



Annual Report

of the **Director of Public Health** 2004/05

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Introduction



The Annual Report of the Director of Public Health provides an opportunity to report on the state of health of the community and also highlight ways in which health can be improved. Building on previous Director of Public Health reports this report is intended to be used as a guide to help partners in the NHS, local authority, voluntary sector, business organisations and the community at large, to do all they can to improve the health of the people of Grampian. I hope to highlight some of the successes NHS Grampian and its partners have had over the last year and the challenges which still remain.

In line with national policy guidance¹, we want to ensure that every person can contribute to, and benefit from, the community in which they live. In collaboration with our community planning partners, we aim to tackle inequalities between and within communities. There are two key strands to our work: firstly to ensure we design and deliver our services to meet the needs of our most disadvantaged communities to improve health and secondly, that we build social capital - the skills, confidence, support networks and resources to take advantage of and increase opportunities within disadvantaged groups and communities. Improving people's life circumstances is an essential element of improving health and is an overarching theme in this report. Last year we said we needed to build a picture of where inequalities exist and we report on progress to date. Unfortunately, there is only limited evidence available to tell us what works in addressing inequalities so we need mechanisms in place to measure how effective our actions are in reducing them.

Following active debate with partner organisations and the public we report, in Section 2, on the agreed health improvement priorities in Grampian. Of particular importance this year is the forthcoming legislation on smoking in public places.

NHS Grampian has always actively supported a comprehensive ban on smoking in enclosed public places believing it to be a potentially significant factor in reducing ill-health and premature deaths. We are actively working with our partners to ensure we support organisations to implement the ban and individuals wishing to quit.

Section 3, on health protection, reflects our statutory responsibilities in public health. Communicable disease and environmental hazards remain important causes of ill-health in our communities and we face new threats such as an influenza pandemic. We highlight the risks, how we plan to manage them and also what each of us can do to protect ourselves.

In Section 4, we consider some of the work the public has been involved in, to develop the health service contribution to health improvement. NHS Grampian has embarked on a major programme of change, Healthfit, and we look at some of the evidence that underpins the proposed changes.

With the departure of the Director of Public Health in April 2005, this year - more than any other - the production of this report has been a team effort. My thanks go not only to the contributors but also to the public health system as a whole for their considerable efforts over the last year.

It is not possible in a brief report to be comprehensive. Feedback on the document and suggestions for the nature and content of future editions is welcome. A feedback form is enclosed for this purpose.

Susan Jappy
Acting Director of Public Health

01

Health status

1.1 Introduction

The General Register Office's 2004 mid-year population estimate for Grampian gave the population as 524,020. During 2004 in Grampian there were 5,317 births and 5,211 deaths, 1,495 of these due to cancer and 1,947 due to cardiovascular diseases.

Grampian remains a good place to live, not only because we have an attractive mix of urban centres and rural communities but also because, in general, Grampian is better off than the Scottish average in rates of unemployment, in educational achievement, in how we feel about our health, in terms of the main causes of death (coronary heart disease, cancer and stroke) and in a number of other health and social measures. However, this overall picture of better than average health is not one that applies to everyone in Grampian with the overall position masking some particular local inequalities in health.



1.2 Major causes of death in Grampian

1.2.1 Cancer

More than one in three of us will be diagnosed with cancer during our lifetime and around one in four of us will die from cancer. Survival for most types of cancer continues to improve with cancers of the blood, lymphatic system and testicular cancer showing the best improvements. Even for more common cancers such as bowel, prostate and breast we have seen survival rates^A increase by more than 10% since the early 1970s. However for cancers of the lung, pancreas, oesophagus and head and neck there has been little or no improvement in survival².

Whilst we continue to get better at detecting and treating cancer, and see greater numbers of people surviving cancer for longer, there is still much to be done in reducing the number of people who develop cancer in the future by changing our behaviour. By improving our lifestyle, by eating more healthily and reducing our alcohol intake, we can help to reduce our risk of developing a number of cancers. However, the biggest impact on both the number of people developing cancer, and dying from it, would be if we could get more people to give up smoking and reduce the number of people taking up smoking.

Key facts for cancer in Grampian

In 2004, 31% of the male deaths and 26% of the female deaths in Grampian were attributed to cancer. In line with the rest of Scotland, lung cancer remained the biggest cause of death from cancer for men in Grampian (133 deaths) in 2004 followed by colorectal cancer (95 deaths) and prostate cancer (83 deaths). For women, the top three were lung (139 deaths), breast (98 deaths) and colorectal cancer (86 deaths).

Figure 1 shows the age standardised death rate^B for all cancer types combined since 1977. As can be seen, the combined death rates in men and women for all cancers has generally been falling over the last 25 years. The decline over this period has been greater in men than in women and despite the slight rise in death rates in 2004 it is likely that this declining trend will continue. Figure 1 also shows the trend for rates of new cases of cancer (all types combined) and we can see that for men, there has

been a continuing decline in rates since the mid 1990s. This decline is largely due to the reduction in rates of lung cancer in men. For women, on the other hand, we continue to see rising rates of new cases of cancer.

Figure 2 shows the trend in Grampian rates of lung cancer between 1977 and 2004. As can be seen clearly, rates of lung cancer, and death from lung cancer, in men have been generally falling whilst in women the opposite is true. Whilst in the last 10 years male death rates due to lung cancer have reduced by 28%, women's death rates have remained largely unchanged. Lung cancer remains difficult to treat, with five year survival rates across Scotland showing only slight improvement over the last twenty five years². Given that smoking is the cause of over four fifths of lung cancer the need to continue to work to reduce smoking in the Grampian population as a whole, and women in particular, is clear.

If we compare this situation to the picture for breast cancer in Grampian, as shown in Figure 3, we see that whilst the rate of new cases of breast cancer continue to rise the rate of death from this type of cancer continues to fall. This reflects a general improvement in survival rates for women with breast cancer across Scotland².

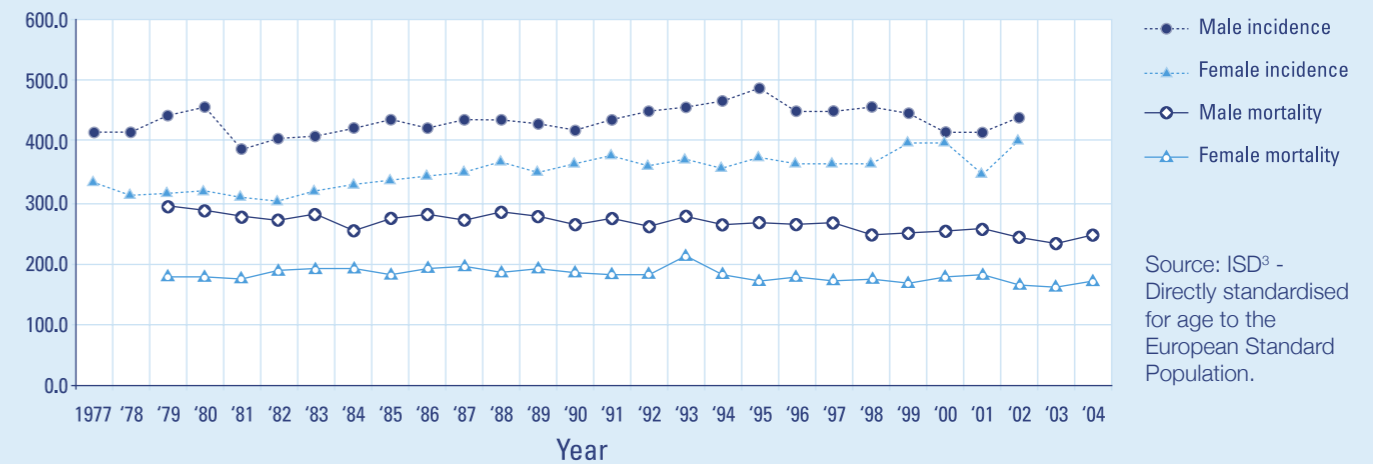
Incidence of breast cancer in Grampian is slightly higher, although not significantly, than the Scottish average with the 98/02 European standardised rate standing at 119.8 per 100,000 population compared to a rate of 115.6 for Scotland as a whole. In terms of mortality Grampian fares better than Scotland as a whole with around eight deaths less per 100,000 population than average based on figures for 2000-04³.

1.2.2 Coronary heart disease

During the 10 years from 1994 to 2003 the incidence (rate of new cases) of coronary heart disease (CHD) in the Grampian population aged under 75 years fell by 25%. Compared to the 22% reduction for Scotland as a whole Grampian has fared slightly better than the national average, although the reduction in men (32%) has been more impressive than for women (12%).

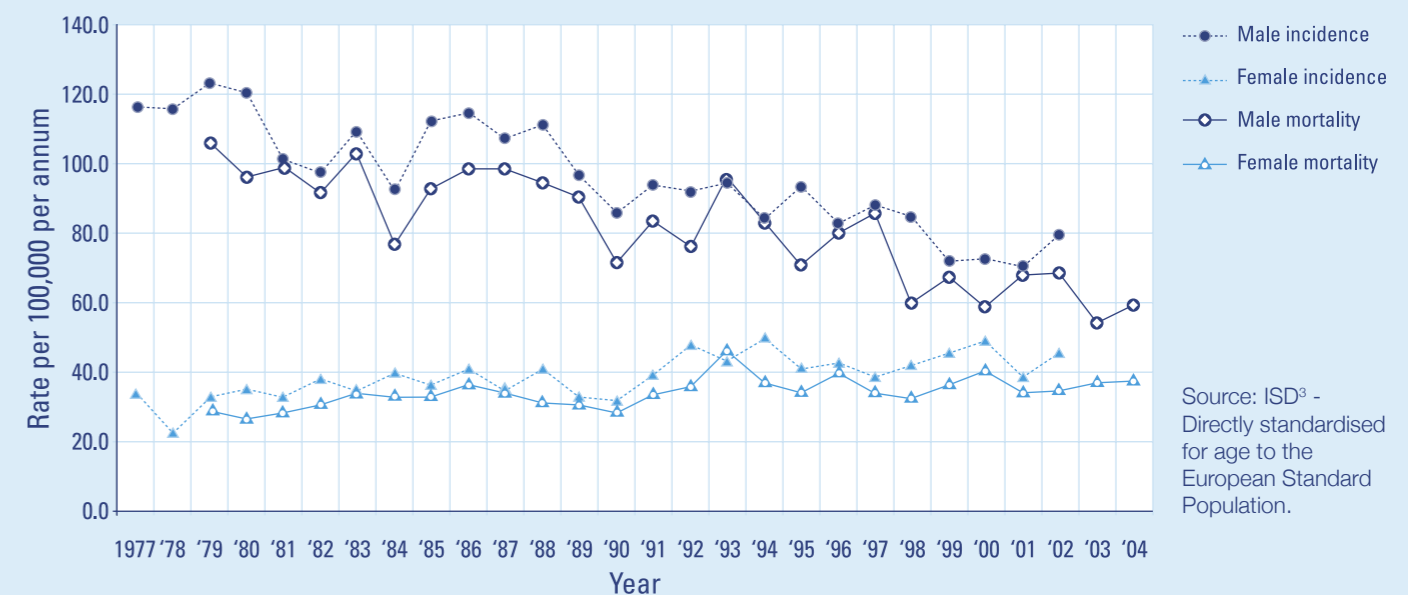
For deaths in the under 75s due to CHD, the Grampian picture has been consistently better than the Scottish average for the last 10 years with a

Figure 1: Cancer incidence and mortality in Grampian 1977-2004.



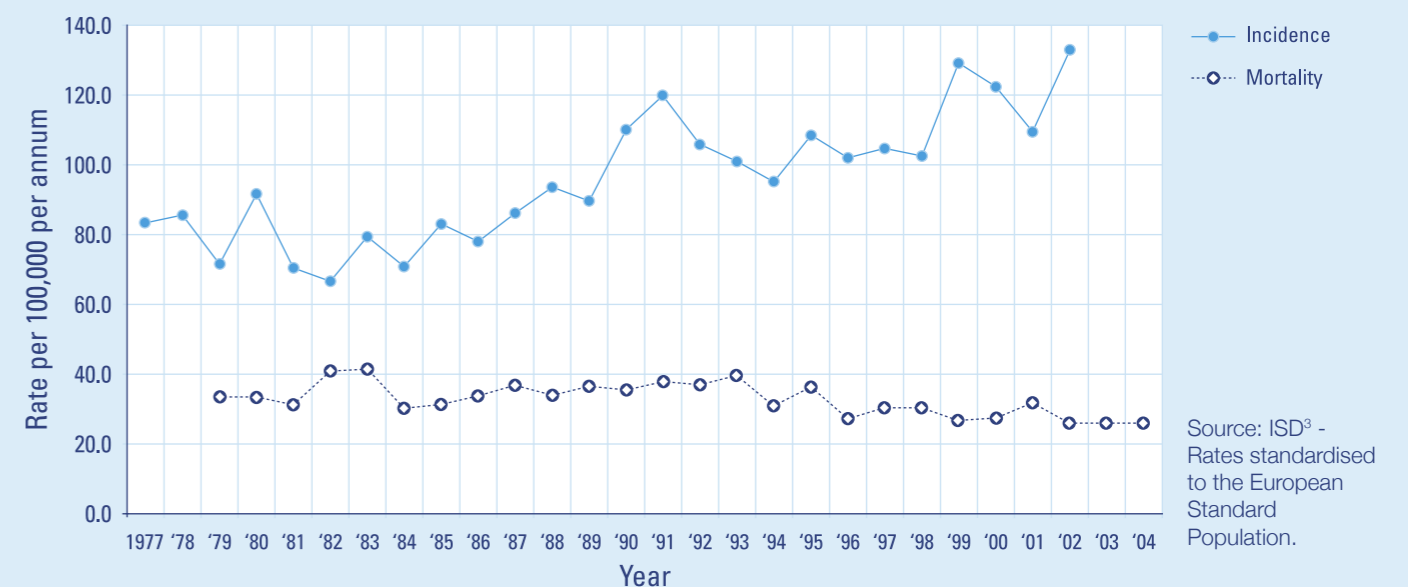
Source: ISD³ - Directly standardised for age to the European Standard Population.

Figure 2: Lung cancer incidence and mortality in Grampian 1977-2004.



Source: ISD³ - Directly standardised for age to the European Standard Population.

Figure 3: Female breast cancer incidence and mortality in Grampian 1977-2004.



