PUBLIC HEALTH REPORT 2004/05

1 SUMMARY

1.1 The Committee to consider the 2004/05 Public Health Report and the implications for the Council.

1.2 Copies of the report have been circulated to Members of this Committee and a further copy has been placed in the Members' Library.

2 PUBLIC HEALTH REPORTS

2.1 The annual Public Health Report from the Castle Point and Rochford Primary Care Trust (PCT) provides a commentary on mortality and morbidity and the health challenges facing the local population.

2.2 The 2004/05 report picks up a number of the national themes from the "Choosing Health" White Paper published in 2004.

2.3 Dr Andrea Atherton, Acting Director of Public Health for Castle Point and Rochford will be attending the Committee to present the key issues from the report.

2.4 To achieve improvements in health, it is important to tackle the causes of ill-health and in this the Council has an important role to play, through the provision of facilities and public protection services and by acting as an example of good practice to the wider community.

2.5 Some issues that arise from the Public Health Report, such as tackling ill-health arising from smoking, obesity and alcohol misuse, require a commitment to joint working through the Corporate Planning process the Local Strategic Partnership, Crime & Disorder Responsible Authority Group and so on.

3 RECOMMENDATION

3.1 It is proposed that the Committee **RESOLVES**

To consider the Public Health Report 2004/05 and to identify issues where the Council can work, with other organisations, to improve health locally.

Graham Woolhouse

Head of Housing Health and Community Care

Background Papers:-

None

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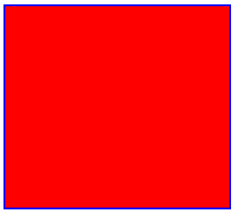
Castle Point and Rochford NHS
Primary Care Trust

Public Health Report

2004/05



Public Health Report
2004/05

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CASTLE POINT AND ROCHFORD PRIMARY CARE TRUST

Public Health Report

2004/05

FOREWORD

I am pleased to write this foreword to the Castle Point and Rochford Public Health Report for 2004/05.

Primary Care Trusts are tasked with improving the health status of their population and to reduce health inequalities. This report, with its recommendations, focuses on our commitment to achieving better health through supporting our population to make informed choices to change behaviour and lifestyles to achieve optimal health.

The report should influence commissioning and be integral to the strategic planning programme as well as giving direction to clinical staff within the Primary Care Trust in their delivery of services. It also recognises that most of the factors that determine the health status of individuals and populations extend beyond the influence of the National Health Service, and that health improvement depends on strong strategic partnerships with others.

I trust this report will further energise this partnership approach to make health everyone's business.

Brian Dawbarn
Chairman
Castle Point and Rochford Primary Care Trust

KEY POINTS

- **It is projected that the elderly population in Castle Point and Rochford (65+) will largely increase by 2018 especially in males aged 85+ where the increase is projected to be 100%**
- **The death rate in Castle Point and Rochford is significantly lower than both Essex and England**
- **Over 70% of residents in Castle Point and Rochford reported 'good health'**

PROFILE OF CASTLE POINT AND ROCHFORD

This profile presents an overview of the health of the people of Castle Point and Rochford. Health is influenced not only by personal attributes such as age and sex, but also by wider determinants such as society, the environment and lifestyles. The data presented here illustrates some of the differences within and between, Castle Point and Rochford and with other parts of the country.

The Area

Castle Point:

The Borough of Castle Point is situated on the coastline of South East Essex and has an area of approximately 17.3 square miles. There are 14 wards within the area and it has a population of approximately 86,600.

Rochford:

Rochford covers an area of 65 square miles and is predominantly rural in its character. It has miles of coastline as well as vast areas of countryside. The Rochford area has 19 wards and a population of approximately 78,500.

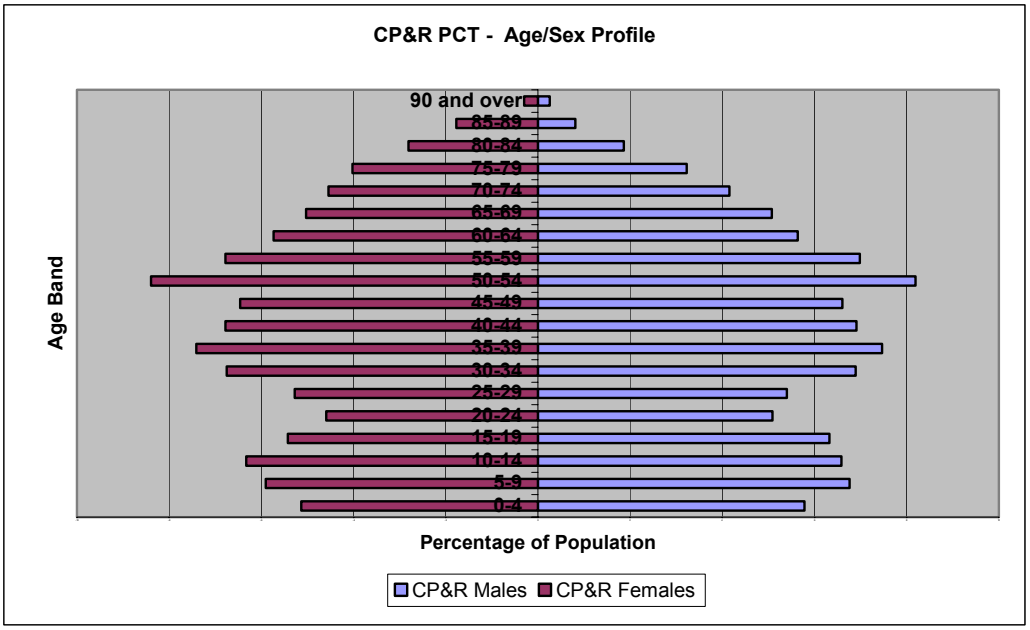
Population size and structure

Following the 2001 Census, the combined population served by Castle Point Borough Council and Rochford District Council was estimated to be 165,100. Castle Point and Rochford Primary Care Trust (PCT) serves a population of 175,000 people, who are registered with a general practice in Castle Point and Rochford.

Age and gender distribution:

Age and gender have a direct effect on health and the need for health services. The young and the elderly have a greater need for health services and the number of women in the reproductive age range affects the demand for fertility services.

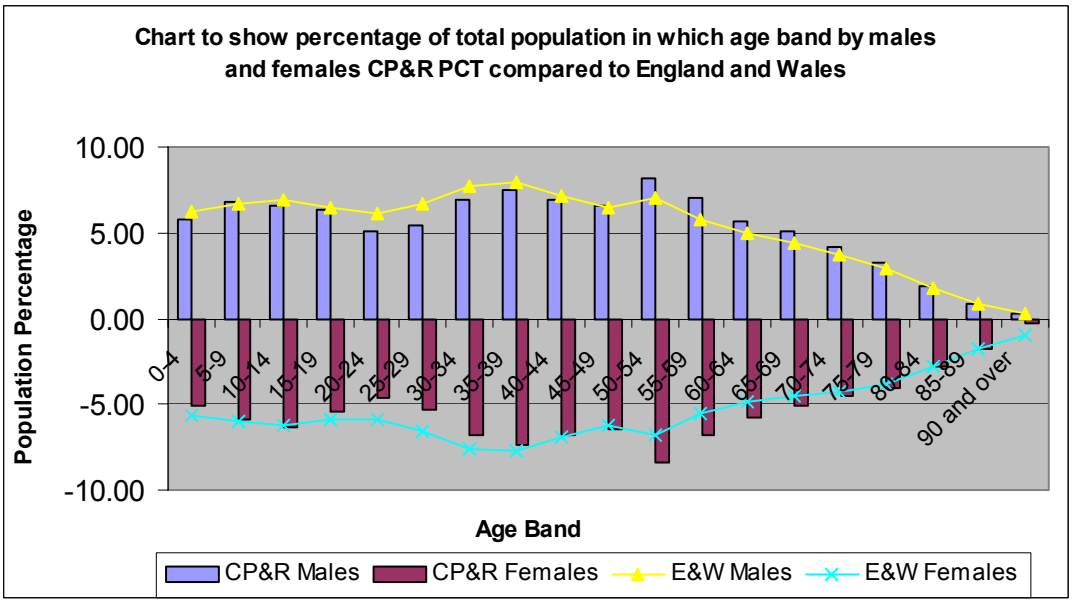
Figure 1.1: Age and gender profile of Castle Point and Rochford



Source: Census 2001, ONS

Figure 1.1 illustrates the population structure of Castle Point and Rochford.

Figure 1.2: Age and gender profile of Castle Point and Rochford population compared to England and Wales



Source: Census 2001, ONS

Figure 1.2 and Appendix 1.2 illustrate the population structure for Castle Point and Rochford. The age structure is quite similar to the England average, with slightly

higher proportion of people aged between 55 to74 years in Castle Point and Rochford and fewer people aged 25 to 40 years.

The 33 wards in Castle Point and Rochford vary in their individual age structures: Sweyne Park and Canvey Island Winter Gardens have the highest percentage of 0-4 year olds, and St James and Whitehouse have the highest percentage of people aged 65 years and over.

Future Population Changes

Population projections to 2018 predict that the population of Castle Point and Rochford is getting older. This is a consequence of falling birth rates, falling death rates and longer life expectancy. In particular there is a predicted increase in population size from age 60 years onwards, with a large increase in the percentage of elderly people in Castle Point and Rochford. In contrast, there will be a reduction in population size in the 30-45 year age band.

The population projections also indicate a reduction in children below the age of ten, with the exception of males aged 0-4 years in Rochford.

Dependency Ratio Projections

One of the most important features of a dynamic population structure is the proportion of the population that is economically active, and how this changes over time. This is partly because the economically active parts of the population support the rest of the population either financially (directly and via taxation) or practically (through being carers). Both Castle Point and Rochford are predicted to have an increase in dependency ratio, due to the increasing number of older people.

Ethnicity

It is recognised that individuals from ethnic minorities are disproportionately affected by particular health problems e.g. diabetes, coronary heart disease and stroke. The ethnic composition of Castle Point is predominantly white, with 98.2% of the population reported in the census as white compared to 90.9% for England. The ethnic composition varies across the wards within Castle Point and Rochford. The wards of Appleton, Canvey Island West and Trinity reported higher proportions of people of ethnic minority background.

Births and Deaths

In 2003, 1604 births were registered to mothers resident in Castle Point and Rochford. The majority of these births were to mothers aged 25-34 years old.

Low birth weight babies

Many factors are associated with low birth weight including multiple pregnancy, maternal country of birth, poor maternal nutrition, low socio-economic status, teenage pregnancy and maternal smoking and drinking in pregnancy.

In Castle Point and Rochford in 2003 there were 95 babies born with a low birth weight (weight under 2500 gms) this equates to a rate of 59.23 per 1000 births, this is a slight rise from 2002 when the rate was 58.12 per 1000 births.

Infant Mortality

The infant mortality rate has historically been considered a good indicator of the health of the population. However, as rates decline the proportion of cases that can be influenced by better maternal health or health care interventions decreases.

Table 1.1 Infant Mortality rate in Castle Point and Rochford compared to county, regional and national data.

	Infant Mortality Rate (per 1000 live births)	CI LL	CI UL
ENGLAND	5.4	5.2	5.6
EAST OF ENGLAND	4.5	4.0	5.1
Essex SHA	3.9	3.1	5.0
Castle Point	1.2	0.2	8.5
Rochford	3.7	1.2	11.4

Source: Compendium of clinical and health indicators 2003

Table1.1 shows that the infant mortality rates in both Castle Point and Rochford are lower than those of Essex, East of England and England.

Deaths

There were 1702 deaths of people resident in Castle Point and Rochford in 2003; with a population of 165,100 this equates to a crude death rate of 1,032 per 100,000 people.

However this crude rate does not take into consideration the population structure. Standardisation enables comparisons to be made between different populations by adjusting for the different age and sex structures of different localities. The standardised mortality rate for Castle Point and Rochford is significantly lower than that of England and the rest of Essex.

