ATTACHMENT 4.3

QUARTERLY REPORT:
HEALTH IMPROVEMENT DIRECTORATE

January 2009

1. Introduction

The BEN PCT Health Improvement Directorate is tasked with the challenge to improve the health and well being of its local population. The population of BEN is largely diverse in that its wards are separated by extreme differences in social and health equality. The Health Improvement Directorate aims to address these inequalities through the development and promotion of services that have been fundamentally influenced by the social and health needs and demands of local people and will ultimately reduce the level of health deprivation that exists across Birmingham.

The issues raised in this paper will provide a local picture of some of the health inequalities that are currently affecting the population of BEN PCT and the strategies that are in place to address them. For the purposes of reporting this quarter, the Health Improvement Directorate has provided updates on,

- Flu activity and Immunisations uptake
- Cervical Screening
- Winter Warmth Paper (presented at PEC Dec 2008)

The information provided in this report is based on developments since the submission of the last paper to the PCT board, during quarter two.

2. Directorate Summary

In general this report provides an opportunity to consider the activities and progress of the Health Improvement Directorate. Although the last SHA quarterly report showed that several in some areas of health improvement targets were not being met, the Health Improvement Directorate is working towards achieving these targets in the next quarter and subsequently throughout the coming year. This report will highlight the current progress and the plans and actions that are in place to improve the delivery of health improvement services.

3. Flu Activity

Introduction

Influenza or 'flu' is a highly transmissible acute viral infection that affects people of all ages[1]. Typically it starts with a sudden onset of fever, chills, headaches, myalgia and cough or other respiratory symptoms. Whilst the majority of individuals get better without complications in 1 - 2 weeks, flu can cause serious ill health and death, particularly in the very young and the old. Flu epidemics take place primarily in the winter months and can lead to widespread disruption to healthcare. A flu vaccine is manufactured annually based on the strains of virus expected to be circulating.

Transmission

Flu is transmitted between humans predominantly by air-borne droplet spread. Coughing and sneezing principally promote spread[2]. Transmission is also assisted by overcrowding, enclosed spaces and sharing the same room as infected individuals.

Epidemiology

Influenza can cause annual winter epidemics of varying magnitude and gravity. All age groups are affected with highest incidence in children and the majority of hospitalisations / mortality in the elderly. Between 3000 and 30000 excess winter deaths are attributed to influenza in the UK[2]. Influenza activity in the community leads to major morbidity, mortality and economic disruption particularly in those with underlying chronic medical conditions[3] such as COPD or diabetes.

Royal College of General Practitioners[4]

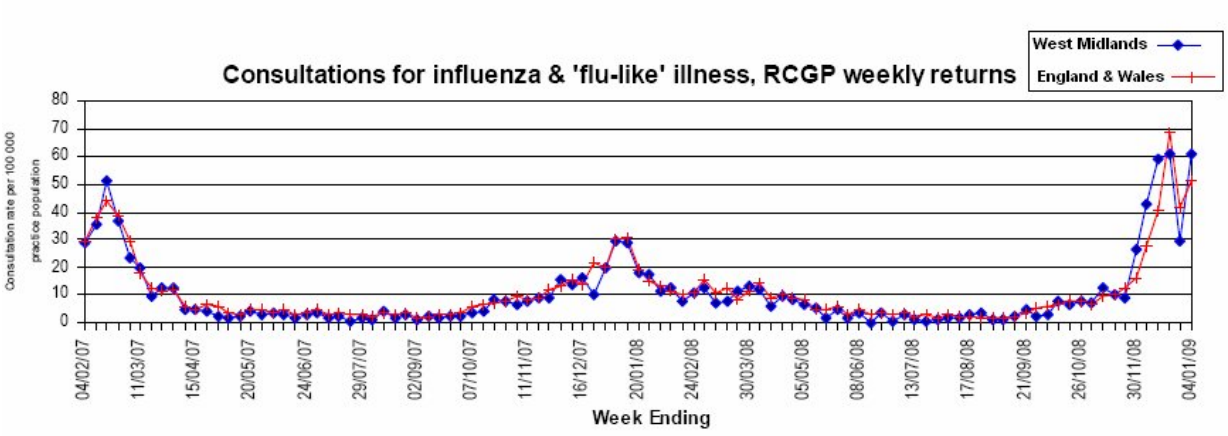
The Royal College of General Practitioners Weekly Returns Service (WRS) is a network of sentinel general practices providing weekly data on illnesses diagnosed in general practice across England and Wales. The WRS contributes to the surveillance of infectious disease, most notably influenza. Surveillance from the Royal College of General Practitioners (Figure 1) shows that influenza consultations in 2008/09 have been higher than previous years both nationally and regionally.

Provisional data from the RCGP for the week ending 04/01/09 show that consultation rates for influenza and 'flu-like' illness have increased during week 1/2009 in the West Midlands and in England & Wales. Levels are within normal seasonal activity in the West Midlands and are at 60.5 per 100,000 population (95% CI 46.5-74.4). For England and Wales the rate is 51.0 per 100,000 (95% Cl 45.8-56.2).

---

[1] http://www.dh.gov.uk/en/Publichealth/Flu/index.htm
[2] Communicable Disease Control Handbook – Hawker J et al – 2nd Edition
[3] Stephenson I, Zambon M, The epidemiology of influenza, Occup Med (Lond). – 2002 Aug; 52 (5): 241-7
[4] Harcourt S.E et al How representative is the population covered by the RCGP spotter practice scheme? Using Geographical Information Systems to assess – Journal of Public Health – Vol. 26, No. 1 pp. 88-94

Figure 1 – RCGP consultation rates for influenza & flu like illness[5]



Q-Surveillance – Health Protection Agency and Nottingham University Division of Primary Care

This primary care surveillance system uses a database of general practice derived data, from which PCT level consultation rates can be generated. Table 1 shows consultation rates for Birmingham East & North PCT during 2008/09.

Table 1 – Influenza like illness consultation rate per 100,000*

	Week 48	Week 49	Week 50	Week 51	Week 52**	Week 1
BEN PCT	44.3	35.3	42.3	63.8	26.9	26.7
West Midlands	18.3	23.3	31.3	40.5	23.3	31.3
England & Wales	13.9	18.9	27.7	42.3	24.6	33.1

* Cells highlighted in red have a significantly higher Standardised Incidence Ratio (SIR) when compared to the UK standard population (standardised for age and sex)
** Week 01 includes a bank holiday when GP surgeries would normally be closed. This often results in artificially lower consultation rates and therefore data for week 1 2009 should be interpreted with caution.

Influenza Immunisation Campaign 2008 / 2009

The national influenza target for the 65 year and over age group is 70%. Currently there is no national target for the under 65 years at risk population. We are in the process of reporting he PCTs influenza uptake. This is reported monthly from October 2008 to February 2009 to the Health Protection Agency via the Health Protection Informatics website. Each month the website is open for data entry for approximately 10 days, during this time period practices can provide the data in one of three ways:

[5] Weekly Influenza Bulletin – Week 01/09 – Health Protection Agency

- Automatic upload- only available for practices with EMIS
- Manual data entry by the practice onto the HPI web site
- Manual data entry by PCT onto the HPI web site

Obtaining the uptake data from practices within the set time deadline, requires considerable effort on behalf of both the Health Improvement team and the Primary Care IT facilitators.

Last year the PCT achieved the national influenza target with an uptake of 71.4% for the 65 years and over population.

The uptake for the under 65 at risk population was 47.6%.

We are now in our third month of Influenza vaccination reporting and currently we are just below target at 69.2 % as of 14th January for BEN PCT. We have one more month in which to increase this to achieve the 70% target for the 65 years and over population. Table 2 shows practice uptake data by locality reported as of 9th December 2008. Washwood Heath and Hodge Hill locality have a low uptake in comparison to the others. Analysing data from previous years, BEN PCT was able to hit its target of 70% (Table 3), although BEN PCT has the lowest uptake relative to other Birmingham PCT's.

Table 2 – Practice Uptake Data by Locality

Locality	Population over 65	Number Vaccinated	% Uptake	Total Needed for all practices to reach 70% per locality	Total Required For PCT to reach 70%
BSA	10245	6484	64.3%	814	
Erdington	8599	5707	66.3%	436	
Kingstanding & Oscott	10535	7062	68.9%	427	
S3	10447	7055	66.8%	407	
Sutton Coldfield	21647	14388	66.3%	889	
WH/HH	5444	3034	57.0%	805	
Total	66917	43730	65.3%	3778	3111

Table 3 – Vaccination coverage for BEN PCT 2006/2007 and 2007/2008

Uptake Data	Percentage Immunised during October and January	
	2006/2007	2007/2008
England	74	74
West Midlands	73	72
Birmingham East & North PCT	71	71
Heart of Birmingham Teaching PCT	80	80
South Birmingham PCT	72	72

Flu Vaccination uptake in BEN staff.

Free flu vaccinations are available for all PCT staff from the Occupational Health department at Heartlands Hospital where drop in sessions are available. Protecting staff with a Flu vaccination reduces transmission in healthcare settings, even if they are not directly involved in patient care. Flu vaccination protects the individual staff member and helps to protect colleagues and vulnerable patients. The number of staff vaccinated in 2008/2009 is about the same as 2007/08, Table 4.

Table 4 – BEN PCT Staff Influenza vaccination – 2007/08 and 2008/09

Clinical		Allied Health Professionals		Clerical		Others	
2007/08	2008/09	2007/08	2008/09	2007/08	2008/09	2007/08	2008/09
77	83	23	10	82	92	12	11

These figures represent only those staff that attended ‘flu vaccination sessions’ and does not include those getting vaccinated at GPs or occupational health department.

Summary

Influenza or 'flu' is a respiratory illness associated with infection by the influenza virus. Flu occurs most often in the winter months, and normally peaks between December and March leading to considerable morbidity and mortality in the population.

In BEN PCT the major priority is to achieve 70% or above influenza vaccine uptake. General advice is as follows:

- Anyone over the age of 65, or under 65 who falls into an "at risk" group, should ensure they receive their flu vaccination.

- Health care workers involved in the delivery of care and/or support to patients should see their occupational health department for their flu jab. Care workers should speak to their GP to establish if they meet the criteria for flu vaccination.
- If affected with flu, stay at home, rest, drink plenty of fluids and use over-the-counter remedies

Poultry Workers

The Department of Health continued the policy to offer poultry workers employees in DEFRA registered premises access to the seasonal influenza vaccine as part of the pandemic influenza preparation. The premises were visited and 10 staff have been vaccinated. The data has been supplied to the Department of Health via the HPI web site

Key Immunisation Focus for the next six months

- Achieve 70% or above influenza vaccine uptake
- Maintain and improve current childhood immunisation levels
- Focus on Pre School Booster immunisation rates
- Focus on MMR 2 immunisation rates
- Work with the PCT's provider services to develop a business case for a Community Immunisation Team
- Improve HPV monthly data return
- Plan for the increased workload of the HPV Vaccination

4. Immunisation Uptake

Childhood Immunisation Uptake

Primary Course

The majority of childhood immunisations in BEN PCT are administered in primary care by practice nurses. One practice in the PCT has opted out of delivering the childhood immunisation programme, (this practices childhood immunisations are administered by their local Health Visiting team).

It was anticipated that the main reason there is a low uptake in year 1 was due to a data quality issue, mainly that data is not returned to Child Health in time to meet the quarterly return for the national COVER data. We have worked with practices and Child Health to encourage the return of data in a timely fashion, this has helped to improve our uptake rate significantly.