Source: ISD³ - Rates standardised to the European Standard Population.

continuing downward trend in age standardised death rates and an improving widening gap with Scotland as a whole. The most recent figures available, for 2003, indicate that for both sexes we have seen a drop in age standardised death rate of almost 52% over the last 10 years compared to a national 40% reduction in the same time period. However these figures disguise a mixed picture within Grampian where Aberdeen City has a much greater burden of CHD deaths than Aberdeenshire or Moray. Table 1 showing the age standardised death rates from CHD for men and women under 65 shows clearly both this geographical inequality is largely seen in men. Given that one in three of all

deaths in the under 65 year age group that result from social inequalities are due to CHD, this is an area that requires continuing effort and work⁴.

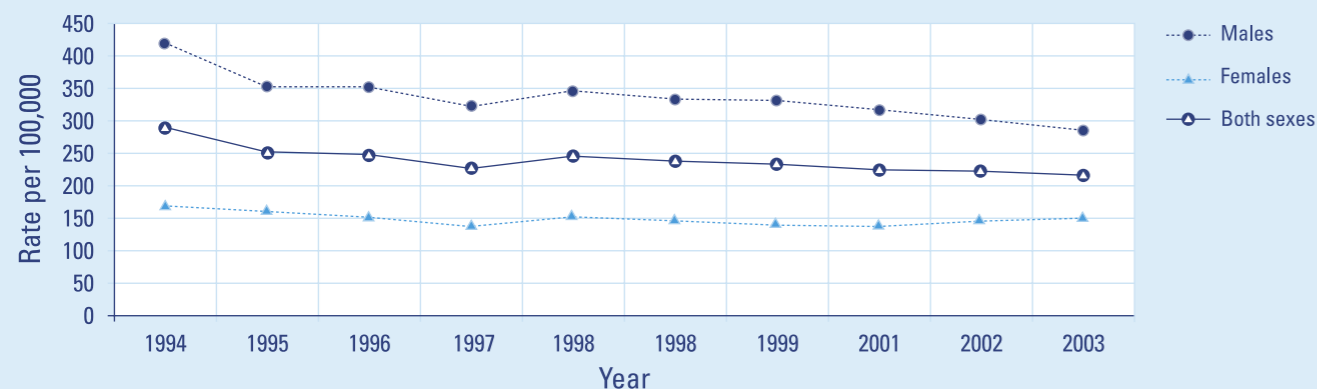
In 2004 the age standardised CHD mortality rate for Grampian was 55.9 / 100,000. The 2010 national target of 49.8⁵ is likely to be achieved ahead of schedule. Given our general level of good health in Grampian we should be aspiring to achieve CHD levels comparable to the European average. Future work in Grampian needs to focus on improving the overall CHD mortality rate still further but more importantly reducing inequality within Grampian.

Table 1: Age standardised death rates from CHD for males and females under 65 1998/2000. Directly standardised to the European Standard Population.

	Age standardised death rate / 100,000 population	
	Males	Females
Scotland	77.45	22.92
Aberdeen City	70.26	14.13
Aberdeenshire	47.11	13.36
Moray	57.31	14.62

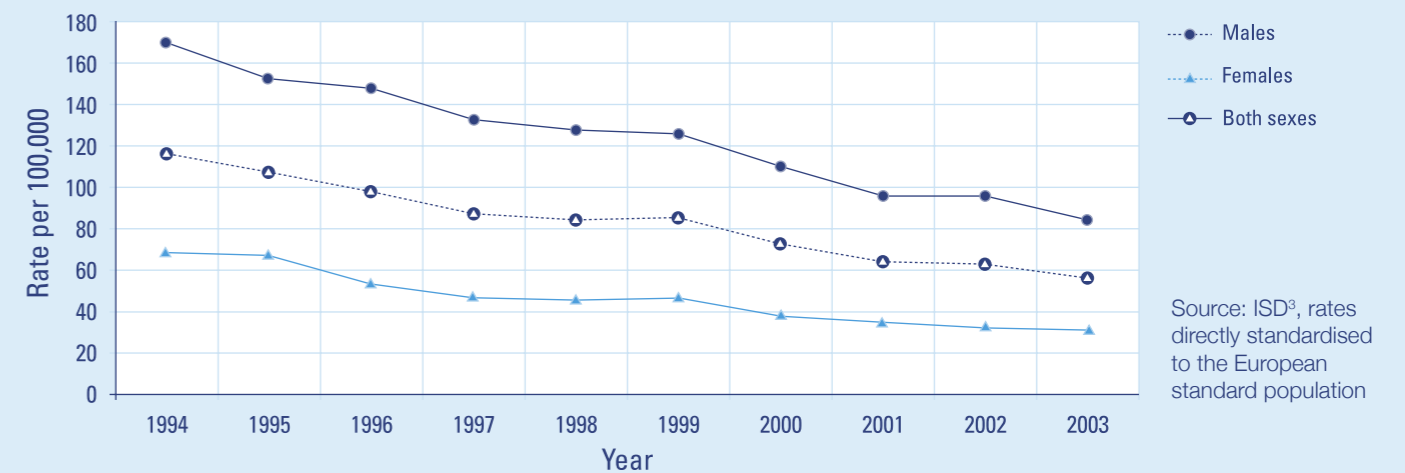
Source: British Heart Foundation statistics⁴

Figure 4: Age standardised incidence rate of coronary heart disease in under 75 year olds per 100,000 population in Grampian 1994-2003.



Source: ISD³, rates directly standardised to the European standard population

Figure 5: Age standardised rates of death per 100,000 people in under 75 year olds due to coronary heart disease in Grampian 1994-2003.



Source: ISD³, rates directly standardised to the European standard population

Risk factors for cardiovascular disease

We await the publication of the 2003 Scottish Health Survey for the most up to date information but in the meantime data from the 1998 Scottish Health Survey⁶ and Grampian's own local lifestyle survey⁷ provide useful information on the level of risk factors for cardiovascular disease in the population. Whilst differences in the collection and reporting of the data limit the scope for drawing direct comparison between Scotland and Grampian the information is useful when looking at the overall risk of disease.

In 1998, the Scottish Health Survey reported the national prevalence of current smokers as 33% compared to 27% in Grampian. The proportion of people who were physically inactive was 20% in the Scottish Health Survey compared to 24% in Grampian, and the proportion who were overweight or obese was identical at 45%. Since 1998, the results of the Grampian Adult Lifestyle Survey have shown that some aspects of the lifestyle of Grampian residents have improved (a further reduction in current smokers to 24%, a 12% rise in those taking regular physical activity, and a 2% rise in those eating 5 portions of fruit and vegetables per day). However, at the same time, there has been a rise in the number of people who are now overweight or obese, and the proportion of the Grampian population who are overweight or obese has risen by 10% in the last 10 years. So whilst we have seen a small risk reduction around smoking, exercise and fruit and vegetable intake we have also seen quite a large increase in obesity. These changes have meant that for many in the Grampian population their CHD risk remains much the same as it did 10 years ago and for some it has become worse.

Treatment for patients with CHD

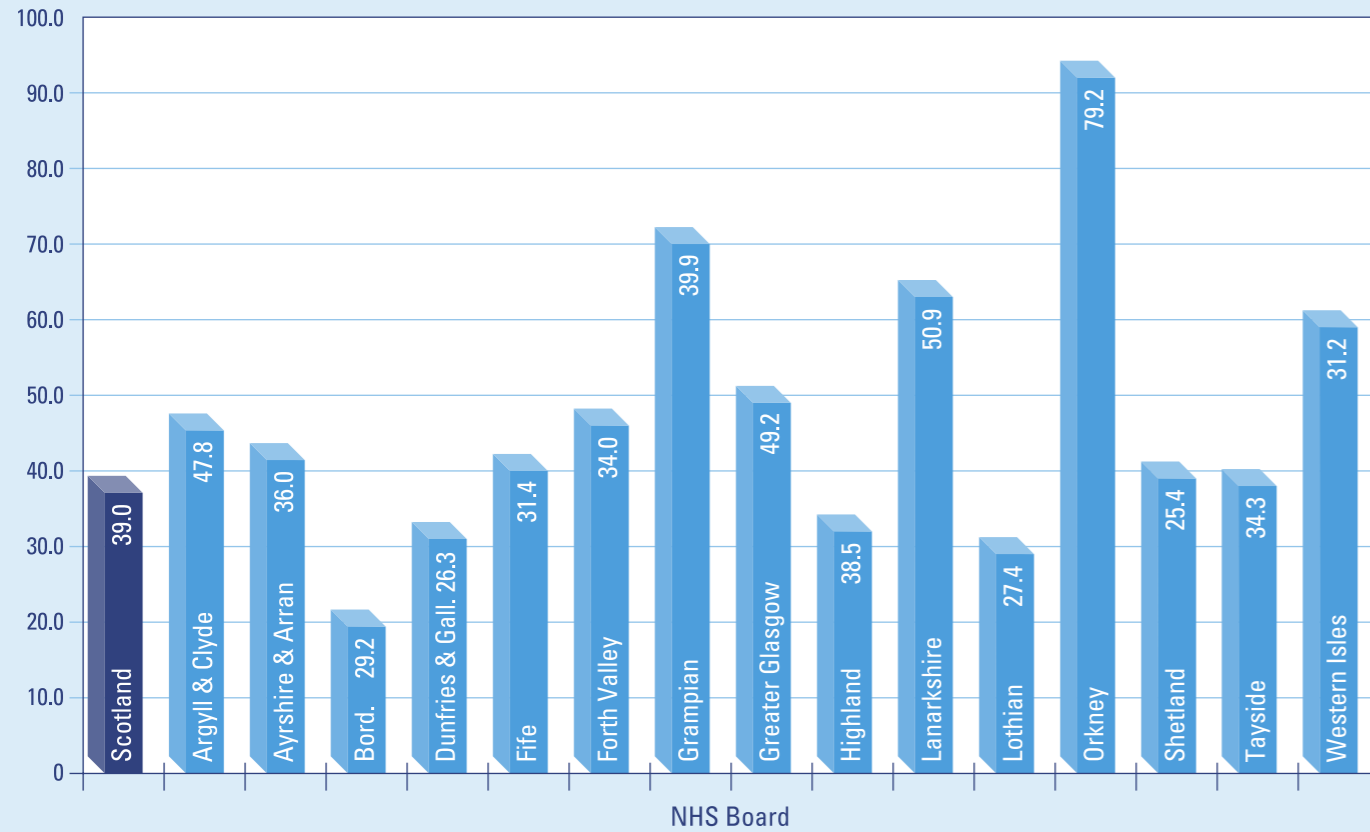
Routine collection of local primary care information i.e. regarding the care provided by GPs has remained limited. Results from audits of care provision in 1998-99 and 1999-2001 indicated that care improved between the two audits for those patients who had already suffered a heart attack. The implementation of the new GP contract in 2004 will begin to provide us with a much richer set of data for primary care, in the form of the Quality Outcomes Framework. This linked to improvements to the way in which prescribing data are reported and collated will allow a deeper analysis to be undertaken than in the past and on a routine basis.

Grampian continues its good record of providing treatment in CHD e.g. rates of contact with GPs and the care provided. Figure 6 shows how Grampian compares to the rest of Scotland for rates of coronary artery by-pass grafts (CABG)⁸.

The fall in CHD mortality over recent years in Grampian coincides with rising rates of investigation and treatment using effective clinical interventions. Grampian has a high rate of investigation and treatment of patients identified with CHD compared to other areas in Scotland, and one of the lowest CHD mortality rates.

On the prevention side work needs to continue on reducing the level of lifestyle cardiovascular risk in the Grampian population, particularly in Aberdeen City. For treatment, we have good evidence that Grampian is doing well in terms of surgery. In primary care we need to consider how we can use the new quality outcomes framework data and link them with prescribing data to provide better quality information about CHD treatment and prevention.

Figure 6: Rates per 100,000 of CABG by Board Area in Scotland 2004/05.



Source: ISD⁹ 2005



1.3 Monitoring and assessing the population's health and wellbeing

We continue to monitor and assess the population's health and wellbeing. Examples of activity over the last year include:

- consolidation of the Health Scotland Constituency Profiles to inform the Health Improvement Healthfit
- the monitoring of breastfeeding rates and establishing mechanisms to review and act on routine data on child health status
- development of a mental health and wellbeing profile
- analysis and interpretation of sexual health data as part of the strategy development
- a number of community needs assessments were carried out to support the three Community Health Partnerships (CHPs) involvement in community planning.

Details of these can be found on our web-based network called Grampian HI-NET: www.hi-netgrampian.org

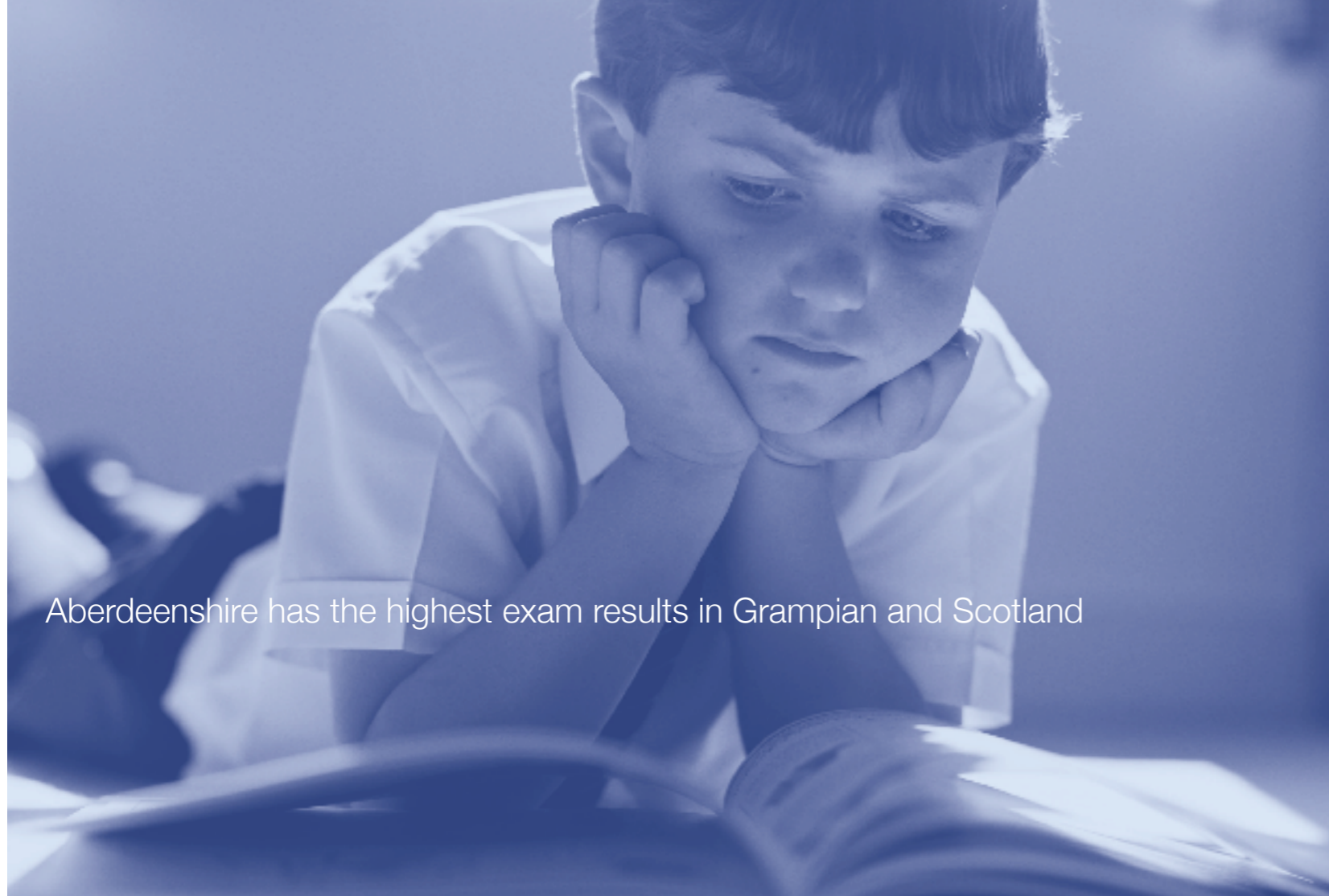
Health is influenced by a range of factors, many of which are not under the direct influence of the NHS. Our partners have a central role to play in improving health and there is a need to consider how best to use information and provide health intelligence across partners to create a shared understanding of the health in our communities and to develop a joint approach to accelerating the rate of health improvement.