Table 1.2: Directly Standardised Mortality Rates (DSR) per 100,000 (with Confidence Intervals) for All Causes, 2001 and 2002 pooled data

	DSR	CI LL	CI UL
England	665.47	664.13	666.81
Essex	626.95	619.96	633.94
CPandR	586.82	566.46	607.17

Source: Compendium of Clinical and Health Indicators

The numbers and standardised rates for selected causes of death are listed in Table 1.3.

Death rates from all cancers in the under 75s, deaths from all circulatory diseases in the under 75s, and deaths from accidents in the under 65s are all significantly lower compared with England.

Table 1.3
Numbers of deaths, Directly Standardised Rates (DSR) per 100,000 population and Confidence Intervals (CIs) for selected causes of death, 2001 and 2002 pooled data

		England				CPandR		
	OBS	DSR	CI LL	CI UL	OBS	DSR	CI LL	CI UL
(2001/2002 pooled data)								
All Cancers <75s	129309	125.41	124.7	126.1	447	109.27	99.06	119.47
All Circulatory Diseases <75s	111356	105.3	104.7	105.92	352	84.2	75.34	93.06
Breast Cancer 50 – 69	7364	66.26	64.74	67.78	39	86.71	59.45	113.96
Accidents >65s	10710	55.26	54.19	56.33	20	30	16.78	43.22

Source: Compendium of Clinical and Health Indicators

Health, Illness and the Provision of Care

Hospital Admissions

The PCT's registered population generated 3974 elective inpatient episodes, 13,671 day cases and 12,287 non elective (emergency) inpatient episodes at Southend Hospital in 2003/4. There are smaller amounts of additional activity at hospitals located outside the area (Table 1.4).

Table 1.4: Hospital Admissions to Southend Hospital and other hospitals in 2003/4

	Castle Point and Rochford	
	SHT	**Other**
Elective	3974	1591
Daycase	13671	1424
Non Elective	12287	1969
New OP	40702	5779
FU OP	88571	18311
AandE Attendances	33924	N/A

Source: Inpatients Database

Primary Care

According to the 2003 national General Household Survey, women are more likely than men to have consulted a GP or practice nurse. In 2003, 11% of males and 16% of females reported consulting a GP during the 14 days prior to the interview. This compares with 13% for males and 17% for females in 2002.

Use of health services is higher among children aged under 5 and adults in the older age groups. The likelihood of having consulted a GP in the 14 days prior to interview was highest for males aged 75 years and over and women aged 65 to 74 years, at 21% and 22% respectively. Overall 13% of people had visited a GP in the previous 14 days.

In 2003, 14% of adults aged 65-74 years had consulted with a practice nurse 14 days before interview, this compared with 1% of 5-15 year olds.

The General Household Survey is a national survey, and the local picture may differ due to its different age, sex and socio-economic profile.

Self-Reported Health

Whilst hospital activity can indicate the levels of more serious illness in a community, we have little information about the amount of chronic and minor illness in Castle Point and Rochford, especially illness that is self treated e.g. using over the counter remedies.

The 2001 Census people asked to describe their health over the preceding 12 months and whether they had any limiting long term illness, health problem or disability that limits daily activities or the work they can do.

Table 1.5: Self-Reported Health of Castle Point and Rochford Residents

	CPandR (%)	EandW (%)
Good	70.17	68.6
Fairly Good	22.11	22.2
Not Good	7.72	9.2
Had a Long Term Illness	16.48	18.2

Source: 2001 Census

Table 1.5 shows how the residents of Castle Point and Rochford reported their own health. A total of 92% percent of people reported 'good or fairly good health' compared with 90% percent for England and Wales.

Unpaid Care

The 2001 Census asked about provision of unpaid care to family members, neighbours or friends. A total of 17,202 or just over 10% of Castle Point and Rochford residents were providing unpaid care, this is comparable to the national figure. Canvey Island Central and Hawkwell South wards had the highest proportion of people providing 50 hours or more of unpaid care.

Disabilities

A total of 3.68% of people in Castle Point and Rochford are recorded as being permanently sick or disabled.

There are two main benefits associated with health that are paid to people needing help with personal care. These are the Disability Living Allowance and the Attendance Allowance.

The Disability Living Allowance is paid to people under 65 who need help with personal care and/or getting around. The Attendance Allowance is paid to people over 65 who are so severely disabled physically or mentally that they need supervision or a great deal of help with personal care.

In 2003, 5,070 people in Castle Point and Rochford were receiving Disability Living Allowance, of whom 1,255 were claiming the higher rate care component. This is a rise from the previous year and appears to follow a year on year rising trend. Similarly, in 2003 there were 3,905 people claiming the Attendance Allowance of which 1,880 were higher rate claimants. The number of Attendance Allowance claimants is also rising year on year.

Health Promoting Initiatives

Initiatives that prevent ill health, such as vaccinations or screening, may prevent morbidity and mortality and the need for healthcare either immediately or in the future.

Screening

Screening can be used to detect some cancers in their very first stages, or even before the disease develops. There has been national adult screening programmes for breast and cervical cancer since the 1980s. Screening has decreased deaths from cervical cancer by over 40% in the past decade. The national Breast Screening Programme has similarly contributed to the 21% reduction in deaths from breast cancer over the same time period. Tables1.6 and 1.7 show the uptake of cervical screening and breast screening respectively by eligible women in Castle Point and Rochford.

Table 1.6

Cervical Screening Programme Coverage – Ages 25-64
(less than 5 years since last test)
As at 31/03/2003

	Eligible	% Screened	CI LL	CI UL
England	12686444	81.2	81.2	81.3
Essex	402892	80.1	80	80.2
CPandR PCT	40656	80.7	80.4	81.1

Source: Compendium of Clinical and Health Indicators

Table 1.7

Breast Screening Programme Coverage - Ages 53-64
(less than 3 years since last test)
As at 31/03/2003

Area	Eligible Women	Coverage Percentage	CI LL	CI UL
England	3519934	75.3	75.2	75.3
Essex SHA	121745	75.9	75.6	76.1
CPandR PCT	14437	73	72.3	73.7

Source: Compendium of Clinical and Health Indicators

Table 1.6 shows that the uptake of cervical screening by eligible women in Castle Point and Rochford is similar to that for the rest of Essex and England.
However, Table 1.7 shows that 73% of eligible women in Castle Point and Rochford PCT attended the NHS Breast Screening Programme in 2003. This is significantly lower than uptake of breast screening across Essex and England.

Lifestyles and Risk Factors

Currently we have very limited data about healthy lifestyles and the prevalence of risk factors so we have to rely on extrapolating information from national data.

Smoking

The 2002 General Household Survey reported that 27% of men and 25% of women smoked. The difference in smoking prevalence between men and women has fallen, although it has not disappeared completely. Smoking among different age groups is a key area of interest. Aspects of smoking are explored further in Chapter 4.

Table 1.8: Smoking Prevalence by Age and Sex (2002)

Prevalence of Smoking by
Sex and Age 2002 in Great
Britain

%	16-19	20-24	25-34	35-49	50-59	60+	All Ages
Men	22	37	36	29	27	17	27
Women	29	38	33	27	24	14	25
All	25	38	34	28	26	15	26

Source: General Household Survey 2002

Since the early 1990s, the prevalence of cigarette smoking has been highest among those aged 20 to 24 years old. The age group with the lowest prevalence of smokers is the 60+ age band.

Obesity and Physical Activity

Obesity is recognised as a serious public health issue, which has the potential to be of equal importance to smoking as a determinant of future health.

Table 1.9: Adults who are Overweight 2000-2002

Adults who are Overweight (BMI over 25-30)

Observed

	Base	Percent	Lower Limit	Upper Limit
England	27055	38.8	38.2	39.4
South East	4011	38.4	36.7	40.1
Essex SHA	924	43.1	39.5	46.6

Source: Compendium of Clinical and Health Indicators 2003

Table 2.0 Adults who are Obese 2000-2002

Adults who are Obese (BMI 30+)	%	CI LL	CI UL
England	21.8	21.2	22.4
East of England	20.9	19.2	22.6
Essex SHA	20.6	17.3	23.9

Source: Compendium of Clinical and Health Indicators 2003

Tables 1.9 and 2.0 show the percentage of overweight and obese people within the Essex Strategic Health Authority area. The percentage of overweight and obese people is not significantly different to that of England and East of England.

However, the number of obese people in Essex has risen from 18.9% in1997-99 to 19.8% in 1999-2001.There is roughly an even split between the percentage of males (20.7%) and females (20.5%) who are classed as obese in Essex.

The topic of obesity is explored later in this report.

Alcohol

Table 2.1: Alcohol Consumption over Daily Recommended Limit

	%	CI LL	CI UL
England	36.1	35.2	37
East of England	35.7	33	38.4
Essex SHA	36.1	32.4	39.7

Source: Compendium of Clinical and Health Indicators 2003

Table 2.1 shows the percentage of people who drink an amount over the Daily Recommended Limit. Over a third of people in Essex drink over the Daily Recommended Limit, although this is not significantly different to the East of England or England as a whole.

In 2003 in Great Britain the highest percentage for those people who drink more than the Daily Recommended Limit was in the age group 16-24, this is the case for both males and females. The topic of alcohol is explored later in this report.

Wider Determinants of Health

The links between health and deprivation are well known. The Index of Multiple Deprivation (IMD) 2000 is now used instead of the Jarman Score to describe deprivation. The Index is based on the idea that deprivation is made up of separate dimensions or domains. Each of the six domains: Income (including child poverty), Employment, Health, Education, Housing and Access: is made up of a number of indicators and is available at ward level.

These domains of deprivation indicate the spread of need within Castle Point and Rochford and allow comparison with the other 8,414 wards in England and Wales.

The IMD 2004 introduced the concept of Super Output Areas (SOA), to overcome some of the drawbacks of using ward level data such as:

- Electoral wards vary greatly in size.
- Electoral wards are subject to regular boundary changes.

In South Essex there are a total of 446 Super Output Areas, of which 110 are within Castle Point and Rochford.

Castle Point and Rochford does not feature in the 10% most deprived SOAs in South Essex. However of the 46 SOAs in the 10% least deprived areas in South Essex, 9 of these are within Castle Point and Rochford wards.

Table 2.4 shows the fifteen most deprived Super Output Areas in Castle Point and Rochford, by ward and IMD.

Table 2.4: Most Deprived SOAs in Castle Point and Rochford

Ward of SOA	IMD Rank
Rochford	6463
Canvey Island Central	7929
Canvey Island North	8442
Canvey Island Winter Gardens	9278
Canvey Island Central	10547
Rochford	10700
Canvey Island Central	11144
Canvey Island West	12025
Sweyne Park	12310
Canvey Island East	12680
Canvey Island West	12843
Hullbridge	13133
Canvey Island North	13623
Hawkwell South	14186
Canvey Island South	14391

Source: Compendium of Clinical and Health Indicators 2003

Canvey Island Central ward has three of the fifteen most deprived SOAs within Castle Point and Rochford. The most deprived SOA in Castle Point and Rochford is within the Rochford Ward.

Households

Poor housing conditions and overcrowding can have adverse effects on both mental and physical health.

In Castle Point and Rochford there were 67232 households at the time of the 2001 census. Of these 3096 were lone parent households with dependant children. Also there were 9975 households comprising of a lone pensioner – this amounts to nearly 15%.

Lone parents tend to have markedly lower household incomes than married or co-habiting couples with children. Single (never married) lone mothers are particularly likely to have low weekly incomes.

Thames Gateway

Thames Gateway South Essex is seen as a 'Vision for the Future' and is hoped to:

- Improve skills and employment
- Secure leading edge infrastructure, focusing on improved and sustainable transport
- Secure investment and site development
- Create a high quality and sustainable urban and rural environment
- Improve the health and well being of all communities throughout South Essex
- Promote a high profile and positive image of Thames Gateway South Essex

It is hoped to improve the health and well being of communities in South Essex by:

- Improving access to high quality health and social care services, in particular recognising the needs of the elderly and supporting those that care for them.
- Regeneration of the most run down estates, thus ensuring the improvement of housing for all. This in effect should bridge the housing affordability gap, which could potentially attract some essential health and education staff to the area.
- Reducing teenage pregnancies as well as providing support to those with learning disabilities and mental health problems and to promote healthy living for all.