BEN PCT's childhood immunisation uptake for the Primary course (DTaP IPV Hib) should be completed by the time a baby is 6 months old. It is measured at a child's 1st Birthday. The uptake rate has increased significantly from 81.4% in Quarter 3, 07-08, to 88% in Quarter 2, 08-09. (See Chart 1)
This is more comparable to our neighbouring PCT's uptake rates, but still requires further work to increase these rates to achieve the national target of 95%. (See Chart 2)

Chart 1: Primary Immunisation rates measured at 1 year in BEN PCT

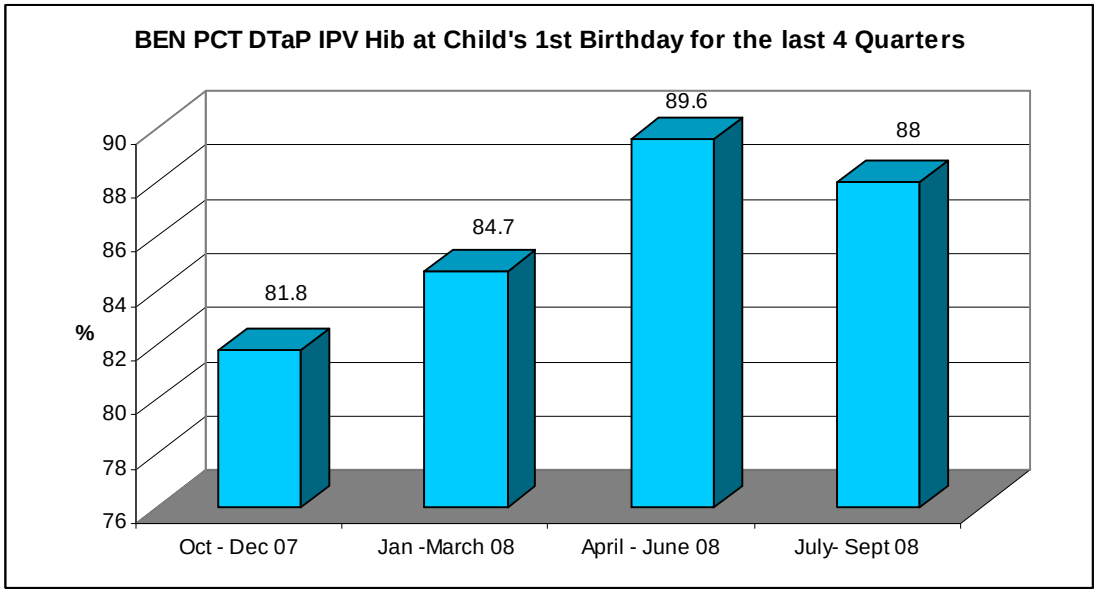
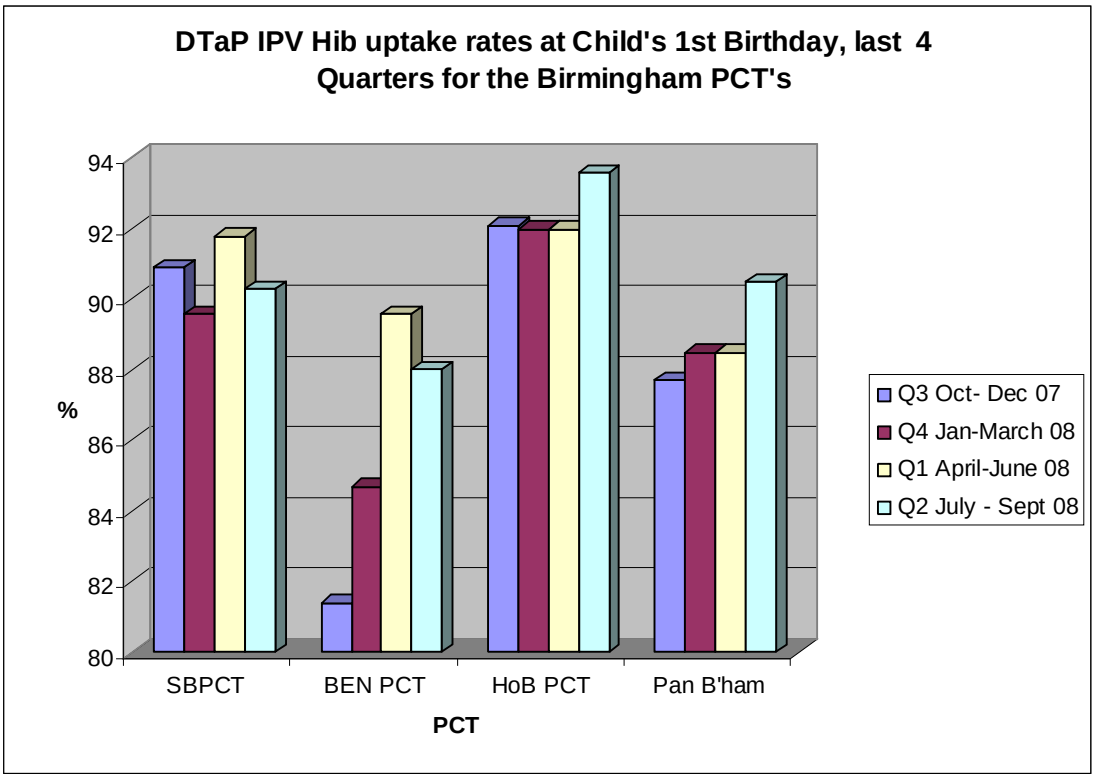
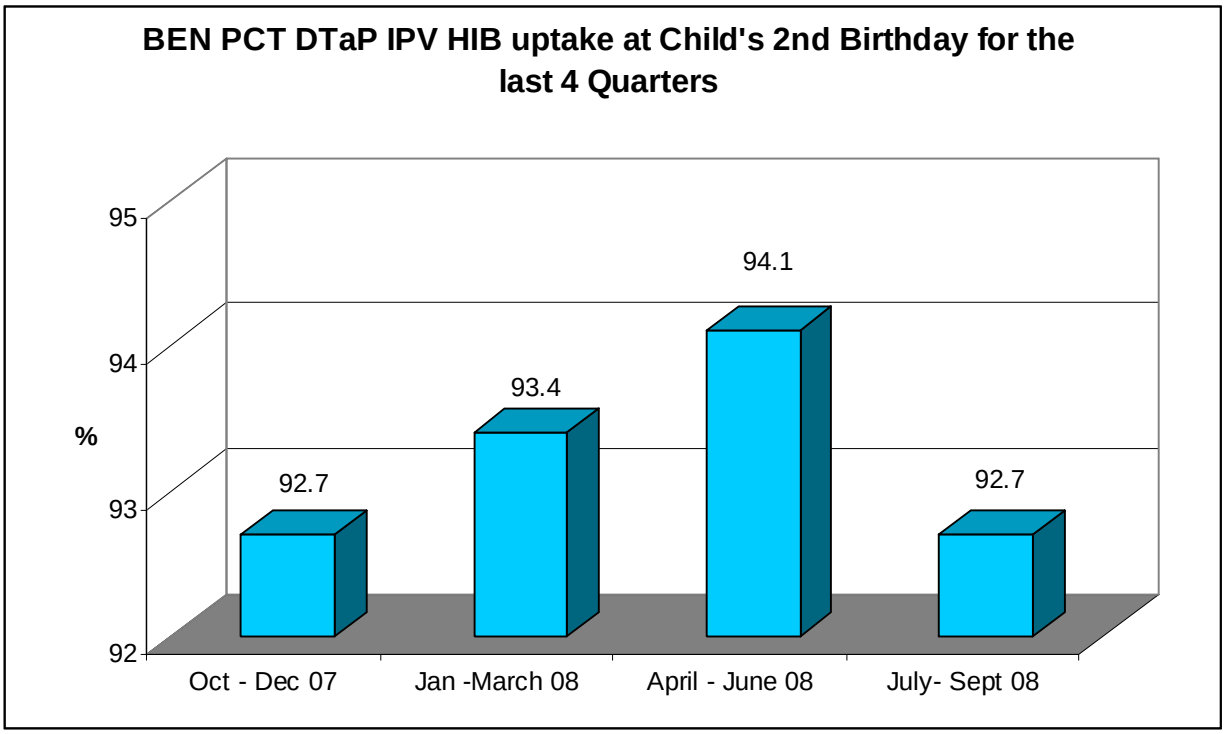


Chart 2: Comparison of the Primary Immunisation uptake, measured at 1 year for the Birmingham PCT's



When the Primary course is measured at a child's 2nd Birthday the PCT achieves a much higher uptake rate, nearing the national target of 95%. (See Chart 3)

Chart 3: Primary Immunisation rates measured at 2 years in BEN PCT



Pre School Booster

BEN PCT's uptake for Pre School Booster (DTaP IPV) immunisation is given at around 3½ years and measured at a child's 5th Birthday. This has increased significantly from 77.4% in Quarter 3, 07-08, to 81% in Quarter 2, 08-09. (See Chart 4)

This is comparable to South Birmingham PCT but below the rates that HOB PCT achieves (See Chart 5).

It is well below the national target of 95% and requires further work to increase this uptake.

Chart 4: Pre School Booster Immunisation rates measured at 5 years in BEN PCT

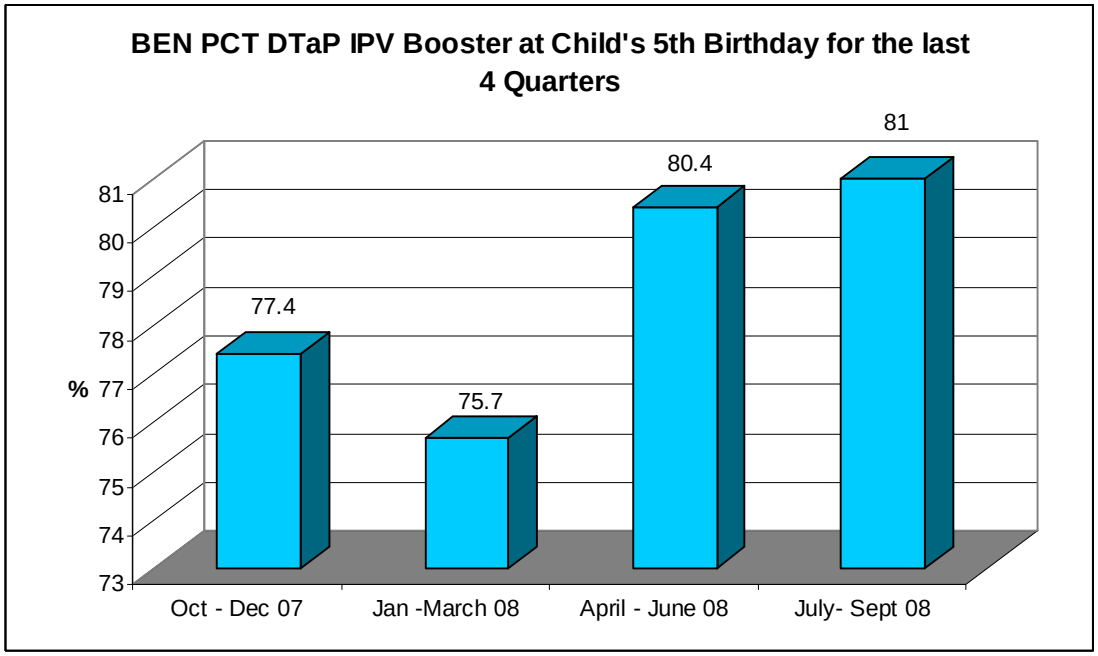
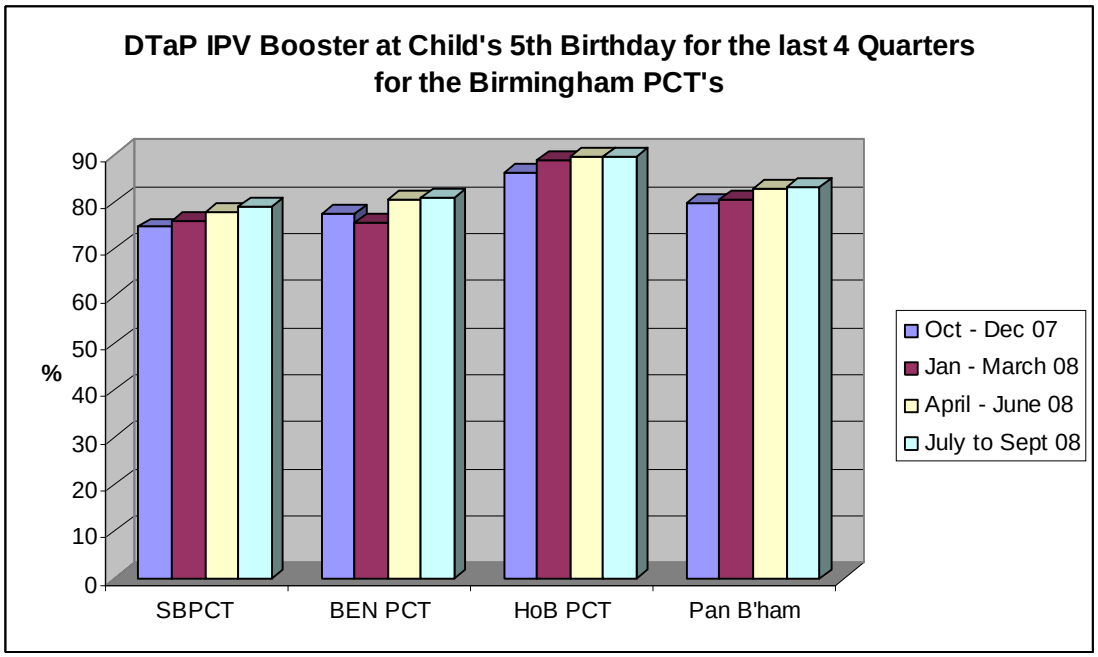


Chart 5: Comparison of Pre School Immunisation uptake measured at 5 years for the Birmingham PCT's



Challenges for the future

- Whilst the PCT Primary Immunisation uptake rate has improved we need to ensure that this trend continues. Our Vital signs target is 95% by 2010-2011.

