

**Annual Public Health Report  
Lambeth 2007/08**

**Health Needs and Outcomes**

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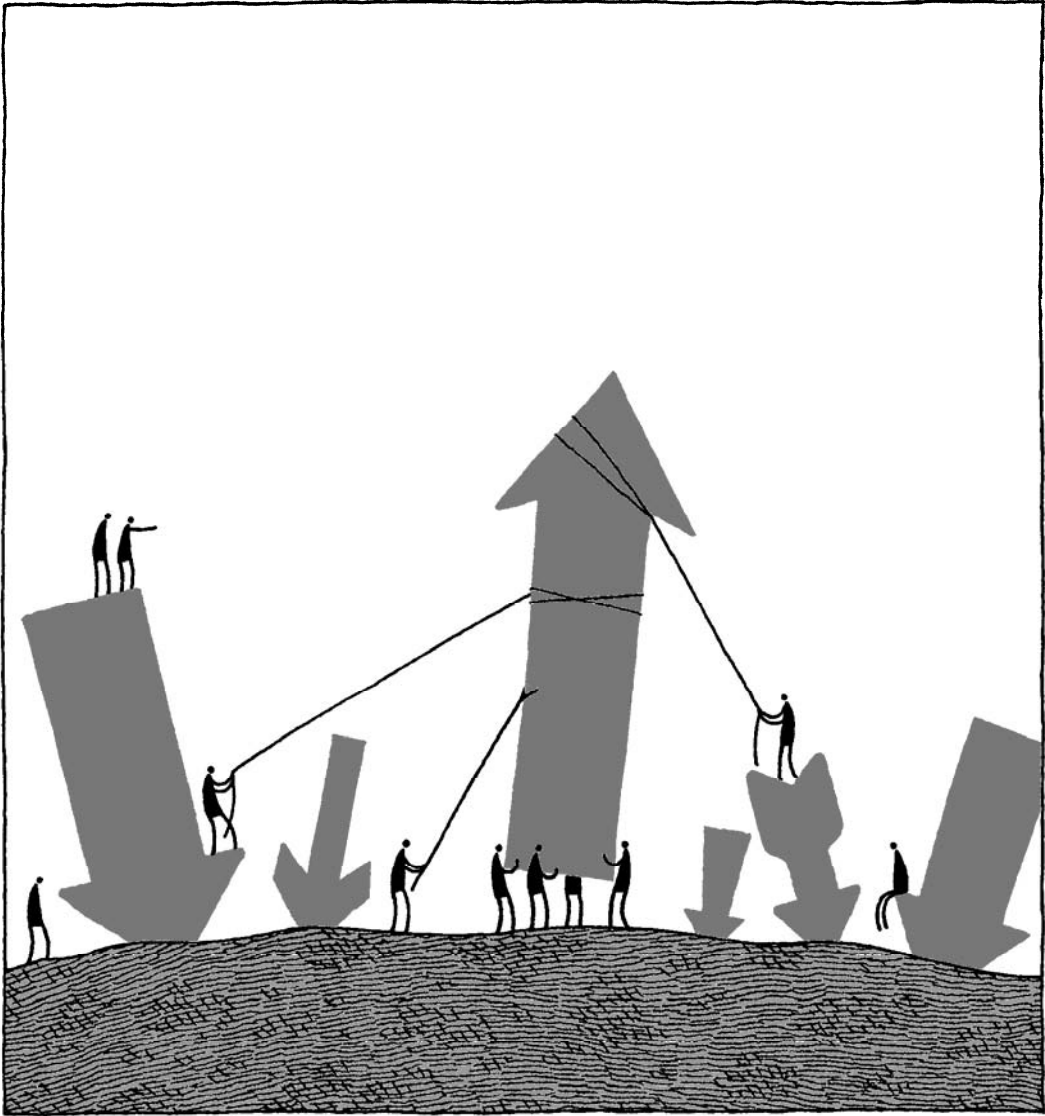
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In order to illustrate some of the themes and concepts inherent to public health, this report is punctuated by the illustrations of the nationally renowned illustrator and cartoonist Tom Gauld. Taking key themes and topics, such as measurement, complexity, priorities and equity as his starting point, we believe that Tom's illustrations add enormously to the report, bringing a fresh perspective to many of the issues taken for granted in the modern NHS. We hope that you will find them intriguing, illuminating and inspiring in your thoughts about public health in Lambeth.

## **Preface**

This report focuses on the different elements that inform our understanding of health needs in Lambeth, helping us to set priorities and agree the health outcomes which reflect these.

Lambeth is a place with high levels of health need, reflecting many different health issues including poor mental health, disability and premature mortality. There are significant inequalities between health in Lambeth and health in other parts of London and England and Wales. There are however now a number of areas where health is improving (these include teenage pregnancy, childhood immunisation and cancer mortality). The PCT and its partners are investing resources in improving health, and have made Staying Healthy one of the strategic priorities over the next five years. The focus of the Sustainable Community Strategy on worklessness provides an important opportunity to improve health and wellbeing for local residents.

Working effectively with partners is fundamental to improving health; work on Joint Strategic Needs Assessment provides an opportunity to develop a better understanding of local health issues, including the perspectives of local people, and to work towards outcomes which really matter in Lambeth.

Ruth Wallis  
Director of Public Health  
September 2008

## Introduction

Lambeth is a unique borough. It has the vitality of central London, with one of the most diverse and densely concentrated populations displaying extremes of affluence and poverty. It is home to some of the most recognisable landmarks in London, as well as some of its least known backwaters. Challenges are presented by its rapidly growing and changing community, home to some of the most deprived areas in the country, sitting alongside those of both relative and real affluence and privilege.

Providing and commissioning the best in healthcare for Lambeth's population, and tirelessly working to reduce the barriers to good health for all within the borough will always be a challenge with finite resources. Assessing needs to enable prioritisation is key to decision making at all levels within Lambeth PCT and amongst its partners, especially in their aim to deliver high quality services in the most equitable way. With stacks of national targets to meet, and recognising the complex needs of the local population, Joint Strategic Needs Assessment offers the PCT and its partners the opportunity to focus on these, and to commission the services needed to achieve the maximum of health outcomes for the local population.

Reducing the burden of disease and the unjust and unacceptable inequalities in health drives the prioritisation process in Lambeth. Equity and fairness are important concepts also, to ensure that the "inverse care law" (where those with the least health needs receive most health service), is reversed so that those with the highest needs are prioritised.

Public health skills and knowledge are essential to unlocking the inherent dilemmas and determining the priorities for healthcare and for a healthier more inclusive community in Lambeth. The public health directorate at Lambeth PCT uses these skills and knowledge and disseminates them widely, increasing the capacity of partners both within the PCT and outside to skillfully employ the best evidence to assess needs, reduce inequalities and prioritise interventions with best effect. Methods used to assess need and set priorities include:

- Epidemiology to assess the burden of disease;
- Health needs assessment - defined by the ability to benefit from interventions and using an epidemiological approach. This includes an assessment of cost-effectiveness, corporate and comparative analysis and a focus on outcomes;

- Health equity audit – identifying how services respond to the needs of different groups and communities with different health needs;
- Patient and public involvement – giving the local people a voice and the power to influence local service planning and delivery;
- Drug appraisals – where new drug treatments are assessed for strength of effectiveness; and
- Exceptional treatment arrangements - where services not normally commissioned by the PCT can be commissioned for a patient in exceptional circumstances.

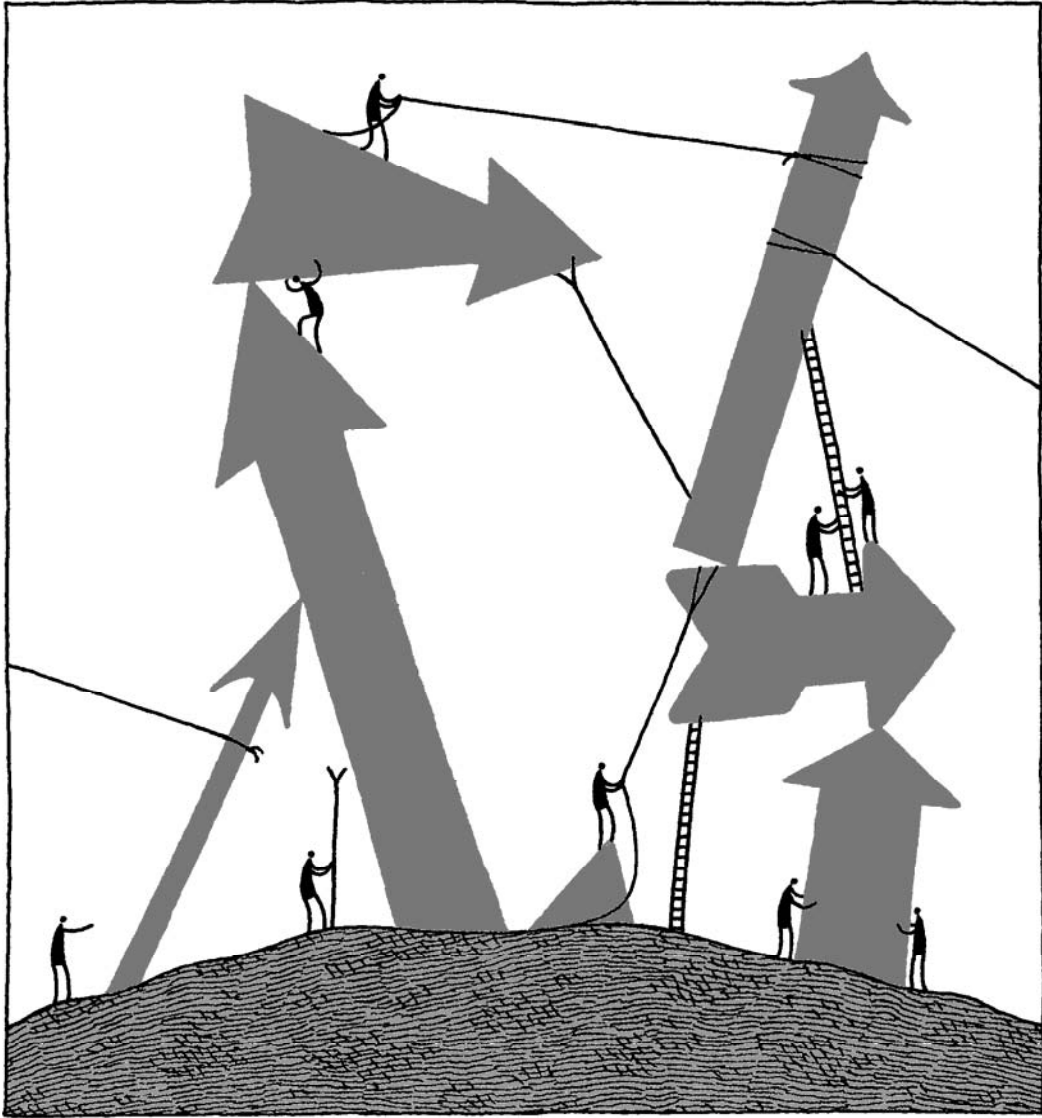
These tools and methods are set out in the report and examples are given to illustrate the broad range of interventions and actions undertaken in Lambeth as well as the dilemmas faced.

Health improvement and healthcare cannot be delivered by the NHS alone. Partnerships between NHS organisations and Local Government, the independent sector and the voluntary and community sector are critical, and Joint Strategic Needs Assessment (JSNA) between Lambeth Council and the PCT can only strengthen the already strong joint working arrangements.

The PCT has recently set out new commissioning priorities for the next five years, developed in conjunction with patients and the public, and which set out the broad themes for priority activity. These are: staying healthy; mental health; and end of life care. These are supplementary to the existing three priorities of sexual health, children and young people, and long term conditions.

The PCT is developing detailed plans under each of these three new priorities, informed by the best of available data on the local population and their health. This is summarised for readers of this report as a statistical appendix.

Recommendations are set out in this report to highlight the necessary steps for the PCT and its partners in the year ahead.



# **Chapter 1. Population Need**

## **1.1. Living in Lambeth**

Public health data is collated by various bodies including the Office for National Statistics, Department of Health, Local Authorities and other partners. This section briefly summarises the health profiles of Lambeth residents and what the current data tell us about health and well-being in Lambeth in terms of the wider determinants of health.

The minimum dataset required to understand the local statistics is included with this report as Appendix 2. Please refer to the Appendix for detailed statistics and description of main health and well-being indicators.

### **Inner city London**

Lambeth is an inner London borough comprising of 21 wards with six major town centre areas namely, Brixton, Clapham, North Lambeth, Norwood, Stockwell, and Streatham. The Census area classifications describe Lambeth as a “London cosmopolitan area” similar to Southwark, Lewisham, Hackney, Islington, Haringey and Brent.

### **Population profile**

Lambeth is one of the most densely populated boroughs in the country with a rapidly growing population. The resident population is projected to grow by a further 15% to 317,000 by 2028. Lambeth has a high proportion of young population compared with the rest of the country with approximately 50% of individuals in the 20-44 age group.

### **Deprivation**

The 2007 Index of Multiple Deprivation places Lambeth as the 5th most deprived borough in London and 19th most deprived in England. Poverty and social exclusion are challenges in the borough. One in twenty Lambeth residents live in fuel poverty and the proportion of children and young people living in poverty is higher than average. It is estimated that 40% of Lambeth workers are well qualified (at NVQ level 4 or better) and the average income is above national average. However, there are high numbers of economically inactive people living in Lambeth and among adults seeking jobs, 60% have no qualifications or low level qualifications.

## **Worklessness**

Lambeth has recognised worklessness to be a major barrier to success and a key factor in poverty and exclusion. There is a clear link between worklessness, poor health and education standards, low aspirations, higher crime and communities which are less integrated.

Tackling worklessness therefore will be an important consideration for the coming years. The benefits of tackling worklessness will be to make improvements in financial prosperity, improve community interaction, improve living standards and promote economic activity. Focussing on worklessness is now a priority in Lambeth's Sustainable Community Strategy (2008-2020).

## **Diversity**

Lambeth is highly ethnically, socially and economically diverse and there is high mobility within and outwith the borough every year. Lambeth's Black and Minority Ethnic (BME) community account for 35% of the borough's total population

## **Mobility**

The high mobility within the borough poses challenges in measuring life expectancy and reductions in premature death rate. In this respect, Lambeth is similar to the inner London boroughs of Lewisham, Hackney, Tower Hamlets and Newham. In terms of internal migration, Lambeth has the highest outflow of London boroughs with 10.6% of population, whereas it stands in the fourth place in terms of inward internal migration, at 8.6%.

## **Wellbeing indicators**

As happiness and mental wellbeing depend on different factors, it is important to measure at least some of these to understand how mentally healthy a population is (as opposed to how many people suffer from poor mental health or mental illness). Some of the factors in the table are being measured by local partners such as perceptions about crime in Lambeth and numbers of people involved in volunteering. Fear of crime remains high in Lambeth relative to falling reported crime levels and improving detection rates.

Figure 1 lists some specific objective health and wellbeing indicators showing whether they are improving or worsening in Lambeth compared either with previous values or with the national average.

**Figure 1: Health and wellbeing indicators**

<b>Health indicators</b>		<b>Status in 2007*</b>
	Life expectancy - Males	Improving
	Life expectancy - Females	No change
	Infant mortality rate	Improving
	Deaths from alcohol related conditions	No change
	Deaths from cancer < 75 years - males	Improving
	Deaths from cancer < 75 years - females	No change
	Deaths from heart disease <75 years - males	Improving
	Deaths from heart disease < 75 years - females	Improving
	Teenage pregnancy rate	Improving
	Smoking prevalence	Improving
	Obesity in children	Worsening
	Obesity in adults	Improving
<b>Socio-economic indicators</b>	Employment rate	Worsening
	Children in poverty	No change
	Reported crime	Improving

\* The performance status mentioned for the above indicators is a comparison of the previous year's data to the latest available data which is either 2006-07 or 2006. For certain indicators such as death rates from cancer or circulatory diseases a three year rolling average is the appropriate comparator which is used to describe the performance status (e.g. 2003-05 compared with 2004-06).

### **Life expectancy**

Male life expectancy in Lambeth has shown more improvement compared with the female life expectancy, although nationally, life expectancy is improving at a faster rate compared with the spearhead PCTs which includes Lambeth PCT. (Spearhead PCTs are 20% of PCTs in England with the highest levels of deprivation).

### **Birth rate**

The birth rate in Lambeth is high and has been rising since 2001. The exponential projections show a transient rise in the number of births until 2013.

### **Infant mortality**

Deaths of infants aged under 1 year have fallen from 8.8 per 1000 live births in 1995-97 to 5.8 per 1000 live births in 2004-06 - a reduction of over 26%. However there still is a need for further reduction in the gap between local and national rate.

### **Teenage conception rate**

Lambeth has amongst the highest rates of teenage conception in England, which is now beginning to reduce significantly. The teenage conception rate has dropped from 86.6 per 1000 females aged 15-17 years in 2004 to 78.1 per 1000 females in 2006.

### **Healthy lifestyles**

Lifestyle issues such as high smoking prevalence; worsening obesity levels related to poor diets and lack of physical activity; and alcohol and drug misuse are having a major impact on Lambeth residents. These are associated with poorer health outcomes such as higher levels of mortality and morbidity related to, for example, chronic liver disease, renal disease and diabetes. In addition, Lambeth has one of the highest incidences of mental health need in London.

### **Smoking**

Smoking prevalence in Lambeth is high, especially in deprived areas and amongst people of lower socio-economic groups or in manual occupations. Estimates show that up to 350 residents may be dying due to smoking related conditions per year. However, it is notable that between April 2005 and March 2007 around 3,000 people attempted to give up smoking using NHS stop smoking services, with a success rate of around 50%.

### **Alcohol and drugs**

Alcohol and substance misuse is a general problem in the borough. It is estimated that 23%-24% of Lambeth's population (70,000 approx.) drink excessively and Lambeth has higher levels of alcohol-related hospital admissions than both London and England. Mortality from alcohol-related conditions in Lambeth is statistically higher than for the rest of London for men (68 people compared to 52 in London and 50 in England per 100,000 population) and somewhat higher for women (31 people compared to 27 in London and 28 in England per 100,000 population).

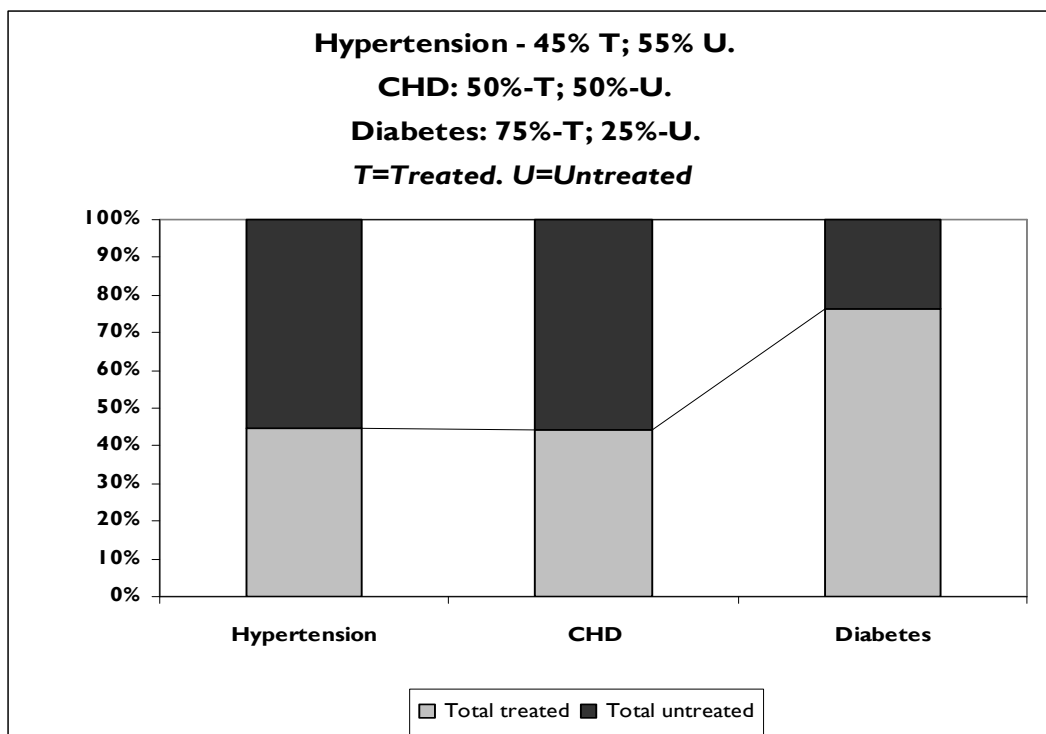
### **Obesity and physical activity**

It is estimated that 30.3% of Lambeth adults eat a healthy diet. This is in line with the average for London and above the national average of 26.3%. The level of adult obesity in Lambeth (18.6%) is lower than the England average (23.6%), probably as a result of the higher than average levels of physical activity in Lambeth. However, obesity in children aged 10-11 is high with up to 1 in 4 obese. 13.3% of children at reception level are obese in Lambeth compared with 11% in London, and 9.9% in England.

## Hypertension prevalence

Similarly the case detection rate of hypertension in Lambeth residents is around 9% compared to 11.3% nationally. There are estimated to be over 34,000 individuals in Lambeth with hypertension who are undetected and who need to be treated to avoid development of coronary heart disease.

**Figure 2: Modelled prevalence versus detected prevalence**



Source: QMAS - Quality Management Analysis System – 2008

PBS: Prevalence models for Hypertension, CHD and diabetes. Reference in Lambeth APHR 2007-08.

## Coronary heart disease (CHD) prevalence

The case detection rate of CHD in Lambeth residents is 1.3% compared to 2.3% nationally. There is estimated to be over 5000 individuals in Lambeth with CHD who are undetected and who need treatment to avoid premature complications and/or death.

## Premature deaths from circulatory diseases

Overall there has been a 33% reduction in mortality rates from circulatory disease in Lambeth (2004-06) from baseline year 1995-97. For men there has been a 32% reduction in mortality from circulatory disease and for females 36% reduction. Overall there has been a 4% reduction in the absolute gap from circulatory disease between Lambeth and England and Wales (2004-06).

## **Diabetes prevalence**

The case-detection rate of diabetes is around 3% which is similar to the national average. However, it is estimated that over 1000 people may still have undetected diabetes and be in need of treatment. Undetected disease is a serious issue in Lambeth, and makes a significant contribution to ill health and premature mortality. It is linked to inequality – especially as it disproportionately affects men and black and minority ethnic communities.

## **Premature deaths from cancer**

Overall there has been a 19% reduction in deaths from cancer in Lambeth (2004-06) from the baseline year of 1995-7, with deaths for males reduced by 17% and for females by 21%. Overall there has been 33% narrowing of the absolute gap (2004-06).

## **Mental ill health**

In Lambeth common mental illness is widespread however, it is difficult to estimate levels of anxiety and depression and other common mental health problems using local data. National survey data (ONS 2000) suggest that about 38 800 adults in Lambeth are experiencing these types of symptoms. Over 24 000 of these are probably sufficiently severe to need treatment. In adults there are marked differences between men and women and for different ages. Between 1000 and 1600 people over the age of 75 years in Lambeth may experience symptoms.

In March 2008, 3941 patients were known to primary care to be experiencing severe mental illness (mainly schizophrenia). This equates to almost 1.2% of the adult GP registered population. The number is likely to be an underestimate because some people are not being followed up in primary care or not registered with a GP. There has been an increase in this figure over the last 3 years but GPs have only recently started recording serious mental illness so the most likely reason for the increase is improvement in recording.

## **Health inequalities**

Health inequalities in Lambeth are high compared to other boroughs in London as well as England; as observed through health indicators such as infant mortality; teenage pregnancy; childhood obesity; primary and secondary school permanent exclusion levels; and the proportion of 16-18 year olds who are not in education, employment or training.

## **Wellbeing**

Mental wellbeing is about how people think and feel. It is subjective but strongly influenced by things that can be changed. The new economics foundation suggests that there are four

elements to wellbeing (see diagram below). all of which can be measured. For instance, in the top left box, personal feelings can be measured by asking people directly using different types of questionnaires. An assessment of how people feel about the social sphere (the top right box) can be also measured by asking people for instance about their experience of their neighbourhood or about friendships and support networks. It also includes the extent to which people gain a sense of being valued at work so employment levels can be important. People’s ‘personal functioning’ (bottom left box) can be measured by assessing their skills, and educational background and asking them about their motivation and levels of control especially in work or financial terms (people in poverty have much less control over their life). The bottom right box is about how society functions; are people actively contributing to civil society? To what extent do people belong to community groups, vote or volunteer? Do employers put something back into the local community?