The vision for Castle Point is to make it a centre of business excellence within South Essex along with Basildon. This will be supported by excellent infrastructure, skills, training and education.

It is also hoped that the local transport network particularly focusing on access to and from Canvey Island and along the commuting routes in to Basildon, this is hoped to include better rail links.

The vision for Rochford has been set out along with Southend and is to transform it into a thriving cultural hub, developing beach facilities, resort and tourism facilities and leisure attractions as well as the overall improvement of the environmental quality. There are plans to develop university facilities, expanding on those already in Southend town centre. It is planned to improve the surface access by road and rail for Rochford and Southend as well as upgrading Southend Airport.

SMOKING

The Problem

Smoking is the single most important cause of preventable illness and premature death, with an estimated 106,000 people in the UK dying every year from smoking-related illnesses. One in two long-term smokers will die as a result of smoking-related illness if they continue to smoke – half of these in middle –age. As well as being a significant risk factor in over 20 different causes of death, smokers also face higher risks in over 50 types of illness which, while not fatal, may cause years of pain and discomfort.

Smoking is not only a threat to smokers. Second hand smoking causes lung cancer, chronic respiratory disease, heart disease and stroke in adults, as well as asthma, lower respiratory tract illnesses, reduced lung growth and function, and middle-ear infections in children. Women who smoke while pregnant increase their risk of ectopic pregnancy and miscarriage and may damage the health of their baby.

Smoking kills over 120,000 people in the UK each year. It is the biggest single cause of preventable illness and early death in the UK. Smoking costs the NHS up to £1.7 billion a year in England. Smoking is the biggest single cause of inequalities in health. Breathing other people's cigarette smoke (second hand smoke) can increase the risk of developing cancer, heart disease and other illnesses.

Key Facts on Tobacco and Smoking

Smoking prevalence has decreased over the past three decades, but smoking remains the most important cause of preventable illness and premature death. Over 1 in 4 adults in England smoke – only slightly lower than the rate at the beginning of the 1990s. The peak smoking age is 16-34, and more young women smoke than men.

Age Group	Estimated current smoking prevalence (%)		
	Males	Females	All persons
16-24	36	43	39
25-34	38	33	35
35-44	33	29	31
45-54	23	26	24
55-64	19	19	19
65-74	13	15	14
75+	11	7	9

Seven out of ten smokers say they want to stop and 4 in 5 wish they had never started.

Smoking causes a third of all cancer deaths, and 1 out of every 7 deaths from heart disease.

Nearly 1 in every 5 pregnant women smoke.

Smoking among people in non-manual groups has fallen more quickly than people in manual groups, around one third of whom still smoke.

Half of people's workplaces are completely smoke-free.

There is strong public support for greater restrictions on smoking in public places

Smoking in pregnancy not only harms the mother, but also associated with increased risk of miscarriage, low birth weight and perinatal death. If the parents continue to smoke after the baby is born, there is also an increased risk of sudden infant death syndrome.

Nationally there has consistently been a marked difference in the prevalence of smoking by socio-economic group, with smoking being more prevalent among manual groups than among non-manual groups. Over the last 30 years the prevalence of smoking has fallen more sharply in the non-manual groups, so this divide has widened. This does not appear to be a difference in people's desire to stop. About two-thirds of adult smokers want to quit, and smokers in the lowest socio-economic groups want to give up, as much if not more, than smokers from more affluent groups. It may be that they find it more difficult to access support.

What Works?

Most people know that smoking is bad for them, but still people take up the habit. Once they start, smokers find it hard to stop. Experience from around the world shows that the best programmes to reduce smoking levels include work to reduce take up, to control supply , provide motivational support for smokers to quit, and to protect people from second hand smoke. Effective use of media and mass communications is crucial to the success of stop smoking campaigns. Stop Smoking Services are an effective and cost-effective intervention for health improvement.

So what is happening locally?

Elements of Tobacco Control
As with national strategy the key elements of tobacco control are

- prevention and education
- helping people to stop - provision of Stop Smoking Services
- protection

The work on tobacco control for Castle Point and Rochford is coordinated through the Stop Smoking Service, the Essex Tobacco Alliance and the Regional Tobacco Control Strategy Group.

Smokefree Essex Tobacco Alliance

A very positive initiative has been the establishment in April 2004 of the Essex Tobacco Alliance. Essex Strategic Health Authority is a key partner and is working jointly with PCTs, Trading Standards, Environmental Health, Customs and Excise, Local Authorities, HM Prison Services and the Council for Voluntary Services, to implement an Essex-wide tobacco control policy and local stop smoking and prevention services.

Regional Tobacco Control Strategy Group

In March 2004 the Regional Public Health Group and the Eastern Region Public Health Observatory published a report Smoking in the East of England. Subsequently a group was established.

Five key strategic areas have been identified. These include exposure to second-hand smoke, action to reduce the uptake of smoking, promotion of Stop Smoking services, to reduce inequalities caused by smoking and action to strengthen community action for tobacco control.

The strategy will be published for public consultation in 2005.

Big Smoke Debate

The conference was also used to present the results of the East of England Big Smoke Debate, a consultation to find out the opinions of the people in East of England on the issue of smoking in enclosed public places. A total of 7882 responses were analysed. 25% of respondents were from Essex. The responses indicated that the majority of people in the East of England favoured greater restrictions on smoking in public places. Key findings were:

- 9 out of 10 people in the East of England, including half of smokers are bothered by tobacco smoke inside public places
- 9 out of 10 nonsmokers and over a quarter of smokers would prefer smokefree public places
- 4 out of 5 people would support a law to make all workplaces smokefree

Prevention and Education

An important element of tobacco control is to reduce the numbers of people starting to smoke as a considerable number of young people continue to take up smoking, the majority doing so (82%) in their teens. Adult smokers in the East of England (76%) said that they started their smoking habit between the ages of 11 to 18 years. The Department of Health survey on young people's health behaviour found that 48% of pupils had tried, or were still smoking cigarettes at some time during their secondary school period.

This 'early adoption' of smoking behaviour is of great concern. Nicotine is very addictive and starting to smoke in childhood or adolescence may establish a behaviour that is very difficult to change.

Schools have included education on tobacco in their curricula since the early 1970's, and smoking education interventions have been shown to delay the onset of smoking in young people. The school years therefore provide a window of opportunity to undertake health education and prevention about smoking.

All schools have to deliver smoking and tobacco awareness education as part of the statutory guidelines outlined in the National Curriculum. This is usually delivered as part of the science curriculum and, naturally, has an emphasis on the physiological aspects of the topic. Primary schools will often include 'smoking' as part of a health awareness week, with secondary schools usually including this as part of their KS3 programme. However it is to be noted that the total amount of 'time' devoted to this topic is limited, perhaps on average one hour per year. The reasons for starting smoking and possible addiction are not statutory and the effectiveness to which schools deliver this area of the topic is extremely varied.

A review of school-based programmes suggested the following as key components of **effective** school based smoking education and prevention programmes are varied.

- Programmes should focus on social influences **i.e.** social norms, sociocultural pressures.
- The curriculum should provide information that focuses on the
- short-term effects of smoking.
- Interactive, participatory methods of teaching should be employed.
- Smoking education should be introduced before regular patterns of smoking behaviour are formed, starting at Key Stage 1 and critically, being covered again at Key Stage 2. By Key Stage 3, patterns of experimentation and beliefs and attitudes about smoking have already formed.
- Smoking education within the curriculum should be part of a **whole-school** approach to the issue.

The National Healthy School Partnership between the Local Education Department of Lifelong Learning and the PCT is developing tobacco education in a number of ways and supporting schools to extend their work in this area.

Healthy Schools – a Way Forward

Drug education (including smoking and tobacco) is one of the eight themes identified in the National Healthy Schools Standard Award Scheme. This means that the Essex and Southend Local Healthy Schools Partnership has both the capacity and capability to support a whole school approach to drug education (including smoking and tobacco). A key objective of the Healthy School Standard Award Scheme is to develop effective health related policies reflecting the legal requirements and non-statutory guidance. A smoking policy as part of a drugs policy is of particular importance in reflecting the response of health and education to smoking issues. A smoking policy should guarantee the right of the non-smoker to breathe clean air.

The Healthy Schools approach to initiate the smoking policy process is through a whole school consultation with pupils, parents, staff, governors and the wider community. This approach engages the views, values and opinions of everyone, creating a greater sense of shared understanding. Below are some suggested ways in which schools can begin the process of implementing a school 'no smoking policy'.

- Develop PSHE and Citizenship that focuses on healthy lifestyles, especially in connection with harmful substances, i.e. drugs, tobacco and smoking
- Raise awareness of good emotional health and negotiation skills
- Liaise with the PCT Health Promotion Team to access specialist knowledge
- Promote national awareness campaign days, e.g. No Smoking Day. World Health Day
- Access specialist skills of School Health Advisors to provide in house health promotion, prevention and health education
- Provide specialist training for teachers and other school staff
- Introduce 'health weeks' including issues around smoking, alcohol and drugs highlighting the effects on people physically, socially and emotionally
- Introduce early in the curriculum – Key Stage 1

Young people and smoking – Trading Standards

Under the Children and Young Persons (Protection from Tobacco) Act 1991, it is an offence for a retail outlet to sell tobacco products (including cigarette papers) to persons under the age of 16. The maximum fine for a breach of this Act is £2500. Sales of cigarettes from machines are also covered by this Act. In addition, the National Association of Cigarette Machine Operators has produced guidelines stating that machines should be in a position where sales can be supervised, not in a lobby or corridor out of view, and should only be to people aged over 16 years of age. Enforcement work carried out by Trading Standards Services in Eastern region indicates that around 20% of all retailers will sell tobacco products to young people under the age of 16 years.

Helping people to stop smoking

Adult smokers

For the last three years the priority has been given to encouraging and supporting adults to stop. This approach has been criticised and people have suggested that since smoking is so difficult to give up, it would make more sense to concentrate on stopping young people taking up the habit.

However there are good reasons for prioritising work with adult smokers:

- Most of the people who will become ill and die from smoking related diseases over the next two decades are current smokers; encouraging them to quit will quickly reduce tobacco related illness and death
- Children are influenced by adult role models, particularly parents and older siblings, so reducing adult smoking will have an effect on children's uptake

- Reducing adult smoking reduces the impact of second hand smoking on babies and young children

It is only recently that the highly addictive nature of smoking has been appreciated. The Royal College of Physicians in their report Nicotine Addiction in Britain concluded that tobacco dependence is a serious form of drug addiction, and that nicotine was as addictive as 'hard' drugs such as heroin or cocaine. This explains the difficulties of quitting without support - two thirds of smokers want to quit, about a third try each year, but only 2% succeed

There are a number of effective methods to assist potential quitters. These range from brief interventions of a few minutes as part of a consultation with a health professional to the intensive support provided by specialist services over several weeks.

New Contract for General Practice

The new GP contract introduced in 2004 aims to reward practices for providing advice to patients in key disease areas. This is a welcome development that will focus health promotion activity on to smoking.

National Stop Smoking Services

Stop smoking services are provided by the NHS and offer intensive support to help people quit smoking. This help includes one-to-one counselling or group support, provided by specialist stop smoking advisors. Trained health professionals including nurses and pharmacists provide the support within the local community

The first few weeks after quitting are the most difficult for smokers, as this is the period when they can experience withdrawal effects. Service effectiveness is monitored by recording both the number of people setting a date to stop smoking ('quit date') and whether the person has stopped smoking at a four week period from the quit date (the 'four week follow-up').

Local Stop Smoking Services

Free local NHS Stop Smoking Services have been established. Smokers are able to access specialist team support and help in primary care, which is provided by practice GPs, nurses and local pharmacists. Stop Smoking health professionals in general practice provide accessible, friendly and practical support to smokers wanting to quit.

The specialist stop smoking support for Castle Point and Rochford is provided by the Essex South Stop Smoking Service and is hosted by the PCT. Smokers can be referred by a health professional or can contact the local service directly on 01268 464511.