- The uptake rate for the Pre School Booster has increased we need to work towards achieving 95% by 2010-2011.

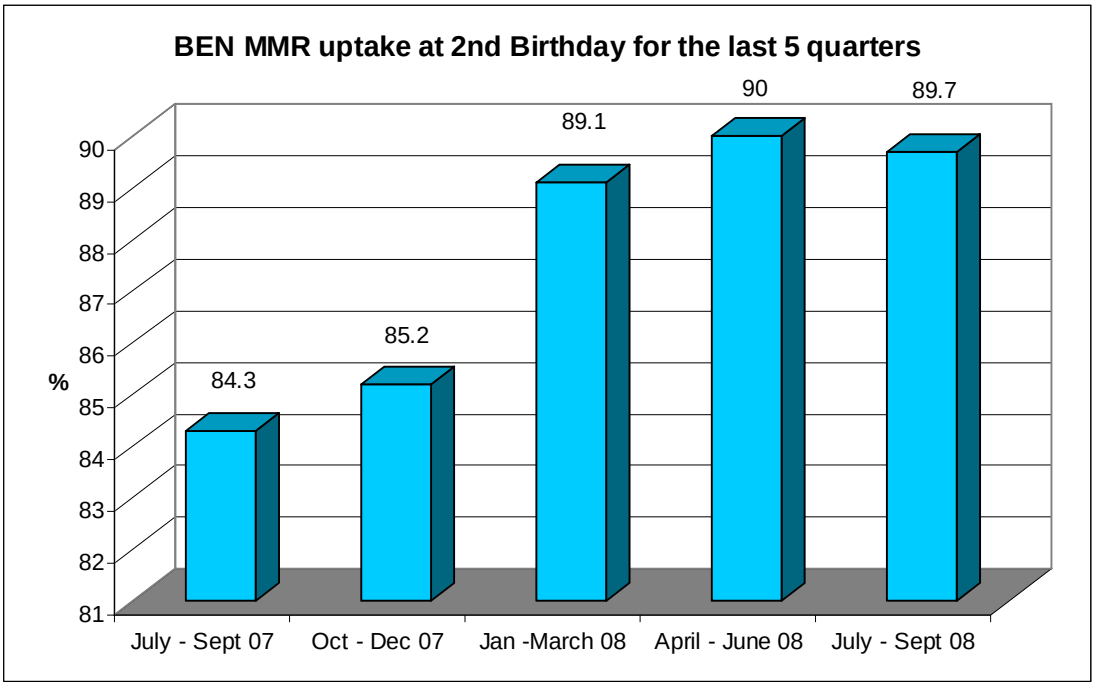
MMR

Following the introduction of the MMR Tail-Gunning project, the PCTs MMR 1 uptake measured at a child's 2nd Birthday, increased by nearly 5% to 89.1% (January – March 2008). Over the following two quarters, this uptake has been maintained (Chart 3).

This SLA with Birmingham Failsafe unit was discontinued in September 2008, the work is now being undertaken by the public health and information team within BEN PCT. The key aim of the service is to maintain and deliver a further improvement in MMR 1 uptake.

Community staff nurses within health visiting teams are working in partnership with Health Improvement and GP practices to target the vulnerable children who have persistently failed to attend for MMR appointments, and will offer domiciliary visits to vaccinate these children at home.

Chart 4: MMR 1 Immunisation rates in BEN PCT following the introduction of the Tail- Gunning project



MMR Catch Up

On the 6th August 2008 the DoH announced the MMR Catch Up programme. In England there are a large number of children who are unvaccinated or partially vaccinated against MMR. The numbers of measles cases in England are now rising and outbreaks are occurring. With a large number of unprotected children there is a high risk of a large measles epidemic. Estimates suggest this could be between 30,000 and 100,000 cases.

Two doses of Measles, Mumps and Rubella (MMR) are required to give level protection against the three attenuated virus strains contained in the vaccine.

To reduce this risk action needs to be taken to vaccinate those communities who are unprotected. The first priority is to vaccinate the children aged 13 months – 18 years who have never had an MMR.

The DoH has procured additional MMR vaccine supplies for use in this campaign and has increased our funding by £30.000 to provide this service. In BEN PCT it is estimated that we have approximately 20.000 individuals requiring further immunisation with MMR, 7.000 of which will be totally unvaccinated. The PCT has commissioned this service via a GP LES.

Challenges for the future

- Maintain and improve the current MMR 1 uptake to achieve the national target of 95%
- Plan and implement an action plan for the improvement of the MMR2 uptake rates.

HPV Implementation

The Department of Health recommended the introduction of the human papillomavirus (HPV) vaccination for 12-13 year olds from September 2008; this is a universal cervical cancer vaccination programme for adolescent girls. The HPV vaccine is a 3 dose schedule administered within 6-12 months.

This year alongside the year 8 programme a catch up programme has also commenced with girls in Year 13 (17 -18 year olds).

After considering the various models to deliver this programme, the PEC decided to use a GP delivery model via a local enhanced services agreement. Part of this agreement includes additional support from the Community Nursing Service to assist with delivery to approx. 20% of girls in the cohort, who may be without a local GP, or are vulnerable and hard to reach. Four GP practices chose not to deliver this service, the service for these clients is being provided via the Community Nursing Service.

The PCT is required to submit monthly and end of year vaccination data. The vital signs target for this programme is 51% for this year.

Also to ensure that there is a consistent delivery model for school age immunisations throughout the trust, the GP model is to be used to deliver the school leaving booster.

Data Collection

The PCT is required to submit monthly uptake data reporting on all HPV vaccinations administered within the PCT. Obtaining the uptake data from practices each month, requires considerable effort, as yet we have been unable to fully report our uptake due to poor returns. Currently our HPV immunisation uptake is reported at 26%, however we only had 50% of practices that returned data.

Accelerated Catch Up Programme

The Catch Up programme was planned to continue until the end of August 2011, at which time all females aged 12 -18 years old will have been offered access to the vaccine. However following the recent announcement the DoH are now suggesting an accelerated catch up programme next year. This will include 4 school years 10, 11, 12 and 13, in addition to Year 8 which is being embedded into the national programme, which increases the number of girls needing vaccination to approximately 14.000 next year.

Challenges for the future

- Implementing the Accelerated Catch Up
- Obtaining the monthly uptake data from practices within the set time deadline
- Achieving 90% uptake by 2010/2011

5. Birmingham Cervical Screening Programme

Birmingham Cervical Screening Programme 2007/2008

Cervical screening is a method of preventing cancer by detecting and treating early abnormalities, which if left untreated, can lead to cancer. All women between the ages of 25 and 64 are eligible for a free NHS cervical screening test every 3 to 5 years. Cervical screening significantly reduces the incidence of cervical cancer and saves up to 5,000 lives each year. The NHS call and recall system invites women who are registered with a GP. It also keeps track of any follow-up investigation, and, if all is well, recalls the woman for screening in three or five years time.

This report provides an update on the profile of the cervical cancer screening programme in BEN PCT and Birmingham including current epidemiology, contractor arrangements, performance against national standards and a forward plan for the coming year.

Our main findings during 2007/8 were:

- Mortality in Birmingham East and North PCT was higher than the West Midlands as a whole.
- Coverage continued to fall - all three Birmingham PCTs fell below the 80% standard for 5 year screening coverage; this was also the case for the West Midlands as a whole. Coverage was especially low in the 25-34 year age-group.

- All inadequate, borderline/mild and moderate/severe sample rates, 8 week waiting time for colposcopy and most positive predictive values were within standards.

- Colposcopy DNA rates continued to increase, and are generally far higher for follow-up appointments. This is a cause of great concern.

- Only one colposcopy clinic met the standards for both 4-week and 8-week biopsy result waiting times.

Actions for the forthcoming year include:

- Improving access and coverage, especially among 25-34 year olds and women with learning disabilities

- Reducing colposcopy DNA rates at all provider units.

- Ensuring that SLAs are in place with all providers.

- Reducing the number of samples from women aged below 25, who are not included in the screening programme.

- Continuing to ensure that all sample takers are competent and up to date with their training.

What we did to improve the service during 2007-8

Coverage

Work is ongoing to improve coverage. This includes cleaning up data to address discrepancies, QoF exceptions and "ghost patients". We are also developing work around improving access to screening for women with disabilities, and are training practice nurses to raise general awareness about the important of cervical screening during the forthcoming HPV vaccination programme.

Notification

Information on transport and logistical issues has been forwarded to practices. PCTs and cervical screening services are working with the Regional Project Group to agree options for the forthcoming implementation of two-week turnaround.

Letters sent by call/recall

Abnormal letters are now sent on Mondays by first class post, so that women will not receive results at the weekend, when support and information are not available.

Colposcopy DNA rates

It is apparent that women are tending to DNA on their follow-up visits. Comparative monitoring is discussed at all Pan-Birmingham meetings. Resources for a colposcopy pilot study have been offered to colposcopy units, and it is hoped this will take place during 2009. Problems with follow-

up are arising from staff retention issues at Birmingham Women's Hospital. Variations in rates across the City will be investigated. These issues will be addressed at future Pan-Birmingham meetings.

Collection and delivery

PCTs and cervical screening services are working with the Regional Project Group to agree options for the forthcoming implementation of two-week turnaround.

Notification of results

Improvements have been implemented.

Training

All PCTs now have databases and sample taker lists. We hope to standardise sample taking policies for all three PCTs in the near future.

Provider and Contractual Arrangements

The lead PCT responsible for the co-ordination of the Birmingham programme is Birmingham East and North PCT. Prof Tony Stewart, Consultant in Public Health at BEN PCT WAS assigned the screening co-ordinator role as part of his contribution to the Public Health Network in July 2008. Each Birmingham PCT now provides commissioning support to the programme.

The Birmingham PCTs have a Pan-Birmingham Cervical Screening Multi-disciplinary co-ordinating group. This group meets quarterly and is chaired by the Birmingham Screening Co-ordinator. It has a full range of representation from all the providers and has a remit to cover quality, commissioning, and co-ordination issues.

QA visits took place during November and December 2008; issues arising from these visits will be discussed in a future report.

The Birmingham Cervical Cancer Screening Programme comprises of a number of components across the Birmingham Health Economy, as shown in Table 1 below.

Table 1: Details of Provider Arrangements

Aspect of Programme	Provider	Accountability Arrangements
Call/recall	• Birmingham Primary Care Shared Services Agency (BPCSSA)	• Board of BEN PCT
Sample taking-GP & Birmingham PCTs	• General Practitioners and Practice Nurses	• General Practitioners through Clinical Governance Mechanisms within PCTs
Sample taking-Family Planning	• Family planning clinical staff	• HOB tPCT Clinical Quality Mechanisms
Cytology & Histology	• Birmingham Heartlands and Solihull NHS Trust (teaching) - incorporating Good Hope Hospital • Birmingham Women's Health Care NHS Trust, Sandwell& West Birmingham Hospital NHS Trust	• Trust Boards and Commissioning Agreements
Colposcopy	• Birmingham Heartlands and Solihull NHS Trust (Teaching) - incorporating Good Hope Hospital • Birmingham Women's Health Care NHS Trust, Sandwell & West Birmingham Hospital NHS Trust	• Trust Boards and Commissioning Agreements
The follow-up system and fail-safe follow-up	• Birmingham Shared Services Agency. All hospital trusts Cytology laboratories as above, General Practices and Family Planning Clinics.	• Board of BEN PCT/ BPCSSA • PCTs GPs and HOB tPCT for family planning • Hospital Trust Boards for relevant laboratory.

