Long-term conditions
6.1 Diabetes

Executive summary

- Diabetes is one of the most significant long-term conditions in Waltham Forest, which can lead to a number of other serious conditions such as heart disease, stroke and chronic kidney disease.
- It is expected to continue to be a significant health issue in Waltham Forest as the local population ages and risk factors continue to increase.
- People of South Asian origin are at the highest risk of developing diabetes with black ethnic groups also having a higher risk compared to their white counterparts.
- Registered prevalence of diabetes in Waltham Forest (2009/10 and 2010/11) across GP practices in Waltham Forest is 5.9%, above the national average. Waltham Forest had 13,214 patients registered in 2010/11.
- Estimated prevalence is 8.2% which is predicted to increase up to 11.1% due to changing socio-demographic predictions locally. These estimates indicate that there is also an estimated 6,550 adults with undiagnosed diabetes.
- There are differences in the systematic, strategic prevention activities for adults with Type 2 diabetes.
- NHS Health Checks Programme is a significant opportunity to identify people early with pre-diabetes as well as established diabetes.
- Insufficient capacity of Diabetes Specialist Nurses in Waltham Forest and inadequate provision of systematic, culturally appropriate structured patient education with equitable access on diabetes.
- There is variation in quality of care across GP practices in Waltham Forest with a number of practices delivering highest quality of care.
- Lack of clear guidance to manage housebound patients is an unmet need.
- The work is in progress through the diabetes network to redesign the local diabetes care pathway (as a priority) to ensure timely detection, integration across care settings and to improve equity, quality, clinical and cost effectiveness of care.
- Examine ways to improve supporting children and young people during the transitional period of diabetic care.

Recommendations

- Further strengthen the capacity of Diabetes Specialist Nurses (DSNs) to improve equitable and culturally appropriate provision of structured education together with innovative publicity to improve uptake.
- Commission more dynamic and proactive community programmes that address modifiable risk factors, such as physical activity and diet and encourage more local uptake.
• Implement the NICE Public Health Guidance 35 (May 2011) on prevention to reduce the demand due to predicted huge growth in the number of people with diabetes; ensuring more targeted Stop Smoking Services to all diabetes patients and establishing a robust obesity care pathway

• Redesign the local diabetes care pathway (as a priority) to ensure timely detection, integration across care settings and to improve equity, quality, clinical and cost effectiveness of care

Explore ways to improve detection of depression among patients with diabetes and improve the provision of psychological support for patients with diabetes.

• Ensure Stop Smoking Services are accessible to all diabetes patients through active identification of smokers and referral into the NHS Stop Smoking Services

• Establish links with all risk factor (obesity) and co-morbidities (CVD) pathways to provide a well-integrated service to patients with diabetes

• Undertake further analysis of exception reporting to improve quality of care and reduce variation

• Undertake an evaluation of family barriers to comply with treatment plan for children with diabetes Type 1 to plan appropriate interventions to improve control of diabetes.

What is Diabetes?
Diabetes mellitus is a condition in which the amount of glucose in the blood is too high because the body cannot use it properly. There are two main forms of diabetes: Type 1 diabetes mellitus (T1DM) occurs when the pancreas produces no insulin. Type 2 diabetes mellitus (T2DM) develops when the pancreas does not produce enough insulin. Type 2 is the more common in the population and accounts for around 90% of cases of diabetes 253.

More than 500,000 who have T2DM in the UK are not aware of it. It is estimated that by 2025 there will be more than four million people with diabetes in the UK. Most of these cases will be T2DM diabetes, attributable to an ageing population, changing ethnic mix and rapidly rising numbers of overweight and obesity. Recent estimates show that 10% of NHS spending goes on diabetes – that is £9 billion a year or £1 million an hour 254, 255.

Why is diabetes important?
Poor control of diabetes can, in the short term, result in diabetic ketoacidosis, and a potentially fatal medical emergency. In the longer term, poor diabetic control increases the risk of complications such as heart attacks, stroke, blindness, kidney failure and amputation. Studies have shown that good diabetes control is associated with a reduced risk of these complications developing. On average diabetes reduces life expectancy by more than 15 years for someone with T1DM and up to ten years for T2DM.

Around half of people with diabetes have cardiovascular or other types of complications at diagnosis, suggesting that they already have had the condition for up to ten years. Undiagnosed diabetes, presenting as an acute emergency, contributes to the need for unscheduled emergency care and acute admission.

Diabetes related accident and emergency (A&E) attendances and hospital admissions have huge implications on the local health and social care economy 256.

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255 APHO Diabetes Prevalence Model Findings for England, Yorkshire and Humber, Public Health Observatory; www.yhpho.org.uk

Risk factors for diabetes
Diabetes is most prevalent among those who are overweight or obese, who have a family history and among smokers. People of South Asian origin are up to six times more likely, and those of black African-Caribbean origin up to five times more likely, to develop diabetes compared to white people. Data suggests that 20% of the South Asian community and 17% of the black African and Caribbean community living in the UK have Type 2 diabetes in contrast to 3% of the general population. For those with diabetes other health outcomes are much higher, especially heart disease (2 to 3 times higher in South Asians), renal failure (4 times higher in Asians) and stroke (3 times higher in African-Caribbeans)\(^{257}\).

Socio-economic deprivation is associated with increased risk of diabetes, with the most deprived people at two and a half times greater risk and the risk\(^{258}\) increases with age in both sexes. These are particularly relevant to Waltham Forest, considering its ethnic mix, high level of deprivation and higher level of physical inactivity and overweight/obesity.

Lifestyle behaviours such as physical inactivity and smoking increase the risk of developing Type 2 diabetes and the risk of diabetic complications\(^{259}\).

Smoking is known to increase the risk of diabetes related complications such as heart disease, stroke, and kidney disease. Diabetic retinopathy deteriorates more rapidly in smokers compared to non-smokers.

Obesity is a leading risk factor for diabetes. In Waltham Forest, a quarter of all adults (25%) are estimated to be obese.

Local picture
In Waltham Forest, diabetes is a significant long-term condition both in respect of prevalence and associated morbidity and mortality. Current diabetes prevalence is estimated at 5.9% but it is predicted to rise to over 10% by 2030 due to changes in socio-demographics. A predicted faster rate of growth among the over-50’s, coupled with a higher rate of growth among black, Asian and minority ethnic (BAME) group in this age cohort in comparison to their white counterparts, are likely to contribute to this increase\(^{260}\).

The modelled prevalence of diabetes for Waltham Forest and for England is 8.2 (16,657 people), and 7.3% respectively. It is predicted that by 2030, Waltham Forest and national prevalence will go up to 11.1% (22,548) and 8.8% respectively\(^{261}\).

