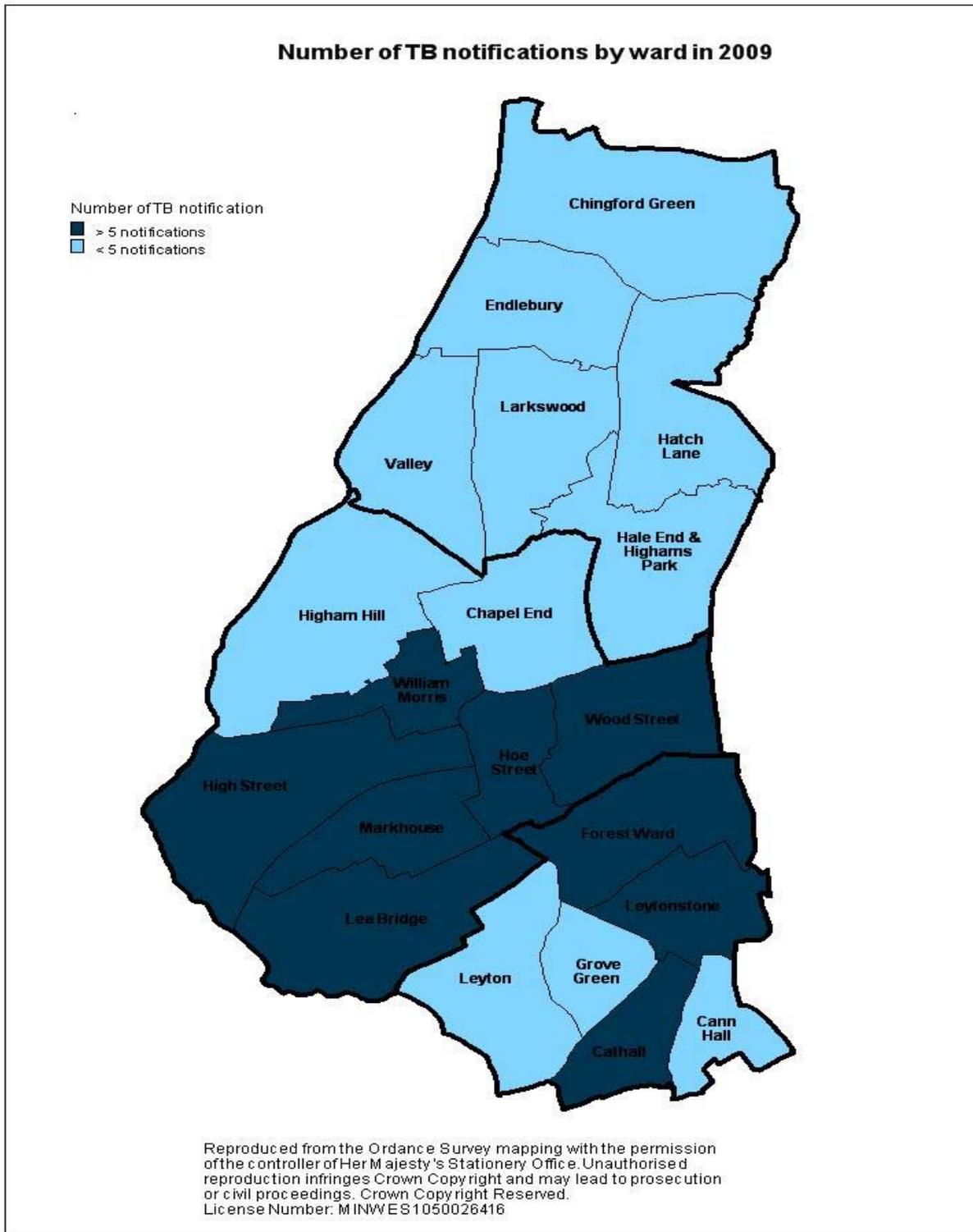
Map 1 shows the incidence of TB by ward for the period 2003-2009.

Map 1



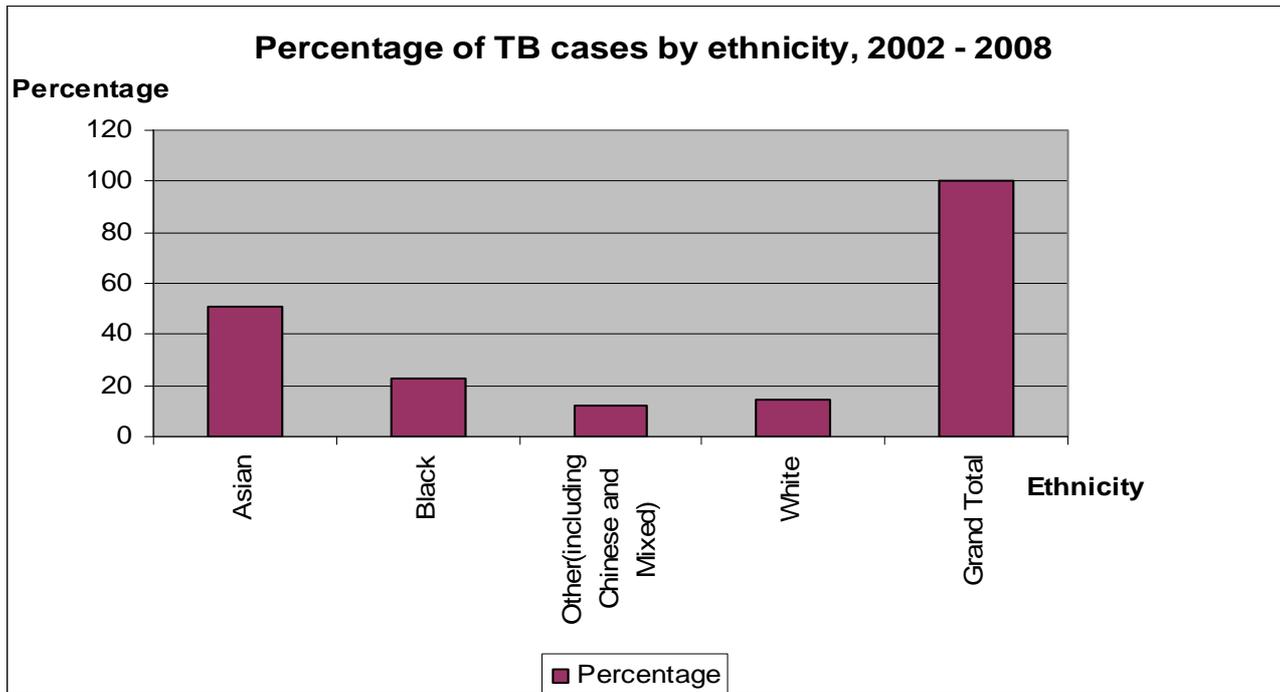
Map 2 shows the number of TB notifications by ward in 2009.

Map 2



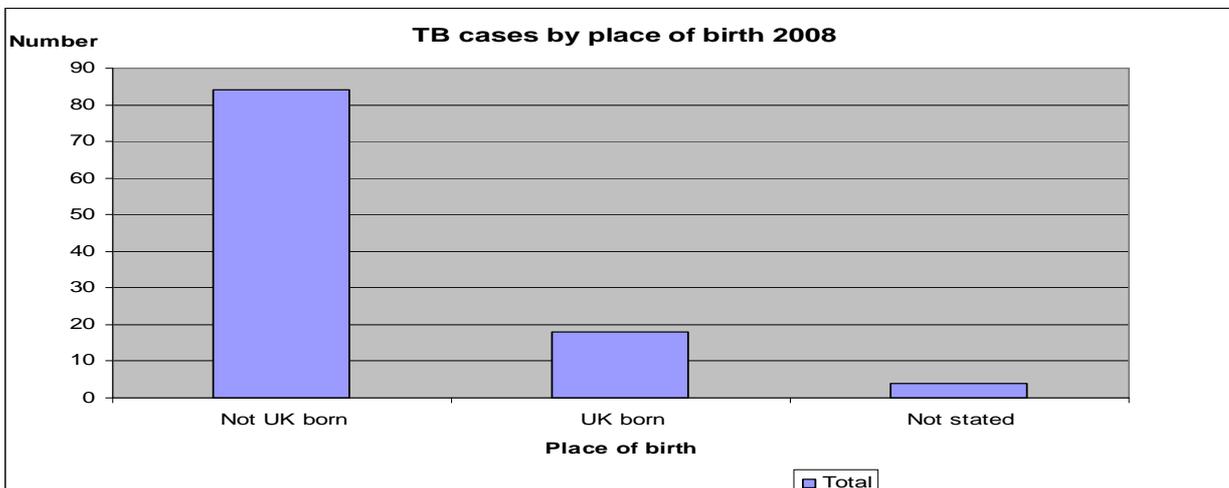
TB predominantly affects BME communities, with Black African, Pakistani and Indian communities having the highest rates of TB. Table 1 shows TB cases in Waltham Forest by ethnic group for the period 2002-2008.

**Table 1: TB cases in Waltham Forest by ethnic group for the period 2002-2008**



There is a particularly heavy burden of disease among people who were not born in the UK. The proportion of cases born outside the UK ranged from 84% in London to 47% in Wales<sup>393</sup>. The majority of cases in London entered the UK two or more years prior to diagnosis and a third have been in the UK for ten or more years<sup>394</sup>. Table 2 shows TB cases in Waltham Forest by place of birth.

**Table 2: TB cases in Waltham Forest by place of birth 2008**



**What are the effective interventions?**

National TB policies are described in 'Stopping Tuberculosis in England; An Action Plan from the Chief Medical

<sup>393</sup> Tuberculosis in the UK, Report on tuberculosis surveillance in the UK 2010, Health Protection Agency- Tuberculosis [www.hpa.org.uk/Topics/InfectiousDisease/InfectionsAZ/Tuberculosis](http://www.hpa.org.uk/Topics/InfectiousDisease/InfectionsAZ/Tuberculosis)

<sup>394</sup> London Health Programmes, London TB Plan, [www.londonhp.nhs.uk](http://www.londonhp.nhs.uk)

Officer'<sup>395</sup>. The National Institute of Clinical Excellence (NICE) guidance for preventing and treating TB<sup>396</sup> cover the effective components of TB management and control including:

- Early diagnosis and treatment.
- Contact tracing and BCG immunisation.
- Access to GP registration for hard-to-reach and vulnerable groups.

The Department of Health published a toolkit the framework for planning, commissioning and delivering high quality TB services.<sup>397</sup> The key components of an effective TB service include having:

- A TB lead in each PCT who will be responsible for coordinating the development of a local plan for TB prevention and control. The TB lead is also responsible for developing partnerships with other organisations key to addressing present /future TB issues.
- A tiered model of commissioning, where each element of the patient's pathway is associated with one of the three levels of organisation: primary GP and other community-owned service providers (level 1), secondary care (level 2) and tertiary (level 3).

Good communication and partnership working between TB services and local voluntary, statutory, community organisations is crucial for delivering effective TB services. Other areas to continually improve are:

- Early referral to chest clinics.
- Screening at new registrations with primary care.
- Establishing good communication links with statutory and voluntary groups working with new entrants.
- Raising awareness about TB among the general public, especially the communities most at risk of being infected.

The draft London TB Plan comprises of the following:

- The case for change which gives details of why TB is a problem for London including the evidence to support the need for action.

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<sup>395</sup> DH(2004) Stopping Tuberculosis in England, An Action Plan from the Chief Medical Officer

<sup>396</sup> NICE (2006) Tuberculosis: Clinical Diagnosis and Management of Tuberculosis and Measures for its Prevention and Control. London: NICE

<sup>397</sup> Tuberculosis prevention and treatment: a toolkit for planning, commissioning and delivering high-quality services in England

- The model of care which sets out the changes required to reduce rates of TB.
- The outline implementation plan which describes how those changes will be implemented.
- The London TB Plan will be revised in light of the feedback received following the consultation period. Final approval will be sought from NHS commissioners in autumn 2011 and the plan will be published following this.
- Waltham Forest will benefit from a pan-London approach that ensures public and patient engagement.
- We currently commission a secondary care (level 2) service which is provided by Whipps Cross Chest Clinic.

### **What evidence is there that we are making a difference?**

- Our performance against the London TB quality criteria remains good consistently although there is a high incidence of TB.
- Whipps Cross University Hospital TB clinic are meeting the national and London standards with 91% of patients completing treatment within 1 year of start of treatment in 2009. There is also 1 specialist TB nurse for every 40 notifications with full administrative support, as recommended by the British Thoracic Society (BTS)<sup>398</sup>.
- By working closely with the commissioners and the TB team at Whipps Cross University Hospital we were able to have systems in place for treating people with no recourse to public funds. This has enabled us to ensure adherence to TB therapy.
- The Waltham Forest TB Prevention Strategy is presently being developed.
- The Public Health directorate is committed to continue working with TB alert and the council to raise TB awareness in Waltham Forest.