Contracting with the acute trusts is carried out on a lead commissioner basis whilst the Birmingham Primary Care Shared Services Agency (BPCSSA) provides services to the three Birmingham PCTs via a Service Level Agreement (SLA) through BEN PCT. These arrangements are likely to continue, though the existing SLA is currently being reviewed. Although no SLAs are currently in place between PCTs and the providers, these will be agreed and implemented in 2009.

Table 2: Details of Services and commissioners.

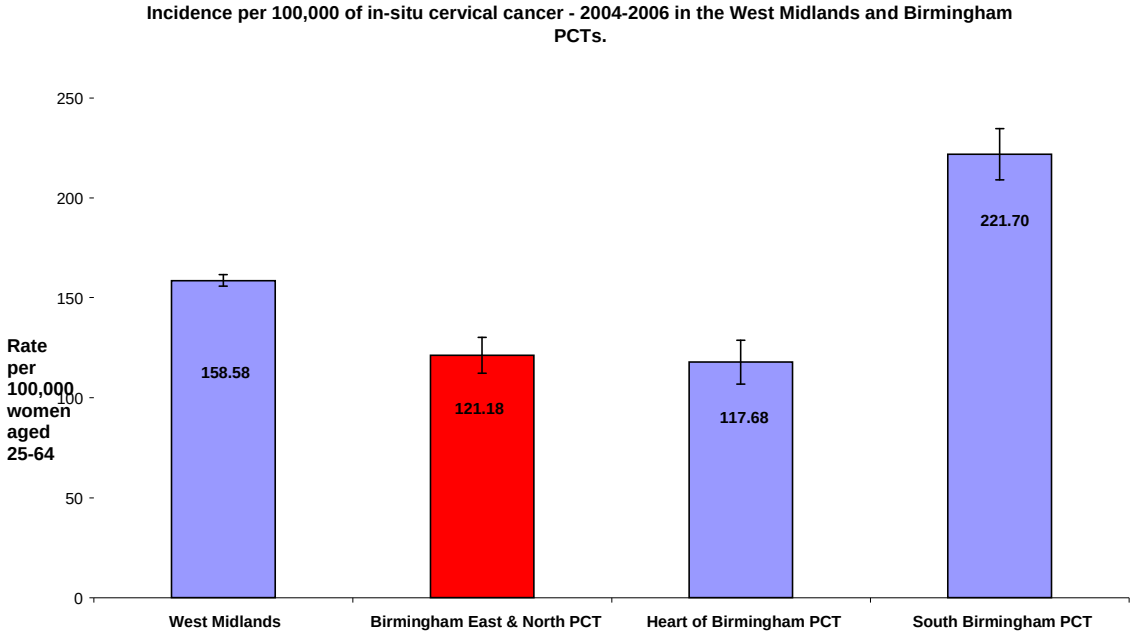
Service	Primary Care Trust	Lead Provider
Cytology & Histology, Colposcopy	Birmingham East & North PCT	Birmingham Heartlands and Solihull NHS Trust (Teaching) - Heartlands Hospital
Cytology & Histology	Heart of Birmingham Teaching PCT	Sandwell and West Birmingham Hospital NHS Trust
Cytology & Histology, Colposcopy	Birmingham East & North PCT	Birmingham Heartlands and Solihull NHS Trust (Teaching) - Good Hope Hospital
Cytology & Histology, Colposcopy	South Birmingham PCT	Birmingham Women's Health Care NHS Trust

Cervical Cancer Epidemiology

Incidence Data - In-Situ Cervical Cancer

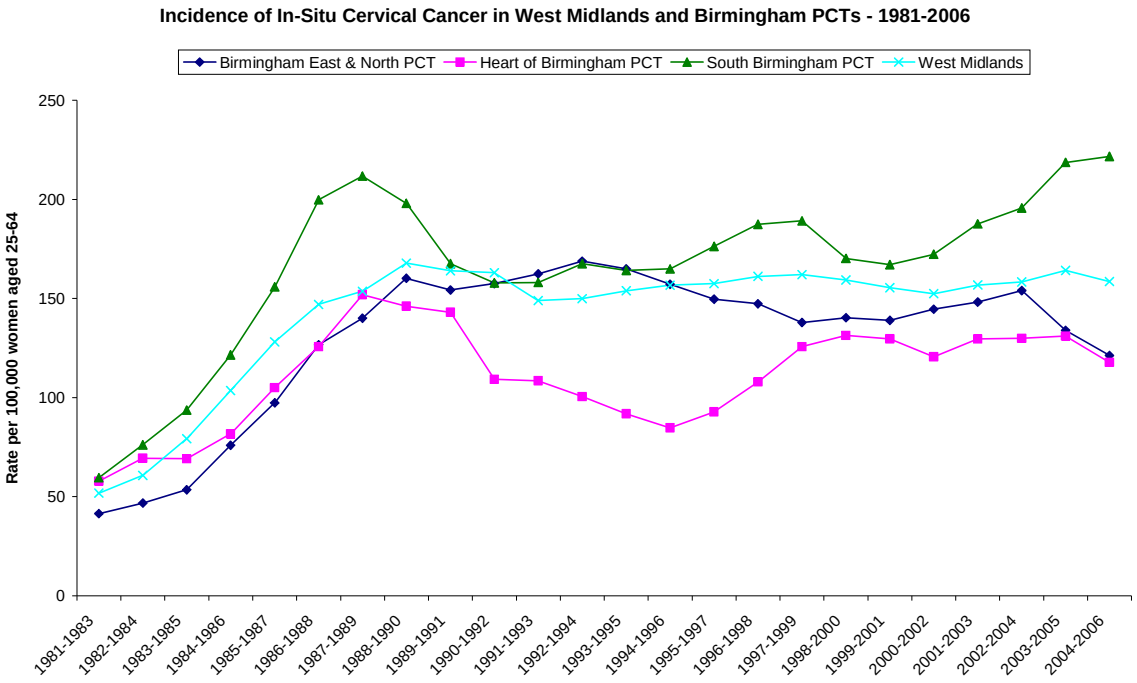
Short Term Trend: Geographically for in-situ cancer (Figure 1), SB PCT has the highest incidence rate, which is significantly higher than the other two PCTs and West Midlands at 221.70 per 100,000 (95% CI: 208.88-234.52). The West Midlands incidence rate is 158.58 per 100,000 (95% CI: 155.72-161.43) with HOB tPCT having the lowest incidence of in-situ cervical cancer, at 117.68 per 100,000 (95% CI: 106.66-128.69). Rates for BEN PCT and HOB tPCT are both significantly lower than SB PCT or the West Midlands. All figures are for women aged 25-64.

Figure 1: Incidence per 100,000 of In-Situ Cervical Cancer in the West Midlands and Birmingham PCTs over a period of three years 2004-2006



Long Term Trend: Figure 2 shows that since the 1980s, the incidence of in-situ cervical cancer in West Midlands area and Birmingham's PCTs increased virtually in parallel. The increase was as a result of the widespread introduction of cervical screening, and reflects more pre-cancer detection in the population. The levels stabilised following this increase with variation between populations. Rates for BEN PCT, South PCT and the West Midlands have declined since 2003.

Figure 2: Incidence of In-Situ Cervical Cancer in West Midlands and Birmingham PCTs 1981-

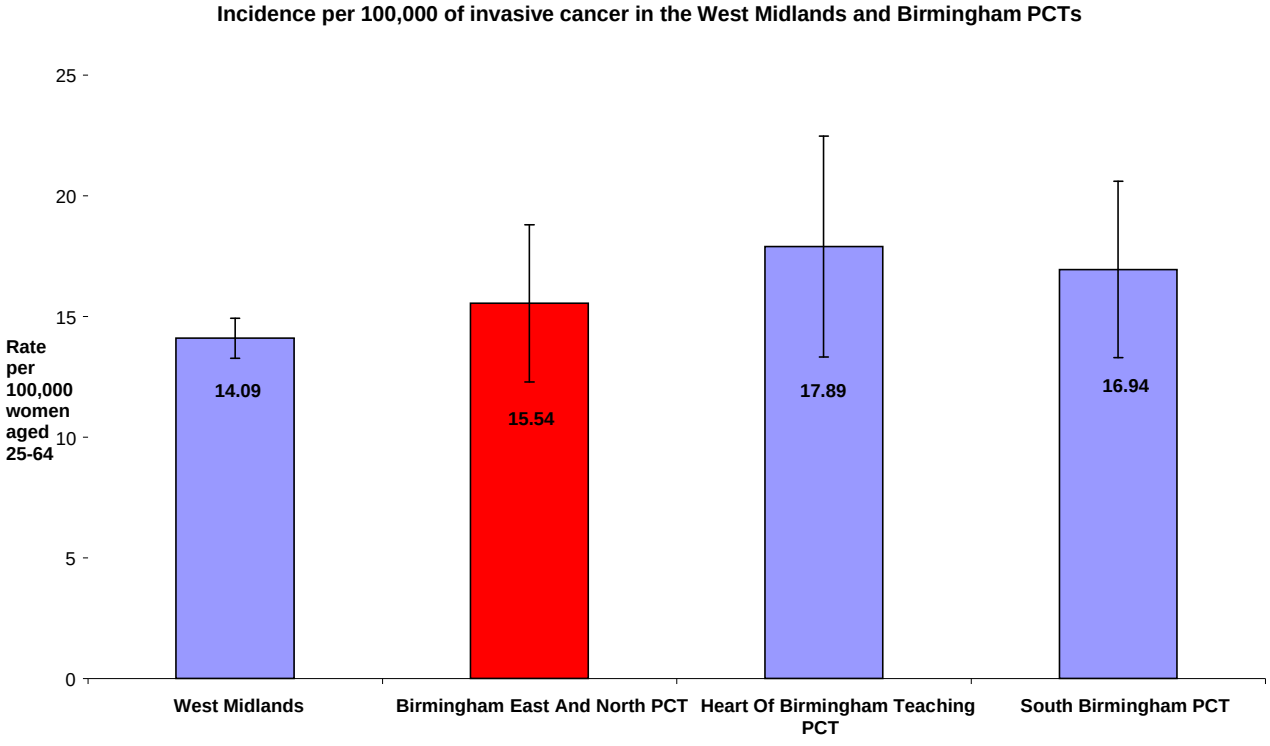


2006

Invasive Cervical Cancer

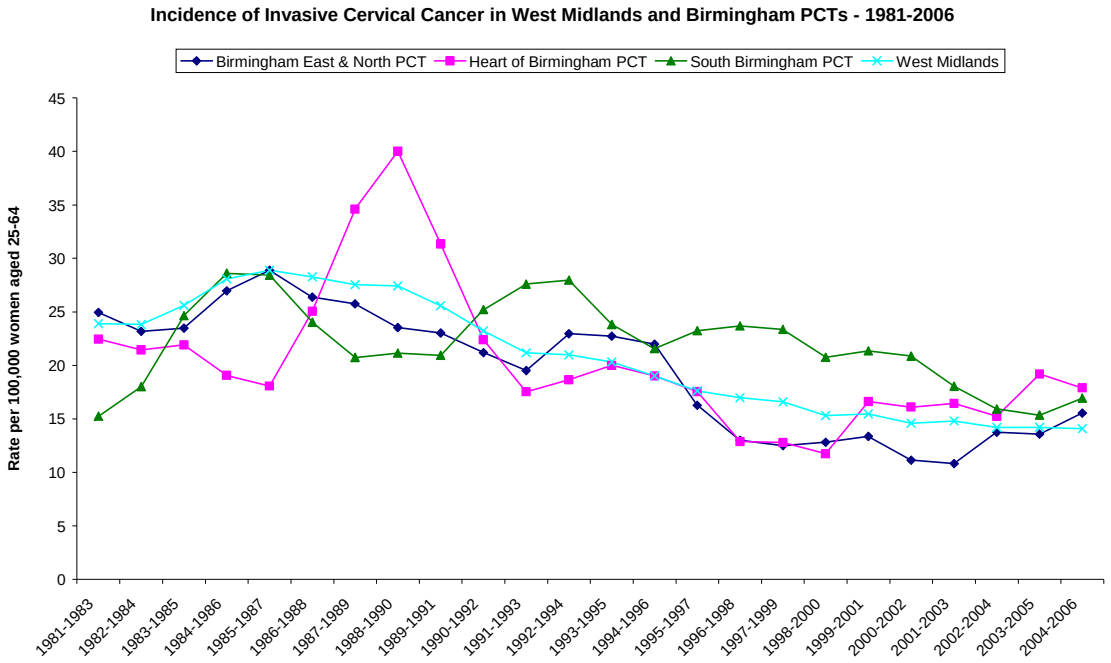
Short Term Trend: For invasive Cervical Cancer data (from West Midlands CIS – Figure 3) shows that for the years 2003-2005, HOB tPCT had the highest incidence of invasive cervical cancer at 17.89 per 100,000 (95%CI: 13.32-20.59), and BEN PCT had the lowest incidence at 15.54 per 100,000 (95% CI: 12.28-18.79) whilst the region of West Midlands had an incidence rate of 14.09 per 100,000 (95% CI: 13.26-14.92) for the same period. These differences were not significant, however.