As has been said before the health experience and distribution of risk factors and behaviours in the Grampian population is uneven. Although unemployment is relatively low, social exclusion and deprivation, including homelessness, exist within all constituencies. During 2004 the NHS Grampian Public Health Unit undertook a needs assessment for mental health and wellbeing⁹. The assessment identified a number of specific issues in Grampian, an extract of which is provided here:

- Aberdeen City has the highest percentage of residents receiving housing benefit, and the lowest percentage of dwellings below tolerable standard in Grampian.

The reverse is true in Aberdeenshire.

- Aberdeen City has the highest levels of domestic violence; house breaking and drug related crime in Grampian.



Aberdeenshire has the highest exam results in Grampian and Scotland



- A third of households in Aberdeenshire and Moray have dependent children.
- Aberdeen City has the highest percentage of lone parent households but the smallest percentage of households with children compared to Aberdeenshire and Moray.
- Moray and Aberdeenshire have half the Aberdeen City rate of looked after children.
- Aberdeenshire has the highest exam results in Grampian and Scotland, however 38.2% of adults in Aberdeenshire have no qualifications.
- Unemployment rates in Grampian are lowest in Aberdeenshire, which has the lowest rate for council areas in Scotland.
- Moray has the lowest average earnings compared to the Scottish average; conversely Aberdeen City rates are above the Scottish average.
- Aberdeen City has the highest percentage of people living in rented accommodation and in overcrowded accommodation, higher in both instances than the Scottish average.

- Banff & Buchan and Aberdeen Central constituencies have the greatest percentage of people living on disability living allowance and reporting long term illness. The percentage of people who say their health is not good and adults who are unable to work due to disability is also highest in these constituencies.
- Moray has the lowest average gross household income at £25,254 compared to £27,290 for Aberdeen Central and £26,386 for Banff Buchan.
- The rate of injecting drug misuse in Grampian, despite falling in the last three years, remains the second highest in Scotland behind Greater Glasgow for those aged 15-54.
- In 2004, Grampian had the second highest number of drug related deaths in Scotland behind the Greater Glasgow Health Board area (120 deaths). The total for Grampian was 39 closely followed by Lothian with 36, Argyll & Clyde with 35 and Lanarkshire with 33.

- Grampian has no areas classified as being in deprivation category 7 (the most deprived category). However 4.9% of the population in Aberdeen City are in deprivation category 6. Moray has no residents in deprivation category 1, 6 or 7, which may reflect a greater balance in that population although the data does mask information available more locally. Overall the majority of the Grampian residents are in deprivation category 2.

interpretation is critical. NHS Grampian needs to build capacity to create shared understanding of the available data and it's implications and limitations.

- New data systems such as the Quality Outcomes Framework for general practice should be considered alongside existing data such as prescribing trend data to provide a more detailed picture of the health status of communities.

1.4 Health status - next steps

- The need for better information and communication to measure progress in improving health and providing quality health care services has been identified. As a health system, and with our partners, and with our partners we need to develop a focused set of measures, drawing on multiple sources of information to develop a picture of where we are now and in order to measure progress. Skilled

02

Improving health in Grampian

In 2002 we began a process for redesigning health and health care services in Grampian so that they meet the present and future needs of the population. We call this process Healthfit[®] and it involves working with the people we serve, and those who work with us, to agree a shared vision for health and healthcare services in the future.



In 2004 we undertook a Health Improvement Healthfit¹⁰ to produce a shared view of health improvement priorities and how services should be developed jointly in order to accelerate health improvement and reduce health inequalities in Grampian. Over 200 people from a wide range of agencies were involved in shaping the agenda for health improvement identifying local priorities as:

- tackling health inequalities
- tobacco control
- mental health
- sexual health
- substance misuse (including alcohol misuse)
- obesity.

2.1 Tackling health inequalities

“ Some variances in inequalities in health are perhaps due to genetic inheritance, exposure to certain environments, individual choices and chance. If such variations are unequally distributed across gender, ethnic or socio-economic groups or are associated with levels of education, income, occupation or access to services, then these should be considered to be unethical and therefore unacceptable to a modern society¹¹ ”

At a national level an example of such inequality would be our poor life expectancy compared to the rest of the UK and many of our European neighbours. Closer to home we saw in the coronary heart disease section how within Scotland, and within Grampian, there are differences in the rates of death due to CHD. We can link deprivation to most of the major influences on health such as educational attainment, likelihood of smoking, occupation related mortality, quality of diet, sexual health, alcohol consumption, fuel poverty, housing quality as well as many health outcomes such as cancer, coronary heart disease and depressive illness. A wide range of changes is needed to make a difference and therefore addressing inequalities should be an overarching priority. Whilst health inequality focussed projects and work are needed it is only by bringing the need to address health inequality into mainstream policy

making and service delivery that we will make significant inroads into tackling inequity. Whilst it is accepted that new services must take account of identified inequalities there is a need to be more proactive by linking health inequality outcomes to the performance assessment of such services. We also need to review existing services and ensure that they meet the needs of the population rather than facilitating maintenance of the status quo. One of the challenges for public health, is to take every opportunity to inform these more mainstream agendas.

To have any possibility of doing this, of course, involves influencing the hearts and minds of the decision makers of today, and where possible to infuse the issues, ideas, and values into the minds of those who are at a formative stage in the development of their careers.

NHS Grampian through its three Community Health Partnerships (CHP) is an active partner in the three local authority based Community Planning Partnerships in Grampian. Established in April 2005, the Community Health Partnerships are showing early signs of increased joint working to tackle inequalities and the root causes of ill-health in our communities. Through the Community Planning partnerships frameworks have been established for local organisations, local authorities, the NHS, police and fire services, the Enterprise Network and the voluntary sector, to express a shared vision for health - the Joint Health Improvement Plan (JHIP)^{12,13,14}.

2.1.1 Making a difference with vulnerable groups

Homeless people are, arguably, amongst the most dispossessed and vulnerable in our communities. They are often stereotyped as a group and their views are rarely heard by policy makers.

Health & Homelessness (H&H) is a good example of what can be achieved through joint working between the Community Health Partnerships, Local Authorities and the Voluntary Sector within and across organisational boundaries. Highlights include:

- Needs assessments - partners have considered the findings of jointly commissioned research in Moray¹⁵ which showed:

- A steady increase in the number of homeless applicants in Moray with recent trends showing an increase in single applicants.
- Proportions of couples and two parent families presenting as homeless remain above the Scottish average.
- The main reasons for homelessness were family and relationship breakdown, domestic and non-domestic violence and loss of a private tenancy.
- Available data indicate that significantly higher proportions of homeless applicants were in poor health compared to health statistics of the population as a whole.
- Homeless applicants were more likely to have been in touch with their GP and less likely to have visited a practice nurse or dentist. Applicants had most frequently been in contact with accident and emergency services.
- Feedback from service providers suggests there is a need to effectively address the link between homelessness, mental health problems and drug/alcohol misuse.

Recommendations arising from the research will be taken forward through the Moray Health & Homelessness Group. A similar needs assessment is being finalised in Aberdeenshire.

- A review workshop in Aberdeen attracted 55 delegates from a wide range of services. The session combined the review with a training session. A series of workshops during 2005 covering drugs, mental health and wellbeing and changing culture have been well received.
- Raising Awareness - a powerful DVD, featuring local people talking about how they became homeless and the implications of homelessness on their health has been produced. The DVD, produced by The Lemon Tree for Aberdeen Cyrenians, has been used with partners and undergraduate students to increase their individual and collective sensitivity to this vulnerable group.

2.1.2 Focusing our work

The publication of data highlighting the differences in life expectancy between communities provides a powerful driving force for change. We identified the need to become increasingly sophisticated in

measuring and identifying inequalities and even more so at sharing these data with others. Last year we said we needed to build a more detailed picture of where inequalities exist in Grampian.

Working with colleagues in Aberdeen City CHP we are piloting a mechanism for communicating and interpreting existing data, along with its implications and limitations, to help to create a shared understanding of health inequality to inform action. Building on the Health and Well Being Profiles produced by Health Scotland¹⁶ a multi-functional Traffic Lights tool has been developed. The tool is area based, currently postcode sector, but has the potential for conversion to geographies compatible with the Scottish Index of Multiple Deprivation. The Traffic Lights take the ‘percentage below or above the Scottish average’¹⁷ and simplifies it by assigning colour coding as follows:

Red - more than 5% worse than Scotland average

Green - more than 5% better than Scotland average

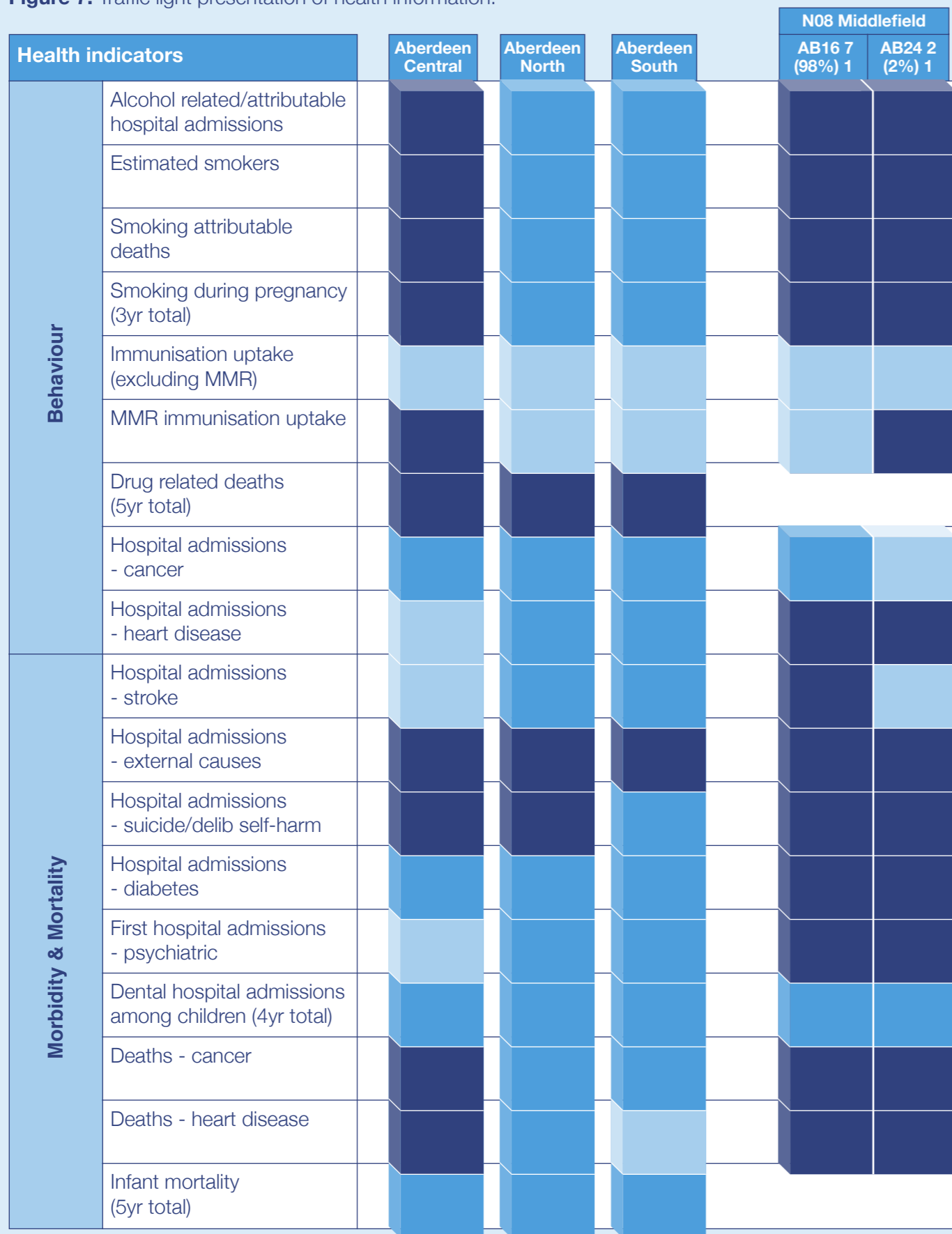
Amber - within + or - 5% of Scotland average.

Please note: due to colour restrictions in printing this document an alternative key has been used (see page 20).