Women with diabetes are 2 to 3 times more likely to have a baby with a congenital abnormality (birth defect) and 5 times more likely to experience a stillbirth than a woman without diabetes. Preconception care can reduce these risks\(^{262}\). In Waltham Forest, in 2009, it was estimated that 2.5% of women between the ages of 16 and 44 had pre-gestational diabetes. This is higher than London (2.2%) and England (1.8%) estimates and equates to approximately 83 births\(^{263}\).

\(^{260}\) GLA Round Ethnic Group Projections (Revised), August 2010.
\(^{263}\) APHO Estimates of births to women with pregestational diabetes, 2009.
Registered prevalence of diabetes in Waltham Forest (2008/09 and 2009/10)
As of end March 2010, there were 12,233 people aged 17 and over with diabetes (both Type 1 and Type 2) in all 46 GP Practice registers in Waltham Forest which increased to 13,214 in 2011/12. This equals a prevalence of 5.9% in both years, higher than the prevalence recorded nationally and in London\(^{264}\) during both years. However, this is lower than the estimated prevalence of 8.6% and indicates that there is also an estimated 6,550 adults with undiagnosed diabetes.\(^{265}\)

The most recent confirmed prevalence figures in Waltham Forest are shown in Table 6.1

### Table 6.1  Registered prevalence of diabetes in Waltham Forest (QOF data 2011/12)

<table>
<thead>
<tr>
<th>Locality</th>
<th>Diabetes register 17+</th>
<th>Prevalence %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chingford</td>
<td>2,780</td>
<td>5.5%</td>
</tr>
<tr>
<td>Leyton Leytonstone</td>
<td>5,250</td>
<td>6.0%</td>
</tr>
<tr>
<td>Walthamstow</td>
<td>5,561</td>
<td>6.1%</td>
</tr>
<tr>
<td>Waltham Forest (total)</td>
<td>13,591</td>
<td>5.9%</td>
</tr>
</tbody>
</table>

The highest prevalence was observed in Walthamstow 6.1%, with Leyton Leytonstone reporting 6.0% and Chingford 5.5%.

### Type of diabetes in Waltham Forest
Table 6.2 shows where patients identified by secondary care are not found on the primary care diabetes register. The figures are only for data relating to the 45 practices (out of 46) participating in the National Diabetes Audit (NDA) 2009/10 and explains the discrepancy in the number 12,233 reported above for 2009/10 and 12,128 in Table 6.2.

### Table 6.2  Diabetes registrations by type for Waltham Forest PCT

<table>
<thead>
<tr>
<th></th>
<th>NDA Registrations (Total number of registrations)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type 1</td>
<td>849</td>
</tr>
<tr>
<td>Type 2</td>
<td>10,924</td>
</tr>
<tr>
<td>All diabetes *</td>
<td>12,128</td>
</tr>
</tbody>
</table>

*All diabetes include MODY, other specified and unspecified

This indicates that Type 1 diabetes represents 7% of the total population with diabetes registered in Waltham Forest.

### Mortality
In 2008–10 period, the directly age standardised mortality rate from diabetes for all ages was 8.42, higher than London (5.82) and England (5.68). Waltham Forest was ranked fourth highest in London\(^{266}\). The estimated percentage of deaths attributable to diabetes among people aged 20 to 79 in Waltham Forest was 14.6%, which was higher than Outer North East London (13.5%) and national (11.6%) rates\(^{267}\).

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\(^{264}\) QMAS database data as at year ends. Copyright © 2007; 2008; 2009; 2010; 2011 The Health and Social Care Information Centre, Prescribing Support Unit.

\(^{265}\) Diabetes Profile 2013.

\(^{266}\) Compendium of Health and Clinical Indicators, January 2012. Available from: https://indicators.ic.nhs.uk/webview/

Diabetes prevention
Studies have shown that lifestyle interventions, particularly those targeted at reducing obesity can prevent or delay Type 2 diabetes\textsuperscript{268}. Within Waltham Forest, there is no specific diabetes prevention programme. However, there are population health improvement programmes such as increasing physical activity, healthy eating and reducing overweight and obesity, which all contribute towards diabetes prevention.

Screening for diabetes
There is no systematic screening programme in Waltham Forest for Type 1 or Type 2 diabetes. Screening is performed at GP Practices based on need or through the NHS Health Check Programme or as part of registering new patients to the practice.

Establishing diabetes risk register to monitor those who may be at risk of developing diabetes in the future will enable appropriate follow up of those identified at risk.

Management of Type 2 diabetes in Waltham Forest
Type 2 diabetes patients are mainly managed by primary care. A number of quality and outcome (QOF) indicators are in place under the General Medical Services (GMC) contract. QOF provides financial incentives for GP practices to achieve targets in a number of domains including clinical care. This data can be used to provide information on a number of indicators of clinical outcomes in people with diabetes. A tool developed by Diabetes Health Intelligence and Yorkshire and Humber Public Health Observatory\textsuperscript{269} allows diabetes care intermediate outcomes in Waltham Forest to be compared with national, regional or the ‘Blue Group’. Waltham Forest falls within the ‘Blue Group’ which has a young population with average deprivation and slightly higher than average population from black and Asian ethnic groups\textsuperscript{270}.

Management of diabetes by CCG level 2011/12\textsuperscript{271}
Primary care has a key responsibility to ensure adequate control of blood glucose (measured through HbA1c), blood pressure and cholesterol among people with diabetes. Further, in order to reduce lifestyle related risk factors patients need to be appropriately referred to stop smoking services, exercise and weight management programmes.

Inadequately controlled blood glucose and other risk factors increase the risk of patients developing complications such as heart disease, stroke, kidney damage, visual impairment.

Figure 6.1 provides a breakdown of the key aspects of clinical management of patients with diabetes and highlights the attainment of HbA1c, blood pressure and cholesterol targets in the 15 months ending March 2012.

Overall performance is within recommended limits. However, the exception reporting for HbA1c indicators is above that of blue cluster group and England.

\textsuperscript{268} NEW England Journal of Medicine article.
\textsuperscript{269} APHO Diabetes Prevalence Model Findings for England, Yorkshire and Humber, Public Health Observatory;www.yhpho.org.uk
\textsuperscript{270} Diabetes Community Health Profile (2010/11) YHPHO.
\textsuperscript{271} Diabetes Profile 2013 (Although CCGs only came into existence in April 2013, the data for 2011/12 provided by YHPHO Diabetes Profiles was presented by CCG, rather than by PCT).
Other conditions related to diabetes

People with diabetes are twice as likely to have depression as the general population. Clinical depression and people with depression are more likely to neglect their diabetes self-care, have worse physical symptoms, worse glycaemic control, increased risk of complications and have two to five times increased mortality. In addition, diabetics with depression have significantly higher medical costs than those without depression. Mental health treatments such as psychological treatments and antidepressants can improve depression outcomes. GP registers for depression among patients with CHD and/or diabetes indicate that the number of CHD and/or diabetes patients with depression increased from 15,253 in 2010/11 to 15,631 in 2011/12, an increase of 2.5%.