Figure 3: Incidence per 100,000 of Invasive Cervical Cancer in the West Midlands and Birmingham PCTs over a period of three years 2003-2005



Long Term Trend: Figure 4 shows that the incidence of invasive cervical cancer dropped substantially in the West Midlands and all Birmingham PCTs over last two decades, with the exception of SB PCT. For example, in West Midlands the incidence rate decreased from 23.89 per 100,000 in 1981-1983 to 14.09 per 100,000 in 2004-6. Over the period, the incidence in BEN PCT fell from 24.95 to 15.54, though an increase is seen from 2002 to the present. Incidence in SB PCT increased slightly from 15.23 to 16.94 per 100,000.

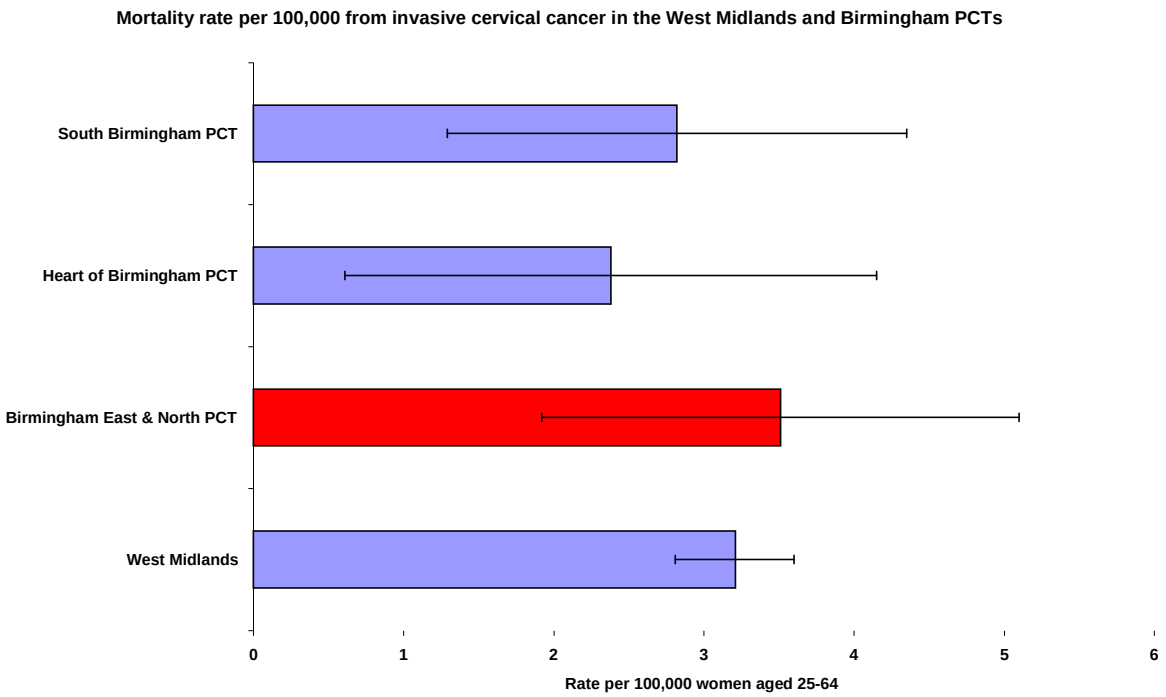
Figure 4: Incidence per 100,000 of Invasive Cervical Cancer in the West Midlands and Birmingham PCTs - 1981 to 2006



Mortality Data

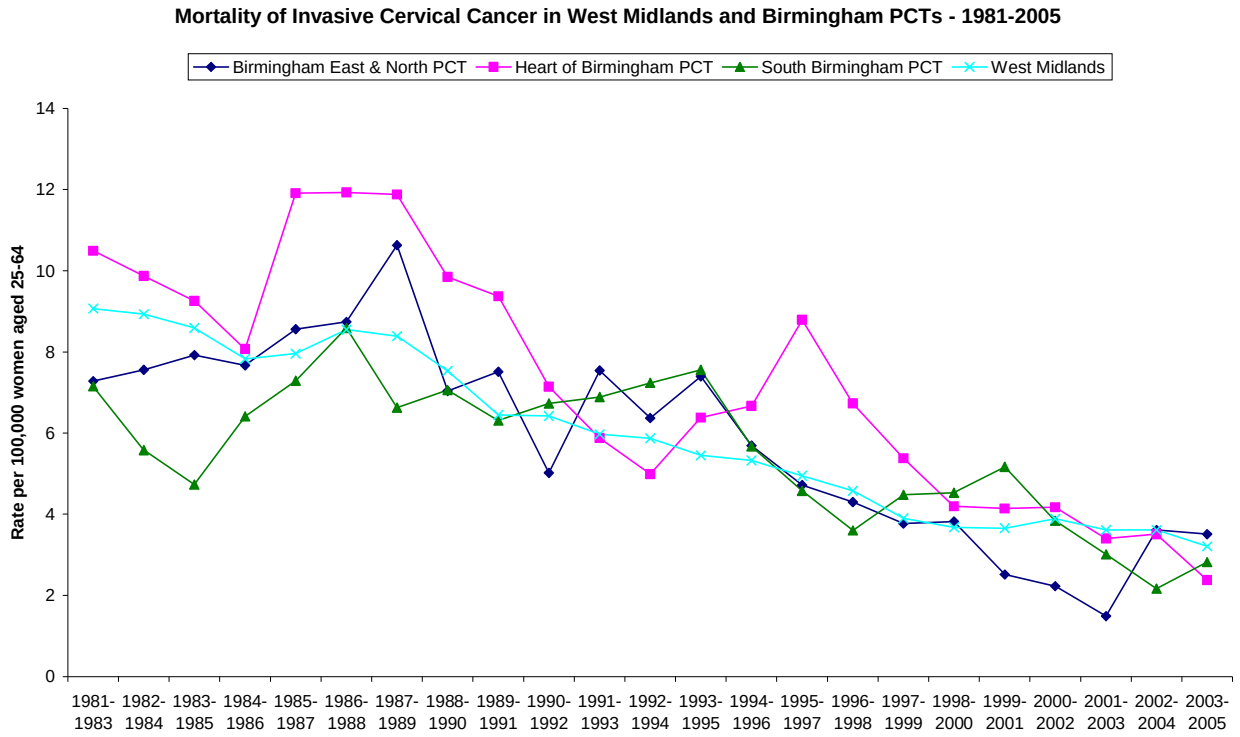
Short Term Trend: Between 2004–2006, the Mortality rate was the highest in BEN PCT at 3.51 per 100,000 (95% CI: 21.92-5.1). In contrast, HOB tPCT had the lowest mortality rate at 2.38 per 100,000 (95% CI: 0.61-4.15) and lower than the region of West Midlands at 3.21 per 100,000 (95% CI: 2.82-3.61) but none of the differences were significant.

Figure 5: Mortality rate per 100,000 from Invasive Cervical Cancer in the West Midlands and four PCTs over a period of three years (2004-2006).



Long Term Trend: The mortality rate of invasive cervical cancer in West Midlands region including the three Birmingham PCTs has dropped significantly over a period of 25 years (1981-2005) - from 9.07 per 100,000 (95% CI: 8.37-9.76) in 1981-1983 to 3.21 per 100,000 (95% CI: 2.82-3.61) for 2003-2005 (Figure 6). In BEN PCT, mortality fell from 7.28 to 3.51 per 100,000, though rates have increased since 2001-3.

Figure 6: Mortality rate per 100,000 from Invasive Cervical Cancer in the West Midlands and Birmingham PCTs for 1981-2005).



Performance against national standards

a. General demographics

Table 3 shows the numbers of eligible women and numbers screened, by age group and PCT. In all, a total of 260,120 women were eligible for screening in Birmingham, and 198,085 screens were carried out. BEN PCT had the largest eligible population, and HOB tPCT the smallest.

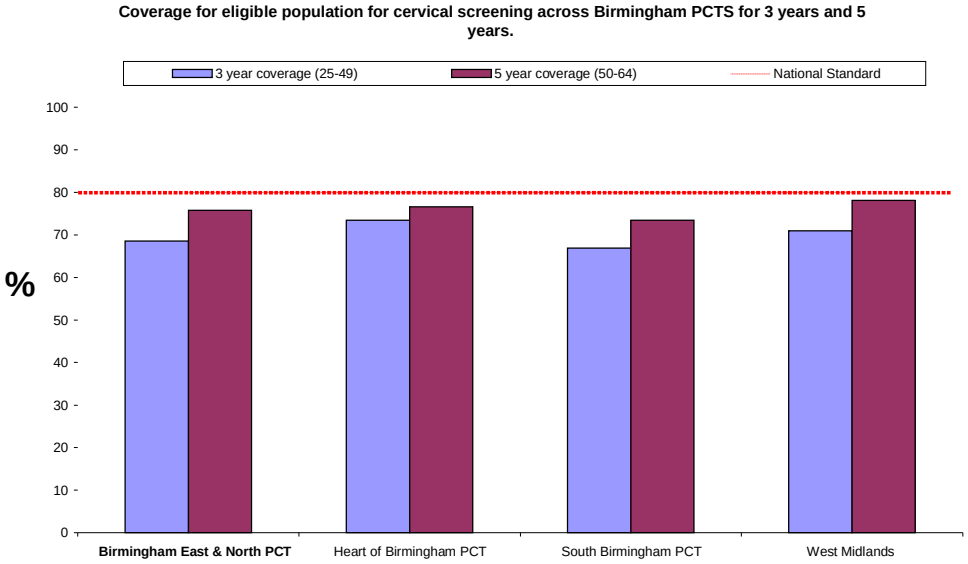
Table 3. Numbers of eligible and screened women, by age group and PCT, as at March 2008

	Age 25-64 5 year coverage			Age 25-49 3 year coverage			Age 50-64 5 year coverage		
	Eligible	*Screened*	*%*	*Eligible*	*Screened*	*%*	*Eligible*	*Screened*	*%*
BEN PCT	101,668	77,573	*76.3*	27,780	19,029	*68.5*	73,888	56,007	*75.8*
HOB tPCT	66,607	52,087	*78.2*	13,847	10,164	*73.4*	52,760	40,414	*76.6*
SB PCT	91,845	68,425	*74.5*	24,417	16,335	*66.9*	67,428	49,492	*73.4*
All	260,120	198,085	*76.2*	66,044	45,528	*68.9*	194,076	145,913	*75.2*

Coverage

The national target for cervical screening is 80%, however cervical screening coverage in the West Midlands has been falling, particularly in the past five years with the regional average now at 78.7% - a further decrease from 79.3% last year.

Figure 7. Coverage for eligible population for cervical screening across Birmingham for 3 years and five years.



The national issue of a pronounced decrease in screening of young women (aged 25 – 39 years) is still applicable to Birmingham. All PCTs in the region fell below 80% 3 year coverage of the 25-29 age group.