The specialist team consists of highly trained advisors, who address issues on addiction, behaviour and motivational support. Advice is also given regarding the use

of Stop smoking aids, such as Nicotine Replacement Therapy (NRT) and bupropion (Zyban), which are available on prescription.

Services are provided in group sessions or one to one, depending on the local area and client's preferences. Groups are run on a rolling programme and in Castle Point and Rochford, groups are held in the local Baptist church in Rayleigh, a Healthy Living Centre at Tyrells and a community centre on Canvey. Smokers are offered options of daytime or evening.

The national help lines are 'Quitline' (0800 169 0 169) and www.givingupsmoking.co.uk

However quit rates will only have a limited impact on smoking prevalence and will have to be focussed on low-income groups to affect health inequalities.

Smoking and Pregnancy

South Essex Stop Smoking service employs a Stop Smoking Pregnancy co-ordinator, who works across two PCTs (Castle Point and Rochford, Southend). All pregnant smokers are offered intense specialist one-to-one intervention to help them stop smoking. This can be clinic based or through home visits. All pregnant women have their smoking status recorded at booking and are given 5 minutes brief intervention to stop smoking during pregnancy. Referrals are made to specialist midwife for those who consent to specialist help.

How successful are local Stop Smoking Services?

A recent Health Equity Audit concluded that the service has higher success rates, and better odds of success relative to England. The service is cost effective, costing £164/ quitter and £240/ discounted life year gained (2003-04). The success rates for the service averages at 70%.

For the period 2003-2004 the target for Castle Point and Rochford PCT was 485 quitters and the actual achievement 511.

For the period 2004-2005 the target was 970 and the actual achievement was 1,161.

Second hand smoke

A key part of tackling the health risks of smoking is protecting people (both smokers and non-smokers) from tobacco smoke.

Smoking is not only a threat to smokers. The smoke in the air around the smoker - environmental tobacco smoke (ETS) - is also a recognised health hazard. Non-smokers exposed to smoky air breathe in the same toxic substances as active smokers but at lower levels, and these can cause serious health problems such as heart disease, cancer, stroke and asthma.

Tobacco smoke contains over four thousand chemicals in gaseous and particulate form. Second-hand smoke (also known as environmental tobacco smoke or passive smoke) is a mixture of side stream smoke from the burning tip of the cigarette, and mainstream smoke exhaled from the smoker.

Second-hand smoke contains five regulated hazardous air pollutants, 47 regulated hazardous wastes, more than 50 known or suspected cancer-causing agents.

Toxic gases such as ammonia, carbon monoxide, nitrogen dioxide and hydrogen cyanide are present in higher concentrations in side stream smoke which makes up about 85% of the tobacco smoke pollution in a room where there are smokers.

Health effects of second-hand smoke

In 1998, the Scientific Committee on Tobacco and Health (SCOTH) issued a report which concluded that adult non-smokers exposed to second-hand tobacco smoke have a 24% increased risk of lung cancer, and a 23% increased risk of heart disease. The report also concluded that second-hand tobacco smoke causes respiratory disease, cot deaths and middle ear disease in children. It is recognised that babies and young children are especially vulnerable to second-hand cigarette smoke, due to a number of factors.

The Committee has recently considered the evidence that has emerged in the past 5 years on the health effects of second-hand smoke. This latest report strengthens the earlier estimates of the size of the health risks, and confirms that second-hand smoke represents a substantial public health hazard.

Smoke free public places

Providing separate areas for smokers and non-smokers and ventilation reduces exposure, levels of visible smoke and smell, and provides a more pleasant environment - but will not make the area safe. Most reviews conclude that there is *no safe level* of exposure to ETS. The only effective way to minimise risk is to have smoke free premises, by introducing restrictions or bans on smoking in public places. This is particularly important in workplaces or in premises used by vulnerable groups such as infants and children. The Chief Medical Officer, at the launch of his 2002 annual report, recommended a ban on smoking in public places

Smoke free workplaces

UK employers already have a requirement to protect their employees under the Health and Safety at Work Act 1974. As part of the employer's duty to provide and maintain a safe working environment, exposure to second hand tobacco smoke also needs to be considered. Failure to adhere to the Act will leave employers at risk of prosecution.

It is estimated that some 3 million UK workers become passive smokers when they go to work, whilst a further one million workers are exposed 75% of the time. Those people working in the hospitality industry, particularly bar workers, waiters and waitresses are particularly vulnerable. One study on non-smoking bar staff in

London pubs in 2001 found that they were 12-16 times more likely to have a high cotinine (an accurate indicator of exposure to second hand smoke) levels than non smokers in the general population.

In Castle Point and Rochford there is considerable variation in the provision of smoke free areas. Many larger employers and particular types of businesses have banned or restricted smoking. However there are still many indoor public places and workplaces that allow smoking throughout in particular smaller premises which do not have the option of physically separate accommodation for smokers and non-smokers.

Environmental Health

Local Authority Environmental Health Officers (EHOs) are responsible for protecting the public health especially in connection with local pollution problems, landlord/tenant housing issues, health and safety at work and food safety. This remit includes enforcing health and safety and food safety legislation at businesses throughout the area. Food and Health and Safety inspections are carried out routinely, with the frequency of inspection being determined largely by the businesses ability (or inability) to regulate itself.

To help prevent health problems that result from tobacco smoke EHOs are working in partnership with the PCT. While the PCT helps people to stop smoking, the role of enforcement officers is concerned with protecting people through the prevention of exposure to tobacco smoke in the workplace. Exposure to tobacco smoke is regarded in the same way as any other health risk and businesses are expected to include smoking policies in their 'risk assessments'. Environmental Health staff offer advice and guidance initially, with enforcement action considered only as a last resort.

Customs and Excise

Contrary to the popular image, tobacco smuggling is not simply individuals importing quantities for distribution at boot sales and markets. It is estimated that illegally imported cigarettes account for about 21% of the total UK market, and smugglers are responsible for an estimated £2.5 billion lost revenue each year.

In health terms these contraband cigarettes are important. One of the most successful national tobacco control strategies has been high taxation. Until recently there was a clear relationship between consumption and taxation. Smuggling avoids duty being paid so reducing the price of cigarettes. This in turn increases demand and consumption, particularly in low-income groups.

What Next?

Through the Local Strategic Partnership and the PCT's Public Health and Wellbeing Committee the following measures and recommendations should be considered to promote a reduction in smoking:

- **Build a healthy alliance for 'Smoke Free Castle Point and Rochford' promoting political and community support, a smoke-free public environment, and workplace smoking policies**

- **Further develop initiatives to encourage young people to remain non-smokers and to encourage and support those who smoke to stop**

- **Encourage women and their partners to be encouraged and supported by healthcare professionals to stop smoking during pregnancy and to remain ex-smokers after the birth**

- **Promote and implement structured stop smoking service provision in Bullwood Hall prison**

- **Review the success of various local interventions in 2004/05 and build on these for the future providing more accessible and responsive stop smoking services and wider availability of nicotine replacement therapy**

- **Improve referrals to the Stop Smoking Service of patients with smoking related conditions from Southend Hospital Trust. Provide an offer of stop smoking advice as part of the clinical assessments in surgical care pathways.**

- **Provide further stop smoking training for front-line health professionals, enabling them to deliver evidence based stop smoking intervention**

OBESITY

Overweight and obesity occur when a person gains excess weight to the point that it starts to endanger their health – both in the long and short term. Without periods of increased calories intake and/or decreased physical activity, individuals will not gain weight, regardless of their genetic make up.

Changes in lifestyle over the last two decades – observed in many countries – are likely to have contributed to trends in obesity. Calorie intake may have increased – portion sizes have increased and snacking, sugary drinks and eating out are more common – and people, on average, are less active – with sedentary jobs, walking less, watching more TV and less likely to play sport.

The Problem

According to the latest Health Survey for England (2003) the number of overweight and obese adults rose from 62% to 66% among men and from 56% to 58% among women, between 1993 and 2003. So, two thirds of men and over half of women were either overweight or obese in 2003.

The number of children who are obese is also rising – in 2001 8.5% of 6 year olds and 15% of 15 year olds were obese. Between 1996 and 2001 the proportion of overweight children increased by 7% and of obese children by 3.5%. If the number of obese children continues to rise, children may have a shorter life expectancy than their parents. Overweight children are more likely to become overweight adults and children of overweight parents have twice the risk of being overweight compared to those with healthy weight parents.

Over the past 20 years the levels of obesity has risen so much that, in 1998, the World Health Organisation declared it a 'global epidemic'. Obesity is now a major preventable cause of ill health in the UK and the Chief Medical Officer (CMO)for England has identified overweight and obesity as a priority for action. [ref CMO's annual report 2002]. The levels of obesity in the United Kingdom has trebled since the 1980s and well over half of all adults are either overweight or obese – that is almost 24 million adults.

The cost of obesity is estimated at up to £3.7 billion per year, which includes £49 million for treating obesity, £1.1 billion for treating the problems caused by obesity and indirect costs of £1.1 billion for premature death and £1.45 billion for sickness absence.

Key Facts on Obesity

Obesity reduces life expectancy on average by 9 years and is responsible for 9000 premature deaths each year.

Obesity can cause serious illness and substantially reduce life expectancy. The most common problems associated with obesity are:

- Heart disease
- Cancers
- Type 2 diabetes
- High blood pressure
- Osteoarthritis

22% of men and 23.5% of women are now obese and well over half of all adults are either overweight or obese – almost 24 million adults.

Overweight and obesity are also increasing in children. Almost 17% of children aged 2-15 years are obese (Health Survey for England 2002).

There are social class differences – 16% of "professional" males and females are obese compared to 23% of males and 29% of females classified as "unskilled manual".

Most evidence suggests that the main reason for the rising prevalence is a combination of less active lifestyles and changes in eating patterns.

Obesity has a substantial human cost by contributing to the onset of disease and premature death. It also has serious financial consequences for the NHS and for the economy.

Excess body weight affects all social groups but is more common in people of lower income and socially disadvantaged groups, particularly among women. There are also differences in the rates and health problems caused by obesity between ethnic groups.

Obesity may also lower self esteem, lead to social discrimination and contribute to mental illness. Immediate consequences of obesity in children include bullying and stigma, which can lead to low self-esteem and depression. Of great concern is the appearance of Type 2 diabetes in children and young people which was a mainly an adult disease.

The human costs include~~s~~ about 18 million sick days per year; 30,000 deaths a year, contributing to 40,000 lost years of working life; and an average reduction in life expectancy of 9 years.

What Works?

Obesity is not an easy problem to tackle. The best long term approach is prevention, particularly in childhood. Critical to this is improving diet – including reducing intakes of fat and added sugars – and increasing physical activity levels. Action needs to take a lifecourse approach – starting from birth (breastfed babies may be less likely to develop obesity later in childhood). Even a modest weight loss can significantly improve the health of people who are already overweight or obese. The NHS

provides treatment for obesity, ranging from general support and advice on diet, physical activity and behaviours to drug treatments and onward referral for specialist help.

Ways of tackling obesity and overweight include helping people avoid becoming overweight and helping those who are already obese. If all obese people in the east of England lost weight so that they dropped into the overweight category, thereby reducing their relative risk of mortality, the number of deaths aged under 65 linked to obesity could fall by as many as 1000 per year.

Priority should be given to all three aspects of tackling obesity - increasing physical activity, changing dietary habits, and managing obesity.

Solutions to tackle obesity need to address the barriers to healthier lifestyles. It is necessary to change the environment (physical, social and economic) to make the healthy choices the easy choices. Examples include healthy school policies covering school catering, healthy tuck shops and vending machines and after school activities; safe walking and cycling routes to schools and workplaces; town planning that discourages car use; cheaper and easier access to leisure and sports facilities, and safe and accessible parks and open spaces.

People need to know how to improve their health and what the benefits in doing so are. This includes providing diet and physical activity education in schools; producing clear messages about healthy eating and increased activity and teachers, healthcare and other professionals trained to provide lifestyles advice.