### **Challenges**

- HIV positive clients are at high risk of developing TB and they are not currently being offered TB testing.
- There are inadequate systems in place to meet the needs of the vulnerable and disadvantaged people such as homeless.

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<sup>398</sup> Miles I (2010), Tuberculosis 1: exploring the challenges facing its control and how to reduce its spread, Nursing Times.net, [www.nursingtimes.net](http://www.nursingtimes.net), date accessed 07/09/2010

- Working and engaging the at risk groups in our community.
- Buy in 'full co-operation' from the wider community (inc. health & social care, and relevant departments within the Local Authority).

**What are the priorities for improvement over the next 5 years?**

TB is a major public health problem in England and Wales, and also in Waltham Forest. The rate of new TB cases in Waltham Forest increased in 2007-2008 and in order to meet the challenges in rate reduction proactive action is needed. Awareness of TB needs to be raised in the general public as well amongst higher risk groups. Raising awareness of TB is paramount and gets people into treatment sooner and reduces onward transmission, which improves health and saves lives.

# Section 8

**older people**



- Falls Prevention
- Dementia
- Seasonal Flu
- End of Life Care

## **Older People**

### **Local Picture**

#### **Demography**

Waltham Forest has a projected total population of 232,700 in 2011<sup>399</sup> and it is increasing. It is predicted that by 2031 the populations of Waltham Forest will have increased by 10% but it is not just that the population is increasing – it is ageing too. By 2020 one in five people in the UK will be aged over 65, which will be more than the number of under 16s. In Waltham Forest the current estimated number of people aged over 65 who live in the borough 26,900 is projected to increase to 36,850 by 2031.

This increasing number of older people will pose challenges in terms of caring and financing support for people over 65. Females survive longer and outnumber males from the age of 65. This has implications as older women are more at risk of poverty, given shorter employment histories and pension contributions. The northern wards have an older and less ethnically diverse population and are less densely populated than the southern wards. This is projected to change as the population ages (See Figures 1 & 2).

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<sup>399</sup> (GLA population projections GLA 2010 Round of Demographic Projections, SHLAA, 2011

Figure 1

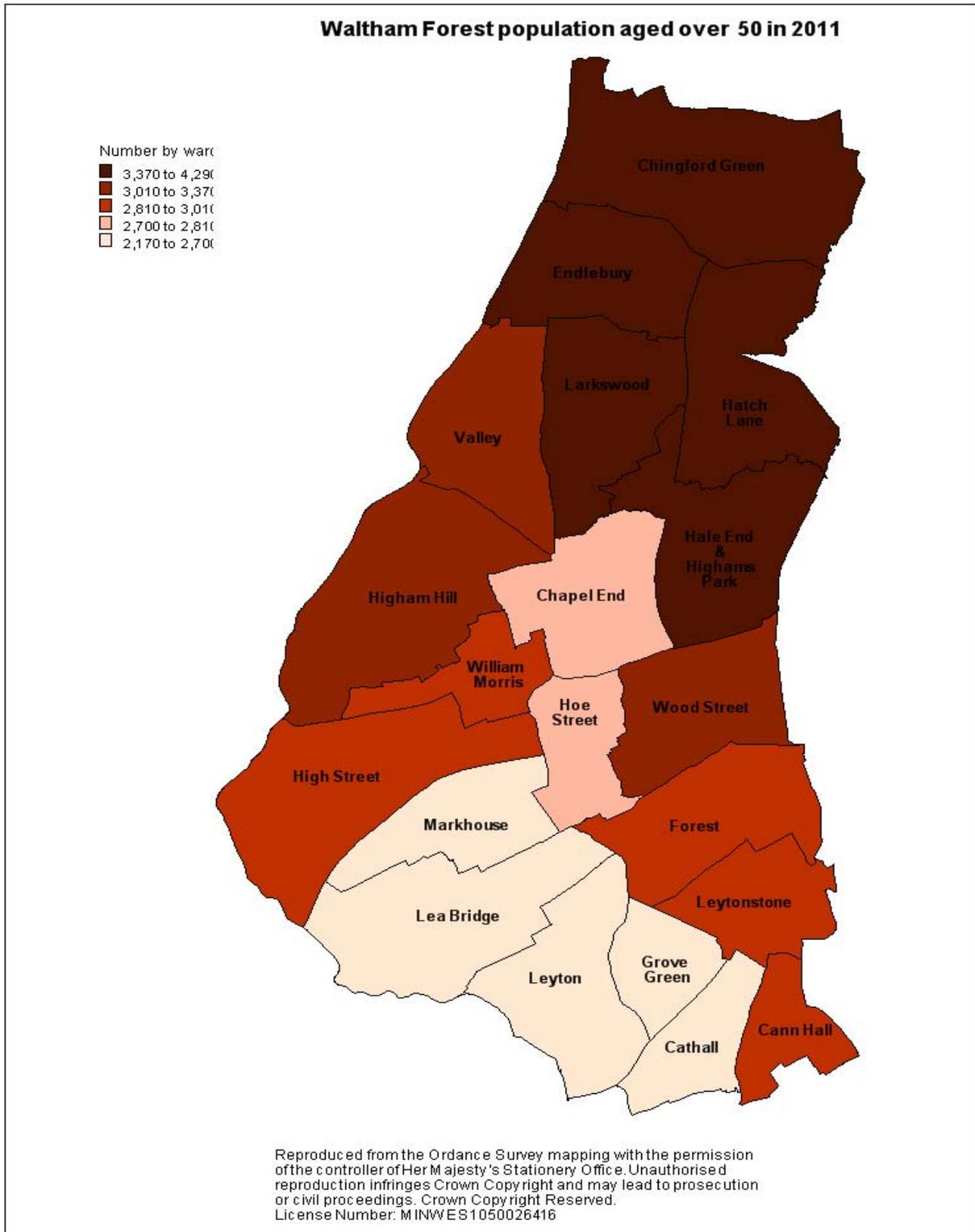
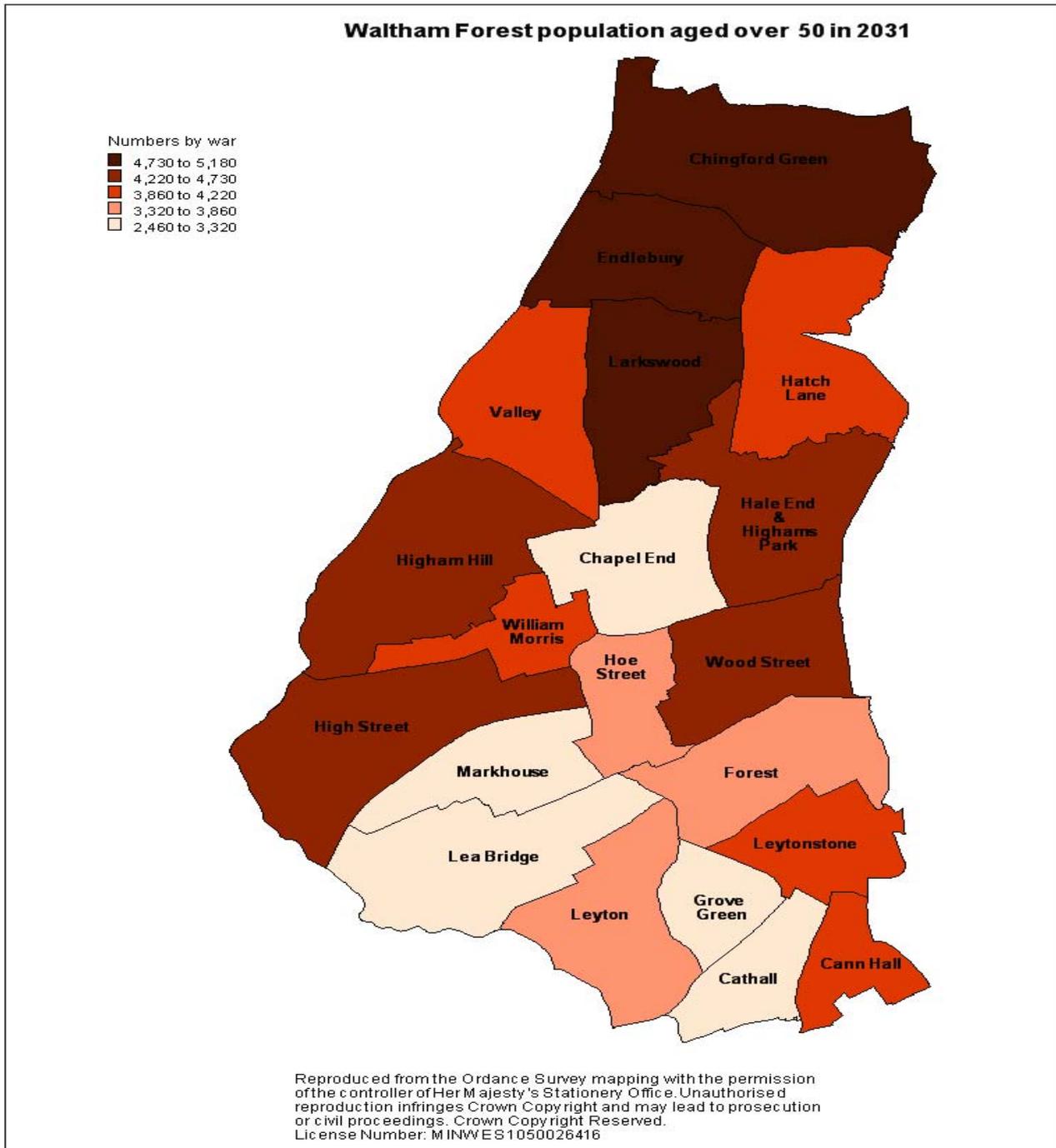


Figure 2



Source: GLA 2008 Round Population Projections – data prepared for mapping

By 2031 42% of all people aged over 50 are projected to be of minority ethnic background. Given the higher numbers of Black, Asian and Minority Ethnic (BAME) groups in the more deprived areas of the borough, this may have implications for future health and social care needs.

## Health and Wellbeing Profile for Older People in Waltham Forest

### Significant Health Inequalities

- In Waltham Forest, life expectancy as of 2007-2009 increased but remained below both the London and UK averages for both men and women. Life expectancy for men is 77.1 years, for women it is 81.6 years.

- There is also a variation of life expectancy across Waltham Forest. A man in the most deprived ward dies 2.8 years younger compared to a man in a more affluent ward in the borough<sup>400</sup>. The difference is 4.6 years for women.
- Healthy life expectancy at age 65 is 17.1 years in Waltham Forest, compared to 18.0 years for England and 18.4 for London for males and 19.9 years for females compared to 21.2 years in London and 20.6 years in England<sup>401</sup>.
- The inequality gap in life expectancy between the most deprived parts of the borough compared to England is mainly due to three major killers: CVD, cancer and respiratory diseases contributing 31%, 22% and 17% respectively.

## **Factors that shape the Wellbeing of Older People**

### **Income Deprivation**

Deprivation affecting older people shows that Waltham Forest is equal to the London average but is worse than the England average. Higher levels of deprivation are found in the middle and southern wards of Higham Hill, Leyton, Cann Hall, Cathall, Hoe Street, Markhouse, William Morris, Forest and Lea Bridge.

### **Home and Neighbourhood**

- 72% of the people over 65 were satisfied with their homes and neighbourhoods, less than London average of 77% and England average of 82%.
- Almost 50% of people aged over 75 live alone in Waltham Forest.
- Of those aged 75+ 30% live in socially rented accommodation.
- Of single pensioner households 39% are considered to live in non-decent homes, mainly due to lack of thermal comfort.

### **Community Safety**

Older people in Waltham Forest are more likely to consider the fear of crime as a negative influence upon their quality of life, although data clearly shows that older people are actually less likely to be the victims of crime, with the exception of distraction burglary.

### **Health Outcomes**

Figure 3 below highlights the significant differences in the determinants of health and health outcomes of the

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<sup>400</sup> (2003-2007 LE by Ward, London Health Observatory, August 2009)

<sup>401</sup> Compendium of Health and Clinical Indicators, April 2011

local population compared to regional and national averages. There are also significant differences within Waltham Forest.

