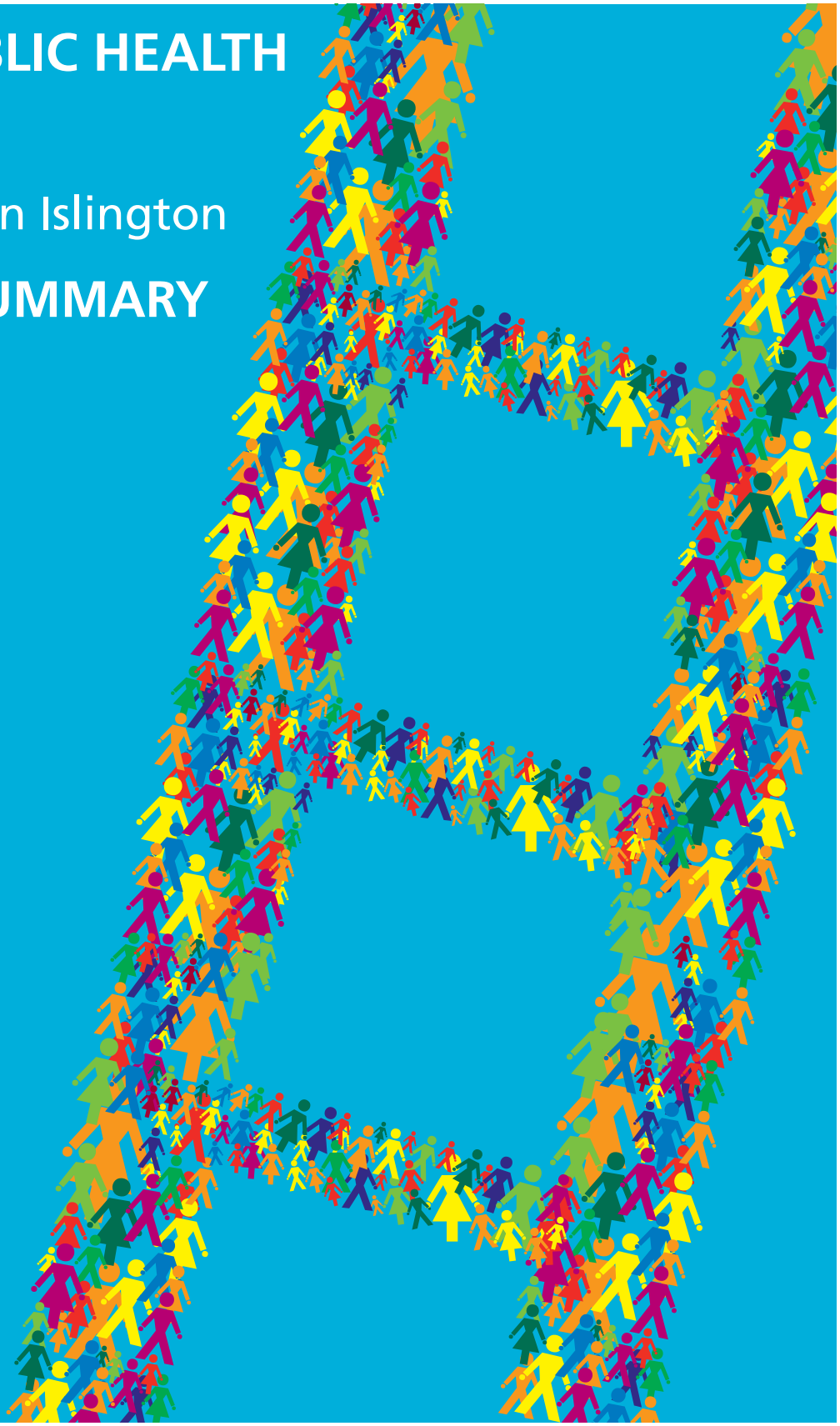
ISLINGTON

NHS North Central London

ANNUAL PUBLIC HEALTH REPORT 2011

Extending life in Islington

EXECUTIVE SUMMARY



Executive Summary

SETTING THE SCENE

KEY MESSAGES

One-in-six (28,149) people aged 18-74 years are diagnosed with a long term condition in Islington