Target groups include:

- All children and young people to prevent the onset of overweight and obesity
- Children and young people who are overweight or obese
- Adults at higher risk of obesity e.g. through family risk, people giving up smoking, pregnant women, or those at greater risk of the problems associated with obesity such as individuals with high blood pressure, diabetes or musculoskeletal problems.

Particular attention needs to be paid to individuals, families and communities who may be disadvantaged in terms of age, gender, income, language, culture, ethnicity, disability or where they happen to live.

Physical Activity

People who are physically active have a 20-30% reduced risk of premature death and up to 50% reduced risk of major chronic disease such as coronary heart disease, stroke, diabetes and cancer. There is evidence that socio economic status and levels of educational attainment impacts on the likelihood of individuals taking part in regular physical activity.

Current recommendations for physical activity are:

- A total of 30 minutes of moderately intensive activity, e.g. brisk walking, on at least five days a week for adults

- A total of at least one hour of moderately intensive activity every day for children.

In England only 37% of men and 25% of women currently achieve the recommended weekly physical activity levels.

The Health Development Agency suggests the following public health interventions show evidence of effectiveness and likelihood of success:

- Incentives to employers to encourage walking and cycling;
- Local travel plans
- Encouragement to walk which does not require attendance at a facility is the most likely to lead to sustainable changes in physical activity.

So what's happening locally

The Government have recognised the need to reduce obesity in children and young people by introducing a Local Public Service Agreement (LPSA) **"to halt the year on year rise in obesity among children under 11 by 2010 in the context of a broader strategy to tackle obesity in the population as a whole".**

The Public Health White Paper 'Choosing Health – making healthy choices easy' has highlighted the important role that reducing obesity has in ensuring the long term good health of the population and this recognition has ensured that action on obesity will be given the priority that it clearly needs.

The need to address our concerns about obesity has been highlighted as a priority for action by the Castle Point and Rochford Health Improvement Plan.

Safer Journeys to School

Over the last twenty years walking and cycling to school has decreased dramatically. The 'school run' by car has become a significant feature of daily life for many families. Ironically, the desire of parents to protect their children on the way to school has helped create a vicious circle: driving to school perpetuates the traffic problems that everyone is trying to avoid and results in less physical activity.

The Safer Journeys to School initiative has been established in Castle Point and Rochford to reduce the problems that have developed through increased car use for school journeys.

Every travel plan document is individual to a specific school and tailored to its characteristics. Those developing a travel plan need to consider "how can we make the journey to school safer, healthier and more pleasant?" and "what improvements can we make to encourage more people to walk, cycle or travel by bus?" Funds can be spent on a wide range of measures from school bicycle shelters to zebra crossings.

School Based Initiatives

Active Schools is the collective name for a variety of initiatives aimed at increasing the levels of physical activity in school age children. The main thrust of government is now through the School Sports Coordinator partnerships.

The aims of the programme are threefold: improving teaching and learning through PE and Sport, developing pathways to ensure greater international success and ensuring our young people live healthier and more active lifestyles. To do this, key agencies in Castle Point and Rochford including the Local Education Authority, have formed new partnerships with schools. Approximately, £1.3 million has been invested nationally in new school sports co-ordination posts and a huge investment in the training and development of Physical Education (PE) specialists within infant/junior and primary schools. The 'freeing up' of these key staff, releasing them from timetable will mean more activities taking place, more young people participating and a strive for all schools to be delivering a minimum of 2 hours high quality PE within and beyond the school day by 2006.

Castle Point and Rochford PCT have jointly funded the Bodycare programme in local schools. This initiative involves qualified fitness instructors visiting schools to explain the importance of healthy living and remaining active. Subjects such as looking after your heart, diet and nutrition and exercise are all covered through mini games and fun resources.

The Star Football project targets young men and women in Rochford District. There are 3 different aspects to the project: a) after school football sessions with coaches from West Ham and Southend United Football clubs, b) a healthy living programme where the coaches teach young people in the classroom about healthy lifestyles and c) a coach education programme where young people can work to achieve a qualification in football coaching. Over 300 hundred young people have been involved in the football project so far.

The Healthy Schools Programme has now been adopted by 55 of the 66 schools in the Castle Point and Rochford area. Supported by the Programme, schools look at a number of topic areas, and after consultation with the whole school community compile an action plan that will result in ‘meaningful change’ within that area of the school. There are eight topic areas including: healthy eating, physical activity and PSHE (personal, social and health education). Many schools within the Castle Point and Rochford area have prioritised these areas, which has resulted in a greater awareness of the need for a healthy diet and physical exercise. Most schools allow children free access to water throughout the day and a number have created healthy tuck shops, increased extra curricular clubs to encourage more exercise and started ‘walking buses’ to encourage more children and parents to walk to school. Links with Essex Country Parks are currently being developed to encourage walking in the countryside.

Recent changes to the school meal provision have also meant that schools have more influence over the food that is provided at lunch times. The programme supports schools to adopt a whole school food policy.

Walking For Health

Walking is a great form of physical activity. The 'Walk for Health' initiatives within Castle Point and Rochford aim to motivate people to get moving. The short definition of a health walk is 'a purposeful, brisk walk undertaken on a regular basis'. Regular walking can both help to reduce weight and maintain weight loss. Walking is a form of exercise which is within the physical capabilities of the majority of people and sedentary people are likely to perceive walking as a more realistic challenge than other more vigorous forms of exercise. In addition to this, organised walks (brisk or not) can have a health impact on individuals by providing an opportunity to socialise (good social networks enhance health) and a distraction from everyday stresses (stress contributes to poor health).

Exercise for Older People

In order to maintain and improve mobility and prevent falls, in conjunction with the PCT Fall's Coordinator and local authority leisure services, exercise programmes have been developed especially for older people. An annual event called Getting On and Getting Better is a health promoting initiative, which encourages older people to maintain and improve their health by remaining active, eating healthily and taking regular exercise. The annual Castle Point Show also provides a good opportunity for health and leisure services to work together to promote health and well being through fitness testing, health food samples, fruit smoothies, exercise demonstrations and promoting local health and leisure services.

Exercise Referral Scheme

The object of the scheme is to provide members of the local community who are largely inactive, or those who have a specific health condition that can be ameliorated through physical activity, with the opportunity to undertake a programme of exercise under the guidance of qualified instructors. The aim of the scheme is to provide participants with the knowledge and confidence to become independent exercisers on completion of their programme so that they may continue to reap the health benefits of a physically active lifestyle.

GPs, nurses and other healthcare professionals involved in the scheme have the opportunity to offer 'exercise on prescription' – a programme of supervised physical activity - to patients with a range of conditions in order to improve their health.

Participants undergo a basic medical examination and give informed consent. They are then referred to a leisure centre where they receive a fitness assessment, an exercise prescription and a series of exercise sessions, often at a reduced cost and sometimes with the option for further sessions on completion of the first series.

Nutrition

The National Diet and Nutrition Survey (2002) shows that people are eating too much of the wrong types of food and not enough healthy foods. Most children and adults do meet dietary requirements. An estimated one in three deaths from cancer

and one in three deaths from coronary heart disease are attributable to poor diet. By reducing fat and salt intake the risk of coronary heart disease and some cancers.

In 2004 the Department of Health published a Food and Health Action Plan with the broad aim of improving the health of the population through better nutrition. Contributing to that broad aim are four objectives

- Increasing access to the wider range of food choices contributing to a healthy diet
- Improving the availability and awareness of nutritional and dietary information
- Increasing fruit and vegetable consumption to at least 5 a day
- Reducing the levels of salt, fat and added sugar and increasing fibre in the diet

5 a day

Having at least five portions of fruit and vegetables a day can reduce the risk from heart disease and cancer by up to 20%. As well as the direct health benefits, eating fruit and vegetables can help to achieve other dietary goals including increasing fibre intake, reducing fat intake, helping maintain a healthy weight, and substituting for foods with added sugars.

Castle Point and Rochford PCT have developed and delivered a variety of projects specifically aimed at increasing awareness of the health benefits of eating fruit and vegetables.

During various school and community events, health fairs and fun days the Five A Day message has been promoted with games, information, and demonstrated through samples of fruit smoothies, fruit tasting and advice direct to the public from health professionals.

National School Fruits Scheme

The Department of Health has made a commitment to this scheme which entitles all children aged 4 to 6 years to receive a **free** piece of fruit or vegetable each school day as part of the national 5 A DAY programme to increase fruit and vegetable consumption and to improve the diet of children. It is the biggest single initiative in child nutrition since the introduction of free school milk in 1946.

At present the national school fruits scheme involves apples, pears, bananas, satsumas, carrots and cherry tomatoes, although as the scheme develops the aim is to introduce a wider variety of fruit and vegetables throughout the year.

The national school fruit scheme has potential spin-offs both educationally and economically as well as the central health aims. The evaluation results so far demonstrate not only how popular the Scheme is proving with teachers and children, but also that many teachers have linked it to educational goals.

Local Education Authority maintained schools in Castle Point and Rochford continue to benefit from the scheme following its introduction last year.

Star Farmer's Market

This Farmers Market in Rochford takes place once a month from March to November each year. It gives people the opportunity to buy good quality, fresh, locally grown fruit and vegetables and it attracts several hundred people each month

Weight Management

The evidence indicates that overweight and obese people should be encouraged to make small sustainable changes to their lifestyles over a longer period of time to maintain the benefits of initial weight loss. There is evidence of effectiveness for:

- Brief advice from a GP, supported by written materials, can produce modest short term weight loss.
- Referral to an exercise specialist can lead to longer term changes in physical activity
- Community based interventions targeting individuals effective in producing mid to long term changes in physical activity
- Programmes which teach behavioural skills and are tailored to individuals, are associated with longer term changes in behaviour
- Interventions that promote moderate intensity physical activity, particularly walking, are associated with longer term changes in behaviour.
- Regular contact with an exercise specialist supports sustained changes in physical activity.
- Interventions that promote moderate and non endurance physical activities (e.g. flexibility exercises) are associated with long term changes in behaviour in older adults
- Telephone support and follow up are associated with long term behaviour change in older adults.

Breastfeeding and Weaning

Breastfeeding is the best form of nutrition for infants and is recommended for the first 6 months of life. A breastfed baby will gain many health benefits such as better immunity, reduced risk of cot death and reduced risk of obesity and coronary heart disease later in life.

Much work is done in Castle Point and Rochford to promote breastfeeding and to support mothers who are breastfeeding. There are a number of breastfeeding support groups for mum's to meet up and share their experiences. There is also a network of qualified, volunteer breastfeeding supporters in the area who provide telephone support, advice and information.

Healthy weaning can contribute to lifetime eating habits therefore weaning support is offered throughout Castle Point and Rochford via health clinics.

Nutrition and Dietetic Services

Dieticians translate their knowledge of food and nutrition into practical advice for patients and the general public in order to promote nutritional well-being and help prevent and treat disease.

The South Essex Dietetic and Nutrition Service provides advice and support to people who are suffering from obesity plus obesity related conditions.

What Next?

Through the Local Strategic Partnership and the PCT Public Health and Wellbeing Committee the following measures and recommendations should be considered to tackle the problem of obesity:

- **Develop a comprehensive 'care pathway' for obesity, providing a model for prevention and treatment**

- **Support the setting up of a Castle Point and Rochford 'Partnership for Obesity' to promote practical action on the prevention and management of obesity as a source of information on obesity (for both diet and physical activity) and evidence of effectiveness**

- **Develop the role of primary care in the prevention and management of obesity**

- **Work with the South East Diabetes and Cardiac networks to target treatment interventions in obese patients with diabetes and heart disease**

- **Focus PCT health promotion and occupational health services in the prevention and management of obesity in our workforce**

- **Work in partnership to further promote healthy eating and exercise in schools and colleges, the NHS, Bullwood Hall, and other public bodies**

ALCOHOL

Alcohol beverages have been used in human societies at least since the beginning of recorded history. Today the drinking of alcohol is widely accepted and associated with socialising, relaxing and pleasure. Over 90% of adults in Britain drink alcohol, and the vast majority of people enjoy alcohol without any problems. However, where it is misused alcohol is also a major contributor to a range of harms including to the individual themselves and to others.