Figure 3: Comparison of selected health and influences on health of people in Waltham Forest

Older peoples Spine chart

Indicator	WF Number	WF Value	Reg Ave	Eng Avg	Eng Worst	England Range	Eng Best
1 Income Deprivation Affecting Older People Index	n/a	0.3	0.3	0.2	1.0		0.0
2 NI 138 Satisfaction of people over 65 with home and neighbourhood (%)	1,768	72.1	77.0	82.1	54.7		92.5
3 Life expectancy at age 65 (Males)	n/a	16.8	18.1	17.7	15.5		23.1
4 Life expectancy at age 65 (Females)	n/a	19.8	21.0	20.4	18.1		26.3
5 NI 137 Healthy life expectancy at age 65	n/a	12.6	13.6	13.9	10.6		16.4
6 People 65+ registered as blind or partially sighted (%)	325	1.4	3.1	2.8	6.2		1.4
7 People 65+ registered as deaf or hard of hearing (%)	15	0.1	1.7	1.8	7.1		0.1
8 Stroke and TIA: GP recorded prevalence (%)	2,345	0.9	1.0	1.7	0.8		2.4
9 Dementia: GP recorded prevalence (%)	738	0.3	0.3	0.4	0.2		0.7
10 Hip fracture aged 65+	164	518.2	454.4	479.8	699.8		219.0
11 Flu vaccination in people aged 65+ (%)	18,538	75.6	72.5	74.1	68.7		79.8
12 NI 133 Timeliness of social care packages following assessment (%)	810	91.1	91.1	90.7	60.8		100.0
13 NI 130 Social Care clients aged 65+ receiving Self Directed Support	165	687.5	650.4	580.6	93.5		4678.9
14 NI 125 People 65+ achieving independence through rehabilitation (%)	155	73.6	85.3	78.2	52.9		100.0
15 Households receiving intensive Home Care 65+ (%)	188	71.0	78.7	72.8	38.9		100.0
16 Permanent admissions to residential or nursing home	235	9.8	6.3	7.5	11.6		0.0
17 Carers aged 65+ receiving breaks and/or for the carer (%)	130	0.5	1.1	1.1	0.0		2.6

**Vaccinations**

In 2009-2010 73.2% of people aged 65 and over were immunised against influenza, compared to 70.9% for London and 72.4% for England. Waltham Forest has one of the poorest uptake rates for pneumococcal immunisation.

**Emergency Hospital Admissions**

Waltham Forest is ranked 2<sup>nd</sup> in London for emergency hospital admissions due to fractures. In 2007 the indirectly standardised rate per 100,000 in Waltham Forest was 114.84, compared with 92.76 for London as a whole. The total number of people aged 65+ predicted to attend hospital A&E departments as a result of falls in 2010 is 1465, of whom some 18% would be admitted.

Analysis of three years Pneumonia emergency admissions data shows that the highest proportion of admissions are from Walthamstow (41%) followed by Chingford (29%) and Leyton Leytonstone (28%)<sup>402</sup>. Urinary tract infections among people aged 70 and above have been a major cause of emergency admissions through A&E with a rapid increase over the three year period from 2007/08. The mean length of stay was 16 days. These could be prevented through protocol based integrated care pathways jointly across health and social care. Patients aged 80+ had the highest spells of admissions.

<sup>402</sup> SUS ODBC query 07.11.2011

## Falls

### Executive Summary

- Falls represent a significant public health challenge, with incidence increasing at about 2% per annum.
- In England, the number of people aged over 65 is expected to rise by a third by 2025.
- Due to consequences of falls such as fractures and fear of falling, the physical, psychological and social functional abilities decrease which can have a considerable impact on perceived quality of life.
- The population of focus is people aged 65 years and over, living in Waltham Forest, because this is the most at risk population for falls.
- WHO categorized falls risk factors into Behavioural, Biological, Environmental and Socioeconomic.
- Hospital admissions for falls have increased by 77% between 2008/9 and 2010/11 financial years. It is projected to continue to increase over the coming years.
- The rate of hospital admissions for falls increases with age.
- Admissions due to falls were highest in Lea Bridge, Markhouse, William Morris, Chingford Green and Hoe Street.
- Whipps Cross Hospital (WX) achieved 11.7% and the national average was 48.2% of one of the Blue Book standards (All patients with hip fractures should be admitted to an acute orthopaedic ward within 4 hours of presentation).
- Effective interventions were adapted from NICE, National Service Framework for Older People and The Care of Patients with Fragility Fracture (Blue Book).

### Recommendations

- Develop the fall health needs assessment and its recommendations will inform commissioners to develop a Falls Prevention Strategy.
- Develop a Falls Prevention Strategy and refresh the current multi agency steering group.
- Pathway development and service redesign to incorporate integrated falls prevention, treatment and management pathway.

- Incorporate falls prevention and awareness into mainstream health and social care services, with criteria for identifying people suitable for falls assessment and evidence based interventions.
- Ensure all patients with hip fractures are admitted to an acute orthopaedic ward within 4 hours of presentation.
- Improve local data and information sharing among the partnerships, including collecting data from the community and from older people in residential care to identify total incidence of falls. This could help establish whether the consequences of a fall are more serious in different groups (demographic or geographical).
- Improve rehabilitation services for people who have lost functional ability or confidence after a fall.

### **What are falls?**

Falls are commonly defined as “inadvertently coming to rest on the ground, floor or other lower level, excluding intentional change in position to rest in furniture, wall or other objects”<sup>403</sup>. The population of focus is people aged 65 years and over, living in Waltham Forest, because this is the most at risk population for falls.

Falls represent a significant public health challenge, with incidence increasing at about 2% per annum. Increased rates of people falling, and the severity of the consequences, are associated with growing older and the rising rate of falls is expected to continue as the population ages. In England, the number of people aged over 65 is expected to rise by a third by 2025. Preventing older people from falling is a key challenge for Public Health; however it is not the preserve of one agency as the consequences of a fall and resultant fragility fracture cuts across all local agencies working with older people. Most falls do not result in serious injury. However, there is often a psychological impact. Evidence suggests that approximately 25 percent of people aged 75 or over unnecessarily restrict their activities because of fear of falling. Due to consequences of falls such as fractures and fear of falling the physical, psychological and social functional abilities decrease which can have a considerable impact on perceived quality of life.

### **Risk Factors**

A number of variables associated with increased risk of falling have been categorised into intrinsic and extrinsic. Intrinsic risk factors are those that present within the individual including mobility, strength, gait, medicine use and sensory impairment. Extrinsic risk factors are those that are external to the individual including hazards within the home environment.<sup>404</sup>

The following are the risk factors<sup>405</sup>:

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<sup>403</sup> WHO Global Report on Falls Prevention in Older Age, 2007

<sup>404</sup> Guidelines commissioned by the NICE (NICE), 2004: <http://www.nice.org.uk/nicemedia/pdf/CG021fullguideline.pdf>

<sup>405</sup> Map of Medicine 2011; Falls in elderly people

- Previous fall - 50% of those who fall will have another fall within the next 12 months.
- Increasing age.
- Environmental hazards, e.g. loose or slippery floor covering.
- Musculoskeletal problems especially affecting the lower extremities, e.g. weakness, arthritis.
- Dizziness.
- Abnormality of gait or balance.
- Visual impairment.
- Neurological disease, e.g. Parkinson's disease, Stroke.
- Cognitive impairment, e.g. Dementia (including Alzheimer's disease), Delirium.
- Cardiovascular problems: e.g. orthostatic hypotension; carotid sinus hypersensitivity; vasovagal syncope; postural hypotension (associated with increased morbidity and mortality, in part due to the increased incidence of falls).
- Drug therapy – hypnotics, sedatives, diuretics, antihypertensive.
- Polypharmacy (four or more medications).

WHO categorized risk factors into four<sup>406</sup>:

- **Behavioural** – Multiple medication use, excess alcohol intake, lack of exercise, inappropriate footwear.
- **Biological** – age, gender, race, chronic illnesses (e.g. Parkinson, arthritis, osteoporosis).
- **Environmental** – poor building design, slippery floors and stairs, loose rugs, insufficient lighting, cracked or uneven sidewalks.
- **Socioeconomic**: low income and education levels; inadequate housing; lack of social interaction, limited access to health and social services, lack of community resources.

### Local Picture

Evidence suggests that about a third of people aged 65 and over will fall at least once a year<sup>407</sup>. This translates to about 7,900 people (aged 65 and over) in Waltham Forest. There were 3,568 admissions over the three year period (2008/9 – 2010/11) among the defined population living in Waltham Forest. Of this, 3,514 (98%) were emergency admissions. On average there are about 1,171 emergency admissions per year in Waltham Forest. This suggests that about 15% of predicted falls (7900) attended A&E per year. This figure is higher than the DH estimated figure of 7%.

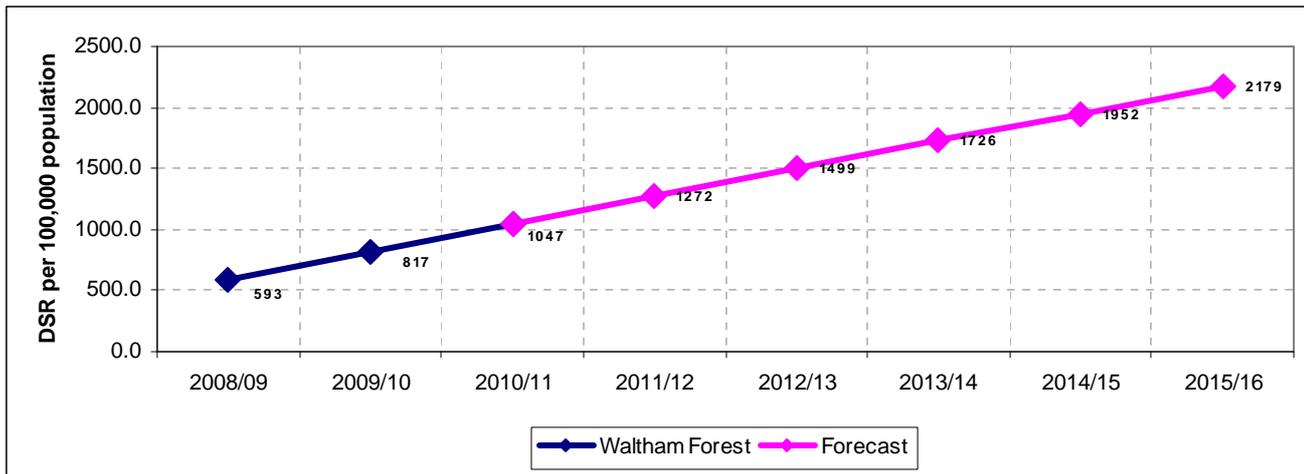
Figure 1 illustrates that hospital admissions for falls have increased by 77% between 2008/9 and 2010/11. The projection shows an upward trend suggesting that admission for falls in Waltham Forest may continue to increase.

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<sup>406</sup> WHO Global Report on Falls Prevention in Older Age, 2007

<sup>407</sup> Gillespie LD, Gillespie WJ, Robertson MC, Lamb SE, Cumming RG, Rowe BH. Interventions for preventing falls in elderly people. Cochrane Database of Systematic Reviews 2003, Issue 4. Art. No.: CD000340. DOI: 10.1002/14651858.CD000340

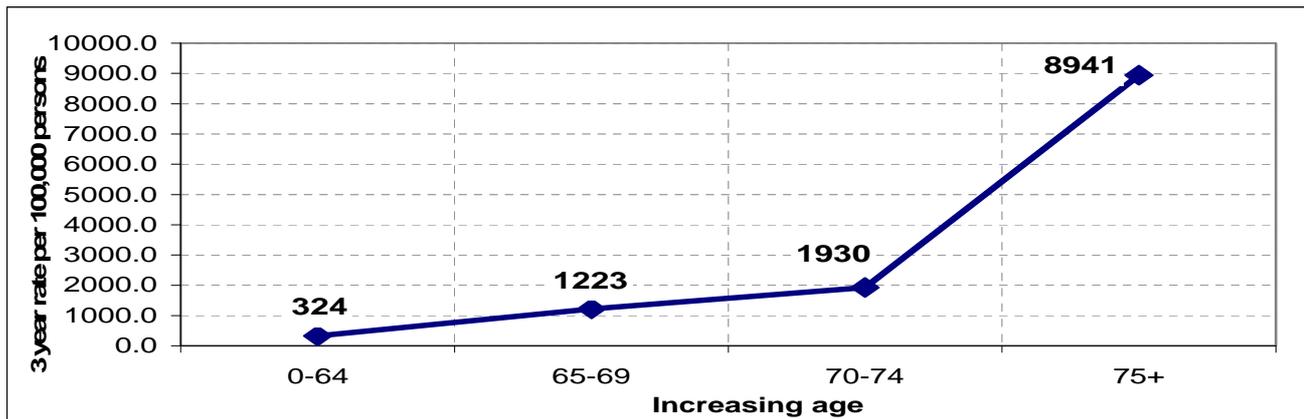
**Figure 1: Hospital admissions for Falls in Waltham Forest (all ages), 2008-2010, projection 2015**



Source: SUS Open Database Connectivity, query run July 2011, 5NC; ONS Mid year Estimates 2008, 2009, 2010, HES 2009-2010 The Information Centre

Figure 2 shows that the rate of hospital admissions increases with age. The admission rates in those aged 75 and over are five times more than those aged 70 to 74.