Figure 8: Coverage of eligible population, 3 and 5 year coverage, by age group – HOB PCT

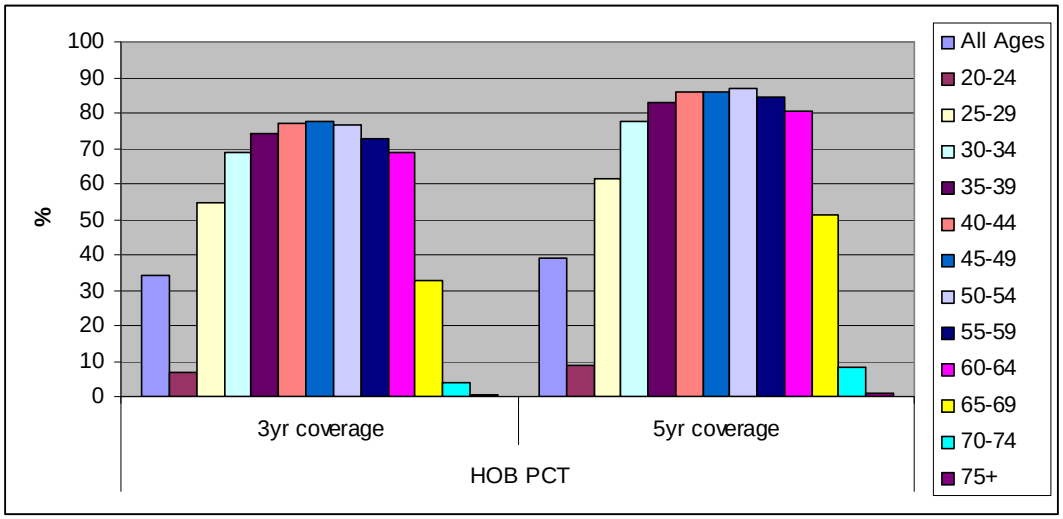


Figure 9: Coverage of eligible population, 3 and 5 year coverage, by age group – SB PCT

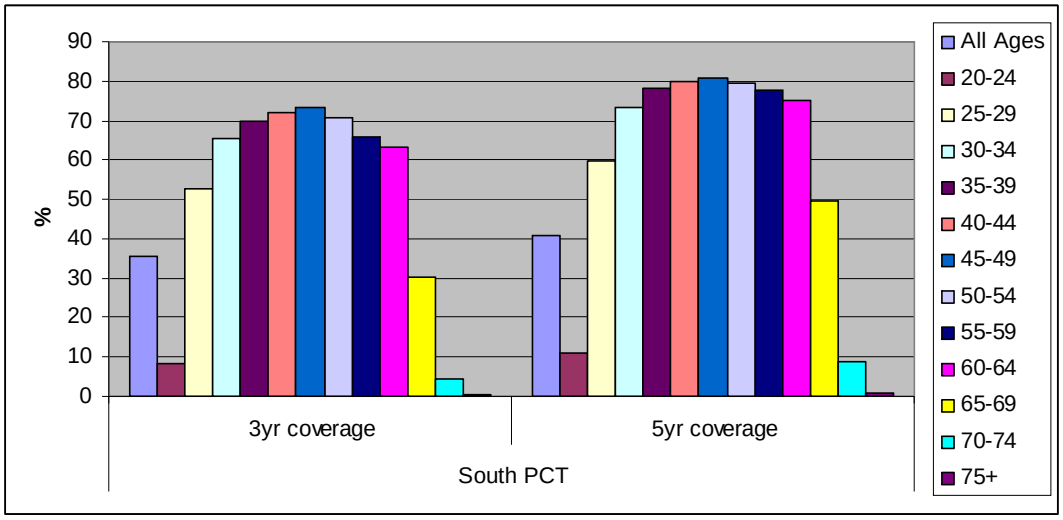
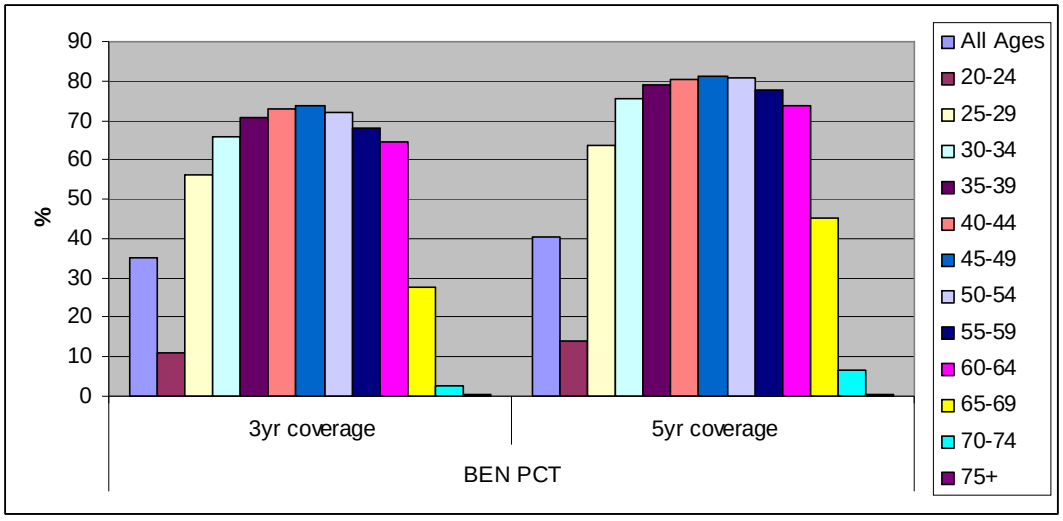


Figure 10: Coverage of eligible population, 3 and 5 year coverage, by age group – BEN PCT



Patterns of coverage by age group in BEN PCT were similar to other Birmingham PCTs. In order for the programme to remain effective, 80% coverage needs to be achieved. There continue to be significant differences between age groups, with a marked decrease in the percentage of women aged 25 to 34 who are attend for screening. Coverage is generally highest in the 45-49 age group.

Laboratory and colposcopy data

Table 4 shows that for all hospitals, the 100% four-week standard for processing was not met (although Birmingham Women's Hospital was 99.9%). PPVs were variable, and Good Hope's PPV rate was above the national standard. Table 5 shows that inadequate, borderline/mild and moderate/severe rates were within standard. All referrals were within the 8 week standard, as shown in Table 6. City Hospital's rate decreased from 99.8 in 2006-7.

Table 4. Laboratory Processing Time and Positive Predictive Value

Laboratory	Screening Programme Samples	Laboratory Processing times (within 4 weeks)	Positive Predictive Value (PPV) *
Heartlands	24,317	99%	79.0
Birmingham Women's	22,564	99.9%	73.6
City Hospital	12,898	91%	82.8
Good Hope	16,271	99.7%	92.3

** Standard in 2007-8: 70.7% - 88.9%*

Table 5. Inadequate rates & classification of adequate rates

Laboratory	Inadequate rate as % of all samples	Borderline / Mild rate as % of adequate samples	Moderate / severe rate as a % of adequate samples
Heartlands	0.9	5.7	1.0
Birmingham Women's	2.1	5.7	1.3
City Hospital	3.8	7.1	1.0
Good Hope	1.7	6.6	0.7

Table 6. Colposcopy waiting time to first appointment

Hospital	*All referral types* < 8 weeks % *(standard 90%)*	High Grade < 4 weeks % *(standard 90%)*
Heartlands	99.8	98.9
Birmingham Women's	96.3	95.7
City Hospital	93.2	90.7
Good Hope	100	99.1

Table 7 shows that the percentage of patients who did not attend their first appointment ranged from 11.6% at the Women's Hospital to 26.6% at Good Hope Hospital. This has generally increased for new appointments, and is a cause of great concern. The standard is <15% for both new and follow-up appointments.

Table 7. Colposcopy – Did Not Attend (DNA) rates for new and follow-up appointments

Hospital	New % Did Not Attend	Follow-up % Did Not Attend
Good Hope	17.0%	26.6 %
Heartlands	19.4%	25.6%
Birmingham Women's	11.6%	21.9%
City Hospital	17.1%	13.6%

Table 8 shows that the outcome for procedure at first attendance varies markedly. This is demonstrated by the proportion of patients who received 'No treatment' at first attendance. This ranged from 40% for Good Hope to 69.2% at City Hospital.

Table 8. Procedure at first attendance

Laboratory (All referrals)	No Treatment %	Biopsy %	Excision %	Ablation, no biopsy %	Ablation & Biopsy %
Heartlands	46.1	41.0	11.2	0.2	1.4
Birmingham Women's	63.5	25.7	8.3	0	0.7
City Hospital	69.2	16.0	14.3	0.4	0
Good Hope Hospital	40.0	47.7	10.2	0	1.3

The standard for biopsy results waiting time is 90% within four weeks and 100% within 8 weeks. Table 9 shows that only Good Hope Hospital completely met this standard.

Table 9. Waiting time for biopsy results

Hospital	<4 Weeks % (Standard 90%)	<8 Weeks % (Standard 100%)	8-12 weeks %	>12 weeks %
Birmingham Heartlands	52.6	98.8	1.2	0
Birmingham Women's	53	88.1	4.5	7.4
City Hospital	66.7	100	0	0
Good Hope Hospital	97.8	100	0	0

Adverse Incidents

No adverse incidents were recorded

6. Winter Warmth

Fuel poverty is an important public health issue in the UK, especially in the very old. The UK has one of the highest numbers of excess winter deaths in Europe, 40,000 deaths in the winter months. Living in cold homes increases the likelihood of ill health, including hypertension, heart disease, stroke, influenza and asthma. Current high energy prices are further exacerbating the issue with estimates that for every 1% increase in energy prices 40,000 people go into fuel poverty. In the UK, around 3.5 million households are in fuel poverty (spending more than 10 per cent of income to meet fuel costs). It is estimated that 22,500 homes in BEN PCT experience fuel poverty. Both the private and social housing sectors suffer from similar rates of fuel poverty, with the lone elderly at highest risk. There are a number of government health policies designed to address fuel poverty, including UK Fuel Poverty Strategy and Fuel Poverty in England: the government's plan for action.

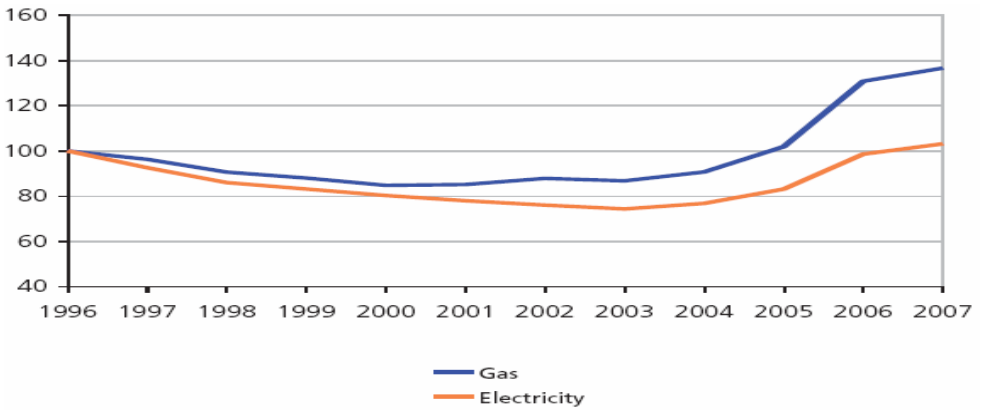
2. Health Economics for Birmingham East & North PCT

There is little published evidence on the costs of fuel poverty to the NHS although it can be assumed that a reduction in the number of cold, damp homes would have a direct effect on NHS resources (DEFRA, 2004). Estimates of the costs to the NHS at 1994 prices are around £600 million (Press, 2002).

Fuel Prices

The current escalation of gas and electricity bills will result in more households experiencing fuel poverty. Energy prices rose in early 2008 by an average of around 15% for gas and 13% for electricity. Subsequently, they rose again during the summer of 2008, by an average of around 30% for gas and 14% for electricity.