Diabetes-related foot care contributes to a significant amount of hospital stays. In Waltham Forest, diabetic foot disease accounted for 4,718 nights in hospital between 2008/09 and 2010/11. The incidence of major amputations between April 2008 and March 2011 was 0.67 per 1,000 adults with diabetes, which was significantly lower than the national average of 1.01 per 1,000. During the same time period, the incidence of minor amputations was significantly lower than the national average: 0.92 per 1,000 adults with diabetes compared to 1.66 per 1,000 in England.

Exception reporting of QOF data

When reviewing a practice’s achievement on any given measure, some patients may be excluded from calculation, so-called ‘exception’ patients. Valid reasons for exception include, the treatment was clinically inappropriate; the patient did not attend or refused treatment, or the patient was only recently diagnosed or registered with the practice. Further analysis of patients who are exception reported is needed in order to identify this cohort of patients to plan appropriate interventions and to reduce variation across practices.

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272 Although CCGs only came into existence in April 2013, the data for 2011/12 provided by YHPHO Diabetes Profiles was presented by CCG, rather than by PCT.
274 Ibid.
275 QMAS Guidance.
Morbidity associated with diabetes complications
The complications of diabetes are the final outcomes of care. Of all aspects of diabetes they have the greatest costs to the patient and the health service. Achievement of treatment targets reduces the risk of developing complications. Apart from diabetic ketoacidosis (DKA) in Type 1 diabetes, which is an immediate consequence of treatment failure, the other complications arise only after many years of exposure to high blood glucose, blood pressure and high cholesterol. The prevalence of complications has been assessed by determining which patients with diabetes identified in the national diabetes audit have had relevant admissions recorded in the Hospital Episodes Statistics database (HES). Data submitted to the NDA from practice and outpatients units are linked to data from the HES. The complication prevalence rate in Figure 6.2 is based on an admission to hospital with one of the listed conditions at any time in the last 5 years, for patients with diabetes from Waltham Forest.

Emergency admission rates for diabetic ketoacidosis and coma
It is important to note that indirectly age and sex standardised emergency admission rates for diabetic keto-acidosis and coma in Waltham Forest are lower than for England, London and statistical comparators except for Enfield (23.9 vs 21.03 per 10,000). The reduction from 2008/09 to 2009/10 is more marked in Waltham Forest.276

As shown in Figure 6.2, there is a clear downward trend in the admission rates in Waltham Forest although there is slightly upward trend nationally and in London. Fluctuations observed in Waltham Forest are likely to be due to a small sample size.

Figure 6.2 Age and sex standardised emergency hospital admissions: diabetic ketoacidosis and coma – trend in persons, all ages

Source: HSCIC.

276 Compendium of Health and Clinical Indicators, January 2012.
The trend of diabetes emergency admission rates for 18+ in Waltham Forest from 2008/09 to 2011/12

After a decrease from 2008/09 to 2009/10 the emergency admission rates for all ages in Waltham Forest has been steadily increasing steadily since 2009/10 to 2011/12. The admission rate was highest in 2011/12.

The diabetes emergency admission rate was highest among people over 80 years of age from 2008/09 to 2011/12 except in 2009/10. The rate among that age group decreased slightly since 2010/11 with the exception of children under 15 years, admission rates for the other age groups rose over this period.

Diabetes related foot complications in Waltham Forest

According to NICE guidelines, 20 to 40% diabetes patients have neuropathy and 20 to 40% have peripheral vascular disease. Approximately 5% develop a foot ulcer in any year and amputation rates are 0.5.277. 15% of patients with diabetes will develop a foot ulcer in their lifetime and at any one time, it is estimated that 1.4% will have a foot ulcer.

The incidence of major amputations in Waltham Forest is currently above the national average this has been below the national average previously. A diabetes foot care audit279 indicates that between 2008/09 and 2010/11, there were 14.2 episodes of care per 1,000 adults with diabetes with foot complications each year, significantly lower than the national rate of 18.1 per 1,000. However, the average number of nights spent in hospital for each episode of care was slightly above the national average of 9.5.

Source: SUS data NELCSU.

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Hypertension
Hypertension is another term for consistent high blood pressure. There is evidence that there is increased prevalence of diabetes in patients with hypertension, with one large study showing those with hypertension are 2.5 times more likely to develop diabetes than those with normal blood pressure\textsuperscript{281}. Diabetes is known to increase the risk of hypertension. Estimates of hypertension prevalence in diabetes patients range from 35\%\textsuperscript{282} to over 70\%\textsuperscript{283}, depending on the populations studied and the definition of hypertension used. Uncontrolled high blood pressure leads to complications such as kidney damage and visual impairment.

Microalbuminuria
Microalbuminuria is the presence of protein in urine and indicates how well the kidneys are functioning. Poor kidney function is a common progressive condition. Microalbuminuria is present in 12\% of Type 2 diabetes patients at diagnosis. Approximately 25\% of Type 2 diabetes patients have microalbuminuria\textsuperscript{284}, which equates to 3,000 patients in Waltham Forest.

Diabetes and mental health
People with diabetes are twice as likely to have depression as the general population and clinical depression and people with depression are more likely to neglect their diabetes self-care, have worse physical symptoms, worse glycaemia control, increased risk of complications and have two to five times increased mortality.

In addition, diabetics with depression have significantly higher medical costs than those without depression. Mental health treatments such as psychological treatments and antidepressants can improve depression outcomes. There are two QOF indicators relating to depression in patients with diabetes (see mental health section).

Structured education for patients with diabetes
Patient education and empowerment is crucial for self-management of diabetes. Waltham Forest has adopted the XPERT model that meets NICE criteria for structured education. This service is provided by Diabetes Specialist Nurses (DSNs). The delivery as well the uptake of this service has been consistently poor and this has been a high priority by the CCG and initiatives are in process to meet the immediate and long-term needs of this service.

Diabetes Eye Screening Programme (DESP)
The aim of screening for diabetic retinopathy (eye disease) is to decrease the incidence of visual impairment in the local community. The national screening committee requires an annual retinopathy screen for all patients with diabetes aged over 12.

A central call-recall register is in place to ensure that all patients who have diabetes are identified and appropriately invited for screening. This needs close working between primary care, community eye screening service and acute trust to ensure patients have equitable access and quality of care in the screening cycle.


All recorded diabetics within the Waltham Forest area must be screened (photographed) by the screening service yearly unless formally excluded (under hospital care or unable to screen or treat). The National Screening Programme requires that patients are put on very strict timelines for screening, grading images, clinic appointments and treatment. The Screening service is delivered in three centres across the borough. Results are checked and validated by specialist ophthalmologists at Whipps Cross Hospital. If further investigation or treatment is required, patients are seen at Whipps Cross.

