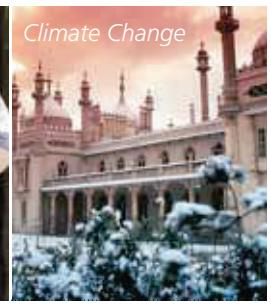
Vital



INCLUDES FEATURES ON

Annual Report of the Director of Public Health Brighton & Hove 2011

NHS Brighton and Hove

WHAT'S INSIDE

Closing the gap

269 lives lost needlessly each year in Brighton & Hove

Most people are familiar with improving life expectancy and falling mortality rates. We have come a long way in the last 100 years. However, whilst mortality rates are falling in all social groups, they are falling at a faster rate among the better off and so health inequalities are in fact widening. The latest analysis shows that men in particular in Brighton & Hove have some way to go.

Startling disparities in life expectancy within the city

The average woman in the city can expect to live five months longer than the average woman in England; 82.5 years compared to 82.1 years nationally. However, the average man in Brighton & Hove will live nearly one year less than his national counterpart, just 77.1 years compared to 78.0 years.

Within the city there are more startling disparities with a 7.0 year gap in life expectancy between the most and least deprived women and a staggering 10.1 years gap for men. But is this analysis fair? How do we fare when compared to 'people like us'?

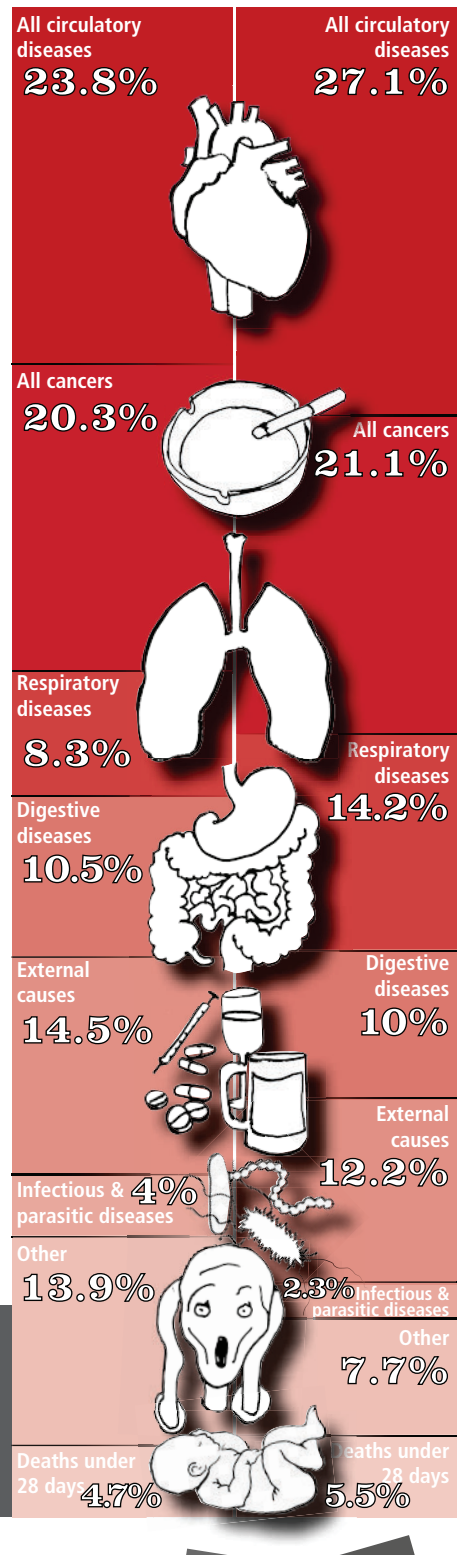
The Office for National Statistics (ONS) compiles tables of so-called 'ONS peers'. These are primary care trusts and local authorities with similar socio-demographic characteristics. Our primary care trust peers are Bristol, Liverpool, Leeds, Newcastle, Plymouth, Portsmouth, Salford, Sheffield and Southampton. For women in Brighton & Hove the news is relatively good with local women having the lowest (all age, all cause) mortality within our peer group. For men it's different – with Brighton & Hove sitting mid table.

How many lives do we need to save to turn this inequality around, and why is it a problem of men?

To achieve the best rate among our peers we would have to save an additional 65 male lives per year and a further 5 (total of 70 additional lives saved) to achieve the England average. If we look at the causes of these deaths we can see that the big mortality areas are cancer and coronary heart disease in both men and women. But the areas where men stand out as different locally in terms of mortality are 'other' and 'external causes'.

continued on page 3

Brighton & Hove inequality gap:
Contribution of different diseases to inequalities in life expectancy.



2003-2007 data: contribution of different diseases to gap in life expectancy between top and bottom deprivation quintiles in Brighton & Hove.

Source: London Health Observatory

> **...being average is not what we aim for in Brighton & Hove...**

Brighton & Hove City Council

The shape of general practice in Brighton & Hove

Over the years within Brighton & Hove we have tended to compare general practices with other practices based within the same locality (East/Central/West). This has meant that some practices have been compared with others with very different populations. Clustering practices according to the characteristics of the practice population allows indicators of need and health outcomes to be compared more appropriately.

Practice classifications with no Brighton & Hove practice

Circle

High percentage under 15 years. Very high percentage of Black population and higher than average Asian population. High deprivation.

Square

Practices with a smaller than average list size, a high percentage of the population aged under 15 years old and fewer aged 65 years or older. A very high proportion of the population from Asian ethnic groups and a higher than average proportion from Black ethnic groups. Very high levels of deprivation.

Hexagon

Located in towns or urban fringe settlements with low deprivation and few people from Asian and Black ethnic groups.

Crescent

Located in villages, hamlets and isolated settlements with a smaller than average list size and a higher proportion of the population aged 65 years and older. Few people from Asian and Black ethnic groups and low levels of deprivation.

The Yorkshire and Humber Public Health Observatory produced general practice classification groups in February 2011 for all practices across England. The groups were based upon practices having similar characteristics according to the following indicators:

- Percentage of population aged 0-4 years old
- Percentage of population aged 5-14 years old
- Percentage of population aged 65-84 years old
- Percentage of population aged 85 years or older
- Percentage of population from Asian ethnic groups
- Percentage of population from Black ethnic groups
- Deprivation score for practice population
- Whether the practice was in an urban area, town or urban fringe area or village, hamlet or isolated settlement

A 'two-step cluster analysis' was used to identify the 'best match' of the classification groups. Each group is designated by a different shape and in England there are ten different shapes/groups.

Within Brighton & Hove practices fall into six of these ten groups. We have no square, circle, hexagon or crescent practices – these classifications are either more rural or have higher proportions of people from Black and minority ethnic groups.

The group descriptions of Brighton & Hove practices are shown. **These groupings are used throughout this report.** The Station Practice and New Larchwood have not been included in the classification as they were newly established at the time the classification was created and there was insufficient information to include them.

More information is available at: www.apho.org.uk/pracprof/

Practice classifications for Brighton & Hove practices

Triangle

Practices with a high percentage of children (under 15 years old) and very high levels of deprivation.

Broadway Surgery; Park Crescent Health Centre; The Avenue Surgery; Willow Surgery; Whitehawk Medical Practice

Oval

Practices with a higher percentage of older people (aged 65 years and older) with slightly higher levels of deprivation.

Eaton Place Surgery; Ardingly Court Surgery; Sackville Road Surgery; St Peter's Medical Centre; Portslade Health Centre; Central Hove Surgery; School House Surgery; Links Road Surgery

Rectangle

Practices with a very low percentage of people under 15 years and a lower proportion of older people (65 years and older) and an above average proportion of the population from Asian and Black ethnic groups. Average levels of deprivation.

Boots North Street Practice; Stanford Medical Centre; Montpelier Surgery; Seven Dials Medical Centre; Pavilion Surgery; Lewes Road Surgery; University of Sussex Health Centre; Albion Street Surgery; North Laine Medical Centre; Brunswick Surgery; Regency Surgery; Goodwood Court Medical Centre; BHH Morley Street; Ship Street Surgery

Pentagon

Practices with an average proportion of the population in younger and older age groups and generally low deprivation.

Preston Park Surgery; Charter Medical Centre; Mile Oak Medical Centre; Ridgeway Surgery; The Haven Practice; Portslade County Clinic; Matlock Road Surgery

Octagon

Practices with a high percentage of the population aged 65 years and older and low levels of deprivation.

Saltdean and Rottingdean Medical Practice; Wish Park Surgery; Burwash Road Surgery; St Luke's Surgery

Kite

Practices with large average list sizes, an average proportion of the population under 15 years old, a higher proportion aged 65 years and older, and low levels of deprivation.

Hove Medical Centre; Carden Surgery; Warmdene Surgery; Beaconsfield Surgery; Woodingdean Surgery; Hove Park Villas Surgery; Hangleton Manor Surgery

"I think this primary care inequality audit is a great idea! We can reduce health inequality and primary care can play a central role. Inequality is our business."

Dr Christa Beesley,
GP, PRIMARY CARE CLINICAL PROGRAMME LEAD FOR MENTAL HEALTH

continued from front page...

These categories include:

- Mental health
- Suicide
- Alcohol and substance misuse
- Accidents

So if we want to improve the lives of men and hit the areas that are contributing to inequalities this is where our focus has to be.

These are very challenging areas but we can be more ambitious still. For let's face it, being average is not what we aim for in Brighton & Hove.

We can go further; for while 70 excess deaths are due to inequalities, even more are due to patients not being fully engaged in preventive measures.

So how do we do it? Some GP practices question what inequalities mean for them and can be sceptical about how they can make a difference.

The Department of Health has developed a model which calculates where we can reduce preventable deaths and by how much at local area level if all the eligible population (men and women) make use of already available interventions. These include anti-hypertensive drugs, statins, blood sugar management, smoking cessation and earlier detection of alcohol misuse.

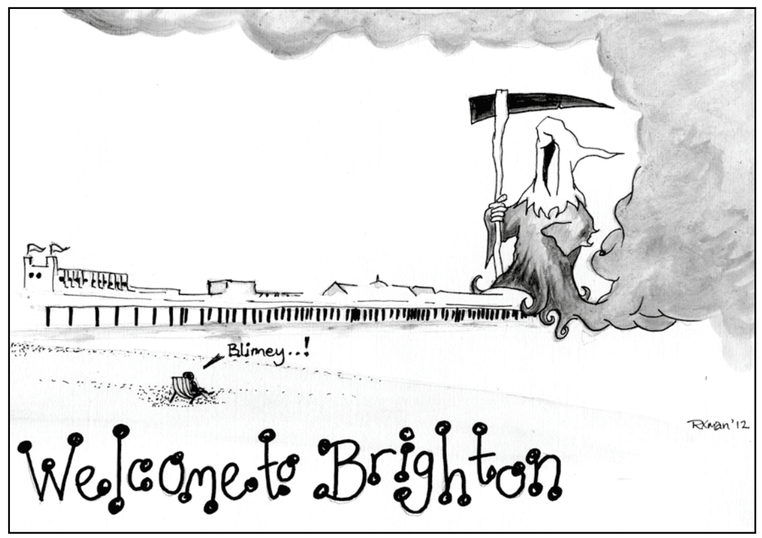
There are potentially 269 lives which could be saved each year in Brighton & Hove. Each practice has role to play. See how you can play your part by signing up to our Preventable Deaths and Inequalities Audit (10 CPD points).

Contact Terry Blair-Stevens at terry.blair-stevens@nhs.net or 01273 574613.

Practice Nurse Trudi Hills reflects on working with two groups of patients

I work at Sackville Road Surgery in Hove and at Brighton Homeless Healthcare in Morley Street. The patients at both surgeries are extremely different as are their needs. The most outstanding inequality in my view is the lack of resources for outreach work. It is very frustrating knowing that so much more could be done in outreach such as flu vaccination, chronic disease management, coronary heart disease prevention etc, all of which are so important for such a vulnerable population. But so much seems to be spent on secondary care, a lot of which could be avoided with more proactive preventive work.

See p38 for new developments in homeless care



CARTOON BY DR RICK CROSSMAN

EDITORIAL

The great leap forward - public health and primary care

DR TOM SCANLON
DIRECTOR OF PUBLIC HEALTH, BRIGHTON & HOVE

Engaging the primary care workforce in a joint public health and primary care agenda is the way forward

At the time of writing the future of the NHS seems both very certain and very uncertain. Certain in that the passage of the Health and Social Care Bill is assured, uncertain in that it isn't clear what it will all mean. Fundamental changes in the NHS will see primary care take on greater health leadership. In public health we have become accustomed to the upheaval of re-organisations but this one is the most dramatic by far, taking us out of the NHS and back into the local authority, where we sat for over 100 years prior to 1974. That gives us more opportunity to work on areas like housing, education, transport, climate change and the local economy. The danger is that it isolates us from the core health agenda.

"This year brings a key moment for the city's public health team and we welcome the formal return of some health leadership to the local authority after a long absence. The city council has always made a significant contribution to public health with our work on housing, transport, education, the environment and the economy.
The integration of the public health team will allow us all to make a bigger difference; more focus, more joining up, improved services and ultimately better health for local people. We are also very keen to work even closer with our local primary care colleagues and our public health colleagues can help us build those bridges. It's good news for the council and good news for the city."

JOHN BARRADELL
CHIEF EXECUTIVE OFFICER, BRIGHTON & HOVE CITY COUNCIL

BREAKING NEW GROUND

So this year the Annual Report of the Director of Public Health breaks new ground (when does it not?) combining public health and primary care with a wide range of contributions from colleagues across both specialities. We've adopted a 'taxonomy of local general practice' to allow practices to compare themselves with other similarly 'shaped' practices; the main lifestyle influences on health are covered; we look at key disease areas and inequality is a recurrent theme but all with a distinctive primary care twist. We've taken a look at some innovative models of primary care too, both locally and from around the country and we ask 'What is the shape of general practice to come?'

On a lighter note you will be able to see what some of your GP clinical colleagues get up to outside of the day job, how they keep fit, what they think of the changes, what difference they hope to make. Laura Beach and Dr Rick Crossman provide a little dark medical humour: a well known clinical coping strategy. And there are some potential CPD points for GPs up for grabs. So if ever there was a time for picking up a Public Health Annual Report, this is it!

MORE ON-LINE HEALTH FACTS AVAILABLE

In addition to this newspaper format there is an e-version and an on-line resource BHLIS (www.bhlis.org/needsassessments/publichealthreports) hosted by the city council where readers can look at a larger collation of health facts and figures, much of it broken down to practice level. References for the evidence quoted in this Report and web resources are also available.

I am grateful to the public health team and our primary care colleagues for pulling the Report together. The core production team this year comprised Kate Gilchrist, Clare Mitchison, Terry Blair-Stevens and Katie Stead (our roving reporter) and they have done an excellent job within a very tight time frame.

The style of the Report this year has tested all our creative juices. I wouldn't like to think that its accessibility dilutes from the important messages within, be assured that we take these issues very seriously.

But I am confident that this Report will achieve a wider readership than we have ever had for an Annual Report. I am confident too that the Report will do what I have asked of it, and engage the primary care workforce in a joint public health and primary care agenda. That for me is the future.

Does the patient still come first?

DR XAVIER NALLETAMBY
GP, CHAIR BRIGHTON & HOVE CLINICAL COMMISSIONING GROUP

As a lifelong GP I never imagined I would be writing an editorial in a Public Health Annual Report! Here goes...

When I trained, I was taught that the only person who matters is the patient in front of me and his or her health need.

That hasn't changed has it?

No it hasn't, but over the years the health of the population and the impact on the individual has become increasingly important. The organisation of practices has allowed us to look at the health of groups of people and not just the individuals who present in the surgery.

Our work in screening and prevention has become at least as important as our dealing with illness and as a result, the importance of public health is critical. We are much more involved in long term illness and we know so much more about the lifestyle choices and circumstances that can lead to disease.

We need to know who our patients are, the pattern of their diseases, their demography and any special needs we should be addressing.

Why do some groups have different health needs to others? Why does unemployment mean poorer health, for example? Why do some parents not vaccinate their children?

We have been working increasingly closely with our colleagues in public health and we now look together at our practice populations and profiles to help understand what we need to do best to help, not just the individual, but all of our patients.

Clinically led commissioning means doctors and nurses talking together in the interests of all our patients.

As long as there remains inequality in health we must continue to work closely with our public health colleagues to make sure everyone gets the best possible healthcare, appropriate to their individual needs and in the context of the society we live in.

So, yes, the patient still comes first.

"We need to know who our patients are... and any special needs we should be addressing."

NEWS

When somebody thinks you're wonderful…

> **The good physician treats the disease – the great physician treats the patient who has the disease.**
>
> William Osler

Beaconsfield Medical Practice comes out on top for patient satisfaction

The 2011 national patient survey results show that levels of patient satisfaction with GP surgeries in Brighton & Hove are similar to the national average. Asked the question 'Overall, how would you describe your experience of your GP surgery?' 46% responded 'very good' and 41% 'fairly good'. This marks a relative improvement as in previous surveys patients in Brighton & Hove have been less likely to be very satisfied compared to patients nationally. However, worryingly, levels of satisfaction locally and nationally have actually been falling gradually over the past two years.

Within Brighton & Hove, Beaconsfield Medical Practice came top of the table for the overall summary question for patients very or fairly satisfied. Several other practices scored consistently well across a range of indicators of patient satisfaction.

For more information see: www.gp-patient.co.uk

Top ten practices for patient satisfaction, 2011

	Overall satisfaction	Ease of getting through on the phone	Can see GP within 48 hours	Able to book ahead to see a doctor	Able to see preferred GP	Satisfaction with opening hours
1	Beaconsfield	New Larchwood	New Larchwood	Hove Park Villas	St Luke's	Brighton Station
2	Matlock	The Haven	Albion Street	The Haven	Links Road	Goodwood Court
3	Haven	Ship Street	The Haven	New Larchwood	Burwash Road	Beaconsfield
4	Portslade Health Centre	Broadway	Matlock Road	Links Road	Hove Park Villas	Links Road
5	Woodingdean	St Luke's	Stanford	Lewes Road	Lewes Road	St Luke's
6	Stanford MC	Albion Street	Broadway	Stanford	The Charter	Lewes Road
7	St Peters	Morley Street	St Luke's	St Luke's	Pavilion	Boots
8	Montpelier	The Willow	Ship Street	Ship Street	Goodwood Court	Matlock Road
9	Carden Ave	Goodwood Court	The Charter	Portslade Health Centre	School House	Morley Street
10	Portslade County	Brighton Station	Links Road	Matlock Road	North Laine	Pavilion

So how do you keep the customers satisfied?

A review of the characteristics that make a patient more likely to express satisfaction with their doctor concluded with the following advice:

- Smile
- Include patients in decision making
- Elicit concerns with questions such as 'What do you think is going on?' or 'What are you afraid of?'
- Dress semi-formally
- Invest in the ongoing development of your team
- Find pleasure in what you do – doctors who report high professional satisfaction also have patients who are more satisfied with their care

Nigel Bird (above), GP partner at Beaconsfield, had this to say about his practice's achievement:

"At Beaconsfield we do our best to combine the traditional values of continuity of care and family medicine with modern clinical practice.