**Figure 2: Age specific hospital admission rates, Waltham Forest, 2008/9 – 2010/11**

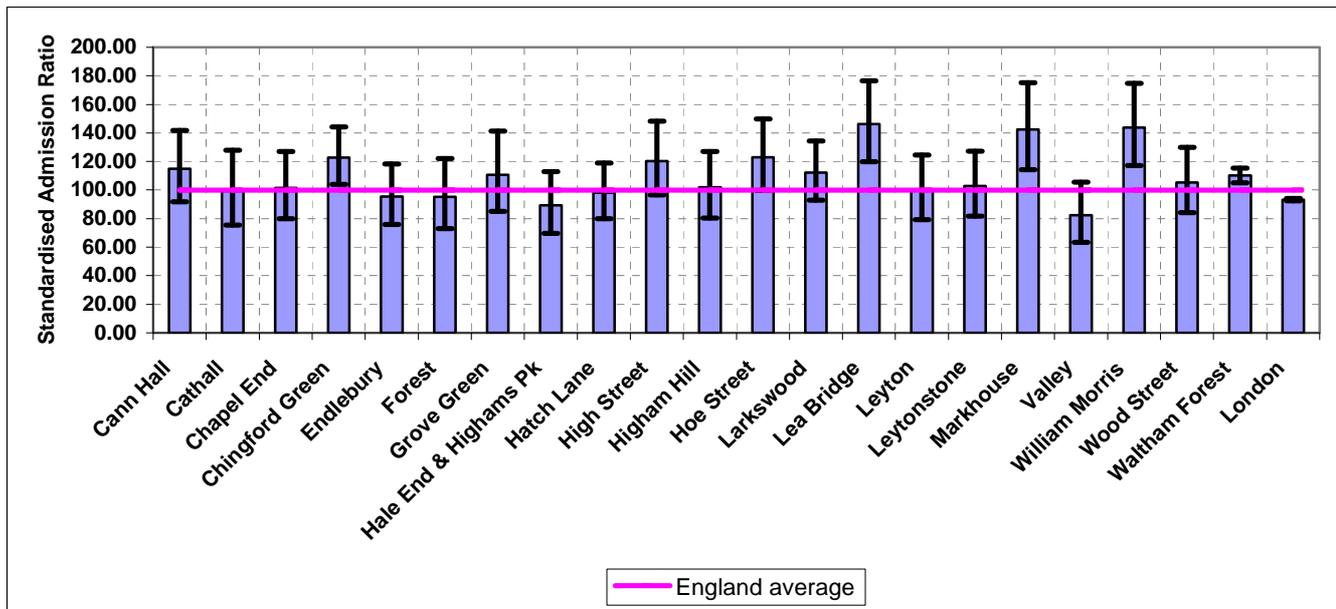


Source: SUS Open Database Connectivity, query run July 2011, 5NC; ONS Mid year Estimates 2008, 2009, 2010, HES 2009-2010 The Information Centre

Figure 3 shows that admissions due to falls are not uniform across Waltham Forest. Indirectly age-standardized ratios were evaluated to compare hospital admission rates between wards, taking into account the different age structures of wards. Admissions due to falls were significantly highest in Lea Bridge, Markhouse, William Morris, Chingford Green and Hoe Street. The (pink) horizontal line across the graph is the England average.

The underlying reasons why people fall and require hospital admissions are complex because there was no significant relationship between increasing deprivation and hospital admissions due to falls. Of the five identified areas with high rate of falls admissions, only one of them (Markhouse) is within 20% of the most deprived wards in Waltham Forest.

Figure 3: Hospital admission ratio by Ward (indirectly age standardized), Waltham Forest 2008/9-2010/11



Source: SUS Open Database Connectivity, query run July 2011, 5NC; ONS Mid year Estimates 2008, 2009, 2010, HES 2009-2010 The Information Centre

Table 1 shows that risk of osteoporosis increases with age. This confirms British Orthopaedic Association 2007 report <sup>408</sup> that Osteoporosis is the most common disease of the bone and its incidence is rising rapidly as the population ages. The femur fracture hospital events are predominantly high in the older population (see Table 2).

Table 1: Estimates of Osteoporosis in Waltham Forest, 2008 - 2010

Age group	Population	Number	Crude rate/100,000 pop
0-14	139,248	0	0
15-59	436,319	14	3.2
60-74	63,727	64	100.4
75 and over	33,351	80	239.9

Source: SUS

Table 2: Waltham Forest: Femur Fracture Hospital Events, 2008 -2010

Age group	Population	Number	3 years crude rate/100,000 pop
0-14	139,248	31	22.3
15-59	436,319	85	19.5
60-74	63,727	150	235.4
75 and over	33,351	631	1892

Source: SUS

<sup>408</sup> British Orthopaedic Association 2007: [http://www.boa.ac.uk/en/publications/fragility\\_fractures/](http://www.boa.ac.uk/en/publications/fragility_fractures/)

## What are effective interventions?

### NICE<sup>409</sup>

In 2004, NICE published its guidelines on the assessment and prevention of falls in older people.

Recommendations for good practice based on the best available evidence of clinical and cost-effectiveness are:

**Case and risk identification:** Older people in contact with health professionals should be asked routinely whether they have fallen in the past year and asked about the frequency, context and the characteristics of the fall.

**Multifactorial falls risk assessment:** Older people who present for medical attention because of a fall, or report recurrent falls in the past year, or demonstrate abnormalities of gait and/or balance should be offered a multifactorial falls risk assessment. This assessment should be performed by healthcare professionals with appropriate skills and experience, normally in the setting of a specialist falls service. This assessment should be part of an individualised, multifactorial intervention.

**Multifactorial intervention:** Older persons with a history of fall, or assessed as being at increased risk of falling should be considered for a multifactorial intervention.

**Encouraging the participation of older people in falls prevention programmes including education and information giving:** Individuals at risk of falling, and their carers, should be offered information orally and in writing about what measures they can take to prevent further falls.

**Professional education** – All healthcare professionals dealing with patients known to be at risk of falling should develop and maintain basic professional competences in falls assessment and prevention.

### National Service Framework for Older People

The Department of Health National Service Framework (NSF) for older people (2001) was produced as a resource for local NHS organisations and local councils to help deliver high quality services for older people.

Standard 6 focuses on falls and states<sup>410</sup>:

- The NHS, working in partnership with councils, takes action to prevent falls and reduce resultant fractures or other injuries in their populations of older people.
- Older people who have fallen receive effective treatment and rehabilitation and, with their carers, receive advice on prevention through a specialised falls service.

### Key interventions

This standard set out changes needed to reduce the number of falls and their impact through:

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<sup>409</sup>NICE 2004: <http://www.nice.org.uk/CG21>

<sup>410</sup> National Service Framework for Older People: standard 6 Falls

- Prevention - including the prevention and treatment of osteoporosis.
- Improving the diagnosis, care and treatment of those who have fallen.
- Rehabilitation and long-term support.

## **The care of Patients with Fragility Fracture (Blue Book)<sup>411</sup>**

### **Six standards for hip fracture care**

These standards reflect good practice at key stages of hip fracture care. Widespread compliance with them would improve the quality and outcomes of care and also reduce its costs. The rationale for them is set out in the Blue Book, and compliance – and progress towards compliance – can be continuously monitored by participation in the National Hip Fracture Database:

1. All patients with hip fracture should be admitted to an acute orthopaedic ward within 4 hours of presentation.
2. All patients with hip fracture who are medically fit should have surgery within 48 hours of admission, and during normal working hours.
3. All patients with hip fracture should be assessed and cared for with a view to minimising their risk of developing a pressure ulcer.
4. All patients presenting with a fragility fracture should be managed on an orthopaedic ward with routine access to acute orthogeriatric medical support from the time of admission.
5. All patients presenting with fragility fracture should be assessed to determine their need for antiresorptive therapy to prevent future osteoporotic fractures.
6. All patients presenting with a fragility fracture following a fall should be offered multidisciplinary assessment and intervention to prevent future falls.

Generally, Whipps Cross Hospital's performance is not too different from the national average, apart from one standard i.e. all patients with hip fracture should be admitted to an acute orthopaedic ward within 4 hours of presentation standard. See Table 3.

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<sup>411</sup> British Orthopaedic Association 2007: The care of Patients with Fragility Fracture (Blue Book)

**Table 3: Six Standard for hip fracture care performance<sup>412</sup>**

Standards	National Average	Whipps Cross Hospital
All patients with hip fracture should be admitted to an acute orthopaedic ward within 4 hours of presentation.	48.2%	11.7%
All patients with hip fracture who are medically fit should have surgery within 48 hours of admission, and during normal working hours.	86%	91.4%
All patients with hip fracture should be assessed and cared for with a view to minimising their risk of developing a pressure ulcer.	3.4%	3.7%
All patients presenting with a fragility fracture should be managed on an orthopaedic ward with routine access to acute orthogeriatric medical support from the time of admission.	6.1%	5-10%
All patients presenting with fragility fracture should be assessed to determine their need for antiresorptive therapy to prevent future osteoporotic fractures.	12%	5-10%
All patients presenting with a fragility fracture following a fall should be offered multidisciplinary assessment and intervention to prevent future falls.	67.5%	78-80%

**What is being done locally to improve falls prevention?**

NHS Waltham Forest's strategic developments are centred towards Health and Social Care services joining together to improve quality of care. The Waltham Forest unscheduled care strategy set an outcome to reduce emergency admissions for fractured Neck of Femur by 20% in one year (50 admissions).

Currently, there are a number of initiatives focusing on prevention, treatment and management across the borough; however the co-ordination of these is fragmented. Each of the services has its own care pathways which are not linked with other partners in the NHS Waltham Forest Multi Agency Falls Group. This raised concern for service redesigning.

**NHS Waltham Forest Multi Agency Falls Group Objectives:**

- To map whole system relationship in falls prevention and management across Waltham Forest.
- To lead the development of an evidence based pathway of intervention for older people at risk of falls or with a falls history.
- To identify high impact changes which would reduce falls.
- Improve standards and quality outcomes.

Relationship mapping and care pathway for falls prevention in the elderly is being developed and will incorporate Whipps Cross falls pathway and community pathways to map of medicines pathway or NICE. This will help to develop the integrated pathway in Waltham Forest.

<sup>412</sup>The National Hip Fracture Database National Report (2011):

[http://www.nhfd.co.uk/003/hipfractureR.nsf/NHFDNationalReport2011\\_Final.pdf](http://www.nhfd.co.uk/003/hipfractureR.nsf/NHFDNationalReport2011_Final.pdf)

A Falls Prevention Co-ordinator has recently been appointed. Crest is funded by the Local Authority for provision of personal assessment of service users, enhanced exercise programme and home hazard assessment for service users who are at risk of falls at locations in the North, Central and North of the Borough. This is a targeted Service.

### **What evidence is there that we are making a difference?**

It is too early to comment on this but with the falls coordinator appointment, QIPP Plans and partnership working, it is likely that hospital admissions for falls may reduce.

### **What is the perspective of the public on support available to them?**

National research has identified several barriers to accessing falls prevention services, including<sup>413</sup>

- Lack of information for non-English speakers.
- Lack of family support.
- Social stigma attached to programmes specifically targeted at 'older people'.
- Barriers to physical activity include low confidence and health expectations, pain and effort.
- Lack of transport to venues where activities are held.

### **What more do we need to know?**

Evidence suggests that hospital admissions for falls are increasing. However, there are still a number of people who experience falls that are not reported. It would be interesting to collect data from the community and from older people in residential care to identify the total incidence of falls and to establish whether the consequences of a fall are more serious in different groups (demographic or geographical).

NHS Waltham Forest Multi Agency Falls Group has identified that there are no evidence-based integrated falls prevention and management pathways for patients. Evidence suggests that a clear and multi agency care pathway allows patients to be identified quickly, assessed and directed to the services they need.