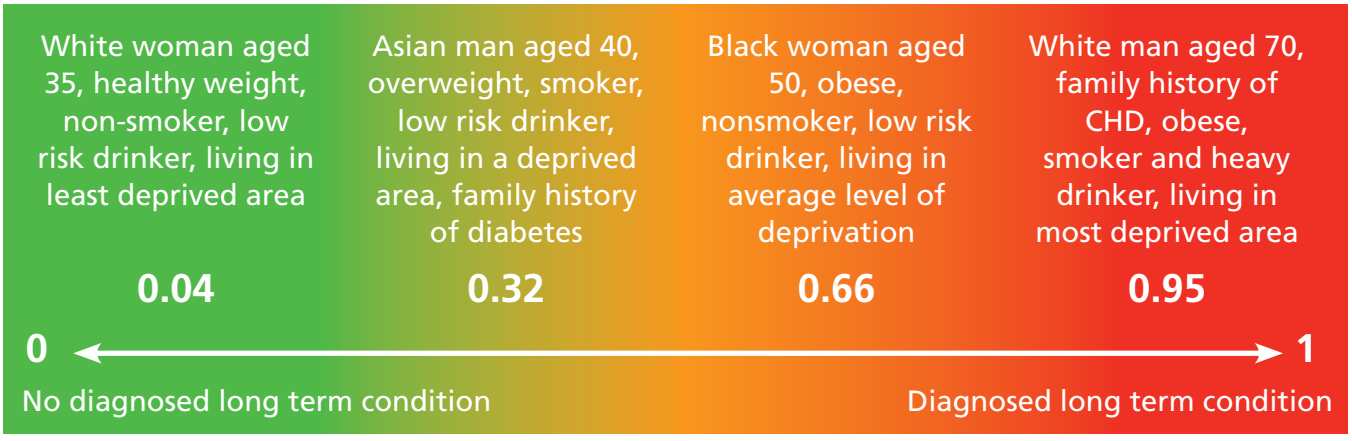
One-in-three of those have more than one long term condition

Commonly diagnosed conditions

RECOMMENDATIONS

- **Going forward, Islington's Health and Wellbeing Board needs to make sure that the focus on long term conditions in Islington is maintained.**
- **Addressing inequalities needs to be central** to any initiatives to improve population health including those related to deprivation, ethnicity and disability. However, it is important that, as well as looking at the differences in rates, the actual numbers of people affected are also considered.
- **There needs to be a shift in investment from secondary care to primary and community based care,** to ensure that long term conditions are being well managed at an earlier stage by a person's GP rather than at a late stage by the hospital, as part of care closer to home, primary care and urgent care strategies.
- **More should be invested in cardiovascular disease programmes in Islington,** to increase earlier preventive diagnosis of these conditions and ensure that the right care is provided earlier on in the course of disease, to reduce early deaths and close the inequalities gap.

Odds of being diagnosed with a long term condition in Islington

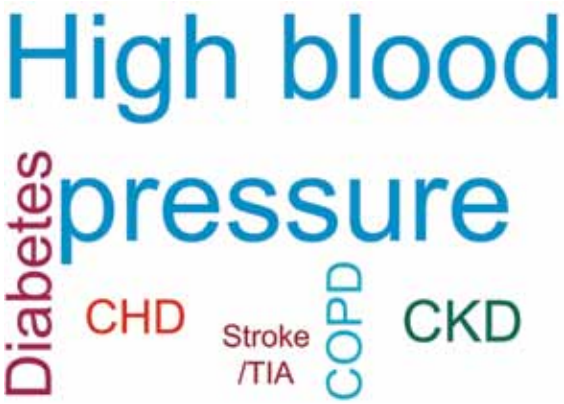


FINDING THE UNDIAGNOSED

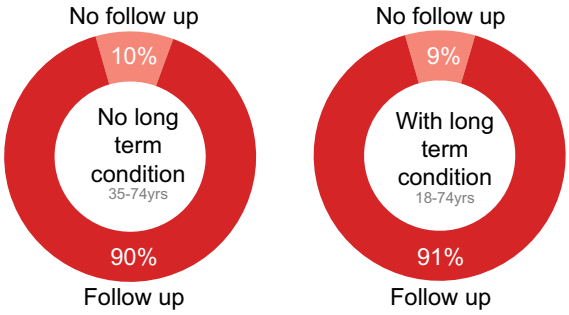
KEY MESSAGES

There are about **45,600** undiagnosed long term conditions in Islington

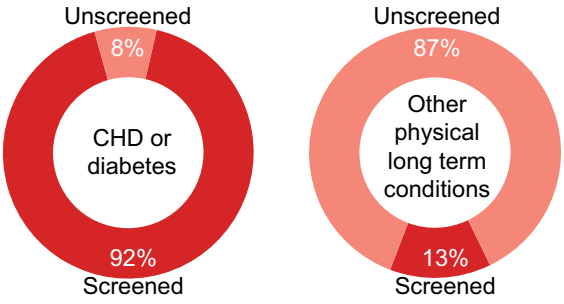
Undiagnosed conditions



High blood pressure readings



Depression screening[18-74 yrs]