Patient satisfaction involves all members of the team, from reception through to clinical staff. We regularly have full-team feedback and training days, as well as social events for staff, which help us to work together better.
We have an active patient participation group, and have acted on suggestions; for example, installing a glass screen in reception to improve privacy. Our patients can book appointments and request some prescriptions on-line.
Finally, we are a teaching practice, so we have the constant re-invigoration of young doctors bringing fresh ideas whilst at the same time keeping in mind a dictum from William Osler…….
The good physician treats the disease – the great physician treats the patient who has the disease."

Find out your practice survey results on www.bhlis.org

Residents with disabilities speak out on primary care

Recent local research has cast a little bit of a shadow on the primary care some disabled people receive in Brighton & Hove. The Fed Centre for Independent Living (formerly the Federation of Disabled People) conducted a study in 2011 which consisted of focus groups and in-depth interviews with 84 adults with a range of physical impairments, mental health conditions and learning disabilities.

One of the main themes explored in the survey was the experience of NHS healthcare. While some respondents were positive about the NHS overall, several reported mixed experiences of the care they received in primary care. Issues highlighted included access to GPs, the care and time taken by doctors, bedside manner, willingness to proactively treat problems, and the extent to which doctors involved them in treatment decisions.

"These days it's a real big deal to make a doctor's appointment because you have to phone up on the day and spend half an hour phoning and phoning and phoning while you're trying to do everything……..it's very stressful so you feel like you've hit the jackpot if you get an appointment"
(Female, 25-50, mobility impairment, long term health condition & mental health condition)

"My surgery is brilliant. All the staff know me, I fall asleep sometimes waiting for my doctor because she takes so long, because when you get there she doesn't chuck you out, she does find things out for me…"
(Female, 25-50, mobility impairment & mental health condition)

Continuity of care was a very important factor in determining their view of healthcare. Those who were able to build up a personal relationship with their GP were more satisfied than those who saw many different GPs.

"My GP's fantastic anyway. They've spent a lot of care on me, both physically and mentally, you know, so they've kept a really good eye on me... they've just been fantastic."
(Male, mental health condition)

Some of the participants in the research had long term, unusual conditions which were less commonly encountered by GPs. These disabled people typically had less positive experiences of their GPs who they felt did not understand their condition and lacked the expertise to treat them effectively. Patients reported that they felt like they had to research their own conditions to improve their treatment outcomes, due to the lack of knowledge of their GP.

"I mean I think they're a brilliant team but they need to find out about the condition that I've got and also to find out about my syndrome. There's so many different medical things that are an important factor."
(Male, 50-65, learning disability)

It is a tough call for GPs looking after people with rare conditions. With the move to larger practices and the opportunities for improved care that they afford, continuity of care is an increasing challenge. But what this research shows is that where we do it properly we can have a profound effect. Having someone in the practice who is familiar with the patient and their particular condition, however unusual, who understands their personal circumstances and whom reception staff ensure is made available for identified patients can go a long way.

You can view the full report at www.bhfederation.org.uk/federation-services/count-ability.html

"You see a doctor, you go in the door and the first thing they get out is a prescription, sometimes you don't want the prescription you know, without listening to you."
(Male, 25-50, mobility impairment & long term health condition)

FEATURE

Killer diseases take their toll on Brighton & Hove's citizens

KATE GILCHRIST
HEAD OF PUBLIC HEALTH INTELLIGENCE

It will come as no surprise to learn that circulatory diseases are responsible for the most deaths in the city, followed very closely by cancers. Respiratory disorders come third but with half the number of deaths.

However, the story is different when looking at deaths under the age of 75. The main cause of death is cancer followed by circulatory disease. The third most common cause of death in this age group is a category called 'death not caused by disease'. This is really a group of causes and consists mainly of suicide and accidents.

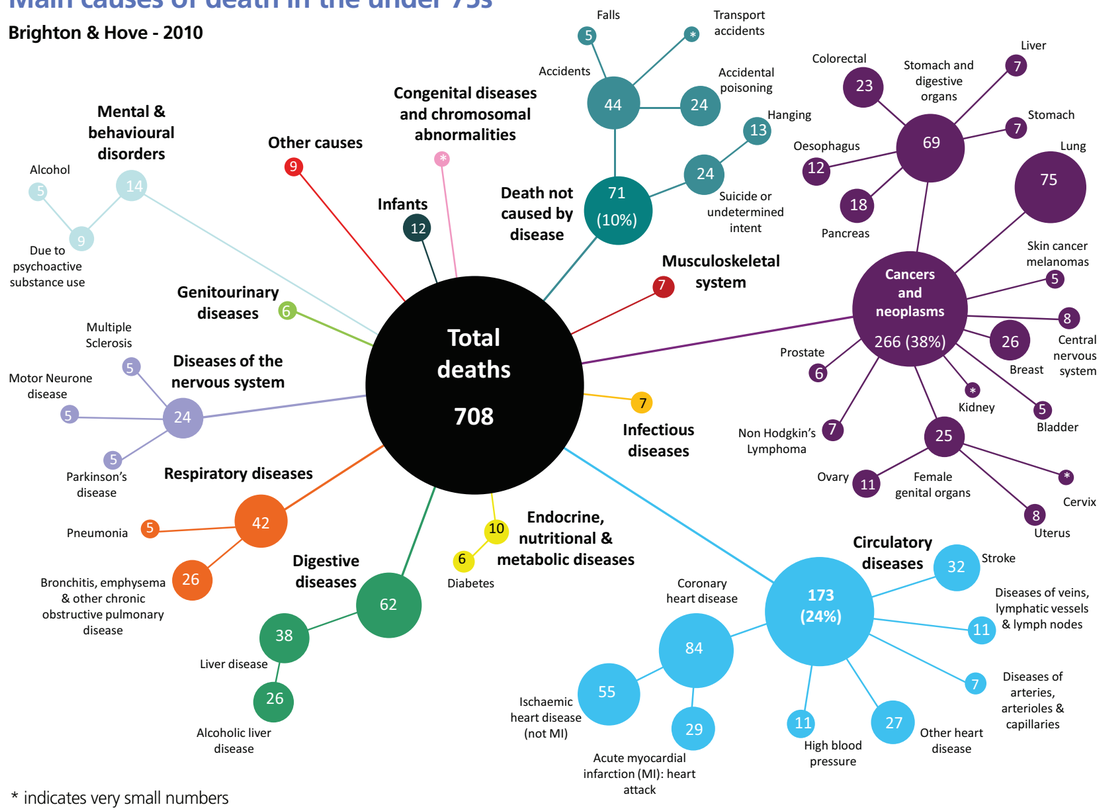
Within this age group there are many deaths that could be prevented through interventions at some point within the health system. This may be through for example, smoking cessation services, effective chronic disease management or early diagnosis of cancers. 'Mortality amenable to healthcare' is a useful marker of how effective the whole local healthcare system is, including disease prevention and management at individual and population level, through the combined efforts of public health, community, primary, secondary and tertiary care.

In Brighton & Hove it is the triangle practices that had higher mortality rates which are amenable to healthcare. Mortality in these practices is higher than it is for the same group of practices in England. The story is different for the octagon practices in the city. Mortality amenable to healthcare in these practices is much lower than the England average for octagon practices.

This raises a number of important questions about healthcare across the city.

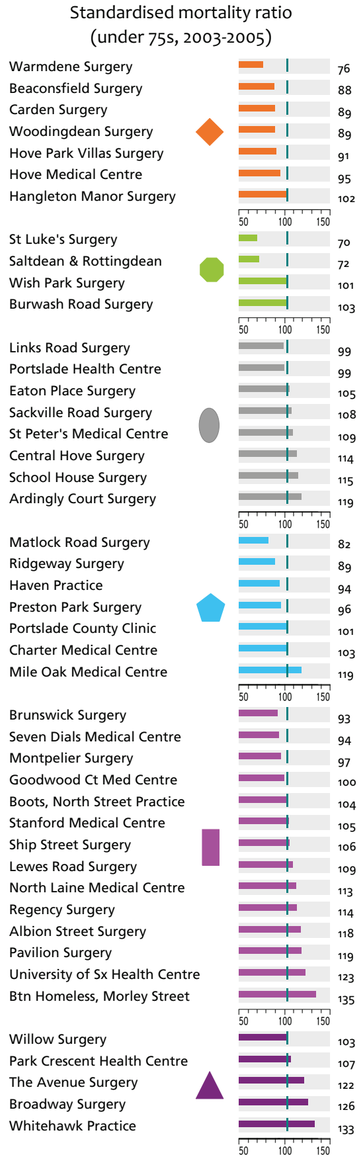
Main causes of death in the under 75s

Brighton & Hove - 2010



* indicates very small numbers

Mortality from causes amenable to healthcare



Notes: | = Brighton & Hove average, 102.8 (avg for England = 100).

THE BIG QUESTIONS

Are our services much more accessible to certain groups?

Are the biggest gains to be made in prevention or in primary care or in secondary services?

Should we be targeting funds differently?

Are there inequalities in availability of services?

What more can we do for the population of the triangle practices to ensure we deliver healthcare that responds to their needs as effectively as possible?

If you want to contribute to the debate, and more importantly make changes, contact public health or the clinical commissioning group and get involved.

"Liverpool and Islington point the way forward"

The accuracy of disease registers varies widely between GP practices. Likewise the achievement of outcome targets is far from consistent. Differences often mirror inequalities with registers in poorer areas less complete and the achievement of health outcomes better in more affluent areas. In cardiovascular disease, inequalities are seen in the treatment of blood pressure and cholesterol; the prescribing of aspirin, beta blockers, ACE inhibitors and anti-coagulants; and in smoking cessation advice and referral. An increasing body of evidence shows that retrospective audits of potentially avoidable deaths can prevent future premature deaths. In Liverpool and Islington, primary care trusts linked patient records from GP clinical systems to routine public health mortality files for cardiovascular disease in an attempt to see how well patients had been managed.

In Islington 31% of those who died from cardiovascular disease were not on disease registers, and 17% had received no primary clinical care for cholesterol or blood pressure in the 15 months prior to death. Additionally, 43% of those who died had a record of poor mental health. This is consistent with the literature, where the link between poor mental health and cardiovascular disease mortality is well documented.

In Liverpool 24% of those who died from cardiovascular disease had not been identified on any practice cardiovascular disease register, and 33% of those on practice disease registers had not had their blood pressure and cholesterol recorded in the 15 months prior to their death.

This demonstrates something that many people working in primary care will recognise; namely that being registered with a GP does not mean that you will avail yourself of primary care services. Learning from these retrospective audits, the primary care trusts in Islington and Liverpool instigated changes to better identify those with previously undiagnosed risk, and to raise the standard of disease management in primary care.

Practices can gain an indication of their overall management of patients with cardiovascular disease from a retrospective audit of patients who have died from cardiovascular disease, establishing the proportion of patients on disease registers, and whether or not recommended interventions had taken place. On a wider level within clinical commissioning groups, clinicians can get an indication of standards of care for their population.

There is now national guidance on 'How to undertake a retrospective cardiovascular disease mortality audit to support more systematic delivery of secondary prevention' (see link below). This involves matching practice data to public health mortality files and looking at four risk factors: blood pressure control, cholesterol, smoking and BMI. The public health directorate will support groups of practices wishing to undertake this audit. Ten CPD credits are available to GPs taking part. If you are interested contact Terry Blair-Stevens at terry.blair-stevens@nhs.net or 01273 574613.

www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/_115109.pdf

INFECTIONS

Brighton beats back the bugs

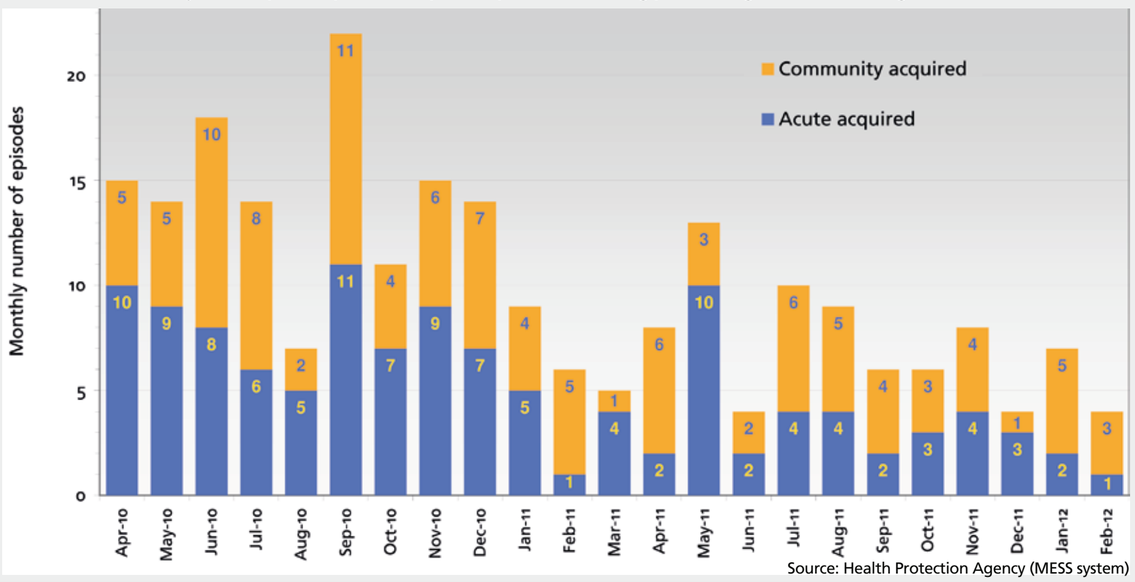
JENNIE LELEUX
PUBLIC HEALTH NURSE
(INFECTION CONTROL)

Not so long ago Brighton and Sussex Universities Hospital Trust (BSUH) was making national headlines because of high rates of healthcare associated infections like blood stream infections with meticillin-resistant *Staphylococcus aureus* (MRSA), and diarrhoea as a result of *Clostridium difficile* infection (CDI). Sustained efforts to prevent and control these infections, however, are now paying dividends. Jennie Leleux reports on the case for celebrating success.

These largely preventable infections have been falling for several years and even last year there was a marked decrease in cases of CDI in both the community and hospital. There were 144 cases of *Clostridium difficile* in the year preceding February 2011, but just 79 cases in the year preceding February 2012. MRSA blood stream infection rates also continued to fall, with only one infection detected locally in 2011/12 compared to ten in the previous year.

CDI cases almost halved in a year

Number of community and hospital acquired CDI episodes per month among patients registered with a Brighton & Hove GP



Source: Health Protection Agency (MESS system)

But these numbers, and in particular CDI, are still too high. Suffering from CDI is often undignified and can isolate patients from their loved ones. So the past year has seen new initiatives to further reduce these infections. These have included improved communication between hospitals and the community, ensuring that inappropriate antibiotics (often a provoking factor for CDI) are not issued, and further development of infection control champions in nursing homes. All significant cases are subject to a thorough investigation (Root Cause Analysis) involving all the staff involved in the care of the patient. Other infections such as meticillin-sensitive *Staphylococcus aureus* (MSSA) have been added to the mandatory surveillance scheme.

“Now wash your hands”

A brighter future

While a germ free future is not an option, a ‘zero tolerance’ mindset and tough targets (now called ‘challenges’) from the Department of Health with no more than 89 cases of CDI and 3 cases of MRSA for 2012/13 mean that healthcare associated infections will remain very much on the agenda.

We are thankfully in a much better place than a few years ago when there were hundreds of CDI and over 70 MRSA infections in Brighton & Hove. Staff across all healthcare and nursing care organisations should feel proud of their contribution to better standards of infection prevention and control and the lives consequently saved.

How you can help to reduce healthcare associated infections

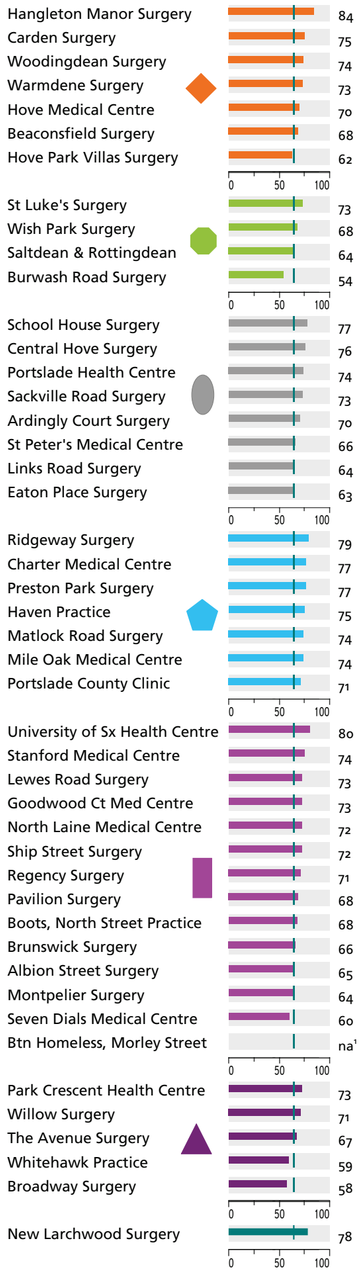
Nine nifty tips from Jennie Leleux

1. Maintain high standards of hygiene by regular hand washing and use of alcohol gel where appropriate;
2. Follow local (PCT) antibiotic prescribing guidelines; these are based on the best advice from the Health Protection Agency and can be downloaded to your desktop in a matter of seconds;
3. Monitor courses of antibiotics prescribed per patient for appropriateness;
4. Make sure patients using proton pump inhibitor drugs have their requirement for these drugs reviewed regularly;
5. Think CDI and record the severity of symptoms in patients with diarrhoea – use the Bristol Stool Chart if possible. This helps with treatment decisions as well as surveillance data collection;
6. Make sure that patients with diarrhoea are not on long term laxatives (this still happens sometimes!);
7. Try to avoid the use of anti-motility drugs in patients with diarrhoea of unknown cause;
8. Check that patients who manage their own care, such as changing dressings, are aware of infection control issues;
9. Make sure that patient records and surveillance surveys are completed accurately.

INFECTIONS

Flu immunisation uptake

(% over 65s, 2011/12)



Note: | = *Brighton & Hove average, 64.6*

[1] Small number of over 65s

We need to talk about...flu

DR PETER WILKINSON
CONSULTANT IN PUBLIC HEALTH

"When you have a disability, a mild cold or dose of flu can hit you hard. As I live by myself I don't want anything that is going to make me feel unwell and be laid up in bed. I would then rely on the help of services, neighbours and friends. So I make sure I have a flu jab every October."

(Male, 50-65, mobility impairment)

Targets, targets

There are three risk groups eligible for seasonal flu vaccination: the 65s and over, the under 65s in clinical risk groups and pregnant women. For the 2011/12 winter, Brighton & Hove did not meet national targets for any of these groups. The best local performance was 70% coverage for the 65s and over: an improvement on 2010/11 but still below the national target of 75%, which was achieved by just ten local practices. Across the city vaccine coverage ranged from just 54% to 84% - well done Hangleton Manor.

Coverage in the under 65s in clinical at-risk groups was 51% against a national target of 60% with only five local practices achieving coverage of 60% or above. Many children who should be vaccinated did not receive the vaccine.

Pregnant women were identified as a risk group during the 2009 pandemic. When infected with flu they have higher rates of hospitalisation, are more likely to require intensive care, and have a higher risk of premature delivery and perinatal death including stillbirths. The national target for pregnant women was 60% coverage but local coverage was just 30%, although immunisation coverage was 59% in pregnant women in clinical risk groups with 18 practices achieving 60% or above. Immunisation coverage for pregnant women *not* in clinical risk groups, however, was just 28% and no practices achieved 60% coverage.