At the time of handing over of the Waltham Forest DESP to NHS England in February, there were a number of gaps in the local care pathway in terms of failsafe system and sharing data across the care settings. This has now been resolved by investment by the NHS England to upgrade software, IT and failsafe process.

DESP programme board was established in 2013, to oversee the quality and delivery of the local service provision. A business case was developed by Public Health making the case for investment to improve quality and safety.

The External Quality Visit that took place on 19 September acknowledged the progress made to the local DESP. This service now enables clinicians to work in a more coordinated and integrated way to improve access and quality and reduce inequalities and patient outcomes including visual effects relating to DESP.

**Programme budgeting total spend per person on the diabetes QOF register in Waltham Forest**

NHS Waltham Forest CCG spent a total of £5.5M on prescriptions for diabetes items between April 2011 and March 2012. This was equivalent to £408 per adult with diabetes. Average spending on items to treat diabetes was not significantly different compared to England.

**Figure 6.4**  Average cost per item for anti-diabetic items NHS Waltham Forest

![Diagram showing average cost per item for anti-diabetic items](image)
Evidence of effective interventions
NICE Guidance published in May 2011, provide evidence-based interventions for prevention of diabetes.285

NICE Quality Standards for Diabetes (2011)
In July 2011, NICE published a Quality standard for diabetes which provides an authoritative definition of good quality care. NICE quality standards enable the following to happen:

- Health and social care professionals can make decisions about care based on the latest evidence and best practice
- Patients can understand what service they can expect from their health and social care providers
- NHS trusts can quickly and easily examine the clinical performance of their organisation and assess the standards of care they provide
- Commissioners to be confident that the services they commission are high quality and cost-effective.

Type 1 Diabetes Mellitus (T1DM)
Diagnosis and management
Diagnosis of T1DM is more likely to occur in a hospital setting following a patient presenting with the consequences of undiagnosed diabetes, e.g. dehydration, weight loss, diabetic ketoacidosis. Type 1 Diabetes patients are usually managed by the acute trusts. GPs see Type 1 Diabetes patients for insulin dose adjustment or for insulin and needle prescriptions.

Every child newly diagnosed with Type 1 diabetes should be evaluated and cared for by a diabetes team consisting of a paediatrician with a particular interest in diabetes, a nurse educator, a dietician, and a mental health professional) qualified to provide up-to-date adolescent-specific education and support.287

Nurses dedicated to communicating basic specialised diabetes education skills are required for adolescents. They require management skills within a context that addresses family dynamics and issues facing the whole family.

It is essential that substantial educational material (necessary for basic management, often referred to as ‘survival skills’) be conveyed to a family of a child with Type 1 diabetes:

- Immediately after the initial diagnosis studies suggest that to be effective, educational interventions need to be ongoing
- Frequent telephone contact, and both in-person care and telephone availability have been demonstrated to improve HbA1c.

Other services and screening for Type 1 diabetes
Children with Type 1 diabetes need to be referred for the following services in order to maximise outcomes related to this condition:

1. Medical nutrition therapy by a registered dietician:
   - As part of initial team education and on referral, as needed.
   - Generally requires a series of sessions over the initial 3 months after diagnosis, then at least annually, with young children requiring more frequent re-evaluations.

285 Preventing Type 2 diabetes: population and community level Interventions, NICE public health guidance35 (guidance.nice.org.uk/ph35).
286 NICE Quality standards for diabetes 2011.
2. Diabetes nurse educator:
   - As part of initial team education, or referral as needed at diagnosis; generally requires a series of
     sessions during the initial three months of diagnosis, then at least annual re-education


4. Depression screening annually for children ≥10 years of age, with referral as indicated:

5. Annual screening for microalbuminuria should be initiated once the child is 10 years of age and has
   had diabetes for 5 years; more frequent testing is indicated if values are increasing:
   - Fasting lipid profile should be performed at the time of diagnosis (after glucose control has been
     established). If values fall within the accepted risk levels (measurement should be repeated every
     5 years).
   - The first ophthalmologic examination should be obtained once the child is 12 years of age and
     has had diabetes for 3 to 5 years. After the initial examination, annual routine follow-up is generally
     recommended.
   - Annual foot exams should begin at puberty.

**Barriers to managing Type 1 Diabetes among children**

A number of factors such as presence of repeated episodes of diabetic ketoacidosis, other health
problems (e.g. asthma), poor school attendance, learning disabilities, and emotional and behavioural
problems and depression are barriers to adhere to treatment regime for diabetes among children.

Certain family characteristics have been identified as risk factors for poor diabetes control. These include a
single-parent home, chronic physical or mental health problems in a parent or other close family member
(including substance abuse,) a recent major life change for the parent (e.g. loss of a job or a death in the
family), complex child care arrangements, and health/cultural/religious beliefs that make it difficult for the
family to follow current diabetes treatment plans. Therefore early evaluation of family barriers to comply
with treatment plan is essential to avoid inadequate control of diabetes.

Working with the patient and family, develop an exercise plan and support package including strategies to
measure blood glucose levels, manage hypoglycaemia, adjust carbohydrate intake and insulin doses will
enable adequate control of diabetes.

**Transition from childhood to adolescence – Type 1 diabetes**

Attention to such issues as family dynamics, developmental stages and physiologic differences related
to sexual maturity are all essential in developing and implementing an optimal diabetes regimen in
adolescents.

Targets of education need to be adjusted to the age and developmental stage of the patient with diabetes
and must include the parent or caregiver.\(^{288}\)

The goal should be a gradual transition toward independence in management through adolescence. Adult
supervision remains important throughout the transition.

Many of the demands of self-care for diabetes interfere with the adolescent’s drive for independence
and peer acceptance. Peer pressure may generate strong conflicts. In this age-group, there is a struggle
for independence from parents and other adults that is often manifested as suboptimal adherence to
diabetes care. Evidence shows that adolescents whose parents exercise supervision in the management
of diabetes have better metabolic control.

\(^{288}\) BUPA diabetes.
What is being done locally to address this issue?
The Waltham Forest Diabetes Network, local clinical leadership and commissioners will improve care through the implementation of the Diabetes Guide for London service model. This model once in place is expected to reduce acute episodes through more proactive management of diabetes in a primary and community setting through personalised care planning and improved education of patients. A pilot to implement the Year of Care model in 2010/11 provided information on some of the barriers to care planning experienced by patients and clinicians.

Prevention Services
Services to improve physical activity and reduce obesity are available across Waltham Forest. The NHS works with the local authority to provide specialist exercise on referral services for secondary prevention of diabetes. They also work in partnership to provide exercise opportunities for young people and those over the age of 55 who would not normally exercise. A service to improve healthy eating entitled Why Weight uses a whole family approach to tackling weight issues through diet.