**Figure 3: Table showing the four elements of mental wellbeing, as proposed by the New Economics Foundation; [www.neweconomics.org](http://www.neweconomics.org))**

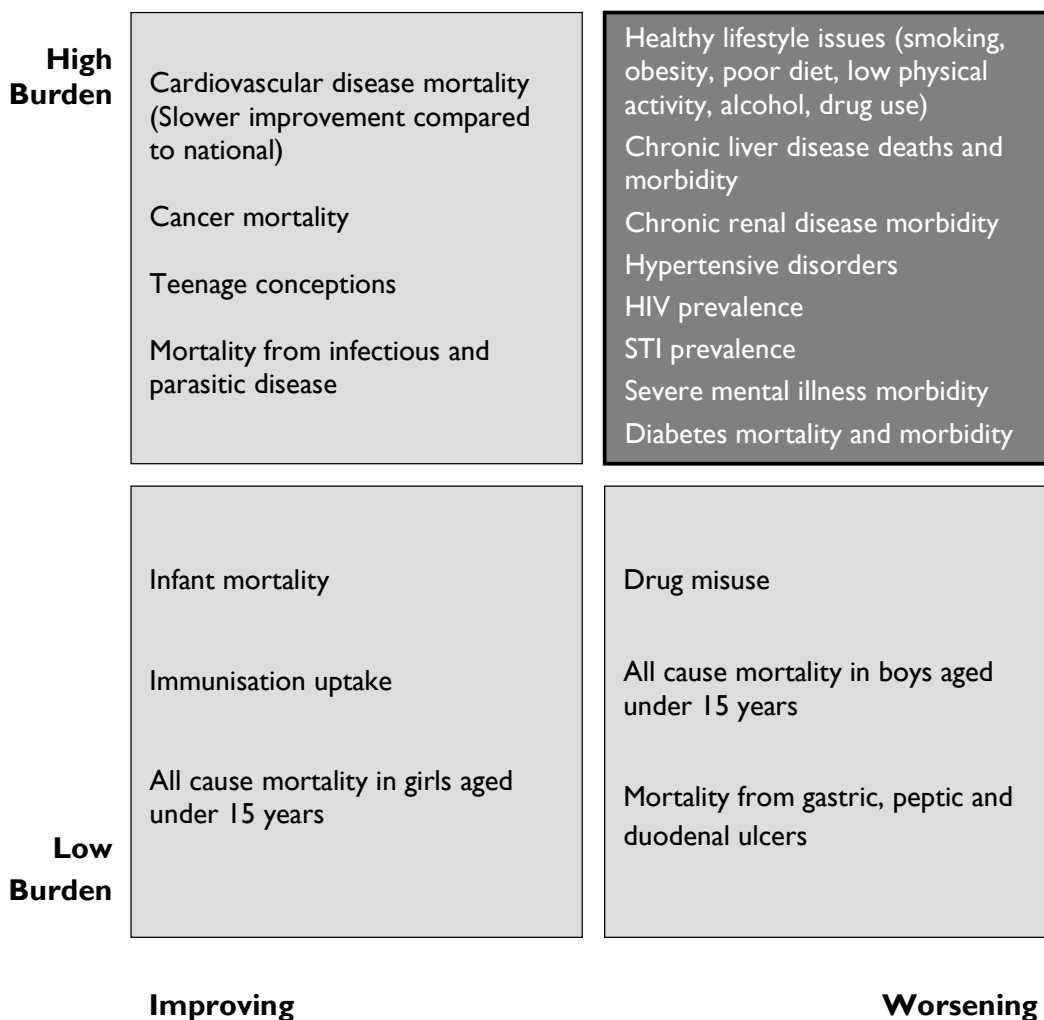
	<b>Personal wellbeing</b>	<b>Social wellbeing (interpersonal)</b>
<b>Feeling (having, being)</b>	Happiness Satisfaction (life, job, income) Depression Optimism Self esteem	Belonging Social support Respect Fear of crime
<b>Functioning (doing)</b>	Autonomy Competence Interest in learning Goal orientation Sense of purpose Resilience	Social engagement Altruism Caring

In Lambeth a measuring wellbeing handbook has been developed which is available for use by voluntary organisations, employers or projects to assess the mental wellbeing of staff, clients, members etc. As part of the Local Area Agreement many of the elements above are being measured in one way or another. A review undertaken by the New Economics Foundation for Lambeth recommended which of these measures could be used to measure mental wellbeing more directly in Lambeth. The aim is to develop a ‘wellbeing report’ for Lambeth based on some of these and other measures.

**Hiten’s Red Box**

The Red Box is informed by detailed epidemiological assessment and highlights the areas of high burden where the status is worsening for priority attention. Hiten’s Red Box informed the PCT’s Commissioning Strategy Plan (CSP), which was then further shaped by the views of local people through a citizen’s forum event.

**Figure 4: Hiten’s Red Box**



**The Commissioning Strategy Plan**

This is a five-year plan setting out the PCT’s objectives for the commissioning of services for the period 2007-2012.

**Methods**

Lambeth PCT commissioned external consultants to organise a Citizen’s Forum for Lambeth residents and enable a sample of the local population to engage with the content of the CSP.

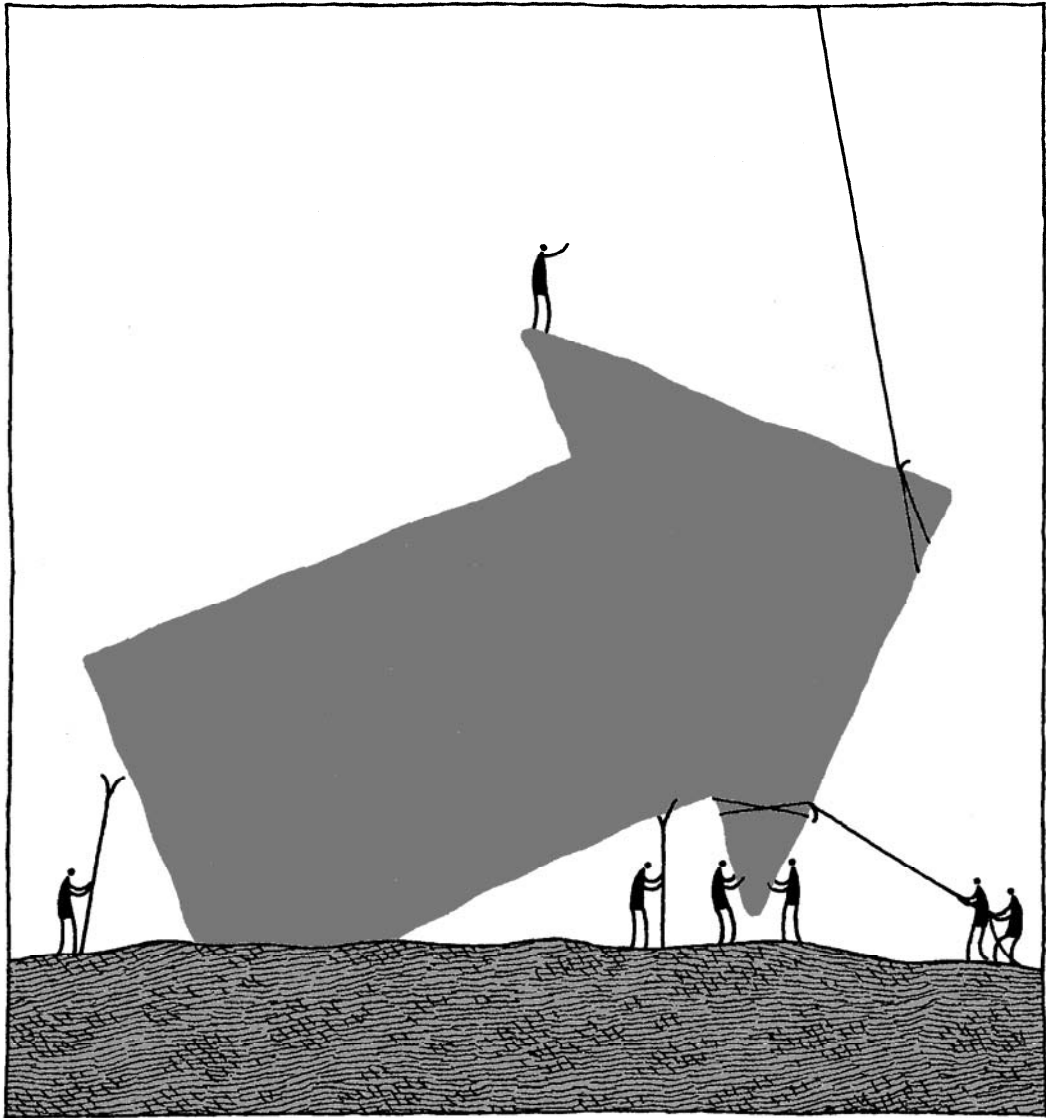
116 residents were recruited on-street for the event, to reflect the particular demographics of the borough. To ensure this mix, potential participants were asked to complete a recruitment questionnaire, with questions relating to their occupation, household composition, age, ethnicity and quality of health.

A further 30 participants were recruited from traditionally excluded or marginalised groups, which include older people, specific patient groups, minority ethnic groups and young parents. These were recruited through Lambeth-based community and voluntary sector bodies and organisations, which identified and invited service-users on behalf of the PCT. Both recruitment phases were limited to English speakers. 105 people attended the event. 79 of these were drawn from the on-street recruitment and the remaining 26 were service users or representatives from traditionally excluded or marginalised groups. A cash incentive was offered to all participants.

### **Results and main findings**

The Citizen's Panel reported the following findings:

- There was difficulty in accessing healthcare services (both GP and hospitals).
- There was a perception that the PCT could do more to communicate better with the public and other key stakeholders on an ongoing basis.
- Respondents emphasised the importance of working closely with the council & the voluntary sector to achieve improvements, recommending improved joint working.
- The needs of children with disabilities were not felt to be adequately addressed by the CSP.
- The importance of working with and placing services within schools to achieve the objectives described for the Staying Healthy and Children and Young People's strategies.



## **1.2. Clinical and cost effectiveness**

Clinical and cost effectiveness are the tools used to assess the magnitude of health benefit and costs incurred to produce that health benefit. An intervention can be clinically effective but have low cost-effectiveness because it is very expensive. This is exemplified by some of the new drug treatments for cancer.

A large number of new drug treatments have become available in the last few years. Many of these drugs are to treat patients with advanced cancer and will not cure the disease but may add a few months of life and improve quality of life. They are usually very expensive and attract considerable media attention. The National Institute of Health and Clinical Excellence (NICE) issues guidance on many of these drugs and PCTs are required to fund drugs that have been approved by NICE. However, NICE does not currently consider all new drugs and for the ones that they do there is often a considerable time period between the drug being licensed and NICE issuing guidance. This means PCTs are faced with difficult decisions about whether to fund routinely these new treatments that NICE is not considering, or treatments before NICE has made a decision. PCTs across the country have made different decisions on which drugs they will routinely fund according to their local priorities and financial position. This has produced what has been termed the 'postcode lottery'. This should not be considered a criticism of individual PCTs as it is a product of a system that allows some local decision-making based on local need. In other words, unless all funding decisions are made centrally there will always be different treatments available in different places.

If a PCT decides not to routinely fund a new drug, patients and their doctor can still apply to receive the treatment through the Exceptional Treatment Arrangements (ETA) which considers treatments for individual patients. However, the 'postcode lottery' extends into the ETAs as different PCTs make different decisions on individual cases and individual drugs.

Currently there is a national discussion on whether patients should be able to pay privately for the latest drug for their condition if it has not been approved by NICE and still receive the remainder of their care funded by the NHS. Presently patients have to opt either to receive the treatment offered by the NHS, or opt to be treated privately for their whole package of care. The debate is polarised between patient choice on the one hand and maintaining equality on the other. Both of these are legitimate but it is difficult to see how both can be satisfied at the same time when funding is finite. A decision is expected in October 2008. Whatever the outcome it is likely there will be increasing scrutiny on how the PCT makes funding decisions for new drugs and other technologies as there is

considerable coverage in the media on this issue. Lambeth and the other SE London PCTs have developed a strategy to fund new cancer drugs in SE London in 2007/08, which is described below.

### **Prioritisation of new systemic cancer treatments in South East London**

The South East London Cancer Network (SELCN) was asked by PCTs in SE London to work to prioritise new cancer drug regimens to inform commissioning of cancer services for 2008/09.

### **Methodology**

A prioritisation tool was designed which built on an earlier tool developed in 1998 in S. E. London, published in the British Journal of Cancer in 2000. The new tool was tested on five cancer drugs for which NICE had published technical appraisals, three of which were positive and two which were negative. The tool correctly discriminated between those drugs recommended by NICE and those not recommended.

The tool has five domains of effectiveness and a rating of the strength of evidence to support effectiveness. Each domain attracts a numeric score on a sliding scale and the rating of strength of evidence from A to U. The highest possible ranking is 20A i.e. strong evidence of high clinical and cost-effectiveness, with the lowest ranking 0A i.e. strong evidence of low clinical and cost effectiveness.

Domains of the prioritisation tool:

- 1 Magnitude of benefit
- 2 Quality of life
- 3 Place in treatment pathway
- 4 Alternative standard treatment
- 5 QALY (Quality Adjusted Life Year)

### **Process**

Cancer doctors in S.E. London were asked to identify new drug regimens that they felt should be available to local patients. A small group of clinicians scored each indication using the prioritisation tool on published peer-reviewed evidence.

A seminar was held to which clinicians and PCT commissioners were invited. Prior to the seminar, clinicians had been sent the prioritisation tool and asked to score the regimens that they themselves wished to prescribe. At the seminar they were asked whether they agreed with the score that the group had given to each of these regimens.

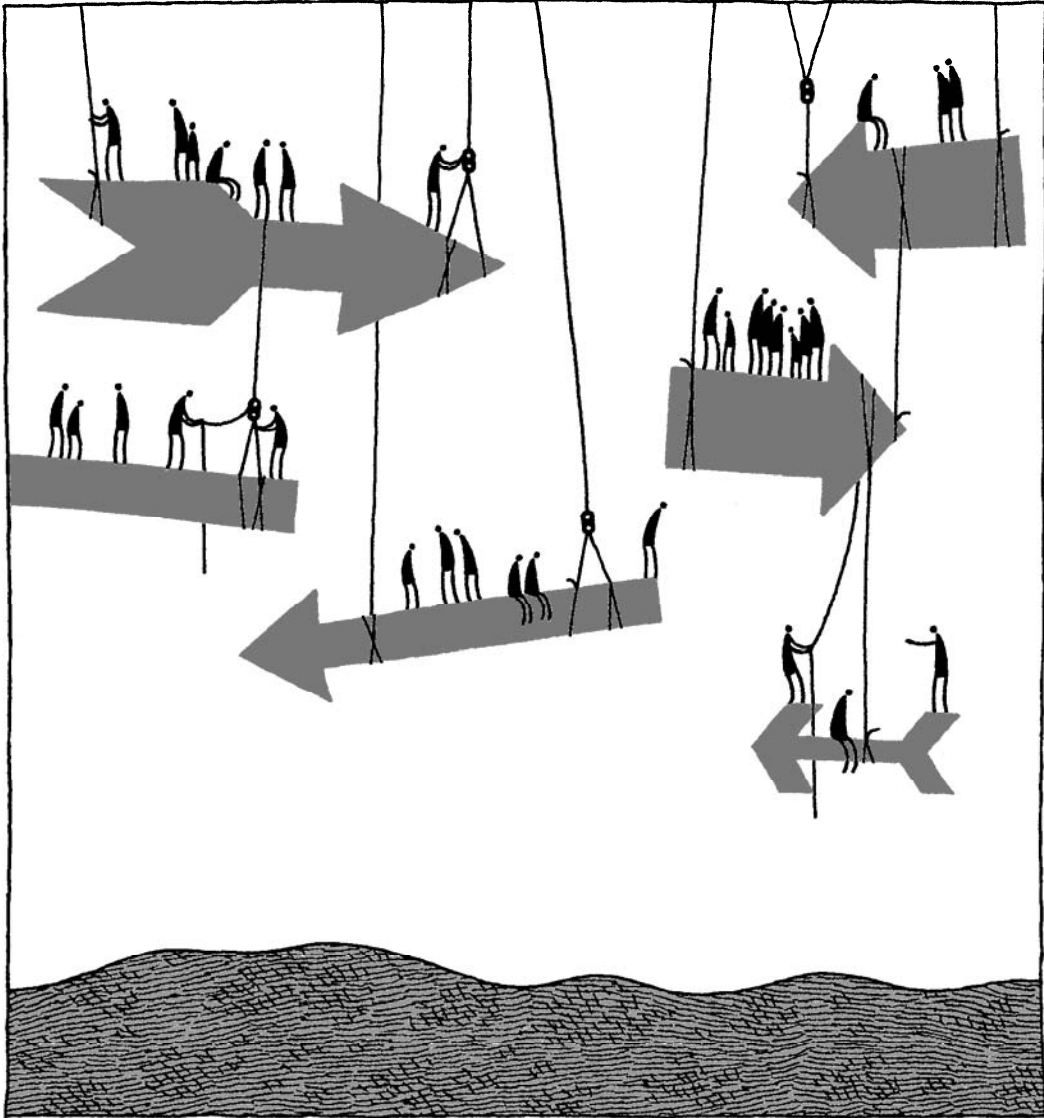
## Results

Clinicians agreed with the scoring for 30 out of the 33 regimens. Two regimens were scored one point higher as it was agreed that there was the evidence to support this. For one indication it was claimed there was new evidence that the group had not considered but the details of this were not available. This new evidence has since been scrutinised and the score remains as it was. After confirming the score for each regimen there was a discussion on what level of evidence was required to support a regimen and what numerical score should merit funding. It was agreed that published randomised data should be generally required (evidence strength A-C).

Possible exceptions could be very rare tumours where it is difficult to accrue sufficient patient numbers to do a randomised study, and where the evidence suggests clinical benefit, or where a regimen scored highly on magnitude of benefit but the research base was relatively immature. The numerical score was more difficult to judge. The top regimen score was 11 and the bottom 0. There was an agreement that those regimens scoring more heavily in domain 1 (magnitude of benefit) should merit further consideration but no overall numerical cut off point was agreed. There was also recognition that some regimens have specific issues, such as small subgroups benefiting considerably more than the patient population as a whole. Additionally, regimens that could have significant offset costs, cost savings or improve patient experience, e.g. an oral drug as opposed to an infusion. The ranking was then set against whether the London Cancer New Drugs Group (LCNDG) had made a recommendation and, if so, whether this was positive or negative. The results were presented to the SE London Executive Commissioning Group and it was agreed that drugs ranked highly and recommended for use by the LCNDG would be funded from 1 April 2008. Other high ranked drugs would be funded when and if the LCNDG gives a positive recommendation during 2008/09.

**Figure 5. Examples of Cancer drugs funded through this system in 2008/09**

<b>Drug</b>	<b>Type of Cancer</b>	<b>Score</b>	<b>LCNDG</b>
Rituximab	Lymphoma	11A	YES
Dasatinib	Type of leukaemia	9C	YES
Docetaxel	Head and neck	8B	AWAITED
Premetrexed	Mesothelioma	6B	YES
Sunitinib	Kidney	6D	YES
Lenalidamide	Type of blood cancer	5A	AWAITED
Sorafenib	Liver	4D	AWAITED



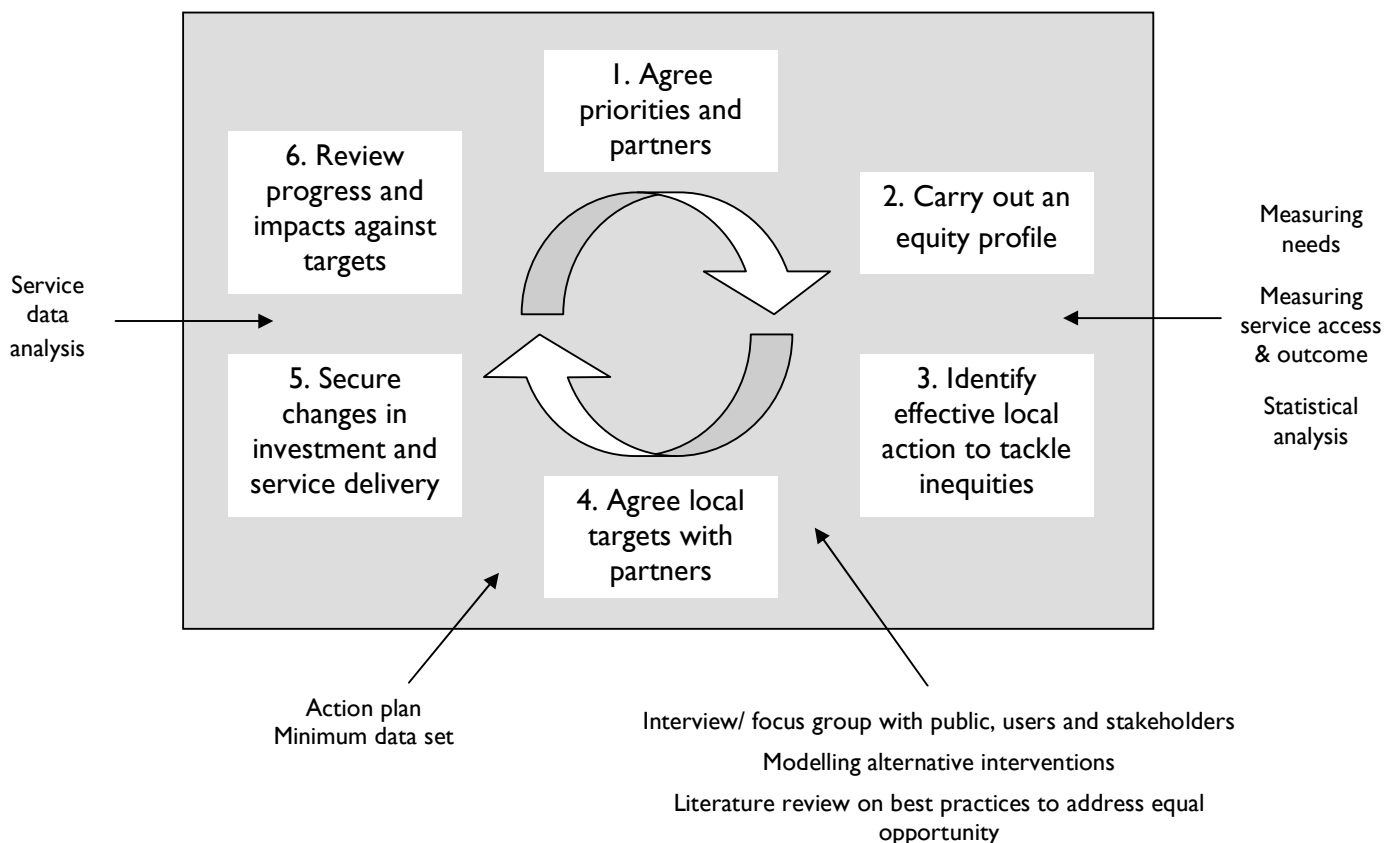
### 1.3. Fairness

#### Health Equity Audit (HEA)

Fairness and equity was a founding principle of the NHS, and more recently, Acheson's 1998 "Independent Inquiry into Inequalities in Health" established the need for equity profiles as a way to assess progress towards reducing health inequalities.

Health Equity Audit was then explained in "Tackling health inequalities: a programme for action" as: "The health equity audit cycle is a mechanism to use evidence about health inequalities to inform service planning and delivery".

**Figure 6. Diagram detailing the Health Equity Audit Cycle**



#### What is Health Equity Audit?

HEA is a process that prioritises interventions based on their effectiveness in reducing health inequities - defined as 'differences in health that are unnecessary, avoidable, or unfair'. It is an audit process seen through an 'equity lens', and identifies how fairly services or other resources are distributed and used in relation to the health needs of different groups of people, or areas by virtue of socio-economic status, gender or ethnicity. It highlights the actions required to provide services according to needs and identifies service

effectiveness gaps which are avoidable, between different groups of people or areas across which disadvantage may exist. It guides allocation of extra resources or the redistribution of existing resources to achieve more health equities, but may be less favourable in terms of cost effectiveness unless reducing the gap is considered when assessing cost–effectiveness.