NHS Health Checks[35-74 years]

1 diagnosis per **9** checks in high risk people

1 diagnosis per **66** checks in low risk people

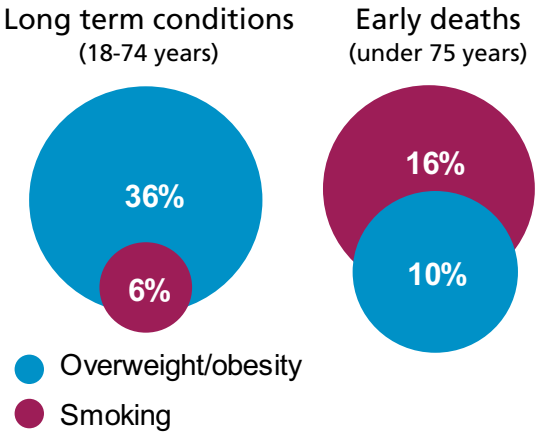
RECOMMENDATIONS

- **Work to increase the uptake of cancer screening programmes needs to continue,** especially for bowel cancer for which uptake is particularly low.
- **Achievements in improving the diagnosis and management of people living with chronic obstructive pulmonary disease (COPD) through Islington's local enhanced service (LES) need to be sustained,** with lessons learnt from the evaluation applied to other disease areas and/or local incentive schemes.
- **All Islington GP practices should be proactively following up people who have a high blood pressure reading** to determine whether they have high blood pressure or not. In addition, those living with diagnosed long term conditions should be monitored regularly.
- **All those with a physical long term condition should be screened for depression,** not just those with coronary heart disease (CHD) or diabetes. Those who are found to be depressed should be managed according to clinical guidelines and referred to appropriate services.
- **Those at high risk of having a cardiovascular disease event over the next 10 years (QRisk2 score >20%) should be proactively invited for an NHS Health Check,** as this is a key opportunity for GPs to offer lifestyle advice to people who are likely to develop cardiovascular disease in the short to medium term. One in nine of these checks is likely to result in an earlier diagnosis of a long term condition.

SUPPORTING LIFESTYLE CHANGE

KEY MESSAGES

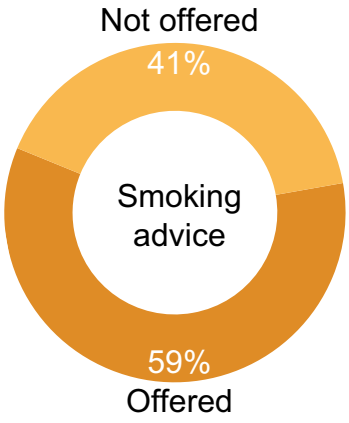
Contribution of risk factors



27% with a diagnosed long term condition are current smokers

28% with a diagnosed long term condition are ex-smokers

Smoking advice and COPD



One third of people living with a diagnosed long term condition are obese

50% with a long term condition do not have a recent BMI recorded

7% of eligible people prescribed Orlistat (weight loss drug)

RECOMMENDATIONS

- **The importance of physical activity and alcohol in the development of long term conditions and subsequent comorbidities should not be forgotten,** and GPs should be making better use of available screening tools and offering of brief interventions.
- **There needs to be greater utilisation of patient self management programmes, exercise on referral, and rehabilitation programmes** (cardiac and pulmonary) to better support people in managing their long term conditions and adopting healthier behaviours.
- **All people with COPD who still smoke should be proactively offered stop smoking advice** by their GP, as well as other healthcare professionals these patients encounter on the COPD care pathway (eg. in hospital, as part of rehabilitation, etc.). Stop smoking services should be further developed to meet the needs of those who may find it more difficult to quit, particularly those with COPD and mental health problems.
- **More should be done to support people living with long term conditions to manage their weight,** including regular monitoring of BMI by GPs to facilitate the offer of brief interventions on weight and increased use of exercise on referral. Prescribing of Orlistat should be considered to help aid weight loss for some people, and in people with the highest BMIs, bariatric surgery may be considered. This all needs to be part of the comprehensive and integrated obesity care pathway.