Figure 1 – Retail Prices Index: Real gas and electricity price index, 1996=100



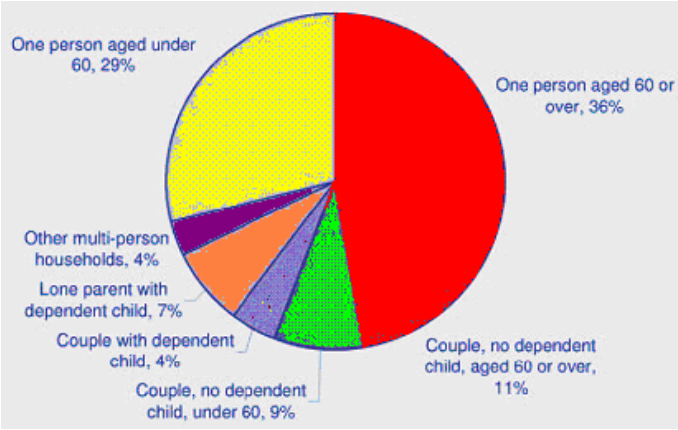
The estimated number of households in fuel poverty in the UK rose between 2005 and 2006 by 1 million, to stand at 3.5 million (around 14% of all households). Projecting these figures to BEN PCT households (160,139), it is estimated that around 22,500 households were in fuel poverty in 2006 compared to 18,000 in 2005.

The method of payment affects prices: direct debit is usually the cheapest and pre-payment meters the most expensive. 14% of electricity consumers (3.6 million) and 10.4% of gas consumers (2.2 million) use prepayment. The numbers installed have increased substantially over the past decade – including a 150% increase in gas prepayment. Prepayment is used by 21% of gas consumers and 23% electricity consumers with an annual income less than £10,000. Meters are more likely to be used by poor elderly, lone parents, those in receipt of welfare benefits, with no bank account or payment difficulties.

Household composition

The English House Condition Survey shows that 85% of fuel poor households are single or couple only households (Figure 2) - 50% are 60 yrs plus. Vulnerable groups are particularly at risk as they tend to spend longer periods at home.

Figure 2 – Breakdown by household composition (2004, England)



Source: English Household Conditions Survey – April 2006

Non decent housing is that which is unfit to live in, and is more expensive to heat. In England, 14.2% of households are in this category and percentage is higher for some groups (Table 2) .

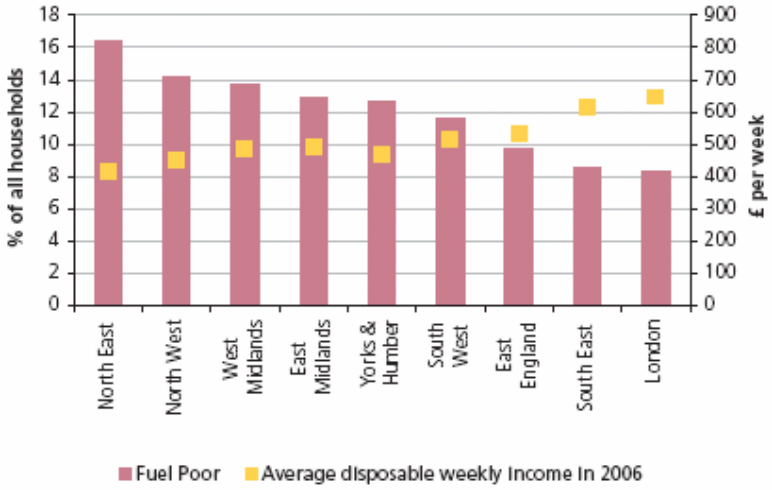
Table 2 – Percentage of the population living in non-decent housing, England 1996

Population Group	Percentage of households in the group living in non-decent housing
Pakistani & Bangladeshi	35%
Black	23%
Young (aged 16-24)	29%
Unemployed	25%
Elderly (75+)	20%
Lone Parents	18%

Income

When annual income is below £10,000 the household will face fuel poverty regardless of other determinants. Around 50,000 (31%) households in BEN PCT have an income below £15,000. The West Midlands ranks third against other regions (Chart1). It shows a negative correlation between income and fuel poverty.

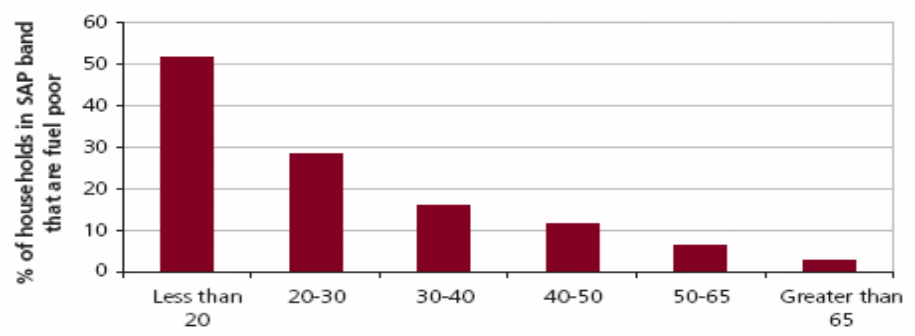
Chart 1 – Fuel poverty as a % of all households; average weekly disposable income[i], 2006



Energy efficiency

Standard Assessment Procedure Ratings (SAP Ratings) is an index of the annual cost of heating. It ranges from 1 (highly inefficient) - 120 (highly efficient). 60 plus is considered efficient. 80,000 households in BEN PCT have a rating of less than 20.

Chart 2 - Percentage of households that are fuel poor by SAP bands, 2006

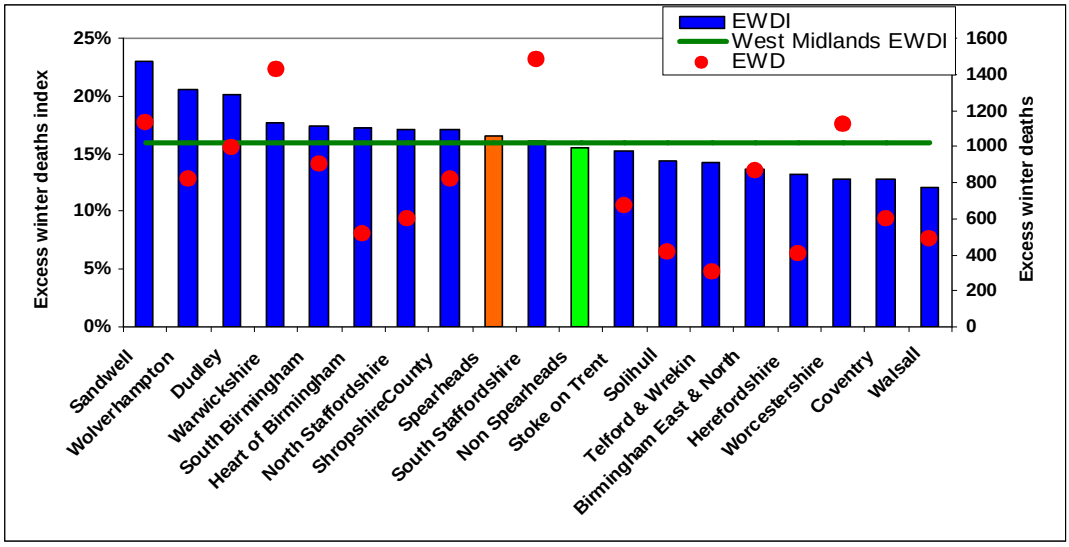


3. Excess winter deaths in Birmingham East & North PCT

Excess Winter Deaths (EWD): the difference between winter (Dec – Mar) deaths and summer deaths. There are over 60,000 cold related deaths throughout the year in the UK. Around 40,000 of these occur during the winter. Over half the excess winter deaths are from cardiovascular disease and a third are from respiratory disease. Analysis of Secondary Outcomes Service (SUS) data – hospital admissions, shows that comparing the top five admission primary diagnoses for 07/08 in the winter months and the rest of the whole year, there is little difference between the two time periods.

Every degree C below the winter average there are 8,000 extra deaths (UK). Excess deaths after a cold day can be predicted: heart attacks - 2 days, strokes - 5 days, and respiratory disease - 2 days. As a PCT excess winter deaths in BEN PCT are towards the lower end of the scale in comparison to other PCTs, in the West Midlands (Chart 3), although the relative affluence of Sutton Coldfield might be responsible for BEN PCT's lower position.

Chart 3 - Excess Winter Deaths Index (EWDI)by PCT, West Midlands



Source: ONS PHO deaths extract, analysis WMPHO

Using data from the ONS annual death files, analysis of EWD and EWDI was conducted at a ward level (Charts 4 / 5). Shard End ward appears to have the highest numbers whereas Sutton New Hall has the lowest. Shard End ward EWD/EWDI have been decreasing for three winters, whilst they have increased in Oscott, Sutton Vesey and Sheldon. BEN PCT as a whole saw a decrease in EWD in 05/06 compared to 04/05.

Chart 4 – EWD by wards in BEN 2003 – 2006

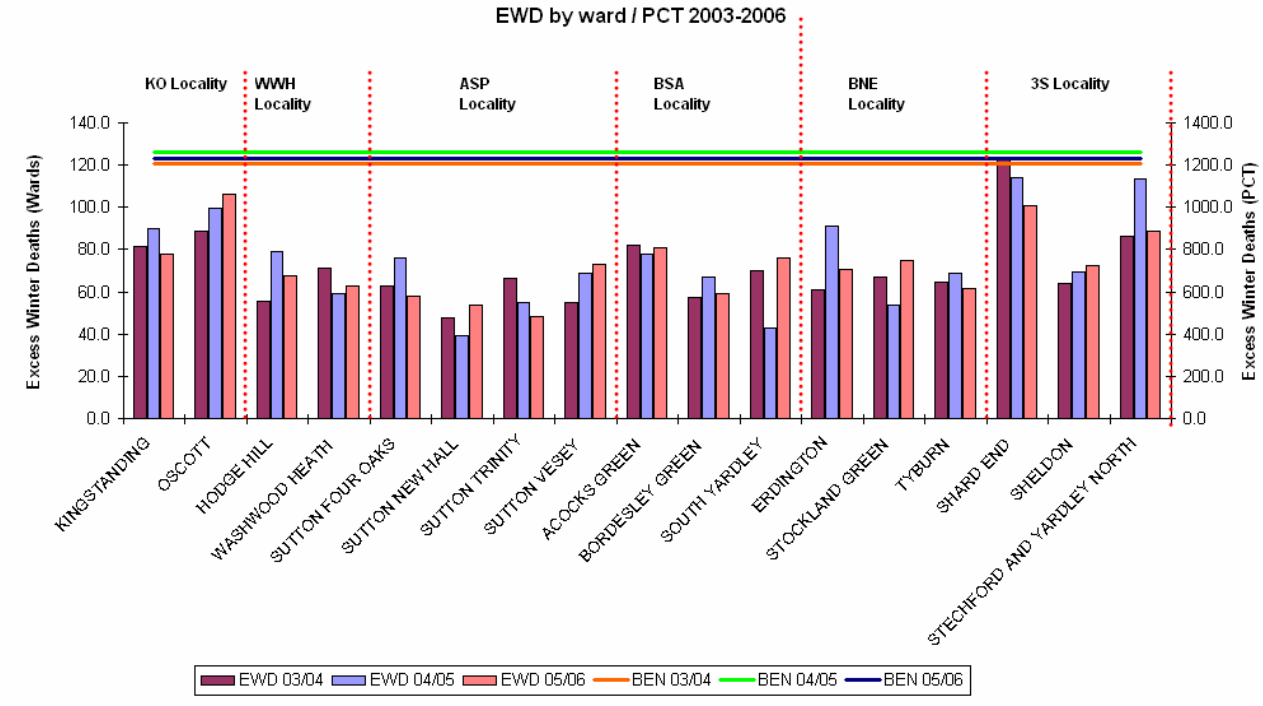
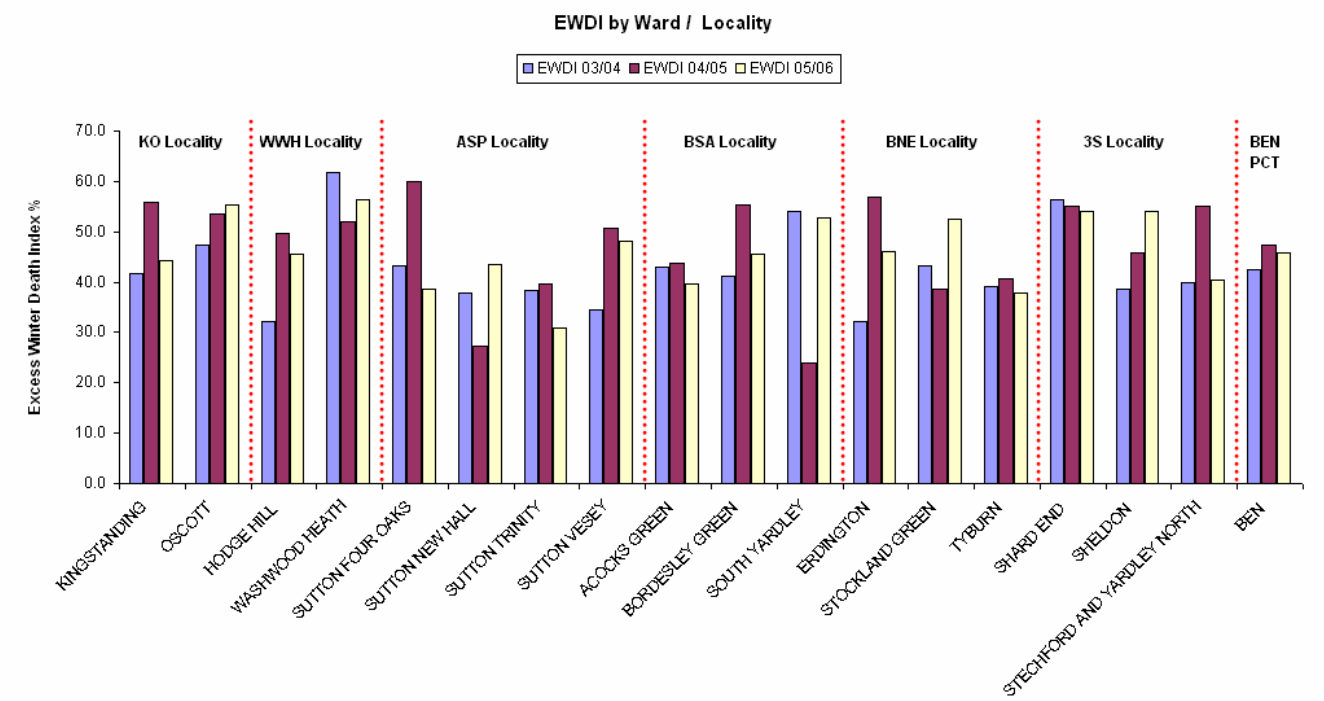