The Problem

Alcohol plays an important role in our society. Most people enjoy alcohol without causing harm to themselves or others. But for some people alcohol misuse can be a serious problem which can harm health through accidents, injuries and violence and in the longer term through alcohol-related liver disease, certain cancers and strokes.

Key Facts on Alcohol Misuse and Health

- Alcohol accounts for 6.8% of total disease burden in developed countries
- Alcohol is causally related to more than 60 different medical conditions, in most cases detrimentally
- Binge drinking is most common in the 16-24 year old age group
- 7% of the adult population are dependent upon alcohol
- 5.9m people in England drink above the Government's recommended daily guidelines on some occasions
- 38% of men and 25% of women drink on 3 or more days in the week.
- 19% of men drink more than 8 units on at least one day in the week. 8% of women drink more than 6 units on at least one day in the week. 33% of men and 20% of women drink more than the recommended daily level (4 units for men; 3 for women) on at least one day per week.
- 24% of children aged 11 – 15 years drink alcohol, and they drink an average of 10.5 units per week.
- Alcohol misuse is associated with 150,000 hospital admissions each year.
- Alcohol-related liver disease is responsible for over 30,000 hospital admissions each year
- Around one-third of all A andE attendances are alcohol related

- Between 15,000 and 22,000 deaths each year are associated with alcohol misuse

- Alcohol misuse costs the NHS up to £1.7 million each year

What Works?

The key is to encourage and help drinkers to take responsibility for their own drinking by providing information and education on the effects of alcohol misuse, to make sure that drinkers are aware of the negative effects that alcohol misuse can have on them and those around them. Since the mid 1980s the Government has provided advice on 'sensible drinking' to help people make responsible choices about when and how much to drink. The health service also supports those people who have more serious problems, by funding the provision of alcohol treatment at around 475 local agencies in England, at a cost of around £95 million per year.

The Health and Safety Executive publishes free guidance *Don't mix it! A guide for employers on alcohol at work.* This guidance recommends that employers have an alcohol policy in place which discourages alcohol misuse and which supports those addicted as they try to recover. The guidance is available on www.hse.gsi.gov.uk/alcoholdrugs.

In response to growing concerns about alcohol related harm, the Government recently published its Alcohol Harm Reduction Strategy for England. It identifies four key ways to tackle alcohol related harm through:

- Improved and better targeted education and communication about sensible drinking
- Better identification and treatment of alcohol problems
- Better co-ordination and enforcement of existing powers to tackle alcohol-related crime and disorder, and improve services to victims and witnesses
- Encouraging the industry to continue promoting responsible drinking and to continue to take a role in reducing alcohol-related harm

Information and education about alcohol

If individuals are to make informed choices about their drinking, they need to have accurate and balanced information. Whilst the Government's 'sensible drinking' message has been effective in raising awareness of the principle of 'sensible' levels of alcohol consumption, only 10% of drinkers check their consumption in units, and only 25% understand the implications of what a unit is.

An added complication to the 'sensible' drinking' message is the fact that drinks are now stronger and glasses are larger, than when the concept of the 'unit' was originally developed.

In general there is little information on the possible consequences of alcohol misuse either at the point of sale or in its advertisements. Whilst there is no evidence that consumers change their behaviour as a result of current information about 'units' on products, labels on alcoholic beverages may play a useful role in raising awareness and in educating drinkers about the risks associated with alcohol misuse.

Further work is planned at a national level to review the current 'sensible drinking' message and a communications strategy. In addition, the alcohol industry is being strongly encouraged to add messages about sensible consumption and unit information on labels of its products.

Education and young people

There is ample provision for young people to receive education about alcohol. Alcohol education is already a statutory requirement of the National Curriculum Science Order. In addition personal, social and health education (PSHE) provides pupils with opportunities to develop their knowledge skills and attitudes about alcohol. The National Healthy Schools Standard also features alcohol as one of the ten themes.

Whilst the evidence suggests that knowledge can be increased and expressed attitudes may be changed, affecting drinking behaviour through school programmes is a very difficult task. There is systematic review level evidence that peer-led prevention programmes can enhance teacher-led programmes in schools.

Identification of alcohol misuse

Early identification and treatment of individual's alcohol problems can help to reduce the host of health and social problems that arise with more serious alcohol misuse. People affected by alcohol misuse are likely to come into contact with the health service, as well as a number of other 'capture points' including:

- Social services
- Schools and educational institutions
- The police and criminal justice system
- Voluntary bodies
- Retailers, including bar and door staff

Although people with alcohol problems can present at any point of the health service or any of the above contact points, their problems are often not picked up. This is due to a number of reasons, such as the lack of recognition that this is part of their role, or the lack of skills to do so.

Screening is a method of identifying alcohol consumption at a level sufficiently high to cause concern, may be undertaken using either a specific audit tool or may take the form of relevant questions asked during the course of any consultation e.g. at a GP surgery.

Following screening, individuals may benefit from a 'brief intervention', which involves giving information and advice to patients to consider their drinking behaviour, and support and help if they do decide to cut down on their drinking. Brief

interventions are usually opportunistic, and there is evidence that screening and brief intervention in hospital accident and emergency departments is effective in reducing hazardous and risky drinking. There is also evidence that heavy drinkers receiving brief interventions in either hospital or primary care settings are twice as likely to moderate their drinking 6 to 12 months after an intervention compared with drinkers receiving no intervention.

Alcohol related crime and disorder

Alcohol misuse is closely linked with a wide range of crimes, disorders and anti-ocial behaviours. Two issues, which are currently of particular concern, are alcohol-related disorder and anti-social behaviour in towns and cities at night, and levels of under-age drinking.

The 'night time economy'
City and town centre evening life, often referred to as the 'night time economy' has developed over the last 10 years, frequently in the wake of urban regeneration. Whilst growth of the night-time economy can bring significant economic and social benefits, at the same time there has also been an associated growth in alcohol-related violence and disorder.

Three main factors appear to be fuelling the alcohol-related violence and disorder that are now becoming a characteristic of the night time economy.

- **Individual reactions to alcohol:** impairment of cognitive and motor skills by alcohol often leads to misunderstanding of a situation and aggressive behaviour in response.

- **Supply of alcohol:** A number of factors around the supply of alcohol raise the risk of disorder. The design of premises, large numbers of young customers, poorly trained staff and excessively cheap promotions are likely to fuel alcohol related disorder.

- **The surrounding infrastructure:** At night fights and disputes occur over scarce infrastructure such as food outlets and transport. These issues are heightened when the majority of premises close at the same time.

- **Changes in licensing arrangements:** The impact of licensing arrangements transferring from the courts to local authorities, and the possibility that local pubs and clubs may seek longer licensing hours, needs to be kept under review.

So what's happening locally

The Health Promotion team have:

- Produced and distributed new schools video on binge drinking.
- Provided training on alcohol issues for teachers, Community Health Educators, Community Development Workers, CONTACT peer listeners, scout andcub leaders.
- Led alcohol education sessions at HMP &YOI Bullwood Hall.
- Piloted interactive alcohol education sessions at two local primary schools.
- Working in partnership with local Crime andDisorder Partnerships and the Essex Drug andAlcohol Action Team:
  Organised Christmas drink-drive media event.
  Supported funding of diversionary projects, such as Legacy XS in Benfleet, youth facilities in Great Wakering, Stambridge and Hullbridge, temporary youth drop-ins in Castle Point and school holiday recreational activities.
- Facilitated inclusion of key alcohol messages in Roadrunner (years 11+), Infology (Year 9) educational projects and Teenessex, Teenessex Plus and Essex Experience peer education camps.
- Organised information and advice displays for parents, carers and other members of the public at 14 local Fairs, carnivals, open days and other public events.
- Supported enforcement measures, including alcohol exclusion zones, under-age test purchasing and confiscation of alcohol from minors.
- Led needs assessment exercises at consultative conferences in both Castle Point andRochford.
- Welcomed local development of outreach services for young people, including Canvey Island Youth Project and Essex Young People's Drug andAlcohol Service.
- Assisted in promoting Drug and Alcohol Action Team (DAAT) workplace alcohol anddrug initiative.
- Backed intensive training for teachers, governors and parents effectively to include alcohol within whole-school drug policies.
- Endorsed advice andinformation sessions at SEEVIC and a number of local schools.
- Provided training on alcohol issues for independent and statutory youth workers included in Star Partnership's Partnership, Action, Community and Training (PACT) initiative.

What next?

Through the Local Strategic Partnership, the Essex DAAT, and the PCT Public Health and Wellbeing Committee the following measures and recommendations should be considered to tackle the problems associated with alcohol:

- **Provide guidance and training to ensure all health professionals are able to identify alcohol problems early**
- **Pilot approaches to targeted screening and brief interventions in both primary care and hospital settings, including A&E Departments**
- **Review the provision of local adult treatment and counselling provision, and support for family members of problem drinkers**
- **Provide clear referral pathways for young drinkers**
- **Review interventions for alcohol-impaired offenders**

SEXUAL HEALTH

Sexual Health is an important part of physical and mental health and is central to some of the most important and lasting relationships in our lives. To maintain good sexual health it is essential that we can easily access appropriate information and services in order to avoid the risks that can result in poor sexual health.

Sexual health is most obviously affected by pregnancy, both planned and unplanned. However it can also be affected by concerns about the health of the reproductive system, sexual behaviour and the individual's experience of, and beliefs about, sexuality. The availability, accessibility and quality of health services also plays a part, as does the individual's access to and experience of sex education in our society.

There is a strong link between social deprivation and poor sexual health which is shown by the higher rates of unintended teenage pregnancies and Sexually Transmitted Infections (STIs) that are higher in areas of socio-economic deprivation. This pattern becomes a vicious circle since poor sexual health increases the risk of reduced social, economic and health prospects.

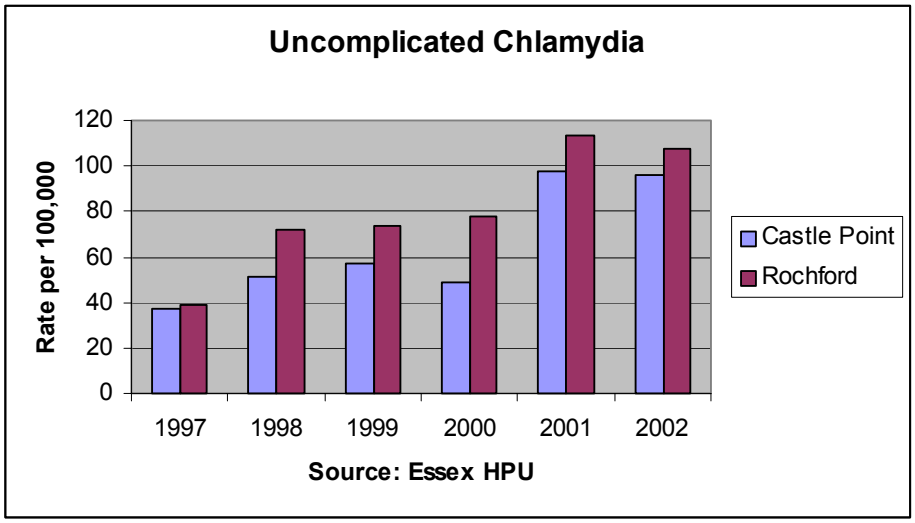
The Problem

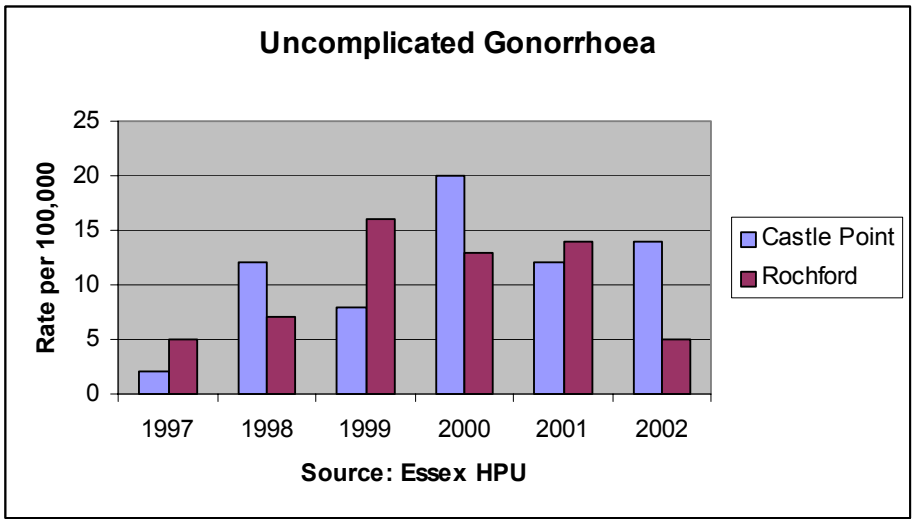
Rising levels of sexually transmitted infections, including HIV, and high levels of unplanned pregnancies are creating pressures on sexual health services. Sexual health is not a priority for local service provision and there is evidence of disinvestments in some areas. Sexual health remains a stigmatised issue and levels of public awareness of the risks are low. It is estimated that approximately one third of HIV infections remain undiagnosed. Serious long-term health problems and disability arise if infections remain undiagnosed or treated, including infertility, or in the case of HIV, death.