This suggests further health needs assessment to identify gaps. The newly appointed falls coordinator (yet to start) will lead on the development, implementation and monitoring of the strategy for an integrated falls prevention and management service across health, social care, housing, voluntary and independent living sector services in Waltham Forest.

There is a need to review the current services in the acute sector particularly standard one of the Blue book which states that all patients with hip fracture should be admitted to an acute orthopaedic ward within 4 hours of presentation. This standard is very low compared to the England average.

### **What are the priorities for improvement over the next five years?**

- Detailed Falls Prevention Health Needs Assessment is needed to identify the population needs and the service gaps to inform falls prevention strategy development.

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<sup>413</sup> Adapted from Tower Hamlets JSNA 2010-11

- Falls prevention strategy is recommended and this will refresh the current multi agency steering group.
- Service redesign to incorporate integrated falls prevention, treatment and management pathway.
- Incorporate falls prevention and awareness into mainstream health and social care services, with criteria for identifying people suitable for falls assessment and evidence based interventions.
- Ensure all patients with hip fractures are admitted to an acute orthopaedic ward within 4 hours of presentation.
- Improve local data and information sharing among the partnerships, including collecting data from the community and from older people in residential care to look to identify the total incidence of falls. This could help establish whether the consequences of a fall are more serious in different groups (demographic or geographical).

## **Dementia**

### **Executive Summary**

Dementia is disease of the brain that is associated with many clinical features including impairment of memory, learning, judgement language and emotions. It is usually chronic and progressive, rare in people under 60 years of age but increases in prevalence in older age groups<sup>414,415</sup>.

There are many types of dementia including Alzheimer's disease which is known to be the commonest type, vascular dementia, lewy body dementia and Parkinson's dementia<sup>416</sup>. Known risk factors include female sex, lower level of education, history of severe head injury and depression<sup>417</sup>. In the UK over 700,000 people are estimated to have dementia with 38% increase in 15 years. The estimate for London is 24,859 (2009) increasing to 65937 by 2021. In Waltham Forest the estimate is 1849 patients (2009).

The prevalence of dementia is estimated at 1.4% among the 30+ age group, rising to 7.3% among those aged 85+. The estimated number is expected to rise with predicted highest rate of growth in the 50+ age group.

### **Recommendations**

- Work in partnership with PCT CVD Board in order to prevent vascular dementia in Waltham Forest.
- Work in partnership with the London Borough of Waltham Forest and the Waltham Forest Federated Clinical Commissioning Group (Clinical Senate) to identify dementia early and to provide quality support in management of patients with established dementia.

### **GP registered prevalence of Dementia**

The prevalence of dementia in Waltham Forest calculated using all age GP list size as the denominator in 2008-2009 was 0.3%. This was lower than that for England (0.4%) but however the same for London, North East London and outer North East London.

In 2008/09, 738 patients were diagnosed with dementia by GPs in Waltham Forest. In 2009/10, the numbers diagnosed in primary care increased to 849. This indicates that 46% of the estimated number is diagnosed at present.

### **Types of Dementia**

Alzheimer's disease is the most common dementia in Waltham Forest from estimated numbers. Vascular dementia is estimated to account for 17% of all dementia. The number of women diagnosed was more than men. Alzheimer's disease is also known to be more common among women. Vascular dementia however is

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<sup>414</sup> Jaccques A. and Jackson G.A. Understanding Dementia. Third Edition. Churchill Livingstone, 2000. P3, 4.

<sup>415</sup> Carter P.J. Lippincott's text book for Nursing Assistants: A humanistic approach to care giving. Second Edition. Lippincott Williams & Wilkins, 2008. P.724

<sup>416</sup> Compton M. T. and Kotwicki R. J. Responding to Individuals with Mental Illness. Jones and Bartlett, 2006. P.110

<sup>417</sup> Kelsey J. E., Newport D.J. & Nemeroff C.B. Psychopharmacology for Mental Health Professionals. Wiley-Liss, 2006. P.287

usually more common among men but women again constitute a larger number in Waltham Forest<sup>418</sup>. It should be noted that the proportion of women in Waltham Forest is slightly higher than men that and these figures are not rates. The actual rates may typify what is expected. Also, these numbers are only of persons with long term chronic conditions.

Evidence shows that the following hard to reach groups need particular attention in developing dementia services:

- People of working age with dementia & people with learning disabilities.
- People with Alcohol-related problems.
- People with low incomes and in poverty.
- Minority ethnic groups.
- Lesbian and gay people.
- Disabled people and those who live alone.
- Prisoners.

### Quality of Primary Care for People with Dementia

GPs are expected to have comprehensive care plans and undertake regular review of patients with dementia. In Waltham Forest, a care plan was recorded in 73% of these and in 90% a clinical review was recorded in the previous 15 months. 81% of the patients who did not attend were followed up by the practices within a fortnight.

Table 1 summarises DEM2 QoF achievements (provisional) by practices and clinical commissioning groups in Waltham Forest, 2009-2010. 45 practices achieved DEM 2 with exceptions and 43 practices achieved DEM 2 without exceptions.

**Table 1: Summary of QoF achievements on mental health in Waltham Forest (2009/10)**

Indicator	National target	PCT		No of practices achieving the target	
		with exceptions	without exceptions	with exceptions	without exceptions
DEM2: The percentage of patients diagnosed with dementia whose care has been reviewed in the previous 15M	60%	80.5%	74.6%	45	43

Source: Quality Outcomes Framework 2009/10

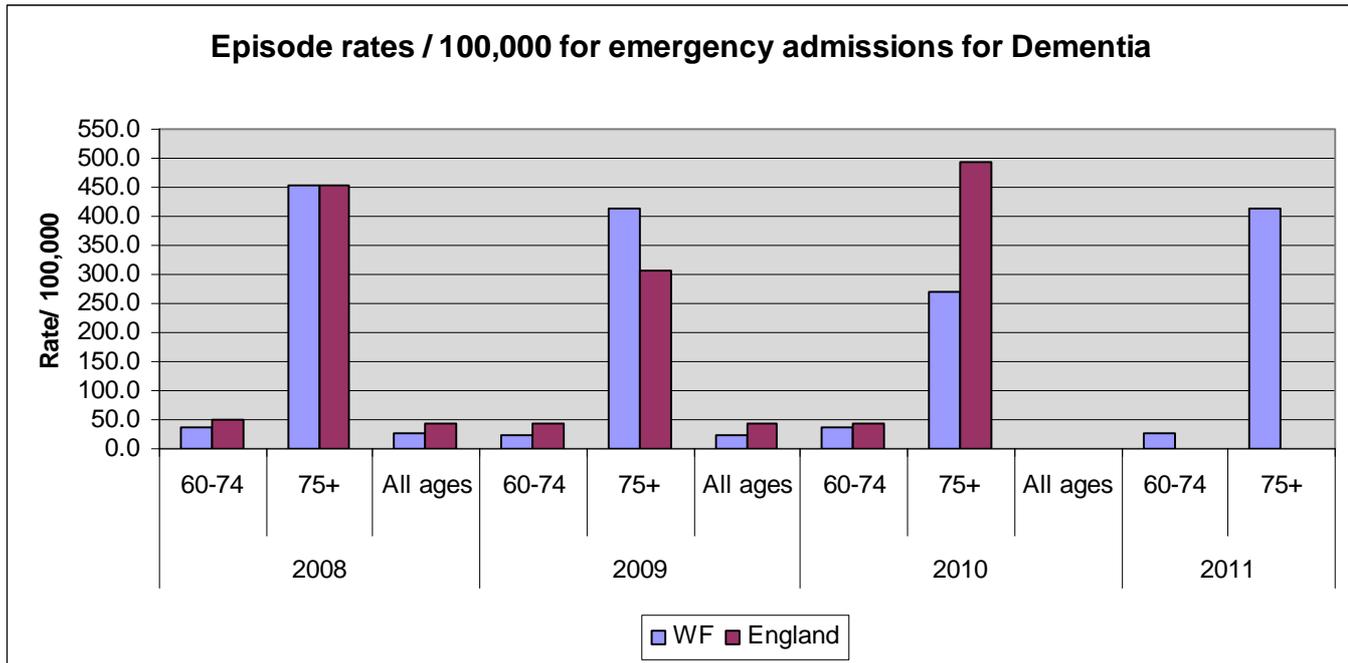
### Demand: Admissions for Dementia

In 2009, there were 53 emergency admissions (all ages) which fell to 38 in 2010 then increased to 52 in 2011. The rate of FCE/100,000 for Waltham Forest for the 75+ in 2009 was 413/100,000 which fell to 269 in 2010. The national rates for 2009 and 2010 were 307 and 494 respectively. There is a need to review the current

<sup>418</sup> Stein G. and Wilkinson G. Seminars in General Adult Psychiatry. Second Edition. Royal college of Psychiatrists, 2007. P.511

care pathway and identify potential areas for reducing high admission rates due to high cost associated with observed trend. The DOH dementia tool kit provides the required capacity based on best models in the UK.

**Figure 1: Emergency admission rates for dementia in Waltham Forest and England, 2007-2009**



Data source: SUS data, Emergency admission episodes for Waltham Forest; HES data 2007-2008 & 2009-2010 for England comparative rates

Among older persons aged 65 years and above, dementia emergency rates also declined in Waltham Forest from 33.4 per 10,000 in 2007-2008 to 26.2 per 10,000 in 2009-2010. However, the rates were higher than the national rate in both years.

### **Joint working with the London Borough of Waltham Forest**

The Joint Prevention Strategy developed in 2010 makes particular emphasis on SMI and dementia.

A joint dementia strategy with action plan was developed in 2010. This will be updated in response to recent changes to the national policy.

### **Social care service provision**

The London borough of Waltham Forest social care provides various services that promote wellbeing and support people with dementia, including for their families/carers. This includes:

- Information and Advice Service.
- Individual Advocacy Service.
- Independent Mental Capacity Advocacy (IMCA) Service.
- Waltham Forest Carers Support Groups.
- Dementia Support.
- Samaritans of Waltham Forest.

## Seasonal Influenza

### Executive Summary

Each year NHS Waltham Forest prepares for seasonal influenza (flu) as a key part of Winter Planning. The objective of the local programme is to minimize the health impact of seasonal flu through effective prevention, monitoring and treatment.<sup>419</sup>

Influenza can be severe for children under 6 months of age, older people, pregnant women, and those with underlying disease, especially chronic respiratory, cardiac disease and immunosuppression.<sup>420</sup>

Influenza can place considerable yet unpredictable pressure on the NHS during the busy winter period. Much work has been undertaken locally to ensure a robust, evidence based approach is taken to local multi-agency planning and implementation of the seasonal flu programme.

### Recommendations

- Vaccination of patients at risk before the virus starts to circulate.
- Vaccination of frontline health and social care staff.
- Ensure hygiene and case management advice is circulated to community services, primary care and the local population.
- Monitor local vaccine uptake in high risk patients and health and social care staff.
- Monitor flu activity and severity of disease in risk groups via the HPA. Work with North East and North Central London Health Protection Unit (HPU) to monitor local flu activity and to manage outbreaks.
- Ensure antiviral medicines are offered and available for patients in at risk groups for treatment of flu as per NICE guidelines.
- Monitor impact of flu on NHS services locally and support acute and community services as winter pressures develop. Work with NHS London to ensure the acute care pathway remains viable in NE London.

### What is Seasonal Flu?

Influenza is an acute viral infection of the respiratory tract transmitted by the aerosol, droplets or by direct contact with the respiratory secretions of someone with the infection.<sup>421</sup> It is characterised by a sudden onset of fever, chills, headache, myalgia and extreme fatigue. Other symptoms include a dry cough, sore throat and runny nose. The illness is usually self-limiting and lasts between 2 and 7 days. It may be complicated by

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<sup>419</sup> Seasonal flu plan. Winter 2011-12. Department of Health. [www.dh.gov.uk/publications](http://www.dh.gov.uk/publications).

<sup>420</sup> Immunisation against infectious diseases, Department of Health.

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_079917](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_079917)

<sup>421</sup> Immunisation against infectious diseases, Department of Health.

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_079917](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_079917)

bronchitis, bacterial pneumonia, otitis media, meningitis, encephalitis or meningo-encephalitis. However, between 30 and 50% of infections may be asymptomatic.

There are 3 types of flu virus: A, B and C. Influenza A causes outbreaks most seasons and is usually responsible for epidemics. The influenza A virus can change gradually from year to year. Major changes in the virus result in a strain new to the population which can cause widespread and sometimes severe disease if there is little immunity to it<sup>422</sup>.