What can practices do to improve uptake?

Persistent campaigns on the risks and consequences of flu and the benefits of immunisation are essential to success. The Department of Health's seasonal flu plan for 2011/12 provides guidance to practices on how to improve vaccine uptake among clinical risk groups:

- Identify a named influenza practice champion to coordinate the programme;
- Identify patients in the different risk groups;
- Set up effective call and recall systems;
- Prepare early with vaccine supplies and appointment slots;
- Chase patients who don't respond – telephone and text;
- Visit patients who are not able to attend the practice in their homes;
- Increase the hours of access to flu vaccine: evenings and Saturday mornings;
- Flag an alert on clinical systems for eligible patients and offer them immunisation opportunistically.

Practices that do well on flu vaccine follow this approach.

Flu vaccine works: it reduces patient deaths and can substantially reduce workload on practices with reduced consultations and home visits.

If you want to know more about how you could improve vaccine uptake in your practice, more detail can be found at www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_127088.pdf

Or contact Jennie Leleux in the public health team on 01273 574667.

And now for some good news on immunisation. Is it bye bye Jenny W's*?

Green shoots of vaccine recovery

Brighton & Hove is a city that has never really afforded vaccines a warm welcome. However, after the dramatic fall in measles, mumps and rubella vaccine (MMR) uptake, which followed from some now discredited research, vaccine uptake in the city is once more on the up.

Even so, in 2010/11, the uptake of primary vaccinations (before the age of one year) was still some way below the World Health Organisation (WHO) recommended coverage of 95%. MMR1 (the first of two recommended doses) which is given at 12-13 months, has improved by almost 20% since 2003 to 86% although coverage is still below primary vaccinations.

Pre-school booster uptake now stands at approximately 80%; this represents an improvement of 10% in the last three years. Teenage booster coverage is low at around 60%.

Having had two measles outbreaks in the last four years it would be premature to trumpet any vaccine success. However we are at last making some progress on immunisation across the board, and in no small part due to considerable hard work from the Immunisation Specialist Team, as well as the city's immunisation coordinators, school and practice nurses and doctors.

Fighting cervical cancer and now eradicating genital warts

The school based human papilloma virus (HPV) programme is now in its fourth year and so far the results are impressive. In 2010/11, the three-injection programme which protects against cervical cancer was completed by 85% of Year 8 schoolgirls.

From September 2012 there will be more good news as the UK switches from the Cervarix vaccine to Gardasil. Gardasil is a quadrivalent vaccine and protects not only against the two HPV strains (16 and 18) that cause over 70% of cervical cancer, but also against two further strains (6 and 11) which cause over 90% of anogenital warts.

*Jenny W's: teenage speak for genital warts

The routine childhood vaccine schedule

2 months:
- Diphtheria, tetanus, pertussis (whooping cough), polio and Haemophilus influenzae type b (Hib, a bacterial infection that can cause severe pneumonia or meningitis in young children) given as a 5-in-1 single jab known as DTaP/IPV/Hib
- Pneumococcal infection

3 months:
- 5-in-1, second dose (DTaP/IPV/Hib)
- Meningitis C

4 months:
- 5-in-1, third dose (DTaP/IPV/Hib)
- Pneumococcal infection, second dose
- Meningitis C, second dose

Between 12 and 13 months:
- Meningitis C, third dose
- Hib, fourth dose (Hib/MenC given as a single jab)
- MMR (measles, mumps and rubella), given as a single jab
- Pneumococcal infection, third dose

3 years and 4 months, or soon after:
- MMR second jab
- Diphtheria, tetanus, pertussis and polio (DtaP/IPV), given as a 4-in-1 pre-school booster

Around 12–13 years:
- Cervical cancer (HPV) vaccine, which protects against cervical cancer (girls only): three jabs given within six months

Around 13–18 years:
- Diphtheria, tetanus and polio booster (Td/IPV), given as a single jab

FEATURE

Alcohol – our most popular drug – and it's legal!

Alcohol makes some big headlines in Brighton & Hove

Health

Each week there are on average:

- 66 alcohol related ambulance calls;
- 97 alcohol related inpatient hospital admissions;
- 48 alcohol related A&E attendances, seven of which are by young people aged 13 - 18 years.

Each month an average of 44 young people are seen by the weekend Alcohol Rescue Service 'Safe Space' and eight people die from alcohol related causes.

Brighton & Hove scores poorly on alcohol indicators, among the bottom 50 (out of 151) primary care trusts in the country. The city fares particularly poorly on alcohol specific hospital admissions (both male and female), alcohol specific mortality and deaths attributable to chronic liver disease.

Social

Alcohol causes significant social problems. The alcohol related crime rate in the city was 9.2/1,000 population in 2010/11, while regionally it was 5.4/1,000. Among working age adults, 184.9 per 100,000 claimed incapacity benefit due to alcoholism in 2010. Dependency is not the only issue: while 11.9% of the Brighton & Hove population abstain from alcohol, of those who do drink, an estimated 22.7% are classed as 'increasing risk drinkers', and 7.6% are 'higher risk drinkers'. An estimated 27.3% of adults consume at least twice the daily recommended amount of alcohol in a single drinking session (binge drinking = 8 or more units for men, and 6 or more units for women). These figures are well above the regional average (2008).

Drinking behaviour in Brighton & Hove compared to the South East of England

Drinking behaviour	Brighton & Hove % (number)	South East %
Abstain	**11.9%** (25,300)	**12.1%**
Lower risk (Men who regularly drink no more than 3-4 units/day or 21 units/week and women who regularly drink no more than 2-3 units/day or 14 units/week.)	**61.4%** (130,400)	**63.7%**
Increasing risk (Men who regularly drink over 3-4 units/day or 21-50/week and women who regularly drink over 2- 3 units/day or 14-35 units/week.)	**20.0%** (42,400)	**18.3%**
Higher risk (Men who regularly drink over 8 units/day or over 50 units/week and women who regularly drink over 6 units/day and over 35 units/week.)	**6.7%** (14,300)	**5.9%**

"Although initially sceptical about what could have been another tick-box exercise, 'FAST' alcohol screening questionnaires have turned out to be a relatively easy way to start a potentially very important conversation and to change behaviour"

Dr Craig Milne, GP

Health inequalities

Alcohol is an important contributor to health inequalities, as it is often the most vulnerable people who are affected, either directly or indirectly. Alcohol related A&E attendances are 50% higher in residents from the most deprived fifth of the population compared to the most affluent. The rate of deaths from chronic liver disease is twice as high in Brighton & Hove compared to nationally and almost twice as many children in Brighton & Hove compared to the national average report that they have been drunk three to four times in the last four weeks. Alcohol is implicated in around half of all domestic violence cases.

Economy

All of this is expensive. The costs of alcohol misuse to the city are estimated at £107m per year: £10.7m from health impacts, £24.5m from economic effects and £71.8m as a result of crime.

However, the city also depends on alcohol sales for trade, tourism and employment, with alcohol being a key part of a dynamic night-time economy. The city has 7,200 people employed in the sale of alcohol and 3% of all employees in the city work in bars. The annual turnover from this is £329m.

The solution

If only it were that simple. Whether leisure, employment and trade benefits, particularly in times of economic hardship, offset dramatic health, social and criminal costs probably depends on your point of view.

So what is being done? A Brighton & Hove Alcohol Programme Board with representation from health, licensing, social care, the police, retail and the universities was established in late 2010 to take shared ownership of and responsibility for harm caused by alcohol.

The Board has four areas of action:

- The drinking culture
- Availability of alcohol
- The night-time economy
- Early identification, treatment and aftercare

The first year of the Board saw some success in licensing with a robust legal defence of the cumulative impact zone (where no new licensees are permitted) and a new licensing matrix to support positive developments; more effective policing with correspondingly reduced alcohol related criminal activity; and new services in A&E and primary care. A Big Alcohol Debate using twitter, a Big Brother style videopod, and paper and electronic surveys saw wide engagement from residents, customers and retailers.

Many people were concerned about antisocial behaviour, vandalism, noise and safety; several

said they would be more likely to visit the city centre if authorities took tougher action on alcohol.

Nationally, there is an emerging debate on minimum alcohol pricing, an issue that saw some support in the Big Alcohol Debate. A minimum price of 40p per unit would not affect pub prices but, it is estimated, would reduce consumption of off-licence sales of cider, beer and spirits. Wine drinking would increase and consumer spending would increase by 3.4%, but alcohol consumption (measured by units) would reduce by 2.7% overall. A ban in off trade discounting would see a further reduction of 2.6%. Alcohol related hospital admissions, deaths, violence, absenteeism, unemployment and crime would all reduce correspondingly. It would be a win-win policy initiative and has the support of the Alcohol Programme Board.

Next year will see a new plan with renewed efforts across the four areas of action and initiatives from the universities, A&E services, licensing and retailers. The proof of the pudding, of course, will be in the drinking.

'Student city'

Brighton & Hove is a student city with over 30,000 students studying at the universities of Brighton and Sussex.

Dr Jan Austera and his partners have watched their Sussex University practice grow with record student numbers including more from overseas. They have also seen rising levels of economic hardship among students.

"We are dealing with the new generations of truly modern patients, well informed, assertive and with high expectations," says Jan.

"We see a lot of sports injuries, genitourinary symptoms, affective disorders, skin problems, increasing allergies and related respiratory and ENT conditions."

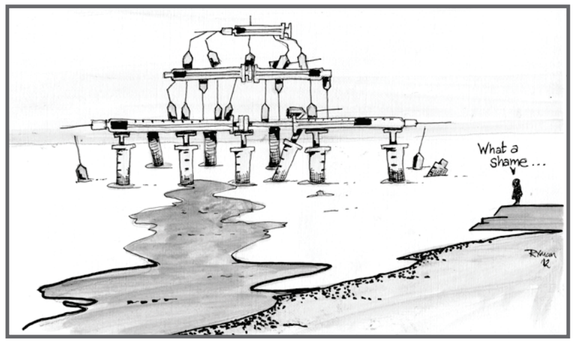
The practice team have also observed first hand the ever rising consumption of alcohol among students and the inevitable impact on their health. *"The whole team is working hard to educate and reduce consumption of alcohol early in people's lives."*

Freshening up for freshers' week

DRUG USE

Substance misuse in Brighton & Hove

Drug deaths capital?



By Dr Rick Crossman

The title of 'Drug Deaths Capital' is one that has been used often by journalists when referring to Brighton & Hove and it is easy to see why. The National Programme for Substance Abuse Deaths (np SAD) reported in 2009 that Brighton & Hove had a rate of 23.6 drug related deaths per 100,000. This was well above the next highest: East Lancashire at 14/100,000 and North Tyneside at 13/100,000. Of the 50 Brighton & Hove residents who died, 12 had been in contact with their GP in the month before their death. Opiates were implicated in 86% of deaths, followed by alcohol (60%) and benzodiazepines (54%).

Brighton & Hove also has one of the highest rates of suicide in the country and 10 of the 26 suicides audited in 2010 had significant substance and/or alcohol misuse recorded. In recent years the pattern of drug related deaths has become less clear; the np SAD programme has not reported since 2009 and the Office for National Statistics (which has traditionally reported a lower number of deaths than np SAD) showed drug related deaths at their lowest recorded level in 2010.

An improving picture?

Although drug related deaths as reported by np SAD are very high, problematic drug use in Brighton & Hove is not, when compared to other areas in England (46th highest of 149). Furthermore, the number of opiate and crack users previously referred to as problematic drug users has been declining for several years. In 2004/05 the prevalence of problematic drug users in the city was estimated by the National Treatment Agency at 19.3 per 1,000 people; by 2009/10 this had fallen by 40% to 11.5 per 1,000. This represents 1,287 fewer people using crack and opiates.

The reduction is mainly due to decreased opiate use as crack use has been increasing. A decline has also been seen nationally however, so there are still significantly more opiate and crack users in Brighton & Hove compared to England (8.9/1,000) and the South East region (6.6/1,000).

Decreased opiate use has seen a decline in injecting, although there are still more users injecting in Brighton & Hove (23.7%) compared to nationally (18.4%) and regionally (22.4%). There are however, lower levels of needle sharing (6.2% compared to 18.4% and 22.4% respectively) which reflects well on efforts in the city to reduce the harm associated with injecting drug use.

Moving to recovery

For many years national drugs policy has focussed on harm reduction, particularly from heroin and crack cocaine. A new national drug strategy launched in December 2010 marked a shift from harm reduction to recovery and covered dependence on all substances including prescription and 'over the counter' medicines, as well as alcohol. This shift will be particularly challenging in Brighton & Hove where relatively high numbers of people enter treatment but where patients are less likely to complete treatment successfully.

The Brighton & Hove Substance Misuse Health Protection Group, soon to develop into a Programme Board, oversees substance misuse strategy in the city. In 2011, following completion of a needs assessment, the group promoted the roll out of training in the use of Naloxone (a drug that can reverse overdose) to users and their friends and families. Additional services have also been established in A&E and treatment services to identify drug users who have suffered an overdose in order to prevent further occurrence. In 2012, the strategy group will oversee a new action plan that will be focussed more on recovery.

Putting theory into practice

Dr Becky Jarvis is GP clinical lead for mental health and substance misuse and sits on the strategy group. Dr Jarvis encourages all GPs to ask about substance and alcohol misuse when routinely assessing patients for depression. She works in St Peter's in Central Brighton, one of 13 local practices collaborating with specialist substance misuse nurses to provide enhanced services for substance misusers. In the past the focus of services has been to support people to become stable and remain on substitute medication. Now primary care, like other substance misuse services, will have to encourage more people to recover fully.

Dr Jarvis said, "The new national policy will provide a real challenge in Brighton & Hove but we have been working hard to strengthen links between primary and secondary care substance misuse services. We have introduced three Substance Misuse Clinical Update meetings a year which are open to all GPs, practice nurses and pharmacists, and we are also developing the enhanced service to focus on the new recovery agenda."

Brighton and benzos

Barbara Pawulska
PHARMACEUTICAL ADVISER

Brighton & Hove has the second highest level of benzodiazepine prescribing in England, significantly higher than other local or even comparator primary care trusts. These drugs frequently leak out into the illicit substances market. In addition to their role in many drug related deaths, in the long term benzodiazepine use is associated with an increased risk of falls and fractures, road traffic accidents, memory loss, confusion, cognitive impairment, ataxia, low mood and insomnia.

A number of local initiatives to reduce prescribing have been tried over the years but with little success. A benzodiazepine working group was established in late 2010 and it pulled together a programme of action with, for the first time, a target for reducing prescribing by 20% across the city.

It is too early to attribute too much to this new initiative but it has been accompanied by a small decrease in the volume of benzodiazepine prescribing across the city.

By September 2011, 26 of the 47 GP practices in Brighton & Hove had achieved a reduction in prescribing,10 of these had hit the 20% reduction target, and a further 8 were not far behind.

Working with Brighton & Hove clinical commissioning group, specialist nurse Charlie Freeman (Charlie.Freeman@nhs.net) has developed Ten Top Tips for prescribing and withdrawing benzodiazepines.

www.brightonandhove.nhs.uk/healthprofessionals/documents/BenzodiazepineTopTen.pdf

Benzodiazepine programme of action

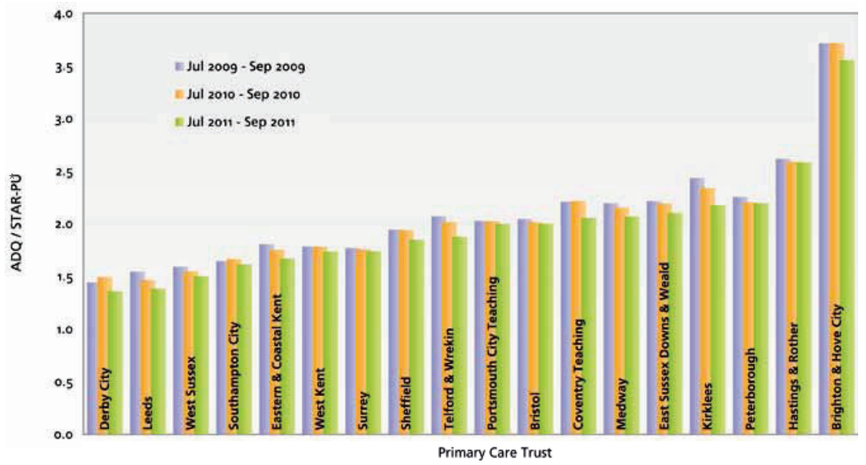
- Reduction in benzodiazepine prescribing included in the GP Prescribing Incentive Scheme for 2011/12, with a target of a 20% decrease
- Patient information leaflet published 'Understanding medication – Benzodiazepines'
- Information circulated to GPs and community pharmacists, including rational prescribing guide 'Benzodiazepine and Z Drug Ten Top Tips'
- Practice based support from a specialist nurse
- Guidance on benzodiazepine prescribing for mental health inpatients more closely enforced
- Rationale behind the drive to reduce prescribing presented to Sussex Partnership Foundation Trust clinicians
- Agreement on the need for clear cross sector communication regarding treatment plans for patients prescribed benzodiazepines

What now?

The apparent success of the Prescribing Incentive Scheme indicator has resulted in its retention for 2012/13. Further practical support materials are in development: these include consideration of random urine screening to check that prescribed benzodiazepines are being taken rather than diverted; additional support, such as counselling, to long term users; and better engagement with colleagues in secondary care to proactively address benzodiazepine use by inpatients.

See www.bhlis.org for the relevant links on tackling benzodiazepine use and misuse.

Benzodiazepine prescribing trends



*ADQ/STAR-PU is a measure which reflects the quantity of benzodiazepines prescribed adjusted for population size. This enables meaningful comparisons to be made between areas with different populations.

FEATURE

The shape of primary care to come

Having visited places like the Bromley by Bow Centre, where ideas were generated in the community, we thought we could learn from their experience. We have been planning a new shared building with the library in Woodingdean. This is an excellent opportunity to link education with health in the community.

Dr Darren Emilianus, GP

DR KATIE STEAD
GP, PUBLIC HEALTH
PRIMARY CARE LEAD

Innovative models of primary care that address more than presenting complaints, and help tackle health inequalities, are springing up all over the country, including Brighton & Hove.

Dr Katie Stead looks at some of the best models and asks 'what is the shape of primary care to come?'

Bunny Hill

Future health artwork

Bromley by Bow

BUNNY HILL – everything including the kitchen sink

In Sunderland the PCT has co-located two primary care centres with council services, linking health with council customer service centres in an area of high deprivation where 39% of residents have no qualifications and 34% of men and 48% of women are economically inactive. Local people were involved in the project, right from the design stage. The Bunny Hill centre hosts a seven partner GP surgery, an NHS primary care walk-in centre, a range of diagnostics, speech and language therapy, a retail pharmacy together with a number of council services and voluntary sector organisations. The council operates its customer service centre network ('First-Stop-Shop') from the building helping residents of North Sunderland access a wide range of services.

Open from 6 am until 8.30 pm, the centre also incorporates a library, an adult and community learning centre, a wellness gym, a children's centre and a community social enterprise which operates a community hall, meeting rooms, office, café, nursery and crèche.