Traffic Lights are presented at three levels of geography - Aberdeen City, North/Central/South areas and neighbourhoods. Figure 8 is an extract from the Traffic Lights dataset and highlights that Aberdeen Central has a poorer health record compared to Aberdeen North and South. However, if we take Aberdeen North and drill down into one of the neighbourhoods, Middlefield, we can see variation in health within the North area. Early evaluations of the tool indicate that health and non health staff have found Traffic Lights easy to use, particularly in helping to identify differences between neighbourhoods and areas. Presentation of data in this format provides a starting point for discussion on health issues and is useful in pinpointing areas for further action/investigation.

There are many causes of health inequalities which makes finding effective solutions very difficult. In addition, there is a lack of robust evidence to inform where best to focus and target our work in order to be more effective in tackling inequalities in health. This is why we need to put in place mechanisms

Figure 7: Traffic light presentation of health information.



Key: Red ■ Green ■ Amber ■

Please note: due to colour restrictions on print an alternative key has been used.

1(%) refers to the % of the neighbourhood population resident in the postcode sector.

Red ■ > 5% worse; Green ■ > 5% better; Amber ■ within + or - 5% of Scotland average; blank = no data

to measure where inequalities exist and how effective our actions are in reducing them. It is vital that we can agree with all of our stakeholders and most importantly, with the communities they represent, the action needed to tackle those areas identified in Health Improvement Healthfit and what outcomes we will use to assess whether we have been successful. Some of this will require us to look at the measures we will use to benchmark our performance, a key action in our inequalities framework¹⁷ now underway, and one which we will return to in next year's report.

2.1.3 A snap shot of health inequalities in Grampian

The national Health and Wellbeing Profiles referred to earlier illustrate that, for many health outcomes, communities in Grampian fare better than the 'average for Scotland'. However, there are a number of communities in Grampian whose health is not as good as the Scotland average, and who are much less healthy than their neighbouring communities in Grampian.

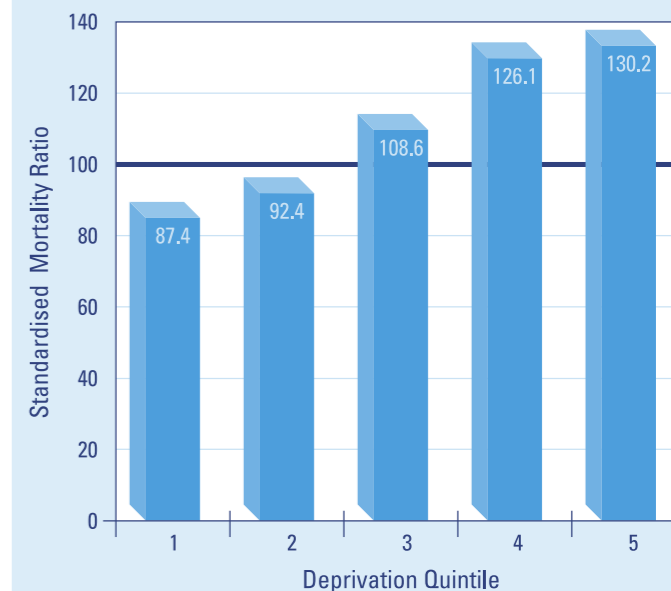
To demonstrate the impact of deprivation locally we can look at mortality rates due to cancer and ischaemic heart disease. To illustrate this Figure 8 shows the age and sex standardised mortality rates for cancer in Grampian by deprivation quintile^E. As can be seen from the chart there is a clear social gradient in mortality rate with deprivation i.e. as we move across the deprivation quintiles from 1-5 we see increasing rates of mortality with increasing deprivation.

Figure 9 shows a similar social gradient for ischaemic heart disease and helps explain some of the variation we saw in mortality rates from coronary heart disease between Aberdeen City, Aberdeenshire and Moray earlier (Table 1).

Figure 10 (overleaf) shows the picture for suicide rates for 10-24 year olds. As can be seen from the chart the inequality is heavily skewed towards the most deprived fifth of the population.

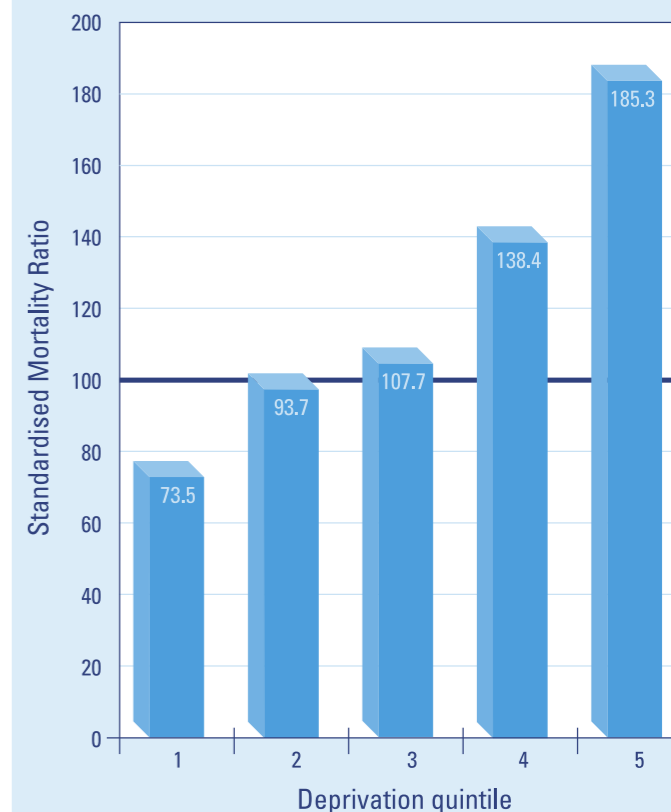
In Figure 11 (overleaf) the standardised rates of teenage pregnancy display a less skewed picture but still a clear social gradient.

Figure 8: Cancer mortality for under 75 year olds in Grampian (1999-2003) by Scottish Index of Multiple Deprivation (SIMD) deprivation quintile.



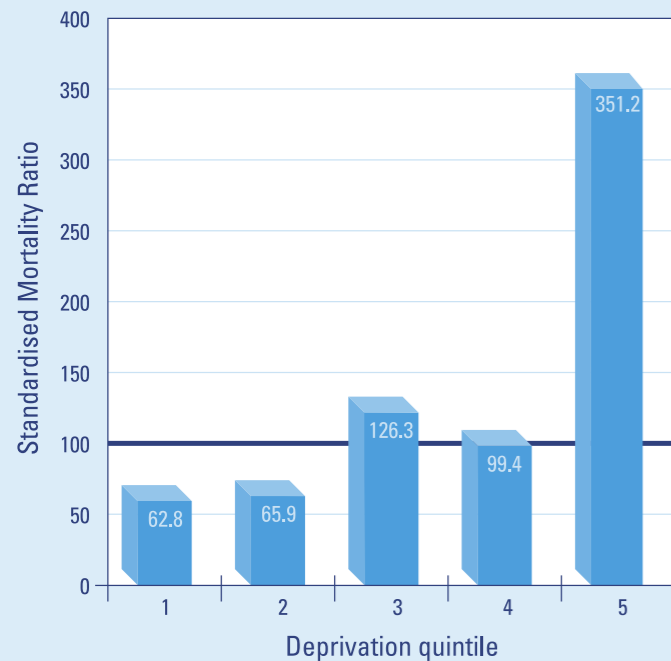
Source: Grampian Public Health Unit. Ratios indirectly standardised for age and sex.

Figure 9: Ischaemic heart disease mortality for under 75 year olds in Grampian (1999-2003) by SIMD deprivation quintile.



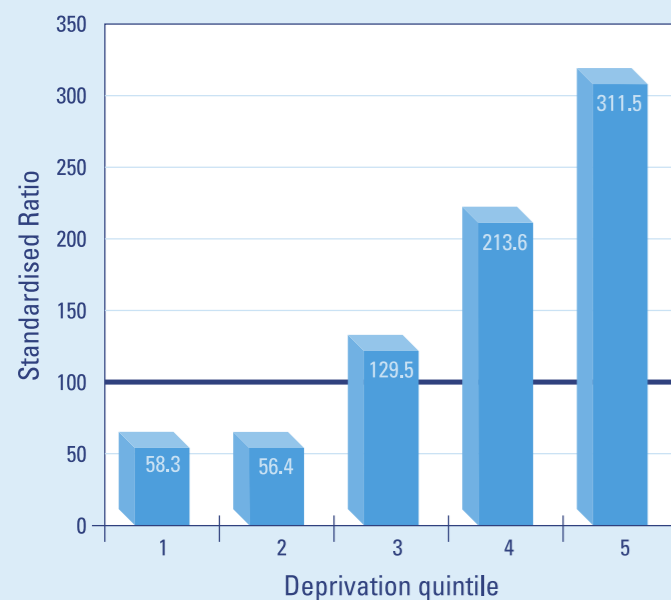
Source: Grampian Public Health Unit. Ratios indirectly standardised for age and sex.

Figure 10: Suicide mortality for 10-24 year olds in Grampian (1999-2003) by SIMD deprivation quintile.



Source: Grampian Public Health Unit.
Ratios indirectly standardised for age and sex.

Figure 11: Teenage pregnancy standardised rate for 13-15 year olds in Grampian (1999-2003) by SIMD deprivation quintile.



Source: Grampian Public Health Unit.
Ratios indirectly standardised for age and sex.

2.1.4 A snapshot of current work in Grampian to reduce health inequalities

In Aberdeen City:

Aberdeen Healthy Living Network - The Aberdeen Healthy Living Network (AHLN) is a joint initiative by NHS Grampian and Aberdeen City Council to work with the most disadvantaged communities (geographic and of interest) focussed on helping to achieve a range of national targets within 'Closing The Opportunity Gap and the Performance Assessment Framework'.

It combines work to address poverty e.g. increasing benefit uptake, with a range of interventions designed to improve life chances and choices, supporting the development of personal competencies and skills.

Research evidence has highlighted the effective community participation in the Network and particularly AHLN's contact and work with hard to reach people. Its complementary focus on addressing underlying factors that contribute to poor health, e.g. fuel poverty, as well as addressing specific health issues, e.g. mental health and wellbeing, is a significant feature in delivering health improvement for a difficult to reach client group.

Examples of AHLN work include:

Mental health and well being - material deprivation is consistently associated with higher prevalence of mental health problems through what has been described as a cycle of invisible barriers: poverty of hope, self-worth and aspiration. Evidence indicates that effective interventions must address both the financial circumstances of targeted groups and lack of opportunities and life chances.

Group work and arts development projects to build confidence and self-esteem and improve mental health and wellbeing among young people who are disenfranchised from mainstream services include:

- work in conjunction with St. Machar Parent Support Project, to support 1st year boys in danger of exclusion from school due to behaviour difficulties, was successful in maintaining the participants in school. Various participants went on to participate in sports through Give Kids A Chance (GKAC)

- an arts project with young people at Northfield Academy on mental health and wellbeing discussed pressures on young people and their mental health and wellbeing. This culminated in a video, 'Pressure Points', which the young people scripted, recorded and edited. It was presented by the young people at a conference for teachers and elicited feedback such as "very effective" and "powerful and moving"
- support and development for grandparents looking after grandchildren permanently due to difficulties such as parental death, abandonment or parental drug use.

Physical activity - Group work on exercise has been supported providing taster sessions, exercise groups, and outdoor pursuits, with people who have not traditionally engaged in physical activities, e.g. young mums, people with long term mental health problems. Some have sustained their participation through mainstream activities or applications for further funding to develop activity groups from taster sessions.

- The Reachout Project works with people with long term mental health problems and/or drug and alcohol related issues, to organise groups to participate in outdoor pursuits. Several participants now hillwalk independently and others participate in other organised groups.

Food and nutrition - Groups focussing on healthy cooking, cooking on a budget, and cooking skills have been set up and developed. AHLN has succeeded in engaging young people and hard to reach groups.

- Through APEX, a group has been learning simple cooking on a budget.
- In partnership with Give Kids a Chance teenage girls in Powis were supported to develop cooking skills. This group continues and their parents now wish to establish a group.

Examples of longer term projects include:

- outreach work with both ethnic minorities and travellers
- a volunteer parent mentoring scheme
- 'one-stop' referral system for benefits advice and other financial support services
- development of credit union membership and community food initiatives

- local take up campaigns in neighbourhoods e.g.
 - health visitors have set up and run clinics and undertaken immunisation at a local travellers' site
 - development of Parent Support Groups in addition to individual support for parents
 - development of Health Information Packs for Ethnic Minorities new to the area
 - promotion of the referral form with a range of professionals, including health professionals, to enable them to refer people for a range of income maximisation benefits. This includes concern over cold homes and fuel poverty
 - in the first two years of the Network a total of £300,000 has been gained in yearly benefits (recurring weekly benefit e.g. Income Support, Pension Credit) and £75,000 in one-off payments.

In Aberdeenshire:

- midwives in Fraserburgh have expanded their role in providing support for pregnant women with a history of substance misuse. Collaborative working with the Kessock Clinic and other agencies aims to provide greater support to this vulnerable group
- the Children's 1st Project in Fraserburgh works closely with families, with children under five, affected by substance misuse
- adolescent health workers are in place in Fraserburgh, Banff and Mintlaw to work with school excluded young people and those who do not engage with other services
- drop-in centres run by health visitors in Banff and Peterhead at the Family Centre. The sessions have proved very popular and successful in attracting the participation of local vulnerable families
- in Banff a self-help group for mothers and families effected by postnatal depression has been set up supported by the local health visiting team and a community psychiatric nurse
- signposting and referral between the local authority and health service have been improved in Banff, Fraserburgh and Peterhead where housing officers have made links to the health service.

In Moray:

- **Safe Message Service (SMS) Young Peoples' Drop-In** - developed by young people for young people this friendly drop-in service provides accurate, relevant information on all lifestyle issues. A variety of services and support are on offer from one-to-one and group advice on topics such as alcohol, drugs, smoking, sexually transmitted infections /sexual health, exercise,

- **Oral Health** - given the poor oral health record of the Buckie community a programme to support children, parents and the community as a whole to take care of their oral health has been developed. Working with the community, the project will provide information (on nutrition and oral health), toothpaste/toothbrush packs for the under 5s and encourage toothbrushing through nursery and primary schools.



health eating and stress. To overcome barriers to access due to rurality a text service has been introduced. A family planning service is delivered through the service with over 800 contacts made in 2004.