In 2002 the rate of teenage pregnancy amongst young women aged under 18 (15-17 yrs.) was, 42.6 per 1000 in England and Wales, 33.3 in Essex, 30.1 in Castle Point and 26.8 in Rochford. In comparison, the rate of teenage terminations is 34 per 1000. this rate tends to show an inverse correlation with deprivation, with those living in greater deprivation less likely to have a termination. A great deal of hard work has been undertaken by Castle Point and Rochford's Sexual Health and Teenage Pregnancy Group. This is a multi agency group made up of representatives of organisations within both the statutory and non-statutory sectors. The Local Action Plan that has been developed and delivered by the group provides evidence of the excellent work that has been undertaken through effective partnership work to reduce teenage pregnancy and improve sexual health.

The rate of STIs in Castle Point and Rochford has, in keeping with the national picture, been increasing over the past few years. The most startling rise has been in relation to the rates of Chlamydia amongst young people. Many factors have contributed to these rises, including an increase in the numbers of young people first having sex under the age of sixteen and more specifically the number not using contraception.

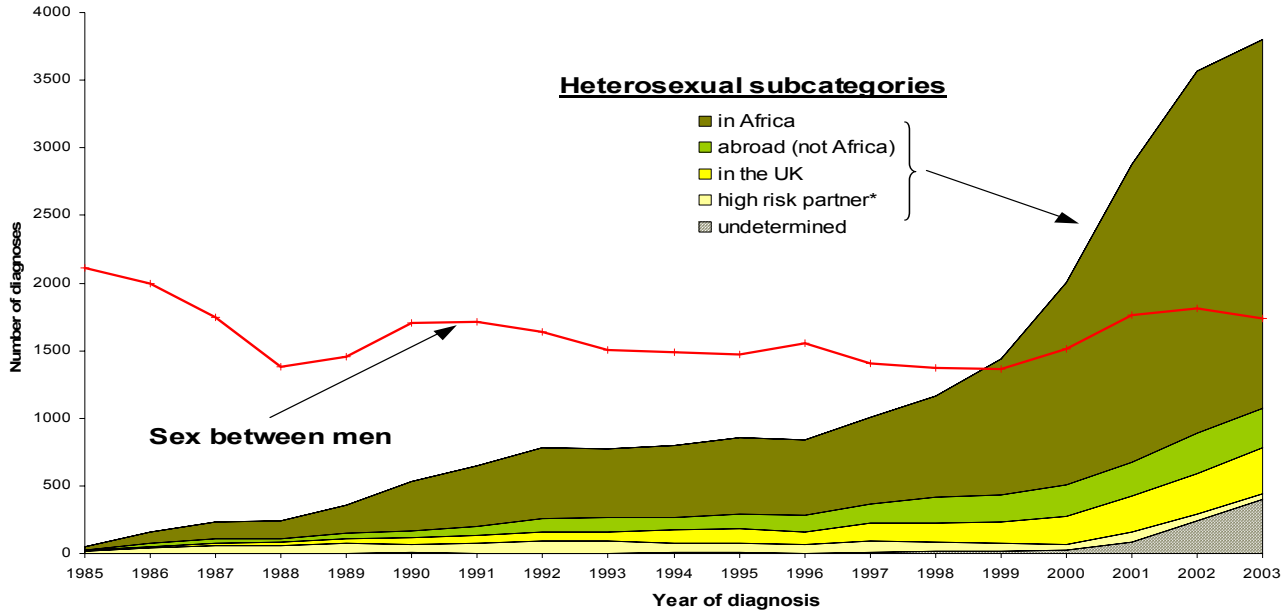
It has been recognised that there is a need for better data on all aspects of sexual health and sexual behaviour if we are to have a clearer understanding of what causes risky sexual behaviour. The Department of Health is currently working on a comprehensive database to support sexual health work locally.





Sexual behaviour is a major factor in determining the incidence of HIV. Up until recently the highest rate of new diagnoses of HIV was amongst men who have sex with men (MSM). However recently more diagnoses have been made as a result of heterosexually acquired HIV, although many of those diagnosed are for infections acquired outside of the United Kingdom. Between 2000 and 2002 there has been a 55% increase in the number of new diagnoses of HIV. This has prompted the Chief Medical Officer to include HIV as a priority area for action in his annual report for 2003.

UK HIV diagnoses by the two main routes of transmission Reports received by end of June 2004



Numbers for 2003 will increase as further reports are received and follow up continues
* High risk partner includes people infected through sex between men, injecting drug use or receipt of blood or blood products

Source: Health Protection Agency, June 2004

The National Strategy for Sexual Health and HIV includes the aim of achieving a 25% reduction in newly acquired HIV by 2007 as well as a reduction of undiagnosed HIV, which accounts for a third of HIV infections, and a reduction in HIV-related stigma.

Key Facts on Sexual Health

Although substantial declines in the incidence of some STIs were observed throughout the 1980s and early 1990s, new diagnoses have risen continually since 1995.

Chlamydia is the most common sexually transmitted infection, with as many as one in ten young women infected. The infection often causes no symptoms, but if left untreated can lead to pelvic inflammatory disease, ectopic pregnancy and infertility.

Numbers of people infected with HIV continue to rise, with 2003 seeing a 20% increase on the previous year. Gay men and people from, or with links to, sub-Saharan Africa continue to be the groups most affected.

Teenage birth rates in England are the highest in Western Europe.

One in four conceptions ends in abortion.

Research suggests that sexual risk taking behaviour is increasing across the population.

Women, young people, gay men and black and minority ethnic communities are disproportionately affected by poor sexual health.

What works?

Good quality sex and relationships education, together with consistent, sustained and culturally, appropriate public health campaigns are effective in improving sexual health. These include targeted investment in campaigns to raise awareness and promote safer sex amongst the groups most at risk.

There is good evidence that school based sex and relationship education, particularly linked to contraceptive services, can have a positive impact on young peoples understanding and beliefs, can delay sexual activity, and reduce pregnancy rates.

Open and timely access to services and treatment, and a framework of patient confidentiality, aid diagnoses and treatment.

Rising levels of sexually transmitted infections (STIs), including HIV, and high levels of unplanned pregnancies create pressure on sexual health services. Sexual health is not a priority for local service provision and there is evidence of disinvestments in some areas. Sexual health remains a stigmatised issue and levels of public awareness of the risks are low. It is estimated that approximately one third of HIV infections remain undiagnosed. Serious long-term health problems and disability arise if infections remain undiagnosed or treated, including infertility, or in the case of HIV, death.

So what's happening locally?

Much partnership work is being undertaken in Castle Point and Rochford by a wide variety of organisations to ensure that information and services are available to ***all*** who require them regardless of age, sex or cultural background.

Chlamydia Screening

Castle Point and Rochford Primary Care and Southend Primary Care Trusts have commissioned a new programme under the Department of Health to become one of the first areas in the country to roll-out the Chlamydia screening programme. This programme offers new ways of screening for Chlamydia which are less intrusive than previous methods as well as being more accurate.

Screening began in October 2003 in the local community and is delivered by staff across a range of health services. The following clinics are offering screening to young people: Genito-urinary medicine, contraceptive and sexual health, gynaecology, ante-natal services, colposcopy, and termination of pregnancy.

In 6 months last year approximately 2,052 young people were screened. 324 positive cases were treated in the community and the overall positive rate was around 16%. Nearly all of these young people were seen in the local services, treated, had their partners treated, and were provided with information to promote healthy sexual practises for the future.

Enhancing Partnerships

The Sexual Health and Teenage Pregnancy Group has continued to develop and strengthen local partnerships with both statutory and non-statutory organisations and groups e.g. the Children and Young People's Strategic Partnership. The group also organise an annual sexual health conference – this year this was an event held jointly with Southend PCT.

Sex and Relationships Education (SRE)

There is ***no*** evidence to show that increased Sex and Relationships Education (SRE) increases the onset or frequency of sex or the number of sexual partners. There ***is*** good evidence that school based SRE, particularly when linked to contraceptive services can have a positive impact on young peoples understanding and beliefs, can delay sexual activity and reduce pregnancy rates.

Training has been provided for school staff on SRE policy development and delivery of sex and relationships education as well as support with the provision of resources and information.

An on-going programme of SRE is also delivered in Bullwood Hall Prison and Young Offenders Institute.

The Star Youth Football Project targeted at young men and women also includes SRE. This project uses professional footballers as a means of engaging with young people, who can then discuss health related issues and direct people to services.

Young People's Services

Over a number of years we have developed a range of sexual health services for young people in Castle Point and Rochford. Examples include a young people's sexual health services in South East Essex Sixth Form College and a Drop-in advice and support services in Greensward School – initiatives that have improved access to local sexual health services to young people.

Teenage Parents

An enhanced health visiting programme for teenage parents is provided in supported housing within Castle Point and Rochford to improve awareness of child development and health issues. The Homestart teenage parenting support project works with young parents to help them to enhance their life skills. A Young Mums support group provides an opportunity for young parents to network and socialise as well as seek information and advice from health visitors.

Teenage Pregnancy Midwife

A teenage pregnancy midwife provides specific antenatal and postnatal care in the community and also within Bullwood Hall Prison and YOI, plus parenting work with young fathers.

Work with Commercial sex workers

Terrence Higgins Trust is funded by Connexions to provide a service to young men selling sex. Combining research and support to identify the young men who are selling sex, a number of individuals have been identified and helped with housing and employment as well as safer sex. Definite links have been found between the use of alcohol and drugs, sexual abuse and the selling of sex.

Work with women is underway, although few have been identified in Castle Point and Rochford. The GUM service in Southend Hospital is in a good position to identify and support both men and women using the service.

Other work is underway across Essex to try to identify the scale of the prostitution among children and young people as part of the strategy Safeguarding Children from Commercial Exploitation. All agencies are working together to identify how best to support young people as well as prosecuting offenders.

Ethnic minorities

Work is underway, funded by social care, with ethnic minorities, particularly those from African populations, to raise awareness of HIV, to offer support and raise wider health issues of importance to the communities. Two of the groups are an African Women's HIV Support Group and a Positive African Men's Support Group.

Support to those with HIV

Terrence Higgins Trust is funded by social care and the PCTs to provide support to people living with HIV to enable them to live productive lives, challenge discrimination as well as adhere to their treatment regimes.

Looked after Children

Through the work on the Teenage Pregnancy Strategy, work has been undertaken to identify all looked after children in Essex, a significant proportion of whom are the responsibility of other local authorities. A Top to Toe bag has been developed and distributed to two age groups, which supports both the young people and their carers to understand issues relating to growing up and information on the availability of services.

What next?

In 2001 the National Strategy for Sexual Health and HIV was published by the Department of Health. The main aims of the strategy are to

- Improve services, information and support for all who need them
- Reduce inequalities in sexual health
- Improve health, sexual health and well being

The strategy recognises that sexual health is important throughout life and that people's needs vary according to their age and lifestyle.