GPs can prescribe exercise, as well as 'Books on Prescription' and a community officer works in the library helping patients with substance misuse problems.

Since opening, the GP practice has attracted 7,000 new patients while the walk-in centre treats 22,000 patients each year. Over 3,800 patients have attended planned care services and one quarter of all under - fives in the area are seen there by the Children's Services Team.

DERBYSHIRE – a marriage of general practice and citizens' advice

Citizens Advice Bureau (CAB) services have become an integral part of NHS Derbyshire County's primary healthcare services. Of the county's 113 general practices, 90% now offer free, confidential, independent and impartial advice.

In 2010/11 help and advice was given to over 5,500 families. This advice helped secure additional income for patients of almost £7m, and rescheduled or managed over £8m of debt with 45% of clients receiving additional income or a one-off payment. The joint model has received praise from patients and GPs alike. Some Brighton & Hove practices are now doing the same.

The proposed Woodingdean site

THE BROMLEY BY BOW CENTRE – re-skilling communities

The Bromley by Bow centre based in one of the most deprived electoral wards in East London supports families, young people and adults to improve their health and wellbeing, learn new skills, find employment and develop the confidence to achieve their goals.

The centre hosts a general practice, a healthy living centre and a number of social enterprises. The partnership between the public, private and voluntary sectors supports thousands of people in East London with more than 100 community projects providing everything from landscape gardening to leadership classes.

The centre is a major driver in creating opportunities, local jobs and wealth, helping to raise aspirations and support people to change their lives. The focus is on tackling causes of chronic illness and unhealthy lifestyles; nurturing new skills to help people reach their full potential; supporting access to employment and reducing dependency on benefits; and fostering new and dynamic businesses that boost the local economy and generate jobs for local people.

Over the past two years, the centre's Women's Capability Initiative supported 120 women, primarily from the Bangladeshi, Somali and Turkish communities, who had English language and employability needs to become job ready. Since 2005, the centre's Beyond Business service has initiated 28 successful new social enterprises with a combined turnover of more than £3m and 200 new jobs. The centre's Working Wonders project helps isolated older people and vulnerable adults with learning difficulties, physical and mental health problems through gardening, art-related and healthy lifestyle activities.

WOODINGDEAN – a local vision for co-located services

An innovative plan for a joint development in Woodingdean is currently out for public consultation. The proposal is for a new surgery to be co-located with the public library, enabling new approaches to health promotion and self-care. The library will provide a 'shop front' for health information, both paper-based and on-line, with support and training for anyone needing help to access internet resources.

The aim is also to support people with long term conditions, their carers, families and friends, providing targeted resources and information. People who might not have a reason to visit their GP surgery could also benefit from informal access to health information, including access outside normal working hours; at weekends and in the evenings.

Work with the surgery's patient participation group is already underway to develop these links, and to inform the choice of websites and resources.

The new purpose-built premises will be fully accessible and will enable a wider range of clinical services to be provided for patients: possibilities include counselling, sexual health services and an area for triage. If all goes according to plan, the new building could be open by April 2013.

A VERY 'BRIGHTON' INITIATIVE?

Local GPs Dr Sarah Andersen and Dr Laura Marshall-Andrews are exploring the opportunities for establishing an integrated holistic general practice 'Future Health' in East Brighton. The service would include a pharmacy, alternative practitioners, an organic café, yoga, art, music and a garden overlooking the sea. Promoting good health would be at the centre of the new service, which would provide clinics offering smoking cessation, alcohol support and obesity management.

The concept is one of patient empowerment which will then inspire whole communities to better health in a beautiful setting. 'Our idea,' says Dr Andersen 'is to take things that are already happening in Brighton, and to make them into a more cohesive network by running them from the same site.'

Some colleagues have pointed to the need to guard against such a service increasing inequalities. A Health Impact Assessment with input from local residents could usefully inform this proposal and reduce this risk. Dr Andersen says, 'rents would be paid into a trust which would plough the money back into the site to offer more to disadvantaged people'.

Planning is forging ahead with a project manager appointed and an enthusiastic architect, Amanda Levete, joining the concept team. A grant from the Department of Health's Social Enterprise Investment Fund is enabling the team to carry out a full feasibility study.

AND THE FUTURE?

Public health and primary care are coming together in Brighton & Hove. More practices are co-locating with services such as pharmacy, dentistry and sexual health and even Citizens Advice. Local enhanced schemes, practitioners with special interests and public health lifestyle initiatives on smoking, obesity, alcohol and substance misuse are helping to drive some of these changes.

There are a lot of good things going on, but there is scope for so much more. We could do better on links with housing and on primary care based initiatives on literacy, training, employment and benefits. We need to ensure that new ideas are put into action and not stifled by bureaucracy.

The new health responsibilities of local authorities and the co-location of public health across the local authority and the clinical commissioning group bring with them a lot of opportunities to make things better.

The new practice would be financially and environmentally sustainable. For example shredded paper from the GP practice would be mixed with café waste to make compost for use in the garden by patients.

Dr Sarah Andersen, GP

NEWS

Sing for better health

Barbara Hardcastle
PUBLIC HEALTH SPECIALIST

Long before Gareth Malone and the Military Wives made choral singing number one, Brighton & Health had its own unique singing groups. The BetterBreathing Singing Groups have been running since 2007 and sing for a good cause – to alleviate breathlessness experienced by people with chronic obstructive pulmonary disease (COPD).

> **"I just don't have to worry about breathing anymore"**

Why the focus on COPD?

An estimated three million people have COPD in the UK. Around 900,000 are diagnosed and around two million are estimated to be undiagnosed. The modelled prevalence of COPD across practices in Brighton & Hove ranges from 2.6% to 4.6%. However, the prevalence based on local Quality and Outcome Framework (QOF) practice registers is much lower (0.2% - 2.8% in 2010/11) suggesting that some patients remain undiagnosed. The prevalence of COPD is higher in deprived practices.

COPD is the second most common cause of emergency admission to hospital and is one of the most costly diseases in terms of acute hospital care in England. The admissions picture is mixed across the city.

Three of the highest emergency admission rates in the city for COPD are from triangle practices, with rates more than double the England value for triangle practices. Conversely, some of the lowest rates are in octagon practices which do much better than similar practices across England. See www.bhlis.org.

The BetterBreathing sessions combine breathing exercises, relaxation and singing for anyone with breathing difficulties, caused by conditions such as asthma, lung disease or smoking. They are also open to people with other long term conditions, mental health issues and the elderly. Singing helps to control breathing.

Group members report significant improvements to their health, including reduced medication requirements, fewer hospital visits, sleeping better and feeling less isolated.

As group member, Bernie says: "This group has been extremely helpful in many ways, physically and psychologically. I just don't have to worry about breathing any more. I am much calmer now and my sleep has improved."

If you have any patients with COPD, asthma or other long term diseases who you feel might benefit, you can find more details about the local groups at: www.singforbetterhealth.co.uk

When the going gets tough

Kevin Claxton
EMERGENCY PLANNER & RESILIENCE MANAGER

'Be prepared' – it still holds true

Contingency planning in primary care is about being prepared to respond appropriately to crises and emergency situations. This might be anything from floods and flu to fuel shortages. When it comes to preparedness, the city has some practices that are leading the way.

The Lewes Road surgery is one of 38 general practices that have completed a business continuity and emergency plan. Practice manager Peta Martin agrees that having the plan and high levels of staff awareness puts them in a good position to deal with emergencies and to bounce back from disruptions.

Peta said "The surgery had a couple of issues with our alarm system. Having a plan in place and everyone briefed on what to do enabled us to have a quick response, and highlighted the fact that the system had problems, which we have now resolved."

Peta also recognises the value in having a 'buddy' practice (the Park Crescent Surgery), to provide mutual assistance during problems such as pandemic flu or severe weather.

The Lewes Road Surgery has vaccinated 100% of staff against seasonal flu. Peta said "All our staff are vaccinated, because we know the value of keeping ourselves protected." She acknowledged that it can be difficult to achieve high seasonal flu vaccination rates among patients in areas like Lewes Road: "It's so important to vaccinate those in our 'at risk' groups as well as our staff. The area does suffer from high levels of deprivation, and we also have large numbers of patients who don't speak English, but we always aim to vaccinate as many as we can."

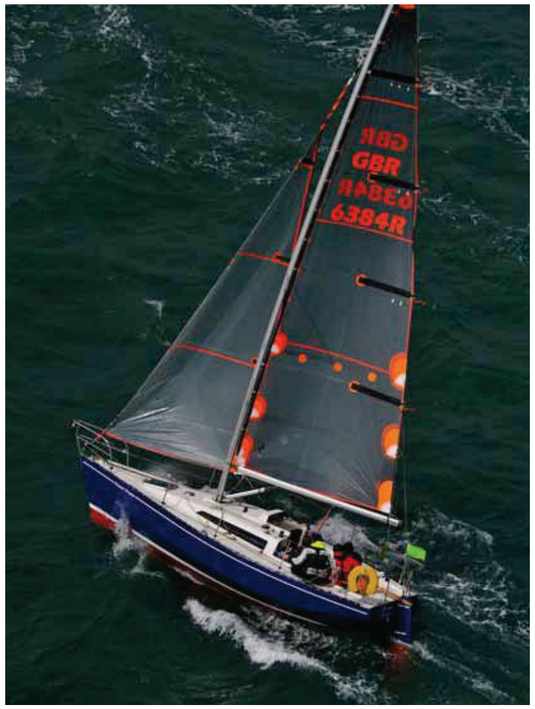
The public health team supports general practices to develop business continuity plans. A simple handy template is available and experienced public health staff can visit practices and help them prepare.

If you would like support with your business continuity plan contact Kevin Claxton on 01273 574731, or if you would like help with raising your seasonal flu vaccine rates in staff and patients, then contact Jennie Leleux on 01273 574667.

Your good health

Dr Xavier Nalletamby –

Riding the waves



My first love is general practice but even so I have reduced my hours to half time in order to chair the shadow clinical commissioning group (CCG). I really hope at some point to get back to seeing my patients full time as I find part time working is so difficult with the lack of continuity. Working as Chair of the CCG has helped me understand the enormous pressures of NHS management and how difficult times are financially. We all have a duty to find ways to reduce waste, to improve the healthcare we provide and to work constructively together.

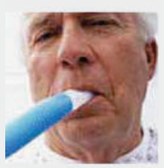
The long working hours mean I am more desperate than ever to get out again and do some sailing, and race on the long summer evenings, enjoying beautiful Brighton from the sea.

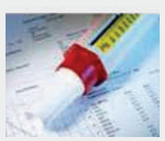
What can the Community Respiratory Team do for you?

Are you taking advantage of everything the Community Respiratory Team has to offer your patients?

The multidisciplinary team aims to support respiratory patients with a diagnosis confirmed by spirometry in the following ways:

- Rapid response service
- Pulmonary rehabilitation programme
- Oxygen assessment
- Nebuliser assessment
- Maintenance home visits
- Education sessions





GPs can refer new and existing respiratory patients for education sessions.

Monthly sessions are held for on average ten patients.

These focus on explanations of the conditions; early signs of exacerbation; how to stay healthy, including vaccinations, diet and smoking cessation.

The service aims to work collaboratively with primary care and is able to give telephone advice.

The service is available from: **Monday** to **Friday 8am** to **8pm** and at the **Weekend** & **Bank Holidays** from **8.30am** to **4.30pm.**

Contact the team on **01273 265593.**

CANCER

Local cancer audit reveals avoidable delays in referral

MARTINA PICKIN
PUBLIC HEALTH
SPECIALIST

Cancer survival rates in the UK do not match the best in Europe; the main reason for this, according to the 2007 Cancer Reform Strategy, is late diagnosis. This is particularly relevant in Brighton & Hove where cancer mortality rates, in contrast to the rest of the country have not been falling, as demonstrated by two of the more common cancers, colorectal and lung cancer.

PRIMARY CARE CANCER AUDIT

A National Awareness and Early Diagnosis Initiative (NAEDI) was established in 2009 to address this. One strand of the programme was a national audit of cancer diagnosis in primary care. Using the same audit tool, 23 Brighton & Hove practices covering 189,784 (64%) of the registered population undertook a local audit. The audit included 526 patients representing around 46% of all new cancers diagnosed in Brighton & Hove.

Non-malignant skin cancers and screen-detected cancers were excluded. Participation in the East of the city, where deprivation is higher and delays in presentation are consequently more likely, was unfortunately very low.

In addition to the audit, each participating practice conducted a significant event analysis for at least two patients. A total of 48 significant event audits were conducted by the 23 participating practices.

The results showed that both locally and nationally around half of patients present within a month of first noticing symptoms, and around two-thirds of patients were referred to secondary care after one or two consultations. A small percentage of patients consulted five or more times before referral, particularly when the presentation was atypical or where there were other co-existing illnesses.

DELAYS IN COLORECTAL CANCER AND LUNG CANCER REFERRAL

Although most (>75%) local cancer patients presented first to their GP, a higher proportion locally than nationally presented first at A&E, particularly those with colorectal and lung cancers. Emergency presentation is associated with poor survival.

Over 60% of patients were referred to secondary care within a month but this varied by tumour site both locally and nationally. Avoidable delays were identified in around 15% of all cancer cases, the highest proportion of which were for colorectal cancer.

Although over 50% of patients both locally and nationally were referred via the two-week route, this varied by cancer type and local two-week wait referrals for lung cancer were particularly low. Local patients referred with lung cancer were more likely than nationally to have distant metastases at diagnosis.

IMPROVING EARLY DIAGNOSIS AND REFERRAL

As in all surveys, some caution is required in reviewing results. There was scope for errors of interpretation and data were missing for some questions. Participation was voluntary, and as fewer practices serving the more deprived areas were represented, the results are likely to be worse than was reported. Nevertheless, a number of areas were identified, particularly from the significant event analyses, where practice could be improved.

> **“It is clear that the city has some way to go in reducing cancer mortality.”**

In general practice:

- Two-week wait forms for rapid referral and treatment need to be more easily accessible, such as on the electronic desk top;
- Locums need to understand the two-week pathways and know how to access referral forms;
- A log of two-week referrals should be kept by practices and the outcome of these followed up routinely;
- Clinical notes should be clear and include full details of what action has been taken;
- Patients should be made aware of the need to attend if potential warning symptoms persist and this should be recorded.

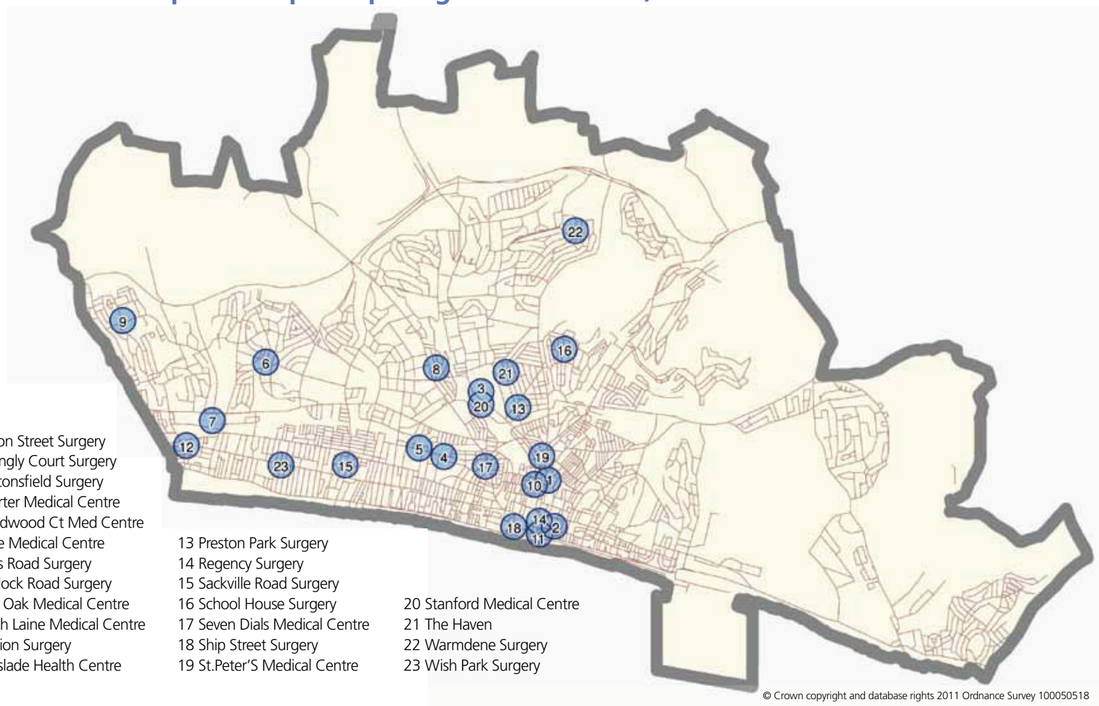
GPs reported that rapid access to certain investigations would have changed their management. This is consistent with proposals in the recent cancer strategy to increase primary care access to computerised tomography scans, ultrasound, magnetic resonance imaging and endoscopy. The new clinical commissioning group might fruitfully pursue this issue locally.

Several local campaigns on lung, colorectal and over 70s female breast cancer delivered by Albion in the Community have been funded through the NAEDI programme. This is an area that needs constant creative input to keep the public’s attention.

This audit raised awareness among GPs of their important contribution to timely diagnosis and referral. It stimulated both practice developments and more collaborative work with secondary care. But it is clear that the city has some way to go in reducing cancer mortality, one of the two commonest causes of premature death. Improvements to patient education, access, speed of referral and treatment in Brighton & Hove, particularly for colorectal and lung cancer, have real potential to save lives.