Primary Care Services
Local GP practices are monitored on achievement against the nine care processes through the Quality and Outcomes Framework. The Clinical Commissioning Group agreed to adopt a process of accreditation based on the Diabetes Guide for London.

Secondary Care Services
Specialist outpatient and inpatient services have been commissioned to provide care for children and adults with Type 1 diabetes, women with diabetes who become pregnant and who develop gestational diabetes, patients with Type 2 diabetes that have difficulties managing their condition or have established complications. Other specialist services include foot care, renal services, and diagnosis and treatment of diabetes related eye conditions.

Community Care
A specialist community service was commissioned in 2008 to provide specialist care for high need patients outside of hospital. Other services include footcare, dietetic services, and two diabetes nurse specialists service.

Structured patient education is available for Type 1 patients through the DAPHNE course and for Type 2 patients using the XPERT patient programme. From 2011 some staff members have been trained on the Conversation Map patient education programme. Both courses are delivered by the community Diabetes Nurse Specialists Nurses and dietician.

Foot care services are provided across Outer North East London and receive over 100 referrals a week for diabetic and non-diabetic foot care needs. Twenty two podiatrists and three podiatry assistants provide sessions in community clinics, hospital wards and in patients homes.

A review of community services revealed that there is a need to increase the provision of Diabetes Nurse Specialists from 2 to 5 nurses per 250,000 population and the number of dieticians from 3 to 4 per 250,000 population as recommended by national guidance.
What is the public perspective?

Figure 6.5  Percentage of people with a long-term condition that received enough support from local services

Figure 6.5 shows the percentage of all people with a long-term condition that have received enough support from local organisations and how confident they feel about managing their own health from the GP Patient Survey. However, no separate information available specifically for diabetes.

What more do we need to know?

Challenges

- Variation in the quality of diabetes care in primary care
- Inadequate capacity in the existing structured education programme
- Inadequacy in provision of culturally appropriate structured education programmes
- Lack of a well-integrated diabetic care pathway across primary, community and acute care
- Gaps in diabetic care for housebound patients
- Psychological support continues to be variable across the localities.
Meeting the challenges (Progress)
1. The work is underway to redesign the diabetes care pathway to strengthen integration across care settings, improve quality of care and reduce variation ensuring local needs are met.

2. There is work in progress to provide adequate capacity for provision of structured diabetes education.

3. Plans are in place to establish a robust system to undertake NHS health checks which will enhance case findings of diabetes.

What evidence is there that we are making a difference?
The CCG has identified strengthening staff capacity particularly Diabetes Specialist Nurses’ cadre to meet national standards. Action is being taken to recruit into two vacant DSN posts in Waltham Forest.

Work is underway to redesign the local diabetes care pathway to improve integration, effectiveness and productivity and ensure a reduction of variation in quality of care.

Subsequent to taking over of the programme by the NHS England, funding was provided to meet the gaps that existed in the programme. The External Quality Visit that took place on 19 September acknowledged the progress made to the local DESP.
6.2 Cancer

Executive summary

Epidemiology

- Waltham Forest mortality from all cancers is higher than England and London average. We are ranked 14th highest in London
- Under 75 years mortality from cancer is higher than England and London average. It is also higher than our statistical comparators Croydon and Greenwich
- During 2008–10, on average there were 872 new cases of cancer diagnosed in the borough and 375 deaths every year.

Breast cancer

- During 2008–10 the directly standardised incidence rate for breast cancer (DSR) in Waltham Forest was 117.2 which is lower than England average at 124.5 but higher than London average of 116.9
- The 2008–10 pooled data show Waltham Forest directly standardised mortality rate for breast cancer (30.3) for all ages is higher than England (25.3) and London (25.16) average
- Similarly, in 2008–10, breast cancer mortality rate (DSR) for under 75s was 23.56 which is higher than England average at 19.25 and London average of 19.15. Waltham Forest ranked second highest in London.

Cervical cancer

- 2008–10 pooled data show Waltham Forest incidence rate of cervical cancer (9.2) is higher than England (8.71) and London (6.37) average
- Three year pooled data (2008–10) show Waltham Forest directly standardised mortality rate for cervical cancer all ages of 2.06 is equal to London average (2.06) and lower than England average (2.24)
- In the same period (2008–10) mortality rate for under 75 years, shows Waltham Forest rate is higher than London and England average. Waltham Forest was ranked 20th highest in London.

Bowel cancer

- The 2008–10 pooled data for bowel cancer (persons) show that Waltham Forest directly standardised incidence rate of 39.99 was lower than England (47.86) and London (42.95)
- During the same period, Waltham Forest directly standardised mortality rate for bowel cancer was lower than England and London average in both males and females
- Waltham Forest’s standardised mortality rate colorectal for under 75 male is above England and London average.
Survival

- Waltham Forest's cancer survival is still one of the poorest in London. Survival rates are also lower than our statistical comparators Croydon and Greenwich.

- The key drivers for the poor survival in Waltham Forest are poor awareness of cancer symptoms by the general population, delay in diagnosis and advanced stage at diagnosis.

Screening coverage

- 2011/12 breast screening coverage for women aged 53 to 70 years in Waltham Forest was 71.7%, meeting the national minimum standard of 70%. It is below England average of 77% but higher than London average of 69.3%.

- Breast screening coverage is variable at practice level ranging from 53.3% to 75.1%; only eight practices achieved the minimum standard of 70%.

- Cervical screening coverage (25 to 64-year-olds) in 2011/12 was 76%. This is below the national minimum target of 80%, below the England average of 78.6% but higher than London average of 74.1%.

- 11 practices out of 45 (24%) achieved the national target of 80% coverage.

- In the same period 99% of Waltham Forest women received their cervical screening results in two weeks. This is above the national average of 95% and London average of 94.2%.

- In 2013 the Waltham Forest bowel screening uptake average was 43.7%, and none of the GP practices achieved the national target of 60%. The bowel screening uptake at practice level ranged from 27.6% to 55.6%.

Local initiatives

Over 10 projects have been implemented in the last two years that are linked to early diagnosis. This included public awareness of cancer symptoms and advice to see GP without delay through media campaign and community engagement, GP training and provision of early diagnosis tools. Continued investment in promoting early detection of cancer will build on the momentum gained with these projects.

Recommendations

- Continued investment in early diagnosis through targeted community outreach work, GP training and increasing access to diagnostics e.g. flexible sigmoidoscopy and x-ray.

- Develop targeted interventions for those who do not participate in screening programmes to increase screening uptake e.g. active follow up of DNAs through telephone calls, text messaging, letters offering second time appointments or recommending screening when eligible persons attend clinics.