The Department of Health have developed a seasonal flu plan for winter 2011-12. This sets out the annual cycle of the seasonal flu programme and details all preparations to be undertaken locally including vaccine ordering (with contingencies for unexpected demand), robust plans for vaccine delivery to all in risk groups; communications to improve uptake and reporting mechanisms.

### **What is the Local Picture?**

Influenza infection usually peaks during an 8 to 10 week period during the winter. The number of cases and severity can vary considerably from year to year depending on the strains of flu virus circulating and whether the general population have any immunity to these strains. The most severe flu season in the last 20 years occurred in 1999-2000. There were an estimated 21,497 excess winter deaths that year in England & Wales potentially attributable to flu. The last flu pandemic was declared in 2009 caused by influenza A (H1N1) v virus. Whilst illness was widespread, for most the disease was mild and there were fewer than 500 confirmed deaths in the UK. Serious complications occurred predominately in people with underlying health conditions and pregnant women but a significant proportion arose in those who had been previously healthy. A large incidence of flu was seen in London early and throughout the pandemic. This is thought to have been due to the large and mobile nature of the population, with many people travelling into or through London each day.

Influenza A(H1N1)v continued to cause widespread illness last season (2010/11) and is expected to be one of the key viruses circulating in the northern hemisphere again during 2011/12. Outbreaks were reported in schools, nurseries and other community settings in Waltham Forest as in all other areas of London.

### **What are effective interventions?**

Influenza vaccination is an effective measure in preventing infection and outbreaks. WHO monitor the epidemiology of flu viruses in the World and how they are changing, making recommendations regarding the strains to be included in seasonal flu vaccine for the forthcoming season. A(H1N1)v is likely to be one of the predominant strains again this season and so the trivalent seasonal flu vaccine will contain this and the two other strains most likely to circulate (A/California/7/2009(H1N1) like virus; A/Perth/16/2009(H3N2) like virus and B/Brisbane/60/2008 like virus).

The trivalent seasonal flu vaccine will be offered to those most at risk:

- All those aged 65 years or older.

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<sup>422</sup> Immunisation against infectious diseases, Department of Health.

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_079917](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_079917)

- All those aged 6 months or older in clinical risk groups (see Green Book).
- Health and social care staff directly involved in the care of patients or clients.
- Those living in long-stay residential care homes or other long-stay care facilities where rapid spread is likely to follow introduction of infection and cause high morbidity and mortality.
- Those in receipt of a carer's allowance, or those who are the main carer of an elderly or disabled person whose welfare may be at risk if the carer falls ill.
- Others involved directly in delivering health care such that they and vulnerable patients are at increased risk of exposure to seasonal influenza.

NHS Waltham Forest works with primary and secondary care to ensure those at risk are offered influenza vaccine prior to virus circulation. This includes health and social care workers who are not only at risk of influenza themselves but also of transmitting it to vulnerable clients.

The Department of Health target for seasonal influenza vaccine uptake is 70%. NHS Waltham Forest achieved coverage in the over 65 age group of 72.8% last year. Uptake in those under 65 years in high risk groups however was 50.4% (2010/11). Pregnant women were included in the seasonal influenza vaccine programme for the first time in 2010/11. Uptake in England was 36.6% amongst healthy pregnant women and 56.6% pregnant women with an additional underlying clinical risk factor.

Uptake of seasonal flu vaccine amongst health care workers is poor. 31% of frontline health care workers in London were immunised last year against flu and only 26% of frontline staff at Whipps' Cross University Hospital. Vaccination of healthcare workers against flu significantly lowers rates of flu-like illness, hospitalisation and mortality in the elderly in healthcare settings. Staff immunisation may reduce transmission of infection to vulnerable patients in acute care, some of whom may have impaired immunity and who themselves may not be able to have the vaccine or produce an immune response to it.<sup>423</sup>

Outbreaks of influenza in high risk settings are reported to North East & North Central London Health Protection Unit (NE&NCL HPU) who provide support and advice on case and incident management.

The Health Protection Agency (HPA) compiles UK flu surveillance information:

- Monitoring new consultations for influenza-like illness (ILI) from GP sentinel practices
- Virological surveillance (for laboratory confirmation and strain typing)
- HPA data on confirmed influenza infection where influenza contributed to death.

The local HPU provide local epidemiology to support outbreak management.

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<sup>423</sup> CMO letter May 2011. Seasonal flu immunisation programme 2011/12

### **What is being done locally to address low vaccine uptake?**

The DH seasonal flu plan, 2010/11 contains a good practice guide for GPs to assist them with increasing uptake of flu vaccine in high risk groups, locally. This will be shared with practices. It is suggested for example, that each surgery have a flu champion to co-ordinate local implementation and to respond to patient queries. Advice is given on raising awareness particularly for those at high risk. Robust call and reminder systems should be in place and a system for addressing defaulters. Consideration should also be given to improve access arrangements e.g. evening and weekend clinics. NHS Waltham Forest (NHS WF) will support surgeries in implementing these recommendations.

Performance data compiled by NHS WF is shared with GPs and best practice is shared to allow dissemination to practices with low uptake.

Work is underway with Whipps Cross Occupational Health department, supported by North East & North Central London Health Protection Unit, to improve uptake amongst health care workers (HCWs).

A local survey was performed by NENCL HPU in 2010 to investigate the reasons for poor vaccine uptake amongst HCWs in North East and North Central London. The outcomes suggested that access to vaccine in the workplace was generally good. The reasons for poor uptake were chiefly due to concerns about the clinical effectiveness of the vaccine and side effects and staff did not seem to consider flu a serious enough illness to prompt vaccine uptake.

There is now much evidence regarding the safety and efficacy of influenza vaccines and it is recommended by the HPU that secondary care staff be offered training about flu vaccine so that they be better informed and make the right choice about vaccination.

### **What are the priorities for improvement over next 5 years?**

The next few years harbour ongoing organisational change within the NHS and public health. It is important that the seasonal flu programme is supported and improved as new structures and organisations come into existence. It is vital that new roles and responsibilities are understood. NHS Waltham Forest is working hard to ensure consistency of planning and implementation of the seasonal flu programme across Outer North East London.

## **End of Life Care**

### **Executive Summary**

- Mortality rates for all causes, all ages in Waltham Forest are significantly higher than the national and London average for both males and females.
- On average there are 1500 deaths in Waltham Forest per year. 61% of these are people aged 75 years and above.
- In 2007-09, circulatory diseases accounted for the greatest proportion of deaths (33.2%) in Waltham Forest, followed by cancer (24.5%) and respiratory diseases (COPD & pneumonia) at 11.6%.
- Approximately 1,122 people or 70% of deaths in Waltham Forest would require palliative care each year according to the Higginson formula.
- 2009/10 QoF data show that just 285 patients who died were on GP palliative registers, representing only 25% of deaths. That means people who require palliative care may potentially not receive the care they need as they are not on a register.
- A recent survey on public preferences for place of death shows 89% of the participants wanted to die at home or in a hospice. However hospital deaths in Waltham Forest is rated the highest in the country at 75.2%; London 63.7% and England 56.7%.
- When we consider Margaret Centre deaths separately as it is a hospice, the proportion of hospital deaths reduces to 62.4%.

### **Recommendations**

#### **Data**

1. Invest in ONS mortality files in order to obtain robust data on end of life care especially place of death data.
2. Routinely carry out after death analysis in primary care and in the community to improve palliative care.
3. Routinely obtain data from Whipps Cross hospital showing hospital utilisation by people in the last year of life.
4. Routinely audit PCT and Trust complaints related to end of life care/from bereaved relatives as a proxy marker for quality of palliative care provision.

## **Quality**

5. Develop clear pathways for end of life care in the disease groups with highest mortality; CVD, respiratory diseases and cancer.
6. Increase early identification of patients in need of end of life care and keep up to date palliative registers, by embedding these indicators in practice appraisals.
7. Strengthen GP education to address gaps in skills particularly communication, assessment and identifying patients needing palliative care.
8. Increase the percentage of people dying in community (hospice, care homes, nursing homes own residence) to 50% by March 2013 in line with NHS Commissioning Support for London recommendation.
9. Commission an increased number of district nurses, and provision of high quality palliative care, as we seek to shift deaths from the hospital to the community.
10. Skill up the nursing home/care home staff to ensure they have appropriate knowledge and skills to deliver appropriate palliative care to residents.

## **Service**

11. Commission provision of out of hour's specialist palliative care in hospitals and the community in line with the national strategy and NICE guidelines.
12. Improving palliative care in hospital for patients who die there- at least 50% of hospital deaths to be on Liverpool Care Pathway.
13. Consult with the public to establish local palliative needs and priorities, and develop a targeted strategy to meet these needs.
14. Compare best practice in end of life care in other parts of the country and implement this locally.
15. Pilot a rapid response service in the community to determine whether hospital admissions can be avoided through speedy access to a dedicated team, this may be especially helpful in out of hours.

## What is End of Life Care?

End of life care is defined in the national end of life care strategy<sup>424</sup>, as care that

*helps all those with advanced, progressive and incurable illness to live as well as possible until they die. It enables the supportive and palliative care needs of both patient and family to be identified and met throughout the last phase of life and into bereavement. It includes management of pain and other symptoms and provision of psychological, social, spiritual and practical support.*

The Department of Health has developed three tools to support health care professionals to do this.

- The Gold Standards Framework supports early identification of patients who may die in the next 6-12 months and enables advance care planning and open discussions with patients.
- The Preferred Priorities of Care document aims to facilitate patient and carer choice, enabling them to document their priorities, and share this with health professionals e.g. preferred place of death.
- The Liverpool Care Pathway is a recommended best practice model of care for the last few days of life which can be used in any care setting.

End of life care is a key central government priority, ensuring that people die in dignity and with a choice of service provision including help to remain in their own homes until they die, should that be their wish.

## Local Picture

### Mortality

Age standardised mortality rates for all causes, all ages are significantly higher in Waltham Forest than the national and London average for both males and females<sup>425</sup>. In 2007-09 Waltham Forest age standardised mortality in males was 747.6 per 100,000 population compared to 673.49 nationally. This is the 9th highest in London. For females in Waltham Forest, age standardised mortality was 513.05 per 100,000 population compared to 478.31 per 100,000 population nationally. This is the 7th highest rate in London. On average there are 1500 deaths in Waltham Forest annually. 61% of these are people aged 75 years and above<sup>426</sup>. This is in line with the national trend, where two thirds of people die aged 75 or over with a recent trend towards an increase in deaths in the over 85s.

The causes of death change with increasing age at death – Alzheimer's, dementia, frailty, pneumonia and stroke becoming more common. The place of death changes too, with a higher proportion of the extreme elderly, who are more likely to be women, dying in nursing or old people's homes. This in part reflects the frailty

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<sup>424</sup> Department of Health (2008) End of Life Care Strategy: promoting high quality care for all adults at the end of life.

<sup>425</sup> The Information Centre for Health and Social Care, Compendium of Clinical and Health Indicators website ([www.nchod.nhs.uk](http://www.nchod.nhs.uk) or [www.nchod.nhs.uk](http://www.nchod.nhs.uk)): Mortality from all causes (ICD10 A00-Y99): Directly age-standardised rates 2007-2009 version 09\_V1 released March 2011.

<sup>426</sup> The Information Centre for Health and Social Care, Compendium of Clinical and Health Indicators website

of many elderly people before death, which often results in the need for 24-hour care; which clearly highlight the changing end of life care needs as the population ages.<sup>427</sup>

For Waltham Forest this points to the need to:

- Skill up the professionals and have clear pathways to be able to address the end of care needs linked to frailty of many elderly people before death.
- Increase capacity to meet the demand for nursing homes or old people's homes.
- Provide 24 hour care to ensure high quality service in the community and reduce unnecessary hospital admissions.

## **Ethnicity**

Black and minority ethnic groups [BME] comprise 42% of the population of Waltham Forest and are concentrated in the southern half of the borough. People of Black or South Asian origin are more likely to suffer from diabetes and heart disease with greater numbers of deaths from renal and heart failure<sup>428</sup>. Although a large proportion of the BME population are young, it is known that in the UK generally the number of 'ethnic elders' (over 55) is increasing<sup>429,430</sup>. In Waltham Forest the projected BME population of over 55 years for the next 10 years will be 19,782 which is a 58% increase from the current population of 12,526<sup>431</sup>.