You can look at information from the audit and find out more about local cancer rates on www.bhlis.org

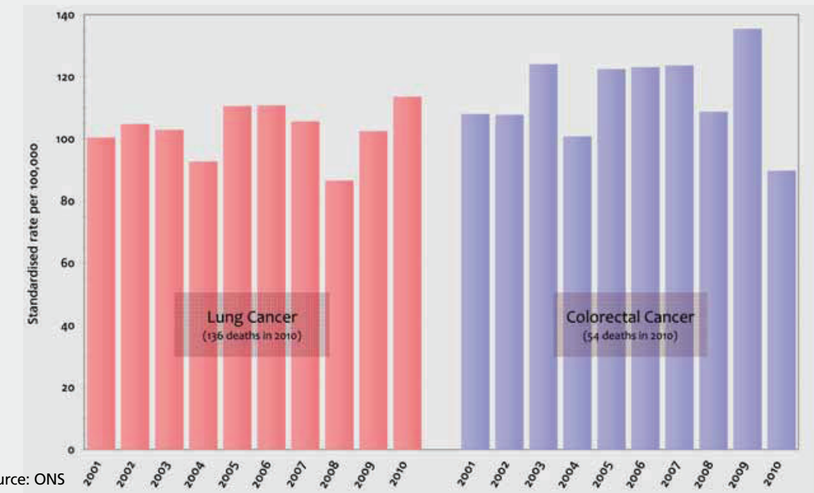
Brighton & Hove practices participating in cancer audit, 2010



1 Albion Street Surgery
2 Ardingly Court Surgery
3 Beaconsfield Surgery
4 Charter Medical Centre
5 Goodwood Ct Med Centre
6 Hove Medical Centre
7 Links Road Surgery
8 Matlock Road Surgery
9 Mile Oak Medical Centre
10 North Laine Medical Centre
11 Pavilion Surgery
12 Portslade Health Centre
13 Preston Park Surgery
14 Regency Surgery
15 Sackville Road Surgery
16 School House Surgery
17 Seven Dials Medical Centre
18 Ship Street Surgery
19 St.Peter’S Medical Centre
20 Stanford Medical Centre
21 The Haven
22 Warmdene Surgery
23 Wish Park Surgery

No change for common cancer deaths

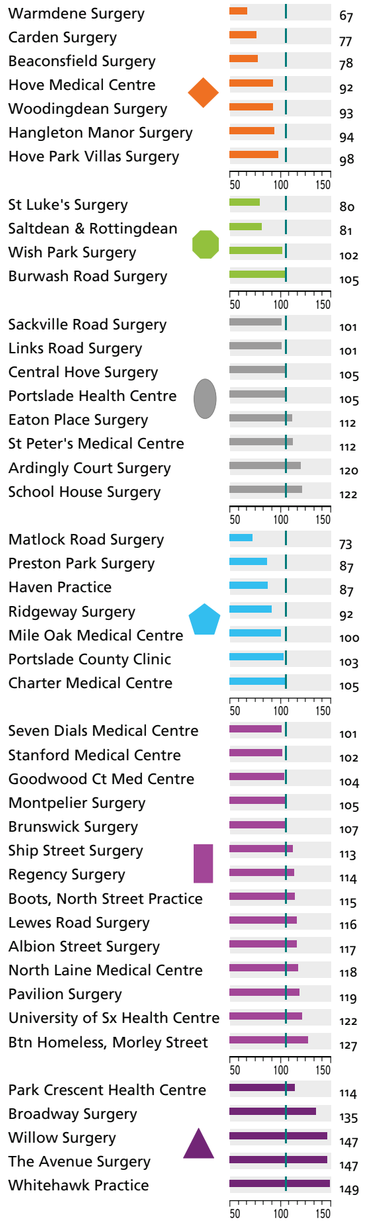
Directly age standardised mortality rates for lung and colorectal cancer, Brighton & Hove, 2001-10



Source: ONS

Deaths from smoking

Age standardised mortality ratio from conditions attributable to smoking, 2003-05



Note: | = Brighton & Hove average, 105.4 (avg for England = 100).

At the fag end of health

Smoking still kills

Smoking is the greatest single cause of health inequalities and premature death. According to information from the Association of Public Health Observatories, the number of people dying from smoking in Brighton & Hove is 5% higher than the national average. Most GP practices are close to or below the national average for their group, however triangle practices have much higher mortality rates than similar practices nationally. By contrast, local kite practices have rates well below the national average.

SMOKEFREE

Stop smoking services

Recent estimated prevalence data suggests that more than one in four adults in Brighton & Hove smokes and in a survey of local school children in 2010, 12% of 14-16 year olds said that they smoked regularly.

Over the years, local stop smoking services have helped thousands of smokers to quit successfully. Quit rates are measured at four weeks, however, and NICE estimates that just 13-23% of people who quit at four weeks will still not be smoking at one year. Local stop smoking services are divided into primary care based services and specialist services provided by Sussex Community Trust. In recent years the service has found it increasingly difficult to meet quitter targets; typically 2,000 - 2,300 quitters each year. The specialist service in particular has struggled and in 2010/11 the majority of the 1,878 four week quitters came from primary care (1,006 from general practice and 250 from pharmacies). Changes are underway to increase the number of people treated by the specialist team, including greater promotion of the service to increase self-referrals.

Maximising quit rates across the city

Smoking rates are closely related to deprivation and much effort has gone into targeting services in Brighton & Hove. It is encouraging to report that referral and quit rates from the East locality are the highest within the city.

New developments include more help for pregnant women and school children who smoke. Pregnant women who smoke are often reluctant to admit it, so all pregnant women are now routinely screened with carbon monoxide monitors, and those who want help to quit are referred to a specialist advisor. A new pilot project; a partnership between the Healthy Schools' Team, Tobacco Control Alliance and Stop Smoking Service is being planned with three local secondary schools. Staff in the schools will be trained to lead the programme, provide information and run a six-week behavioural support programme for smokers.

So with appropriate targeting of smoking prevention and cessation services, the city is on the right track to reduce the impact of smoking, although given the higher rates of smoking and the associated higher mortality, it may be some time before Brighton & Hove can claim to have stubbed out tobacco.

No Smoking Day 2012

LIFESTYLE

The other 'Big Society'

Lydie Lawrence
PUBLIC HEALTH SPECIALIST

Trying to understand what is happening with obesity trends in children is not easy; it is more difficult still in adults. Among adults in the UK, obesity appears to be decreasing in teenage and young adult (20- 29 years) males, but not in females.

In Brighton & Hove, there are actually no reliable long term data on obesity in adults. The good news is that at least there appears to be a national decrease in some groups which is in contrast to most other developed countries.

The co-location of public health across the NHS and local authority brings with it more opportunities for collaborative working with town planners, transport planners, environmental health and licensing; and for the healthy school and school meals teams to address the factors – the "obesogenic environment" – that contribute towards obesity.

In 2012 partners from health, the local authority, the voluntary sector and the business world will come together to establish a Brighton & Hove Obesity Programme Board. This will report to the new Health and Wellbeing Board and will undertake a range of coordinated initiatives to tackle obesity in the city. These activities will be based on evidence from the NICE and the Department of Health, and on local needs identified in the Joint Strategic Needs Assessment.

Four areas of work are planned:

- Preventing obesity across the life course
- Transforming the environment for better health
- Managing and treating people with obesity
- Improving data collection and analysis

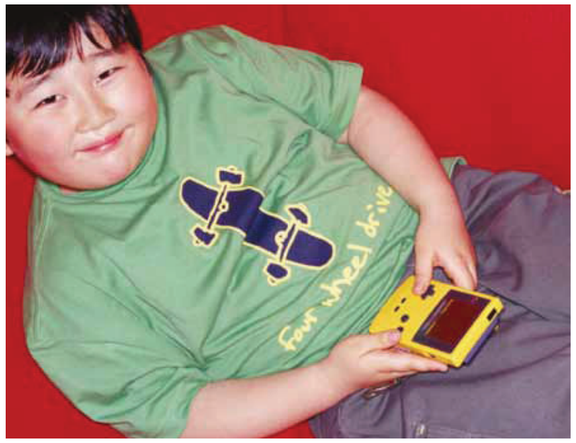
This joint working demonstrates a shared commitment to tackling obesity in Brighton & Hove. The childhood data will continue to be monitored and as Quality and Outcomes Framework (QOF) data improves, it may be possible to use primary care to monitor adult obesity better. This joint working bodes well for more progress to be made and, who knows, for the city to take a national lead in reducing obesity.

Brighton & Hove's kids make progress on obesity

For every ten children in the city, two are overweight or obese in reception year and by their last year in primary school another child in every ten will be overweight or obese. These are the figures from the 2010/11 National Child Weight Measurement Programme where across the country pupils in reception and their final year of primary school are weighed and measured.

The local picture is actually slightly better than the picture across England and in recent years the percentage of overweight children in year 6 has been falling in Brighton & Hove – from around 18% in 2007/08 to 15% in 2010/11 in year six pupils.

However, there is no room for any local complacency as high numbers of children and young people are affected – almost 14,000 of those under the age of 20 years are estimated to be overweight or obese and growing up with an increased risk of heart disease, diabetes and cancer.



More involvement of local GPs needed

With the large numbers of overweight and obese children it is important that GPs and other health professionals are aware of the full range of community weight management services on offer across the city. Currently child referrals are at rock bottom compared to adult referrals – only 30 child referrals were received via GP practices in 2010/11 compared to over 500 for adults. Feedback from local GPs indicates that tackling the sensitive issue of weight with families can be difficult and that there is a lack of awareness of services available.

Healthy Weight Referral Scheme
The team at the Brighton & Hove Food Partnership offer free visits to all GP practices to update practice staff on the range of community services available for children and to provide support with raising the sensitive issue of weight as well as using body mass index (BMI) measurements. Only a dozen or so practices have taken up this opportunity. If you haven't referred before or wish to talk through a particular family's situation, the Healthy Weight Team can be reached on 01273 431703 or email healthyweight@bhfood.org.uk

The inclusion and exclusion criteria for children are based on a BMI for age centile assessment (although referrals can be made without plotting the BMI):

- Children with a BMI 91st centile or over can be referred into the Healthy Weight Referral Scheme and are then assessed by trained coordinators.
- Children with a BMI on the 98th centile or over can be referred via their GP to a Brighton and Sussex University Hospital (BSUH) paediatrician.

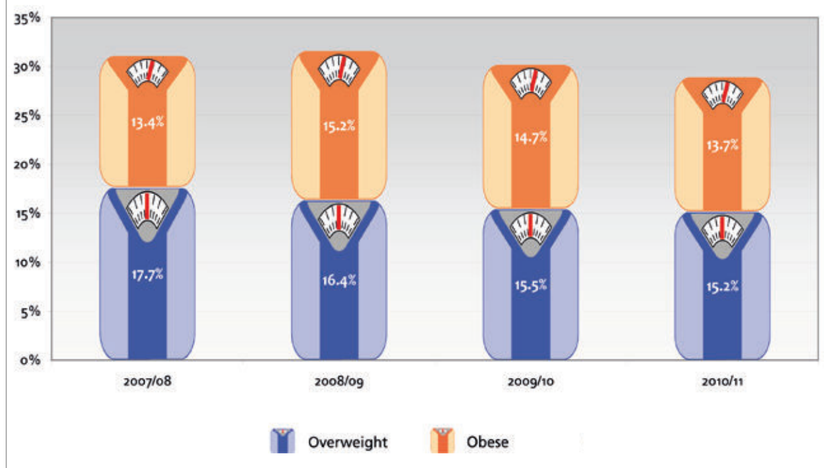
Several programmes are available for obese children:

- **MEND (Mind, Exercise, Nutrition… Do it!)**
This 9-week after school programme for 5-7 and 7-13 year olds offers obese children and their families a combination of nutritional information, support and physical activity.
- **GOAL (Get Out And Live)**
This programme is aimed at young people (12-19 year olds) who already have healthy lifestyle knowledge and skills.
- **Children's Weight Management Clinic**
If group interventions are not appropriate or acceptable, then a referral to the Children's Weight Management Clinic can be made. In the clinic a paediatrician leads a team offering a combination of behavioural, dietetic and activity advice with input from a specialist school nurse, dietician and an Active for Life trainer.

To refer to the Brighton & Hove Healthy Weight Referral Scheme visit http://www.bhfood.org.uk/how-to-refer

Year 6 national child measurement results

Percentage of children overweight or obese for Brighton & Hove, 2007/8 to 2010/11



Source: National Child Measurement Programme

NEWS

At the top of the wrong league: Brighton & Hove and suicide

Despite achieving the lowest number of suicides for a decade in 2010, Brighton & Hove remains in the top ten nationally for suicide deaths.

Ministry of Justice data show that in 2010 there were 27 suicides and a further 11 deaths with an open verdict in Brighton & Hove. The number of suicides has been declining for the past few years and the city is on track to achieve the national target of a 20% reduction in suicides from the 1995-1997 level of 15.1 per 100,000. However, as has been the case for many decades, the suicide rate in Brighton & Hove remains among the highest in the country.

The most recent data for the three years 2008-2010 put the city in seventh place out of all PCTs nationally, with a directly age standardised rate of 12.1 per 100,000 people. These rates are well above those of the South East Coast (7.7) and England (7.9).

Furthermore, recent evidence presented in the British Medical Journal suggests that the increasing use of narrative verdicts by Coroners may result in an underestimate of suicides as narrative verdicts are more likely to be classed as accidents in official statistics. It is unclear if this has had an impact in Brighton & Hove. However, if it is part of the reason for the modest decline in rates then we should be careful about celebrating any apparent success.

SELF HARM IN THE CITY

Brighton & Hove also has a very high rate of self harm, with over 1,000 hospital stays due to self harm between April 2009 and March 2010. Several practices have very high rates of admissions due to self harm. Morley Street, Whitehawk Medical Practice, Ardingly Court, Boots North Street Practice, Brunswick, North Laine, Regency and St Peter's all have rates significantly higher than the city level. The relationship between self harm and suicide is not a straightforward one but this is an area that requires ongoing monitoring and support in both public health and primary care.

NEW INITIATIVE: CLINICAL REVIEW OF SUICIDES

For many years, all suicides in the city have been reviewed by the public health team and reports on trends and common factors considered by a city-wide Suicide Prevention Strategy Group. Under a new initiative from this group, led by Dr Becky Jarvis, a multidisciplinary clinical group will review selected suicides with the relevant clinicians involved in the care of the person prior to death. These clinical reviews will consider why the suicide happened and whether clinicians can learn anything to prevent similar events in the future. A recent study has suggested that clinical reviews like this can help to reduce suicide rates.

Dr Becky Jarvis, GP, Primary Care Clinical lead for mental health

THE PRACTITIONER HEALTH PROGRAMME

All suicides are tragedies. One of the suicides which particularly affected local clinicians last year was the suicide of a general practitioner. Doctors have a higher rate of suicide than most professions and it is estimated that 1 in 15 will have an addiction problem (drugs or alcohol) at some point in their career. However, doctors often shy away from using local mental health services for fear of being recognised by some of their own patients or colleagues. The primary care trust is considering a proposal to set up a confidential service for doctors living in Brighton & Hove who have a mental health or addiction problem. This service – the Practitioner Health Programme – which has been successfully trialled in London has the potential to provide effective and confidential care for the city's doctors, and perhaps reduce of the risk of suicides among the medical profession.

So for 2012 and onwards, work will continue on self harm, on improved clinical reviews of deaths by suicide and practitioner support. Who knows, with continued effort these figures may continue to decline and eventually the city may find itself at the right end – the bottom – of this tragic league.

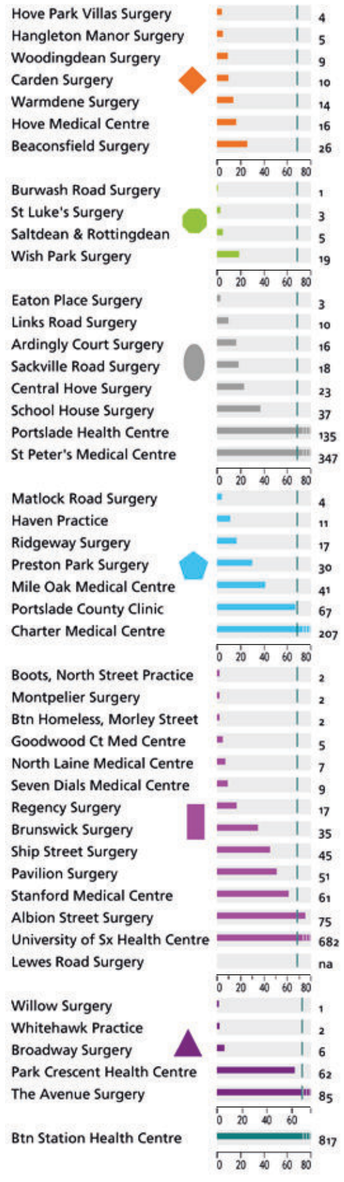
> **"Suicides are not inevitable. An inclusive society that avoids the marginalisation of individuals and which supports people at times of personal crisis will help to prevent suicides."**
>
> Draft government strategy on preventing suicide in England

SEXUAL HEALTH

Roses are red, violets are blue, I've got Chlamydia, you might have too

Chlamydia screening

(numbers screened 2010/11)



Note: | = Brighton & Hove average, 68

Chlamydia is the most common sexually transmitted infection. It is particularly common amongst young people. Women with chlamydia infections can develop pelvic inflammatory disease, infertility and ectopic pregnancy. The complications of infections in males include pharyngitis, urethritis, epididymitis, prostatitis and proctitis. The health consequences then are potentially very serious; worse still, many acute Chlamydia infections are asymptomatic and go undiagnosed.

Yet despite the high prevalence of infection, the consequent health risks and a national screening programme only a minority of local practices are succeeding in screening many of their young patients.

Screening uptake

The National Chlamydia Screening Programme offers 15-24 year olds who are sexually active opportunistic screening. The programme is a government priority.

In 2010/11 the Brighton & Hove Chlamydia screening programme achieved 27% coverage compared with the regional average of 19% and national coverage of 25%. The local positivity rate was 4.2% compared to 5.6% nationally. In Brighton & Hove just 25% of screening tests were undertaken in primary care.

Screening uptake by practice varies enormously. Some of this is due to variations in practice size and demography but much of it is due to how systematic practices are in their efforts to screen (see chart).

How can we improve screening rates in primary care?

Laura Hutchinson, Chlamydia Screening Programme Lead from Sussex Community Trust knows first hand how some local practices have increased uptake of tests. "Firstly, a practice has to identify a lead, someone who will be the point of contact for all sexual health information. Train reception staff and adopt an 'opt out' process for all under 25s so that all young patients coming in for an appointment are offered screening routinely at reception. Reception staff give young patients an envelope with instructions to provide a urine sample (males) or small swab (females) and hand it to the doctor when they are seen. This means that screening does not impinge unnecessarily on valuable clinical time. Put a poster in the reception area that states: 'We routinely screen ALL under 25's for Chlamydia at this practice as part of the National Chlamydia Screening Programme.' This means that nobody is discriminated against and everyone is offered the screen."

This is exactly how Brighton Station Health Centre has achieved the highest rate for Chlamydia screening. As Deb Jeavons-Fellows, the practice manager, puts it:

''Our high screening rate has been achieved through the engagement of both the clinical and reception team. We have Chlamydia screening packs readily available for patients to pick up prior to reaching the clinical area. Our clinical system has automatic alerts that remind clinicians to offer screening to the patient. We display posters which explain to everyone that Chlamydia screening here is routine."

With the right system and training in place, screening needn't take up a lot of clinical time and a lot of preventable health problems, like infertility, can be easily averted.

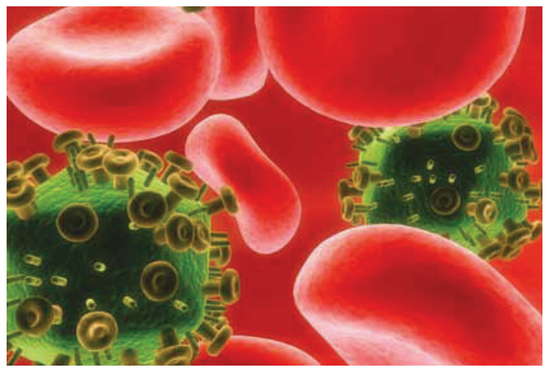
HIV: making the diagnosis earlier in primary care

Stephen Nicholson
LEAD COMMISSIONER HIV & SEXUAL HEALTH

It is recommended that in areas such as Brighton & Hove, where HIV prevalence is above 2 per 1,000 population, all new GP registrations and all general medical admissions should be routinely tested for HIV. NICE guidelines also recommend increased testing for men who have sex with men and for Black Africans.

The Department of Health has funded two pilot studies in Brighton & Hove to explore the acceptability, feasibility and effectiveness of HIV testing. The hospital pilot study offered HIV testing to all acute general medical admissions aged 16 - 79 years. The other pilot offered testing in the local practices providing the local enhanced service for the care of patients with HIV in primary care.

