

QUARTERLY REPORT **HEALTH IMPROVEMENT DIRECTORATE** **JULY 2009**

Introduction

NHS Birmingham East and North (BEN) has the responsibility to lead the commissioning of services that provide appropriate health care that will meet health and well being needs of a population of 440,000 people. This is not an easy task. The population of BEN is an eclectic mix of race and culture. For this reason, the Health Improvement Directorate is particularly challenged to ensure that all health care services are delivered fairly and appropriately to the people who need them most. With this in mind, the Health Improvement Directorate has designed every service we offer to match this challenge. Every individual will have the opportunity to access the support that will help them address their own personal behaviour and lifestyle so that people can gain control of their own health and therefore reduce the burden on the NHS and ultimately improve the health, economic and cultural conditions that impact on the health of the population of Birmingham.

This paper will give an example of some of the services that are being provided by NHS BEN in relation to the health and well-being of its population. The report is based on the data that has been available up to the end of the 2nd quarter for the year 2008/2009.

Directorate Summary

Overall this paper will provide a summary of the progress made by the Health Improvement Directorate during the last quarter. It provides an opportunity to demonstrate the crucial developments made by the Directorate in their endeavour to improve the health of the population and to achieve national and local targets. It outlines the most recent achievements and developments within the following functions,

- Expert Patient Programme
- Health Trainers Programme
- Cancer
- Smoking
- Teenage Pregnancy
- NHS Health Checks

Expert Patient Programme

Introduction

An estimated 15.4 million people in England, almost one in three of the population, suffer from a long-term condition (LTC), for example, diabetes, asthma and heart disease. Patients with long-term conditions are very intensive users of health care services.

Patients with long term conditions usually live with them for many years and often want to understand what they can do to manage the disease themselves. This can be achieved by ensuring that the knowledge of their condition is developed to a point where they are empowered to take some responsibility for its management. The Expert Patients Programme (EPP) is a lay-led self management programme specifically designed to reduce the severity of symptoms and improve resourcefulness and self-efficacy for participants.

NHS Birmingham East and North have been delivering an Expert Patients Programme since 2004. This report will give an update on the policy background, the contribution of the programme to key Trust priorities and the latest evidence to support the continuing benefits of the service. Some details will be given of the service model and the performance of the service in the last year and possible developments to enhance the programme as part of the wider self-care agenda.

Policy Context and Contributions to Key Policy Outcomes

The Expert Patients Programme should be considered in the context of changes in the whole approach to the management of long-term conditions and the political context of a patient-led NHS. The Expert Patients Programme is one component in the Government's wider strategy to improve the care offered to people with long-term conditions.

The NHS Improvement Plan (2004) set out the priorities for the NHS until 2008. The plan clearly identified increased support for people living with long-term conditions as a major priority. As part of this commitment, the Government announced that the EPP would be rolled out nationally. Development of the Expert Patients Programme also links into the National Service Framework (NSF) for Long-Term Conditions published in March 2005.

In the White Paper 'Our Care, Our Health, Our Say' (January 2006), the Government recognises the role that the Expert Patients Programme plays in empowering people with long-term conditions to take effective control of their lives.

The General Medical Services (GMS) contract from GPs provides financial incentives to improve the quality of care for some people with long-term conditions. The Quality and Outcomes Framework (QOF) in the GMS contract sets out clinical standards for ten different areas of health, including heart disease, hypertension, asthma and mental health. In addition, the National Institute for Health and Clinical Excellence (NICE) continues to produce guidelines on the clinical treatment of long-term conditions including heart failure, chronic obstructive pulmonary disease and depression. All of these initiatives are intended to improve the clinical care given to people with chronic conditions. A summary of current policy drivers is shown in Figure 1.

Figure 1: Summary of Current Policy Overview

Key Policy	Target	EPP Contribution
Vital Signs National Priority Vital Signs Local Deliverable	Improve Public Engagement Proportion of people with long-term conditions supported to be independent and in control of their condition	EPP volunteer tutors recruited from local community and Third Sector organisations EPP courses marketed directly to patients with long term conditions via GP patient lists
World Class Commissioning	Health Inequalities Life Expectancy	Promotion of EEP in deprived wards to target and increase uptake by those who traditionally do not access services Promote self-care and signpost 'at risk' individuals to other lifestyle risk services e.g. stop smoking and health trainers

The Department of Health has used a pyramid (Diagram 1) to show the different levels of care for patients with long-term conditions. It shows that 70-80 per cent of people with long-term conditions are considered to be the self-care population who would benefit from initiatives such as the Expert Patients Programme.

Diagram 1: Levels of Care for Patients with Long Term Conditions



Source: Department of Health (2004) Improving chronic disease management

The Evidence for Expert Patients Programme

The Expert Patients Programme has the potential to meet three elements of good chronic disease management at Level 1, in particular:

- the involvement of patients in their own care
- minimizing unnecessary visits and admissions to health care providers/facilities
- providing care in the least intensive care setting

Cost Effectiveness of the Expert Patients Programme

A National Evaluation of the Expert Patients Programme was published by the Centre for Health Economics, University of York and the National Primary Care Research and Development Centre, University of Manchester in the Journal of Epidemiological Health in 2007. A randomised control trial involving 629 participants with long term conditions was undertaken. It was found that the Expert Patients Programme increased patients' self-efficacy by a moderate amount and overnight hospital stays and use of day case facilities were reduced.

There were also small gains in secondary outcomes including psychological wellbeing and partnerships with doctors. There was high satisfaction with the course and particularly being part of a group. Additional benefits may include reduction in social isolation.

The Expert Patients Programme intervention evaluated in this trial is very likely to provide a cost effective to usual care in people with long term conditions. A further analysis looked at the change in QALYs (Quality-Adjusted Life-Years) and cost-effectiveness. The results found there was one extra week of 'perfect' health per year for individuals on the Expert Patients Programme course.

The Service Model

People with conditions such as arthritis, heart disease, MS, ME and Parkinson's for example, tend to experience similar symptoms such as depression, a lack of self-esteem, and difficulties in managing pain. The Expert Patients Programme is a 'generic' course that is open to anyone with a self-defined long term condition. Participants are taught by a pair of tutors, either from NHS Birmingham East and North Expert Patient Programme or volunteer tutors who have to be trained and are subject to quality assurance.

The Expert Patients Programme is a specific 6-week programme which is licensed and therefore has to be run exactly as stated; it is not possible to miss sections out of the programme or add new ones. Every course is run exactly the same with the same subject matter covered; all tutors work from a scripted manual that must be followed exactly as stated. The 6-week programme is designed to equip people to:

- Lead a healthy life
- Communicate with others more easily
- Take care of pain, tiredness and depression
- Use problem solving and action planning skills
- Work better with professionals

Patients are asked to attend all 6 group sessions. As these patients have long-term health conditions it is accepted that they may not always be well, and therefore attendance at each of the six sessions may not be possible. Each course must have a minimum of 12 people registered on it in order for it to be run. There are a maximum number of 16 participants on each programme. The only criteria as such for patients attending a programme is that they are 18 years old

and above, have a long-term health condition or care for someone with a long-term health condition, and that they are willing to learn how to self-manage.

Performance Management

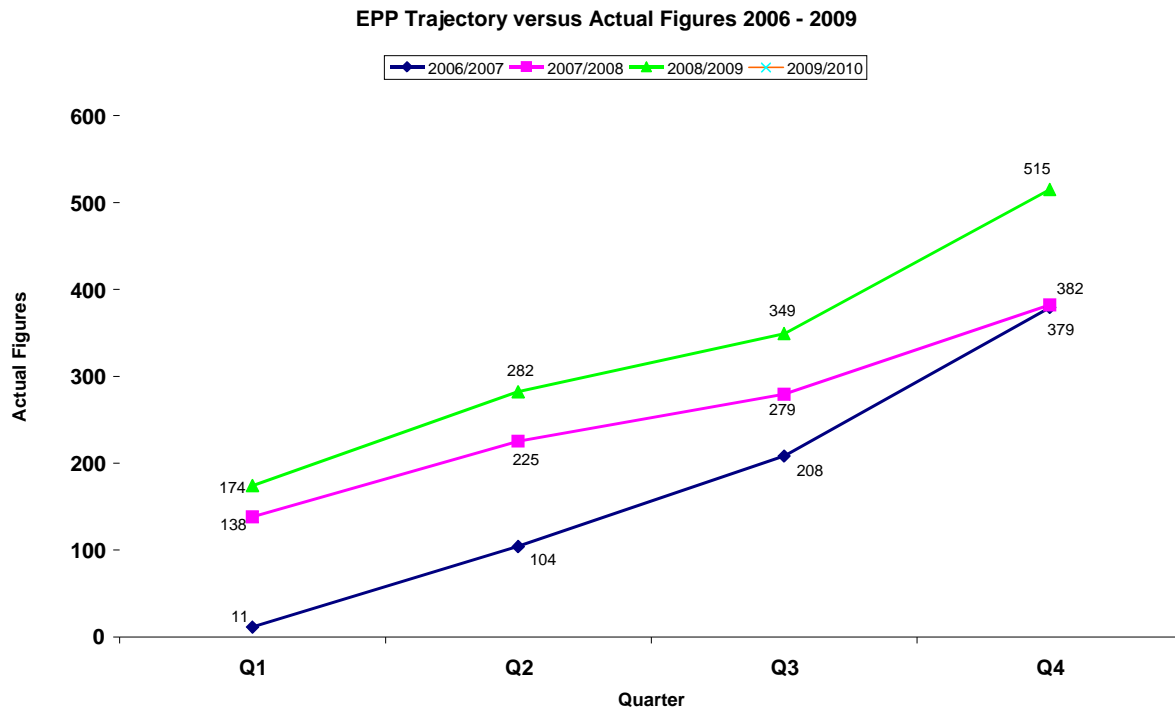
In Our Health, Our Care, Our Say, the Department of Health set out its ambition to increase the capacity of the Expert Patients Programme to 100,000 places per year nationally by 2012. The level of annual activity required in PCTs has been calculated by NHS West Midlands. The figures are based on the numbers of people estimated to be living with a long term condition. In the 2001 Census, 8,369,174 adults (18years and above) reported that they had a limiting long term illness in England. 894,762 (or 10.7%) of these people were resident in the West Midlands. This suggests that 10.7% of the national target should be delivered by the NHS in the West Midlands. The figures for the share of people with long term conditions for Birmingham PCTs are shown in Figure 2 below:

Figure 2: Capacity Required for Birmingham PCTs to Contribute to National Expert Patients Programme Target

Primary Care Trust	Number of People with Limiting Long-Term Illness (18+)	Number of EPP Places Available per year by 2012 Equitable share of national target
South Birmingham	62,219	743
Heart of Birmingham	41,760	499
Birmingham East and North	66,946	800

These figures have been given as a guide to PCT business and financial planning and are not be used to assess PCT performance in the Quarterly Health Improvement Report. The service trajectory below (Figure 3) shows that the trend for NHS BEN is upwards and the targets set are achievable:

Figure 3: Expert Patients Programme Trajectory of Course Places Versus Actual Figures



Current Performance

The Long Term Conditions Indicator: Health Improvement Monitoring Report Birmingham East and North Quarters 3 to 4, 2008/09 is the reporting mechanism for the performance measure of the Expert Patients Programme in the West Midlands region. The indicator measures the number of patients completing the Expert Patients Programme per 10,000 adults with long term conditions. Current performance is as follows:

**NHS Birmingham East and North EPP rate for Jan-March was
23.2 per 10,000 patients**

**Current performance is significantly higher than the latest
baseline average (i.e. the upper control limits for trend)**

**Current performance is significantly higher than the West
Midlands average**

***Of the 17 PCTs, 2 were better than and 10 were worse than
expected from the West Midlands average.***

Actual numbers of participants have seen a steady rise since 2006. This is illustrated in the Figure 4 below:

Figure 4: NHS Birmingham East and North Participant Numbers 2006 to 2009

	2006/07	2007/08	2008/09
Q1	11	138	174
Q2	93	87	108
Q3	104	54	67
Q4	171	103	166
Total	379	382	515

The Expert Patients Programme team has delivered 49 of the 56 courses run this year. Some courses are commissioned out to the Third Sector or to the Expert Patients Programme Community Interest Company. Commissioning of the programme is put in place if existing courses are fully booked or there is a need for more specialist input. For example the Terrence Higgins Trust was recently commissioned to run an Expert Patients Programme for people with HIV and Rethink, the mental health charity, was commissioned to work with mental health service users. Course activity varies throughout the year. Quarter 1 and quarter 4 have always been well attended with easy recruitment due to weather and seasonal variation. Quarter 2 figures were slightly lower due to staff sickness. Quarter 3 shows the continuing effects of staff sickness plus a whole time facilitator vacancy. However, quarter 4 demonstrates an increase in activity when all staff were in place. A summary of numbers of courses run last year is provided in Figure 5 below:

Figure 5: NHS Birmingham East and North Numbers of Commissioned Courses Compared to PCT Led Course

	2008/09 Courses	Commissioned	PCT Led
Q1	16 Courses	0	16
Q2	11 course	0	11
Q3	8 courses	3	5
Q4	21 course	4	17
Total	56	7	49

Opportunities for Expert Patients Programme

- NHS Birmingham East and North Expert Patients Programme team have a well-developed relationship with the Third Sector. For example, there are

currently twelve volunteer tutors of whom four are from the Somali Disability Group. These tutors will be able to offer the Expert Patients Programme in Somali. A further eight tutors are from Community Touch, an organisation working with clients who are deaf or hard of hearing. These tutors will be able to use sign language to deliver the Birmingham East and North Expert Patients Programme.

- Self-care is an expanding area and the opportunities to link the Expert Patient Programme to more specific diseases are being developed e.g. with Chronic Kidney Disease (CKD) and Chronic Obstructive Pulmonary Disease (COPD).
- In light of the current economic situation, the course could offer more support to help people with long-term conditions negotiate welfare agencies and claiming benefits – a key problem for people who are unable to work or need assistance to return to work.
- The appointment of a bi-lingual Expert Patients Programme facilitator will enable the service to further develop courses for Black and Minority Ethnic groups. A steering group to specifically look at developing the programme in Black and Minority Ethnic communities is being convened by the Expert Patients Programme facilitator, working in partnership with local community organisations and other community workers.