### **Why prioritise through Health Equity Audit?**

Despite the increase in resources allocated to health and technological progress, there continue to be large disparities in health status according to socio-economic status, gender or ethnicity. Examples of the inequalities present in Lambeth’s population are as follows:

#### **In Lambeth:**

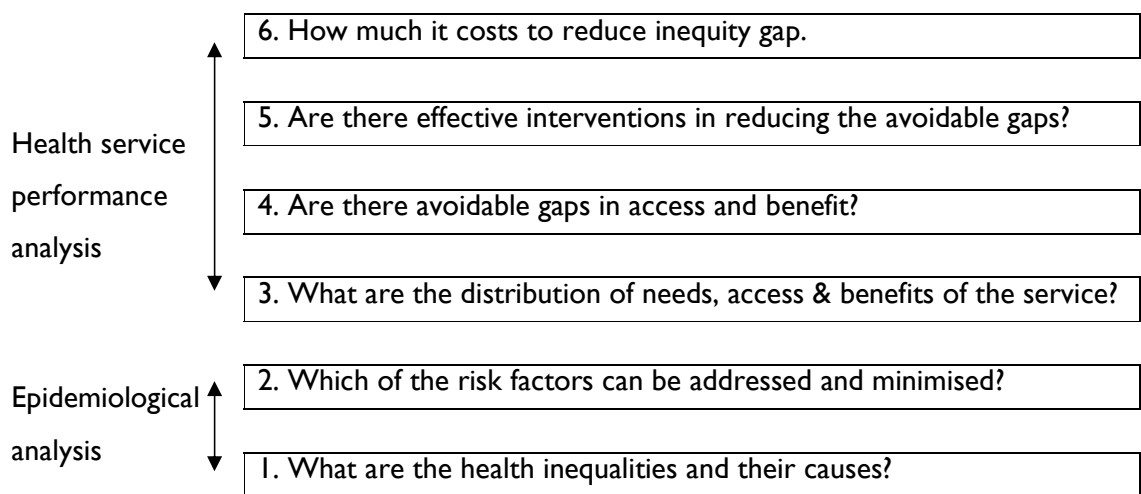
- People on average die younger than in the rest of England
- Men die younger than women - 75 years compared to 80 years
- The two main causes of early death in both men and women are cancers and circulatory diseases
- Infants born in England to women who were born abroad - especially those from the BME community - have a higher risk of dying within first year of birth than infants born to mothers who were born in England.

Access to services is described by the inverse care law. Those who need health care least use the services more often and more effectively, than those with the greatest need. This effect is seen in both health promotion and the treatment of illness and disease. The increasing social, cultural, and economic diversity in English society affects not only the risk of disease and the ability to prevent and self manage illness, but also attitudes towards the health care system. The main modifiable risk factors of the causes of health inequalities are associated with lifestyle and behaviours. Not only is there an unequal distribution of the risk factors but also unequal distribution of opportunity to adopt healthier lifestyles.

In HEA the distribution of access to and effectiveness of the service across categories of people is assessed and compared to needs and equity standards. The observed difference of effectiveness between socio-economic groups, gender, age or ethnic categories, or area of residence may be called the “effectiveness gap”.

HEA provides a phased approach to prioritisation. At each step specific criteria lead progressively to a focused priority. This process is described in the “prioritisation ladder” covering the first five stages of the HEA cycle.

**Figure 7. The decision ladder of health equity audit**



**Example of a HEA: Smoking cessation services**

An equity profile of the specialist Smoking Cessation Service (SCS) was initiated in February 2005 as the first step of the Health Equity Audit (HEA) process provided by the PCT.

Smoking cessation services have been provided to Lambeth smokers since 2000, with the aim of reducing smoking, one of the risk factors of cardiovascular diseases and cancer, and an important component of the inequalities in health status and the death rate among social classes in the UK. The equity profiling aimed to identify inequalities and inequities in the use and effectiveness of the service and establish a baseline against which to monitor the impact of service provision. Inequalities were identified as differences in rate of service use and quit rate between age groups, genders, ethnic groups and wards within different deprivation categories. An equitable service was defined as a service that provides access proportional to needs and equal opportunity to stop smoking for all smokers independently of their demographic and socio-economic characteristics.

Overall a small number of smokers living in Lambeth used the smoking cessation services with 4 in 100 smokers having set a quit date between January 2000 and January 2005. The proportion of smokers who relapse has been rising up to 12% in the 9 months April 2004-January 2005. The current strategy resulted in equitable use of SCS with a higher proportion of smokers living in deprived wards using the service than in better off wards. However smokers from black minority groups were less likely to set a quit date than white smokers. Findings of the equity profile suggest that the needs of male smokers have not been addressed as well as the need of female smokers with 4 in 100 male smokers setting a quit date compared to 7 in 100 for female smokers.

SCS in Lambeth have a lower short-term effectiveness than the England average with 34% of smokers with a quit date reporting not smoking by 4 weeks compared to 61% nationally. This low effectiveness is partially explained by a high proportion of smokers who did not come back to the service after having decided to stop smoking, especially among young and ethnic minority smokers.

Findings of the equity profile suggest that a standardised and vertical service provision may not suit the needs of the most vulnerable to smoking in Lambeth: quit rate decreases with increasing ward deprivation level, and 1 in 4 black smokers quit smoking compared to 1 in 3 white British smokers (after controlling for confounding effect of age, gender, addiction and ward deprivation level). The findings of the equity profile suggest that there is a risk for the target-based approach to widen the inequality gap because of the inequitable service outcome.

The wide variation of individual and environmental factors, which influence smoking behaviour, is a challenge for the provision of effective smoking cessation services. SCS have to adapt to the needs of specific groups especially pregnant smokers, youth and smokers living in deprived areas if service effectiveness is to be equitable. To reach a similar outcome for all groups more resources are required for deprived populations than the better off population.

While the current strategy for SCS provision allowed equitable use of the service, further improvement is required to provide equal opportunity to men, youth and ethnic minorities, and smokers living in deprived wards to adhere to the cessation process and have a successful outcome. Reducing the inequity of SCS effectiveness will contribute to reaching the target because of the significant contribution of smokers from deprived areas and ethnic minorities to the overall number of smokers living in Lambeth. Different types of interventions will be critical to reach the target while addressing equity issues:

- Improving data quality through computerising data entry, update and define the dataset with a written operating manual for users of the database. Agree a minimum dataset to monitor equity.
- Exploring other existing databases such as Quality and Outcomes Framework (QOF) data to develop monitoring of local smoking behaviour trend.
- Improving effectiveness of SCS through:
  - Better understanding of the constraints to stop smoking and culturally appropriate channels for delivering smoking cessation and tailoring of the service

to the needs of the ethnic minority smokers and those living in a deprived environment. Social marketing research will clarify perceptions and communication channels;

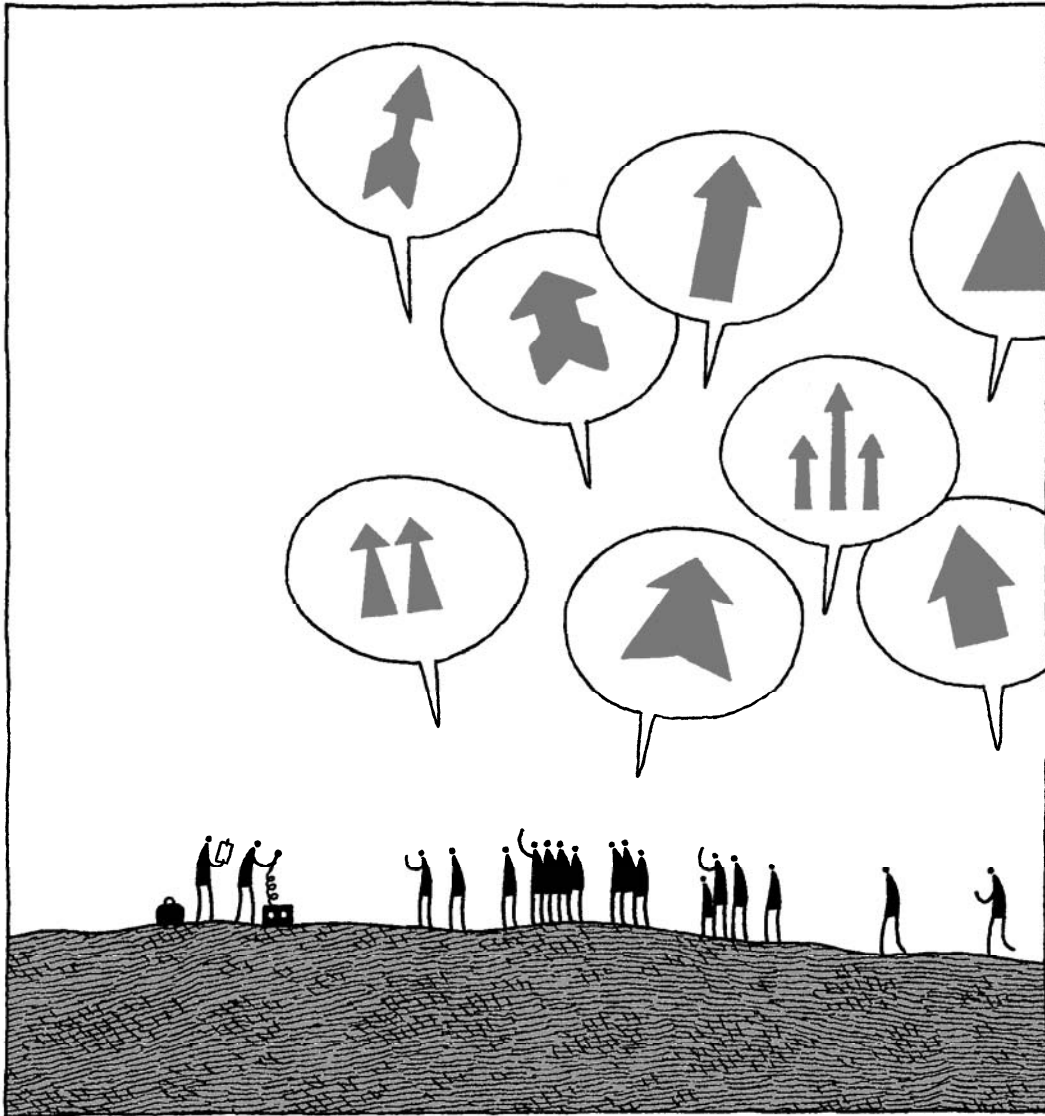
- Strengthening the management of language and cultural diversity by building the capacity of health service providers and PCT employees in working in a multicultural environment, and reviewing the use and delivering modalities of the interpreter services;
- Partnership and integration of smoking cessation services with interventions aiming at decreasing incidence. A smoking cessation strategy clearly spelt out for the next 3 years, as part of the tobacco control strategy, will provide the framework.

**Figure 8. Summary of equity issues for Stop Smoking services.**

<b>Characteristics</b>	<b>Use of service</b>	<b>Present at follow up</b>	<b>Quit after 4 weeks</b>
<b>Gender</b>	A higher proportion of women than men	Similar rate for men and women	Similar rates for men and women
<b>Age</b>	Younger smokers less likely to access	Older smokers more likely to be present at follow up	Quit rate decreases with age
<b>Ethnicity</b>	Same proportion of white smokers & black smokers	Ethnic minority groups 14-29% more likely to be lost to follow up than white	White British 22% more likely to quit than other ethnic groups
<b>Deprivation</b>	Increases with deprivation	Does not vary with ward deprivation level	Quit rate decreases with the Indices of Multiple Deprivation ward level

### **Conclusions**

- Health equity audit informs service provision. Achieving equitable outcomes requires increased investment.
- The stop smoking service is reaching a small proportion of Lambeth residents who smoke.
- Stop smoking services are an essential part of the tobacco control strategy for Lambeth.



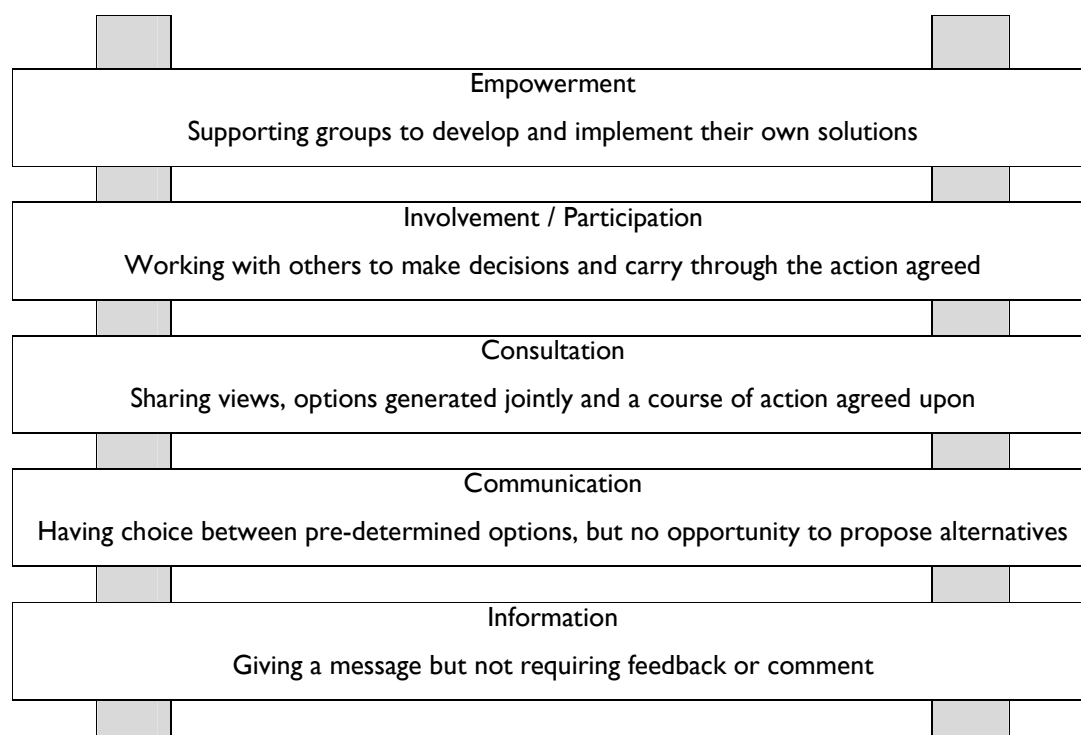
## 1.4. Views of local people

The most recent guidelines on community engagement from the National Institute for Health and Clinical Excellence (NICE) suggest that different levels of patient and public involvement can directly and/or indirectly affect health. They suggest a number of approaches to facilitate successful community engagement, and recommend that four interlocking themes should be taken forward:

- a) pre-requisites for success (including policy development);
- b) infrastructure (to support practice on the ground);
- c) approaches to support and increase levels of community engagement; and
- d) evaluations (2008).

The degree of patient and public involvement can be defined by the public's relationship to authority, represented by a 'ladder of participation'. All five stages of the ladder constitute a level of engagement with different levels used depending on the particular circumstances.

**Figure 9. The Ladder of Participation (Adapted from Wilcox, D. 1994)**



The PCT Board adopted a Patient & Public Involvement (PPI) strategy in March 2005. This states that “ ...PPI will be embedded in our service development, planning and delivery ... (and) understood and practised across the organisation with managers and staff”. This strategy was evaluated in 2007 by the PPI team, revealing high levels of awareness and regard for PPI amongst managers; with clarity of purpose and understanding of processes.

However, it was revealed that patient and public involvement was not clearly embedded in daily PCT practice and largely remained “erratic” or “ad hoc”. This issue is addressed by the recommendations of this report on page 55.

There are good examples of PPI being performed within the PCT, as detailed below. The principles of which have been to:

- Seek out those who feel they have little power over their own lives
- Promote the idea of people acting together to create change
- Work on the assumption that health changes cannot be made by individuals alone
- Build on a premise of community empowerment
- Promote the sharing of knowledge and skills between the PCT and communities
- Value the engagement process as a means of facilitating the growth of self esteem and confidence
- Involve the community in the definition of issues.

### **The HIV Service User Review**

South East London has the highest prevalence of HIV in London and Lambeth has the highest rate in the UK. Sector expenditure on HIV treatment through the HIV Consortium is £56,138,669, with South East London PCTs also making significant investments in HIV prevention, care and support. An important underlying principle is that local services should be responsive to the needs and preferences of service users. However, in order to plan and deliver services effectively, providers and commissioners require constructive, ongoing input and feedback from service users and must ensure that arrangements for involvement are fit for purpose and deliver value for money. Two HIV service user groups provide consultancy to local HIV treatment centres by involving service users within their specific service.

**Aim:** To develop a sustainable system of service user involvement in South East London that enables a broadly representative proportion of people living with HIV to contribute to service development, delivery and commissioning and which is valued by service users, service providers and commissioners.

**Objectives:** To map the extent of current service user involvement in statutory and voluntary sector services in South East London; to find out from service users whether and how they would like to contribute to service delivery, planning and commissioning; to review the aims, objectives and activities of the two user groups in order to understand how they fit within the South East London commissioning systems.

**Methods:** These included face-to-face interviews, questionnaires and focus groups capturing perspectives from a cross section of service users and other stakeholders.

**Results:** As many of the care and support services for people living with HIV are commissioned jointly as part of the South London Partnership, it was agreed to extend the review to cover South West London PCTs. The fieldwork is now complete and a draft of the final report will be available in mid September 2008.

### **Teenage Pregnancy Media and Communication Strategy 2007-10**

Lambeth has the highest rates of teenage conception in England, although these are now beginning to reduce significantly.

**Aim:** To support the Lambeth Teenage Pregnancy Strategy in achieving a reduction in the conception rate in under-18s in Lambeth.

**Objectives:** To promote positive sexual attitudes and behaviours; reduce the proportion of young people having unsafe sex; and increase the proportion of young people having safer sex.

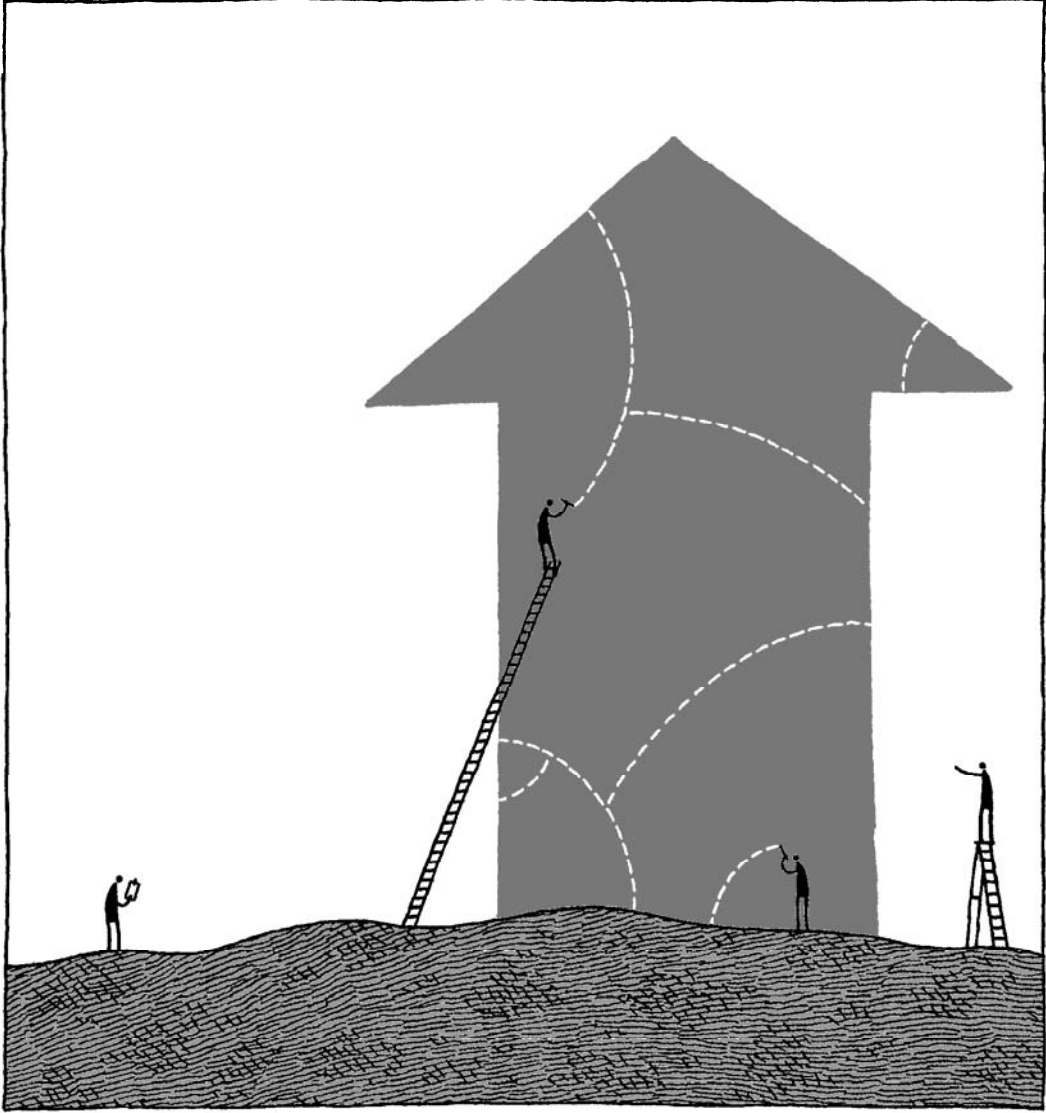
The messages for this strategy are consistent with national good practice, targeting audiences such as: those who are curious about sex; those who are already engaging in sex; parents/carers and the wider community (including BME and faith organisations); and professionals.

**Methods:** A literature review identified best practice and examples of effective local initiatives. A topic guide and survey was developed to support focus groups with young people in order to gain an insight and understanding of the behaviours that led to teenage pregnancy, and to identify the types of media young people accessed. Consultation took place with young people including looked after children, the Lambeth Youth Council, children excluded from school, Lambeth Youth Outreach, Lambeth Youth Offending Service and teenage mothers.

The key messages to be promoted are:

- Addressing peer pressure and delaying sex
- Condom use negotiation
- Myths
- Information & advice
- Sexually Transmitted Infections (STIs)
- Drugs and alcohol

**Results:** The campaign is now into its first year with bus shelter posters on display, and postcards distributed. Local radio adverts are also in production.



## 2. What are we trying to do?

This chapter sets out the steps the PCT is taking to respond to the assessed health needs of its population. Using World Class Commissioning competencies, the PCT will commission health services to meet the explicit outcomes necessary to meet needs, identified through joint strategic needs assessment.

### **Joint strategic needs assessment**

The Local Government and Public Involvement in Health Act (2007) [Clause 116] places a duty on local authorities and PCTs to undertake a Joint Strategic Needs Assessment (JSNA). This provision came into force from April 2008. The Director of Public Health, Director of Adult Social Services and Director of Children's Services are expected to take a lead in producing a joint strategic needs assessment through strong partnership. The Department of Health (DH) published *Guidance on Joint Strategic Needs Assessment* in December 2007 in partnership with Communities and Local Government (CLG) and the Department for Children, Schools and Families.