> **"Our focus in the early 1990s when I worked in the community HIV team was to ensure that GPs gave full pre and post test counselling. Now I try to tell patients that testing for HIV is as routine as testing for other long term conditions, for example diabetes."**
>
> **Dr Katie Stead, GP**



The primary care pilot ran for six months in 2010. Nine practices offered point of care HIV testing to all newly registered patients aged 16-59 years attending for a new patient health check. Patients with a reactive result were referred to the local specialist sexual health service for a confirmatory test. Of the 2,478 patients eligible for HIV testing, 1,473 (59%) patients accepted the test and two new cases of HIV infection were identified.

Regardless of whether or not they accepted or declined the test, an overwhelming majority (88%) of primary care patients agreed that the offer of HIV testing was a good idea; 79% agreed that they had enough time to make the decision to test and 85% were happy to be tested in their GP's surgery. Only 8% preferred to have a test at a specialist sexual health clinic.

Clinicians' views were also positive overall and many were surprised by their patients' responses to being offered a test. Routinely offering testing increased clinicians' confidence regarding HIV and rather than cause an awkward situation, actually helped to build rapport and prompted further useful discussions on sexual health. Clinicians did have some concerns about the impact on consultation times.

One of the issues brought out by the pilot was the low uptake of new patient health checks by patients, and the varied approaches to registering new patients such as on-line registration so that some new patients did not attend the surgery for some time. Nevertheless, building on the findings from these pilots and from NICE guidance, HIV testing will now be extended to all practices who have signed up to provide the HIV local enhanced service, and then to the remaining practices. The day may not be too far off when HIV infected patients are no longer dying of ignorance.

Eradicating the state of ignorance

Many readers will remember the national campaign urging people not to 'die of ignorance' when HIV and AIDS first hit the headlines in the 1980s. It will come as a surprise to many readers to learn that today around 25% of people in the UK who are infected with HIV don't know they have it: that is around 22,000 people. This state of ignorance means that these patients cannot benefit from treatment, and that they risk passing on the infection.

Late diagnosis is associated with worse treatment outcomes. In 2008-2010 in Brighton & Hove, 39% of people diagnosed with HIV were diagnosed at a late stage of infection (with a CD4 cell count <350 cells/mm3) and 18% were diagnosed at a very late stage (with a CD4 count <200 cells/ mm3). This is better than the overall national rates for 2010 (50% and 28% respectively) but is in line with the rates for men who have sex with men (MSM) reflecting that the majority of people living with HIV in Brighton & Hove are MSM.

With excellent early treatment now available, the benefits of early diagnosis are incontestable. In recognition of the importance of early diagnosis, the 'number of people presenting with HIV at a late stage of infection' has been included in the new Public Health Outcomes Framework for 2013-16.

SEXUAL HEALTH

Free Health Promotion Training

www.brighton-hove.gov.uk/healthpromotion

Brighton & Hove city council offers health promotion training in partnership with NHS Brighton and Hove public health department. These courses are designed to develop the skills, knowledge and confidence you need to improve the health of people living in your area.

The courses are suitable for anyone working in: primary and community health, education, housing, social care, mental health, police and criminal justice, and voluntary organisations that support these service areas.

Substance misuse courses

- Ageing & Alcohol
- Alcohol Screening Brief Interventions
- Blood Borne Viruses
- Safer Injecting & Vulnerable Populations
- Cannabis: All You Need To Know
- Domestic Abuse Substance Misuse
- Drug and Alcohol Basic Awareness
- Legal Highs New Trends
- Young People & Alcohol
- Smoking Prevention

Behaviour change courses

- Supporting Health Behaviour Change

Sexual health courses

- Sexual Health Basic Awareness
- Sexual Risk Taking

Other Training Opportunities

- Oral Healthcare Training
- C-Card Training (issuing condoms)
- Providing a Pregnancy Test

Contact us

If you would like to speak to someone about these courses please contact:

Workforce Development
01273 291232 or coursesforcare@brighton-hove.gov.uk

If you would like to talk to someone about health promotion courses in general, please contact:

Kate Lawson, Health Promotion Lead on 01273 296558, or kate.lawson@brighton-hove.gov.uk

We look forward to seeing you soon!

17

Teenage pregnancy & substance misuse

– what does success mean?

Kerry Wheeler
Teenage parent advisor, B&HCC

As the government moves from harm minimisation to recovery a teenage pregnancy worker reflects on a local case:

Katy (fictitious name) is a 15 year old who was referred to the 'Targeted Teenage Pregnancy Worker' after she turned up at a Youth Advice Centre drop-in service. She presented with a number of typical risk factors: she was in a relationship with a young man of similar age and expressed ambivalence towards pregnancy - she used condoms occasionally. She was starting to use drugs and alcohol and even though she was on a reduced timetable at school, she rarely attended. She had very low self-esteem and not much confidence.

Using motivational interview techniques I was able to establish that Katy was worried that she was infertile, as she was experiencing irregular bleeding. Her mother had been diagnosed with ovarian cancer and Katy believed that because of her mother's health problems, she might be unable to have children and so she was less concerned about sexual health risks. Katy also said her mother's illness was contributing to her drug and alcohol use.

I have been able to support Katy with her relationship with school and make improvements. Katy is now using long term reversible contraception and condoms, and she has more knowledge and, more importantly, more confidence regarding sexual health and relationship issues. She is attending school more regularly and is back on track to attain predicted grades. She still gets counselling and emotional support and her drug and alcohol use is still addressed on the basis of harm minimisation, but Katy reports that she feels much more confident and assertive. These are all small, but very important steps.

Teenage conception rate cut by a quarter over the last decade

Across England and Wales the conception rate for under 18s for 2010 is the lowest since 1969. Brighton & Hove has also seen significant decreases according to the latest figures from the Office for National Statistics.

Between 1998 and 2000 there were on average 189 under 18 conceptions each year in the city and this fell to 148 per year between 2008 and 2010 – a fall of 41 conceptions per year.

In terms of showing improvement, the city is the 21st best performing local authority in the country with a 27% reduction in the under 18 conception rate over this period. The equivalent reduction across England was 15% and 17% across the South East so there is certainly some cause for celebration locally.

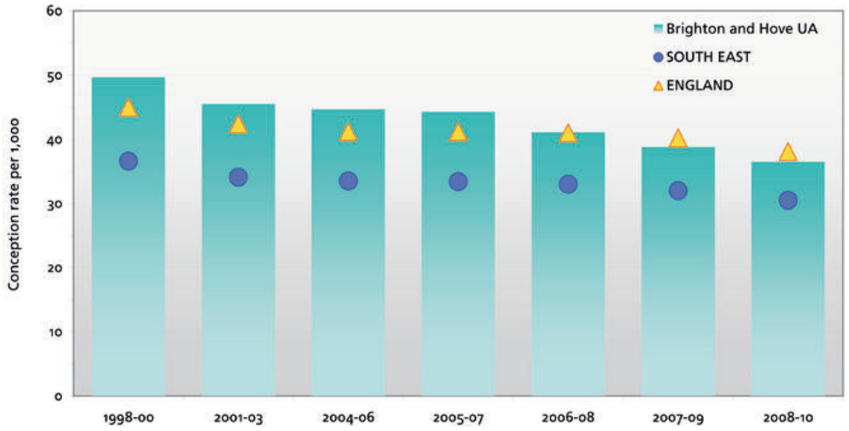
However, for the first time since 2007 there was a slight increase in the annual teenage conception rate in 2010. Even so, the actual number of conceptions was lower at 144 in 2010 compared with 149 the previous year. In general, the long term trend for teenage pregnancies shows that fewer young women are becoming pregnant - with reductions in both the maternity and abortion rates.

Two in every three local under 16 conceptions ends in termination

There were 26 conceptions to under 16 year olds in 2010 in the city. Since 2001 this has changed little until a very recent fall. In this age group, two in every three conceptions lead to a termination of pregnancy – higher than the South East and England. Pregnancies that end in termination have historically been higher for this age group compared to 15-17 year olds, where 50% of pregnancies lead to termination in Brighton & Hove (37% across the South East and 45% in England).

Brighton & Hove – a decade of improvement

Conception rate per 1,000 female population aged 15–17



Source: Office for National Statistics

Service improvements since 2010

There have been major improvements across the services. Morley Street clinic became open access in 2010/11: there were a total of 3,881 contacts from under 19 year olds, compared with 3,097 in 2009/10. The introduction of the young women's support worker has improved access to long acting reversible contraception for young women post termination. More schools now have health based drop-ins and in 2010/11 there were a total of 1,053 contacts which was a great improvement.

INEQUALITIES

Educational attainment in Brighton & Hove

Are we turning the corner at last?

Last year the Director of Public Health's Annual Report shone a spotlight on community resilience and the factors that contribute to it. One of the most influential factors is education and in this respect in Brighton & Hove the picture was decidedly mixed.

Low educational achievement at secondary school level has wide implications with higher risks of involvement in drug and alcohol use, in crime and antisocial behaviour and of teenage pregnancy as well as being a key determinant of future health, employment and income.

'Could do better'...

The city has a low proportion of adults without any qualifications and a high proportion of adults with the highest level qualifications; but many of the highly educated residents are migrants to the city. Primary school achievement is good, but there are poor results at GCSE level; and relatively few schoolchildren go on to further education. Although GCSE attainment in Brighton & Hove improved from 45% in 2004/05 to 49% in 2009/10, improvements were greater around the country and hence the city's GCSE ranking fell from 73rd out of 150 (where 1 is the best) in 2004/05 to 132nd in 2009/10.

Turning things around

Recognising the problem, the Council established the Secondary Commission in 2011 challenging head teachers and schools to aim for top quartile performance by 2014. The Secondary Commission recognises that partnership working and head teacher leadership are essential to improvement and the challenge has been enthusiastically taken up both by head teachers and governing bodies.

An improving report card

In the summer of 2011 local GCSE results improved with more than half (53%) of pupils now achieving five or more GCSEs at grades A*-C including English and Maths. More significantly, and for the first time since 2004/05, the city's relative ranking also improved. Although for GSCE results the city still sits in the bottom quartile of similar local authorities, for level 3 (A level equivalent) qualifications, Brighton & Hove is in the second quartile nationally, and sits in the top five for most improvement between 16 and 19 years. The proportion of adults aged 16–64 years in the city qualified to at least level 4 (above A level) also rose from 38% in 2004 to 48% in 2010 (latest data) compared to a rise from 26% to 31% in the same period in England. In terms of relative ranking for 16-64 year olds, Brighton & Hove has held a stable position between 10th and 17th and in 2010 was placed 12th in England.

However, the gap between children's and adults' educational achievements is still huge and Brighton & Hove now has the second greatest education inequality gap in England between high adult level qualifications and GCSE attainment – behind only Islington.

The role of primary care in education and skills training

Data derived from the education, skills and training sub-domains of the 2010 Indices of Multiple Deprivation show a clear association between education and skills achievement of children and adults at practice level. So whilst at city level there is a large gap between child and adult educational achievement, in areas where more children and young people do not go into higher education, there are also more adults with no or low qualifications.

The distribution of educational attainment across the city is also strongly correlated with affluence levels. The triangle practices do worst for both children and adults with the Willow Surgery, The Avenue, Broadway Surgery and Whitehawk Medical Practice all with the poorest qualification levels.

Some of this will come as no surprise to GPs and analysis at practice level does beg the question: what can GPs do about it? Around the country some practices like Bromley on Bow have taken a very proactive approach, working with benefits agencies, public libraries and literacy services to promote participation in learning, skills development and training from a base of general practice. The new development at Woodingdean with its links to library services could be in a position to offer similar opportunities (see page19 for more information).

The 'deprivation life cycle'

East Brighton GP, and governor at Whitehawk Primary School, Dr Anita Amin reflects on how GPs can tackle health inequalities.

Health inequality is part of what I call the deprivation life cycle. It starts in the womb with poor maternal diet and smoking, and by the time deprived children start school, they are already two years behind their peers. Add in factors like child abuse (one in five children at our practice is on the child protection register) and you get a self perpetuating cycle of teenage pregnancy, deprivation and poor health outcomes.

My number one priority in East Brighton is contraception for teenage girls. So often young mothers tell me about how they wish they had had a chance to study and how they feel they don't have a full life. If we can reduce teenage pregnancy we stand a better chance of stopping the deprivation life cycle.

We have identified a number of actions in our practice:

1. Improve teenage sexual health and contraception uptake. We provide a drop-in service but uptake is poor. We hope to bring in youth centre workers to improve uptake.
2. Work more with health visitors on children at risk. I personally think we need to fund health visitors directly so they are in a better position to meet up with us.
3. Liaise fortnightly with the long term conditions nurses to make sure that patients get regular checks, and some health promotion.
4. Increase healthy living referrals particularly for advice on food and exercise.
5. Screen adults for hypertension, diabetes and coronary heart disease and offer healthy living and smoking cessation advice at screening.

INEQUALITIES

Primary care tackles poor housing in Brighton & Hove

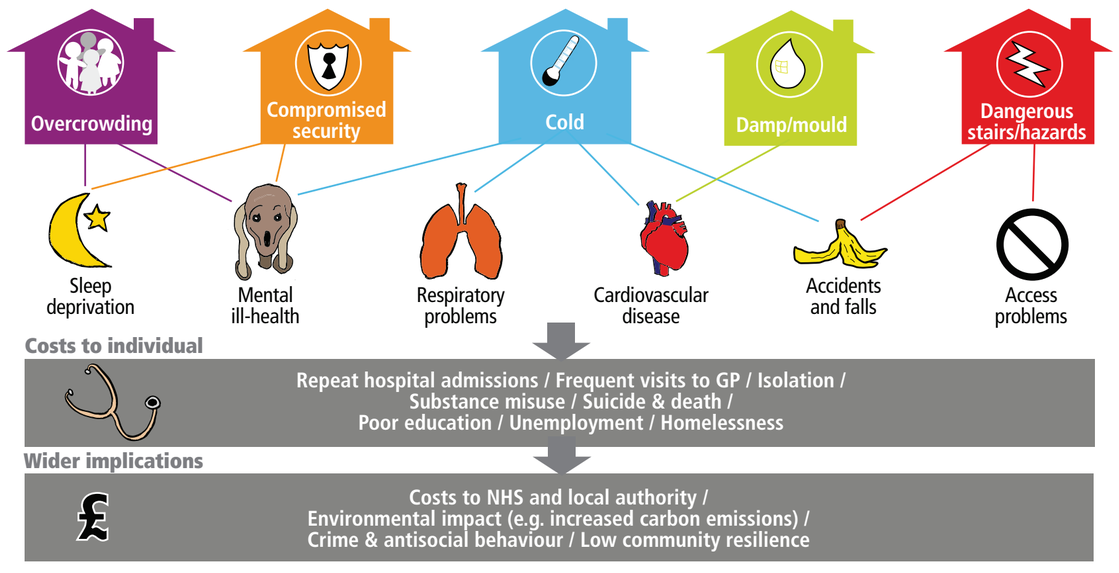
SARAH PODMORE
HEALTH PROMOTION SPECIALIST

"I have written about the links between poor housing and poor health for the past 40 years, and campaigned on the issue through Shelter and other organisations. I know from my own experience that a decent home makes all the difference, and I have seen the change it can make to people's lives. In Brighton & Hove too many people live in sub-standard and overcrowded housing. The ill-health they endure as a result, affects their health and wellbeing and puts an extra and unnecessary burden on the health service. I welcome the new housing scheme that will involve GPs and others working more closely with the city housing scheme, and the other health and housing initiatives now in hand. The health and business cases are both overwhelming."

Councillor Bill Randall
Green Party, Brighton & Hove City Council

Brighton & Hove has longstanding significant housing issues. Over 35% of the city's private sector housing, and over half of its social housing stock fails to meet the Decent Homes Standard. This means that more than 97,000 homes have inadequate protection against heat and cold or lack modern facilities.

A new housing scheme allows GPs and other health professionals to refer patients directly to the city council's Private Sector Housing Team for practical and financial assistance. This includes negotiations with private landlords to make homes warmer, safer and more secure (e.g. dealing with damp, fire safety, trip hazards, or insufficient heating) and referral of council housing tenants for council support.



Poor housing can affect anyone's health. Parents with young children, the elderly or even working age adults would all be affected by unreliable heating or dangerous stairs. In addition to the plethora of negative consequences that poor housing can have on individuals (accidents, falls, respiratory problems, cardiovascular disease, mental ill-health... the list goes on) there is a ripple effect from inadequate housing that is felt throughout wider society and the environment.

To tackle an issue as big as housing and health we need a coordinated response from councils, housing associations and from the healthcare community.

In November 2011, Chris* was facing a daily life of inadequate heating, widespread mould, housing disrepair and fire safety hazards. Following referral by a vigilant GP, the council's Private Sector Housing Team negotiated works with the landlord and all concerns were resolved within a matter of weeks.

A keen health professional keeping an ear out, asking a pertinent question, being vigilant on a home visit and then quickly referring can make a huge difference to a vulnerable resident, and will mark a step towards a healthier society and environment for us all.

*The individual's name has been changed to protect their identity

Your good health

Dr Alex Mancey-Barratt & Lulu at the allotment –

"Keeping healthy is much more than just access to good medical services. The allotment keeps me sane. Everyone should have one."

INEQUALITIES

Homeless and hungry ...for change

Brighton Homeless Healthcare in Morley Street was established to provide bespoke primary care for homeless people; a group of people with very poor health. Should persistently poor patient outcomes then simply be accepted, or should more be done for this group of patients?

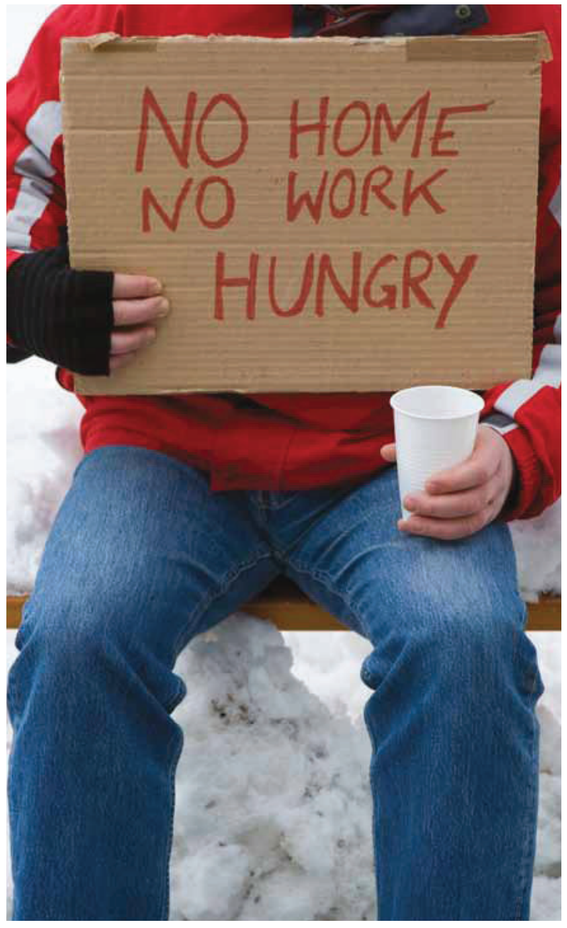
The practice population of Brighton Homeless Healthcare is significantly different to the average population of England, and indeed Brighton & Hove, with a lower percentage of children and older people and many more men than women registered. The practice falls within the most deprived decile in the country using the Index of Multiple Deprivation (a measure of deprivation across several domains: income, employment, health, education and more).