Historically in the UK, it appears that ethnic minorities have not had access to specialist palliative care as much as would be expected according to their percentage in the population<sup>432</sup>. The reasons for this are not fully understood, but include low referral rates and lack of knowledge of services.<sup>433,434</sup>

There is evidence that the religious needs of some South Asians and Black Caribbeans have not been well

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<sup>427</sup> Deaths in Older Adults in England; National End of Life Care Intelligence Network; October 2010

<sup>428</sup> Waltham Forest joint strategic needs assessment 2011-12

<sup>429</sup> Department of Health Social Services Inspectorate. 'They look after their own, don't they?' Inspectorate of community care services for black and ethnic minority older people. London: Department of Health, 1998.

<sup>430</sup> Ebrahim S. Caring for older people: ethnic elders. *Br Med J* 1996; 313: 610-13.

<sup>431</sup> Greater London Authority (GLA) 2009 Round Ethnic Group Projections - SHLAA (revised) for Black & Minority Ethnic Groups aged 55+ years

<sup>9</sup> Firth S [2004] Minority ethnic communities and religious groups. In: Oliviere D, Monroe B, [eds] *Death, dying and social differences*. Oxford: Oxford University Press p25-41

<sup>432</sup> Firth S [2004] Minority ethnic communities and religious groups. In: Oliviere D, Monroe B, [eds] *Death, dying and social differences*. Oxford: Oxford University Press p25-41

<sup>433</sup> Ahmed, N, Bestall J, Ahmedzai S, Pyne S, Clark D Noble B [2004] Systematic review of the problems and issues of accessing specialist palliative care by patients, carers and health and social care professionals. *Palliative Medicine*, 18: 525-545

<sup>434</sup> Koffman J, Burke G Dias A Raval B Byrne J Gonslaes J Daniels C [2007] Demographic factors and awareness of palliative care and related services. *Palliative Medicine*, 21 145-153

catered for.<sup>435,436</sup> However, hospices have been shown to be sensitive to the religious and cultural needs of minority patients, and patients and families are largely happy with the care received<sup>437</sup>. Language barriers are probably the most significant reason for the needs of non English speakers not being met.<sup>438,439</sup>

It is not known whether there is unmet need among ethnic minority patients in Waltham Forest in respect of access to specialist palliative care, whether language barriers are overcome and patients receive care that is sensitive to their religious and cultural needs.

Given the high incidence and high morbidity of diabetes and heart disease in the BME population in the borough, an increased need for palliative care in end stage renal disease (ESRD) and heart failure can be predicted. This means for Waltham Forest there is need to:

- Develop heart failure and renal disease pathway.
- Liaise with the heart support team.
- Work jointly with the renal support team.
- Consult with BME groups to determine their preferences for end of life care.

### **Deprivation and Poor Housing**

It is known that people living in areas of high social deprivation, especially central London are less likely to die at home.<sup>440</sup> The 2007 Housing Market survey for Waltham found 13% overcrowding for all households and 23% for Local Authority housing,<sup>441</sup> half of these being 'severely overcrowded' and 39% of Local Authority dwellings fell below the 'decent home standard' in 2009.<sup>442</sup> It is known from qualitative studies in inner London boroughs that relatives find it difficult to look after terminally ill people in poor home conditions<sup>443</sup>. Lack of facilities (bathroom/bedrooms) may contribute to hospital admission<sup>444</sup>. There is a need to establish how

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<sup>435</sup> Koffman J, Higginson I, [2002] Religious faith and support at the end of life: a comparison of first generation black Caribbean and white populations. *Palliative Medicine* 16 540-541

<sup>436</sup> Vydelingum V [2000] South Asian patients' lived experience of acute care in an English hospital: a phenomenological study. *Journal of Advanced Nursing*, 32 [1] 100-107

<sup>437</sup> Worth A, Irshad T, Bhopal R, Brown D, Lawton J, Grant E, Murray S, Kendall M, Adam J, Gardee R, Sheikh A. [2009] Vulnerability and access to care for South Asian Sikh and Muslim patients with life limiting illness in Scotland: prospective longitudinal qualitative study. *BMJ*: 338 p183 [online version]

<sup>438</sup> Vydelingum V [2000] South Asian patients' lived experience of acute care in an English hospital: a phenomenological study. *Journal of Advanced Nursing*, 32 [1] 100-107

<sup>439</sup> Richardson A, Thomas VN, [2006] 'Reduced to nods and smiles' Experiences of professionals caring for people with cancer from black and ethnic minority groups. *European Journal of Oncology Nursing*, 10, 93-101

<sup>440</sup> Higginson I, Jarman B, Aston P, Dolan S (1999) Do social factors affect where patients die; an analysis of ten years of cancer deaths in England. *Journal of public health Medicine* 21[1] 22-28

<sup>441</sup> Waltham Forest Housing Needs and Market Survey – 2007

<sup>442</sup> Waltham Forest joint strategic needs assessment 2011-12

<sup>443</sup> Koffman J, Higginson I. (2004) Dying to be home? Preferred location of death of first generation black Caribbean and native-born white patients in the United Kingdom. *Journal of palliative medicine*, 7[5]:628-636

<sup>444</sup> Hinton J, (1994) which patients with terminal cancer are admitted from home care? *Palliative Medicine*,8: 197-210.

significant housing conditions are in contributing to the lower home death rate in Waltham Forest compared to the London and England average.

### Cause of death

In 2007-09 circulatory disease accounted for the greatest number of deaths in Waltham Forest (33.2%), followed by cancer (24.5%) and respiratory (COPD & pneumonia) diseases (11.6%). See Table 1 below.

Nationally there were on average 33.0% deaths from circulatory disease in the same period, 27.4% deaths from cancer and 10.4% deaths from respiratory causes.

**Table 1: Deaths in Waltham Forest by cause in 2007-2009**

All causes of death	4,500	Average per year 1500	
		% of total deaths by category	Average death per year
Circulatory disease (I00-I99)	1,493	33.2%	498
Cancer (C00-C97)	1,102	24.5%	367
Pneumonia (I60-I69)	300	6.7%	100
Chronic Obstructive Pulmonary disease (COPD) (J40-J44)	220	4.9%	73
Suicide and Undetermined injury	38	0.8%	13
Fracture of femur	40	0.9%	13
Hypertensive disease*	63	1.4%	21
Accidents	113	2.5%	38
Diabetes (E10-E14)	65	1.4%	22
Infectious & Parasitic disease	77	1.7%	26
Gastric, Duodenal or Peptic ulcers	34	0.8%	11
Chronic Liver disease, including Cirrhosis	70	1.6%	23
All categories listed above	3,615	80.4%	1,205

Source: NCHOD

### Palliative Patients' Identification

The 2009/10 QoF data show that there were 285 patients on GP palliative registers. However, using the formula provided by Higginson<sup>445</sup> (estimating need for palliative care based on total number of cancer deaths and 2/3 other deaths), a total of 1,122 people in Waltham Forest would require palliative care each year. This shows the palliative registers in primary care only capture 25.4% of the people needing palliative care. However QoF data reflect the number of people on the palliative registers at one point in time not the entire year so there may be some slight underestimate. Although the number on palliative registers does not reflect

<sup>445</sup> Higginson, I. 2001. The Palliative Care for Londoners: Needs, Experience, Outcomes and Future Strategy. NHS Executive London Region

the level of need, QoF provisional data for 2010/11 shows an increase in patients to 377. There is need to work with primary care to continue developing the Gold Standard Frame work (GSF) and to support GPs to identify more patients in need of palliative care.

### Place of death

According to national end of life care intelligence network<sup>446</sup>, 3,384 deaths (from all causes) occurred in hospital in Waltham Forest between 2007 and 2009.

This represents 75.2% of all deaths, which is significantly higher than average proportion of hospital deaths nationally (56.7%) and in London (63.7%). See Table 2 below.

**Table 2: Place of death proportion in Waltham Forest compared to London and England average, 2007-09**

Place of Death	Waltham Forest		London	England
	%	Number	%	%
Hospital	75.2%	3384	63.7%	56.7%
Own Home	16.4%	739	18.3%	20.0%
Residential Care (old people's home)	3.3%	148	4.4%	7.2%
Nursing Home	2.2%	99	5.7%	9.0%
Hospice	0.9%	42	5.9%	5.2%
Elsewhere	2%	88	n/a	1.9

Source: National End of Life Care Intelligence Network, 2007-09 average

Waltham Forest is ranked as having the highest hospital deaths in the country. However it should be noted that the data captured here include deaths in Margaret Centre which is a hospice within Whipps Cross Hospital and those deaths have been included as hospital deaths. The Office for National Statistics place of death statistics only counts deaths in a hospice building. Deaths in a hospice/palliative care unit in an NHS hospital or receiving the support of a Hospice Home Care Team cannot be captured with routine statistics<sup>447</sup>.

According to Margaret Centre data between 2007 and 2009 there were a total of 575 deaths which gives an average of 192 deaths each year. When we take these data into account, and subtract the Margaret Centre deaths from the Whipps Cross total, deaths in the acute hospital setting were 62.4% (2,809) which is below the London average.

Between 2007 and 2009, the major disease areas that contributed to hospital deaths in Waltham Forest are

<sup>446</sup> National end of life care intelligence network, End of life care profiles, place of death, available at <http://www.endoflifecare-intelligence.org.uk/home.aspx> accessed 14/08/2011

<sup>447</sup> National End of Life Care Intelligence Network; Variations in Place of Death in England. Available at [Variations in Place of Death in England](#)

respiratory, circulatory and cancer. The National Audit Office report for end of life care suggested that up to 35% of people who die in hospital could die in other settings<sup>448</sup>.

### **What are effective interventions?**

The Department of Health End of Life Strategy (July 2008) states a 'good death' for many would involve:

- Being treated as an individual, with dignity and respect.
- Being without pain and other symptoms.
- Being in familiar surroundings.
- Being in the company of close family and/or friends.

The End of Life Care Strategy aims to improve the provision of care for all adults approaching the end of their life. The Strategy centres on:

- Improving the provision of community services by, for example, making rapid response community nursing services available in all areas 24 hours a day, seven days a week; and improving coordination of care between local authorities and PCTs.
- Equipping health and social care staff at all levels with the necessary skills to communicate with, and deliver care to people approaching the end of life, and their carers.
- Developing specialist palliative care outreach services by encouraging PCTs and hospices to work together to provide appropriate support to all adults in the community, regardless of their condition.

NHS Commissioning Support for London recommends a model of care that provides for at least half of deaths outside hospital by March 2013.<sup>449</sup>

Health care for London has identified six quality markers for end of life care and recommends PCTs to incorporate these standards in their contracts with provider organisations<sup>450</sup>:

- Identification of patients.
- Care planning.
- Co-ordination of care.
- Communication skills.
- Support to nursing and residential homes.
- Discharge to preferred place of care.

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<sup>448</sup> National Audit Office (2008). Identifying Alternatives to Hospital for people at the End of Life

<sup>449</sup> *End of life care: Good practice guide*, Healthcare for London, Commissioning Support for London, March 2010

<sup>450</sup> End of life care good practice guide | March 2010 available at <http://www.londonhp.nhs.uk/wp-content/uploads/2011/03/EOLC-good-practice-guide-plain-text.pdf> accessed 16/8/11

A recent survey on public preferences for place of death shows 89% of the participants wanted to die at home or in a hospice<sup>451</sup>.

However other qualitative studies demonstrate that the preference for home as a place of death declines with the progression of illness<sup>452</sup> and is less among carers<sup>453</sup>. Hospital will remain the place of death for a large proportion of the population in the foreseeable future. It is therefore important to place equal emphasis on improving the quality of care in hospitals as in facilitating deaths in community settings.

The provision of end of life care services has become increasingly complex. People are living longer and the incidence of frailty and multiple conditions in older people is increasing. As a result, people approaching the end of their life require a combination of health and social care services provided in the community, hospitals, care homes, or hospices. There is need to ensure that the different providers give a seamless service.

### **What is being done locally to address this issue?**

#### **Palliative patients' identification**

The gap between the numbers of patients identified as end of life and those currently on GP practice palliative care registers should be bridged. In Waltham Forest only 25% of estimated people who need palliative care were on registers. The palliative care steering group has agreed to embed patient identification to GSF meetings and heart failure/COPD MDT meetings at Whipps Cross Hospital.

#### **Primary Care**

There has been a GP education programme with two formal presentations a year over the past three years incorporated into the pre-existing GP lecture programme held on Thursday lunchtime. Topics covered so far have been:

- The three 'End of Life' tools.
- GSF, PPC LCP.
- Symptom management: pain, nausea and vomiting, constipation, respiratory secretions, breathlessness.
- Symptom management and care in the last days of life.
- Palliative Care and ethnic minorities.
- Palliative Care in COPD.
- Palliative Care in end stage renal disease.
- Future sessions will include ethical issues, palliative care in heart failure and dementia.
- GP education in the NAEDI initiative included detailed after death analyses (ADAs).