MANAGEMENT AND CONTROL

KEY MESSAGES

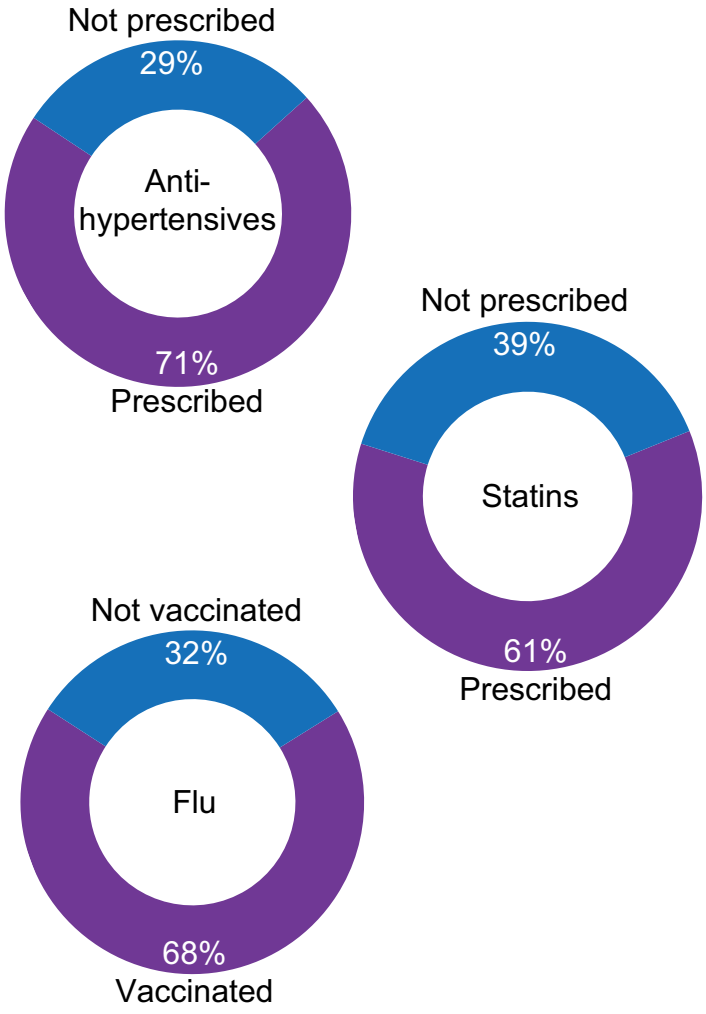
Clinical risk factors

26% with high blood pressure have uncontrolled or unmonitored blood pressure

34% who have had a stroke have uncontrolled or unmonitored cholesterol

51% of people with diabetes have uncontrolled or unmonitored blood sugar levels

Prescribing where eligible



RECOMMENDATIONS

- **At a GP practice level, reasons behind the variation in processes and outcomes need to be better understood and the variation** reduced. Lessons should be learnt from practices which are achieving comparatively good outcomes.
- **Islington GPs should ensure all people who are eligible for anti-hypertensives and statins (without contraindications) are offered these drugs to help control their conditions.** Lifestyle changes alone are unlikely to be effective. GPs should also offer patient education and support to encourage adherence to treatment. Healthcare professionals also need to proactively encourage younger people (<65 years) with diagnosed long term conditions to have the seasonal flu vaccination.

HIGH QUALITY INFORMATION & INTELLIGENCE

- **A workplan for future analyses from the public health dataset should be agreed with Islington's Clinical Commissioning Group and the Health and Wellbeing Board** to inform and underpin commissioning decisions and quality improvement, including addressing any coding issues in GP IT systems.
- **Extraction of the anonymised primary care dataset for public health purposes should be undertaken on an annual basis,** at the end of each financial year, to enable assessment of current need and the impact of any interventions from this 2010/11 baseline.

FURTHER INFORMATION & FEEDBACK

For more information and the full Annual Public Health Report visit:
www.islington.gov.uk or www.ncl.nhs.uk

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