A strategic needs assessment is intended to provide:

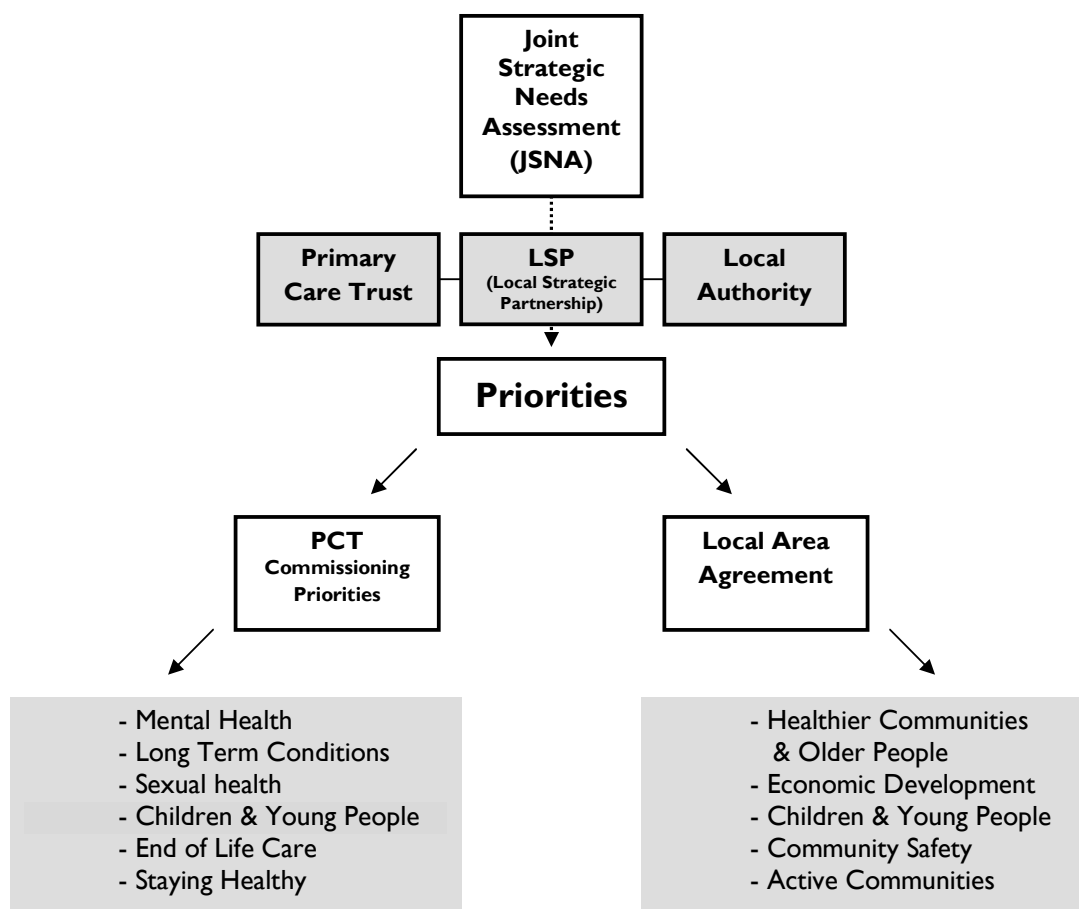
- Evidence about the population on which services are planned to address health inequalities;
- An opportunity to engage with the population and enable them to contribute to targeted service planning and resource allocation;
- Information on gaps in equitable distribution of services;
- An opportunity for cross-sectoral partnership working and developing creative and effective interventions;
- An opportunity to identify priorities and offer strategic recommendations for service planning and improvement.
- A key tool to achieve a shift towards commissioning to improve health and well-being outcomes and reduce inequalities.

To identify priorities and offer recommendations, the following steps will form an important part of the JSNA:

- Profiling the population in terms of current health and well-being status.
- Populating the primary dataset proposed in the DH guidance on JSNA (2007).
- Mapping of current services against identified needs e.g. deprivation, population projection etc.

- Review of existing and ongoing needs assessments in the Local Authority, PCT, academic and tertiary and voluntary sector.
- Stakeholder consultation undertaken across statutory and non-statutory agencies in Lambeth.
- Review of evidence of effectiveness, and cost-effectiveness, of existing and planned interventions from a commissioning perspective.

**Figure 10. Diagram depicting the prioritisation process regarding JSNA and LAA**



JSNA is an opportunity to influence and inform several strands of work by providing evidence to prioritise work areas, through the following strategies/plans:

<ul style="list-style-type: none"> <li>▪ PCT and Local Authority commissioning strategies</li> <li>▪ PCT Local Delivery Plans</li> <li>▪ Children and Young People’s Plan</li> <li>▪ Practice Based Commissioning plans</li> <li>▪ Local development plans</li> <li>▪ Community regeneration strategies</li> </ul>	<ul style="list-style-type: none"> <li>▪ PCT Pharmaceutical needs assessments</li> <li>▪ Supporting People strategies</li> <li>▪ Housing strategies</li> <li>▪ Community Strategies</li> <li>▪ Carers strategies</li> <li>▪ Workforce planning strategies</li> </ul>
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A range of data and tools are expected to inform JSNA such as *Health Survey for England*, *Health Inequalities Intervention Tool*, *disease prevalence models*, *National Centre for Health Outcomes Development*, *Projecting Older People Information System*, *Disease Management Intervention Tool*, *NICE guidance*. The development of *LINKs* (Local Involvement Network) and implementation of the *Connected Care* model will play a central role in design and delivery of services planned to address priorities. JSNA will lead the process of prioritisation by identifying local needs and recommending interventions to achieve the desired future health and well-being outcomes.

### **World Class Commissioning**

Commissioning describes the process by which the PCT purchases healthcare services, on behalf of the local population, from various providers within an allocated budget to meet identified needs and priorities. Commissioning is a core responsibility of PCTs. By deciding which services are commissioned, the PCT can have a positive impact on the health and wellbeing of the local population. World Class Commissioning (WCC) aims to deliver a more strategic and long-term approach to commissioning services, with a clear focus on delivering improved health outcomes.

In essence, WCC is expected to deliver:

- **Better health and well-being for all**
  - People will live healthier and longer lives;
  - Health inequalities will be dramatically reduced.
- **Better care for all**
  - Services will be evidence-based and of the best quality;

- People will have choice and control over the services that they use, so they become more personalised.
- **Better value for all**
  - Investment decisions will be made in an informed and considered way, ensuring that improvements are delivered within available resources;
  - PCTs will work with others to optimise effective care.

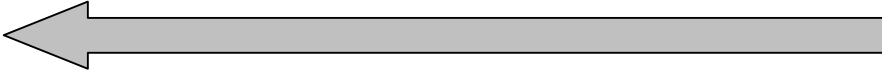
The process has been designed to be:

- **Transparent:** a clear assessment methodology with clear descriptions of incentives and interventions and how these can be applied;
- **Standardised:** one nationally consistent system managed locally by the SHAs;
- **Relative:** recognising the starting point of different organisations and focusing on improvement;
- **Flexible:** so that the framework can adjust over time as PCTs improve, and to support local innovation;
- **Challenging:** matching or exceeding the rigour that 'Monitor' applies to Foundation Trusts;
- **Developmental:** focusing on supporting improvement as PCTs move towards World Class Commissioning;
- **Incentivised:** with clear incentives for PCTs that show improvement and interventions for those that do not;
- **Proportionate:** focusing on the key indicators of performance and capabilities rather than being an all-encompassing audit;
- **Consistent:** with the developing NHS performance regime.

### **Outcomes framework**

In order to meet these requirements, the Public Health Directorate of Lambeth PCT has developed an outcomes framework that attempts to integrate these expectations and principles. It also begins to integrate with the broader partnership health agenda related to Local Area Agreements, Sustainable Community Strategy, and Joint Strategic Needs Assessments. The following diagram and description outlines the framework.

**Figure 11. The outcomes framework**

High Level Goals	Stay Healthy		Stay Safe	Enjoy and Achieve	Positive Contribution	Economic Security	
<b>Care Pathway</b> 							
High level Outcomes	1 Adding years to life and reducing the gap	2 Reducing avoidable deaths and premature deaths and reduce the gap	3 Reducing avoidable complications from disease / increasing quality of life for people with disease and reduce the gap	4 Screening or early detection of disease and reduce the gap	5 Reducing risks / harm and reduce the gap	6 Avoiding risks and reduce the gap	7 Adding life to years and / or wellbeing and reduce the gap
<b>Priority Areas</b> <span style="float: right;">e.g. Health Inequality</span>							
Specific Outcome or proxy Indicators	e.g. Life expectancy (male + female)  All cause death rates per 100,000					e.g. Deprivation Score	

The framework is divided into three levels:

**High level goals:** indicating the borough level contribution to aspirational goals such as staying healthy, staying safe, enjoying and achieving, positive contribution and economic security.

**High level outcomes:** to help achieve the aspirational goals. These reflect a care pathway approach combining universal, ‘upstream’ prevention and population approaches together with the more ‘downstream’ individual care and specialist approaches. Two high level outcomes are given: outcome 1: increase quantity of life and outcome 7: increase quality of life/wellbeing and this reflects the first expectation of WCC outlined above. This latter outcome also reflects what in public health terms would be the “wider determinants of health”.

This level of outcomes is what public health aims to achieve, i.e. reduce the incidence of disease where possible (within the context of the current evidence) and manage prevalent chronic disease (by early detection or screening programmes). Health inequality cuts across all of these high level outcomes.

**Specific outcome or proxy indicators:** that are specific to a condition/disease, measurable, attributable (i.e. causally related), valid, reliable, and time related. An example of such an outcome measure would be the reduction in premature mortality from all circulatory disease by 2010 from the baseline year of 1995/7 by 40% and to reduce the absolute gap in mortality in the most deprived PCTs by 40% compared to the national average.

This level can be used to look at indicators for specific PCT priorities and can also be used to take into consideration a particular condition and used to work out systematically specific indicators across all high level outcomes.

### **Process**

Using the above framework, Public Health has mapped existing indicators from vital signs and other sources by the key commissioning priority areas of the PCT. Other indicator sets can be added to the framework provided the data is statistically robust and data collection is not an onerous burden. In order to prioritise outcome indicators Public Health has suggested the following criteria and broad definitions:

- **Size of the problem:** (based on measures of incidence, prevalence, mortality rates). The size can be considered in terms of the condition being very common (1:100 cases), common (1:1000 cases), rare (1: 10,000 cases) or very rare (1:1,000,000 cases).
- **Impact of intervention/cost effectiveness:** high impact at low cost; medium impact at low cost; high impact at high cost; low impact at low cost or no impact/negative impact.
- **Gap in service provision or quality of care:** new service development; existing service but low coverage/update; existing service with medium uptake; high uptake. In terms of quality, clinical audit shows low quality service, medium quality service or high quality service.
- **Inequality:** there is good evidence of avoidable health inequality (inequity) in terms of mortality, service access, service uptake and/or other outcomes with reference to

race/ethnicity, gender, age, disability, sexual orientation and social status. This can be quantified as very high, high, medium, low or very low impact.

- **Patient and public perception:** can be broadly classified or benchmarked as poor perception, average perception, and high perception.
- **Overlap between LAA and vital signs:** no overlap, some overlap or common overlap/outcome between partners.

Based on these criteria it is suggested that the specific indicators chosen for the priority areas are scored on a scale of 1-5 with:

1 = Very low priority

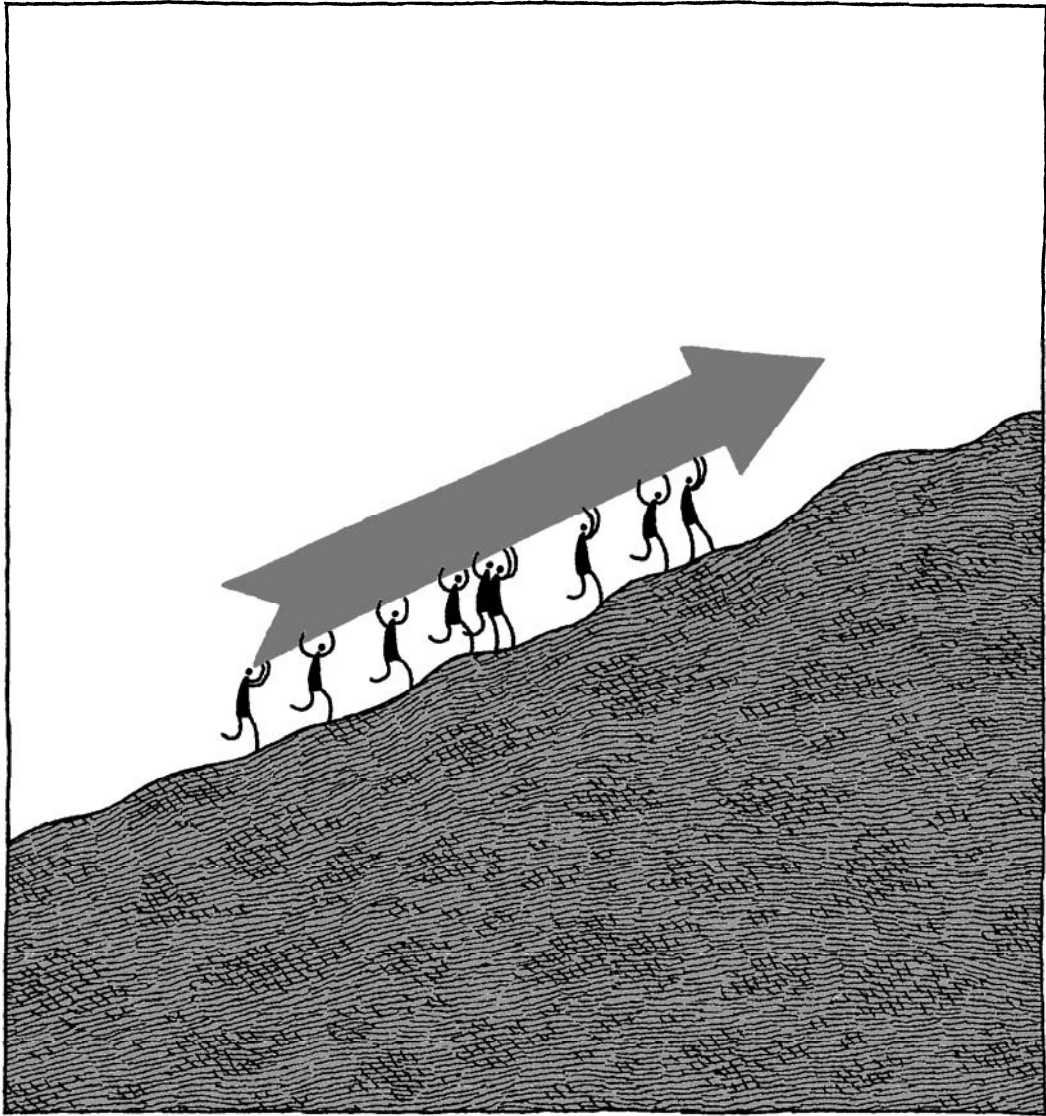
2 = Low priority

3 = Medium

4 = High

5 = Very high priority

Using this scoring system the highest priority should be given to outcome measures that focus on a common condition, where the impact of intervention is high at low cost, where there is a service or quality gap, i.e. new development or low uptake/coverage levels; there are issues related to avoidable health inequality; there is a poor perception amongst patients or the public, and there is a good overlap with between different partners.



## **Public health interventions**

Interventions designed to improve health outcomes cover a wide range of methods, and settings. They are delivered by practitioners from the complete spectrum of public health practice, including GPs and primary care nurses, community and neighbourhood workers, voluntary organisations and workers in other public sectors such as education, social care and the emergency services.

Interventions will work to different timescales and will deliver beneficial outcomes at different times, across the range from short to long term. For instance, 'upstream' interventions aimed at reducing the prevalence of diabetes through prevention, will benefit those at risk from developing diabetes, but will not benefit those people with diabetes related complications such as retinopathy whose needs could be met by downstream interventions.

There is huge variety in the methods available for interventions, for instance, one intervention could focus on medical screening to identify risk so as to prescribe a drug which reduces this risk; whilst another intervention could be to encourage parents on an estate to work together to improve play facilities for the under 5s. Commissioning from such a wide variety of public health interventions is not straightforward due to competing demands on resources, the different methods and timescales, and the vastly differing scopes and remits. When commissioning interventions, we routinely consider:

1. The treatment of chronic disease
2. Fairness
3. Patient choice
4. The balance of treatment and prevention

## **Outcomes**

Some current public health interventions in Lambeth work towards the following outcomes:

- Reducing risk of contracting healthcare associated infections through the strengthening of infection control across primary and secondary care and improvement of care pathways for those found to be infected;
- Reducing disease related to alcohol misuse through improved screening and intervention in primary care settings;
- Preventing transmission of HIV through specific work programmes based in African Muslim communities;
- Reducing blindness and eye complications in people with diabetes through retinal screening and management of retinopathy for people with diabetes.

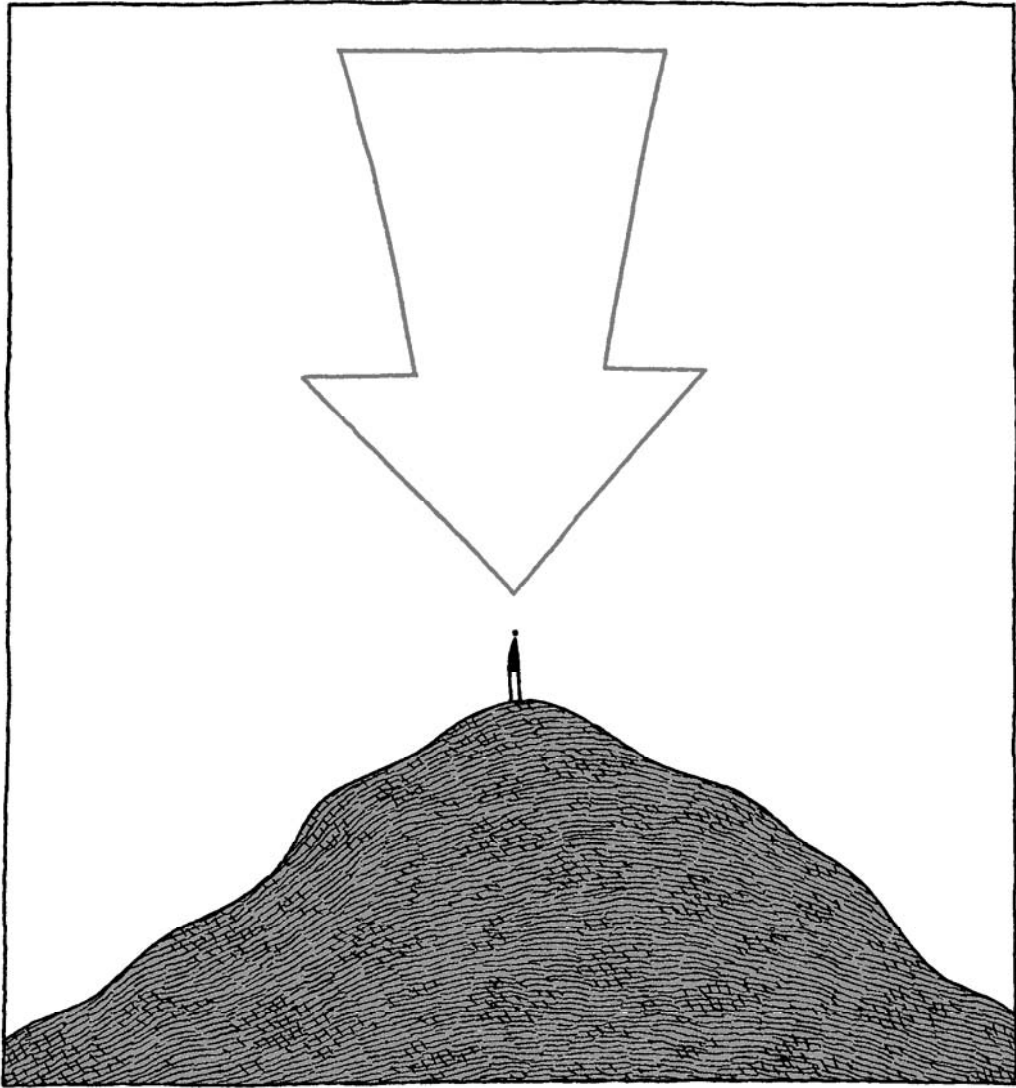
The following matrix model has been developed, which groups interventions, making comparisons and prioritisation more straightforward.

**Figure 12. Matrix of interventions**

	<b>A</b>	<b>B</b>
<i>Short term outcomes</i>	<b>Short-term community based intervention</b>	<b>Short-term health service based intervention</b>
	<b>C</b>	<b>D</b>
<i>Long term outcomes</i>	<b>Long-term community based intervention</b>	<b>Long-term health service based intervention</b>
	<i>Community based input</i>	<i>Health service based input</i>

**Values for the development of outcomes**

- Outcomes should address the major health issues in Lambeth: CHD, Cancer, HIV, and Diabetes
- Outcomes should address inequalities
- Outcomes should not be exclusive, but inclusive
- Outcomes should be evidence based
- Outcomes should be informed by the views of local people.



## Examples of public health interventions in Lambeth

<b>A</b>	<b>B</b>	<b>Example of a short-term community based intervention -</b> Improving infection control across the primary / secondary care interface – healthcare associated infections (HCAI) care pathway development
<b>C</b>	<b>D</b>	

**Outcome:** To reduce HCAI in Lambeth residents

**Aims:** To strengthen infection control across primary and secondary care by enhancing existing arrangements, agreeing local care pathways and by sharing with all local stakeholders.

Nationally, infection control has been driven up the agenda by a number of high profile reports e.g. Healthcare Commission (HCC) reports into outbreaks of *Clostridium difficile* (*C. difficile*) and policy e.g. Hygiene Code; and the strengthening of infection control targets.

In early 2007, the Guy's and St. Thomas' Trust (GSTT) quality monitoring schedule incorporated infection control through national targets and local standards. Later in 2007, the Director for Infection Prevention and Control (DIPC) presented the team's work at the Board, where additional funding was agreed to deliver on this high priority target.

This HCAI care pathway project has arisen out of a need to improve cross organisational working when addressing infectious conditions. There are links between the community and acute trust (hospital) settings in relation to infection control. Rates of infection in the acute trust are affected by rates of infection in the community and vice versa. Cases of *MRSA* and *C. difficile* may be acquired in either setting and be transferred between them. Root cause analyses of *MRSA* bacteraemia episodes recorded in the acute trust showed that about 13% were present on admission and 30% were in patients who were difficult to manage because of poor venous access and social problems (including for example, intravenous drug users). The Department of Health *MRSA* improvement team are now recommending that acute and community sectors should work together to reduce *MRSA* bacteraemias acquired in the community on, or within 48 hours of admission. This project is building on existing close working between Lambeth PCT and GSTT infection control teams (ICTs).

In 2007, the Department of Health released funds to be allocated regionally for local work to improve infection control and cleanliness. Lambeth PCT and GSTT submitted a successful joint bid to NHS London for this funding.

Lambeth PCT has employed a project team, consisting of a project nurse and project worker, to take this forward. This team has been working on the following:

- Establishing remote access to laboratory data from key community locations
- Developing an investigation process for community *MRSA* bacteraemias and *C. difficile* for those diagnosed within 48 hours of admission through close working with acute and community staff
- Strengthening the *MRSA* and *C. difficile* care pathway by enhancing existing arrangements and developing a locally agreed care pathway
- Improving communication with staff, patients and the public by sharing infection control information with all local stakeholders. Work is underway to develop the PCT's infection control intranet and internet sites

In April 2008, a multi-agency workshop was held to start the process of agreeing the HCAI Care Pathways in the form of algorithms. The project will be completed by the end of summer 2008. Agreed pathway processes will be implemented by the infection control team.

<b>A</b>	<b>B</b>	<b>Example of a short-term health service based intervention</b> Local Enhanced Service (LES) for Alcohol Screening Services in Primary Care
<b>C</b>	<b>D</b>	

**Outcome:** Decrease alcohol related ill health in Lambeth.

**Aims:** To improve screening for problematic alcohol misuse in primary care, and ensure this is provided in a more systematic way, becoming embedded in routine primary care services. To increase knowledge and skills in primary care with regards to screening for and management of alcohol misuse, including onward referral where appropriate.

To provide brief interventions for alcohol misuse in general practises. To develop a register of identified patients with alcohol dependence and problematic alcohol misuse, to inform service development.

- Alcohol is the most widely used drug in the UK – consumed by over 90% of the population.
- Crude estimates of excess drinking based on standardised data suggest that in Lambeth (based on intake on the heaviest drinking day in the last week, aged 16 and over, HSE 2004 survey):
  - 31,790 (30%) of men drink excessively (8 units or over)

- 20,717 (19%) women drink excessively (6 units or over)
- In total, about 52,508 (24.4 %) people drink excessively
- 9,804 (5%) of the 16-64 yr old Lambeth population are dependent drinkers, a subset of the excessive drinkers figure above (London estimate).
- Little difference is seen between ethnic groups in dependent drinking
- A pilot 'Alcohol Use Survey, 2005' in Lambeth general practices suggested that 23% of people surveyed were misusing alcohol and, in line with national data, the risk factors were being young, male and white.
- Levels of alcohol associated violent crime in Lambeth have risen since 2000 and are higher than those of neighbouring areas, and are associated with the night-time economy and alcohol availability.
- The report also highlighted significant unmet need. There has been an increase in admissions to hospital attributable to alcohol in recent years. Services in Lambeth tend to be focused on dependent drinkers and there is a need to improve services for all alcohol misusers.