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<sup>451</sup>Local preferences and place of death in regions within England 2010, available at:

<http://www.endoflifecare-intelligence.org.uk/resources/publications/default.aspx> accessed on 15/08/2011

<sup>452</sup> Higginson I, Sen-Gupta GJA. [2000] Place of care in advanced cancer: a qualitative systematic literature review of patient preferences. *Journal of Palliative Medicine*. 3, [3] 287-300

<sup>453</sup> Brazil K, Howell D, Bedard M, Krueger P, Heidbrecht C, [2005] Preferences for place of care and death among informal caregivers of the terminally ill. *Palliative Medicine*, 19: 492-499

- Case based discussion during GSF meetings and Macmillan nurses provides brief topics during their visits to practices.
- Communication workshops have been held.

### **Secondary Care**

- Establishment of an End of Life Steering Group chaired by the Director of Nursing.
- Roll out of the Liverpool Care Pathway (LPC) across the Trust.
- Localisation of a 'Rapid Discharge of the Dying Patient Pathway' to enable choice at end of life for those who wish to return home.
- Establishment of a bereavement sub group to examine the bereavement pathway. This group is reviewing all relevant Trust policies and procedures, environments where the bereaved are seen, the quality of information given out and will directly seek the opinions of bereaved relatives in a 'Have Your Say Day' planned for October 2011.
- Ongoing development of staff within the specialist palliative care team.
- Regular extended multidisciplinary team meetings for heart failure and COPD patients.
- Education and training including mandatory training for all nursing staff during the roll out of the LCP, two modules on the LCP and care of the dying patient on the mandatory Training Tracker electronic system for all doctors within the Trust, free study days on end of life care for community and care home staff, ongoing training on care of the dying and symptom control to junior doctors within the Trust, external teaching by all members of the multi-disciplinary team as appropriate.

### **Community**

In order to facilitate patients Preferred Priorities for Care (PPC) and raise the level of generalist palliative care provision in the community, provider services have established additional support and clinical training for community and nursing home staff, including:

- Ongoing education, clinical skills training, mentoring in communication and end of life care management in nursing homes (NH).
- Regular syringe driver and LCP training sessions for Community Nurses and NH Staff from Specialist Palliative Care Team.
- Access to support for individualised complex care issues (hands on) for community staff from EOLC lead.

- Support overnight from the OOH Community Nursing and Palliative Care team for all community patients, including Nursing Home Patients.

### **Evidence that we are making a difference**

Since October 2010 community services have had a community matron providing on site education and mentoring in communication and end of life care management in nursing homes, as well as supporting clinical practice. In addition, NH staff have been included in the Specialist Palliative Services update sessions, along with community nursing staff. For the nursing home population, this approach has reduced deaths in hospitals from 23% before a system of advice and support from the community matron was put in place (October 2010), to 4% over one year period, with over 90% of the residents achieving their preferred place of care.

After the roll out of Liverpool Care Pathway across the trust by end of March 2010, 36% patients who died in the trust were on LCP. For nursing home patients this had risen to 87% by March 2011, with two nursing homes actively seeking GSF accreditation, and all homes operating a palliative register, including regular monthly MDT review.

For community staff there has also been an increase in patients achieving their preferred place of care/death. However, the use of the LCP tool is not universal. As a result an audit has been commenced to establish barriers for the staff, so that training can be targeted for the future.

### **For the future**

A Community Matron Service is being commissioned to be rolled out across the borough. It is the aim of the service to manage care for the elderly, frail and chronically ill in collaboration with others, and it is hoped that this will assist in the recognition and inclusion on palliative care registers of patients currently not identified as 'palliative'. The matrons will co-ordinate and manage supportive care for the most compromised patients, including EOLC.

### **Public and patient perspectives**

At the time of writing this section there is no current public and patient perspective on palliative care, although Whipps Cross Hospital has planned a 'Have Your Say Day' in October 2011 and will be seeking opinion of bereaved relatives.

Plans are also being developed to include relative feedback in the after death analysis audits.

### **What more do we need to know?**

- Local people's views on palliative care provision in the borough and establish what their needs and priorities for palliative care are.
- Establish how significant housing conditions and deprivation are in contributing to the lower home death rate in Waltham Forest compared to the London and England average.

- Accurate data on palliative registers in primary care and on place of death.
- End of life care provision for minority groups (BMEs, disabled, lesbian/gay, homeless) in Waltham Forest. Establish what their needs and priorities for palliative care are.
- End of life care provision for children and young people in the borough - level of need, services available, children and young people's needs and priorities.

### **Priorities for improvement over the 5 years**

- Commission provision of out of hours specialist palliative care support for generalists working in the community and for hospital specialists.
- Increase early identification of patients in need of palliative care and keep up to date palliative registers.
- Consult with the public to establish local palliative needs and priorities, and develop a targeted strategy to meet these needs.
- Embed best practice Gold Standard Framework and Liverpool Care Pathway in all sectors of health care provision to enable people approaching the end of their life to live and die in the place of their choice and provide best care for the dying.
- Education of professionals (primary, secondary and community) to address gaps in skills particularly communication, assessment and identifying patients needing palliative care, and in diagnosing dying.
- Commission an increased number of district nurses to provide palliative care in the community, as we shift deaths from the hospital to the community. This will reduce unnecessary hospital admissions.
- Develop clear pathways for end of life care in the disease groups with highest mortality - CVD, respiratory diseases and cancer.
- In order to meet the 50% target of people dying in community (hospice, care homes, nursing homes own residence) by March 2013 in line with NHS Commissioning Support for London recommendation, commissioners need to invest in acute services to ensure adequate capacity for rapid and seamless discharge to community.

### **Key insights**

- There is still a major gap between preference and place of actual deaths. Comparisons of survey data on preferences with contemporary official statistics on place of death suggest that most people are still likely to see their preferences unmet regardless of where they live. National figures show the majority of

deaths in 2010 took place in hospitals (53%) and only 21% died at home<sup>454</sup>. In Waltham Forest more people die in hospitals indicating greater need to increase deaths at home/community. NHS Commissioning Support for London recommends increasing percentage of people dying in the community to 50% by 2013.

- Only 25% of patients who need palliative care are on palliative registers. About 69% of the deaths in the borough are from cancer, respiratory and circulatory diseases. Therefore focusing on identifying patients in these disease groups will bridge gaps in patients needing palliative care and those currently on GP practice palliative care registers.
- There is need to strengthen education of professionals to identify and assess patients needing palliative care and to encourage open discussion with patients and families when the end of life is near.
- The generalist palliative care service provided by PELC out of hours does not appear able to respond consistently to the palliative care needs in the community:
  - The response times are variable according to levels of demand.
  - There is no specialist palliative care support for generalists out of hours.
- NICE guideline and Improving Outcomes Guidance (IOG) in end of life care stipulate that 24/7 specialist palliative care cover should be in place to ensure generalist services have access to advice for cases with complex needs or symptoms which are difficult to manage. Waltham Forest currently is non compliant with this requirement. A lack of prompt access to services in the community leads to people approaching the end of their life being unnecessarily admitted to hospital. Studies show that absence of 24 hour response services and timely access to advice and medication leads to unplanned admissions<sup>455</sup>.
- There is need to improve communication between the different professionals and care givers in end of life pathway and provide an integrated service for palliative patients.

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<sup>454</sup> Local preferences and place of death in regions within England 2010, available at:

<http://www.endoflifecare-intelligence.org.uk/resources/publications/default.aspx> accessed on 15/08/2011

<sup>455</sup> National Audit office; Value for money report 2008. Available at [http://www.nao.org.uk/publications/0708/end\\_of\\_life\\_care.aspx](http://www.nao.org.uk/publications/0708/end_of_life_care.aspx)

Accessed 2608/2011

## Appendix 1 definitions

### The directly standardised rate (DSR)

This uses direct standardisation method. The age specific mortality or morbidity rates of a subject population are applied to age structure of reference or standard population in this case European standard population. The DSR gives a rate per 100,000 people.

### The standardised mortality ratio (SMR)

This uses an indirect standardization method. The age- specific mortality of rates of the reference or standard population (England) are applied to the age structure of subject population to give the expected number of deaths that would be expected in the pattern of mortality in the subject population was the same as standard population. The actual number of deaths, the observed figure is then compared to the expected figure as a ratio. SMR for standard population is always 100. An SMR above 100 indicates higher rates in the subject population and an SMR below 100 indicates lower rates of mortality.

### Benefit claimants: definition of types

Claimants have been allocated to statistical groups to give an indication of the main reason why they are claiming benefit. This is only one of the possible ways in which claimants could be classified and alternative classifications are possible.

IF CLAIMANT RECEIVES...	THEN ALLOCATED TO...
Jobseeker's Allowance	Jobseeker
Incapacity Benefit or Severe Disablement Allowance	Incapacity benefits
Income Support with a child under 16 and no partner	Lone parent
Carer's Allowance	Carer
Other Income Support (including IS Disability Premium) or Pension Credit	Other on income related benefit
Disability Living Allowance, Attendance Allowance or Industrial Injuries benefits	Disabled
Widow's Benefit, Bereavement Benefit or Industrial Death Benefit	Bereaved

Benefits are arranged hierarchically and claimants are assigned to the top most benefit which they receive. Thus a person who is a lone parent and receives Incapacity Benefit would be classified as incapacity benefits, whereas someone receiving both Bereavement Benefit and Disability Living Allowance would be classified as disabled. For this reason the group lone parent, for example, will not contain all lone parents claiming Income Support. Some will be included in the incapacity benefits group instead.

### Working-age benefits definitions

The list below gives a summary of the different working-age benefits for which information is available on ONS service on labour market statistic. Further information can be obtained from the Department of Work and Pensions website. [www.dwp.gov.uk](http://www.dwp.gov.uk)

### **Bereavement Benefit (BB)**

This was introduced on 9 April 2001 as a replacement for Widow's Benefit. It is payable to both men and women widowed on or after 9 April 2001. There are three types of BB: Bereavement Payment, Widowed Parent's Allowance and Bereavement Allowance.

### **Carer's Allowance (CA)**

This is paid to carers who look after a severely disabled person for at least 35 hours a week. The severely disabled person must be getting either higher or middle rate DLA care component or AA or maximum rate Constant Attendance Allowance with their War Pension or Industrial Injuries Disablement Benefit.

### **Disability Living Allowance (DLA)**

This is paid to people who have become disabled before the age of 65 and who need assistance with personal care and/or mobility.

### **Incapacity Benefit (IB)**

This is paid to people who have been incapable of work because of sickness or disability for at least four days in a row and who have paid sufficient contributions throughout their working lives.

### **Income Support (IS)**

This is available to those under 60 who have a low income. Until October 2003, IS was also payable to males aged 60 to 64 and was called Minimum Income Guarantee (MIG). From October 2003 MIG was replaced by Pension Credit. Both MIG and Pension Credit claimants aged 60 to 64 are included in the working age client group dataset (and the related children and families client group data sets) as IS claimants. They do not appear in the pension age client group dataset.

### **Jobseeker's Allowance (JSA)**

This was introduced on 7<sup>th</sup> October 1996 and is a contributory or income related benefit paid to people under State Pension age who are available for and actively seeking work of at least forty hours per week. They agree with Jobcentre Plus any restrictions on their availability for work and the steps they intend to take in order to find work. Additional help is available for partners and children of claimants.

### **Pension Credit (PC)**

This was introduced on October 6<sup>th</sup>, 2003 and replaced the Minimum Income Guarantee (MIG) - Income Support payable to people aged 60 or over. Pension Credit is paid to those aged 60 or over and guarantees an income of a certain amount per week, depending on whether they are part of a couple or are single. It also rewards those over 65 who have some savings for their retirement. Male claimants of Pension Credit aged 60 to 64 are included in the Working Age Client Group dataset, where they appear as Income Support claimants, and not in the Pension Age Client Group dataset.

**Severe Disablement Allowance (SDA)**

This was paid to those unable to work for 28 weeks in a row or more because of illness or disability. Since April 2001 it has not been possible to make a new claim for Severe Disablement Allowance.

**Widow's Benefit (WB)**

This was introduced on 6 July 1948 and is payable to women widowed between 11 April 1988 and 8 April 2001 inclusive. There are three types of WB: Widow's Payment, Widowed Mother's Allowance and Widow's Pension. Women widowed before 11 April 1988 continue to receive Widow's Benefit based on the rules that existed before that date.