Conclusions

The Expert Patients Programme is delivering successfully in NHS Birmingham East and North. In its current form the Expert Patients Programme is helpful for some individuals and is valuable as one of a range of options for self-care.

The suite of self care interventions needs to be broadened so that numbers of clients engaged in their own care and management can be maximised. The Expert Patients Programme is currently delivered in multi-condition groups and client evaluations have indicated that these are more beneficial than condition specific courses. However, there is a role for condition-specific courses.

There is a need to evaluate the Expert Patients Programme against other models of professionally or lay delivered self care support. Rather than being concentrated on a single course, it may be useful to invest in self care support which can be directed at a variety of systems and interventions which are able to meet a wide range of needs of patients with long-term conditions.

Health Trainers Programme

Introduction

This report is to update Board members on the background, progress and current performance of the Health Trainer Service provided by NHS Birmingham East and North. Also highlighted are the contributions that the Health Trainer Service makes to the PCT's key health outcomes and opportunities for the service in the coming year.

Contribution to Key Policies

Health Trainers will improve the health and wellbeing of the local population by helping people to adopt and sustain healthier lifestyles. Services are targeted at the most deprived local communities in the Trust area. Furthermore, the service is well placed to deliver against a number of the PCT’s priority outcomes and support work identified by the social marketing element of the Trust’s PRIME programme (Figure 1):

Figure 1: NHS Birmingham East and North Priority Outcomes

<p>HEALTH OUTCOMES</p>	<p>Reducing health inequalities Smoking cessation Increase in physical activity Reducing premature mortality from Cardio Vascular Disease Reduction of obesity in adults, children and families Reduction of alcohol admissions for alcohol related harm</p>
<p>VITAL SIGNS 2008</p>	<p><CVD mortality rate/<cancer mortality rate/smoking prevalence/obesity among primary school-aged children</p>

Policy Context

As part of the consultation exercise for Choosing Health (DH 2004) people set out clear ambitions for their health and for their families, and commented that it was difficult to turn these intentions into sustained lifestyle changes. This has resulted in the Health Trainers role being developed within the public health workforce, with the principle remit to support people from disadvantaged communities to make healthier lifestyle choices.

“In keeping with a shift in public health approach from advice on high to support from next door, health trainers will be drawn from local communities” Choosing Health 2004. This theme continued in “Our Health Our Care Our Say” White Paper (2006) taking forward the principal from Wanless (2004) that individuals need to take more personal responsibility to improve their own lifestyles. By introducing the NHS “Health Checks” programme and “Health Trainers”, individuals in NHS BEN will be supported to improve their physical, emotional and mental health.

The “fully engaged scenario” is further supported within Commissioning a Patient Led NHS (2004) where local people participate in decisions about their own health and help to improve their own health and that of their immediate community. The West Midlands Regional Assembly undertook a consultation exercise as part of the “Regional Health & Well-Being Strategy” (2007) which emphasised that good health and well-being relies on people living within strong communities. Health Trainers can help to support this local approach.

Development of the Health Trainer Service in NHS Birmingham East and North

Recurrent resources were made available to PCTs in 2006/7 and 2007/8 to establish Health Trainer Services as part of the Choosing Health Initiative. In June 2008, five Healthy Heart Worker posts were redefined as Health Trainers when the Male Life

Expectancy Project ended in June 2008. Three existing part time posts within Health Improvement were also re-developed into Health Trainers posts. NHS Birmingham East and North has now commissioned a Health Trainer Service for the period 2009 to 2012. The 3 year contract has recently been awarded to Health Exchange Community Interest Company, based in Birmingham. Prior to this, the service was provided by Gateway Family Services Community Interest Company for one year. Four of the five existing staff, recruited and trained by Gateway, were protected under Transfer of Undertakings (Protection of Employment) Regulations (TUPE) and have been transferred to Health Exchange Community Interest Company.

Current Position

The Trust currently has four full time posts, one vacant post in the process of recruitment, a service co-ordinator, the three (1.4 WTE) part time Health Trainers working within the Health Improvement Team and 3 posts (2 WTE) working with the Birmingham's Own Health Project. This gives us a total of 8.4 whole time equivalent Health Trainer posts in NHS BEN.

The Health Trainer Role

Health Trainers deliver one-to-one, self-referred and referral-based interventions, targeting people with lifestyle risk factors such as smoking, obesity, low physical activity and people with existing long term conditions that could also benefit from lifestyle changes (e.g. coronary heart disease, diabetes and hypertension). Health Trainers also work with people who have already taken part in a health improvement programme and want further support to help them maintain the lifestyle changes they have made. The Health Trainer will identify and help the client overcome barriers to lifestyle change, motivate, encourage and support them to set realistic and achievable goals which can improve their health and well being.

A multi-disciplinary steering group has been overseeing the performance and direction of the contract. The steering group membership includes representation from procurement, CVD Nurse Consultant, Head of Communications, a Locality Manager and other lifestyle service leads. This group is chaired by the strategic lead for Health Trainers, who is part of the Health Improvement Team.

Key Priority Areas

Health Trainers work in the most deprived local communities in a range of different settings to ensure accessibility to services for clients. For the coming year, three priority areas have been identified in order to target services:

- Primary care services, including GP practices and local pharmacies, targeting individuals with a high risk of CVD or having an existing long term limiting condition
- Schools and Children Centres delivering “healthy family” support to parents and children who are overweight as part of the Obesity Care Pathway
- Other community agencies or services in order to work with ‘disengaged, seldom heard’ but most ‘in need’ communities such as carers, asylum seekers, unemployed people etc
- Patients referred from Birmingham Own Health or other existing lifestyle services

Taking into account the broader range of national indicators, the performance of the local service is currently exceeding target across a number of measures. Performance is monitored through a national web-based tool and structured around a range of national service indicators.

Performance indicators for all West Midlands PCTs are based on the number of Health Trainers NHS West Midlands calculated each PCT should have in place. This figure was based on the proportion of people estimated to live in ‘most deprived’* areas at Super Output Area (SOA) level with four Lifestyle Risk Factors. Therefore, the number of required Health Trainers for NHS BEN has been calculated as 30 whole time equivalent Health Trainer posts.

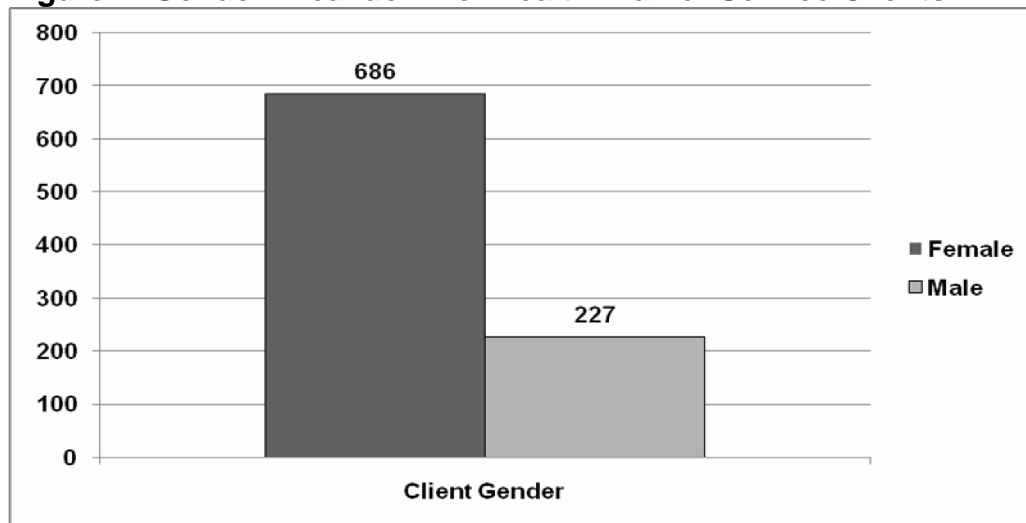
As already stated, the Trust currently has 8.6 WTE Health Trainers in post. Therefore, our overall performance will remain below target trajectories which have been calculated for 30 Health Trainers. However, it is encouraging that our current performance is within the top 4 Trusts within the West Midlands region. The NHS West Midlands last Health Improvement Monitoring Report for NHS Birmingham East and North Quarters 3 and 4 2008/09 summarises progress of the Health Trainer Service:

- Current performance for January to March 2009 was 151.7 per 10,000
- Current performance is significantly higher than the latest baseline average (i.e. above the upper control limits for trend)
- Current performance is below the target trajectory of 281.1 per 10,000 (based on having 30 Health Trainers)

(The following information doesnot include data from the BoH Health Trainers)

Gender

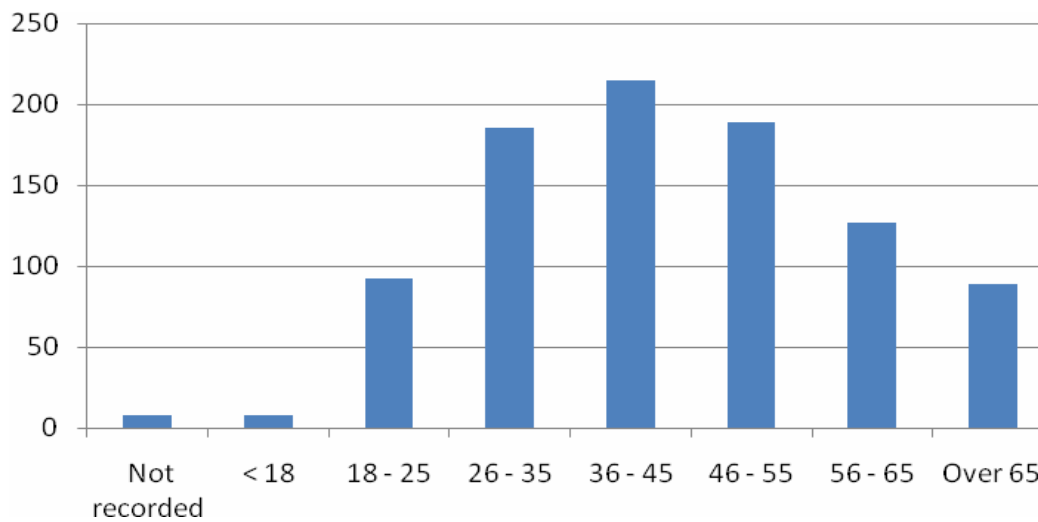
Figure 2: Gender Breakdown of Health Trainer Service Clients



Age Profile of

Clients

Figure 3: Age Profile of Health Trainer Service Clients



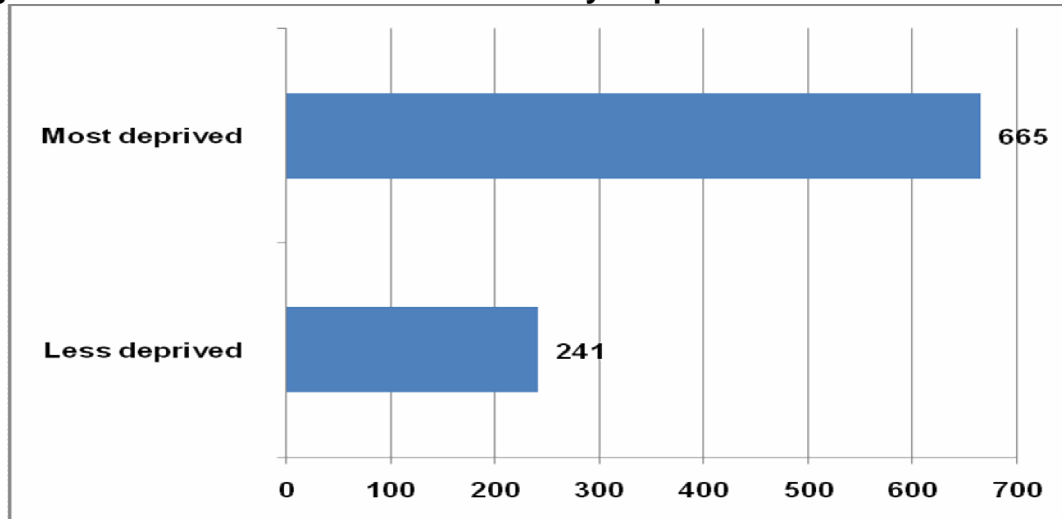
Ethnicity

31% of clients were from Black and Minority Ethnic Groups (NHS BEN population of Black and Minority Ethnic groups is 18%).