- **Mobile Information Bus (MIB)** - the MIB has an on-going programme of visits to rural communities to provide information and advice to young people of secondary school age. Since its launch in 2000, over 13,000 young people have visited the MIB. Workshops/discussions on key health issues (alcohol, drugs, sexual health and tobacco) account for 50% of the activities undertaken.
- **Lhanbryde Minor Illness Clinic** - the village has a high number of low income single parent families with poor and expensive public transport to Elgin. The local community identified the need for a local health service, access to pharmacy provision and health information. The drop-in service has a nurse led clinic providing treatment and advice on a range of minor illnesses, a mini Healthpoint providing up-to-date health related information and a range of group work - young parents group, 65+ activity group and training in areas such as accident prevention.

2.2 Tobacco

Tobacco smoking is the single most important preventable cause of ill health and premature death in Scotland. Whilst we have achieved the 2005 target for the number of adults smoking in Grampian, this masks the differences across the area. For example, people living in disadvantaged areas are twice as likely to smoke when compared to Grampian as a whole. They are also five times more likely to be exposed to environmental tobacco smoke (passive smoke) than their more affluent counterparts. The forthcoming tobacco legislation preventing smoking in enclosed public places provides a unique opportunity to protect the population's health. The approval of this legislation together with increased support for smoking cessation, full implementation of international restrictions on tobacco advertising and marketing and the Lord Advocate review of sale of age restricted products in Scotland are crucial in affecting change in smoking prevalence and subsequent disease and disability from those using and being exposed to tobacco use.

2.2.1 A snapshot of tobacco control in Grampian

From Table 2 it can be seen there is significant work still to be done in Grampian. Adult tobacco prevalence figures have seen a slight increase and continue to be seen at high levels among our most disadvantaged communities. In addition, youth levels of tobacco use continue to be adrift from the national target and considerable work is required in order to deliver improvement in levels of youth tobacco prevalence. Smoking in pregnancy is crucially important to the health of the mother, pregnancy, delivery and early health of the child. Grampian has work to do in addressing smoking during pregnancy and positive efforts should be maintained and increased to seek to reduce tobacco use. In addition national data have shown high

prevalence of tobacco use in those living with mental illness both within psychiatric institutions and in the community.

Table 3 provides the estimated impact of smoking, and reducing the number of people smoking, in Grampian on smoking related deaths, NHS

admissions and NHS expenditure. It is estimated that in 2004 the work of the Smoking Advice Service would have avoided four smoking related deaths, the admission of 27 smokers to hospital and saved £65,000 in NHS costs to treat smoking related illness.

Table 2: Grampian performance against smoking targets.

	National Target	Grampian Rate
Adults (aged 16-64)	Reduced to 33% by 2005 and to 29% by 2010	24.2% (2002 Grampian Adult Lifestyle Survey) 30.9% (Constituency Health & Wellbeing Profiles 2004)
Young People (aged 12-15)	Reduce to 12% by 2005 and to 11% by 2010	19.3% (2001 Grampian Youth Lifestyle Survey)
Pregnant Women	Reduce to 23% by 2005 and to 20% by 2010	24% (as reported in 2002 PAF)

Table 3: Estimated impact of the Grampian Smoking Advice Service.

Number of deaths attributable to smoking expected each year in Grampian	Estimated number of deaths that would be avoided in Grampian if smoking prevalence were reduced by 1%	Estimated number of deaths that would be avoided in Grampian if smoking prevalence were reduced by 2%	Estimated number of deaths avoided in Grampian during 2004 linked to the work of the Smoking Advice Service
994	34	68	4
Expected NHS admissions attributable to smoking each year in Grampian	Estimated potential reduction in NHS admissions each year if smoking prevalence were reduced by 1%	Estimated potential reduction in NHS admissions each year if smoking prevalence were reduced by 2%	Estimated potential reduction in number of NHS admissions in 2004 linked to the work of the Smoking Advice Service
6227	214	428	27
Expected NHS expenditure attributable to smoking each year in Grampian - £000s	Estimated potential reduction in NHS expenditure each year if smoking prevalence were reduced by 1% £000s	Estimated potential reduction in NHS expenditure each year if smoking prevalence were reduced by 2% £000s	Estimated potential reduction in NHS expenditure in 2004 linked to the work of the Smoking Advice Service £000s
15178	521	1042	65

Source: Grampian Smoking Advice Service



from this pilot will be available in October 2005. In addition, Grampian continues to participate in the national pilots of smoking cessation support for young people, for example the 'Fag Break' project in Moray.

Prevention: The prevention programme is targeted at school aged young people. As part of the Health Promoting School programme a package of support for tobacco control is available which includes; workshops for primary and secondary school pupils; curriculum support; policy development and training for those working with young people to raise awareness of tobacco issues and evidence based approaches. All schools are required to be Health Promoting Schools by 2007. Young people should be given every opportunity to explore the impact that the engineering of tobacco - the product, previous and new marketing practices, peer and family influences have on their decisions to smoke or not in an open and non judgmental manner.

Passive smoking: NHS Grampian, Aberdeen City, Aberdeenshire, Moray Council, the voluntary sector, the business community and citizens have a key role to play in reducing the harm from exposure to tobacco smoke. Children in particular often have limited choices about the environment that they find themselves in and therefore implementation of legislation to reduce passive smoking in public places will have important implications for health improvement. There are considerable challenges ahead for all in Grampian to understand the impact and to support the implementation of future legislation.

Through Scotland's Health at Work (SHAW), 176 companies who are bronze award holders, have implemented a policy on smoking that promotes a smoke free environment and provides smoking cessation support.

Advice and guidance is available to workplaces offering support in preparation for the new no smoking in public places legislation.

- If you want to stop smoking contact the SAS freephone **0500 600 332**.
- If you smoke try not to expose others to your tobacco smoke.
- For information on tobacco issues or services contact the healthline **0500 20 20 30**.

The Grampian Tobacco Control Strategy has identified young people, pregnant women, adult smokers - particularly those in disadvantaged communities and people living with mental ill health as priority groups for targeted action. In line with the National Tobacco Control Action Plan the Grampian strategy outlines action to achieve the strategic objectives in the following areas:

- action on exposure to passive smoking
- prevention
- smoking cessation.

2.2.2 A snapshot of current work in Grampian on tobacco control

Smoking Cessation: Recognised nationally as an example of good practice the Smoking Advice Service (SAS) has continued to grow since its launch in January 2000. Individuals can refer themselves to the service or can be referred by their health professional. The service includes a community pharmacy programme, a hospital based service and community service delivered across Grampian in response to identified need. Where appropriate, prescriptions for Nicotine Replacement Therapy (NRT) or Zyban to aid smoking cessation success are also available. In 2004, 5,170 clients attended the Smoking Advice Service for smoking cessation support. At the end of the programme (6 weeks) 53% of clients had stopped smoking and at 3 months 45.1% remained non-smoking.

The SAS has also piloted a smoking cessation service with the HM Prison Peterhead. The results



2.3 Mental health

“ The capacity of individuals within groups and the environment to interact with one another in ways that promote subjective wellbeing, optimal development, the use of mental abilities and achievement of individual and collective goals consistent with justice ”

Australian Health Ministers, 1991

Generally, in common usage, the term mental health is misunderstood and is often used to mean mental illness. This misunderstanding is likely to mean that people working in a broad spectrum of everyday services will react with confusion to the suggestion that they should now play a part in improving mental health. NHS Grampian, with the help of experts in the field, has developed a framework for mental health promotion in Grampian to help partners and agencies understand how to exercise their responsibility to improve mental health.

Poor mental health can be a consequence of chronic disease, of adverse life circumstances such as child abuse, domestic violence, poor living and working conditions, poverty, homelessness and of unemployment. The physical and social environment in which someone lives and the extent to which the individual has acquired life skills to deal with stressful circumstances can all influence mental health outcomes. The framework aims to promote the mental and emotional health of the people of Grampian paying particular attention to those who are at greatest risk, raise awareness of determinants of mental health and to support those who have a role to play in promoting mental health. The framework provides a range of evidence based interventions to improve mental health for consideration by the Community Planning Partnerships.

2.3.1 A snapshot of mental health in Grampian

Young people

Information on the mental health of young people is limited on a national basis and local information is also fairly poor. However, the Grampian Lifestyle Surveys provide some indication of the issues that inhibit and support mental health for young people aged 11-17¹⁸. Respondents were asked what their perceptions were of their general health, lifestyle, issues that concern them, feelings and how they deal with problems. Their responses include:

- the majority of young people felt their health was good (52%) or average (25%)
- in line with national surveys young males appeared to have a more positive view of themselves than young women did
- young women were more likely to feel overweight, worry about gaining weight and unhappy if they eat too much
- 24% of young people reported that they felt continually (5%) or frequently stressed (19%), this altered with age with 10% of pupils in year 5 and 6 feeling continually under stress and 31% frequently under stress an increase of 3% for both age ranges since the 1998 survey
- young people appeared to be more concerned with individual than environmental or structural issues such as being concerned about their exams/school, physical appearance and their future
- when asked about their feelings the majority of young people indicated that they were happy (70%). They identified contributing factors as: being with friends (35%) playing or listening to music (27%), and playing sport/being active (26.7%). The impact of friends was a consistent theme related to young people's feelings



63%

of adults in Grampian stated they were very or quite happy with their physical wellbeing

- music was identified as the most popular way to reduce stress with 85% of people feeling that it helped. Fewer young people identified drinking (26%), smoking (12%) or using drugs (6%) as ways to deal with problems. However, of those who did, over half felt that it helped. 73% of those using drugs felt this was an effective way to deal with stress
- young people felt they would be most likely to discuss a problem with friends (87%) or parents (51%).

Adults

Highlights from the Grampian Adult Lifestyle Surveys include:

- the majority of adults in Grampian were very or quite happy with their physical wellbeing (63.4%), mental/emotional wellbeing (69.1%), overall quality of life (75.5%), current standard of living (81.6%) and confidence in the future (64.8%)
- the largest number of those quite or very unhappy (7.6%) was in response to the enquiry regarding their mental/emotional wellbeing
- most adults (85%) indicated that they would try to find a solution to their problem - by trying to see it in a different light (72.9%) or by talking to someone about the problem (66%). There was some gender difference with females more likely to talk to someone (72.1% v 60.0%) or read (54% v 33%) and males more likely to work harder (50.1% v 47.6%) or ignore the problem (16.9% v 12.0%)
- the majority of adults indicated that stress caused the biggest problem in their lives (51.8%) with the majority of stress being reported at work (40.4%), although this was a decrease from the 1998 survey

- females were more likely to say that the health of others, family and loneliness cause problems in their lives with males reporting job insecurity, being overworked, trying to find a job and being unemployed cause them problems in their lives.

2.3.2 A snapshot of current work in Grampian to improve mental health

Joint Health Improvement Plans are in place for Moray, Aberdeenshire and Aberdeen City. Each highlights mental health as a priority and takes a community development approach which in itself promotes mental health.

- Also common to each is:
 - a focus on supporting families in the ante and post-natal periods
 - targeting vulnerable families for assessment and support
 - parenting classes
 - support for teenagers through transitions
 - the comprehensive development of health promoting schools
 - the development of health promoting workplaces
 - the development of supportive communities.

The Mental Health Improvement Framework will be used to inform updated versions of the Joint Health Improvement Plans.

Examples of good practice include:

- partnership training with health visitors and Family Centres to deliver the 'Triple P' parenting programme across Grampian. The aim to facilitate the development of parenting/care giver skills to strengthen child/carer relationships
- the multi-sector Wellbeing Project and Training Pack in Aberdeen City
- 'Pathways to Wellbeing' (Middlefield Counselling Service) a user-led service aimed at promoting positive mental health and wellbeing and signposting to appropriate agencies
- support for national awareness campaigns e.g. 'See-me' to eliminate stigma and discrimination
- the Workplace Mental Health Commendation developed by Scotland's Health At Work will highlight exemplary workplace policies with employers
- delivery of a training programme to ensure relevant knowledge and skills to promote individual and community wellbeing through Scottish Mental Health First-aid, mental health promotion, evaluating mental health
- Making Connections and the School Counselling Programme in Aberdeen City which supports school children with mental health issues across school and family settings
- the Aberdeen Foyer 'Lifeshapers' and 'Sorted not Screwed up' projects
- the inception of Good Practice Guidelines on User and Carer Involvement by Mental Health Services in Grampian
- the NHS Grampian Good Practice Guidelines for the Detection and Management of Perinatal Mental Ill-health
- work in Aberdeenshire to enhance supported employment opportunities for people with mental illness.

The development by NHS Health Scotland of a set of mental health indicators to be published in late 2005 and the provision of training in the evaluation of mental health initiatives will enable a new level of rigour in the evaluation of mental health promotion projects.

The development of the Centre for Confidence and Wellbeing and its support from the Scottish Executive (www.centreforconfidence.co.uk) seem likely to lead to a wave of interest in mental

wellbeing, optimism and confidence in Scottish institutions. This may provide unprecedented opportunities for the improvement of mental health nationally. Work to improve mental health in Scotland, has until now, concentrated largely on community development and the development of social capital. This initiative will raise interest in the development of individual capital (or the development of individual capacity to maintain mental health). The two are complementary, and in Grampian we should grasp the opportunity to blend them into our efforts to maximise health improvement potential locally.

2.4 Sexual health

The World Health Organisation (WHO) provides a broad definition of sexual health which has been adopted locally:

“ A state of physical, emotional, mental and social wellbeing related to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sex experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled ”

Sexual health affects our physical and mental wellbeing and is central to some of the most important and lasting relationships of our lives. Sexual activity is increasing amongst young people and for some at a younger age. Society is changing - many middle aged and older people who have spent time in stable relationships are now single again and there is greater societal acceptance of cohabitation of non-married partners and of homosexuality. Sexually active individuals are at risk of a range of sexually transmitted infections (STIs). Almost all STIs are becoming more common but the rate of infection of chlamydia in Scotland and in Grampian has been rising steadily. Nationally an increase in chlamydia of 39% in people aged under 25 and 36% in the over 25s between 2002 and 2003 has been reported¹⁹. Teenage (13-19 yrs) conceptions in Scotland are amongst the highest in Western Europe and whilst the rate has declined overall in Grampian, Aberdeen City continues to be

above the Scottish average¹⁷. Young women living in the most disadvantaged communities are more likely to become pregnant than their counterparts in the most affluent parts of the country. Poor sexual health is commonly associated with poverty and social exclusion.