- It is estimated that about a third of cancers could be prevented by eating a healthy diet, being physically active and maintaining a healthy weight. Address cancer risk factors such as smoking, obesity, physical inactivity and excessive alcohol consumption.

- Implementing age extension for both bowel and breast screening programmes.

- Implement systems to facilitate completeness in recording stage of diagnosis.

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289 NHS Breast Screening Programme: coverage of women aged 53–70 by Primary Care Organisation, at 31 March 2011 and 2012.


What is cancer?
Cancer is a term used to describe a group of diseases that affect different parts of the body. Other terms used are neoplastic disease or malignancy. Cancer accounts for nearly 30% of all deaths among men and 25% of deaths among women in England every year. Cancer remains a high priority in Waltham Forest as the second most common cause of death. Between 2007 and 2009 cancer accounted for nearly 25% of all deaths in the borough.

Cancer risk factors
Cancer risk factors can be divided into two broad categories:

1. Fixed risk factors – these are factors that one cannot control. They include:
   - Age: ageing is the primary factor for the development of cancer, for example 85 per cent of breast cancer cases occur in women 50 years of age and above.
   - Gender: certain types of cancer (e.g. prostate cancer) are gender specific.
   - Family history: research shows that there is an inherited predisposition to cancer for people with family history of cancer. Women who have a family history of breast or ovarian cancer are at a higher risk for breast cancer than those who lack such a history.

2. Modifiable factors – these are factors that one can change as they are related to lifestyle choices.

3. Smoking: smoking causes 9 out of 10 lung cancer cases. The Waltham Forest estimated smoking prevalence in the general population aged 16+ is 19.3% and 24% in people aged 40 to 74 attending a health check:
   - The death rate from smoking per 100,000 population is 263.3, one of the highest in England.
   - Obesity: research has shown that many types of cancer are more common in people who are overweight or obese. Waltham Forest adult obesity rate (model-based estimates) is 20.2% which is higher than London (18.4%) but lower than England (23.6%).
   - Lack of exercise: regular physical exercise has been shown to reduce the risk of breast cancer. A physical activity survey by Sport England in 2007/08 highlighted Waltham Forest’s residents have lower levels of physical activity; only 15.5% of residents aged 16 years and over participate in 30 minutes of moderately intense physical activities 3 times a week compared to 16.4% in England and 16.5% in London.
   - Diet: generally a diet rich in fruit and vegetables, high in fibre and low in red meat, processed foods and sugar will contribute to a protective effect against many diseases including breast cancer, bowel cancer etc.

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292 London Health Observatory (LHO); Mortality from all cancers (directly age standardised rate per 100,000 population, persons under 75 years) by local deprivation quintile. Metadata. Available at http://www.lho.org.uk/Download/Public/16127/1/Stratified_cancers_under%2075s%20MetaData.doc. Accessed 5/7/2011

293 National Centre for Health outcome and development (NCHOD); compendium of indicators.


Alcohol consumption is associated with an increased risk of oral, esophageal, breast, and other cancers. Six per cent of cancer deaths in the UK are caused by alcohol and all of these deaths could be avoided. Other lifestyle and environmental factors known to affect cancer risk include certain sexually transmitted diseases (such as those conveyed by the human Papilloma virus (HPV), exposure to radiation from the sun or from tanning beds and certain occupational and chemical exposures).

The vast majority of cancer risk factors are environmental or lifestyle-related, leading to the claim that cancer is a largely preventable disease. http://en.wikipedia.org/wiki/Cancer – cite_note-Danaei-34#cite_note-Danaei-34

Local picture

Cancer incidence

There were 872 people diagnosed with cancer annually in Waltham Forest during 2008–10. This represented a 21% increase compared to 2007–09. Between 2008–10 there were 1,799 cancer cases diagnosed in people aged under 75 in Waltham Forest – 927 males and 872 females.

Waltham Forest’s directly standardised incidence rate (412 per 100,000 population) for all cancers in all ages between 2008–10 is higher than the England (386.9) and the London average (366.2). Similarly the incidence rate is higher than our statistical comparators Croydon (368.9) and Greenwich (407.3).

Mortality from all cancers

The most recent (2008–10) pooled data show there were 1,124 deaths from all cancers in the borough. This is an average of 375 deaths annually. Directly standardised mortality rate (DSR) from all cancers, all ages for Waltham Forest (169.45 per 100,000 population) is higher than England (169.42) and London (161.69) averages. It is also higher than Croydon (151.74) our statistical comparator but lower than Greenwich (180.01). Waltham Forest is ranked 14th highest in London.

Analysis by gender shows Waltham Forest male DSR is ranked 18th highest in London, it is lower than England average but higher than both London and Croydon average. Female DSR is ranked 9th highest in London and it is higher than England, London and Croydon average but lower than Greenwich. See Figure 6.6 below.

Ibid.
Under 75 mortality rate from cancer
2008–10 pooled data show there were 604 premature deaths (less than 75 years) from all cancers in the borough. Waltham Forest directly standardised mortality rate for under 75 years is 113.85 which is higher than England (110.08) and London (106.08) averages. Compared to our statistical comparators it is higher than Croydon but lower than Greenwich. Waltham forest is ranked 12th highest in London.302

Analysis by gender shows Waltham Forest male DSR is ranked 13th highest in London. It is higher than England, London and Croydon but lower than Greenwich. Female DSR is ranked 9th highest in London and it is higher than England, London, Croydon and Greenwich average. See Figure 6.7 below.

Figure 6.7  Directly standardised mortality rate from cancer under 75 years, 2008–10 pooled data

Source: Health and social care information centre.

Collaborative working with CCG and local authority is vital in ensuring improvement in these outcomes.

**Survival**
The latest age-standardised relative survival rates for breast, cervical, colorectal and lung cancer in England are for people diagnosed in 2004–06 and followed up until December 2011. Data is not available at borough level but Waltham Forest rate is based on North East London Cancer Network (NELCN) rate. Likewise local one year relative survival rate is estimated from the NELCN average. In all four cancers above NELCN survival rates are below both England and London average and therefore its estimated Waltham Forest survival rates are lower than England and London average.

See Table 6.3 below for more information.

**Table 6.3** Breast cancer 1 and 5 years relative survival rate

<table>
<thead>
<tr>
<th></th>
<th>1 year survival</th>
<th>5 year survival</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Breast</td>
<td>Cervical</td>
</tr>
<tr>
<td>England</td>
<td>94.7%</td>
<td>80.9%</td>
</tr>
<tr>
<td>London</td>
<td>94.9%</td>
<td>80.6%</td>
</tr>
<tr>
<td>North East cancer Network</td>
<td>92.3%</td>
<td>72.6%</td>
</tr>
</tbody>
</table>

Source: Health and social care information centre.