Deprivation

73 % clients were from 'most deprived' areas on NHS BEN, as defined by NHS West Midlands (Figure 4):

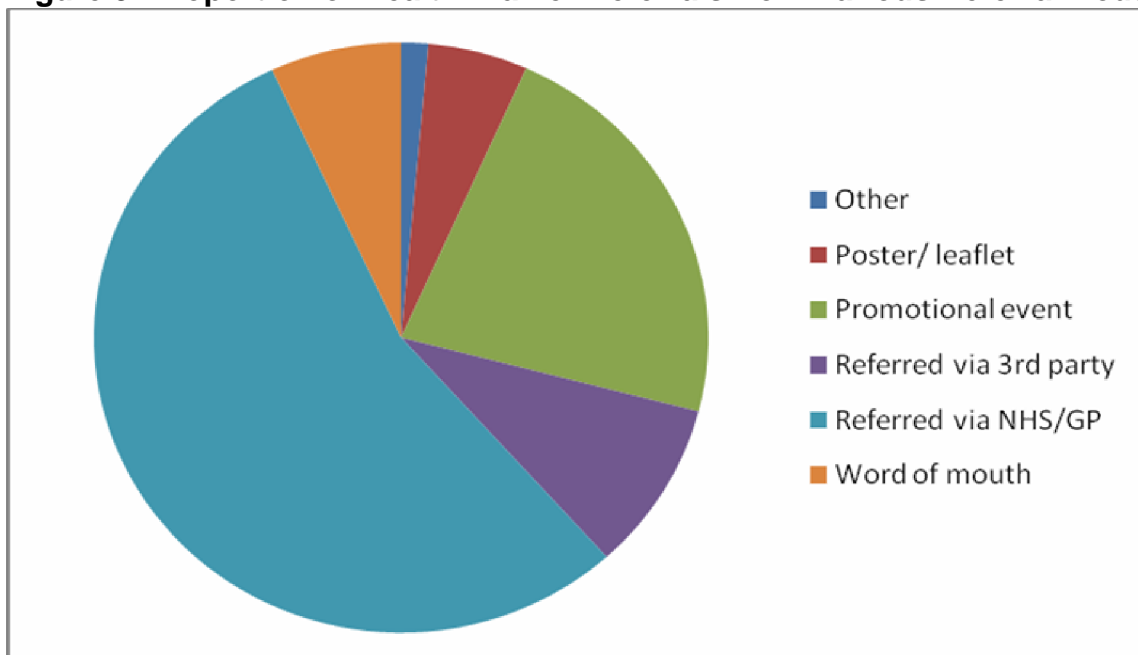
Figure 4: Health Trainer Service Clients by Deprivation



Referral Routes

55% referrals were referred from GP practices and 22% were self-referrals from promotional events (Figure 5):

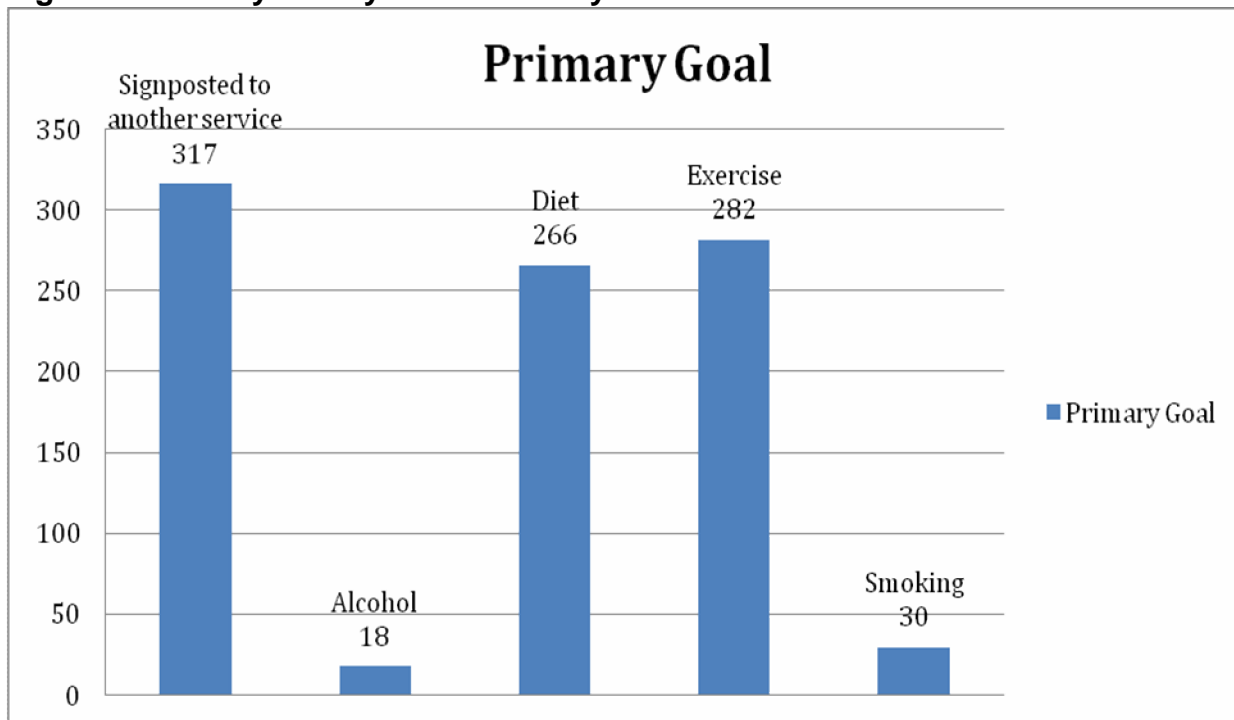
Figure 5: Proportion of Health Trainer Referrals from Various Referral Routes



Primary Goals Set by Client

The main lifestyle change goals set by clients were for diet and exercise and a similar proportion of clients were signposted to other services such as Call to Quit, Weight Watchers or Exercise on Prescription (Figure 6):

Figure 6: Primary Lifestyle Goals set by Clients



Exercise on Prescription accounts for 30% of signposting to other agencies.

Case Studies

The following case studies illustrate how Health Trainers can support people in making positive lifestyle changes:

- *White British – 23 years of age – Stechford and Yardley North Ward*

Mrs X met with a Health Trainer at a promotional event, she reported that she had attempted to give up smoking on a number of occasions.

Intervention

The Health Trainer compiled a Personal Health Plan with the client, through the completion of this plan it was identified that Mrs X had previously attempted to give up smoking through attendance of group sessions; Mrs X felt that attending group sessions was not the right support for her.

The Health Trainer made contact with Call to Quit and discussed the route that was best for the client. Following further discussions with Mrs X, the Health Trainer made arrangements to attend the one to one stop smoking sessions at a local venue at a time and place that was convenient for Mrs X.

Future

Mrs X is motivated to attend the sessions on a one to one basis with a Stop Smoking Advisor. She has stated that she feels very confident to achieve her goal of giving up smoking.

- *Pakistani – 54 years of age – Acocks Green*

Mr X referred himself into the service after picking up a leaflet in their GP practice. He had recently been diagnosed with Type 2 Diabetes and wanted to access some advice and guidance around increasing his physical activity and improve his diet, this would then help to reduce his weight.

Intervention

The Health Trainer met with MR X and compiled a Personal Health Plan. Following this meeting the goals were set for Mr X to join his local Gym, through Exercise on Prescription. The Health Trainer booked the induction at the local Gym of Mr X's choice and attended the initial introduction with the client.

Mr X was also referred to the Diabetes Education Programme to equip him with the knowledge and specialised advice required to manage his condition in the future. Following on from the support, advice and guidance from the Health Trainer Mr X has lost to date 1 stone in weight, reducing his BMI from 37 to 34.

Future

Mr X continues to eat healthier and attends the gym on a regular basis. Mr X has reported that he is feeling much healthier and happier.

Conclusions and Next Steps

The first year of the Health Trainer Service has enabled us to establish the direction of the Service focussing therefore in primary care and the community. We are beginning to obtain insight into the profiles of individuals requiring support, the issues that create barriers to behavioural change and the type of interventions which enable people to begin or maintain change.

We endeavour to continue to monitor the outcome of interventions preliminary data indicates that the service is targeting our most deprived communities and that individuals are coming forward for support for lifestyle change, particularly for weigh management and physical activity.

Future plans will certainly explore why smoking is not the first change people want to make and anecdotal evidence suggests that individuals want to start with something less difficult such as increasing their physical activity first.

As clients are offered support for up to one year, outcomes for goal setting and long-term behaviour change are not yet available. However, it is anticipated that as the Health Trainer Service matures the date will be available within the next few months.

The implementation of the NHS Health Checks will also shape the referral routes into the service. This will be reviewed by the steering group when final decisions are made once the pilot phase has been evaluated.

Recommendations

Board members are asked to note the content of this Health Trainers report.

**Most Deprived' areas defined by NHS West Midlands as Index of Multiple Deprivation(IMD) at Super Output Area(SOA) level with the proportion of people with 4 Lifestyle Risk Factors (LRF) in deprived areas.

Cancer

Introduction

In response to the Cancer Reform Strategy (2007), NHS Birmingham East and North have established a Local Economy Cancer Group in conjunction with Solihull Care Trust and Hearth of England Foundation Trust. The Group has a remit for working together towards the requirements of the Cancer Reform Strategy and in response has outlined a Programme of Action for achieving this

This paper outlines recent developments and plans surrounding the Public Health elements of the Cancer Reform Strategy Programme of Action, namely cancer prevention and early detection.

Cancer Prevention

Cancer Prevention focuses on reducing and managing risk factors associated with developing cancer. The Cancer Reform Strategy states that “over half of all cancers could be prevented by changes to lifestyle”.

Cancer prevention focuses on increasing the awareness of the potential effects of unhealthy lifestyle behaviours and providing opportunities for healthier lifestyles. NHS Birmingham East and North provide and commission an existing portfolio of evidence based interventions and services, in areas such as Smoking Cessation, Obesity Management and Physical Activity that support healthier behaviour change. National Awareness programmes are also in place in areas such as excessive alcohol consumption and the Sunsmart campaign aimed at promoting behaviour change to prevent skin cancer.

In 2008/09 a new opportunity for cancer prevention was rolled out nationally through a vaccination programme for young girls against Human Papillomma Virus (HPV). A full course of the vaccination will protect against the strains of the HPV virus which cause around seven out of ten cases of cervical cancer (Cancer Reform Strategy, 2007).

Early Detection

In general, the earlier a cancer can be diagnosed the greater the chance of a cure (Cancer Reform Strategy, 2007). There are two primary approaches to increase early detection:

Increase awareness of signs and symptoms

Improving the knowledge of the general public of signs and symptoms of cancer and encouraging presentation in General Practice or through other relevant health professionals will provide opportunities for potential cancers to be investigated and diagnosed earlier, particularly where a national screening programme is not in place.

Screening

Screening is vital to diagnosing some cancers early. Currently, three national screening programmes are in place to screen for Breast, Cervical and Colorectal (Bowel) Cancer.

Breast Cancer

Breast cancer is the most common cancer in women worldwide, it accounts for about 25 per cent of all female malignancies and the proportion is higher in women in western developed countries. One in 9 women will develop breast cancer at some time in their life however survival rates in England are good and improving (Cancer Research UK, 2009).

Methodology

The NHS Breast Screening Programme provides free breast screening every three years for all women in the UK aged 50 to 70.

National plans are in place to develop Breast Screening services through extending the age criteria to 47 to 73 by 2012 to ensure that all women will have their first screening. This will be facilitated by the roll out of digital mammography in 2010 which is more appropriate for screening younger breast tissue. Strategies for identifying genetic predisposition and surveillance of individuals are also in progress.

Performance

The national target for Breast Screening uptake is 70% for each Primary Care Organisation. In 2007/08, NHS Birmingham East and North achieved an uptake of 75.2% and was ranked 7th in the West Midlands (see fig 1).

PCT	No. of women invited	Number of women screened		Rank in the West Midlands
		No.	%	
Birmingham East and North	10,649	8,013	75.2	7
NHS Coventry	12,672	8,593	67.8	16
Dudley	9,564	7,054	73.8	8
Heart of Birmingham Teaching	8,511	5,177	60.8	17
Herefordshire	9,347	7,388	79.0	3
North Staffordshire	8,936	6,538	73.2	9
Sandwell	7,017	4,955	70.6	13
Shropshire County	17,400	14,162	81.4	1
Solihull	9,663	6,640	68.7	14
NHS South Birmingham	13,671	10,006	73.2	9
South Staffordshire	16,107	12,252	76.1	5
Stoke on Trent	5,982	4,348	72.7	11
Telford & Wrekin	3,274	2,320	70.9	12
NHS Walsall	8,265	6,445	78.0	4
NHS Warwickshire	16,115	12,147	75.4	6
Wolverhampton City	8,476	5,792	68.3	15
Worcestershire	11,996	9,573	79.8	2

Fig 1: Breast Cancer Screening uptake (Cancer Intelligence Unit, 2009)

Birmingham East and North area is provided through screening centres aligned to Sandwell and West Birmingham and Walsall Hospitals. In the most recently reported quarter (October – December 2008) screening rates for NHS Birmingham East and North had fallen to 69.1%. (Fig 2)

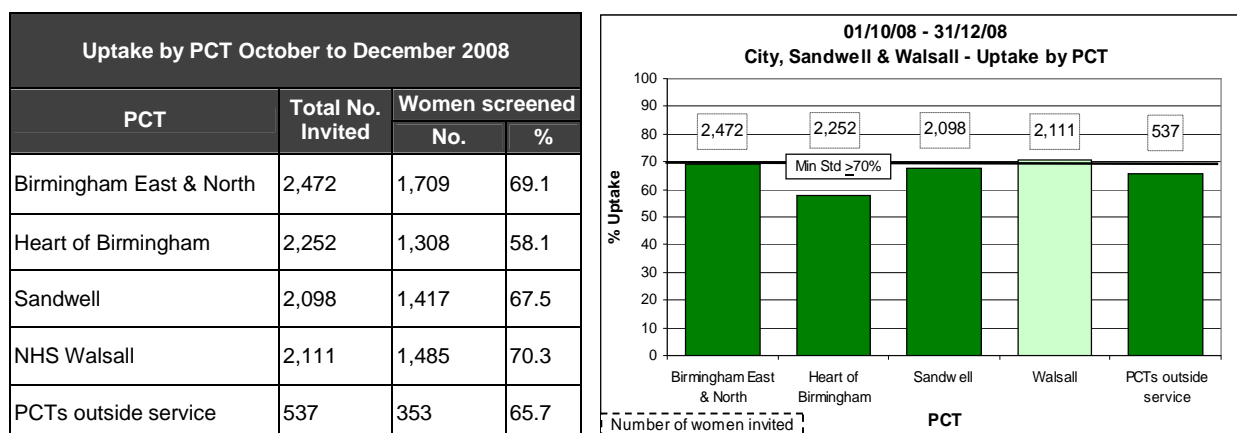


Fig 2: Breast Cancer Screening uptake rates for City, Sandwell and Walsall screening centre :October – December 2008 (Cancer Intelligence Unit, 2009)

The Cancer Commissioning teams and public health are working with the provider to manage performance and plan future service delivery.

NHS Birmingham East and North submitted a successful bid the National Cancer Action team and will receive £20K for a project to increase levels of screening in women who have never been screened as evidence shows that women are more likely to attend subsequent invitations for screening of they have attended an appointment before. Part of this funding will support a small scale social marketing project aimed at a targeted population.

Cervical Cancer

Cervical screening prevents up to 3,900 cases of cervical cancer per year in the UK and saves approximately 4,500 lives per year in England (Cancer Research UK, 2009)

Methodology

All women between the ages of 25 and 64 are eligible for a free cervical screening test every three to five years. Women are called through their GP practices and receive their results within 2 weeks.