The National Treatment Agency guidance and "Our Health, Our Care, Our Say", highlight the need for more preventative action within primary care and community settings. The Department of Health's Models of Care for Alcohol (which in effect provides a National Service Framework for the development, commissioning, management and evaluation of the range of health focused treatment interventions in relation to alcohol) guided the development of the LES for alcohol with the Alcohol Health Needs Assessment 2006-7 for Lambeth.

The practices incorporate alcohol screening using the FAST screening tool, into new patient checks (over 16 years old), and as part of routine care for patients receiving enhanced substance misuse services, and patients on the severe mental illness register. Screening is offered where clinically appropriate, triggered by consultations on conditions recognised to be associated with alcohol misuse.

Patients with an identified need are offered a brief intervention, using the protocol for simple structured advice, and referred on to specialist services, as appropriate.

The LES will be evaluated by reviewing the numbers of patients screened, the number of brief interventions delivered, and the number of referrals onto other services. Where possible, comparison will be made with baseline activity levels before the LES was available.

Questionnaires and feedback will be monitored, and effective innovations encouraged at practice level to increase uptake of screening and development of 'best practice'. The evaluation will be used to inform future local service developments, and change and development of the LES in future financial years.

Since the end of July 2008, over 20 practices have contracted to provide the service.

These practices have identified a lead GP and lead nurse for the alcohol screening services, both of whom have attended training sessions run by the PCT. They are required to cascade training internally to all clinicians working in the practice.

<b>A</b>	<b>B</b>	<b>Example of a long-term community based intervention</b> Lambeth Southwark and Lewisham African Muslim Campaign against HIV
<b>C</b>	<b>D</b>	

**Outcome:** To prevent transmission of HIV in African Muslim communities.

**Aim:** To involve the Muslim community in; raising awareness on HIV and STIs; preventing HIV transmission; showing compassion, support and help to Muslims living with HIV so they can live without stigma and discrimination.

Africans constitute a significant part of Lambeth's population with well-established communities from East Africa, the Horn of Africa and West Africa, and since 1996, Africans have been the group in which the greatest number of newly diagnosed cases of HIV infection have occurred in South East London. This now exceeds the number of new infections in the gay community, and whilst the majority of infections in Africans were acquired outside of the UK, there is evidence of primary transmission taking place locally. In 2006, 2,306 Lambeth residents were known to be living with HIV, with approximately 24% of these being African people.

The epidemiology of HIV within Lambeth identifies this population as a priority because it faces a significant burden which is getting worse. Work with this community has increased over recent years in the following ways:

- Facilitating an Islamic leader's circle to discuss these issues
- Funding a sessional worker at an Islamic cultural centre to support the work
- Workshops for mentors to develop knowledge and skill in spreading HIV prevention messages within the community

- Youth activities, including discussion and information groups on HIV, STIs and teenage pregnancy, resisting peer pressure, and the use of Islamic rap and drama.
- Setting up a support group for HIV positive Muslim people which is facilitated by a Muslim person living with HIV.

The work has resulted in increased participation and project ownership by the African Muslim community, including parental commitment to supporting sexual health campaigns as well as supporting their teenage children in taking an active part in sexual health promotional activities.

The project has also improved understanding of the impact of stigma and isolation of people who are HIV positive, leading to increased community support networks for individuals and families living with and affected by HIV. Access to local sexual health services has also been encouraged including referral for HIV testing. Referrals have also been made to other Islamic cultural centres and mainstream services such as housing benefit, immigration and social services.

Challenges to the work have included:

- The autonomy of mosques, which necessitates individual approaches to leaders to build the necessary trust and not threaten their authority.
- The insecurity felt in relation to the current political climate and Islamophobic views of sections of the media.
- Whilst Islam (as well as many other religions) stresses abstinence and mutual fidelity within marriage as the moral ideal, a pragmatic approach acknowledging that not all Muslims practice their faith to the letter is needed.
- There are a diverse range of African traditional beliefs which also influence people's behaviour. Sometimes it is difficult to separate cultural from religious issues.
- The full involvement of women has been integral to this project. As some mosques may not encourage female attendance, different strategies to engage women are needed.

Factual public health messages can be combined with Islamic teachings and values. Ownership and involvement of the community is key. With a correct and thoughtful approach most Muslim communities are not "hard to reach" and are concerned about health.

A formal evaluation of the project is now underway, and plans are to involve more Islamic Centres in Lambeth, Southwark and Lewisham as full partners. The project won the 2008 London Health and Social Care Improving Access Award.

<b>A</b>	<b>B</b>	<b>An example of a long-term health service based intervention</b> Retinal screening and early management of retinopathy for people with diabetes
<b>C</b>	<b>D</b>	

**Outcome:** To reduce blindness and eye complications in people with diabetes through retinal screening.

**Aim:** To reduce the risk of visual impairment and blindness due to diabetes; risk is substantially reduced by quality assured early detection and effective treatment of diabetic retinopathy. To identify those with sight-threatening retinopathy who may require preventive treatment. Screening and treatment for diabetic retinopathy will not eliminate all cases of sight loss, but will minimise the number.

Diabetes affects increasing numbers of people in the UK and the burden of serious complications and their consequences can be considerable for both individuals and health services. Diabetic retinopathy is the leading cause of blindness in people of working age in industrialised countries and also a major cause of blindness in older people. In its early stages, diabetic retinopathy is symptom free. Progression of disease can be prevented by laser treatment, therefore early detection by regular screening is beneficial. At any time up to 10% of people with diabetes will have retinopathy requiring ophthalmological follow up or treatment. 20 years after the onset of diabetes, more than 60% of people will have diabetic retinopathy. The personal and social costs of blindness in terms of higher possibility of dependence, loss of earning capacity, and increased likelihood of greater social support needs, are significant for individuals, for the caring services and for society. The quality of life of those who develop visual impairment can be improved by access to low vision aids, information, psychological support and appropriate welfare benefits.

The National Screening Committee (NSC), NICE guidance, Diabetes NSF and delivery strategy have given this intervention national priority. The rising prevalence of diabetes means that retinopathy will remain a major health and economic problem.

In 2002, NICE Clinical Guideline “Retinopathy Screening and Early Management (Management of type 2 diabetes), Feb 2002” identified screening as an important priority.

The Diabetes NSF highlighted important standards whose aims were to minimise the impact of the long-term complications of diabetes by early detection and effective treatment and by maximising the quality of life of those who develop long-term complications. These include:

- **Standard 10:** All young people and adults with diabetes will receive regular surveillance for the long term complications of diabetes
- **Standard 11:** The NHS will develop, implement and monitor agreed protocols and systems of care to ensure that all people who develop long-term complications of diabetes receive timely, appropriate and effective investigation and treatment to reduce their risk of disability and premature death
- **Standard 12:** All people with diabetes requiring multi-agency support will receive integrated health and social care

The Diabetes NSF delivery strategy and the planning and performance framework in 2003-06: *Improvement, Expansion and Reform: the next 3 years*, set the priorities for the NHS for that period. It established two critical diabetes specific targets for eye screening and registers in the early stages of delivery:

- By 2006, a minimum of 80% of people with diabetes to be offered screening for the early detection (and treatment if needed) of diabetic retinopathy as part of a systematic programme that meets national standards.
- By 2007, 100% coverage of those at risk.

Implementing the screening programme has become a key element of the Lambeth PCT Long Term Conditions Strategy.

A Retinopathy Steering Group has been charged to monitor the implementation of the programme by the two Diabetes NSF Networks of Lambeth, Southwark and Lewisham. The lead commissioner is Lambeth PCT and the lead provider is Guys and St Thomas Foundation Trust (GSTT).

Additional funding has been provided across the three PCTs. Progress on the key requirements of the programme recommended by the NSC are summarised as follows:

- **Programme size: minimum 12,000 patients**  
Lambeth is part of a three borough programme with an estimated 30,000 people with diabetes.
- **Accurate Data Collection**

This remains an important gap. Work is underway to accurately identify all patients with diabetes from primary care and develop a central collated call-recall list.

- **Central management of call-recall lists and administration**

The programme office is based at GSTT with the call-recall lists being administered from this office. All administrative staff are now employed to develop the required processes to manage call-recall for the programme.

- **Implementation and effective use of appropriate software**

A major change programme was carried out in 2007 following extensive tendering process and a PASA approved software has now been implemented to run the screening programme.

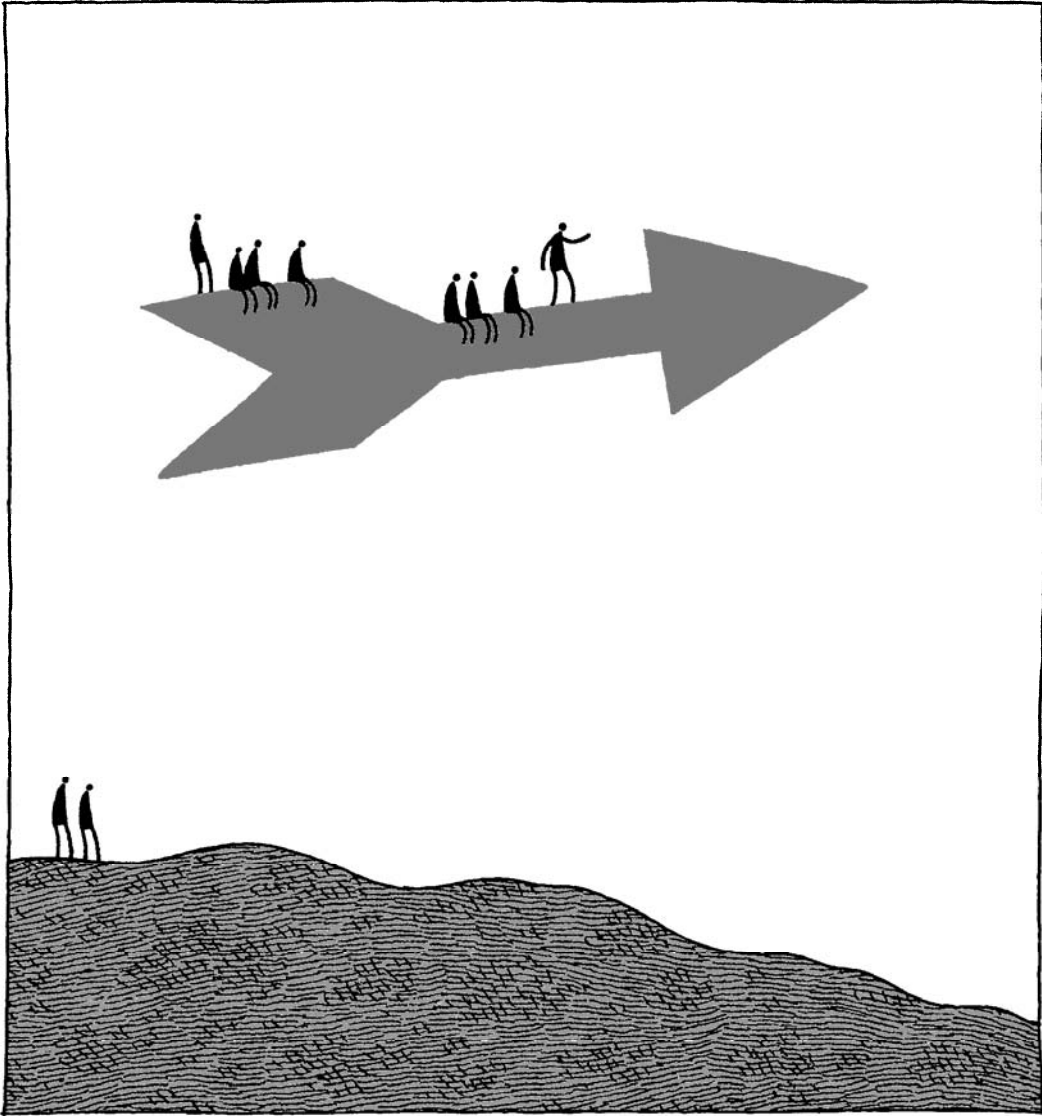
- **Screening method**

Only the use of digital photography, using approved cameras and capture software is now acceptable. Ophthalmoscopy is NOT acceptable and slit-lamp bio microscopy was only acceptable until December 2006. DECS has been using digital photography for a number of years and as part of the capital funding, upgraded to approved cameras and capture software.

- **Secure and efficient links to eye departments**

The clinical lead for the programme is now a consultant ophthalmologist with a special interest in retinal disease. Another consultant ophthalmologist has been appointed to King's who will provide the service at King's and Lewisham. In addition, the new IT systems should help facilitate better sharing of screening and treatment data for quality assurance purposes.

Based on cumulative data our current levels of people with diabetes offered screening is 95% with exclusions (84% without exclusions). The actual number screened is 86% with exclusions (77% without exclusions).



### **3. Recommendations for the future**

#### **Conclusions**

- Lambeth residents have poorer health and increased mortality compared with England and Wales. Health need includes a wide range of health issues.
- Detection of long term illness is improving in primary care, but significant numbers of local people have serious undetected and untreated conditions (diabetes, high blood pressure).
- Population based prevention reduces health inequality, and requires long term investment.
- In Lambeth prevention needs to be both population based and targeted.
- Health outcomes in Lambeth are improving.
- Delivering services which produce equitable outcomes usually requires additional resources.

#### **Recommendations**

1. The PCT must continue to work closely with the Local Authority to improve the understanding of health and wellbeing issues in Lambeth, and to improve information sharing.
2. The JSNA should include evidence of effectiveness for a range of interventions in assessment of need.
3. The PCT should pilot and evaluate outcomes based commissioning for a defined population group/health need in 2009/10. Extra resources are needed for this.
4. Develop and resource common approaches to consultation, patient and public involvement and community engagement across the Local Authority and PCT.
5. The PCT should work with the Local Authority to develop programmes to improve health and wellbeing that reach the most deprived communities (using the health trainer model), via estates, schools and faith communities.
6. The Local Authority should invest resources in the partnership work necessary to deliver health and wellbeing improvement programmes.
7. The PCT should continue health equity audit for the three priority areas (Mental Health, Staying Healthy and End of Life Care) in 2009/10.
8. Partners should ensure that the Sustainable Communities Strategy focus on worklessness will improve health and wellbeing, and develops partnerships between health practitioners and employment and training services.
9. Support Health Scrutiny to develop a plan to reduce alcohol consumption in Lambeth.

## Appendix I. Review of Recommendations 2005-6

The APHR fed into the PCT's priorities and has been used by the PCT to draw up its 5-year plan in particular the Staying Healthy element.

**The PCT should invest resources to support the strategic shift needed to improve health and reduce future demands for healthcare. This should include:**

<b>Recommendation</b>	<b>Progress &amp; Outcome</b>
1 Ensuring that health improvement and health protection are developed elements within major programmes such as NSF implementation, care pathways, demand management, and neighbourhood renewal.	This is being taken forward directly as part of the Staying Healthy work, one of six priorities of the PCT's 5 year Commissioning Strategy Plan (CSP). The other CSP's priorities are focusing on implementing the strategic shift along the core pathway to improve health and reduce future demands for healthcare.
2 Commissioning specialist health promotion on the basis of local needs, new contract and service specification which is outcomes based (including evidence of effectiveness).	The service was re commissioned in 2007/08 and integrated more closely with the provision of community services and the development of Public Health strategy. The new teams are commissioned to provide support to the newly established Staying Healthy Programme.
3 Mainstreaming the posts which enable/inform health improvement, including immunisation coordination, health equity audit and tobacco control.	This is being taken forward as part of the World Class Commissioning work streams that form part of the PCT's 5 year commissioning strategy.
4 Asking public health to undertake a detailed needs assessment which documents the impact of alcohol health and wellbeing in Lambeth, and makes recommendations to the Local Strategic Partnership in 2007. In 2007/2008 there should be investment in specific interventions to reduce harmful drinking for Lambeth residents.	A detailed alcohol health needs assessment has been completed. Safer Healthier Socialising in Lambeth will address harm minimisation in the night-time economy. A local health promotion strategy for alcohol is being developed. A Local Enhanced Service (LES) has been developed and implemented for GPs to perform screening and brief interventions for new patients and those registered with certain chronic conditions for example diabetes.

**Frontline staff are our biggest resource available to promote health, and need to be supported to fulfil this role. It is recommended that:**

- |  |  |
|--|--|
| 5 The job descriptions, workplans, professional development plans of clinical staff reflect their role in health promotion, and the need to maintain skills and knowledge in this area.  | This is being taken forward as part of the Staying Healthy work stream that forms part of the PCT's 5 year Commissioning Strategy Plan. There is a specific work-stream on embedding health promotion delivery within community health services. |
| 6 Induction and training support the maintenance and development of health promotion and health protection skills, (including infection control) and their availability is audited.  | Public health provides a programme of infection control training. Training is also provided in a number of non-health settings, for example, SRE training for Youth workers based at the council.  |
| 7 That consistent evidence based health education material is available to support clinicians in their health promotion/health protection role. In 2007/2008 an audit of health education material in use should be called out. Health education supporting health promotion related to PCT priorities should be commissioned. | This is being taken forward by the Staying Healthy Board as part of the Staying Healthy work stream that forms part of the PCT's 5 year commissioning strategy.  |

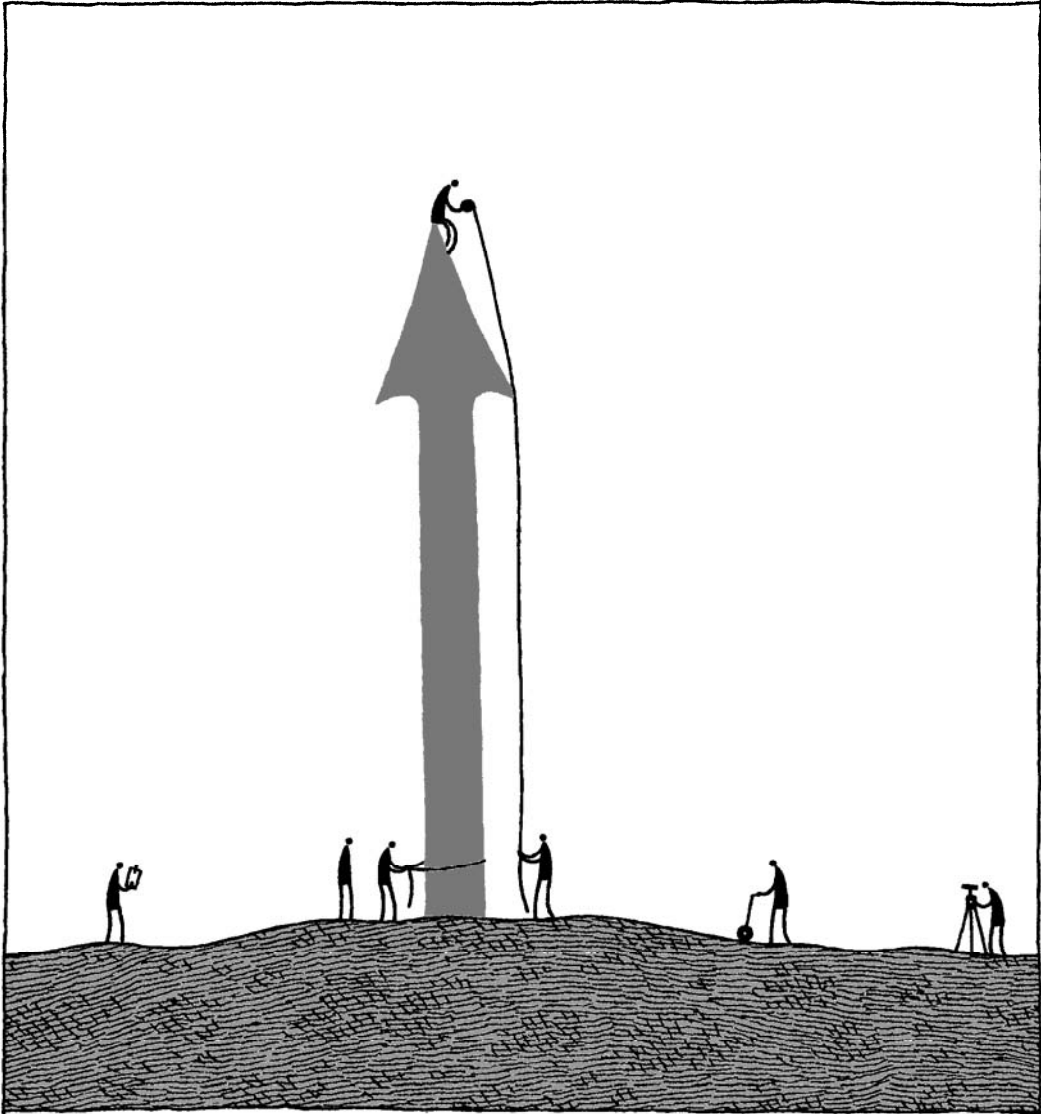
**The role of hospital trusts in health improvement should be supported by:**

- |  |   |
|--|---|
| 8 Commissioning service specifications should include requirements to promote and protect health, and to produce monitorable plans.  | Infection control and tobacco control have been implemented in acute contracts in 2008/09. Introduction of specific requirements for other lifestyle factors are being developed for future service specifications for 2009/10. |
| 9 The PCT should ensure that all hospitals are compliant with Health Act requirements, and inform the Health Protection Unit of incidents of significant healthcare associated infections. | Lambeth PCT has a quarterly quality monitoring meeting with GSTT which includes infection control. Lambeth PCT is represented on the GSTT Infection Control Committee, and so is able to monitor compliance with the Act.       |

**Low income is a significant risk in Lambeth. Outstanding recommendations from previous annual Public Health Reports not actioned:**

- |    |  |   |
|----|--|---|
| 10 | Ensuring the mainstreaming of Sure Start Plus.                                       | Maintained through the St. Michael's Fellowship. Jointly funded by PCT and LA on a 3 year rolling contract. |
| 11 | To review and evaluate uptake of welfare benefits in adults and children in Lambeth. | Taken forward as an LAA target with an agreed action plan.  |