The key drivers for the poor survival in Waltham Forest are poor awareness of cancer symptoms by the general population, advanced stage at diagnosis and delay in diagnosis. Waltham Forest is addressing these issues as part of the national early awareness and diagnosis initiative.

Poor awareness of cancer symptoms by the general population and delay in diagnosis would suggest reviewing our overall spending to ensure adequate resources for investment in cancer prevention, early awareness and detection work streams.

**Cancer Screening Programmes**

**Breast Screening**

Waltham Forest screening coverage for 53 to 70 year was 71.7% in 2011/12, meeting the national minimum standard of 70%. This is an improvement from the previous year’s coverage of 70.7%. Waltham Forest’s coverage is below England average of 77% but higher than London average of 69.3% and ranks 10th best compared to London’s 33 boroughs.

Waltham Forest breast screening coverage compared our statistical neighbours is higher than Greenwich but lower than Croydon.

There is a wide variation in breast screening coverage at practice level ranging from 53.3% to 75.1%. Only eight practices had achieved the minimum standard of 70%. The coverage variation is seen in localities with Chingford having the highest coverage in 2011/12 of 70.7% followed by Walthamstow with 65.7% and lowest coverage is in Leyton/Leytonstone areas with 62.5%. This suggests there are inequalities, probably driven by factors related to the locality and residents’ age. Chingford area is relatively more affluent with older population compared to Leyton/Leytonstone areas with a more deprived and younger population. See Figure 6.8 below for more information on practice level coverage.

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303 NHS Breast Screening Programme: coverage of women aged 53-70 by Primary Care Organisation, at 31 March 2011 and 2012.
Breast screening age extension (47 to 49 and 71 to 74-year-olds)
Currently people aged 50 to 70 years are eligible for the national breast screening programme. Age extension will increase the age range from 47 to 74 years.

Breast screening age extension for the Waltham Forest has not been implemented as the Provider, Central and East London Breast Screening Service (CELBSS) is not meeting some of the qualifying criteria.

Familial breast cancer
The majority of breast cancer occurs as isolated cases; however about 20 to 30% is ‘familial’, of which a minority (15 to 20%) is caused by mutations in breast cancer genes such as BRCA1 and BRCA2.

Women with a first degree relative (mother, father, sister, brother, daughter and son) with breast cancer are twice as likely to develop breast cancer themselves and the risk of breast cancer increases with increasing family history. Surveillance of familial breast cancer aims at detecting breast cancer early and has been demonstrated to improve mortality and morbidity.\(^{304}\)

Cancer Reform Strategy, 2009 recommended that:

- Women who are at increased risk of breast cancer (e.g., those with a family history) should be offered risk assessment and extra surveillance, using the existing NHS Breast Screening Programme for follow up.
- All women who are currently unaffected with breast cancer but who are concerned about their risk of breast cancer because of a family history should have access to appropriate information, risk assessment and surveillance.

The National Screening Office has requested Breast Screening Units to undertake breast screening surveillance for women at high risk of breast cancer from 2012 and have also agreed a protocol for the surveillance of this group. The London Screening Improvement Board has agreed the London Guidance for the screening of women at increased risk of breast cancer.

**Cervical screening**

Waltham Forest cervical screening coverage for women aged 25-64 in 2011/12 was 76%, which is a 1% decline from previous year. Waltham Forest coverage is below the national minimum target of 80%, below the England average of 78.6% but higher than London average of 74.1%. The coverage is higher than our statistical comparators Croydon and Greenwich. In general older women (50 to 64) have better coverage than the younger ones (25 to 49) which is similar to national picture, and in 2011/12 the Waltham Forest biggest coverage decline was in the younger women from 70.1% in 2010/11 to 68.9% in 2011/12. See Table 6.4 below.

**Table 6.4 Cervical screening coverage 2010/11 and 2011/12**

<table>
<thead>
<tr>
<th>Area</th>
<th>Coverage 2010/11</th>
<th>Coverage 2011/12</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>25–49 (Less than 3.5 years since last adequate test) (%)</td>
<td>50–64 (Less than 5 years since last adequate test) (%)</td>
</tr>
<tr>
<td>England</td>
<td>73.7</td>
<td>78.0</td>
</tr>
<tr>
<td>London</td>
<td>67.6</td>
<td>76.0</td>
</tr>
<tr>
<td>Croydon</td>
<td>70.9</td>
<td>77.8</td>
</tr>
<tr>
<td>Greenwich</td>
<td>69.2</td>
<td>73.7</td>
</tr>
<tr>
<td>Waltham Forest</td>
<td>70.7</td>
<td>80.1</td>
</tr>
</tbody>
</table>

Source: Health and social care information centre

Cervical screening coverage is variable across the borough; only 11 practices out of 45 (24%) achieved the national target of 80% coverage, see Figure 6.9 below.

GPs are central to the delivery of an effective cervical cancer screening programme. General practice can help increase screening uptake by providing more convenient times for appointments, and translating information to women who cannot read English.
The Cancer reform strategy\textsuperscript{305} highlights falling participation in cervical screening for women aged 25 to 35. There is a need to have targeted initiatives to increase screening uptake among this group.

**Screening results**

In 2011/12, 94.3\% of all adequate screens were negative which is higher than national and regional average. Waltham Forest has better outcome in all the categories apart from severe dyskaryosis which is higher than London average, (Waltham Forest 0.6\% versus London 0.5\%).

**Laboratory turnaround time (TAT)**

The Cancer Reform strategy 2007 confirmed that by 2010 all women should receive the results of their cervical screening test within 14 days of it being taken. Whipp's Cross Hospital Lab has continuously made improvement towards achieving the two week turnaround time target. In 2011/12 99\% of Waltham Forest women received their results in two weeks; this is above the national average of 95\% and London average of 94.2\%.

**Inadequate smear rates**

Inadequate smears are those where no result can be issued and include those where blood or other matter in the sample makes it impossible to see the cells on the slide properly. Inadequate smears can be caused by not taking enough cells from the cervix to give a result. Whipp's Cross laboratory's inadequate rate has continued to decrease and in 2011/12, the inadequate rate was 1.3\% which is lower than the national average (2.4\%) and London average of 3.4\% inadequate smears.

A reduction in inadequate smears reduces anxiety for the women as they are less likely to be recalled for a second test and it also reduces costs to the NHS.

Colposcopy
Whipps Cross colposcopy unit provides services for Waltham Forest. In 2011/12, Whipps Cross colposcopy unit had 150 cases of moderately/severely dyskaryosis which were all seen within four weeks as per national requirement. This is above the national average of 96.4% and London average of 95.4%. Whipps cross performance for two weeks wait for severe and query invasive carcinoma and query glandular neoplasia is 100% which is consistent and well above the national average 94.5% and 92% respectively.