Performance

The national target for Cervical Screening uptake is 80% for each Primary Care Organisation. NHS Birmingham East and North are achieving below the national target at around 76%, although uptake varies widely between localities (see fig 3).

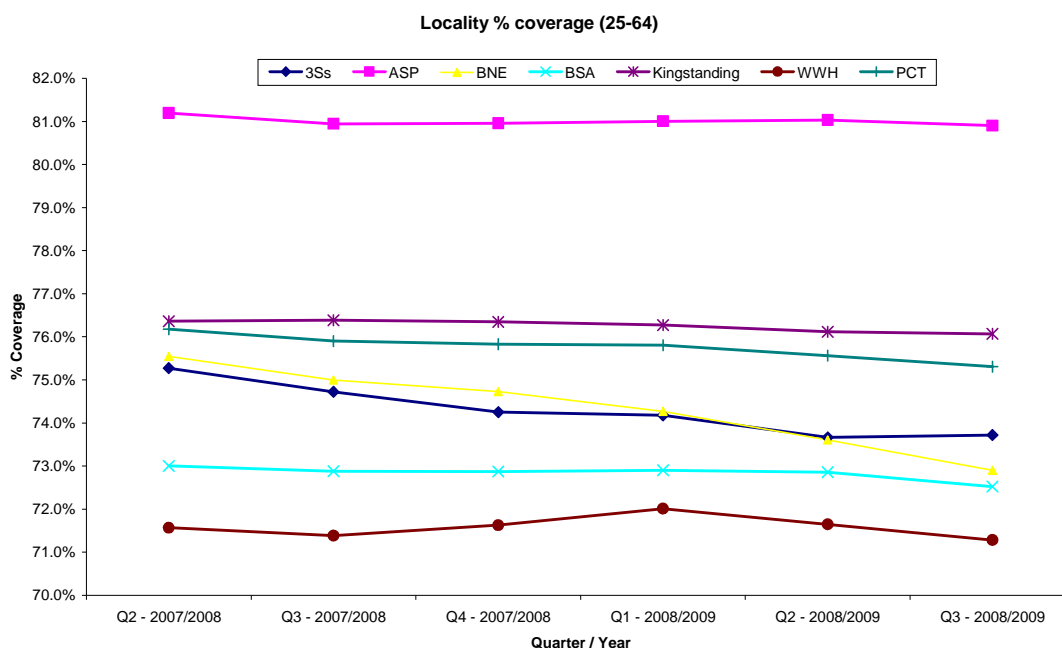


Fig 3: Graph representing Cervical Screening uptake by PCT and by each locality

Screening rates are highest in the Sutton Coldfield (ASP) locality and lowest in Hodge Hill and Washwood Heath (WWH). Screening uptake is being managed through locality commissioning.

Colorectal (Bowel) Cancer

Bowel cancer is the third most common cancer in the UK and the second most common cause of cancer deaths in the UK. The lifetime risk of developing bowel cancer in the UK is 1 in 18 for men and 1 in 20 for women. If bowel cancer is diagnosed early, 85–95% of patients live for more than five years after treatment (Cancer Research, 2009)

Methodology

Initial screening is via a faecal occult blood test (FOBT), posted to men and women aged 60 to 69 and completed by participants in their own home. People aged 70 or over can request screening. Those with an abnormal FOBT result will be offered a colonoscopy. Screening could reduce the number of bowel cancer deaths in 60–69 year olds by 16%.

Performance

Bowel Cancer screening is a new screening programme with the coverage of the whole eligible population to be achieved by the end of 2009. NHS Birmingham East and North commission the service for local residents which is provided by a regional screening centre and Heart of England NHS Foundation Trust.

Supporting maximum uptake of bowel cancer screening will require a focused approach considering the methodology of the initial screening test which may seem unpleasant or complex for some people. A Screening Manager has been appointed to co-ordinate and increase uptake of the three main screening programmes, including Bowel Cancer.

Future plans

Cancer Prevention

The following plans are in place for 2009/10 and beyond to ensure further progress towards supporting the population to make healthier behaviour changes in order to prevent cancer and cardiovascular disease.

The Health Improvement directorate continue to develop and commission services to support populations to uptake healthier lifestyles. These include services for smoking cessation, healthy eating, physical activity and alcohol.

As part of the Social Marketing workstream of the PRIME programme, campaigns and projects to increase the uptake of Smoking services and reduce inequalities in populations effected by Obesity and Alcohol. These workstreams will support communities most at risk to adopt healthier lifestyles in methods that are most appropriate to them.

Early Detection

Along with the plans outlined for the screening programmes, the NAEDI (The National Awareness and Early Diagnosis Initiative) team, incorporating Cancer Research UK, University College London, King's College London and University of Oxford have developed a Cancer Awareness Measure (CAM) tool to assess the awareness of the population of cancer symptoms. Completing this will enable a baseline to be set in order to develop an action plan for increasing awareness amongst the population.

Smoking

Introduction

The stop smoking service met the annual target for 2008/09. The purpose of this report is to update the board on the stop smoking services overall activity for 2008/09 and outline the planned activities for 2009/10 to ensure future targets are met.

Key Points

- a) The primary role of Birmingham East and North stop smoking service is to provide a high quality clinical smoking cessation service to the local population.
- b) In line with a recent service evaluation of the stop smoking service, a revised strategy is in progress, taking into consideration the effectiveness and cost-effectiveness of the stop smoking services offered to our local population, particularly focusing on smokers from routine and manual groups, pregnant smokers and BME communities.

National Picture

In 1998 the first White Paper on Tobacco was published, 'Smoking Kills'¹. The document set out three targets for 2010 to tackle the underlying determinants of ill health and health inequalities. The targets include a reduction in smoking in three groups, reducing the prevalence of cigarette smoking among adults in

England to 24%, to reduce the prevalence of pregnant women smoking at delivery to 15% and a reduction in the prevalence of children smoking to 9%. In 2004, the Department of Health agreed a new Public Service Agreement (PSA) which revised the target downwards, the aim now is to reduce the prevalence of cigarette smoking among adults to 21 per cent or less.

Reducing smoking is also one of three key commitments at the heart of the NHS Cancer Plan (2000)² In particular, the Cancer Plan focuses on the need to reduce the comparatively high rates of smoking among those in manual socio-economic groups, which result in much higher death rates from cancer among unskilled workers than among professionals. The more recent PSA targets therefore include a target of reducing prevalence among routine and manual groups to 26 % or less by 2010.

A number of National Service Frameworks (NSF's) highlight the need to reduce smoking. For example, the NSF for Coronary Heart Disease (2000), Diabetes (2003), Older people (2001). Reducing smoking rates is a key improvement area within the overarching Health for the Population Public Service Agreement (PSA), the Strategic Health Authority LDP and the NHS Operating Framework¹

There are a number guidance and implementation tools developed by the National Institute of Clinical Excellence (NICE) directly relating to smoking. These include, Bupropion and Nicotine replacement Therapy (2005)³, 'Brief interventions and referral for smoking cessation (2006)⁴, Varenicline (2007)⁵, and Workplace interventions to promote smoking cessation (2007)⁶. The most recent NICE guidance for smoking cessation services(2008)⁷ highlights the importance of reducing the prevalence of smoking among people in routine and manual groups, some minority ethnic groups and disadvantaged communities to help reduce health inequalities. Although NHS Stop Smoking Services have helped large numbers of people to quit smoking, smoking cessation rates are still lower among people in routine and manual groups compared with those in higher socioeconomic groups

In May 2008 the Department of Health (DH) produced an evidence-based resource to support local alliance, 'Excellence in tobacco control: 10 High impact changes to achieve tobacco control'⁸ This document provides guidance on how smoking prevalence can effectively be driven down in our communities and emphasises that tackling smoking needs to be everyone's business

The NHS stop smoking services monitoring guidance(2009)⁹ set out best practice guidance relevant to the provision of all NHS stop smoking interventions and the fundamental quality principles for the delivery of services. Another recent publication from the DH, 'Tackling Health Inequalities(2009)'¹⁰ emphasises the firm rationale for targeting routine and manual smokers to help reduce health inequalities and contribute positively to the health inequality PSA target.

Smoking is one of the most significant contributing factors to life expectancy, health inequalities and ill health. Smoking kills an estimated 86, 500 people in England each year¹¹. Smoking causes over 50 diseases and conditions. About one third of all cancer deaths can be attributed to smoking. Smoking causes almost 90% of deaths from lung cancer, around 80% of deaths from bronchitis and emphysema, and around 17% of deaths from heart disease¹². Shisha, (also known as hookahs,

narghiles and waterpipes) use is becoming increasingly popular in England. Evidence suggests that Shisha usage is likely to increase the risk of cancers of the lung, mouth and bladder. It is also associated with markers for cardiovascular disease and respiratory disorders.

Recent research into the economic burden of smoking related ill health estimated that the direct costs to NHS services was £5.2 billion in 2005-06¹³.

The General Household Survey (2007)¹⁴ reports a downward trend in the national smoking prevalence, that is currently 21% in the general adult population. Prevalence has been higher among men than women, and this continues to be the case, in 2007, 22 per cent of men and 20 per cent of women were cigarette smokers.

The prevalence for smoking in routine and manual groups has dropped significantly between 2006 and 2007 from 29% to 26%. Evidence from other sources suggests that some smokers who quit because of smoke-free may relapse, and that unless we maintain our programme of work, prevalence may go back up, putting PSA delivery at risk.

Local Picture

Smoking in the East and North of Birmingham is higher than the national average. A recent adult smoking prevalence survey for Birmingham PCT's revealed that NHS BEN has a smoking prevalence of 26%, emerging higher than neighbouring PCT's (Heart of Birmingham 25% and South Birmingham 24%).

The prevalence of smoking in NHS BEN varies considerably between wards. Deprived wards such as Shard End and Kingstanding have a prevalence of 38% and 37% respectively, whereas more affluent wards in the North, such as Four Oaks have a much lower prevalence of 14%. As smoking is strongly associated with deprivation, it is a major contributor to health inequalities across NHS BEN.

The survey showed that smoking prevalence was below average among the BME communities (22%) and higher among the white population (26%). 38% of former smokers received support from the Birmingham Stop Smoking Services, suggesting that further work is needed to encourage smokers in BEN to quit using NHS services rather than alternative methods or through self-help. The survey also showed that the estimated number of smokers who wish to stop smoking in Birmingham is lower than national estimates (69%) at 49%.⁷

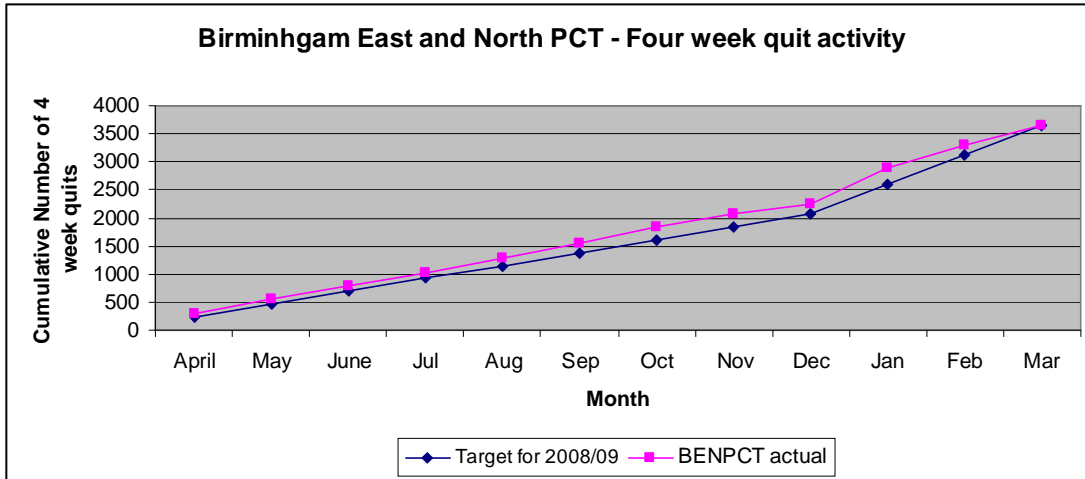
In NHS BEN there were 6,293 births, and 960 mothers smoking at delivery (15.2%) in 2008/09. This is comparable to the smoking at delivery rates for the West Midlands (15.4%). At the end of quarter 3 in 2008/09, NHS HOB and South had smoking at delivery rates of 7% and 19.7% respectively.

There is little local data on the prevalence of Shisha use within the East and North of Birmingham. Work is currently underway across Birmingham to increase local knowledge in this area.

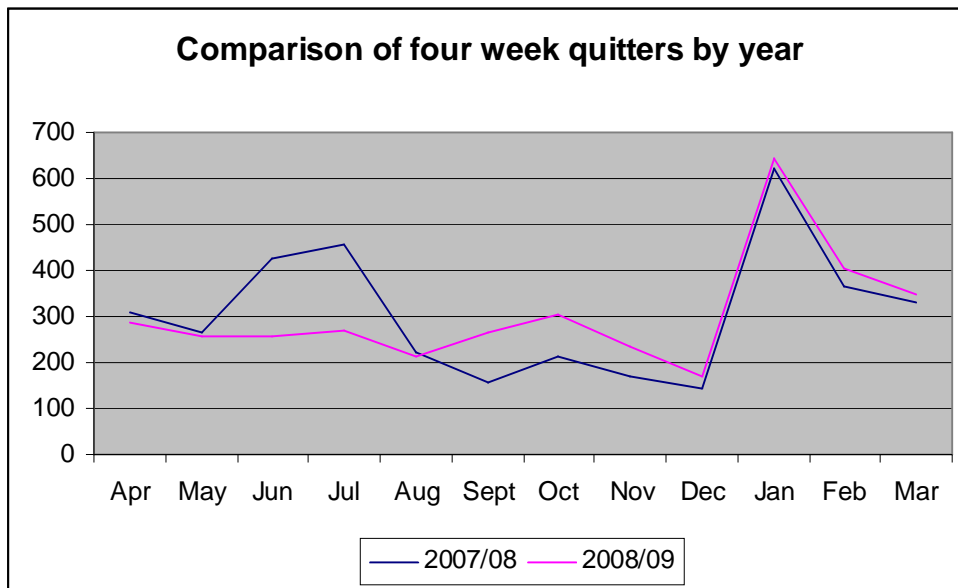
NHS BEN had a challenging Vital Signs target (VSB05: Smoking prevalence among people aged 16 or over and, aged 16 or over in routine and manual groups) of 3641 four week quits. The service exceeded this target achieving 3649 four week quits.