The Public Health White Paper 'Choosing Health – making healthy choices easier' (DH 2004) sets out the governments plans for a major new campaign on sexual health, which includes the commitment of new funding in order to improve the range of NHS sexual health services. The focus will be to

- Communicate better with people about the risks associated with poor sexual health
- Offer more accessible services to provide faster and better prevention and treatment
- Deliver services in a different way to make them more appropriate and relevant to people's needs
- Psychological damage from sexual exploitation and abuse
- Poor educational, social and economic opportunities for teenage mothers leading to social isolation

Through the Local Strategic Partnership and the PCT Public Health and Wellbeing Committee the following measures and recommendations should be considered to improve sexual health:

- **Improve local surveillance**

- **Identify further local needs**

- **Develop further the coordinated sexual health education, advice and contraceptive services for young people**
  Coordinated programmes through children's trusts involving the NHS, local authorities and schools. In particular continuing to establish close working relationships with school governors in the area of sex education and sexual health promotion.

- **Support the delivery of a teenage pregnancy strategy**
  Strengthen delivery to reach vulnerable groups and target areas with high rates of under-18 conception as part of the broader programme to improve sexual health

- **Continue to build close working relationships with Bullwood Prison and YOI to ensure the promotion of sexual health in this changing and challenging environment**

- **Promote sexual health in intravenous drug users**

- **Further develop the provision of safer sex advice and self empowerment strategies particularly targeted at young gay men and men who have sex with men**

- **Promote information to tourists and travellers about the dangers of contracting HIV overseas**

- **Modernise Sexual Health Services**
  Provide more accessible and effective contraception, abortion and sexually transmitted infection services, with consideration of an expanded role for primary care.

  Progress the roll out of chlamydia screening, including screening in non-traditional sites.

HEALTH PROTECTION

Infections and hazards in our environment are sometimes seen as problems of the past. With the development of modern vaccines, antibiotics and the introduction of wider controls, many of the challenges of the 20th century have been tackled successfully. However, the 21st century brings with it new problems to challenge the health protection function. These include:

- Resurgence of diseases such as tuberculosis
- Antibiotic resistance
- New treatments for diseases that reduce the body's immunity to infection
- The emergence of new diseases in different parts of the world
- Threat of rapid spread of infections across the world by increased speed and frequency of foreign travel
- The threat of the deliberate release of poisons, chemicals or microbiological substances.

In response to these modern challenges, a new national organisation covering England and Wales - the Health Protection Agency (HPA) was launched in April 2003. This new agency has brought together a number of different organisations (Table 1) that had previously been individually responding to threats to health protection. The strength of the Health Protection Agency is that it now provides an integrated approach to protecting public health and reducing the effects of infections, poisons, chemical and radiation hazards on human health.

Table 1. Organisations that have merged to become the HPA

- The Public Health Laboratory Service – including the Communicable Disease Surveillance Centre
- The Centre for Applied Microbiology and Research
- The National Focus for Chemical Incidents
- The National Poisons Information Service
- The Regional Service Provider Units that support the management of chemical incidents
- NHS public health staff responsible for infectious disease control, emergency planning and other health protection support
- The National Radiological Protection Board (NRPB) is also being incorporated into the Health Protection Agency.

The HPA has nine Regional Health Protection Teams and 39 Local Health Protection Units. Each local unit has a leader, consultants in communicable disease control, infection control nurses and other staff with specialist health protection skills.

Whilst primary care trusts are responsible for the health protection function at a local level, they fulfil this requirement mainly with the support of a Local Health Protection Unit. Castle Point and Rochford Primary Care Trust is supported by the Essex Health Protection Unit.

As part of the specialist advice and support to Castle Point and Rochford PCT, the Essex Health Protection Unit investigates and manages a full range of health

protection incidents (including outbreaks of diseases such as food poisoning), undertakes surveillance, and provides co-ordination, support and monitoring of local implementation of key national programmes.

Communicable Diseases in Castle Point and Rochford

Populations of individual PCTs or Local Authorities are too small to show meaningful trends even in the most common infections. Variations in reported cases between years may be real or may reflect erratic reporting. Table 2 shows selected notifiable diseases for Castle Point and Rochford PCT

Table 2: Selected notifiable diseases for 2002-2004 for Castle Point and Rochford PCT

Year of report	2002		2003		2004	
Disease /Organism	Number	Rate*	Number	Rate*	Number	Rate*
Campylobacter	95	57.1	125	75.6	108	64.9
Salmonella	24	14.4	45	27.2	33	19.8
Cryptosporidium	0	0	5	3	7	4.2
Giardia	4	2.4	9	5.4	2	1.2
E. Coli 0157	2	1.2	1	0.6	1	0.6
Meningitis- all forms	2	1.2	3	1.8	7	4.2
Meningococcal infections	4	2.4	3	1.8	4	2.4
Tuberculosis – all	9	5.4	4	2.4	9	5.4

(Source of data: Essex Health Protection Unit)
*** rate per 100,000 population**

Food poisoning

Campylobacter remains the most common cause of food poisoning in the UK and Essex, accounting for around 65% of cases. Salmonella accounts for around 17% of cases of food poisoning notifications overall, and the disease incidence is around a third of that for Campylobacter

Clinically Salmonella and Campylobacter infections are very similar and one of the major sources of both Salmonella and Campylobacter is poultry. In recent years the message has been that meat and poultry should be thoroughly cooked, and there should be good kitchen hygiene to prevent cross-contamination from raw to cooked foods.

Tuberculosis

Tuberculosis is an illness caused by the bacterium Mycobacterium tuberculosis. It can affect all parts of the body but the predominant form is pulmonary (lung) tuberculosis. The notification of tuberculosis is of significant public health importance as it allows for the prevention of secondary cases. This is achieved through

screening of contacts and protection of them with BCG immunisation and chemoprophylaxis as necessary.

In 2004, Castle Point and Rochford PCT had the fifth highest incidence of TB out of the 13 Essex PCTs, with an incidence of 5.4 cases per 100,000 population.

Meningitis

There were 7 cases of meningitis (all types) in 2004. The efficacy and high uptake of the Men C vaccine has led to a dramatic fall in the number of cases of Meningococcal Group C infections, with only one case reported across the whole of Essex in 2004.

Outbreaks

Strictly an outbreak is any situation where 2 cases of a disease are clustered in time and place. In 2004 there were 6 outbreaks of diarrhoea and vomiting in either nursing or residential homes in Castle Point and Rochford, compared with 2 outbreaks in the previous year. Laboratory confirmation is important, as it is impossible to identify a causative agent from clinical symptoms alone. There is sometimes reluctance to submit samples, particularly if patients are recovering by the time the outbreak is reported. Long-term control measures also depend on our ability to accurately identify the cause of outbreaks.

Essex Health Protection Unit have identified a number of common features of outbreaks of diarrhoea and vomiting in community residential settings across Essex that may contribute to their spread. These include manual handling of foul linen, bedpans and other contaminated items, and poor design including lack of sinks for staff handwashing in client areas.

Immunisation

Community-wide childhood immunisation is an effective means of reducing the burden of morbidity and mortality resulting from many infectious diseases. Diseases against which immunisation are routinely offered during childhood in accordance with national guidelines include:

- Diphtheria
- Tetanus
- Polio
- Whooping Cough (Pertussis)
- Meningitis C
- Hib (Haemophilus influenzae type b)
- German Measles (Rubella)
- Measles
- Mumps
- Tuberculosis

Apart from its protective effect, immunisation also produces an indirect effect known as ‘herd immunity’, where enough people are immunised to prevent the spread of

disease in a community. The vaccination strategy has to be continually monitored and appropriately modified to meet the challenge posed by changes in the epidemiology of infectious disease.

At the end of 2004, changes were made to the childhood immunisation programme. These were:

- Using inactivated polio vaccine (IPV) instead of live oral polio vaccine (OPV) for all ages.
- Using a new acellular pertussis vaccine instead of whole cell pertussis vaccine.

The underlying reasons for these changes were:

1. Polio infection has very nearly been eradicated from the world, and the risk of acquiring wild polio virus is very low. This means that a switch can be made to IPV. This vaccine is as effective as OPV in protecting the individual and carries no risk of vaccine associated paralytic polio.
2. The new vaccines contain an acellular pertussis component (aP) which offers the same level of protection as whole-cell pertussis vaccine (wP) but has fewer minor reactions such as swelling and redness.

The new vaccines are combined so that children are able to receive them as one injection.

Immunisation data for Castle Point and Rochford, with regional and national data for comparison is shown in Table 3.

Table 3. Percentage of children immunised by their 2nd birthday 2003/4

Area	No. of Children (thousands)	Diphtheria	Tetanus	Polio	Pertussis	Hib	MMR	Men C
CP &R	1.7	96	96	96	96	97	77	98
Essex	17.7	94	94	94	94	95	77	94
East of England	59.2	95	95	95	94	95	80	94
England	548.3	94	94	94	93	93	80	93

Source: Department of Health (3)

There is a national target to immunise 95% of eligible children. Although Castle Point and Rochford coverage is equal or higher than the coverage in England for most vaccines, the low uptake of MMR is a cause for concern. As part of their daily activities, health visitors provide information to parents and carers on the importance of immunisation. Primary care staff are also provided with regular training to keep them up-to-date with new developments in childhood immunisation

Uptake of childhood immunisations in Castle Point and Rochford is reviewed in the South East Essex Immunisation Co-ordinator Meeting. Work is currently underway to review the immunisation defaulters protocol.

Emergency Planning in Castle Point and Rochford

Emergencies, outbreaks of disease and chemical incidents have the potential to cause disruption for communities on a large scale and present operational problems to the NHS.

Because emergencies can develop very rapidly, being prepared and emergency planning are essential components in minimising the impact on the public. Responding effectively means organisations working together to minimise the impact and achieving a return to normality as quickly as possible.

The new Civil Contingencies Act 2004 (4) provides a coherent and unambiguous framework for building resilience to disruptive challenges in the UK, which may include events such as an epidemic, contamination of land with a chemical, disruption of fuel supplies or a terrorist attack. Under this act, PCTs are now recognised as a Category 1 Responder. The duties of Category 1 responders include the duty to assess the risk of an emergency occurring and to maintain plans for the purposes of responding to an emergency.

In order to meet its responsibilities around emergency planning, Castle Point and Rochford PCT has a Major Incident Plan, which can be activated in response to any type of emergency. The PCT is now looking at the implications of Civil Contingencies Act, and will be reviewing its Major Incident Plan to ensure that it fully meets the requirements of the Act

Castle Point and Rochford PCT is represented on a number of countywide emergency planning groups. In addition there is a multi-agency South East Essex Emergency Planning Forum, with membership from the blue-light services, Southend Hospital NHS Trust, local authorities as well as Castle Point and Rochford and Southend PCTs. The Forum recently undertook an emergency planning tabletop exercise, which helped partner agencies to develop a greater understanding of each other's role in an emergency.

Integrated Pollution Prevention and Control (I PPC)

Integrated Pollution Prevention and Control (IPPC) is a regulatory regime to ensure that industries have mechanisms in place to deal with routine and accidental emissions into the environment.

IPPC only applies to number of prescribed activities, including the energy, metals, oil, chemical and waste management industries, paper production, food production and some intensive livestock rearing. Operators of any of these activities must apply to a regulator for a permit. The regulator is either the Environment Agency for the larger industrial installations, or the local authority for smaller installations.

Under the IPPC regulations PCTs are statutory consultees. As part of this role, PCTs are asked to provide a view on the potential risks to human health and the proposed measures to minimise these. PCTs are also asked to report on whether there are any particular local health problems that are relevant.

IPPC applications contain highly technical data, and specialist advice is available to PCTs from the Chemical Hazards and Poisons Division of the Health Protection Agency to assist with its interpretation. The response from the PCT is compiled and submitted to the regulator, when it is placed on the public register.

Castle Point and Rochford PCT has responded to just one IPPC application to date: Hanson Building Products, Great Wakering that is regulated by Rochford District Council.

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Public Health Report

2004/05

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