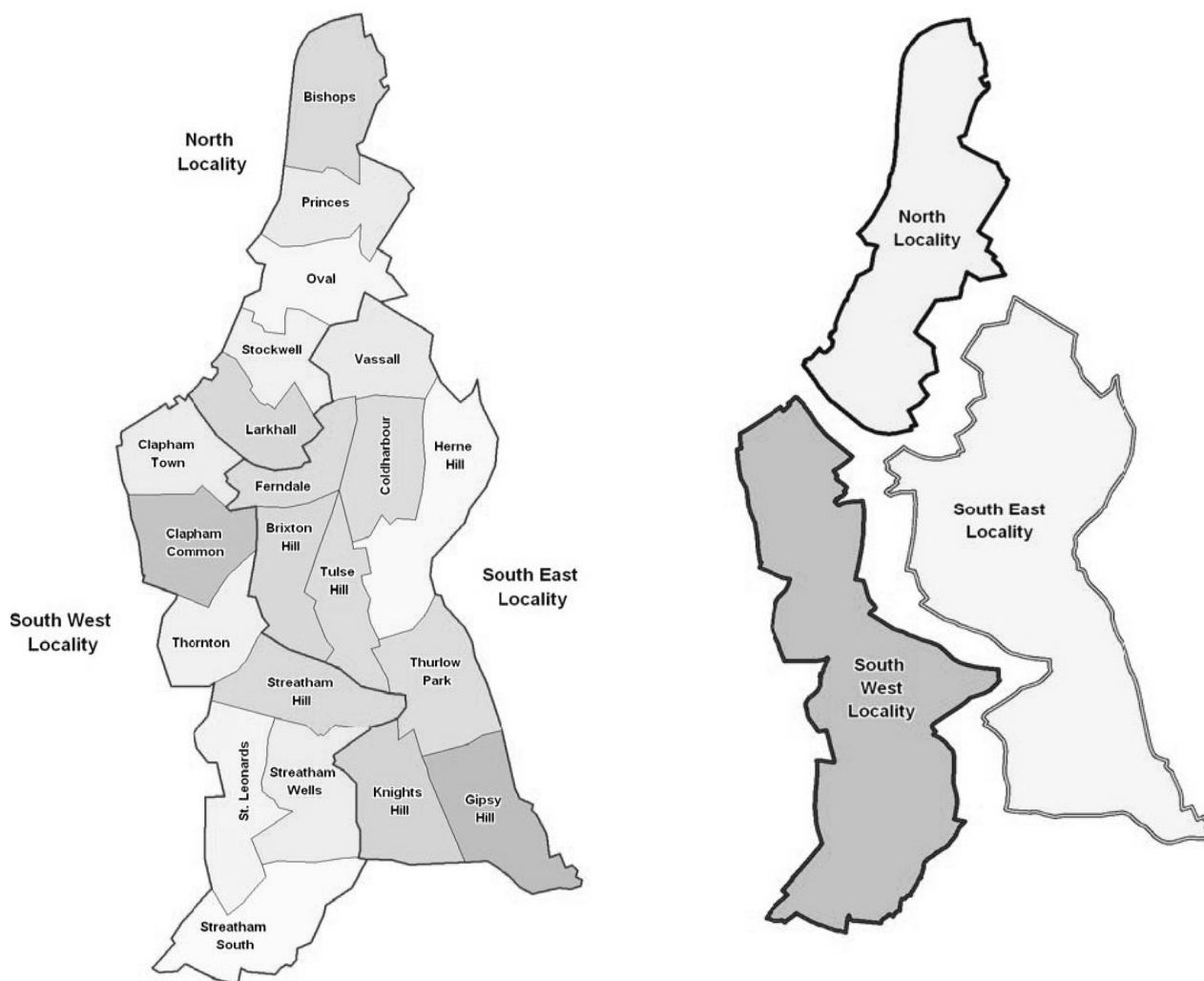


## Appendix 2. Statistical Update 2006-07

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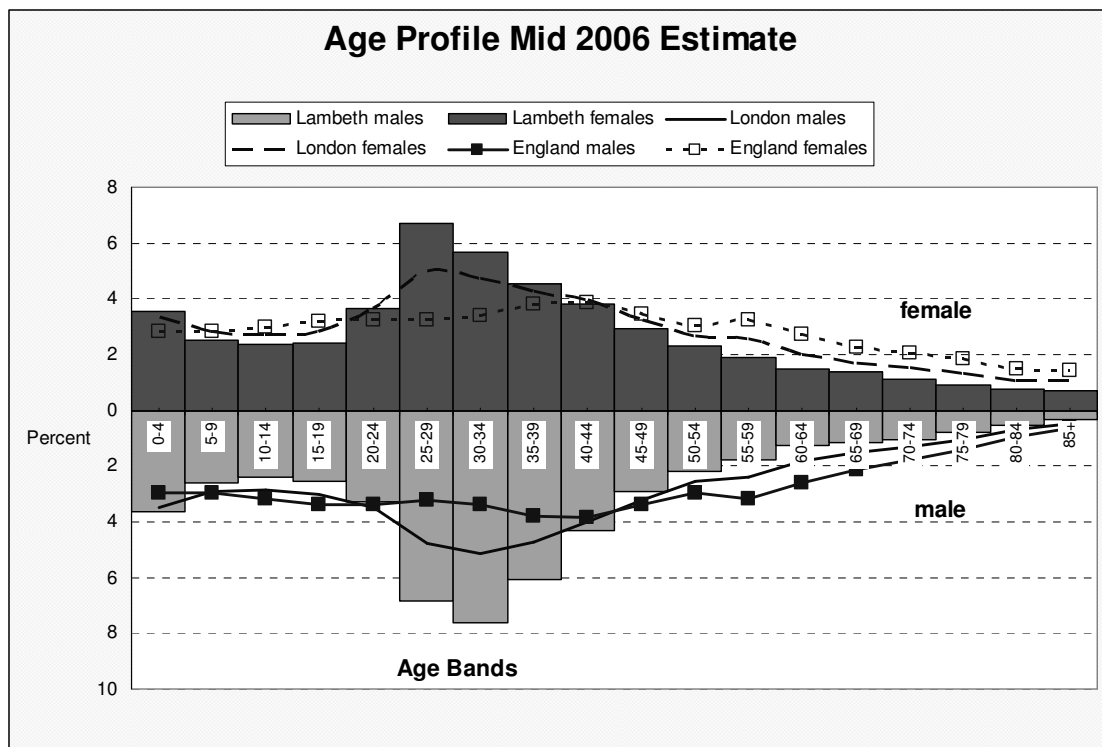
## I. Lambeth wards and localities

Lambeth is an inner London borough with its northern boundary on the river Thames and is situated with Wandsworth to the west, Southwark to the east and Croydon to the south. Lambeth is one of the most densely populated boroughs in the country with a rapidly growing population and relatively high levels of deprivation. Lambeth has 21 wards and comprises six town centre areas namely, North Lambeth, Stockwell, Clapham, Brixton, Streatham and Norwood. The census area classifications describe Lambeth as a London Cosmopolitan area similar to Southwark, Lewisham, Hackney, Islington, Haringey and Brent. According to this classification, Lambeth has a breadth of ethnic and cultural traditions which have established their presence in particular town centre areas and quarters. Lambeth PCT has further divided the borough into three localities - North, South East and South West locality - for facilitation of primary care programmes and interventions



Lambeth Wards and localities

## 2. Population of Lambeth



Source: National Statistics Mid-2006 Population Estimates

Lambeth population age profile

### Population

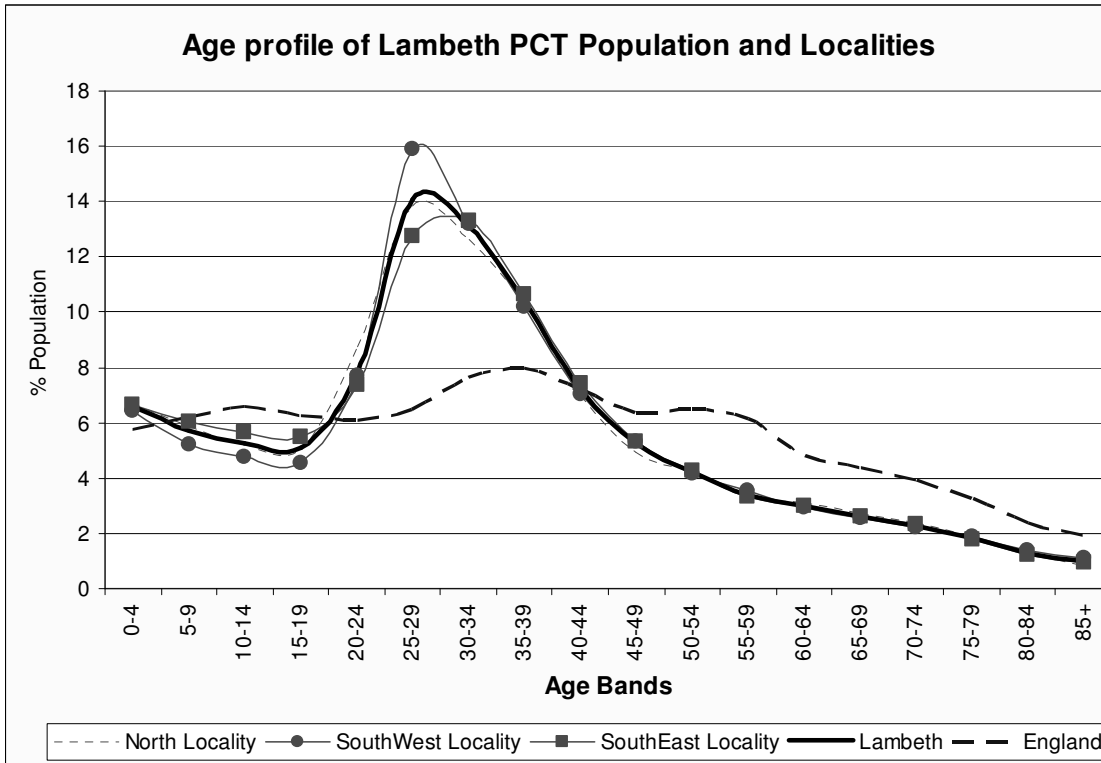
The Office for National Statistics (ONS) published 2006 mid-year estimate showing the population of Lambeth at 271,950. Greater London Authority (GLA) 2005 estimates show the Lambeth population at 286,400. The General Practice registered population in Lambeth in March 2007 was 323,868.

### Gender

The 2006 ONS estimates show 51.2% males and 48.8% females in the Lambeth population, while GLA estimates show 49% males and 51% females within the Lambeth population.

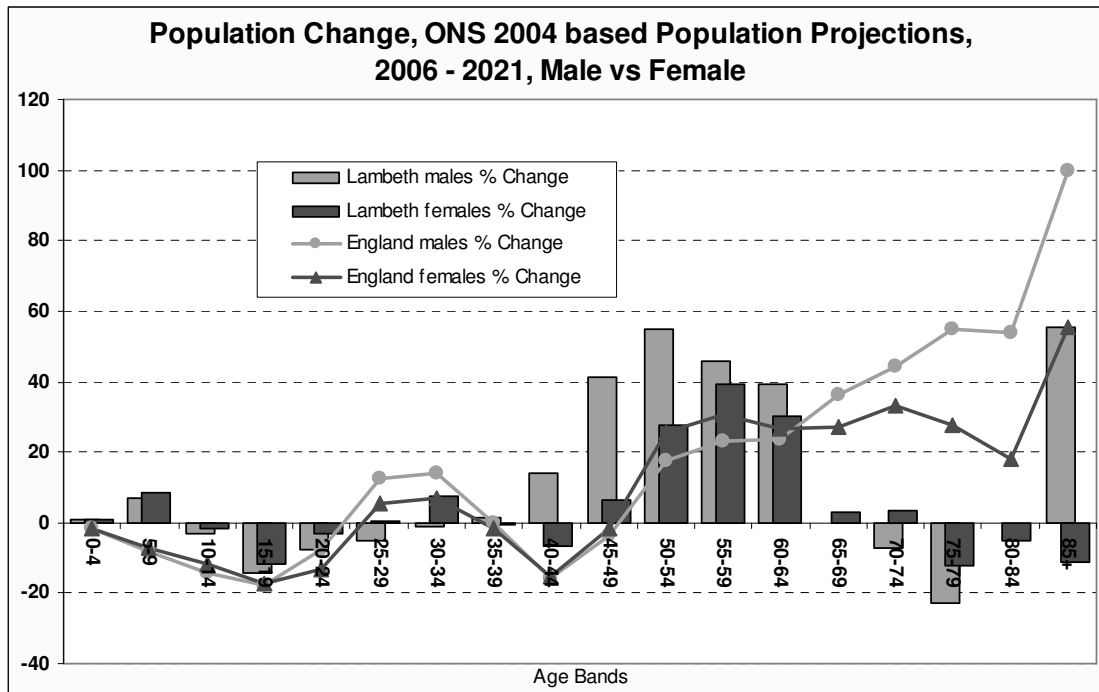
### Age profile

London has a relatively young age profile compared to the whole country and in Lambeth around 45% of the population is in the age group 20-39 years compared with 36% in London in that same age group. The following figure 2b shows the age profile in the three localities of Lambeth compared to the Lambeth average and England.



Source: National Statistics Mid-2006 Population Estimates

## Population Projection



Source: ONS 2004 based Population Projections

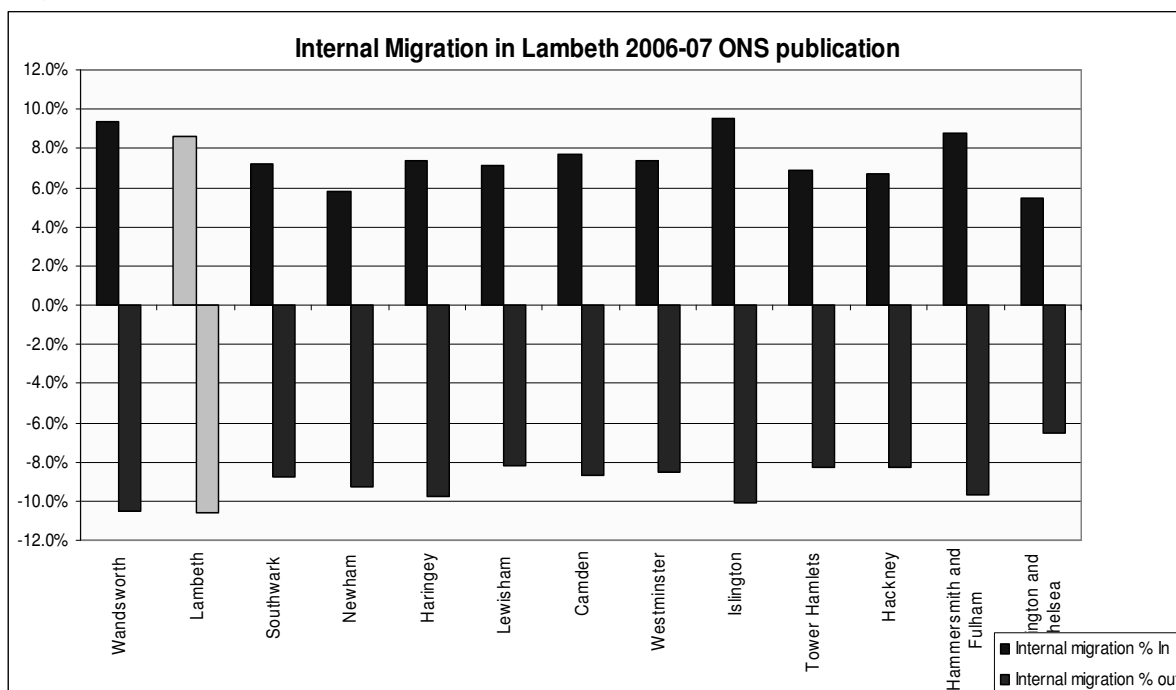
The GLA population projections estimate Lambeth's population will reach 317,000 by 2028. The projections predict Lambeth will remain a young borough with most increases in the

ethnic group occurring in the 0-19 and 20-44 year age ranges, indicating a high proportion of employable adults within the borough.

Age Group	Male		Female		Persons	
	% Change	Diff	% Change	Diff	% Change	Diff
0-4	8.08	800	8.33	800	8.21	1600
5-9	16.90	1200	20.29	1400	19.42	2700
10-14	3.08	200	6.25	400	4.65	600
15-19	-20.29	-1400	-16.92	-1100	-17.91	-2400
20-24	-15.73	-1400	-8.00	-800	-11.64	-2200
25-29	-6.42	-1200	1.09	200	-2.70	-1000
30-34	1.45	300	10.39	1600	5.54	2000
35-39	4.24	700	0.00	0	2.42	700
40-44	16.24	1900	-6.73	-700	5.43	1200
45-49	45.57	3600	3.75	300	24.53	3900
50-54	58.33	3500	23.81	1500	41.46	5100
55-59	48.98	2400	38.46	2000	42.57	4300
60-64	44.12	1500	31.71	1300	39.19	2900
65-69	3.12	100	8.11	300	5.80	400
70-74	-7.14	-200	6.67	200	1.75	100
75-79	-18.18	-400	-12.00	-300	-14.89	-700
80-84	7.14	100	-10.00	-200	-2.94	-100
85+	77.78	700	-5.26	-100	21.43	600
<b>ALL AGES</b>	<b>8.97</b>	<b>12500</b>	<b>5.28</b>	<b>7000</b>	<b>7.17</b>	<b>19500</b>

Percentage Change in Population from 2006 to 2021 in Lambeth: ONS 2006 mid-year Population Projections

## Migration



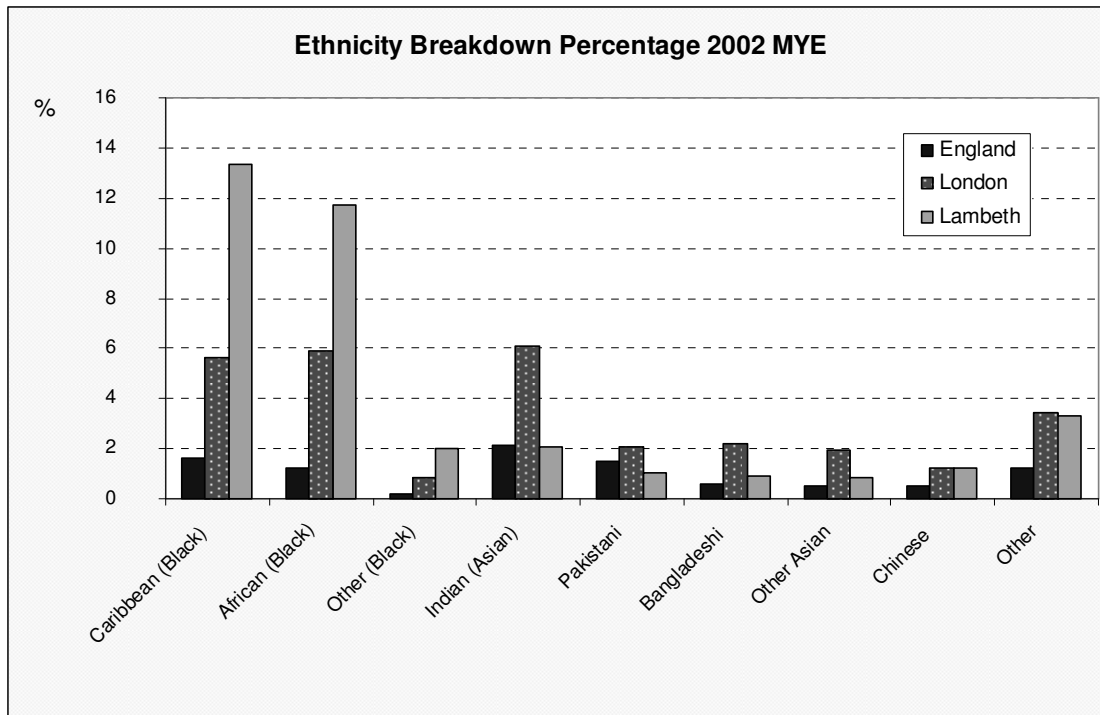
Internal migration (Inflow and Outflow) in Lambeth expressed as a percentage of population 2006-07

### 3. Ethnicity

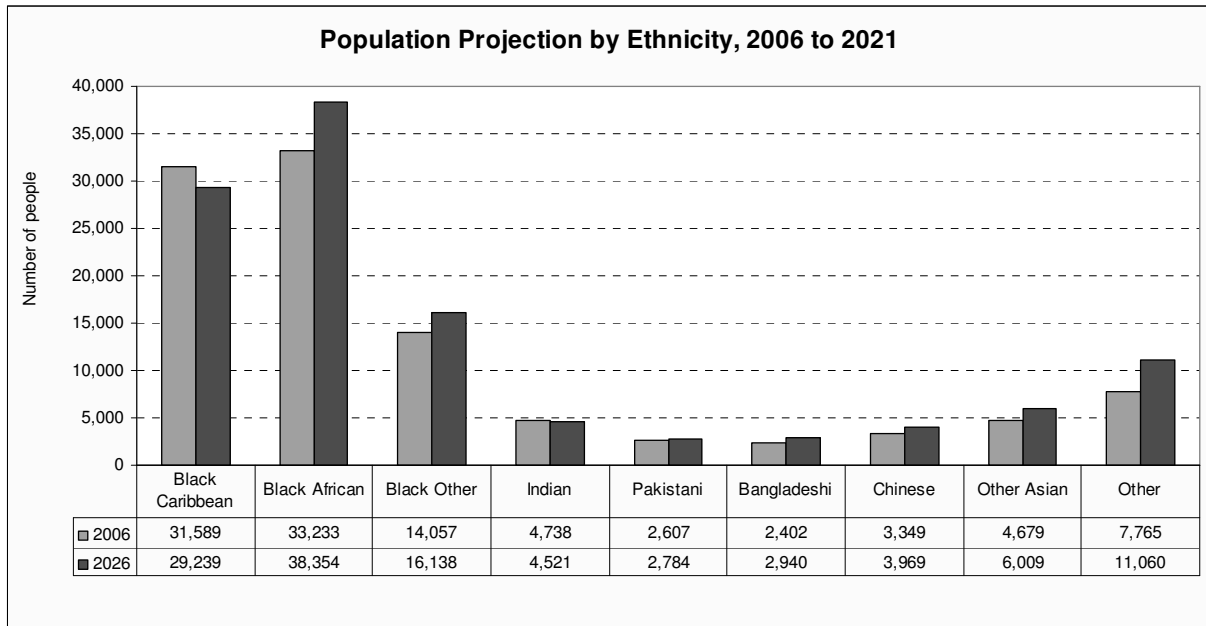
Lambeth has an ethnically diverse population with the Black and Minority Ethnic (BME) community accounting for 35% of the total population which is the seventh highest proportion in the country. In Lambeth over 68,000 (approximately 23%) people are classified as Black with almost equal proportions of Black African (11.5%) and Black Caribbean (11.5%). The borough has the second highest proportion of Black Caribbean residents after Lewisham and fourth highest proportion of Black African residents. Approximately 21% people within the inner London boroughs speak a foreign language at home and based on reports from schools, around 132 different languages are spoken by families within the borough.

	White	Caribbean (Black)	African (Black)	Other (Black)	Indian (Asian)	Pakistani	Bangladeshi	Other Asian	Chinese	Other
<b>ENGLAND</b>	90.397	1.645	1.240	0.202	2.164	1.495	0.587	0.523	0.514	1.232
<b>LONDON</b>	70.687	5.651	5.886	0.838	6.110	2.047	2.178	1.913	1.229	3.463
<b>Lambeth</b>	63.559	13.375	11.717	1.990	2.063	1.032	0.884	0.847	1.253	3.316

Population figures from different ethnic groups.



Source: ONS; Estimated resident population by ethnic groups, age, sex, mid-2002 (experimental statistics)



Source: GLA 2005 Round Interim Ethnic Group Projections

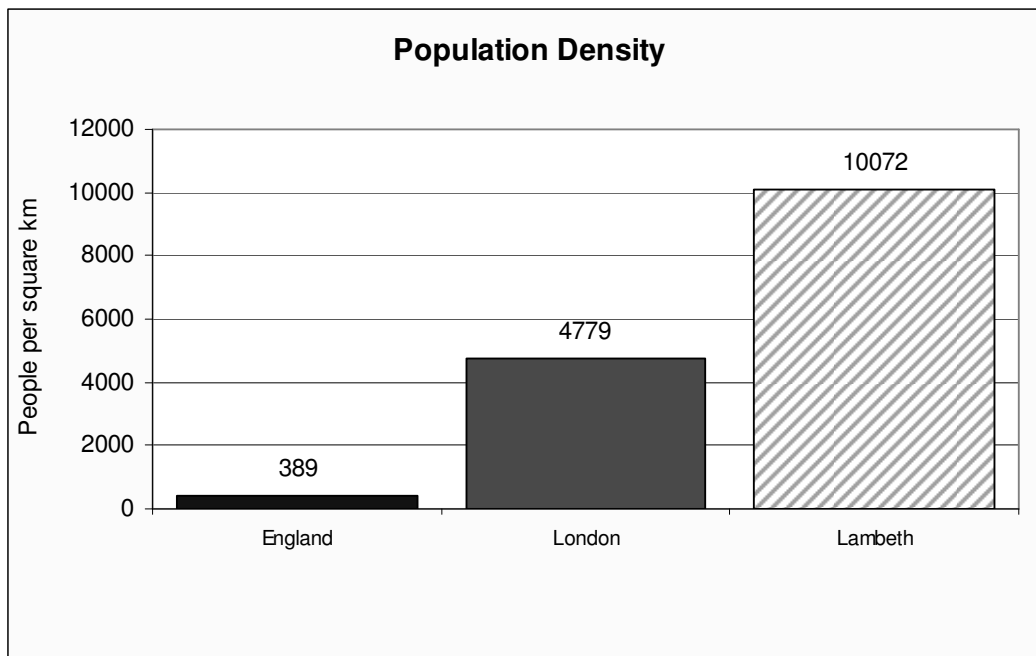
Ethnic group projections from GLA suggest that the Black Caribbean group in Lambeth is likely to decrease by 2% of the total population in the next 25 years, compared to an increase in the Black African population by 15% and in the Asian population by 26%. These projections are based on the Census ethnic complexity of Lambeth’s communities and this pattern is not expected to change during the period 2008-2033.

#### 4. Density

Lambeth is one of the most densely populated boroughs in the country with a rapidly growing population that is projected to grow by 15% over the next 20 years. In 2006, the density (measured in terms of people occupancy per square kilometre) in Lambeth shows an increase compared with 2005 by 77 people per Sq. Km almost similar to that of London.