The practice has the lowest life expectancy in the city at 70.3 years – life expectancy across the city is 81.7 years.

Looking specifically at what is known as 'mortality amenable to healthcare' – from preventive measures to acute care – Brighton Homeless Healthcare has the highest rate in the city. The practice also has the second highest cancer mortality rate in the city. But of greatest concern is that it has by far the highest mortality rate for coronary heart disease at 12 times the second placed practice in the city. Between 2008 and 2010, the equivalent of 2,000 patients per 100,000 died of coronary heart disease each year compared with a Brighton & Hove average of 70.

To put this in context – if the whole city had the mortality rate for coronary heart disease of the Brighton Homeless Healthcare practice, each year there would be almost 5,200 deaths from coronary heart disease alone – this is almost two and a half times the total deaths in the city from any cause (2,082 total deaths in Brighton & Hove in 2010).

Common illnesses can progress and injuries intensify in homeless people, so there are often increased A&E visits and hospital admissions. Patients at Brighton Homeless Healthcare are almost five times more likely to attend A&E and more than twice as likely to be admitted as an inpatient to hospital than other people across Brighton & Hove. Most of this care is unplanned, with patients four times more likely to be admitted as an emergency. Brighton Homeless Healthcare patients are actually a third less likely to have an inpatient elective admission. Once discharged, patients from Brighton Homeless Healthcare are twice as likely to be readmitted to hospital within 28 days.



Cardiovascular deaths and alcohol

A recent large scale study in Russia led by David Leon, from the London School of Hygiene and Tropical Medicine, investigated the relationship between death from cardiovascular disorders and heavy alcohol consumption. The research found a positive association between alcohol consumption and increased cardiovascular disease mortality. This may be best explained by a combination of chronic and acute alcohol consumption resulting in alcohol-related cardiac disorders, especially cardiomyopathy but also, and more surprisingly, ischaemic heart disease. Further work is required to understand the mechanisms underlying the association between heavy alcohol consumption and ischaemic heart disease. Given the characteristics of the patient population in Brighton Homeless Healthcare and the extremely high mortality rate from coronary heart disease – this association could be an important consideration.

Can outcomes be improved?

The Brighton Homeless Healthcare practice has significantly lower performance on QOF achieving just 46% of total points compared with an England average of 95%. This is the tenth lowest practice in the country. The significantly lower prevalence of coronary heart disease on the practice register at 1.2% – just 12 of the 1,036 patients – as at March 2011, compared with 2.3% across the city and 3.4% across England, is a particular cause for concern given the very high coronary heart disease mortality rate for the practice. Can we do better for this particularly vulnerable group?

London Pathway being piloted in Brighton & Hove

Brighton & Hove is piloting the London Pathway Project (LPP). This model, which involves integrated primary and secondary healthcare for homeless people has had some success in Leicester and London. The model, which will operate through Brighton and Sussex University Hospital Trust (BSUH) involves training hospital staff on better identification and treatment of homeless patients; improved channels of communication between the hospital and community services with weekly multi-disciplinary meetings; a specially trained GP and nurse working with community and mental health teams focusing particularly on improved discharge and reduced A&E attendance and hospital admission. In London the adoption of the pathway saw emergency admissions reduce by 3.2 days per homeless person and the proportion of homeless people staying in hospital for more than 30 days fell from 14% to 3%. The net health cost saving was £300,000 but more importantly homeless people received much improved multi-agency care when discharged.

National Institute for Health Research funding means that this pilot will be part of a larger randomised controlled trial looking at its impact on hospital admissions. The pilot has the potential to contribute to the evidence base as well as providing local homeless people with much better care.

It is essential then that this initiative links in with the service delivered through Brighton Homeless Healthcare and ties in with work to reduce unnecessary healthcare costs. Maybe then we will start to see, not just reduced hospital admissions, but significantly improved health outcomes for what is after all the most vulnerable population in the city.

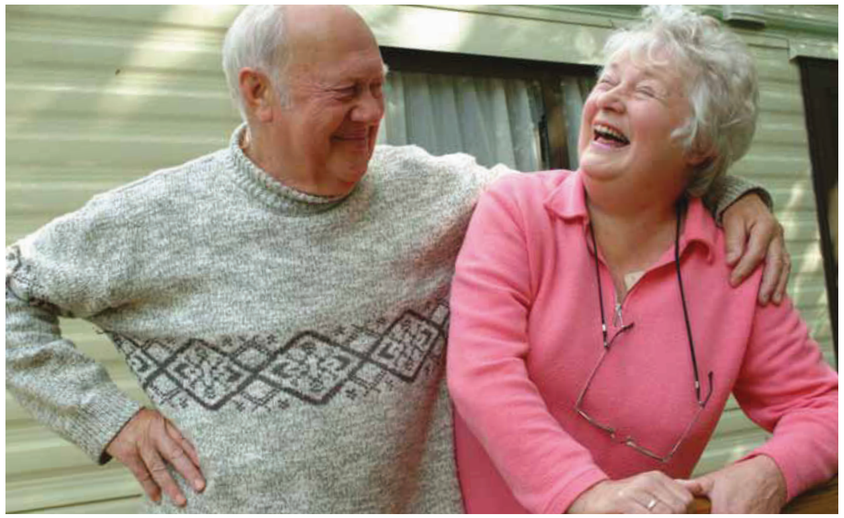
(http://www.londonpathway.org.uk/uploads/index.php/facts)

Returning to the city as part of this initiative, Dr Chris Sargeant is all too aware of the problems faced by homeless people.

> **"The Pathway project at BSUH should improve discharge planning with better communication across medical, housing and support services for homeless people. Research shows that hospital readmissions of homeless people are common, traumatic for patients and costly for hospitals. The Pathway project in Brighton should improve the care experience for homeless people admitted to hospital, reduce readmission rates and make financial savings for the NHS."**
>
> **DR CHRIS SARGEANT**
> **GP & Clinical Lead ISIS Project Islington**

MENTAL HEALTH

Dementia – much to do, much to undo



The importance of early diagnosis

More than 3,000 people aged 65 years and over in the city are estimated to have dementia and this number is predicted to increase by over 25% by 2030. Early diagnosis and intervention can make a big difference, helping patients and their carers to understand the condition and plan for the future. This means that patients can stay at home for longer, reducing the need for costly residential care and inpatient stays.

Charlotte Clow is well placed to understand the problems people with dementia face: "The stigma associated with dementia can prevent people from going to their GP about memory loss. Dementia is considered by some people, including some GPs, as a normal part of ageing. Only one third of people with dementia get a diagnosis at any point in their illness, and if they are not diagnosed early they can end up reaching a crisis point before they have any contact with services. Clinical support for early memory loss and psychosocial interventions can make an enormous difference to the lives of patients and carers."

Charlotte Clow, Programme Manager for the Sussex Dementia Partnership

More than 50% of people with mild cognitive impairment go on to develop dementia. NICE recommends early referral of people with mild cognitive impairment for memory assessment to recognise early signs of dementia. This is particularly prudent for people in high risk groups such as those with learning disabilities, Parkinson's disease, stroke, diabetes and hypertension, or with risk factors including smoking, excessive alcohol consumption, obesity and raised cholesterol.

Antipsychotic medication and dementia

While antipsychotic medication is the right treatment for a minority of people with dementia, it is ineffective in 70% of cases. It can also have serious side effects and put patients at increased risk of other health problems such as stroke and falls. Practices in Brighton & Hove will for the first time be ranked on antipsychotic prescribing for people with dementia as part of a national audit to be published in summer 2012. This will be available on www.bhlis.org

More evidence based care to come

A new dementia care home inreach team has recently been established and will help care homes to reduce reliance on antipsychotic medication and manage challenging behaviour in a more person centred psychosocial approach to managing dementia. To support earlier assessment and treatment, a new integrated community based memory assessment service will be set up in Brighton & Hove in 2013.

There is much scope for improving care for patients with dementia in the city and these new services will offer dementia sufferers the improved care that they deserve.

A new era for primary care mental health?

An innovative new mental health service to be provided within primary care from Summer 2012 will support GPs in caring for patients with the most common mental health problems, including anxiety and depression. Experienced mental health professionals including support workers, counsellors, therapists and CPNs will be based within practices. They will ensure that people seeking help receive comprehensive mental health assessments and appropriate support including psychological interventions.

The service will offer flexible support on a one-to-one basis or in groups, via the telephone, internet and through computerised programmes such as Beating the Blues. It will also link with other community teams and wellbeing services across the city, including educational and vocational support. Those with more complex needs can be referred to secondary care as appropriate.

The service will be provided by the Mental Health Partnership, which brings together well established and experienced providers: seven local GP practices, Brighton & Hove Integrated Care Service (BICS), Sussex Partnership NHS Foundation Trust (SPFT), and independent providers Turning Point and Mind in Brighton & Hove. A challenge will be to ensure that this new multi-agency partnership delivers more efficient responses to GP referrals and stronger integrated pathways of assessment, care and support for patients with mental health problems.

Dr Christa Beesley, GP and primary care clinical lead for mental health, has been instrumental in developing this important new service. Dr Beesley said, "This is an exciting new development designed to make it easier for people to get effective help for common mental health conditions such as depression and anxiety, in accessible settings close to home. We developed this service with the help of patients, the public and professionals. We hope that we will now be able to provide more mental health support when and where people need it."

Dr Christa Beesley, GP and primary care clinical programme lead for mental health

> **"The new partnership model for mental health has the potential to make a real contribution to the wellbeing of the population of Brighton & Hove - my hope is that a really good service delivered in primary care will be well received by patients, prevent crises and reduce the demand for secondary care."**
>
> **Dr Nick Patton, GP**

Integrated Primary Care Teams

DEIRDRE PROWER
CLINICAL PROGRAMME LEAD, LONG TERM CONDITIONS

As an advanced nurse in primary care I am very excited about the new Integrated Primary Care Teams. In my practice I look after a high proportion of people living with long term conditions and see the impact this has on their lives. For many people negotiating the minefield of health and social care services is a daunting prospect.

With the new teams, patients with complex care needs will have an individual case manager. The new teams will enable closer working with many different services including social care whilst putting the patient at the heart of decision making.

> **"The transfer of responsibility for public health back to local authorities presents a great opportunity for us to build on the existing joint working between the city council and NHS and to tailor local services to local need."**
>
> **Gill Mitchell,**
> **Leader of the Labour & Co-operative Group, Brighton & Hove city council**

NEWS

Ghostbusting in Brighton & Hove

KATE GILCHRIST
HEAD OF PUBLIC HEALTH INTELLIGENCE

Official population figures from the Office for National Statistics (ONS) for Brighton & Hove give a figure that is 38,000 lower than the GP registered population for the city (258,800 versus 296,900 mid-year 2010).

The Department of Health suggests that 30,000 of these people are what are known as 'ghosts' – making the city the 9th most haunted area in the country, with the rest of the top ten being London primary care trusts. This is equivalent to one in ten people on local GP registers compared to just 4% across England.

Why the difference?

There are two reasons for this. On the one hand GP lists overestimate the population because they contain patients who have died, those who have moved out of the area and duplicate registrations – the ghosts. ONS population estimates on the other hand may underestimate the population because of the limitations of the available data sources on internal and international migration.

How old are these ghosts?

The biggest difference is in the age group 25-44 years (23,000). This is likely to reflect our large student population.

Does it matter?

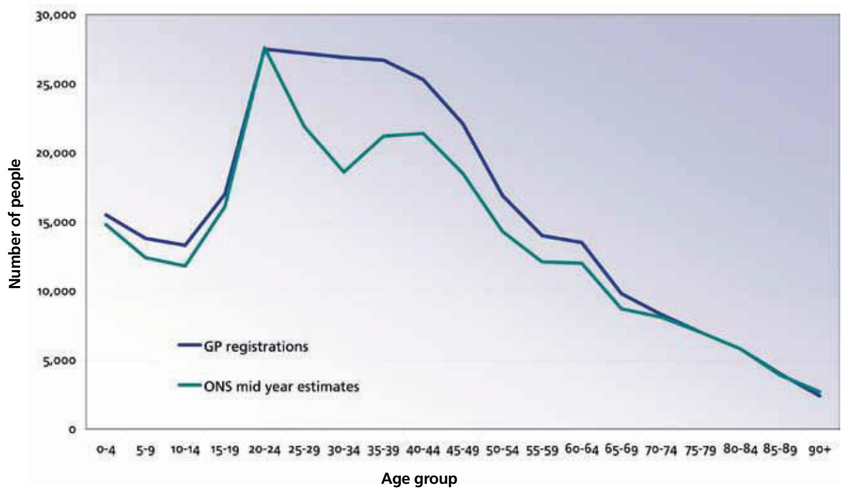
Money, money, money

Primary care trust funding is currently allocated according to ONS populations. Allocations to clinical commissioning groups in the future may however be based on GP list data. For limited national funds to be spread fairly across the country, shouldn't we feel obliged to produce lists that are as accurate as possible? Or will we feel the squeeze more than other clinical commissioning groups if we reduce our ghosts and others don't?

QOF improvement?

List inflation raises other questions too. If lists are inflated by ghosts are we actually doing better than our QOF scores suggest? Could our high level of ghosts partly explain our high levels of exception reporting? Our disease prevalence rates are also generally much lower than modelled estimates. But if all the ghosts were removed, would the prevalence rates match what we expect?

Comparison of 2010 resident population estimates by age band



Source: Office for National Statistics versus GP registered.

The 2012 Audit Commission Report highlighted examples of data quality initiatives. They include:

Student checks
Some areas with large student populations have procedures in place to ensure that student details are checked; for example, comparing the number of registrations at a hall of residence against the number of places.

Residential and nursing homes
Some areas annually compare how many places there are in each home to patient registrations and investigate any variances.

Multiple occupancy checks
Several areas carry out annual checks to identify households where there are more than eight residents.

Annual overseas patient checks
A few areas check to see if patients who moved to the UK on a temporary basis have left the country.

Elderly patient checks
This is the most common local data quality initiative, which involves checking with GPs to see if elderly patients are alive.

Local list cleaning projects include:

Returned post – the Summary Care Record project resulted in practices being informed of over 17,000 people who might have moved.

Students – Sussex University students registered prior to 2007 have been followed up to see if they have left the city.

Overseas patient checks – follow up of patients new to the UK as Office for National Statistics data show that 30% of immigrants will emigrate out of the UK again within two years of their initial arrival and 50% within five years.

Do financial incentives improve the quality of patient care?

THE CASE OF QOF

The introduction of the Quality Outcomes Framework (QOF), where practices are remunerated for achieving certain patient care standards, appears to have improved some patient outcomes. So do financial incentives to doctors improve the quality of care for patients? This is the question that Martin Roland, Professor of Health Services Research at the University of Cambridge, has been seeking to answer. He presented his research findings at the 2011/12 Brighton and Sussex Medical School Annual Discourse arguing that while QOF seems to have accelerated improvements in some areas of care, it may also have had some detrimental effects.

A STORY OF CONTINUED IMPROVEMENT

Quality of primary care has been improving in England since the early 2000s, before the introduction of the QOF in 2004. Clinical outcomes were improving with the implementation of national service frameworks, NICE guidelines and appraisal of doctors in the NHS. It is unlikely then that the introduction of pay for performance alone has been responsible for this continued improvement.

Over time, after controlling for national trends in admissions, improvements in quality in general practice have been associated with reductions in hospital admissions. There is some evidence that QOF has contributed to reduced hospital admissions. For example those practices with better quality diabetic care as illustrated by QOF had fewer emergency admissions for short term complications of diabetes.

NO DATA NO PAY

QOF has also stimulated better data collection systems in clinical practice as well as improvements in care with larger primary care teams, more nurses and other non-doctor roles. Larger teams are in a better position to offer the widest possible service to patients as well as collect better data and receive the remuneration accordingly.

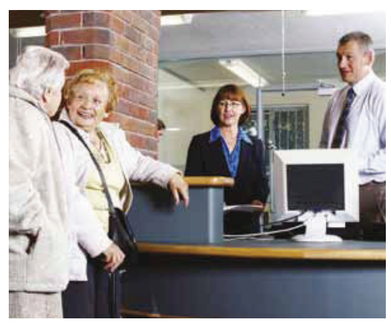
IT'S NOT ALL GOOD NEWS

There is some evidence that QOF has introduced a more fragmented, less holistic service, with patients reporting reduced access to a dedicated practitioner and reduced continuity of care. These are important aspects of care for many patients. In addition, there is some evidence of a reduction in the quality of care for conditions not included in QOF.

Exception reporting of patients has also been an issue, particularly in more deprived practices. Practices can 'except' patients, i.e. remove them from any calculation of participation, if they decline an invitation on three separate occasions or if the procedure is inappropriate for a particular patient. There is a modest association between QOF achievement and socio-economic deprivation – with more deprived practices tending to achieve higher scores nationally. Professor Roland's research indicates higher QOF scores in more deprived areas were not achieved by excepting more patients. However, the picture in Brighton & Hove is different and appears to show that some practices in more deprived areas have achieved high QOF scores by higher exception reporting.

THE JURY IS STILL OUT

So there is much to consider in this not so simple question of whether or not financial incentives for GPs lead to better care for patients. Research in this important area will continue. In the meantime, you can read more about how this issue has played out in local practices on page 44.



NEWS

Exception reporting masks lower QOF scores in local deprived practices

Birmingham shows the way

Terry Blair-Stevens

Getting underneath the headline QOF figures

The Quality and Outcomes Framework (QOF) which rewards practices for improved standards of chronic disease management has had its critics. Across the country, however, there is some evidence that standards of care have improved in many disease areas as a consequence of its implementation. Moreover, differences in QOF performance between the least and most deprived practices have gradually decreased and all but disappeared in recent years.

It is worrying then that local analysis matching QOF data with practice deprivation scores (IMD 2007) reveals an unfortunate association. Practices may 'except' a patient from care if there are exceptional circumstances or the patient refuses an 'invitation to care' on three occasions. However, when these 'excepted' patients are added back into the analysis in Brighton & Hove, a correlation between deprivation and low QOF achievement appears for several indicators. This suggests relatively more patients from deprived practices in Brighton & Hove are 'excepted'.

At one level this is perhaps to be expected. However, these missing patients can affect estimates of disease prevalence significantly: approximately half of patients with coronary heart disease, well over half of patients with hypertension, just over one third of patients with stroke and three-quarters of patients with COPD are probably not formally detected through QOF by local general practices.

It also affects treatment outcomes. While there were similar levels of achievement between general practices working in affluent and deprived areas for COPD, cancer, mental health and depression, practices in more deprived areas achieved lower scores in the smoking, asthma, hypothyroidism and epilepsy treatment areas.

There is evidence from around the country that it needn't be like that and patients from deprived practices can be encouraged into treatment programmes.

Follow the Brummies

As part of a city wide initiative to increase male life expectancy and get the right people on the right register, the city of Birmingham undertook to 'sweat the asset' of disease registers in primary care.

Practices systematically identified patients who:

- Had been diagnosed, but missed off the register;
- Had been identified as possible cases, but had no confirmed diagnosis;
- Had attended the practice, but where there was no record that a relevant health issue had been raised with them despite apparent risk factors;
- Had rarely if ever attended the practice.