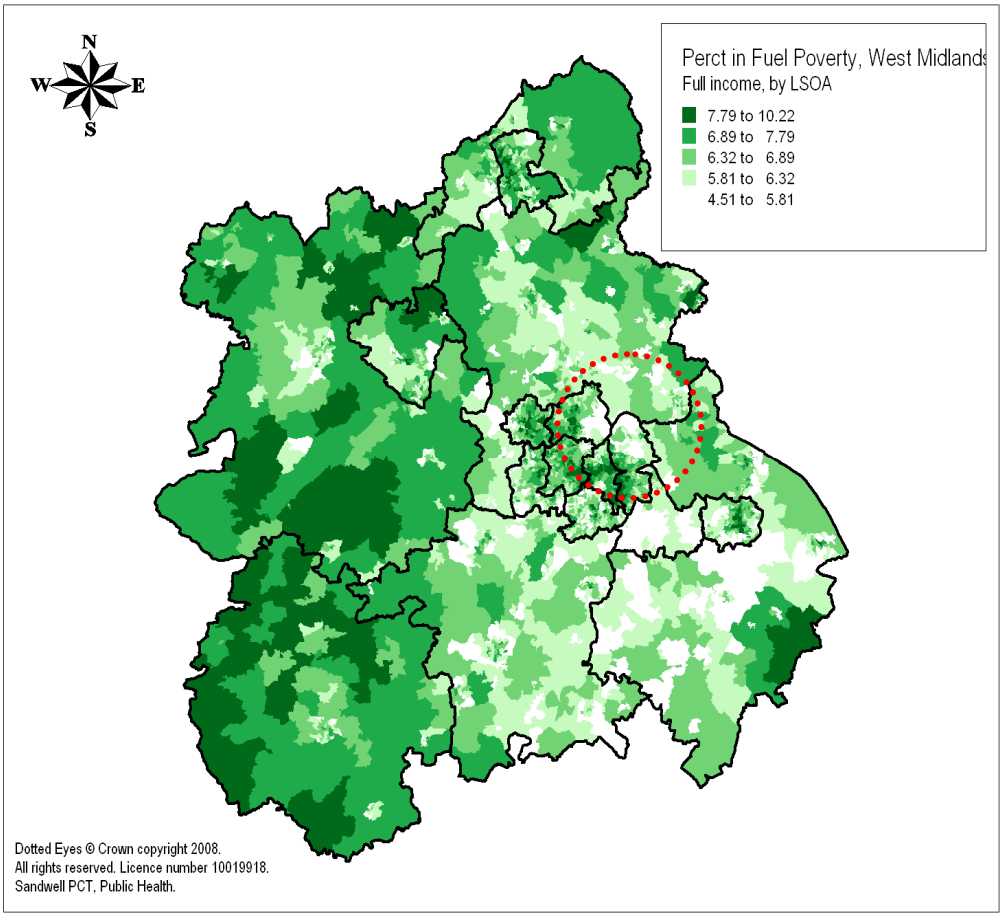
Chart 5 – EWDI by wards in BEN 2003 – 2006



4. Fuel Poverty in Birmingham East & North PCT

Figure 3 shows percentage fuel poverty across the West Midlands by PCT. BEN PCT seems to have an East / West split with the East suffering higher fuel poverty than the West. The north portion of the PCT seems to be suffering from lower fuel poverty. This area has a greater older population and some of the most affluent areas in the country, although it must not be assumed that the appearance of affluence negates the possibility of fuel poverty.

Figure 3 – Percentage in Fuel Poverty – West Midlands



Mosaic Lifestyle Categories – from Doctor Foster Intelligence

In order to identify the type of people who are encountering fuel poverty / winter warmth issues and where our interventions should be targeted, we can use the map - see below to target interventions at the type of individuals in the various areas. This map correlates very well with the epidemiological information presented earlier and shows that Lifestyle Group F and I are at highest risk.

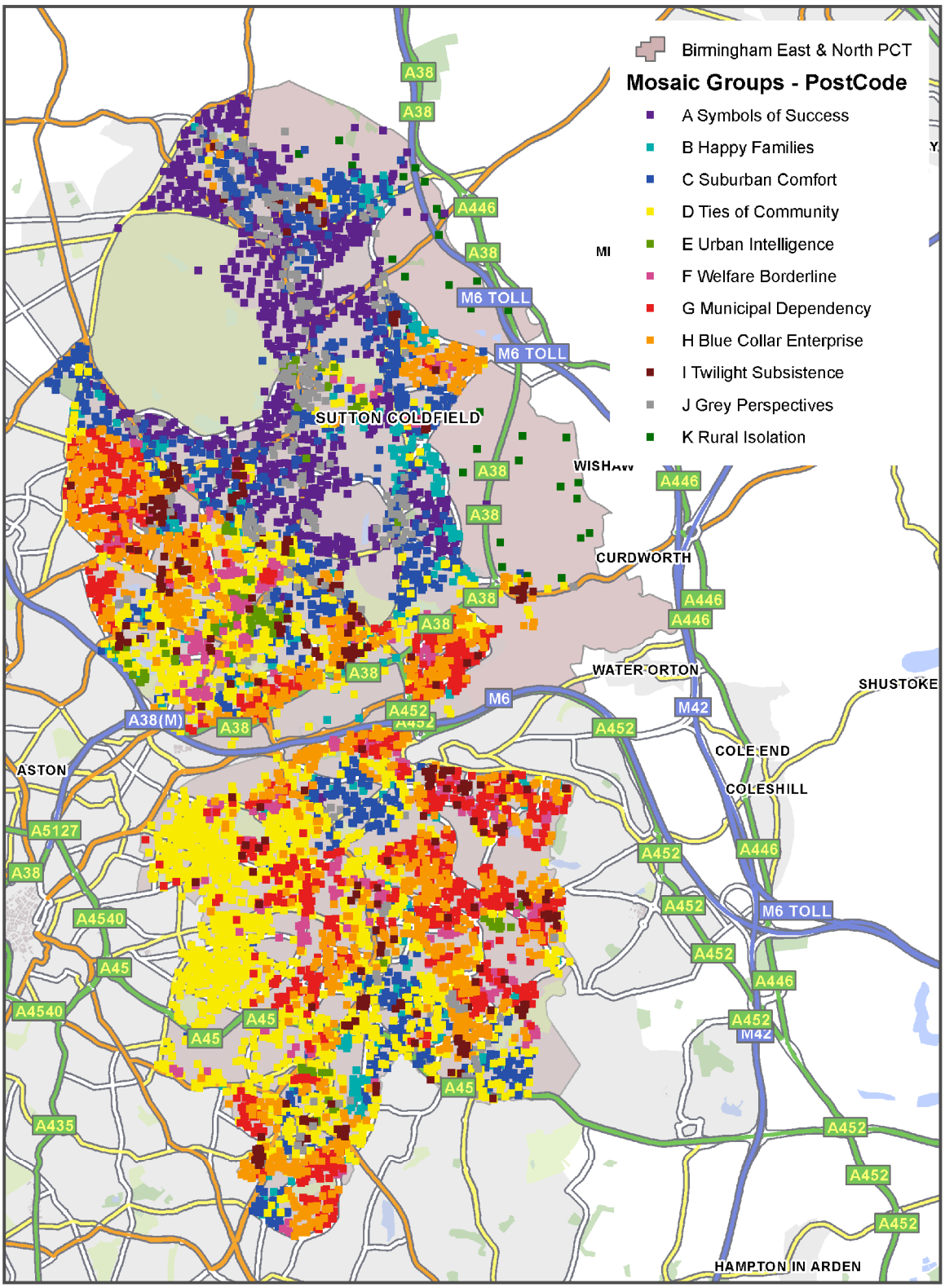
Mosaic Lifestyle groups

A Career professionals living in sought after locations	G Low income families living in estate based social housing
B Younger families living in newer homes	H Upwardly mobile families living in homes bought from social landlords
C Older families living in suburbia	I Older people living in social housing with high care needs
D Close-knit, inner city and manufacturing town communities	J Independent older people with relatively active lifestyles
E Educated, young, single people living in areas of transient populations	K People living in rural areas far from urbanisation
F People living in social housing with uncertain employment in deprived areas	

Mosaic groups by postcode for BEN PCT (overleaf)

Birmingham East & North PCT

Mosaic Public Sector - Groups Postcode Level



5. Birmingham East and North PCT Initiatives

Activity in BEN PCT

Anecdotal accounts exist of frontline staff helping patients, their families and carers but the levels of intervention and their quality are unknown.

There are two Handyperson schemes. Oscott has access to both whilst the rest of the wards only have access to one, and Shard End does not have access to any.

Articles about staying warm appear in *Health News*.

In order to identify the type of people to target who are experiencing fuel poverty Mosaic Lifestyle Categories maps – from DFI, can be used

The LAA has modest targets for reductions in low energy efficiency homes and increases in high energy efficiency homes

6. Recommendations

Strategically – the PCT to establish a local fuel poverty action team (including partner agencies); local fuel poverty strategy, local fuel poverty champion, and develop referral networks and pathways.

PCT staff have a role in tackling fuel poverty as many frontline staff are ideally placed to identify, advise and refer those at risk. This has training and workload implications. Focus should be at the most at risk, i.e. the lone elderly.

Identify partner agency with expertise in promoting winter warmth and reducing heating bills, e.g. Home Heat.

Whilst in its infancy, the PCT's Health Trainer service is well placed to advise and sign-post those at risk

The PCT commissions more Handyperson schemes, ensuring targets are set around keeping people warm. It should also include a review of the SLA to assess whether the targets are appropriate and that the interventions are linked to evidence.

7. Summary

This report is a brief summary of three of the key activities currently taking place in BEN PCT. The Health Improvement Directorate continues to work towards improving the health of the population by reducing health inequalities through its services. It is anticipated that the health of the population will continue to improve through services that are designed to involve local people at ground level. BEN PCT is a diverse population and all health improvement indicators are addressed with this in mind. The SHA monitoring report shows that in some areas the directorate is underachieved, however all possible measures are currently being put in place to improve performance in all areas.