2.4.1 Snapshot of sexual health in Grampian

Sexually transmitted infections

Chlamydia infection is the most common sexually transmitted infection in Grampian rising steadily since 1993. Compared to Scotland, chlamydia detection in under 25s is markedly higher in Grampian. Grampian does not compare favourably to Scotland for genital herpes in males or females. The last 10 years has seen an increase in the rate of hospitalisation due to pelvic inflammatory diseases (a complication of STI) from 237.9 to 311.6 per 100,000 in Grampian females^{3,19}.

HIV

At March 2005 the cumulative total of reported HIV cases in Grampian was 271 of whom 200 are still alive¹⁹. Since 1994 heterosexual transmission has been the most common route of acquisition in Grampian and accounts for 54% of the total number of individuals infected, the majority of whom have acquired their infection abroad¹⁹. Health Protection Scotland (HPS) estimate that between one third and one fifth of imported infections occur in Scottish travellers¹⁹. In Grampian, as in the rest of Scotland, the proportion of infection amongst men who have sex with men is declining. Raising public awareness of the risks of HIV and how it can be prevented through protected sexual intercourse remains one of our priorities.

Teenage pregnancies

Teenage pregnancy (13-19 yrs) rates vary across Grampian with Aberdeen City having a consistently higher rate compared to Scotland. Whilst the high rate in Aberdeen City will be due to several factors there is a strong link with deprivation. The target is to reduce teenage pregnancy among 13-15 year olds by 20% by the year 2010 (baseline 1995)²⁰.

Abortion

The abortion rates among 13-19 year olds in Grampian (15.1 per 1000 women) over the last 10 years have been reducing however they remain above the Scottish average (13.2 per 1000)¹⁹. It cannot be detected from these figures alone why there is a slightly higher rate of abortion in Grampian compared to the rest of Scotland. It may be that the services provided locally are more easily accessible to women needing them than elsewhere. Or it may be that women in this part of the country when they find themselves with an unwanted pregnancy are more likely to seek an abortion as a solution.

Inequalities

There is a strong link between social disadvantage and early initiation into sexual activity²¹. The overall teenage pregnancy rates for the most deprived areas are more than treble those for the least deprived areas²¹. Almost 50% of looked after children become mothers within 18 to 24 months after leaving care.

Knowledge and behaviour

In the Grampian Youth Lifestyle Survey 75% of sexually active young people in Grampian reported using condoms whilst 85% knew where to get free condoms¹⁸. Clear differences in attitude to condom use by gender have been found with boys more likely to think condom use reduces enjoyment and less likely to value the importance

15,000 patients a year visit Square 13 for sexual health contraception, pregnancy advice, and chlamydia testing.

of planning protection from an STI. Young men from deprived areas and those with low educational attainment were found to have a negative attitude to condoms²¹.

Hard to reach groups

There is evidence to show that there are groups in the population who are at risk of poor sexual health such as Lesbian, Gay, Bisexual and Transgender (LGBT) people and those with a learning or physical disability who would benefit from services designed to meet their specific needs²¹.

- ensures that individuals and groups are able to resist coercion
- supports the development of self esteem
- promotes respect for self and others
- builds a clear sense of the rights
- enables people to develop practical skills as key elements of sexual health and related decision making e.g. negotiation or assertiveness skills
- provides support for parents with their children about sexual relationships and sexual health.

Source: Adams 2001²²

2.4.2 A snapshot of current work to improve sexual health in Grampian

Promoting positive sexual health is a major public health challenge. In recognition of these concerns, 'Respect and Responsibility: a Strategy and Action Plan for Improving Sexual Health' was published by the Scottish Executive in 2005. Development of a strategy for sexual health in Grampian began some time ago but was delayed awaiting the publication of the national strategy. The local strategy is now taking shape following consultation and will be published later in the year.

In developing this local strategy we are mindful of differing if not polarised attitudes in society to many aspects of sexual behaviour resulting in challenges for both policy-making and individual behaviour change. In order to be effective, sensitive and appropriate in meeting the wide range of sexual health needs within communities, all sexual health work should have a clear and explicit values base which:

- is grounded in a positive and holistic model of sexuality and sexual health
- recognises and embraces the cultural, spiritual and ethical components impacting on any individual's sexual health
- works towards achieving equity in terms of access to services and resources
- affirms diversity

Aberdeen City, Aberdeenshire and Moray councils and NHS Grampian are required to ensure that Community Plans, Grampian Health Plan and Children's Services Plans complement the sexual health strategy paying regard to the factors outlined above and in particular to addressing inequality. NHS Grampian and the three Community Planning Partnerships in Grampian have already begun to take action that is beginning to improve sexual health. The 2005 strategy aims to build on success to date.

In partnership NHS Grampian undertakes a comprehensive range of sexual health improvement activity including:

- condom and lubricant distribution allowing easier access to safer sex resources
- public awareness campaigns supporting national and local issues such as World Aids Day and Grampian Blood Borne Viruses public awareness programme
- single and multi-agency training, which we anticipate, has a cascade effect throughout the community
- Mobile Information Bus (MIB), a mobile health 'drop-in' which provides information, advice and sign-posting for young people living in Moray. There were 1916 recorded visits by young people to the MIB from April 2004 - January 2005

Advertising from HIV travel health campaign and sexual health awareness poster.





- health promoting school community HIV & sexual health pack
- NHS Grampian Health Points - 701 enquiries about sexual health in Moray with 50% of enquires to the Aberdeen Health Point concerning sexual health
- workplace services including Scotland's Health at Work Awards Scheme (SHAW). Sexual health/travel health delivered to workplaces and 5700 leaflets on sexual health requested by workplaces
- health improvement inputs including educational workshops, presentations and advice in various settings - approximately 120 hours of work for 22 different organisations
- SMS Young People's Drop-in Service approximately 59 young people use the service per calendar month, age range 13-15 years, with equal use by males and females
- with additional funding from the Scottish Executive we intend to increase the capacity of the genito urinary medicine service which will reduce the wait from enquiry to appointment time. In the short term we have trebled the number of Clinical Assistant led sessions available. Through redesign nurses have taken on an extended role increasing the throughput of the clinics
- in addition 95% of general practices offer testing for STIs
- Square 13 (Sexual and Reproductive Health) sees around 15,000 patients a year for sexual health contraception, pregnancy advice, and chlamydia testing for young people.

2.5 Substance misuse

All strategic developments, resources, service monitoring and evaluations for alcohol and drugs are co-ordinated through three local authority aligned Alcohol and Drug Action Teams. These teams are multi-agency planning groups that bring together NHS Grampian, local authorities, Grampian Police, Scottish Prison Service and the voluntary organisations.

2.5.1 A snapshot of drug misuse in Grampian

The misuse of drugs continues to be a major barrier to improving the health of significant numbers of people across Grampian. The 2001 Youth Lifestyle Survey highlighted that 21% of 12-16 year olds had 'ever' used illegal drugs, mainly cannabis, a significant decrease from 1995 when this was reported at 30%¹⁸. This level of drug misuse was consistent with national SALSUS survey results²³. Results from the 2002 Adult Lifestyle Survey⁷ indicated that 22% of the Grampian population had used illegal drugs. The main drug of misuse was cannabis. Levels of illegal drug use was found to increase to 40% in the 16-34 age group.

A nationally commissioned drug misuse prevalence study reported that the estimated number of problem drug users in Grampian was 4350 in 2003, of which 1091 were known to be injecting drugs (usually heroin)²⁴. Grampian estimates of drug injector population prevalence rates for the age group 15 to 54 suggested that a decrease from 1.4% (95% CI 1.0-2.6) to 0.96% (0.83-1.12) had

taken place in this population between 2001 and 2003 respectively. The Grampian rate remained the second highest in Scotland after Greater Glasgow Health Board.

The level of injecting drug use is an area of particular concern. In 2003/04, 62% of the new people entering into drug treatment services were currently injecting drugs, of which a significant proportion were sharing needles. This represents a 9% increase in injecting behaviour since 2001

2.5.2 A snapshot of alcohol misuse in Grampian

Alcohol is the drug of choice for many Grampian residents and the current level and pattern of drinking is an area of public health concern. The 2002 Grampian Adult Lifestyle Survey reported that, for 25% of males and 13% of females, drinking levels were above the sensible daily/weekly guidelines⁷. The 2001 Youth Lifestyle Survey recorded that 30% of Grampian 12-16 year olds

Alcohol is the drug of choice in Grampian and the current level and pattern of drinking is an area of public health concern.

which could be associated with the number of heroin overdoses seen by accident & emergency departments. However, limitations in the way the information has been collected must be recognised since it is based on patients entering specialist drug misuse services only.

The number of hepatitis C cases in Grampian continued to increase with a further 163, 131, 121 new cases diagnosed in 2002, 2003, 2004 respectively, the vast majority of which will have contracted this through sharing of injecting equipment. HIV infection in injecting drug users has remained very low with a single case reported in each of the above-mentioned years.

In 2003/04 1146 new individuals entered into treatment across Grampian, nearly double the number that had entered in 2000/01 (633)²⁵.

had been drinking in the week prior to the survey. Of these, males had consumed an average of 19 units and females an average of 16¹⁸. Information consistent with these locally produced figures was available from the SALSUS 2002 data of Grampian adolescents revealing that 53% of 15 year olds and 24% of 13 years had drunk alcohol in the previous week and that 18% of 15 year olds had consumed five or more drinks on more than four occasions in the last month²³. From this data we can conclude that a significant minority of young people aged 12-16 are not only drinking at high levels for their age but higher than recommended levels even by adult standards.

Since 1996 there has been an increase in the number of individuals that have needed hospital treatment for alcohol related problems, this includes acute intoxication, psychiatric problems, liver disease and alcohol related deaths. In 2004, there

Think B4U Drink board game.



were 1,261 drink/drug driving incidents recorded by Grampian Police. During 2004/05 around 500 new individuals were referred to the NHS Specialist Substance Misuse Service across Grampian, indicating that there are significant problems associated with alcohol misuse.

2.5.3 A snapshot of current work in Grampian to tackle substance misuse

- accessibility to the integrated drug services has been improved through reduced waiting times
- employment support services for people with alcohol and drug related problems have improved
- a range of support services for children and families affected by drug and alcohol related problems have been established
- greater use of the alcohol and awareness board game 'ThinkB4Udrink' across Grampian and successful school participation in the UK Rock Challenge (drug prevention initiative)
- implementation of a training programme for a wide range of organisations to raise awareness of drug and alcohol issues
- a CD Rom to raise awareness of drug and alcohol issues was developed by NHS Grampian, Grampian Police and the oil and gas industry and drug and alcohol service specialists and funded by Scotland Against Drugs. 1,500 free copies have been supplied to the oil and gas industry
- through funding from Scottish Executive the Joint Alcohol and Drug Action Teams are able to improve access to a range of integrated alcohol misuse services including interventions, community safety initiatives and awareness raising activity
- the opportunities for needle exchange continue to expand with increasing numbers of needles and syringes being accessed throughout Grampian.

Local data indicates that Grampian reflects the national trend with in excess of **15%** of adults being clinically obese and **58%** of men and **45%** of women being overweight.

2.6 Obesity

The maintenance of a healthy body weight stems from a balance between energy input and expenditure. Unfortunately, achieving this balance in modern life is becoming increasingly difficult. We live in an environment which is supportive of eating more and being less active - this has been described as an obesogenic environment.

Our energy input is increasing through readily available and affordable energy-dense food combined with increasing food portions. Our energy expenditure through physical activity is reducing through increasing car ownership and use, the availability of labour saving technology and the attractiveness of sedentary leisure pursuits (such as watching TV). Furthermore, research suggests that our metabolic and behavioural legacy leads us to instinctively over-consume food when available^{26,27} and that we lack the physiological drive to engage in physical activity for its own sake²⁸.

The scale and seriousness of the problem should not be underestimated. Obesity is not solely an issue for the individual but one for society as a whole. Population level change can be achieved through a collective determination to challenge the values upon which today's society has been built. Fundamental to effective action is a universal recognition of the consequences for society of the impact of increasing rates of obesity and of our collective responsibility for change.

We have seen that change is possible - recent improvements to the nutritional standards of school meals in Scotland²⁹, and in Grampian in particular, demonstrates that components of our society can be challenged and changed but there is much left to do.

As individuals we can:

- be active - walking is great exercise, take the stairs, walk the kids to school, take the stairs rather than the escalator



- reduce our portion sizes. Do you really need to take the supersize option? Try not to increase food consumption in response to marketing offers such as buy one, get one free
- look for healthier options - in cooking (grill rather than fry, try steaming or boiling), in shopping (watch your labels look for hidden salt, sugars and fat) and when eating out
- seek information and support to maintain a healthy weight. Call the freephone healthline **0500 20 20 30**.

Workplaces can:

- provide healthy eating options in vending machines, canteens and other catering facilities
- provide supportive options for staff members to be active at work - walk in to workout initiatives should be supported.

2.6.1 A snapshot of obesity in Grampian

The continued increase in national rates of obesity shows no signs of abating. Local data indicate that Grampian reflects the national trend with in excess of 15% of adults being clinically obese and 58% of men and 45% of women being overweight⁷. Children are following in their parents' footsteps with one in five children being classified as obese.

Our body shape is changing and perceptions of obesity, fuelled by media attention, have become more than cosmetic. It is recognised that the condition also poses a major risk factor for a wide range of chronic conditions and has a negative impact on a person's energy levels, functional ability and mental wellbeing. It reduces individual quality of life, can result in prejudice and denies people the opportunity to reach their full potential.

Obesity incurs a cost not only to individual health but also to society as a whole. Estimates indicate this to be in excess of £2 billion annually to the wider economy (sickness from work and costs to productivity)³⁰ and £171 million to the NHS in Scotland (mainly comprising treatment of conditions related to overweight such as heart disease and diabetes)³¹. The longer term impact of rising rates of obesity, particularly on the incidence of Type II diabetes has been covered in previous reports.

Research shows that obesity is an increasing problem across all social groups and regions, with some variation. Men and women show different patterns and there are critical time periods for weight gain that include the early and school years, pregnancy, co-habitation/settling down and smoking cessation. Additionally, obesity in childhood is known to be an independent risk factor for adolescent and adult obesity.

2.6.2 A snapshot of current work in Grampian to tackle obesity includes:

- work underway to establish a protocol for the enhanced collection of local obesity data
- improving the environment by influencing policy through for example Hungry for Success, Scottish Healthy Choices Award Scotland's Health at Work
- work to reduce stigma around obesity, encouraging individuals and the population to achieve and maintain a healthy weight with an emphasis on healthy living
- support for the integration of weight management services within Grampian based on current evidence and available examples of good practice in order to offer a more client centred service
- providing a strategic framework to address obesity through the development of Joint Health Improvement Plans and related topic strategies (breast feeding, Food in Focus, physical activity and mental health)
- programme support and delivery (Hungry for Success, Active Schools, Confidence to Cook, Healthy Helpings)
- deliver training and build community capacity (Kids in Condition, Positive Playtimes, physical activity training for people working with older people, accredited nutrition and food skills training)
- promoting the maintenance of a healthy weight through media campaigns and the provision of health information.