Details of activity are outlined below. The target for 2009/10 is a pan Birmingham target of 1015 quits per 100,000 resident population. BEN stop smoking service will contribute 3147 quits towards this target.

4.1 Figure. 1 Shows how quitters were achieved through the year.

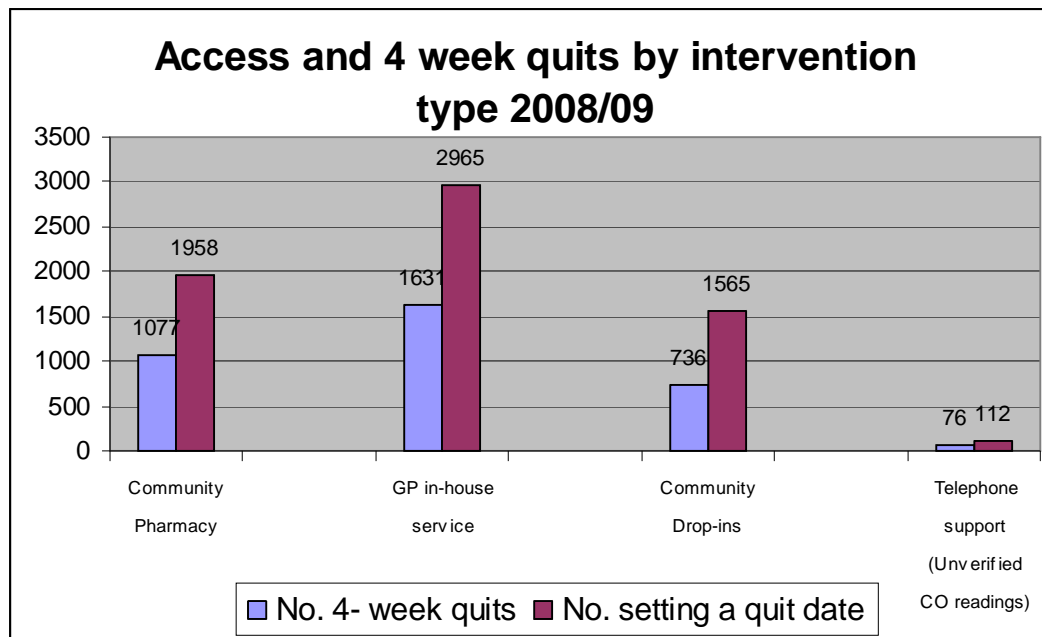


4.2 Comparison with previous years.



2007-08 saw the introductions of the smoke-free legislation on 1st July that affected both the seasonal pattern of quitters and the overall number of 4 week quitters within the year. The graph shows clear similarities in the number of quits between the two years, common peaks of activity occur in September/October and in January.

Table:1 Number of four week quits by intervention type.



Main Actions for 2009/10 Strategy /Business Plan

A strategic plan will be developed and from that an annual stop smoking business plan. The strategy will outline a tobacco control agenda, the model of service provision and a monitoring and evaluation plan. The strategy will be developed from a wide evidence base and from evaluations of the effectiveness and cost effectiveness of the service.

Service Configuration

A Stop Smoking Nurse Practitioner has been employed to work across two hospital sites (Good Hope and Heartland’s Hospital). The post will be based at Good Hope Hospital and will be responsible for the coordination of stop smoking activity within secondary care including the training of frontline staff. The post will also be responsible for implementing a robust stop smoking care pathway and a ‘stop before your op’ programme. Two Stop Smoking Outreach Workers are due to commence in the summer. The remit of the roles will be to work at a community level, providing specialist advice at drop-in clinics, workplaces and community health events.

Service Provision

In 2009/10 69 practices have signed up to providing an in-house stop smoking service. Figure: 1 shows that this intervention stream provides a large proportion of the overall activity with regards to 4 week quits (approx 40%). GP’s have been given revised targets based on local smoking prevalence and practice population. The service has 49 community pharmacies providing under a Service Level Agreement (SLA), currently managed by ELC Consultancy. This intervention stream contributed just under one third of all 4 week quit activity (see figure: 1). Systems for data collection have been improved, allowing for better performance management.

The Nicotine Replacement Therapy by post and telephone service has shown superior four week quit rates compared to other interventions in the last year. This scheme was initially offered to the 'lost to follow up' smokers from the pharmacy service. The service is now open to all smokers wishing to quit along with the other interventions and a full range of NRT products is now available through this scheme. Systems to ensure that 4-week quitters are carbon monoxide verified are currently being investigated.

Stop Smoking Referrals

65 dental practices in the PCT received a tailored referral pack and training package to assist in directly referring smokers into the service. We anticipate this new approach with dental practices will increase access to services from a previously 'untapped' market of healthy smokers who are not in contact with other primary or secondary care services.

A national scheme (Smoking Cessation in Primary Care) has been initiated in two GP practices currently not providing an in-house stop smoking service. This is a systems-based approach for delivering brief opportunistic advice to smokers before referring directly into the service. The practices will receive feedback on the quit status of the patients they actively refer to the stop smoking service. The scheme will be evaluated at 3, 6 and 12 months. Depending on the outcome of early evaluations, the scheme may be adopted by other non-LES GP practices.

Smoking in Pregnancy

A robust referral system to enable quick access to the stop smoking service was implemented in February 2009. A clear pathway is now in place for referral to the pan Birmingham 'Call to Quit' centre. Specialist training to service providers has taken place to broaden the services available to pregnant women by building capacity into the service. To improve detection of pregnant smokers, all community Midwives have received 'Brief Opportunistic Training' and have been provided with a carbon monoxide monitor.

Social Marketing

As part of the ongoing PRIME Programme, Dr Foster Intelligence (DFI) recommended a short-term social marketing strategy which was implemented to increase referrals in to the stop smoking services New Year drop –in clinics. Strategies included, face to face marketing, letters to previous clients inviting them back into the service and a flyer drop to targeted households. During 2009/10 an autumn quit campaign will be implemented, aimed at improving access rates from male smokers aged between 35-54 years. The stop smoking service has been re-branded, in line with national advertising. This will assist with the local service being recognised as part of the national NHS stop smoking services.

Workplace Activity

To help achieve the four week quit target, contact was made with over 100 employers in the BEN area. Following this activity the service has seen an increase in workplaces requesting stop smoking support and information. It is anticipated that these partnerships will continue and an increasing number of workplace stop

smoking initiatives implemented. This component of work will be investigated further within the business plan.

Pan Birmingham

The 'Tobacco control and smoking cessation programme' was developed to help tackle specified targets within outcome 12 of the Local Area Agreement. The programme will take a city-wide approach to reducing inequalities in health and mortality across Birmingham. Activities have been planned for 2009/10 to ensure access rates into the stop smoking services are maintained. Interventions include: 1) engagement with priority groups through the use of a targeted face to face contact with smokers 2) programmed case finding during quarters 3 and 4 using Birmingham City Council leisure services data and call2quit manager 3) reduce lost to follow up numbers from clinics.

Other work includes the development of a pan Birmingham stop smoking website. This aims to compliment the 'call to quit' centre currently hosted by South Birmingham, providing up to date information on local stop smoking clinics within Birmingham.

Healthy Incentives Pilot

The stop smoking service has been actively involved in the design and implementation of this pilot. The pilot aims to reward pregnant smokers from targeted communities for quitting smoking and remaining abstinent for up to 12 months. The pilot aims to assess whether incentives schemes improve uptake into services and conversion rates. The outcomes from this pilot will be evaluated next year.

Conclusion

The service achieved a challenging target during 2008/09 and is in a position to be able to exceed this target during 2009/10. The service is configured to ensure that inequity in service provision is being addressed and traditionally hard to reach groups are provided with the best chance of accessing local services.

1) *Smoking kills – a White Paper on tobacco* (1998) The Stationery Office: London.

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4006684

2) *The NHS Cancer Plan*, Department of Health, 2000

www.dh.gov.uk/assetRoot/04/01/45/13/04014513.pdf

3) Bupropion and Nicotine Replacement Therapy. NICE TA 39 (2005) <http://guidance.nice.org.uk/TA39>

4) Brief interventions and referral for smoking cessation. NICE public health guidance 1 (2006)

<http://www.nice.org.uk/Guidance/PH1>

5) Varenicline. NICE: TA123 (2007) <http://guidance.nice.org.uk/TA123/Guidance/pdf/English>

6) Workplace interventions to promote smoking cessation. NICE public health guidance 5 (2007)

<http://www.nice.org.uk/Guidance/PH5>

7) Smoking cessation services in primary care, pharmacists, local authorities and workplaces, particularly for manual working groups, pregnant women and hard to reach communities. NICE public health guidance 10 (2008)
<http://www.nice.org.uk/Guidance/PH10>

8) Excellence in tobacco control: 10 high impact changes to achieve tobacco control – An evidence-based resource for local alliance (2008). http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_084847

9) Willis, N, Croghan, E and chambers, M. NHS Stop Smoking services: Service Monitoring and Guidance 2009/10.
www.dh.gov.uk/publications

10) DH National Support Team. (2009) Tackling Health Inequalities: Targeting routine and manual smokers.
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4006684

11) Willis, N. NHS Stop Smoking Services: Service and Monitoring Guidance, 2007/8. Tobacco Programme, Department of Health. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_079644

12) Ash (2006) http://www.ash.org.uk/ash_4k3664v4.htm

13) Allender, S, Balakrishnan, R, Scarborough, P, Webster, P and Rayner, M (2009) The Burden of smoking-related health in the United Kingdom. Tobacco Control: 0: 1-7.

14) Office for National Statistics: General Household Survey (2007) Smoking and Drinking among Adults 2007.

Teenage Pregnancy

Outline

Using the latest available data, this report will describe current level of teenage pregnancy in Birmingham and the Trust. It will examine the related risk factors and summarise local action to reduce unwanted teenage pregnancies in order to achieve the World Class Commissioning and National teenage pregnancy targets.

Key Targets

World Class Commissioning

- By 2012, no ward in BEN will have more than 8 babies born each year to teenage mums

National

- To reduce the under 18 conception rate by 50% by 2010 from the base line data of 1998
- To increase to 60% the proportion of teenage parents aged 16-19 in education, employment or training in 2010.

Targets	Current Position
World Class Commissioning target Conception rate \leq 30.4 per 1,000 females aged 15-17 by 2012	44.87 per 1,000 females aged 15-17
Reducing the conception rate by 50% by 2012 from the base line data of 1998 from 58.3 to 29.2 for Birmingham	44.87 per 1,000 females aged 15-17
Increase to 60% the proportion of teenage parents aged 16-19 in education, employment or training in 2010	Services commissioned via Connexions, data not available at present for the whole Trust

The interventions developed in the Trust over the last two years have been in line with national recommendations from the Next Steps report Guidance for local Authorities and Primary Care Trust on Effective Delivery of Local Strategies (Department for Education and Skills 2006) and the Birmingham City wide Sexual Health Strategy.¹

Key Points

- The greatest challenge is to reduce the under 18 conceptions by approx 40 every year in order to achieve the world class commissioning target by 2012.
- Teenage pregnancy is a complex issue, affected by young peoples aspirations, education and self-esteem as well as their risk-taking behaviour and access to contraception.
- Birmingham has shown an overall downward trend, in conceptions with a percentage change of 9.5% since the 1998 baseline. In 2007 the rate was 52.8 per 1000 young women 15 to 17 which is a slight reduction on the 2006 rate of 53.2 per 1000.
- NHS Birmingham East & North has a lower teenage conception rate, which is 44.87 per 1000 in 2007/08.
- Significant investment is being made by the Trust, to enable three full time posts to be commissioned to work specifically on the prevention strategy for teenage pregnancies. A key focus of their work is the development of a school based holistic health service that offers advice, information, support and a full range of contraception services to young people in targeted schools.

¹ http://www.everychildmatters.gov.uk/_files/8845F3C6EC567906D4E1F95616ED6BFB.pdf

- Commissioning Connexions service to provide personal advisors to work specifically with young parents regarding positive engagement in education, training and employment in order to reduce second unplanned pregnancies and reduce social isolation of young parents.
- Joint working with locality practice based commissioning in high rate areas to address under 18 conceptions, and young peoples sexual health needs.

Introduction/ National Picture

The reduction of under 18 conceptions by 50% by 2010 is one of the five national Indicators against which progress on Public Service Agreement target (PSA) 14 is measured as part of the broader strategy to improve sexual health. Sexual Health is identified as a priority area in the 2009/10 NHS Operating Framework. The High Quality Care for All: NHS Next Stage Review Final report has identified sexual health as one of the six priority areas for PCTs to commission comprehensive wellbeing and prevention services to meet the needs of the young people.

Teenage pregnancy is a major inequality and social exclusion issue. Having children at a young age (<18 years) can damage young women's health and well-being and severely limit their education and career prospects. There is considerable evidence that children born to teenagers are much more likely to experience a range of negative outcomes in later life.

National findings from the Teenage Pregnancy unit report Next Steps 2006 show that teenage mothers share the following characteristics:-

- Tend not to finish their education
- Bring up their child alone and in poverty
- 60% higher rate of infant mortality
- Are more likely to smoke during pregnancy
- Are less likely to breastfeed
- Are three times more likely to suffer from post-natal depression

Since the introduction of the Government's Teenage Pregnancy Strategy in 1998, under 18 conceptions in England have fallen by 10.7%, to 41.7 per 1000 females aged 15 to 17, with rates now the lowest for 20 years. Under 16 conceptions fell by 6.4% to a rate of 8.3 per 1000 over the same period. Despite this progress, the UK still has one of the highest rates of teenage pregnancy in Western Europe.

The cost of teenage pregnancy to the local NHS in Birmingham and Solihull is estimated to be around £1.5 million a year (Sex and the City 2008). National estimates suggest that for every £1 spent on preventing teenage pregnancies there is a saving of £4 to the public purse when assessed over a period of five years (Next Steps 2006)².