Patients who needed further screening or diagnostic work were contacted through a variety of approaches:

- Sending further invitation letters to attend the practice;
- Telephoning and texting patients to attend;
- Making use of expert patients (patients with relevant conditions);
- Visiting patients; this was done with community nursing and other local outreach staff like health trainers.

These initiatives saw disease registers improve and more at-risk patients attend for appropriate care.

Health Trainers? Expert patients? Let's fix it

In Brighton & Hove there is a thriving Expert Patient Programme (01273 574647, or sc-tr.epp@nhs.net) and an excellent Health Trainer Programme (01273 296877).

Several excellent health trainers are already working in communities and expert patients have a lot to give back. As one expert patient puts it, "I attended an Expert Patient Programme course for people living with persistent pain. At the time I'd been living in pain for two years. I felt incredibly depressed, isolated and alone. Going on the course saved my life and was a huge inspiration to me. It also gave me the motivation that maybe I could do something to make a difference to other people's lives."

The building blocks are in place then for this problem to be sorted and for yet another source of health inequalities to be remedied by better public health / primary care cooperation.

The CCG challenge

Dr Tim McMinn, GP

The challenge for us in the new clinical commissioning group is to manage increasing demand with limited resources and capacity. So we need to work in a more integrated way and not just move the problems from one system to another.

In primary care, we need to explore new technologies like improved websites, virtual patient groups, electronic communication and social media. Of course we need to involve patients in this as they will be critical in ensuring we can meet their future needs. It's all about shared responsibility.

Your good health

Park running in Hove

Dr Anne Miners, GP

Parkruns are 5k runs that take place in parks all over the country (and in other countries too). We're lucky to have our own parkrun every Saturday morning at 9am in Hove Park. It is free and anyone can come along. All you need to do is register and bring along your registration bar code.

We have runners of all ages (from 8 to 80 years) and of all shapes and sizes, family groups, some with pushchairs, some with dogs (on leads). It's a great way to start running if you've never run before. It's sociable, we meet in the park café for coffee afterwards and everyone takes their turn to help out so you get to know other runners with the added satisfaction that you are putting something back into the community. Many runners go on to other running events like Race for Life or even the Brighton Marathon. I love it! Come along and see for yourself.

NEWS

Residents with learning disabilities miss out on preventive healthcare

As a group, people with learning disabilities have poorer health and a shorter life expectancy. Certain conditions such as epilepsy and dementia are more common among people with learning disabilities, who are also more likely to experience unemployment and financial hardship. Many people with learning disabilities rely on others to maintain a healthy lifestyle. They may not be able to identify their own health needs and so programmes need to support them and their carers to access preventive healthcare. This may be through help with physical activities or assistance with advice.

Adults with learning disabilities in Brighton & Hove

Over 5,000 adults in the city are estimated to have a learning disability; with more than 1,000 of them having a moderate or severe disability. The number of people with learning disabilities is predicted to increase by 5% over the next decade. However, data from general practice shows that there is wide variation in recorded prevalence of adults with learning disabilities across local GP practices (from 0% to 4%).

The Big Health Check

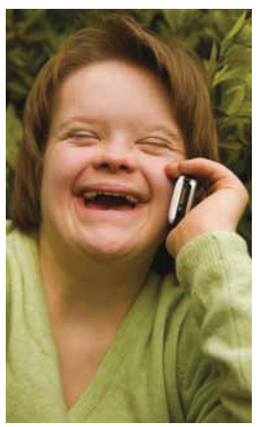
Getting preventive healthcare right for people with learning difficulties is imperative but too often it doesn't happen. The Big Health Service Check is an annual self-assessment of healthcare services for people with learning disabilities carried out by PCTs and councils.

Since its introduction in Brighton & Hove in 2007, the number of people having health checks has increased from 81 to 428 people (2010/11). However, this is equivalent to just 42% of those on the GP learning disabilities registers, a figure itself considered to be an underestimate. Still, local people with learning disabilities are more likely to have a health check than across England and the South East Coast.

Results from a separate local survey (2010/11), with 23 local GP practices responding, indicated that there was room for improvement in preventative healthcare.

Of the 576 people included in the review:

- 80% had their BMI recorded
- 31% of these were obese
- 76% of obese people were recorded as having received dietary advice
- 23 of the 29 people with diabetes had an annual review
- 19 of the 22 people with coronary heart disease had an annual review



What is being done locally to address this?

There is still some way to go in improving preventive healthcare for this group of vulnerable patients. The community learning disability team provides training for primary care and community services to ensure access to mainstream services for people with learning disabilities. This training has developed to include healthy living and health promotion services.

The team can be reached on 01273 295550 or at www.brighton-hove.gov.uk/learningdisabilities

Clara faces up to benefits challenges

John Francis
Brighton & Hove city council, housing benefit team

Clara's story

Clara lives in a two bedroom flat in Brighton with her disabled daughter who is 13 years old. She is one of many benefit claimants who rent in the private sector, and who will be affected by significant welfare reforms. Clara's landlord charges her £850 per month. She receives carer's allowance for looking after her daughter and her daughter receives disability living allowance. Until January 2012 housing benefit covered all but £4 per week of Clara's rent. From January 2012 she will pay £18 per week out of her other income.

Benefit changes

Clara is not alone. Just over 58,000 people live in similar circumstances in Brighton & Hove including 15,000 children. Almost a third of these adults have been found to be unable to work due to sickness. The reforms mean that many people in receipt of sickness benefits face reductions in the amount they receive in housing benefit. Affordable housing is set to become even harder to access for many people in Brighton & Hove.

In addition to changes in housing benefit, 4,800 people in the city are in the process of moving from incapacity benefit to the new replacement benefit – employment support allowance – where entitlement is subject to a work capability assessment.

In other changes, from April 2013 some tenants in the social sector will see benefit levels reduce if their properties are deemed too large for their families' needs. Furthermore, all non-pensioner claimants are likely to have to contribute towards their council tax when benefits previously covered this liability.

Local authorities manage limited discretionary schemes to top up levels of standard benefit payments. Access to these funds may increasingly be necessary to enable secure long term accommodation. Eligibility criteria include the health of the claimant and the suitability of their current accommodation. Local GPs are likely to see an increase in requests for information about their patients' health.

> **"The council administration is very concerned about how the intended and unintended consequences of benefits changes will affect the city's most vulnerable residents"**
>
> **Councillor Jason Kitkat,**
> Brighton & Hove city council

DIABETES

Local diabetes patients may be missing out on vital foot health checks

ALISTAIR HILL
PUBLIC HEALTH CONSULTANT

There are more than 9,500 people in Brighton & Hove living with Type 1 or Type 2 diabetes, and the number is increasing by 5% year on year. But hundreds of them are not receiving vital checks, placing them at risk of developing serious health problems. Diabetic neuropathy can cause several problems including foot ulcers. These can be treated successfully, particularly if spotted in the early stages. However, if neglected they can lead to serious problems and even require amputation. In Brighton & Hove a lower proportion of patients receive foot checks compared to the national average.

THE IMPORTANCE OF GOOD CARE

Between 2008/09 and 2010/11, 254 individual patients were admitted to hospital with diabetic foot disease, accounting for an annual rate of 193.7 per 1,000 adults with diabetes: 13% higher than the England average of 171.3 per 1000. There were 31 major amputations (above the ankle) many of which might have been prevented if action had been taken sooner.

It is something that Anne Smith, practice nurse and clinical quality manager, understands well. "In my experience feet are not checked because the healthcare professional may lack confidence about what to look for. However, with support and education, they can help patients to manage their own feet so we are less likely to see preventable complications."

Regular foot checks are one of the '15 healthcare essentials' recommended by Diabetes UK and one of the nine checks that NICE include in the core annual review 'bundle' (measurements of weight, blood pressure, smoking status, HbA1c – a marker for blood glucose, urinary albumin, serum creatinine, cholesterol, and tests to assess whether the eyes and feet have been damaged by diabetes).

Anne Smith, practice nurse and clinical quality manager

LOCAL EVIDENCE

Evidence from two independent sources suggests that hundreds of people locally may be missing out on vital preventative care.

The first data source is the national Quality and Outcomes Framework (QOF). Each year, every GP practice reports the percentage of adults aged 17 years and over recorded on the diabetes register having had foot sensation measured (neuropathy testing).

For 2010/11, Brighton & Hove practices reported:

- 7,769 patients had received this check (82.1% of patients with diabetes, compared to 86.0% for England)
- 1,689 had not received this check of whom more than half had been 'exception reported'. (See Exception reporting masks lower QOF scores in local deprived practices, page 44)

QOF data is not standardised by age or sex and some practices may have relatively small numbers of diabetic patients with disproportionate effects on comparison of proportions. Nevertheless, there is considerable variation between GP practices.

The second data source is the 2009/10 National Diabetes Audit, in which 38 out of 47 local GP practices participated. This showed that 79% of patients had received a foot risk assessment in the previous year – 5% lower than the national average. This places Brighton & Hove in the lowest 25% of PCTs nationally.

WHAT CAN BE DONE?

If foot checks increased just to the national average an additional 400-500 people might benefit. However, the problem lies not just in foot checks: the National Diabetes Audit showed that in Brighton & Hove just 43% of patients received all nine of the NICE recommended checks compared with the national average of 53%, again putting the city in the bottom 25% of PCTs for diabetes care.

Since April 2011 practices have been asked to report on the proportion of patients with diabetes with a record of a foot examination and a risk classification (from low risk to ulcerated foot). This will provide more specific information across all GP practices and increase the opportunities for improvement.

As Anne Smith notes, patients should be educated about their condition and encouraged to speak to their clinician about the management of their condition to reduce their risk of complications.

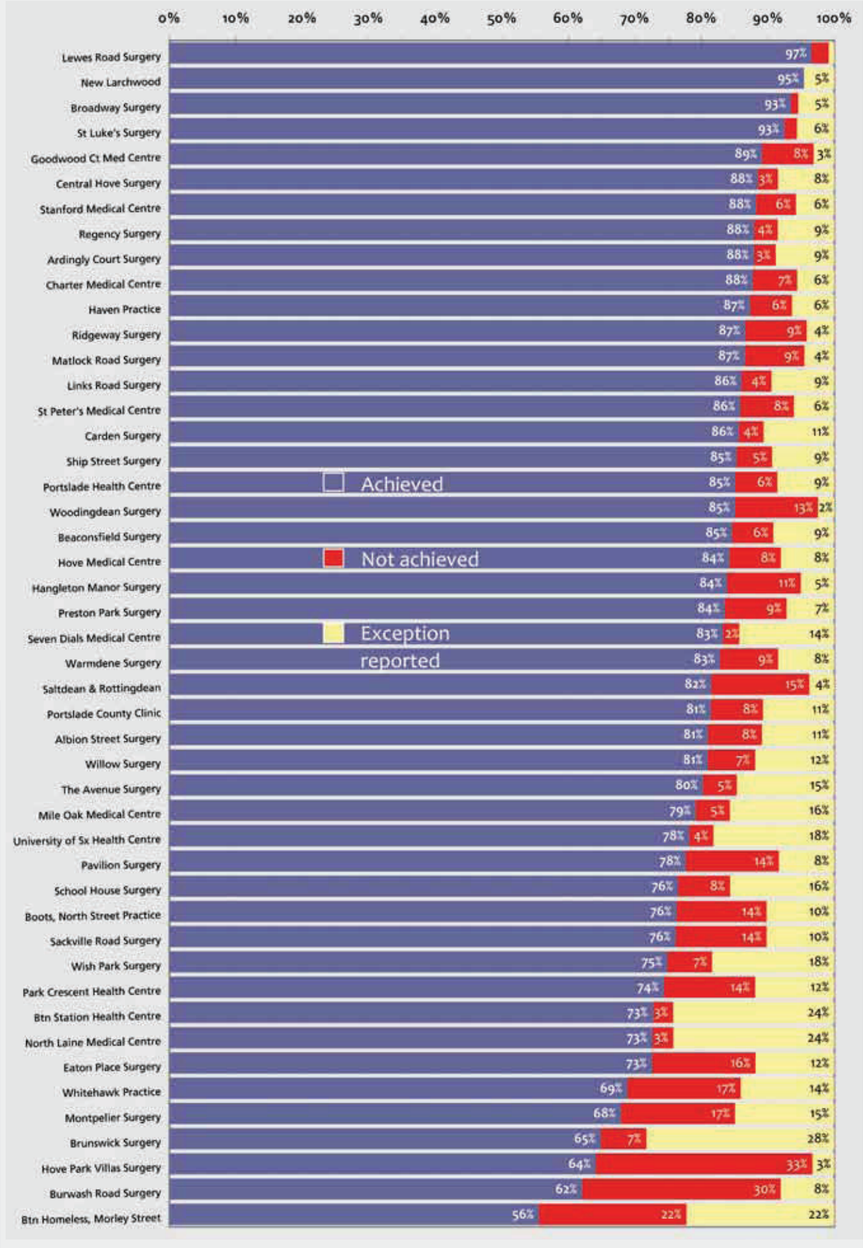
GP practices and the Integrated Primary Care Teams in turn should identify patients who are not receiving foot checks and consider how these can be provided. The primary care trust can support practices in identifying patients and providing them with these vital checks.

What does is all mean?

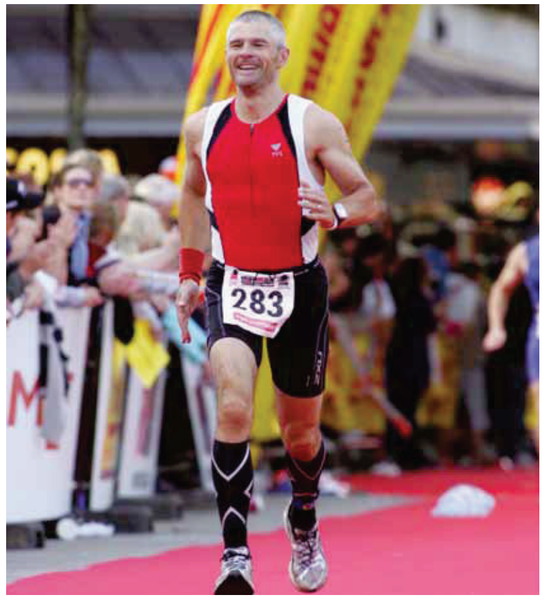
A little caution is required in interpretation. Some diabetes care may be delivered outside of annual reviews and not be recorded, some patients may get most of their care from hospital and not from GPs, and some data may be missing. But the short answer is that diabetes care in Brighton & Hove could be much improved. We need to ensure patient call and re-call systems work well, we need to improve communication with the hospitals and work collaboratively to improve diabetic care across the city. The new clinical commissioning group puts us in a good position to do just that.

Disappointing foot check results

Percentage of patients aged 17 years or over recorded on the diabetes register that have had their foot sensation measured (neuropathy testing) QOF 2010/11



SUSTAINABILITY



Your good health

Reborn to run

Dr Jim Graham, GP

In recent years, regular participation in exercise has provided me with a healthy balance to the hard work involved in being a GP. It started with mountain biking on the South Downs and progressed to Ironman Triathlon, then Double-Ironman Triathlon (4.8 mile swim, 224 mile cycle, 52 mile run).

Previously, I avoided running (since school cross-country) because of a damaged knee from skiing plus a damaged ankle from a motorcycle accident. But somehow it all took off and 'Good-for-Age' qualification for the London Marathon became a target - that took three years to achieve. Marathon times trickled down from 4:45 to 3:11, thanks to "barefoot running" inspired by Christopher McDougall's best selling book "Born to Run".

There is always another goal to aim for. Later this year I will be competing for GB (as age group 45-50 athlete) in Germany at the European Championships Iron-Distance Triathlon as well as competing in Switzerland for World Championships Long Distance Duathlon. And all with dodgy knees - who'd have thought...

Your good health

Doctors on bikes

At Mile Oak Medical Centre they take energy sustainability very seriously – but still manage a laugh. The building is highly energy efficient and over the last couple of years more and more of the team have swapped their cars for bikes, even using them for home visiting (at least on dry days). It takes a little extra thought to dress for the consulting room and the bike lane. But there are compensations: no fruitless searching for a parking space when you can ride straight up to the front door; money saved on petrol soon pays back the cost of a bike; and the health benefits are obvious.

The practice is about to take delivery of a new bike rack as part of the council's scheme to encourage cycling around our city. What started as a couple of apparently eccentric enthusiasts seems to have become a bit of a trend!

Brighton & Hove GPs go green and pocket savings

TONY WRIGHT
HEALTH DEVELOPMENT SPECIALIST

10:10 comes to primary care

General practices in Brighton & Hove have become among the first in the UK to take direct action to tackle climate change. Over 25% of the city's practices have signed up to 10:10 – a voluntary initiative which aims to help participants measure and reduce their carbon footprint. The project was pioneered by local GPs Dr Sally Barnard and Dr Rachel Cottam. Both worked independently in their practices to raise awareness about climate change and its impact on health. Now another 11 practices have signed up.

Participating practices undertake to review their energy use, from supply tariffs to the condition of the building and the efficiency of lighting and heating. The project also raises staff awareness about how to save energy. Each practice receives a carbon footprint summary report and is benchmarked against national and city average performance which gives staff an indication of the scope for improvement. Practices are then supported to draw up a list of energy saving opportunities.

Dr Christine Habgood with one of the Mile Oak practice's electric bikes.

The benefits from changes: small and not so small

St. Peter's Medical Centre has put in place a series of changes:

- Confidential shredding and recycling of all paper waste;
- Installation of new energy saving hand dryers;
- Installation of new smart toilet roll dispensers;
- Switch off stickers on all light switches;
- Purchase of a small waste bin and large recycling bin;
- Electronic scanning of all documents instead of photocopying;
- Installation of a new seven day timer on the boiler;
- Change of energy supplier.

Gary Toyne, practice manager in Montpelier Surgery implemented a series of similar initiatives: "We have seen a reduction in the cost of our gas bill as our usage has gone down. This is largely due to resetting the boiler times and reducing usage at the weekends."

So, it's not just the environment that benefits from these measures. Typical savings range from 10% to 15% but have been as high as 30% in some practices. This is equivalent to £1,000 per annum.

The 10:10 programme is demonstrating that there is an appetite among practices to make a real contribution to climate change, and that there is scope too for genuine savings – a win-win situation.

If you want to know more about how your practice can take part in 10:10, contact Tony Wright in the public health team on 01273 294557.

Trish Kennard reflects on the role practice nurses play in improving public health

Practice nurses –

putting public health into primary care practice

My working day at the Park Crescent Surgery runs from 8.30 am 'til 6 pm and it is pretty non-stop. Although the work is mostly face-to-face with individual patients, a lot of it falls very much into the public health domain. We practice nurses are the ones who deliver immunisation, cervical screening, weight management, smoking cessation and most sexual health services. We play a key role in improving the management of chronic diseases like COPD, diabetes, asthma and even mental health which has real long term health benefits. I like to think that while we are helping patients in the here and now, we are also building up lots of community health for the future.

NEWS

Caption competition

It's open to any reader and the winning entry will be posted in the clinical commissioning group GP Bulletin. The prize for the winning entry is a £100 donation to a charity of your choice. Send your entries along with your selected charity to tom.scanlon@brighton-hove.gov.uk by 1 August 2012 .

Good luck!

WHAT'S INSIDE

Source: Department of Health (open government licence)

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