2.7 Health improvement - next steps

The recommendations from the Health Improvement Healthfit remain valid:

- negotiation and acceptance of fundamental principles, aims and objectives for tackling health inequalities are needed throughout the sectors of the health system. Monitoring progress should include intervention indicators as well as organisational development
- smoking cessation services and new investment for tobacco control should be targeted where need is greatest e.g. areas of socio-economic deprivation and vulnerable groups e.g. pregnant women. Preventative and educational programmes should be co-ordinated with other community efforts
- proposals within the new mental health improvement strategy must be translated into a collective, prioritised action and implementation plan
- in taking forward the inter-agency Sexual Health Strategy, leadership is required at all levels to improve integrated service planning and delivery
- substance misuse including drug and alcohol plans should concentrate on ways to extend the knowledge and expertise of clinical professionals to provide intensive or brief interventions for patients which modify attitudes, beliefs and behaviour. New initiatives should be supported to conduct rigorous evaluation
- an obesity network should be established to develop a single strategy covering prevention, management, maintenance and treatment
- local evidence should be generated by local people where there are known gaps and greater collaboration is needed with university departments to shape and deliver the research agenda.

03

Health protection

3.1 Communicable disease and environmental health

Communicable disease and environmental hazards remain important causes of ill health in our communities and we also face new threats e.g. an influenza pandemic. The NHS must continue to work closely with our colleagues in the three local authorities and our many other partner agencies to investigate and manage the public health implications of infections and environmental hazards. It is also important that we let the public know what these risks are and how we plan to manage them, and also what they can do to protect themselves.



Table 4: Notifications of communicable disease in Grampian in 2000-2004.

Disease	2000	2001	2002	2003	2004
Dysentery	5	13	11	16	17
Campylobacter	987	861	819	592	638
Chickenpox	2990	2136	3150	1930	2554
Erysipelas	1	1	5	2	1
Food poisoning: total	605	584	589	452	422
- Aeromonas*	88	77	75	93	67
- Cryptosporidium*	173	170	237	107	116
- E coli O157*	69	61	69	31	51
- Giardia*	13	4	17	21	14
- Salmonella*	225	231	162	174	149
- Yersinia*	11	13	15	20	20
Listeria	0	3	2	1	0
Lyme Disease	0	0	0	0	1
Malaria	4	17	10	18	15
Measles	16	22	8	6	7
Meningococcal infection	16	4	16	6	14
Mumps	22	14	16	8	194
Rubella	24	22	25	13	15
Scarlet fever	25	27	29	59	21
TB respiratory	17	24	22	11	16
TB non respiratory	6	7	11	7	8
Typhoid	0	0	1	2	0
Hepatitis A	10	87	12	4	3
Hepatitis B (acute)	85	26	22	14	3
Hepatitis B (chronic)	NA	35	18	22	34
Hepatitis C	197	163	131	121	126
Legionellosis	2	2	0	1	0
Whooping Cough	17	5	1	6	8

*included in food poisoning figures.



Table 4 shows notifications of communicable disease in Grampian in 2000-04. We see most of these infections regularly, although the numbers do vary from year to year. Grampian continues to have one of the highest rates of gastro-intestinal infections in Scotland i.e. campylobacter, salmonella, cryptosporidium and E coli O157. Some of these infections are the result of our lifestyles e.g. contact with animals, the use of untreated or poorly maintained private water supplies, handling raw food or travel abroad. However there are some simple steps that we could all take to minimise the risk of acquiring these infections or passing them on to our families, friends and work colleagues. The NHS and our partner agencies should consider how best we can work together to improve adherence to this basic advice.

1 Hands should be washed thoroughly after:

- handling raw meat
- handling animals
- changing nappies
- visiting the toilet
- outdoor working or recreational activities
- handling dirty clothes after outdoor working or recreational activities
- handling used tissues/nose blowing.

2 Hands should be washed thoroughly before:

- cooking
- handling food
- eating
- feeding the young or elderly.

3 Always adhere to good food handling techniques including appropriate storage, careful preparation and cooking. Hot food must be cooked thoroughly or reheated or kept hot appropriately. Food, which is eaten raw, must be washed prior to consumption. It is essential to keep raw and cooked foods and kitchen utensils used in the preparation of raw and cooked foods separate.

4 Individuals with acute illnesses should not attend work, school or visit friends or relatives, especially those in care homes or hospitals.

The importance of this advice was demonstrated last year during an investigation of an outbreak of Norovirus infection that affected over 400 people who attended a concert at the Music Hall. The lessons learnt from this outbreak emphasised the importance of the standard advice that people with symptoms of vomiting and diarrhoea should stay away from work and school, and other public places, for 48 hours after their symptoms have settled to avoid spreading the illness.

Results from general practitioner records in Grampian demonstrate that immunisation uptake is at, or above, the Scottish average for all primary immunisations.

The NHS and our partner agencies should do all we can to facilitate adherence to good personal hygiene practices. This simple advice will help minimize the risk of transmission of all infections, including influenza.

3.1.1 Immunisation and vaccine preventable diseases

For some serious infectious illnesses there are safe and effective vaccines and it is important that both children and adults are fully protected through immunisation. We need to maintain uptakes of vaccination in excess of 95% if we are to avoid outbreaks of vaccine preventable diseases. By maintaining uptakes at this level the consequent high level of immunity in the community greatly reduces the opportunity for bacteria and viruses to circulate and cause illness. Vaccination provides good protection for the individual, and by promoting community-wide immunity also helps to protect especially vulnerable individuals such as small babies who are too young to be vaccinated. In 2004 the numbers of mumps cases notified has remained high. This reflects an outbreak of mumps that is affecting the whole of Scotland, primarily amongst 13-25 year olds. This outbreak is not a result of the fall in recent years of uptake of MMR vaccine. Young people in the 13-25 year age group did not have the opportunity to have two doses of mumps containing vaccine, and also attended primary school in the years when mumps infection had fallen to very low levels, so did not have the opportunity to develop natural immunity. GPs are now offering vaccination to those individuals in this age group who have not previously received two doses of a mumps-containing vaccine.

None of the cases of measles or rubella notified in 2004/05 were confirmed on further testing.

3.1.2 Immunisation: data review and recommendations

Whilst we share the challenges experienced elsewhere in terms of refusal on behalf of parents

and defaulting from appointments, a number of investigations locally have identified that current data recording systems also contribute to our poor reported immunisation rate. During 2004/05 an extensive investigation was completed which compared the accuracy of national data with information contained in local general practitioner case records. As expected, considerable discrepancy was found between the two data sets, and this was largely due to delays and inaccuracies in the submission of data from general practice to the national vaccination recording system. Results from general practitioner records demonstrate that immunisation uptake is at, or above, the Scottish average for all primary immunisations. Full implementation this year of the national vaccination scheduling and recording system (SIRS) in Grampian will resolve this problem. In addition, it will benefit babies and young children by improving the efficiency of scheduling of vaccinations to ensure that they are fully protected as early as possible.

3.1.3 Pandemic influenza

There is increasing concern about the outbreaks of Highly Pathogenic Avian Influenza in birds in South East Asia, and more recently in parts of Russia and whether this will lead to a pandemic of influenza. A pandemic is a world-wide epidemic that occurs when a new influenza virus emerges that can spread easily from person to person and against which the population has no immunity from past infection or vaccination. A pandemic will cause significant ill health and loss of life plus profound social disruption and economic loss.

A new influenza virus has emerged and has affected people in four countries in South East Asia. As of October 2005 there is no evidence this new virus can spread easily from person to person. However, the WHO has advised that we are now the closest to the next Influenza Pandemic since 1968. Another influenza pandemic is inevitable, but we cannot forecast when it will happen or how bad it will be.

Often pandemics occur with little or no warning, but we have a rare opportunity to improve our



preparedness to respond and we should all make the most of this. Responding to an Influenza Pandemic may, initially, be considered to be a Health Service responsibility, but because of the potential impact on our society the response must be multi-agency and the Grampian plan is being developed under the aegis of the Grampian Joint Emergencies Executive Committee (GJEEC).

The Grampian Influenza Pandemic Plan was updated in 2004 and this plan is being revised following publication of the UK and Scottish Influenza Pandemic Plans in 2005.

The pandemic is likely to last three - four months in any one area and there may be two or more waves of illness over a longer period. A vaccine is very unlikely to be available for use in the first wave.

All sectors of the NHS and our partner agencies need to ensure that we all have robust contingency plans in place to enable us to respond to an influenza pandemic. All organisations should be planning how they will respond if 25% of their workforce are ill for one - two weeks over a three month period.

Further information, including the SEHD plan that was reissued in October 2005 and supporting documentation, is available on the Scottish Executive and the Health Protection Scotland websites at www.show.scot.nhs.uk/sehd/pandemicflu and www.show.scot.nhs.uk/scieh

3.2 Screening programmes

3.2.1 Antenatal screening

During pregnancy women are offered screening for four infectious diseases. These are HIV, hepatitis B, rubella and syphilis. Their early detection not only has benefits for the mother but also for the child by reducing the risk of infection being transferred from mother to baby and by preventing disability in the child.

Hepatitis B, rubella and syphilis have been screened for some years and routine screening for HIV was introduced in Grampian in 2003. In the first full year that all four tests were available the pathology laboratory was able to report high levels of uptake of the tests viz 98% for rubella, 97% for syphilis and hepatitis B and 94% for HIV. Only a tiny number of women were found to be positive for HIV, syphilis and hepatitis B but 61 women were found to be vulnerable to infection with rubella. Although rubella, otherwise known as German Measles, may appear to be a trivial infection of childhood, should a woman catch the infection in early pregnancy it can have devastating effects on the unborn child. Women who are not shown to have immunity to the infection in one pregnancy are offered vaccination soon after the birth of their baby so that they will be protected in any subsequent pregnancy.

Women are also offered screening to assess the risk of the presence in their baby of Down Syndrome and neural tube defect (NTD), otherwise known as spina bifida. The screening currently involves a combination of blood tests at 16 weeks of pregnancy and ultrasound scanning at 20 weeks.

The Scottish Executive Health Department is considering offering women in Scotland screening for Down Syndrome in the first 12 weeks of pregnancy by looking for certain additional marker substances in serum from a blood test. The results of these would then be combined with the results of an ultrasound scan to measure nuchal translucency ie the size of a small area of clear fluid at the back of the baby's neck. At 20 weeks women will be offered a detailed anomaly scan to screen for neural tube defect.

A short-life working group was established in 2004 to look at the implications for Grampian of proposed changes to Down Syndrome and NTD screening. In Grampian the main changes would

be to offer the additional blood tests and ultrasound scan at 12 weeks. The detailed scan at 20 weeks is already available. Initial cost estimates suggest that substantial additional funding will have to be identified to support these changes and, as yet, there is no timescale from the Scottish Executive for making these changes.

3.2.2 Neonatal

As well as having general medical examinations to check for problems such as heart murmurs, babies a few days old have the opportunity to be tested for three specific metabolic disorders. These are cystic fibrosis, phenylketonuria and congenital hypothyroidism. The test involves taking four spots of blood from a heel prick.

Considerable work in recent years has gone into producing detailed information to explain the nature and purpose of the tests so that parents, when they agree to the tests, understand what is being offered and the seriousness of the conditions being tested for. The adverse effects of phenylketonuria and congenital hypothyroidism can be prevented with relatively simple lifelong treatments. Untreated they both lead to severe and irreversible brain damage. Cystic fibrosis results in a failure to thrive because the baby is unable properly to digest its food and lung secretions are thickened, leading to repeated respiratory infections which over time cause progressive lung damage and loss of function. With treatment, also lifelong, the outlook for young people with CF has improved steadily over the years. There are now as many adults in Grampian living with CF as there are babies and children.

NHS Grampian has put in place resources to offer hearing screening to all babies soon after birth. Women will receive information about the screening shortly before the baby is due to be born. Specially trained screeners have been employed at Aberdeen Maternity Hospital, to provide the service including

at weekends for babies born on Friday, Saturday and Sunday. In other parts of Grampian screening will be carried out by specially trained midwives. The aim is to detect babies with a hearing impairment early so that measures can be put in place, including the fitting of hearing aids, to reduce the impact of their disability. Evidence has shown that deaf children treated before the age of one year are less impaired by their deafness in acquiring speech and language skills and also in socialising with others.

3.2.3 Pre-school child health surveillance

This is a wide ranging programme which starts soon after the baby is born and is designed to promote the health and wellbeing of babies as they grow to age five when they enter school. It is available to all but with additional resources targeted to those that need them.

As well as supporting the mother with information and advice the child's development is monitored at various ages and a few specific screening tests are carried out. These include checking for congenital dislocation of the hip, undescended testes and vision checks e.g. looking for the red reflex.

Work has begun to develop a plan for extending orthoptic (vision) screening to all four year olds in Grampian. At the moment this is offered to children in the city and Moray but not in Aberdeenshire. It is also hoped to offer this screening through local nurseries in the future as the evidence from boards elsewhere in Scotland is that uptake improves significantly.

3.2.4 Breast screening

The uptake of breast screening in Grampian remains high. Table 5 below shows the uptake for the 3 year periods from 97/98 to 03/04.

Table 5: Breast screening uptake rates for Grampian and Scotland 97/00-01/04.

	97/98-99/00	98/99-00/01	99/00-01/02	00/01-02/03	01/02-03/04
Grampian	83.3%	83.0%	82.6%	82.3%	82.5%
Scotland	72.9%	73.2%	73.5%	74.0%	74.9%

Source: ISD³

The main issue facing the programme locally is the extension of the age limit for calling women for breast screening to 70. Since the start of the breast screening programme it has been the case that women over the age of 64, who are no longer called routinely by the programme, can refer themselves for screening every three years. In 2004-05, 2202 women over 64 did this in Grampian. However the Scottish Executive has changed the policy for the Scottish programme and additional resources, are put in place, to call routinely all women aged between 65 and 70. Long term difficulties in recruiting and retaining staff in the key disciplines, including radiology and radiography, resulted in a significant delay to the introduction of age extension in Grampian. However, as of November 2005 women up to the age of 70 in the region will be routinely invited for mammography. Women over this age can continue to refer themselves for screening every 3 years if so wish.