Local Picture

The Office of National Statistic recently released the 2007 teenage conception rates for Local authorities. Birmingham's rates have come down from 53.2 in 2006 to 52.8

² http://www.everychildmatters.gov.uk/_files/8845F3C6EC567906D4E1F95616ED6BFB.pdf

per 1000 in 2007. Birmingham is compared against 4 statistical neighbours, in which it ranks third (Table 1)

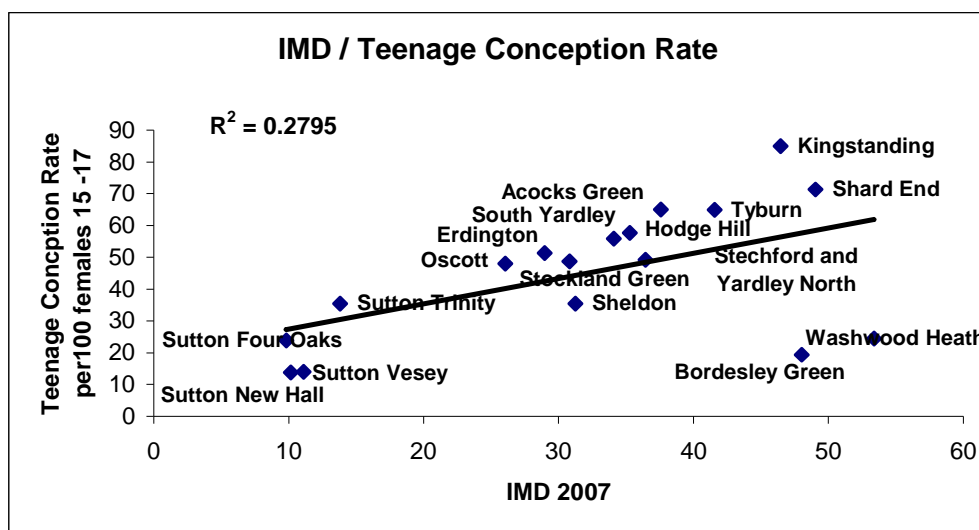
Table 1: Under-18 conception trends by DCSF statistical neighbours

LA	Deprivation score	Under-18 conception rate		% difference
		1998	2007	1998-2007
Luton	24.7	43.1	35.6	-17.4%
Sandwell	37.0	69.1	58.0	-16.1%
Birmingham MCD	38.7	58.3	52.8	-9.5%
Wolverhampton	33.0	66.3	64.9	-2.1%
Nottingham City	37.5	74.7	69.3	-7.2%

Across the Trust, eight of NHS Birmingham East & North wards appear in Birmingham's top 20 highest rate wards for teenage conceptions. At a ward level, variations in the under 18 conception rate largely reflect the pattern of deprivation, poor educational attainment and disengagement at school across the Trust with the majority of conceptions occurring in the most deprived wards with the exception of Washwood Heath and Bordesley Green. This could possibly be explained by the ethnic make up of the population in the area, with a high proportion of people from South Asian backgrounds.

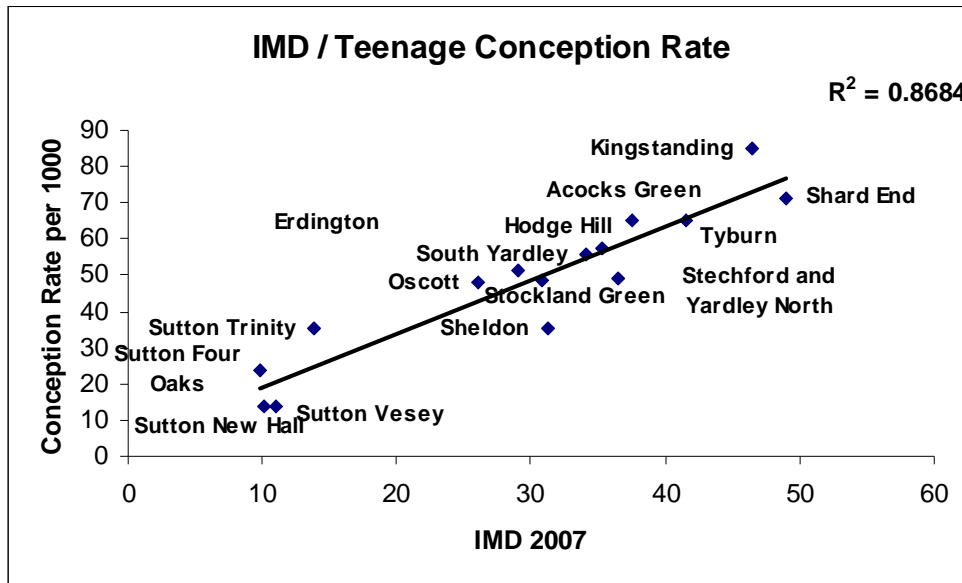
Figures 2 and 3 show the correlation between the deprivation score (IMD 2007) of individual wards and under-18 conception rates. Figure 2 shows all the wards in NHS Birmingham East & North revealing a correlation coefficient of 0.28, suggesting a weak relationship where around 28% of the variation in conceptions can be explained by deprivation. Figure 3 shows the same correlation, but with Washwood Heath and Bordesley Green wards omitted for the reasons stated above. This correlation produces a very high correlation coefficient 0.87 suggesting a very strong relationship between teenage conception and deprivation.

Figure 2 – Correlation of IMD and teenage conceptions 2007/8



Source PCT Information Team

Figure 3 – Correlation of IMD and teenage conceptions – Adjusted 2007/08



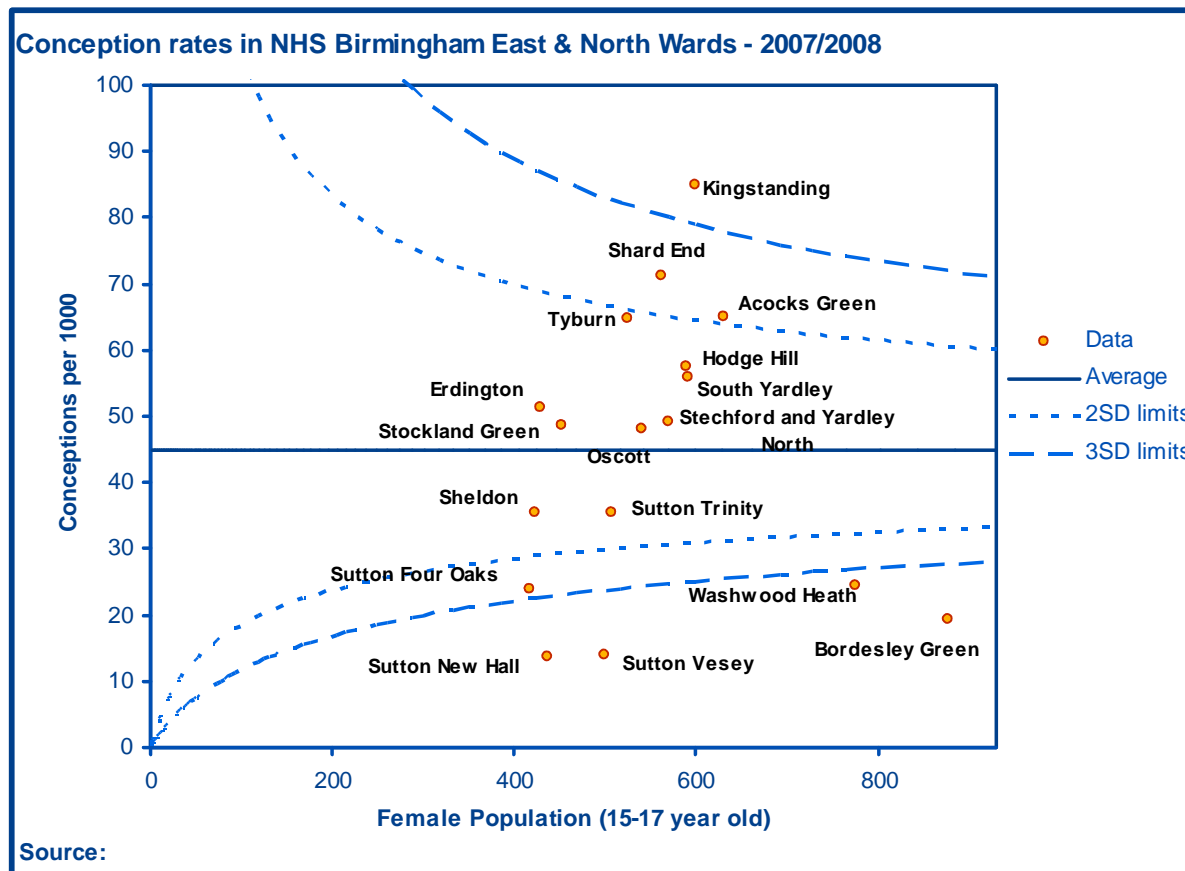
Source PCT Information Team

To understand the local variation in teenage pregnancy rates, it is necessary to further explore the cultural, religious and ethnic issues in sexual health. We also need to consider the type and quality of sexual health education as a factor in teenage pregnancy rates.

Target Wards

To further analyse and identify wards with very high conception rates and requiring interventions, a statistical process control chart (funnel plot) was produced as shown in Figure 4.

Figure 4 – Funnel plot – Conception rates by ward.



Source PCT Information Team

The control limits are set at ± 3 Standard Deviation within which we expect 99.7% of the values to fall. There is less than a one in five hundred chance that a value falling outside these lines would do so purely because of natural variation: there are almost certainly some factor or factors influencing the conception rate that is/are not present across all wards. Kingstanding ward stands out requiring attention as this ward is outside the 3 standard deviation limit. Sutton New Hall, Sutton Vesey, Washwood Heath and Bordesley are also outside by having a low rate of conceptions.

Washwood Heath and Bordesley Green are below the control limit possibly because of higher proportion of ethnic population and religious and cultural issues whilst Sutton New Hall and Sutton Vesey are below the limit because of low level of deprivation.

The chart is used to prioritise work, based on the findings work has been developed within the wards which fall outside the +3SD and then in due course will move to other wards.

Some of the issues above maybe explained by the table below, showing IMD and number of 15-17 year olds per ward (Table 2).

Table 2 – Number / Rate of conceptions by Ward and IMD.

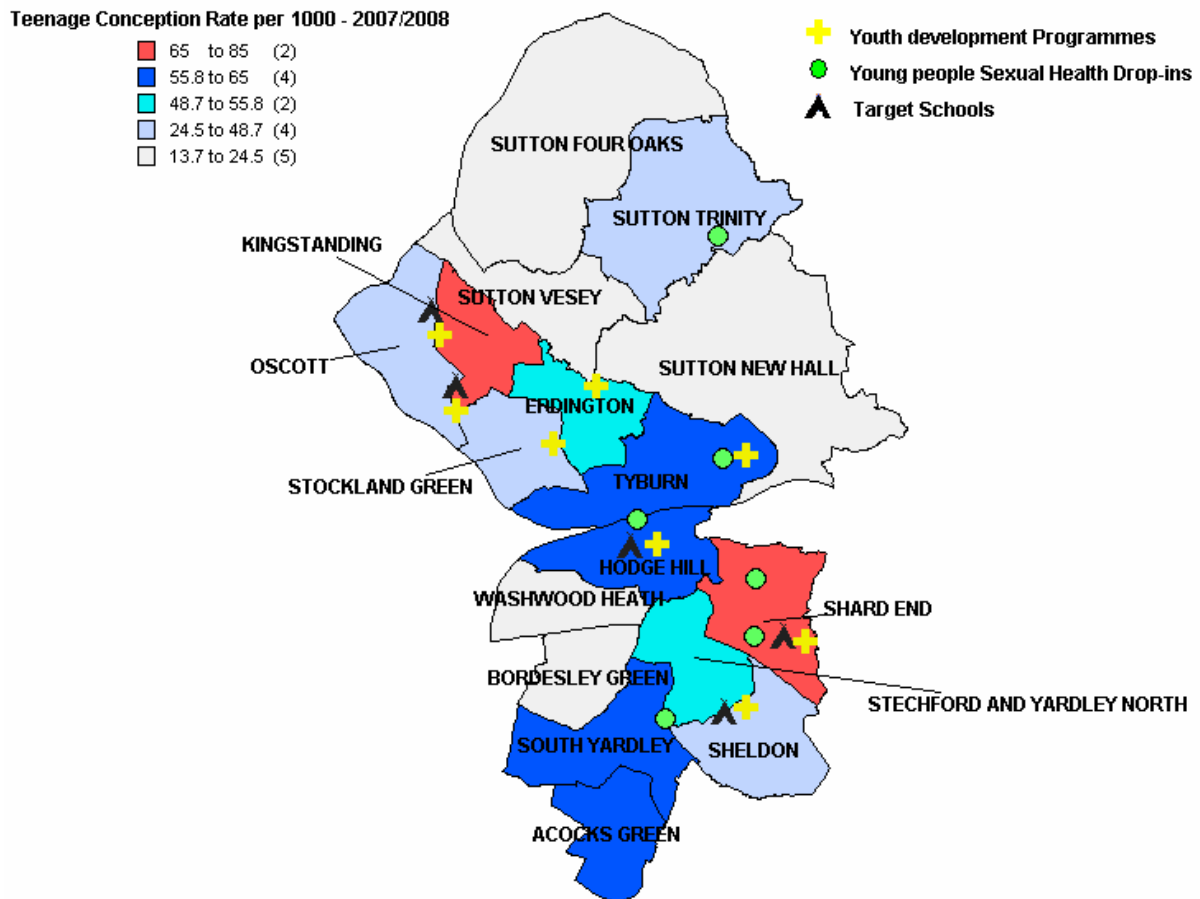
Wards	NUMBER OF CONCEPTIONS (2007/2008)	Number of 15-17 year olds	Rate	IMD 2007
Acocks Green	41	631	64.98	37.59
Bordesley Green	17	878	19.36	48.02
Erdington	22	429	51.28	28.97
Hodge Hill	34	590	57.63	35.28
Kingstanding	51	600	85.00	46.44
Oscott	26	541	48.06	26.06
Shard End	40	561	71.30	49.03
Sheldon	15	423	35.46	31.24
South Yardley	33	591	55.84	34.08
Stechford and Yardley North	28	569	49.21	36.45
Stockland Green	22	452	48.67	30.8
Sutton Four Oaks	10	418	23.92	9.81
Sutton New Hall	6	437	13.73	10.16
Sutton Trinity	18	508	35.43	13.82
Sutton Vesey	7	500	14.00	11.09
Tyburn	34	524	64.89	41.56
Washwood Heath	19	776	24.48	53.37
NHS BEN	423	9,428	44.87	

Current activities, new developments and future needs

The Trusts strategy for teenage pregnancy has produced some success. Conception rates have fallen most significantly in wards that have received targeted interventions (e.g. Shard End and Kingstanding), however there is still a big challenge ahead to maintain the downward trend and to resource work in other high rate wards. Since the merger of the Trusts teenage pregnancy service, it has become a more integrated part of the Trust Sexual Health Strategy and is working closely with Youth Service, Connexions, GPs and Birmingham Reproductive and Sexual Health (BRASH) service.