	Area (Sq Km)	MYE	People per Sq Km
England	130281	50,726,382	389
London	1572	7,512,372	4779
Lambeth	27	271,950	10072

Population Density

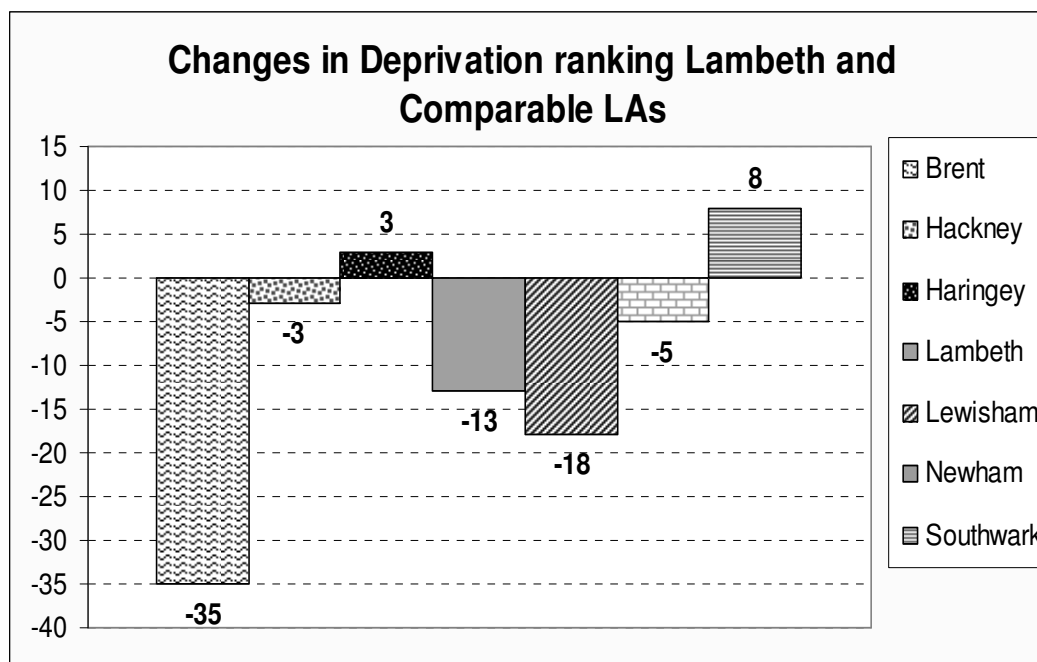


Source: Estimated Resident Population Mid-2006, ONS

Population Density

## 5. Deprivation

The 2007 Index of Multiple Deprivation (IMD) places Lambeth as the 5th most deprived borough in London and 19th most deprived in England. Poverty and social exclusion are some of the social challenges in the borough.



Local authority	Score 2007	Rank	Score 2004	Rank	Change	Status
<b>Brent</b>	29.22	53	24.85	88	-35	Worsening
<b>Hackney</b>	46.10	2	42.90	5	-3	Worsening
<b>Haringey</b>	35.73	18	36.11	15	3	Improving
<b>Lambeth</b>	34.94	19	32.21	32	-13	Worsening
<b>Lewisham</b>	31.04	39	28.43	57	-18	Worsening
<b>Newham</b>	42.95	6	39.33	11	-5	Worsening
<b>Southwark</b>	33.33	26	34.74	18	8	Improving

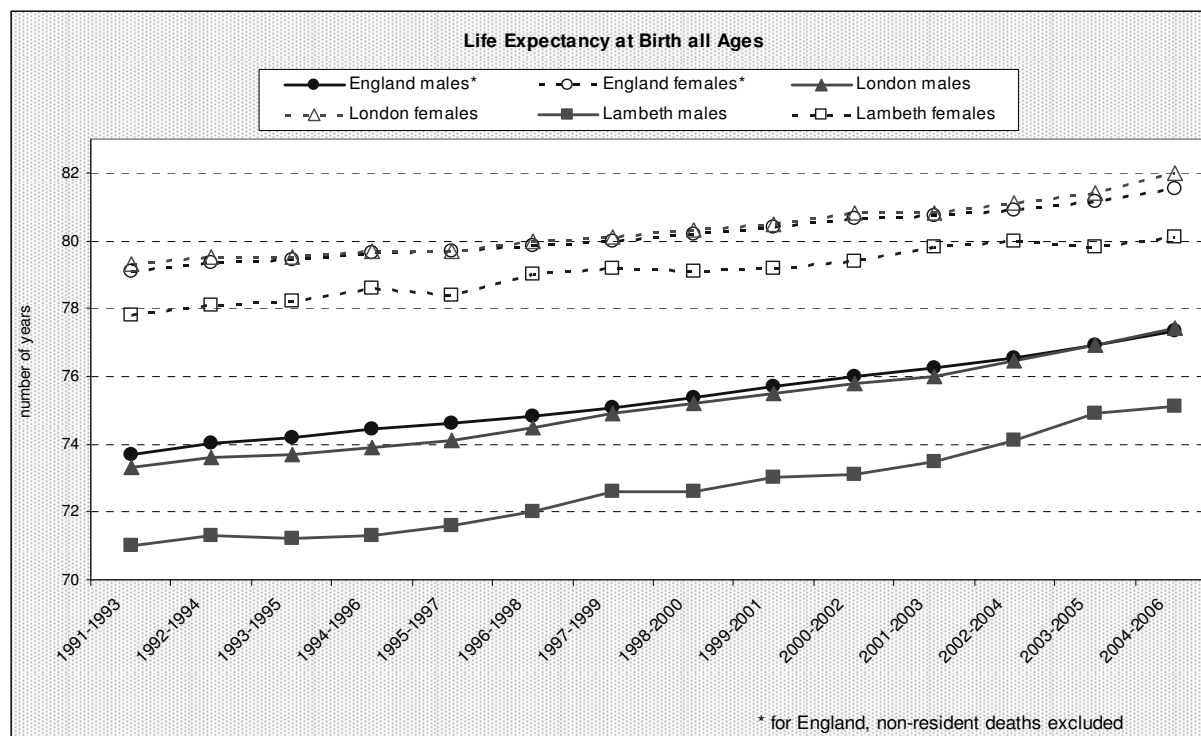
Changes in IMD deprivations scores and ranks 2004 - 2007

The above table describes the relative change in deprivation indices for the London cosmopolitan boroughs. It is notable that Lambeth is now the 5th most deprived borough in London. Lambeth has 177 super output areas (SOA's) - with roughly 1,500 residents. In 2007, 26 (14.7%) of these were in the 10% most deprived in the country compared to 20 (11.3%) in 2004. Overall the most deprived are the areas of Coldharbour between, roughly, Railton Road and the Moorlands Estate; the Crown Lane area of Knights Hill ward and the Angell Town Estate in Coldharbour.



## 6. Life Expectancy

Lambeth male life expectancy has shown improvement compared to the female life expectancy, although nationally, life expectancy is improving at a faster rate compared to the spearhead PCTs of which Lambeth is one. (Spearhead PCTs are the 20% of PCTs in England with the highest levels of deprivation).



Source: Estimated Resident Population Mid-2006, ONS

	1991 - 1993	1992 - 1994	1993 - 1995	1994 - 1996	1995 - 1997	1996 - 1998	1997 - 1999	1998 - 2000	1999 - 2001	2000 - 2002	2001 - 2003	2002 - 2004	2003 - 2005	2004 - 2006
England male*	73.69	74.02	74.18	74.44	74.61	74.84	75.09	75.38	75.71	76.00	76.23	76.53	76.90	77.32
London male	73.30	73.60	73.70	73.90	74.10	74.50	74.90	75.20	75.50	75.77	76.01	76.44	76.90	77.42
Lambeth male	71.0	71.3	71.2	71.3	71.6	72.0	72.6	72.6	73.0	73.1	73.5	74.1	74.9	75.1
England female*	79.12	79.37	79.44	79.64	79.69	79.84	79.97	80.19	80.42	80.66	80.72	80.91	81.14	81.55
London female	79.30	79.50	79.50	79.70	79.70	80.00	80.10	80.30	80.50	80.80	80.80	81.10	81.40	82.00
Lambeth female	77.8	78.1	78.2	78.6	78.4	79.0	79.2	79.1	79.2	79.4	79.8	80.0	79.8	80.1

\* England, non-resident deaths excluded

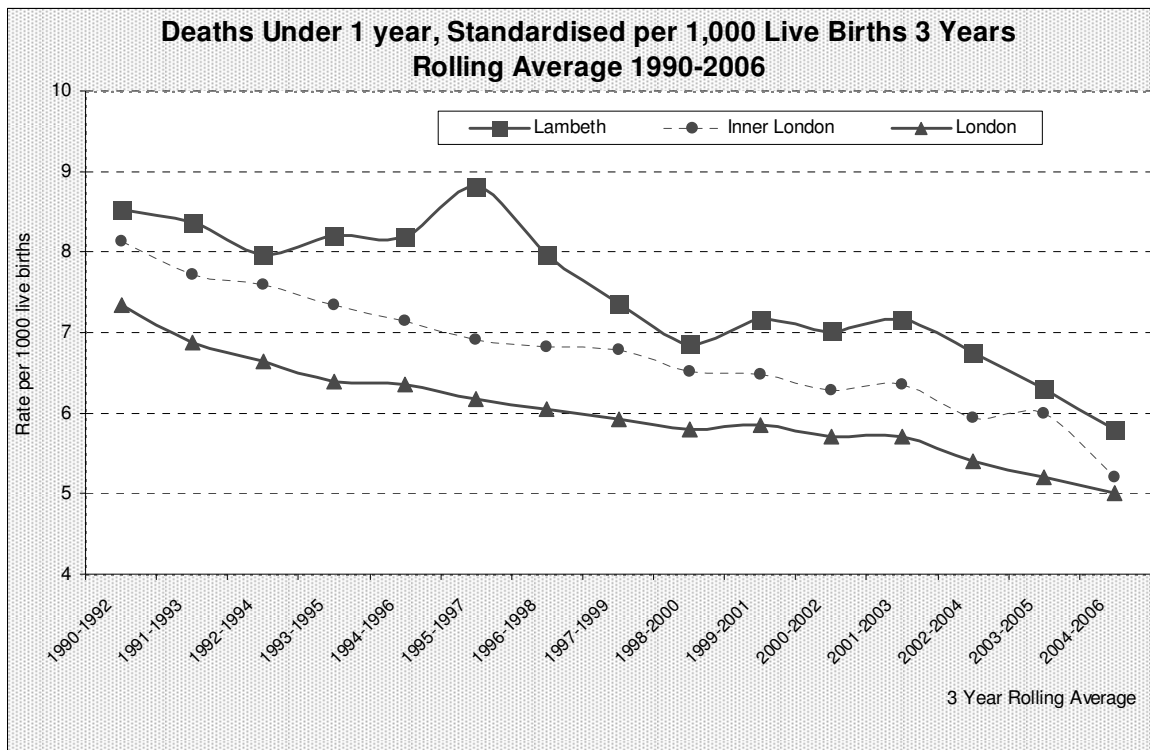
### Life Expectancy at birth all ages 1991-2006

The estimated life expectancy for Lambeth males increased from 74.1 in 2002-04 to 75.1 in 2004-06. The projected life expectancy of males in Lambeth by 2009-11 is 76.1 years.

The estimated life expectancy for Lambeth females remains unchanged from 80.0 in 2002-04 to 80.1 in 2004-06. The projected life expectancy of females in Lambeth by 2009-11 is 80.8 years.

## 7. Infant mortality

Infant mortality (deaths of infants aged under 1 year) has dropped from 8.8 per 1000 live births in 1995-97 to 5.8 per 1000 live births in 2004-06 which is a reduction of over 26%; however there is still a gap when compared to the London rate as seen in the graph below.



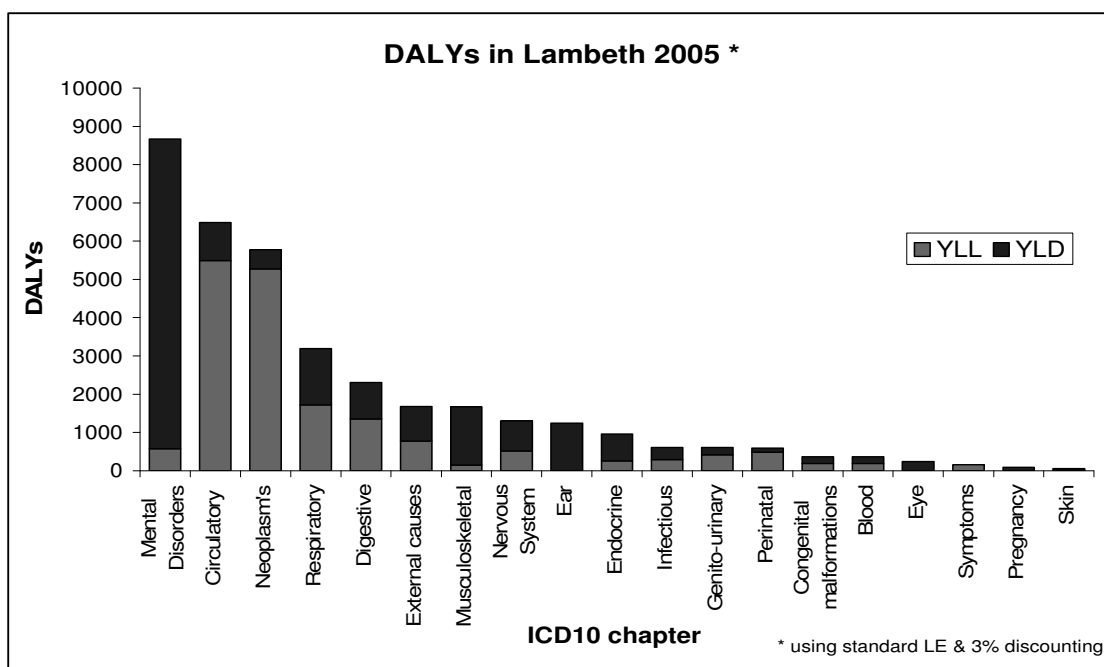
Source: Office for National Statistics (ONS). NCHOD – National Compendium of Health Outcomes Development. ([www.nchod.nhs.uk](http://www.nchod.nhs.uk))

	1991-1993	1992-1994	1993-1995	1994-1996	1995-1997	1996-1998	1997-1999	1998-2000	1999-2001	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006
Lambeth	8.4	8.0	8.2	8.2	8.8	8.0	7.4	6.9	7.2	7.0	7.2	6.8	6.3	5.8
Inner London	7.7	7.6	7.3	7.1	6.9	6.8	6.8	6.5	6.5	6.3	6.3	5.9	6.0	5.2
London	6.9	6.6	6.4	6.4	6.2	6.0	5.9	5.8	5.8	5.7	5.7	5.4	5.2	5.0

Mortality in Infancy 1991-2006

## 8. Mortality and morbidity

The bar chart below summarises the current mortality and morbidity burden by International Classification of Disease chapter (ICD 10) as measured by Disability Adjusted Life Year (DALY) - a measure of the years of life lost (YLL) and years lived with disability (YLD) from an ideal standard (the standard expected years of life). The diagram illustrates that the current burden in Lambeth when ranked for both mortality and morbidity by ICD 10 chapter is highest for mental disorders (including dementia), followed by cardiovascular disease and neoplasms (cancers).



Source: Lambeth Commissioning Strategy Plan 2007-2012

Early intervention provides effective outcomes in the long-term and the importance of prevention and early detection and treatment has been highlighted through the “Staying Healthy” work stream adopted and developed by the PCT in its five year Commissioning Strategy Plan (CSP).

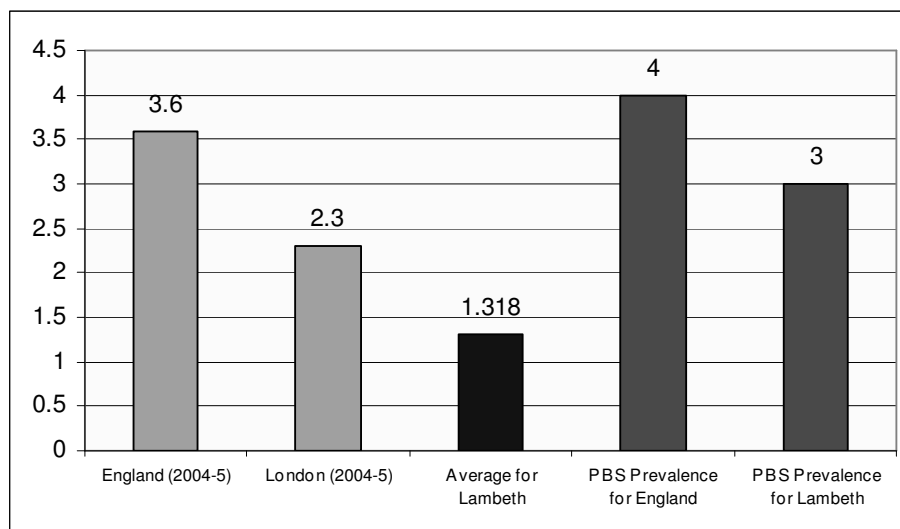
### Hypertension

One of the conditions that put individuals at high risk of premature morbidity and mortality – especially from cardio-vascular disease - is hypertension. Case detected prevalence of hypertension (from GPs’ QOF data) was similar throughout the three localities of Lambeth PCT. This equates to approximately 34,000 people in Lambeth who may have hypertension but are not diagnosed, and therefore not receiving treatment.

Comparison of case detected prevalence in Lambeth and actual population prevalence estimated using the “PBS prevalence models” published by the Association of Public Health Observatories estimate approximately 30,000 in Lambeth who are undiagnosed as having hypertension. QMAS data shows an average case detected prevalence of 8.9% in Lambeth. The PBS model estimates the actual prevalence in Lambeth to be 19.9% - over 10% higher than detected prevalence. The GP register data shows that out of the 9.1% detected hypertensive patients around 6.6% are receiving treatment at the moment.

### Coronary Heart Disease (CHD)

The graph below shows CHD prevalence from Lambeth QOF data compared to prevalence measured using the Association of Public Health Observatories’ (APHO) PBS model.

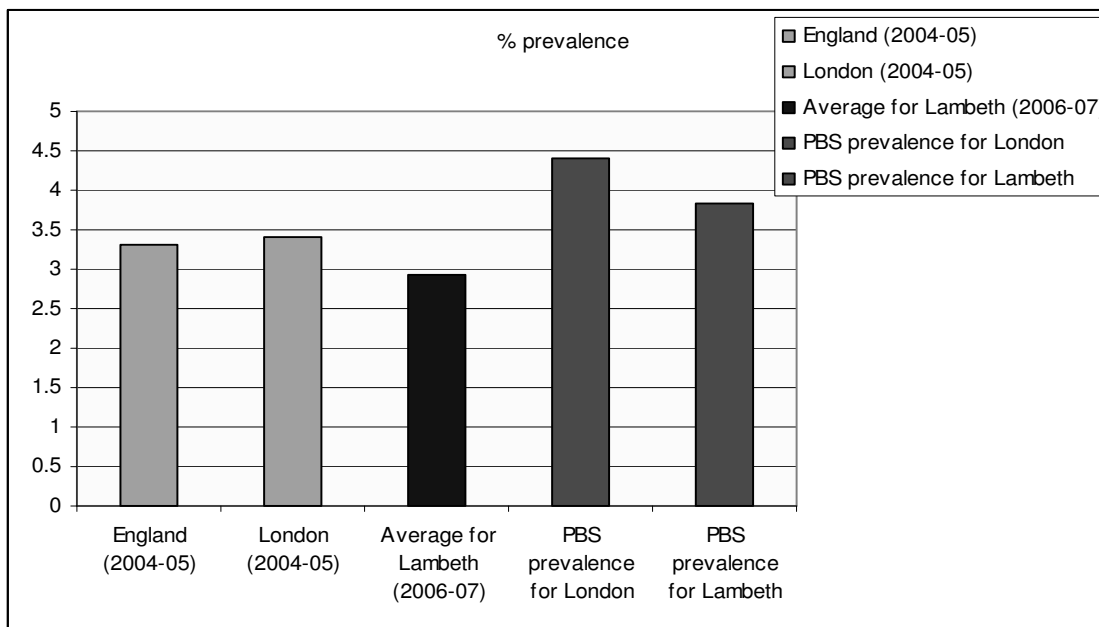


Source: CHD (Coronary heart disease) Prevalence model. YHPHO – Yorkshire and Humber Public health observatory. Doncaster PCT. 2006

When CHD case-detected prevalence is compared with the population prevalence using the model, the findings show that there may be over 5000 undiagnosed cases of people with CHD in Lambeth. Cardio-vascular diseases have a direct impact on the quality of life of an individual. In addition they are directly associated risk factors causing premature mortality. Lambeth PCT aims to detect hypertension early and to offer timely and cost-effective treatment for cardio-vascular diseases, using the health inequalities intervention tool published by the London Health Observatory to plan interventions.

## Diabetes

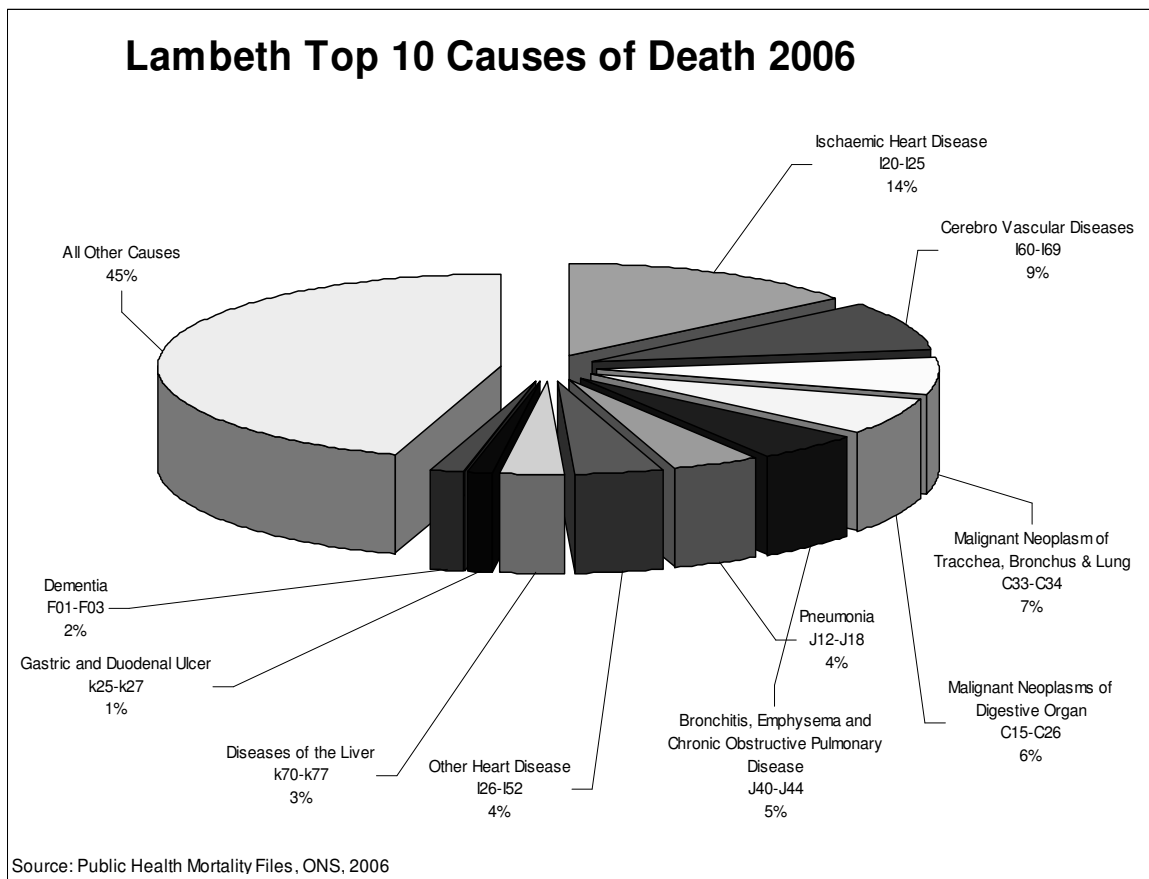
The graph below shows diabetes prevalence from Lambeth QOF data compared to prevalence measured using the APHO PBS model.



Source: Diabetes PBS Model Phase 2. YHPHO – Yorkshire and Humber Public health observatory. 2005.

QMAS data shows an average case detected prevalence of 2.9% in Lambeth, whilst the PBS model estimates the actual prevalence in Lambeth as 3.8% and 4.4% in London. This equates to roughly a quarter of cases in Lambeth (about 1000 patients) which may be undiagnosed in the community. Uncontrolled diabetes can lead to several complications such as eye, kidney and heart problems, which can significantly affect the quality of life of an individual.