3.2.5 Colorectal Screening (Pilot) Programme

This programme offers men and women aged 50 to 74 a test designed to look for blood in the stool. A testing kit is sent to the person's home every two years.

The pilot of bowel screening first started in Scotland in April 2000. The third round of the pilot commenced earlier in 2005 and is now known as Phase 1 of the Bowel Screening Programme. The reason for this is that the work going on now in the pilot sites, Grampian, Tayside and Fife, is preparing the ground for the introduction of bowel screening to all parts of Scotland from March 2007. The main concerns at the moment are to redevelop the patient information leaflets, make minor modifications to the protocol and develop plans for offering screening to hard-to-reach groups such as the homeless, disabled and ethnic minorities.

To date uptake has been satisfactory in all three of the pilot sites with Grampian generally having the highest. In the second round, the most recent for which data are available, uptake in Grampian was 55%, in Tayside 54.4% and in Fife 51.1%.

It has also been shown in all three areas that women are more likely to do the test than men. So in Grampian 50.8% of men completed the kit compared to 59.2% of women. In Tayside the comparable figures were 50.6% compared to 58% and in Fife the figures were 47.8% for men and

54.2% for women. However, men are at greater risk of developing the disease and so would benefit more from taking part in screening. From birth to age 64 the lifetime risk of developing bowel cancer is 1 in 59 for men and 1 in 85 for women. From birth to 74 this rises to 1 in 27 for men and 1 in 38 for women.

3.2.6 Diabetic retinopathy screening

Diabetic Retinopathy Screening started in Grampian in April 2002. The aim is to invite each year all those diagnosed with diabetes over the age of 12. The objective is to detect, at an early and treatable stage, changes in the back of eye (the retina) caused by the diabetes which can lead ultimately to blindness. Since the screening programme started the numbers being called have increased steadily. In 2002 approximately 10,000 patients were being called and as of January 2005 this number had risen to over 17,350. As obesity and diabetes with which it is associated become increasingly common it is expected that the numbers requiring to be screened will also continue to rise.

3.2.7 Cervical screening

Mortality from cervical cancer has dropped steadily in both Grampian and Scotland for many years. In 1993 there were 12 deaths from cervical cancer in Grampian. In 2003 this figure was eight. The rates per 100,000 person-years at risk were 4.5 and 3 respectively. For Scotland these rates were 6.4 and 4.6.

Incidence, too, has gone down. In 1991 in Grampian there were 47 cases of cervical cancer but only 26 in 2001. These represent rates per 100,00 person-years at risk of 18 and 9.8 compared to the Scottish figures of 17.4 and 11.7. If the rates are standardised to take account of differences in the ages of the two populations it can be seen that Grampian's figures improved from being 4.5% above the Scottish figures to almost 16% below.

Uptake of cervical screening is tending to decrease over time. For the year 1999/2000 86.6% of Grampian women had had a smear in the last 3.5 years compared to 81.4% of Scottish women. By 2004/05 these figures had dropped to 82.9% for Grampian and 79.3% for Scotland. Although fewer women are making a conscious decision to opt out of screening, more women are defaulting i.e. failing to come along for a smear when called.



NHS Grampian staff have shown an ability to cope with most incidents. However, we continue to refine and develop the skills to work at the highest levels to manage the community wide consequences of exceptional events. This includes the appointment, during 2005/06, of a dedicated Emergency Planning Officer to help build resilience and meet the challenges of the Civil Contingencies Act.

3.4 Health protection - next steps include:

- all sectors of the NHS and our partner agencies need to ensure that we have robust contingency plans in place to enable us to respond to an influenza pandemic
- the NHS and our partner agencies need to do all we can to facilitate adherence to good personal hygiene practices. The simple advice outlined on page 41-42 will help minimise the risk of transmission of all infections, including influenza
- NHS Grampian needs to fully implement the national vaccination scheduling and recording system (SIRS) in Grampian by March 2006
- child health surveillance - pilot pre-school surveillance ensuring implementation is co-ordinated with the child health surveillance programme
- given the changes in NHS Grampian the Emergency Planning Group needs to review the rota for senior managers to ensure strategic leadership during major incidents
- the Emergency Planning Group also needs to support the provision of training to improve staff ability to respond to all major incidents and to communicate risks as effectively as possible
- NHS Grampian needs to continue to enhance organisational ability and capacity to respond a wide range of major emergency situations.

During 2004 the letter used in most Grampian practices to invite women for screening was amended to conform to the GMC guidance on offering chaperones. Work was also underway to develop a suite of letters so that all women would be sent the result of their smear in writing. Up until recently only women with negative results have received a letter. Work is continuing nationally on the new call/recall system for Scotland, known as SCCRS. It is still hoped to introduce this from October 2006.

Over the summer of 2004 smear reporting times became lengthy due in part to staff taking their annual leave and to staff turnover. The situation was monitored and once the staffing situation was rectified the reporting times dropped so that by the end of the year they were back within the usual parameters and conforming to the national

standard. For the year 2004/05 the average reporting time in Grampian was 16.75 working days compared to the Scottish average of 11.

The Grampian programme continues to see the benefit from the introduction of liquid-based cytology for taking and reading the smear. Table 6, below, shows the decline in the percentage of smears which are classified as being unsatisfactory for reading.

This means that far fewer women are now experiencing the anxiety of being recalled to have their smear repeated simply because it could not be read reliably. Staff in the programme also benefit. For smearer takers it is easier to get a satisfactory sample first time and for the pathology laboratory fewer scarce resources are being expended dealing with unsatisfactory smears and the repeat samples

they generate. Colposcopy too has reported a substantial fall in the number of women being referred there for examination because it has proved impossible to obtain an adequate smear.

3.3 Emergency planning

The Civil Contingencies Act 2004 places a responsibility on all "Category 1" responders (essentially all the emergency services, including NHS Grampian and local authorities) to:

- co-operate
- share information about and assess risks within their area
- plan to jointly manage those risks and the consequences both for the local community and the organisations' business
- communicate those plans and actions with the public and other interested parties.

Changing risks, particularly regarding security issues, have emphasised the need to regularly review and update our plans and ensure that together all the emergency services can co-operate to manage an incident, including the community wide implications; maintain normal services, as far as possible; and guide the community's return to normality.

Table 6: Unsatisfactory smears: Grampian and Scotland: 2000/01-04/05.

	2000/01	2001/02	2002/03	2003/04	2004/05
Grampian	9.2%	5.5%	5.8%	3.0%	1.5%
Scotland	8.6%	8.8%	7.4%	3.9%	2.2%

04

Health and social care

In 2002, NHS Grampian began to develop a way forward for the health service in Grampian - Healthfit - and how it might be achieved. Members of the public were involved with doctors, nurses, other health professionals and managers in thinking about how health services should be improved and developed across Grampian.



It is encouraging to see that the messages in Healthfit are the same as those in the recent Scottish report, Building a Health Service Fit for the Future,³² (produced by Professor David Kerr) so the way forward nationally is consistent with local thinking. Healthfit can be summarised as follows:

- **A service delivered by people for people:** the public should be involved at the outset of changes to the pattern of healthcare services. Patients are key partners and should be involved in deciding their own healthcare.
- **Deliver care in local communities wherever possible:** treating patients in primary or community settings (GP practices, health centres and community hospitals) will be the preferred choice. Treatments will only take place in specialist secondary care facilities (Aberdeen Royal Infirmary, Woodend Hospital and Dr Grays) when complex care/facilities are required. Any changes that take place must take account of patient safety, the best clinical standards, availability of the right clinical staff and sustainability.
- **Further integrate the NHS (including the contribution of hospitals, general practice teams, social care providers, patients and their carers) to meet the challenges:** Community Health Partnerships act as a focus to integrate health and social services at a local level and deliver health improvement for their community. The focus is on the patient and their pathway of care, the system working in partnership rather than separate departments/organisations. Managed Clinical Networks are being strengthened to support the development of integrated services across Grampian, the North of Scotland and nationally.
- **Complex, specialist care in centres of excellence:** acute hospitals will focus on complex care improving access and ensure the most effective use of specialist skills within the health services. More cases will be delivered on a day-case basis and in intermediate care facilities.
- **Make greater use of technology:** to improve the standard and access to care through the use of technology such as the Electronic Patient Record.
- **Develop new skills to support local delivery of services:** working as a multi-professional team enhancing skills to deliver new roles.



Members of the public health team have a key role to play in both planning of services to meet changing population needs and in assessing service outcomes.

Key areas of activity include:

- assessing the population changes and forecasting the impact of such change on health services
- using modeling techniques to inform service change proposals.
- helping to ensure resources, be they staff, equipment, facilities or capital, are utilised to best effect
- to improve performance through supplying evidence for service change and translation of performance data.

Examples of work carried out last year to support service planning and redesign include:

Demand and capacity modeling: The public health unit has developed a model to estimate changes in demand for services over the next 20 years. This model also allows the impact of changes in the provision of services to be estimated. The model has been developed based on local data and uses assumptions to improve productivity drawn from local knowledge and national experience.

£760 million is currently spent by NHS Grampian on health service provision and has a good track record of providing high-quality services and for making best use of this money

Computer simulation and process mapping: This has involved the translation of historical data and planning assumptions into a tool to demonstrate the impact of change. An 'Out of Hours' model, which tested the impact of service changes in GP out-of-hours care proved very successful. The model combined validated, historical data with a number of planning strategies to demonstrate the likely impact on staffing requirements and waiting times. The tool has also been used to map demand and capacity in community hospitals.

Best in class: Work has begun which we have called 'Best in Class' which will provide an in-depth comparison of hospital utilisation data by Scottish Health Boards and English NHS Trusts. This will compare Grampian hospitals by specialty for length of stay, bed occupancy, day case rates, new to return ratios and waiting times. Contact will be made with those organisations identified as 'best in class' to learn lessons and share experiences in improving performance.

Theatre capacity audit: An in-depth audit of theatre capacity and usage by speciality in Grampian hospitals was undertaken over a two-week period during 2004. Performance indicators used by the Audit Commission's Operating Theatres, review of National Findings 2003, were used to ensure a consistent approach of utilisation analysis across all sites and comparisons with elsewhere. Results suggest utilisation could be increased although available capacity was mostly unstaffed.

Intermediate Care Audit: An audit of intermediate care was undertaken involving the assessment of the number of patients currently occupying an acute care bed, who could be cared for in an alternative setting. Data was gathered on 1,126 patients during a four-week period in March/April 2005 involving patients in Aberdeen Royal Infirmary, Dr Grays and Woodend Hospital. Key findings include:

- about one in four patients, in the opinion of individual medical and nursing staff, could be cared for in an alternative setting such as community hospital, nursing home or at home

- the most preferred alternative by both medical and nursing staff is a GP/nurse-led facility with rehabilitation support
- almost three-quarters of patients who could be seen in an alternative setting are aged >70 years and therefore alternative facilities should be geared towards the elderly population
- almost three-quarters of patients who could be seen in an alternative setting have a pre-existing condition
- patients identified as being appropriate for an alternative care setting have a high re-admission rate, with a quarter being readmitted within 30 days of discharge
- improved management of chronic disease could reduce the requirement for alternative facilities.

North of Scotland Health Intelligence Function: The North of Scotland Planning Group commissioned a Regional Health Intelligence Project aiming to extend health intelligence capacity to support strategic planning. This is being conducted as a case study, action research project and is being co-ordinated by NHS Grampian. Individual Health Boards are each undertaking projects on behalf of the North of Scotland Public Health Network. These individual projects will provide valuable health intelligence in themselves whilst the wider project will explore the capacity of the individual health intelligence teams to work together to provide a North of Scotland function.

The pressure on the health service is unrelenting. NHS Grampian currently spends £760 million on health service provision and has a good track record of providing high-quality services and for making best use of this money. Whilst health spending has grown at a rate above the historical average in recent years much of this additional money has been needed to pay for the cost of the national pay award for all staff, to cover increased costs of drugs prescribed on the NHS and the cost of the out-of-hours services providing medical cover when GP surgeries are closed.

Healthfit is a long-term process and we will not achieve our plans for service change overnight. Any investment required to change services and infrastructure must be from within available resources - staff, facilities, money. Difficult choices about what services we provide, and at what level, still need to be made and such decision making must engage with the community. We need to continue to develop how our local NHS works with the people it serves and provides care for - giving the public the chance to influence and to contribute to change - working together to deliver tomorrow's health today.

4.1 Health and social care - next steps

NHS Grampian must continue to develop meaningful engagement with the communities of Grampian to shape the health services of the future.

Programme budgeting and marginal analysis have the potential to foster a shared appreciation, between managers and clinicians of the need to focus on resources and health outcomes and balance clinical autonomy with financial responsibility. As part of the prioritisation process NHS Grampian should consider piloting programme budgeting.

NHS Grampian must continue its programme of change if it is to deliver services fit for the future. In developing the change programme, NHS Grampian must draw on the best available evidence in how to make systems/organisations work effectively.

Footnotes

- ^A Absolute difference in relative survival at five years between the time periods 1971-5 and 1996-9.
- ^B **Age standardised rates** - we use age standardised rates when we want to compare rates e.g. death between two or more groups of people. By standardising for age we adjust for any difference in the rates that would be simply caused by a different age structure in the population. For cancer this is important as rates generally increase with age, therefore if one of the populations was more elderly than the other we would generally expect a greater number of cancer deaths.
- ^C **CABG** - This operation involves surgically putting in an alternative route for blood to flow to the heart muscle. This new route by-passes any obstruction in the existing blood vessel that has caused reduced flow to the heart before the operation.
- ^D Reflecting the aspirations communicated in the local health plan to move to comparing Grampian mortality and morbidity data to European averages the actual Scottish average figures have been raised by 5% to reflect the relative poor health record in Scotland.
- ^E Deprivation quintiles simply divide the population in to five equal groups based on deprivation. Those in deprivation quintile 1 are the most affluent fifth of the population and those in quintile 5 are the most deprived fifth of the population.

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Notes

If you would like:

- more information on specific issues and initiatives
- copies of other documents referred to in the Plan
- this Plan in an alternative format e.g. large type, audio
- to give us your views.

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OR further information on

- improving health
- health conditions and procedures
- sources of support and
- health related services/organisations.

Please contact Healthpoint:

Visit or Mail: Aberdeen Indoor Market, Market Street, Aberdeen AB11 5NX
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