We need to provide young people with the means to avoid early pregnancy but also have a long term aim to tackle the underlying circumstances which leads to teenage pregnancy, as well as providing support to teenage parents.

Figure 5 – Map of teenage conception rate and current services in NHS Birmingham East & North



Map produced by NHS Birmingham East & North using Digital Mapping Solutions from Dotted Eyes © Crown Copyright and / or database right 2008. All rights reserved. Licence Number 100019918

In the last three years, our strategy has focused on establishing a range of services and projects which reflect the national guidance. Evidence (Next Steps report 2006) has identified 10 key elements which need to be in place to ensure reduction rates in teenage pregnancy can be achieved as outlined below.

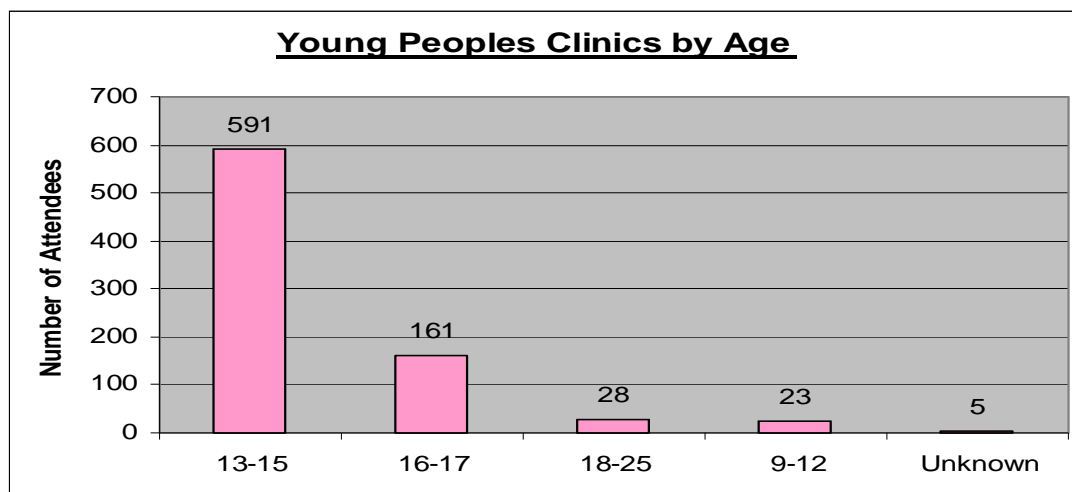
1. Teenage Pregnancy Champions

Within the Trust we have a strategic lead for teenage pregnancy that works with a wide range of agencies and organisations as well as the City Council teenage pregnancy lead.

2. Young People Friendly Contraceptive Service

There are 6 young peoples clinics which offer access to sexual health information, free condoms, pregnancy testing, Chlamydia screening and emergency contraception. Figure 6 shows attendees by age at the various clinics.

Figure 6 – Clinic attendees by age for 2007/08



- 3 schools have full contraceptive services, developed in partnership with BRASH
- 49 Pharmacies provide free access to Emergency Contraception to under 21s
- 1 clinic, Base K/s Youth information shop offers a full contraceptive service
- C Card Condom distribution services are limited within the Trust and needs further development.

3. Strong Messages to Young People and Partner Agencies

The Trust has a strong multi agency partnership group that meets bimonthly and has been instrumental in the development of service and resources for young people.

The Trust has produced the following resources some of which have been adopted as good practice and taken on city wide.

- C Booklet Every teenagers guide to relationships, sexual health and contraception
- Bump 2 Baby A young persons guide to pregnancy, distributed to all pregnant young women under 19 in the trust

4. Workforce Training on Sex and Relationship Education (SRE)

A comprehensive approach to training has been developed within the city with workers from a range of agencies and organisation being able to access free sexual and young peoples training via sexual health promotion. Also the Trust has supported a significant number of School Nurses to complete the National Personal and Health Education qualification.

5. Strong Youth Service

The local Youth Service are key members of the partnership group and work in conjunction with school nurses to deliver drop-in services and youth development programmes. A new full time sexual health youth worker post is being commissioned by the Trust to work in targeted areas along side health service staff.

6. Targeted Sex and Relationship Education (SRE).

In 2008/09, ten schools across the city with high numbers of pregnancies were identified. Five of these are in the Trust and action plans have been drawn up jointly by the schools and the Trust to tackle the issue.

The Trust aims to provide the following:-

- Drop-in services in 4 out of the 5 schools, providing a full contraception service
- An extra 5 hours school nursing time to support the drop-in and curriculum development for Sex and Relationship Education in each school
- Service Awareness Campaign with year 11 pupils in each school
- The development of three full time posts to support the development and delivery of SRE in our targets schools and further education establishments

The development of SRE in schools is challenging, as it has not been part of the national curriculum. However from September 2010 schools will have to deliver a basic SRE programme and this provides us with leverage to encourage schools to develop this area of work.

7. Strong use of Local Data

The Trust generates local teenage conception data from abortion data from Birmingham Pregnancy Advice Service (BPAS), Calthorpe Clinic and child health records. However this should only be used as a trend indicator and does not replace the ONS data, which is not very well timed. This locally generated data provides us with a more timely indication of teenage conceptions at a ward level and helps us plan our interventions and resource allocation.

8. Building Aspiration and Self Esteem

It is important that all agencies recognise their work in contributing to the teenage pregnancy agenda. Self esteem is a crucial part of teenage pregnancy work, is a thread that runs through all the work and specifically within the youth development programmes.

9. Supporting Parents to Discuss Sex and Relationships

The city teenage pregnancy partnership has funded a speakeasy training the trainers programme. Speakeasy is a programme supporting parents to talk to their children about sex and relationships. The aim is to run this programme in our 5 targets schools, one has already started.

10. Sex and Relationship Education (SRE) in Schools and out of School Settings

Seven youth development programmes have been commissioned from Birmingham Youth Service to target hard to reach young people. These provide high quality sex and relationship education and aim to raise young people's self-esteem, confidence and aspirations. These programmes run in hot spot areas and are often linked to the target schools.

The Trust is commissioning three full time posts to:-

- Support the development and delivery of SRE in our targeted schools and further education establishments.
- To develop on site health services including contraception in targeted schools
- To implement the Social Norms project in two of the target schools

Supporting Young Parents

Twenty percent of teenage pregnancies are second pregnancies; therefore intervention with first pregnancies is very important. The following services and projects have been developed and commissioned:-

- Two personal advisors commissioned from Connexions to support and enable young parents to access education training, employment and contraceptive services in order to reduce the number of unplanned second pregnancies.
- Two young parents groups providing young parents with the opportunity to develop confidence and self esteem, and provide important health messages
Young parents drop-in service, one afternoon a week at Base K/s in Kingstanding
- Development of “Bump 2 Baby - A young person’s guide to pregnancy” developed by a group of young moms in Shard End, distributed to all pregnant young women under 19 in the Trust.
- Two part time teenage pregnancy community midwives working with vulnerable pregnant young women

Work with GP practices

Evidence suggests that teenagers visit their GP an average 2 to 3 times a year. For a number of reasons however, their sexual health needs may not be expressed or addressed. In conjunction with Sexual Health in Practice (SHIP) and the Teenage Pregnancy Lead, a pilot “C Card” scheme has been designed and piloted to support practices in initiating contact with their young patients and help to overcome barriers to sexual health.

This pilot has now been extended to incorporate more practices and links with the HPV vaccination for 17 and 18 year old young women. HPV provides a unique opportunity for practices to build a positive confidential relationship with young women and provide them with information about the broad range of sexual health services practices can offer. The aim is to extend this work with GP practices in order that they meet the Your Welcome standards and improve access for young people to sexual health services.

Recommendations

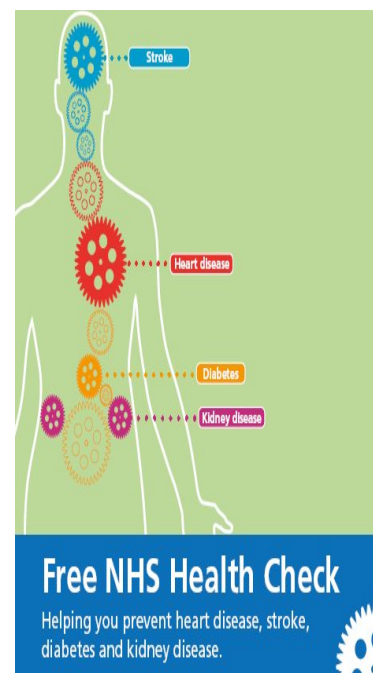
- If we aim to meet the world class commissioning and national teenage pregnancy target there needs to be sustained investment in teenage pregnancy and sexual health service within the Trust
- The success of the teenage pregnancy strategy relies on all local agencies and organisations working together to achieve the target.

- Develop closer links with the identified schools in the hot spot areas and support the development of the SRE curriculum.
- Increase holistic services in targeted schools in order to increase access to contraception and Chlamydia screening
- Develop links with further educational establishment and develop access to sexual health services for young people
- Implement the Social Norms project into targeted schools and evaluate the programme outcome

NHS Health Checks

Introduction

The purpose of this report is to inform NHS Birmingham East and North's board members of the Department of Health's (DoH) introduction of the NHS Health Check programme (formerly called Vascular Checks) which was launched in April 2009. The policy requires all Primary Care Trusts (PCT) to implement a Cardiovascular Disease (CVD) screening and management programme for all residents aged 40-74. The burden of CVD falls disproportionately on people living in deprived circumstances and on particular ethnic groups, such as South Asians. Consequently, CVD accounts for the largest part of the health inequalities in our society. As CVD remains the leading cause of premature death in NHS Birmingham East and North, early prevention, diagnosis and management is vital to the achievement of the Trust's core purpose and goals. This report provides an overview of the NHS Health Check programme, discusses the burden of CVD both nationally and locally, explores the policy's strategic fit with the Trust's core objectives, identifies the Trust's current position in implementing the programme, and identifies some of the key challenges in the programme implementation.



Key Points

- In April 2009 the DoH introduced the NHS Health Check programme, requiring all PCTs in England to implement a CVD screening and management programme for residents aged 40-74 by 2012.
- 51% of the Birmingham population are in the most deprived quintile (20%) nationally. 20.7% of the population is of South Asian ethnicity compared to a national average of 5.5%. As the burden of CVD falls disproportionately in these two groups, CVD prevention and management is a major priority for all Birmingham PCTs.
- Once established, the NHS Health Check programme could prevent 1,600 heart attacks and strokes, prevent at least 650 deaths, prevent 4,000 people a year from developing diabetes and detect at least 20,000 cases of diabetes or kidney disease earlier, allowing individuals to be better managed and improve their quality of life.
- An NHS Health Check Planning and Implementation Group has been established to oversee the introduction of this important programme.
- The CVD Health Improvement team are currently coordinating several pilot projects to test effective and sustainable delivery options to enhance the NHS Health Check programme provided to local residents.

National Picture

On the 1st April 2008 the DoH published a consultation paper entitled 'Putting prevention first'. The document identifies that CVD currently affects the lives of over 4 million people in England. With 36% of all deaths being related to the disease, it is the leading cause of premature death, and is responsible for a fifth of all hospital admissions. The burden of

CVD conditions falls disproportionately on people living in deprived circumstances and on particular ethnic groups, such as South Asians. Consequently, CVD accounts for the largest part of the health inequalities in our society.

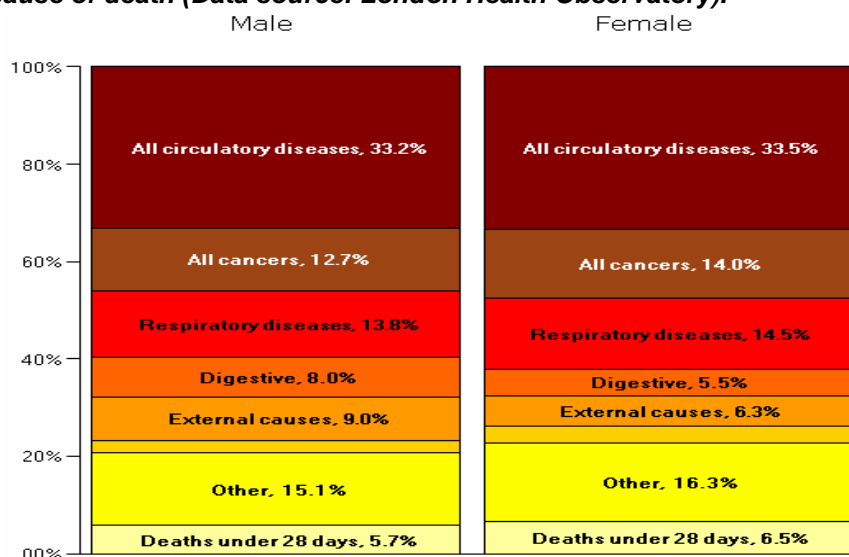
CVD conditions, namely Coronary Heart Disease (CHD), stroke, diabetes and Chronic Kidney Disease (CKD), share a number of common modifiable risk factors. Obesity, sedentary lifestyle, smoking, high blood pressure, high cholesterol and impaired glucose regulation all increase an individual's risk of developing CVD. The UK National Screening Committee has previously provided evidence demonstrating that it is possible to identify CVD risk factors and act to change them. The 'Putting prevention first' (2008) document proposes that early intervention to reduce risk will prevent, delay, and in some circumstances, reverse the onset of vascular disease.