## Cause of Death



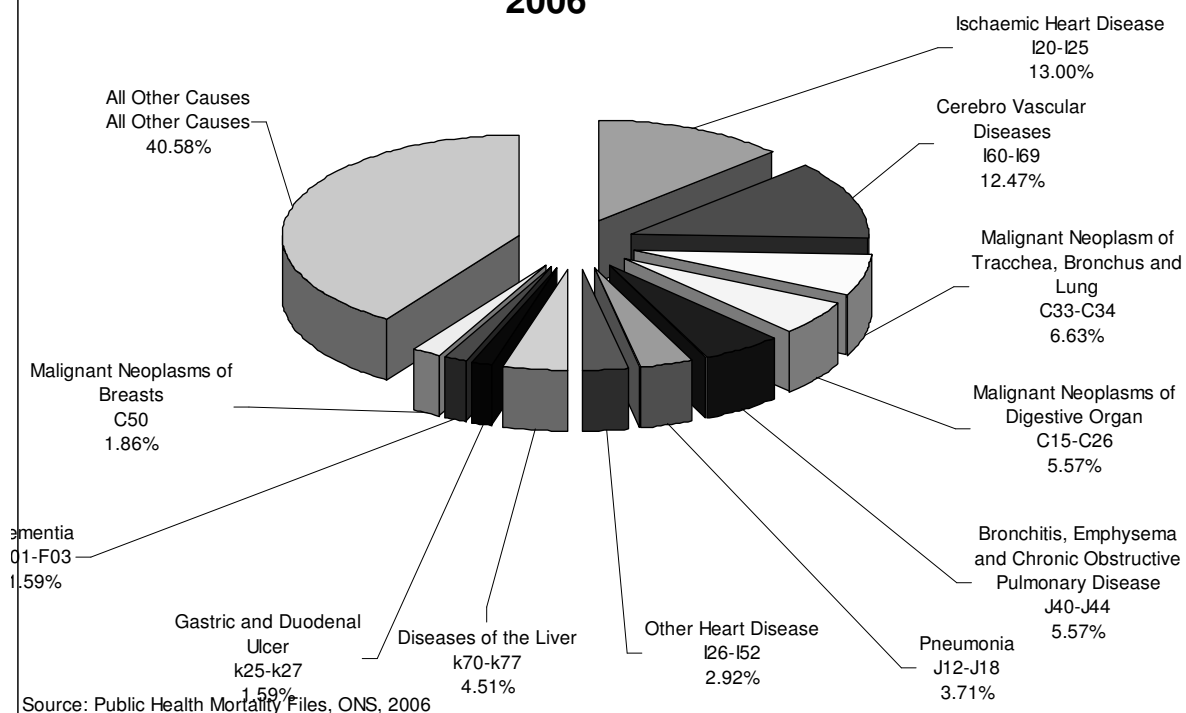
Code	Description	Count	%
All Cause	All Cause	1640	
I20-I25	Ischaemic Heart Disease	231	14.09
I60-I69	Cerebro Vascular Diseases	143	8.72
C33-C34	Malignant Neoplasm of Trachea, Bronchus & Lung	107	6.52
C15-C26	Malignant Neoplasms of Digestive Organ	106	6.46
J40-J44	Bronchitis, Emphysema and Chronic Obstructive Pulmonary Disease	81	4.94
J12-J18	Pneumonia	71	4.33
I26-I52	Other Heart Disease	66	4.02
k70-k77	Diseases of the Liver	53	3.23
k25-k27	Gastric and Duodenal Ulcer	18	1.10
F01-F03	Dementia	25	1.52
All Other Causes		739	45.06

Source: Public Health Mortality Files, ONS, 2006

### Lambeth top 10 Causes of Death, 2006

The data on cause of death is derived from the Public Health Mortality Files which are provided by the ONS annually. The pie charts show the proportion of each cause of death. As noted in previous years, the top three causes of death in Lambeth are ischaemic heart disease, cerebro-vascular diseases and malignant neoplasms or cancer, followed by chronic obstructive lung disease at fourth place. The following pie charts present the cause of death in North, Southeast and Southwest localities of Lambeth.

## Lambeth Top 10 Causes of Death, North Locality 2006

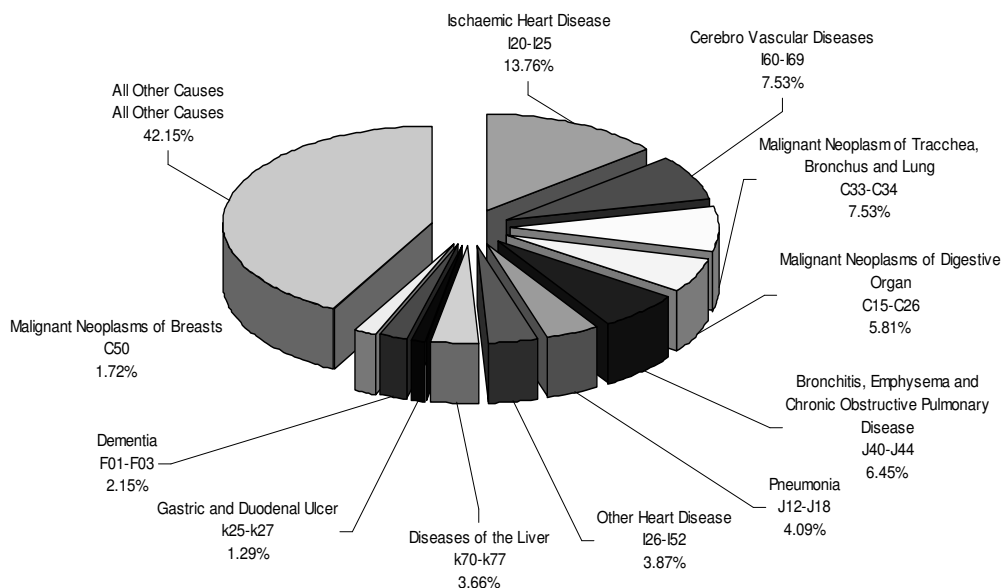


Code	Description	Count	%
All Cause	All Cause	377	
I20-I25	Ischaemic Heart Disease	49	13.0
I60-I69	Cerebro Vascular Diseases	47	12.5
C33-C34	Malignant Neoplasm of Trachea, Bronchus and Lung	25	6.6
C15-C26	Malignant Neoplasms of Digestive Organ	21	5.6
J40-J44	Bronchitis, Emphysema and Chronic Obstructive Pulmonary Disease	21	5.6
J12-J18	Pneumonia	14	3.7
I26-I52	Other Heart Disease	11	2.9
k70-k77	Diseases of the Liver	17	4.5
k25-k27	Gastric and Duodenal Ulcer	6	1.6
F01-F03	Dementia	6	1.6
C50	Malignant Neoplasms of Breasts	7	1.9
All Other Causes		153	40.5836

Source: Public Health Mortality Files, ONS, 2006

Lambeth Top 10 Causes of Death, North Locality 2006

## Top 10 Causes of Death, South West Locality 2006



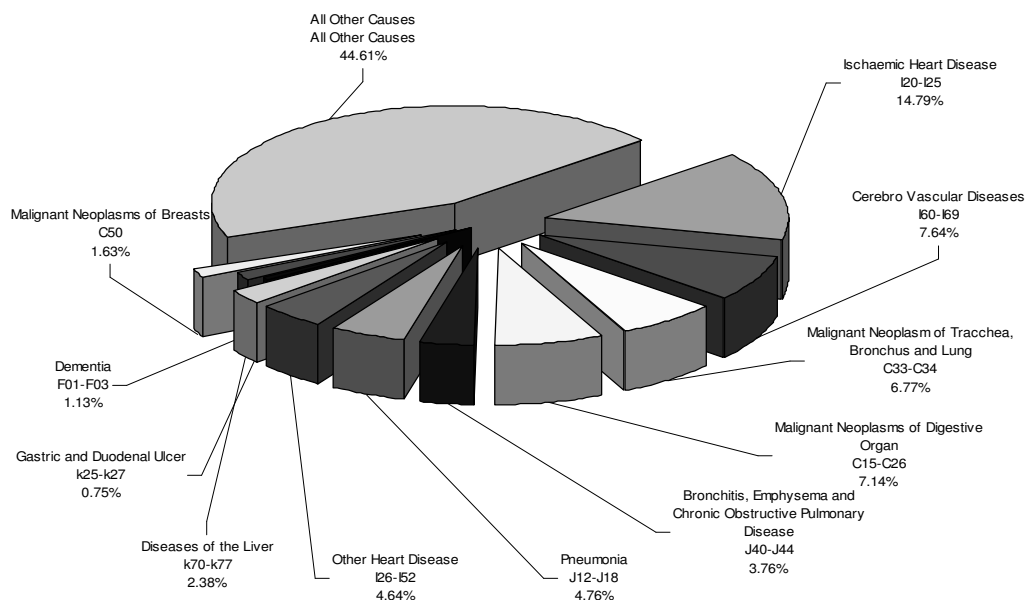
Source: Public Health Mortality Files, ONS, 2006

Code	Description	Count	%
All Cause	All Cause	465	
I20-I25	Ischaemic Heart Disease	64	13.76
I60-I69	Cerebro Vascular Diseases	35	7.53
C33-C34	Malignant Neoplasm of Trachea, Bronchus and Lung	35	7.53
C15-C26	Malignant Neoplasms of Digestive Organ	27	5.81
J40-J44	Bronchitis, Emphysema and Chronic Obstructive Pulmonary Disease	30	6.45
J12-J18	Pneumonia	19	4.09
I26-I52	Other Heart Disease	18	3.87
k70-k77	Diseases of the Liver	17	3.66
k25-k27	Gastric and Duodenal Ulcer	6	1.29
F01-F03	Dementia	10	2.15
C50	Malignant Neoplasms of Breasts	8	1.72
All Other Causes	All Other Causes	196	42.15

Source: Public Health Mortality Files, ONS, 2006

## Lambeth top 10 Causes of Death, South West Locality 2006

## Top 10 Causes of Death, South East locality 2006



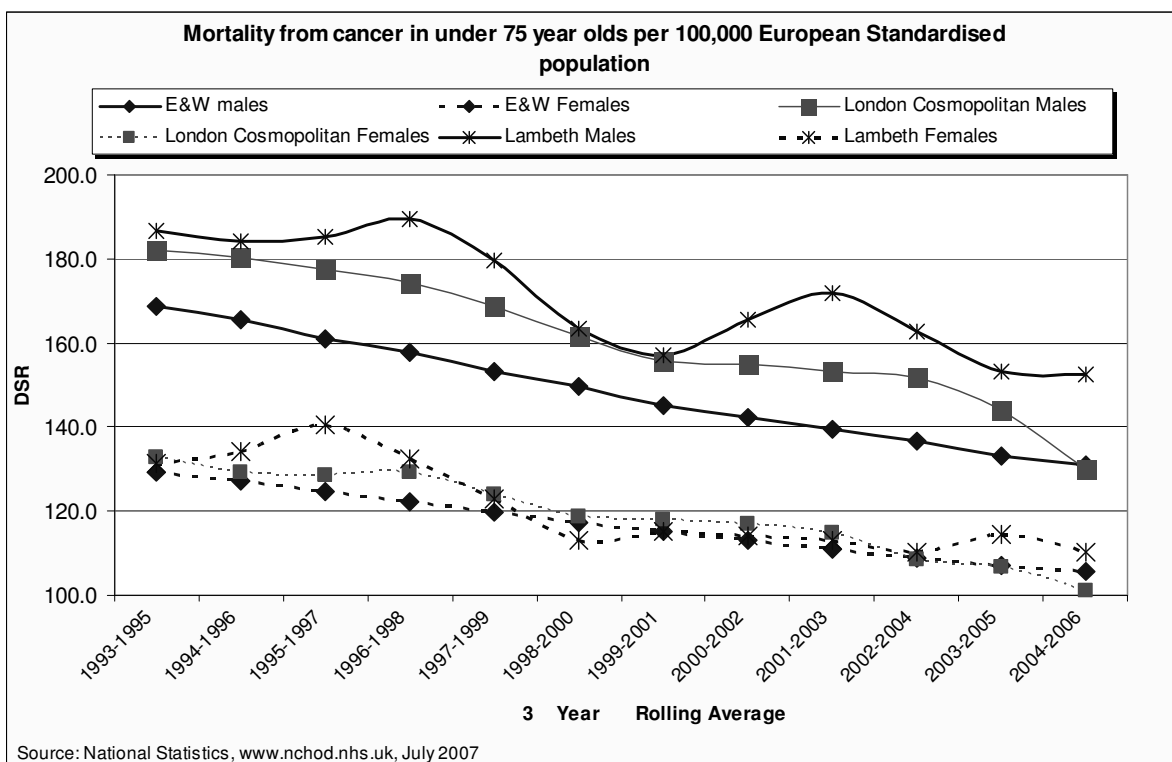
Source: Public Health Mortality Files, ONS, 2006

Code	Description	Count	%
All Cause	All Cause	798	100
I20-I25	Ischaemic Heart Disease	118	14.79
I60-I69	Cerebro Vascular Diseases	61	7.64
C33-C34	Malignant Neoplasm of Trachea, Bronchus and Lung	54	6.77
C15-C26	Malignant Neoplasms of Digestive Organ	57	7.14
J40-J44	Bronchitis, Emphysema and Chronic Obstructive Pulmonary Disease	30	3.76
J12-J18	Pneumonia	38	4.76
I26-I52	Other Heart Disease	37	4.64
k70-k77	Diseases of the Liver	19	2.38
k25-k27	Gastric and Duodenal Ulcer	6	0.75
F01-F03	Dementia	9	1.13
C50	Malignant Neoplasms of Breasts	13	1.63
All Other Causes	All Other Causes	356	44.61

Source: Public Health Mortality Files, ONS, 2006

## Lambeth Top 10 Causes of Death, South East Locality 2006

## Mortality from all Cancers



Source: National Statistics, NCHOD December 2007

### Mortality from all Cancers – 3 years rolling average 1993-2006

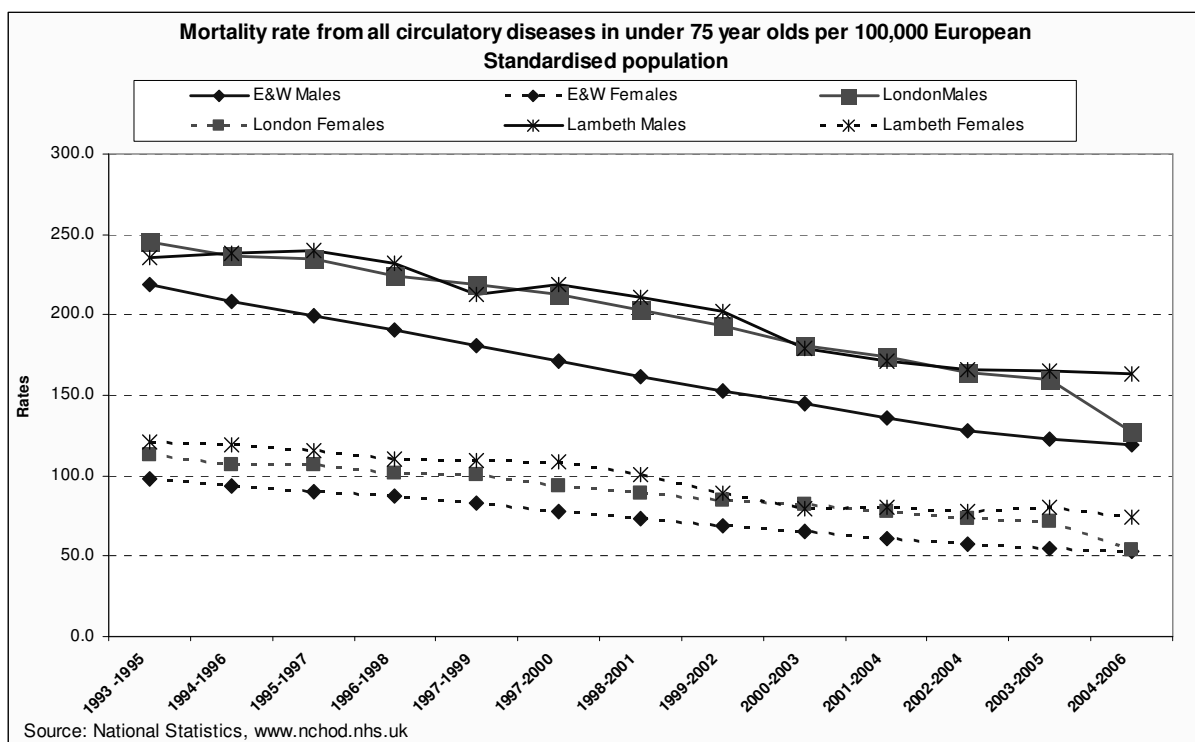
	1993-1995	1994-1996	1995-1997	1996-1998	1997-1999	1998-2000	1999-2001	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006
ENGLAND male	167.89	164.98	160.78	157.58	152.88	149.29	144.70	142.11	139.44	136.51	132.90	130.37
LONDON male	167.51	165.79	161.46	158.55	153.68	148.47	143.84	141.46	139.85	135.80	131.60	130.08
Lambeth male	186.48	184.17	185.21	189.41	179.74	163.26	156.88	165.37	171.77	162.12	152.20	152.62
ENGLAND female	129.08	126.85	124.52	121.96	119.29	116.97	114.72	112.66	110.32	108.33	106.55	105.10
LONDON female	129.05	126.68	125.16	123.79	120.31	117.27	113.89	111.44	108.54	105.87	103.45	100.95
Lambeth female	131.25	134.24	140.52	132.42	122.81	113.01	115.00	113.94	112.60	109.83	113.70	110.35

Source: [www.nchod.nhs.uk](http://www.nchod.nhs.uk)

### Mortality from all Cancers Aged Under 75, 3 Year Rolling Average 1993-2006

There has been a relatively small change in the reduction in mortality rate from cancers in Lambeth residents in 2004-06 compared to the 2003-05 average.

## Mortality from all Circulatory Diseases



Source: National Statistics, NCHOD, December 2007

### Mortality from all Circulatory Diseases – 3 years rolling average 1993-2006

	1993-1995	1994-1996	1995-1997	1996-1998	1997-1999	1998-2000	1999-2001	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006
ENGLAND male	217.0	206.6	198.4	189.2	179.3	170.0	160.2	151.4	143.7	135.6	127.0	118.4
LONDON male	218.2	211.6	203.7	193.5	183.2	176.4	167.2	160.5	153.6	146.7	137.5	127.5
Lambeth male	235.8	238.6	239.7	232.2	212.3	218.3	210.4	201.6	179.3	171.0	164.7	163.0
ENGLAND female	97.0	92.9	89.6	86.3	82.0	77.5	72.5	68.3	64.8	60.6	56.4	52.2
LONDON female	94.0	90.6	87.5	83.9	81.0	77.4	74.5	70.6	67.8	63.5	59.2	54.0
Lambeth female	120.6	119.3	115.7	110.6	109.7	108.1	100.7	89.3	79.3	80.3	77.6	73.8

Source: [www.nchod.nhs.uk](http://www.nchod.nhs.uk)

### Mortality from all Circulatory Diseases Aged Under 75, 3 Year Rolling Average 1993-2006

There has been a marked reduction in the death rates in females from circulatory diseases in 2004-06 compared to 2003-05 three year rolling average. There has been a small reduction in death rates in males. The target of 10% reduction in relative gap by 2010-11 from 1995-97 baseline is still challenging for both indicators.

## 9. Vital Statistics

Type	Lambeth	Lambeth	London	London	England	England
	2004	2006	2004	2006	2004	2006
Crude Birth Rates	17.70	18.05	15.60	16.09	12.1	12.52
General Fertility Rate	63.8	67.9	63.8	65.4	58.5	60.3
Period Fertility Rate	1.87	1.9	1.79	1.86	1.8	1.85
Still Birth Rate	6.1	5.9	6	6	5.4	5.4
All Births Proportion Under 2500 Grams	8.6	8.8	8.7	8.3	7.6	7.9
Crude Rate Deaths, All Ages	6.10	6.10	7.10	6.82	9.6	9.27
Standardised mortality ratios <sup>1</sup>	108	114	95	95	100	100
Infant Mortality Under 1 Year	6.1	5.7	5.1	4.9	5	5
Infant Mortality Under 4 weeks	4	4.7	3.4	3.6	3.4	3.5
Perinatal	9.4	9.4	8.5	8.8	8	8

## Glossary of terms

<b>A&amp;E</b>	Accident and Emergency	<b>LA</b>	Local Authority
<b>AGI</b>	Africans Getting Involved	<b>LAA</b>	Local Area Agreements
<b>AIDS</b>	Acquired Immunodeficiency Syndrome	<b>LCNDG</b>	London Cancer New Drugs Group
<b>APA</b>	Annual Performance Assessment	<b>LES</b>	Local Enhanced Service
<b>APHO</b>	Association of Public Health Observatories	<b>LDP</b>	Local Delivery Plan
<b>BME</b>	Black or Minority Ethnic persons or groups	<b>LINKs</b>	Local Involvement Networks
<b>CAA</b>	Comprehensive Area Assessment	<b>LSL</b>	Lambeth Southwark and Lewisham
<b>CHD</b>	Coronary Heart Disease	<b>LSP</b>	Local Strategic Partnership
<b>CLG</b>	Communities and Local Government	<b>MMR</b>	Measles Mumps and Rubella vaccine
<b>CSCI</b>	Commission for Social Care Inspections	<b>MRSA</b>	Methicillin Resistant Staphylococcus Aureus
<b>CSP</b>	Commissioning Strategy Plan	<b>NHS</b>	National Health Service
<b>DALY</b>	Disability Adjusted Life Year	<b>NICE</b>	National Institute for health and Clinical Excellence
<b>DECS</b>	Diabetes Eye Complication Screening	<b>NRT</b>	Nicotine Replacement Therapy
<b>DH</b>	Department of Health (a government department)	<b>NSC</b>	National Screening Committee
<b>DIPC</b>	Director for Infection Prevention and Control	<b>NSF</b>	National Service Framework
<b>DSR</b>	Directly Standardised Death Rate	<b>ONS</b>	Office for National Statistics
<b>EIA</b>	Equality Impact Assessment	<b>OPM</b>	Office for Public Management
<b>ET</b>	Exceptional Treatment	<b>PASA</b>	Purchasing and Supply Agency
<b>ETA</b>	Exceptional Treatment Arrangement	<b>PBC</b>	Practice Based Commissioning
<b>FSL</b>	Feedback South London	<b>PCT</b>	Primary Care Trust
<b>GLA</b>	Greater London Authority	<b>PPI</b>	Patient and Public Involvement
<b>GSTT</b>	Guy's and St Thomas' Foundation Trust	<b>QA</b>	Quality Assurance
<b>HCAI</b>	Healthcare Associated Infections	<b>QALY</b>	Quality Adjusted Life Year
<b>HCC</b>	Healthcare Commission	<b>QMAS</b>	Quality Management and Analysis System
<b>HEA</b>	Health Equity Audit	<b>QOF</b>	Quality and Outcomes Framework
<b>HIV</b>	Human Immunodeficiency Virus	<b>SELN</b>	South East London Cancer Network
<b>ICD 10</b>	International Classification of Disease (10 <sup>th</sup> Revision)	<b>SELECG</b>	South East London Executive Commissioning Group
<b>ICT</b>	Infection Control Team	<b>SCS</b>	Smoking Cessation Services
<b>JSNA</b>	Joint Strategic Needs Assessment	<b>STI</b>	Sexually Transmitted Infection
		<b>TP</b>	Teenage Pregnancy
		<b>VFM</b>	Value For Money
		<b>WCC</b>	World Class Commissioning
		<b>WHO</b>	World Health Organisation

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The information within the statistical update is derived from various sources. While every precaution is taken to ensure that the information is accurate; interpretation of information from certain data sources should be treated with caution. For e.g. mortality rates and prevalence rates from GP practice registers (QMAS) [as these are case detected prevalence rates and do not reflect the true prevalence].

These are only examples; if you have any queries please contact the Lambeth Public Health Intelligence Department:

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## Comments and feedback

Your comments on this report are very welcome. We would urge you to let us know what you think about the report, and about public health in Lambeth. Please e-mail your comments to us at:

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