The Burden of CVD in NHS Birmingham East & North

The Life Expectancy Report published in February 2009 by the Birmingham Public Health Information Team identifies that life expectancy has increased in NHS Birmingham East and North over recent years. However, this increase remains lower than that observed nationally and these gaps have been shown to be widening. The Life Expectancy Report (2009) also demonstrates that the Trust has seen the lowest increase in female life expectancy compared to Heart of Birmingham and South Birmingham PCTs over recent years. These findings maybe attributed to the historical focus on male targeted CVD services, particularly as CHD has commonly been perceived to be a male illness.

51% of the Birmingham population are in the most deprived quintile (20% nationally). 20.7% of the Birmingham population are of South Asian ethnicity compared to a national average of 5.5% (The Life Expectancy Report, 2009). As the burden of CVD falls disproportionately in these two groups, CVD prevention and management is a major priority for all Birmingham PCTs. These findings are also reflected in the significant variation in life expectancy observed across our different localities. The Health Improvement Annual Report 2007-2008 identifies that NHS Birmingham East and North have five of the most deprived wards in Birmingham: Kingstanding, Shard End, Washwood Health, Stockland Green and Bordesley Green. Men living in these wards can expect to live up to seven years fewer than men in the less deprived areas such as Sutton Coldfield. Figure 1 illustrates the life expectancy gap between the most deprived quintile and least deprived quintile of Birmingham by cause of death and circulatory diseases account for 33% of this difference in both males and females.

Figure 1: Life expectancy gap between the most deprived and the least deprived population for Birmingham by cause of death (Data source: London Health Observatory).



Aims, Coverage and Justification of the NHS Health Check Programme

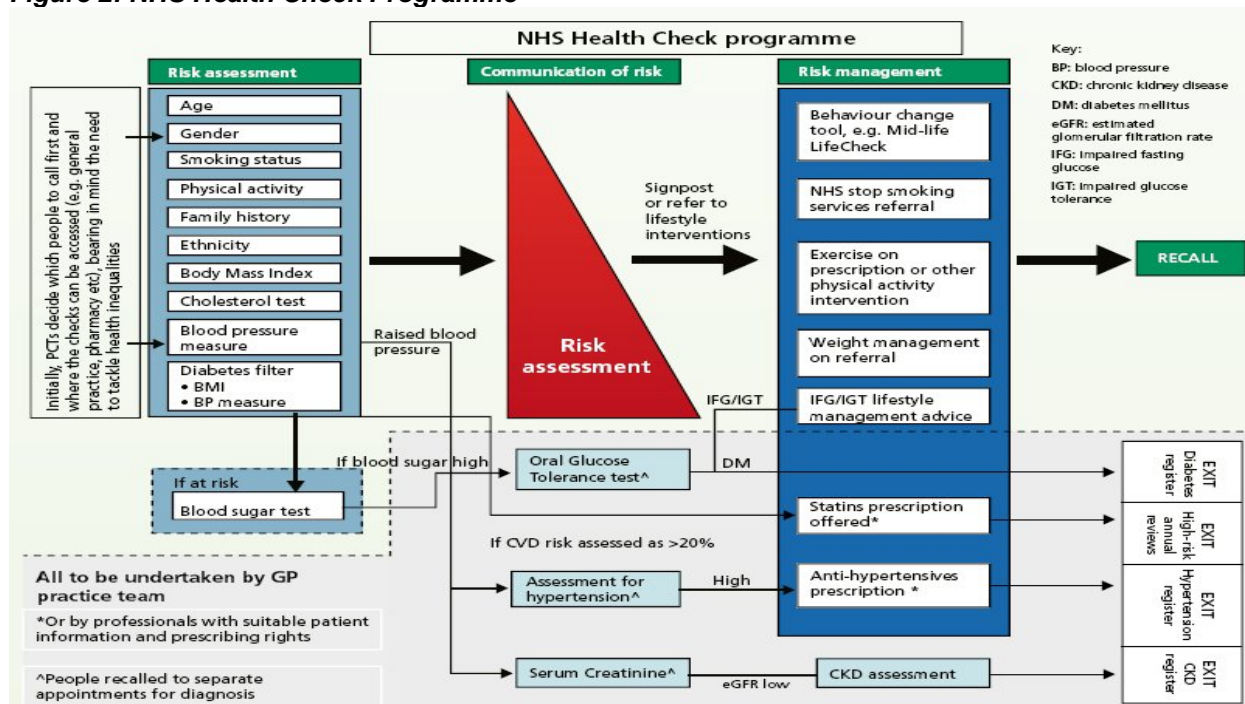
In April 2009 the DoH introduced the NHS Health Check programme, requiring all PCTs to implement a system for systematic review of its population aged 40-74 (excluding those already on a CVD register). The DoH recognise the enormity of delivering such a large scale screening and management programme and have consequently provided an incremental phased role-out approach. However, it is expected that all PCTs will provide the service for appropriate residents by 2012.

The aim of this programme is to identify an individual’s CVD risk and then facilitate a risk reduction management plan. Those identified at low or moderate risk should then be recalled every five years for repeat assessment, whilst those at high risk should exit the programme and receive an annual review. Thus the Health Check Programme will:

- Increase life expectancy
- Reduce health inequalities
- Reduce the CVD burden and allow for investment/disinvestment

The justification for this programme was outlined in the ‘Economic Modelling for Vascular Checks’ consultation paper published in July 2008. It is anticipated that the NHS Health Check programme could on average prevent 1,600 myocardial infarctions and strokes, and prevent at least 650 deaths nationally each year. The programme could also prevent 4,000 people a year from developing diabetes and detect at least 20,000 cases of diabetes or kidney disease earlier, allowing individuals to be better managed and improve their quality of life. The programme’s cost effectiveness was evaluated using the NICE Quality Adjusted Life Year (QALY) model. As all scenarios tested gave a cost per QALY of below £3,000, it has been agreed that this programme will be very cost effective. Figure 2 provides a diagrammatic representation of the vascular risk assessment and management programme.

Figure 2: NHS Health Check Programme



Strategic Fit with other Priorities & Initiatives

The NHS Health Check programme has been designed to fit within the DoH’s wider policy framework, in particular the increasing emphasis on prevention and to further progress work on tackling health inequalities. Vascular Checks (former title for the NHS Health Check programme) are featured in the Next Stage Review, High Quality for All, Our Vision for Primary and Community Care and the Pharmacy White Paper. The key policies and frameworks which the Health Check programme can enhance delivery of are summarised in Table 1.

Table 1: Key policies and frameworks & the NHS Health Check programme

Public Service Agreements (PSAs)	National Service Frameworks (NSF)
<ul style="list-style-type: none"> ▪ Reducing health inequalities (PSA 18.2) ▪ Improving life expectancy (PSA 18.1) ▪ Reducing mortality from circulatory diseases (SR 2004 PSA 1.1 and 6.1) 	<ul style="list-style-type: none"> ▪ NSF for Coronary Heart Disease ▪ NSF for Diabetes ▪ NSF for Renal Disease ▪ National Stroke Strategy
Vital Signs	World Class Commissioning Health Outcomes
<ul style="list-style-type: none"> ▪ Vascular risk score (VSC23) <p>Contribute to the improving health and reducing health inequalities vital signs:</p> <ul style="list-style-type: none"> ▪ the all-age all case mortality rate per 100,000 population; ▪ CVD mortality rate among people under 75 years of age; ▪ implementation of the stroke strategy; ▪ smoking prevalence among people aged 16 or over in routine and manual groups; ▪ health life expectancy at age 65; and ▪ the proportion of people where health affects the amount/type of work they do. 	<ul style="list-style-type: none"> ▪ Health inequalities ▪ Life expectancy ▪ Smoking quitters ▪ Stroke admissions ▪ CHD Management

Implementing the Health Check Programme in NHS Birmingham East and North

NHS Birmingham East and North have been at the forefront of delivering vascular risk assessments prior to the launch of the NHS Health Check programme earlier this year. During 07/08, the Trust worked in collaboration with the Birmingham Health and Wellbeing Partnership (BHWP), Lloyds Pharmacy and local GPs to provide nearly 7,000 vascular risk assessments for men living in the most deprived wards. This project has provided invaluable learning both nationally and locally and will also influence the future NHS Health Check programme local strategy.

A strategic NHS Health Check Programme Planning and Implementation Group has been established to ensure that an effective and systematic programme is delivered across the PCT by 2012. The group has representation from a variety of internal and external stakeholders.

Pilot Sites Established to Deliver NHS Health Check Programme

Two NHS Health Check Programme pilot sites have been established in Bordesley Green, South Yardley and Acocks Green (BSA) and Kingstanding Practice Based Commissioning localities. These localities have the lowest life expectancies and highest incidence of CVD in the PCT. Both pilots have now successfully passed through the PCT’s Gateway process and should start to report back valuable learning to the Strategic Planning and Implementation Group. Table 2 identifies the key service delivery differences between the two pilot sites.

Table 2: Key service delivery differences between the BSA and Kingstanding pilot sites

BSA Pilot	Kingstanding Pilot
Cohort identification and invitation undertaken by individual GP Practice	Remote data extraction to be performed weekly for cohort identification and invitation undertaken by Kingstanding Locality Workforce
No alternative appointment service provided	Those declining a practice based appointment will be sent a voucher to attend an opportunistic pharmacy based service as an alternative option
Health Check appointment delivered by the patients registered practice team	Health Check appointment delivered by Kingstanding Locality Workforce
Lipid profile analysed using local laboratory services (Results not immediately available)	Lipid profile analysed using Near Point Testing (Results immediately available)
General advice given but no risk score provided at the first appointment (Results communicated via letter or further appointment once blood results returned and risk score calculated)	Risk score calculated at appointment and information relayed to patient immediately (One-stop Appointment)
Health Check appointment results entered into the clinical records using standardised clinical template	Health Check appointment results entered into the clinical records using N3 Connection via a locally developed IT solution, thus allowing assessments to be performed outside of the registered practice
Life style referrals made using existing referral pathways	Life style referrals made using IT solution, providing paper free referral system

Other programmes, Pilots and partnerships

The NHS Health Check programme is one of the largest preventive screening and intervention programme ever delivered by the NHS. Not only does the Trust need to commission a service to deliver 108,795 Health Checks over the next five years, but also ensure that individuals have access to evidence based life style management, diagnostic and intervention services. A Health Check service which only delivers the clinical assessment will be sure to fail in achieving the programme’s full potential to make significant inroads to increasing life expectancy and reducing health inequalities in our PCT.

As a result, the Health Improvement team is working with several stakeholders and external partners for an effective delivery of this programme. Table 3 highlights some of the key pilots, programmes and partnerships being developed to support the PCT’s long term strategy for delivering the NHS Health Checks programme.

Table 3: Pilots, Programmes & Partnerships

BSA Health Check pilot	IT solution being developed with independent partner to allow data posting using N3 Connection and development of paper free referral system	Audit completed to identify access to non-invasive cardiac investigations such as ECG and 24 hour blood pressure monitoring
Development of a NHS Health Check call and recall pilot with Health Intelligence + BHWP	Kingstanding Health Check pilot	Pilot using Near Point Testing to provide immediate cholesterol results, providing a one-stop based service
Funding received from the DoH to provide education and training for the workforce delivering the Health Checks programme	Health Incentives programme being explored in partnership with The Young Foundation	Opportunistic voucher pharmacy Health Check pilot
Social marking for Health Check programme performed by Dr Foster Intelligence	Working in partnership with Kidney Research UK with a DoH grant of 95k to increase awareness of CVD risk factors and NHS Health Checks	Considering partnership with Flora to deliver an online behavioural change programme
Be Active programme exploring physical activity strategy	Weight reduction programmes being piloted such as Weight Watchers and Slimming World	

Key Challenges and Concerns

NHS Birmingham East and North are committed to reduce health inequalities and increase life expectancy for its local population, which is demonstrated in the Trust's purpose and objectives. The Trust Board should therefore acknowledge the huge potential this new policy has in assisting the Trust achieve these objectives. If delivered sensitively, the programme has the potential to substantially contribute to key delivery targets for the PCT. However, there is the risk for this programme to be provided and taken up disproportionately within the community. Commonly in the NHS, areas of greatest need get a poorer service and uptake is low; thus a programme aimed at reducing inequalities can end up exacerbating them. Consequently, how this programme is delivered within the Trust will dictate whether it is successful in tackling key health inequalities.

Table 4 reflect the programmes key challenges and concerns identified at a recent Trust workshop which captured the views of health professions, commissioners and members of the local community.

Table 4: Key Challenges and Concerns

- A poorly designed or delivered Health Check programme could result in a widening of the health inequalities gap.
- The predicted reduction in NHS financial growth could result in the Health Check programme being diluted or postponed.
- This programme is at risk of being viewed/delivered as a screening programme rather than an assessment and lifestyle management programme, therefore not delivering its full potential.
- The increasing screening culture needs to be joined up as we are at risk of developing silo programmes.
- Adequate capacity to lifestyle interventions, diagnostics, and treatment is critical to delivering an effective prevention programme.
- A national call and recall system is yet to be developed to support this programme.
- Investment in future workforce capacity and training will be of real importance.

These concerns are being explored further by the Health Improvement team and the NHS Health Checks Strategic Planning and Implementation group. However, the board members are requested to support the team in implementing this important but challenging programme.

Summary

This report has been produced for the purposes of updating NHS BEN Trust board. The report identifies that in many areas of Health Improvement the Directorate has produced strong levels of performance and achievements and have clear action plans in place to address poorer performance. The report has presented several examples of the services that are currently commissioned by BEN Health Improvement Directorate. It is clear from this report that all services are designed using a strong evidence base and an approach that will reach all of the population Birmingham East and North in particular those who are most vulnerable. The Health Improvement Directorate continue to work towards achieving both local and national targets and have a clear strategic vision that will realise better levels of health across Birmingham as a whole but in particular in areas where there is greatest need.