Bowel Screening
Bowel cancer screening uptake has been improving over the years from 36.86% in 2007 when the project was rolled out to 44.18% in 2010/11. Uptake of bowel cancer screening in 2011/12 was 43.70%. Bowel cancer screening is variable across the GP practices and none of the GP practices achieved the national target of 60%. The bowel screening uptake at practice level ranged from 27.61% to 55.56%. See Fig 6.10 below.

Figure 6.10  Bowel cancer screening uptake by GP practice 2013

Evidence from the bowel screening pilots has shown that uptake of the screening test varies significantly between different groups in the population. Typically, areas with high deprivation and high proportions of minority ethnic groups have the lowest uptake rates. Uptake is also lower among men than among women. Bowel cancer is the second leading cause of cancer death in Waltham Forest, and improved screening uptake could contribute towards early detection of bowel cancer and reducing the number of deaths caused.

Bowel screening age extension (70 to 74 years old)
Currently people aged 60 to 69 years are eligible for the national bowel screening programme. Age extension will increase the age range from 60 to 74 years.

Age extension ‘roll out’ began in April 2010. The age extension roll out at each screening centre is controlled by the National Office and London Quality Assurance Reference Centre (QARC). The requirements for implementing age extension are:

• The local area has completed two years of screening i.e. they are in the recall phase
• The Screening Centre has demonstrated that they have the capacity to provide the age extended service along with the existing workload in screening and diagnostic service
• The Hub has the capacity to deal with the increased administrative and laboratory work and the necessary space.
In Waltham Forest age extension was due to roll out in 2011/12 but since bowel screening is commissioned as a sector across North East London some sections of the sector did not meet the criteria and London QARC advised that age extension be postponed until the whole sector meets the criteria.

**Effective interventions**

Overall, the most plausible drivers for improved cancer survival appear to be presentation and diagnosis at an early stage, including through effective screening programmes, access to optimal treatment and improvements in the management of older people\textsuperscript{306}.

**Table 6.5** Evidence base for effective interventions

<table>
<thead>
<tr>
<th>Work area</th>
<th>Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevention</td>
<td>Improved outcomes in cancer can be achieved by tackling cancer risk factors such as smoking, obesity, physical inactivity and excessive alcohol consumption. It is estimated that about a third of cancers could be prevented by eating a healthy diet, being physically active and maintaining a healthy weight\textsuperscript{332}.</td>
</tr>
<tr>
<td>Screening</td>
<td>Targeted outreach, health promotion and cancer awareness has been shown to be effective in increasing screening uptake: Provision of culturally and linguistically appropriate cancer awareness in targeted venues like grocery shops\textsuperscript{333}. Provision of tailored print intervention (newsletter/booklet) and telephone counselling\textsuperscript{334}. Active follow up of DNAs through telephone calls, text messaging, letters offering second time appointments or recommending screening when eligible persons attend clinics\textsuperscript{335}. Client reminders, particularly telephone calls\textsuperscript{336}. Provision of flexible appointment times to meet client needs and easy means to change appointments\textsuperscript{337}.</td>
</tr>
<tr>
<td>Population awareness</td>
<td>The Healthy Communities programme supports community volunteers to work in partnership with primary care staff and other specialist cancer service providers, in both statutory and voluntary sectors, to lead improvement locally. Community members and professionals are taught to use improvement tools to identify what can be changed to make an improvement, and then to measure that improvement. Outcomes include not only improvement in a specific topic area, but benefits to the individual volunteers and to the community itself\textsuperscript{338}.</td>
</tr>
</tbody>
</table>


\textsuperscript{310} Approaches to improving breast screening uptake: evidence and experience from Tower Hamlets; KW Elieb, K Carroll, J Peach, S Khatoon, I Basnett and N McCulloch; British Journal of Cancer 101(S2), S64 – S67 (2009).

\textsuperscript{311} Interventions to increase the uptake of Cancer Screening: Guideline recommendations; M Brouwers, C De Vito, A Carol, J Carroll, M Cotterchio, M Dobbins, B Lent, C Levitt, N Lewis, S E McGregor, L Paszat, C Rand and N Wathen; Cancer Care Ontario; 26 March 2009.

\textsuperscript{312} Why Islington women do not attend for breast screening; Dr Edwina Affie; 29 September 2009; Cancer Inequalities Workshop.

\textsuperscript{313} Lyon D, Knowles J, Slater B and R Kennedy Improving the early presentation of cancer symptoms in disadvantaged communities: putting local people in control.
### Best practice early detection commissioning pathways: summary of recommendations

#### Table 6.6 Ovarian cancer

**Recommendation**

Due to the risk of false negatives associated with the CA125 test, the London early detection best practice commissioning pathway recommends both Ca125 and trans vaginal ultrasound should be undertaken concurrently with referral to secondary care if either is positive.

If it is not clear where the symptoms originate from, the GP should consider referring along a colorectal pathway.

#### Table 6.7 Colorectal cancer

**Recommendation**

Reduction of the threshold age for referring new onset colorectal symptoms from 60 years of age in 2013-2014 to 55.

To reach a rapid definitive diagnosis, GPs should refer the patient to a ‘Diagnostic service’, a designated referral centre which will triage referrals and assign the most appropriate diagnostic test. This test will be booked directly with the patient.

#### Table 6.8 Lung cancer

**Recommendation**

Chest X-Ray reports should be returned to the GP ideally within three days and no more than five working days. GPs should receive a clinic letter containing appropriate information.

It is recommended commissioners refer to the guidance issued by NICE on communication; emphasis on improved communication is included in the updated 2011 NICE guidance.

A lung cancer Clinical Nurse Specialist is available at all stages of care to support patients and carers.

GPs should use every opportunity to discuss smoking with their patient and direct those who want to give up to specialist stop smoking services and/or offer pharmacotherapy to support any quit attempt.

Primary care, secondary care and pharmacy staff to be trained in Very Brief Advice (VBA) for smoking cessation.

All GP surgeries should ensure there is a relationship/links to the local stop smoking service so that smokers can be referred swiftly and appropriately.

#### Table 6.9 Endoscopy commissioning strategy

**Recommendation**

CCGs should only commission endoscopy from Joint Advisory Group on GI Endoscopy (JAG) accredited providers whether NHS or private sector. Where units are not currently JAG accredited, they must be able to show they are on the journey to achieving JAG accreditation (which can take two years).

Barium enema is not to be used as a first line diagnostic for suspected colorectal cancer.

Surveillance for symptomatic patients must ensure consistent approach to recall of patients so that no patient misses a recall for repeat endoscopy. CCGs should commission repeat endoscopy as per the national guidelines set out by NICE.339

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What is being done locally?

Local projects

Table 6.10 below provide a summary of the recent and some ongoing cancer projects/initiatives.

Table 6.10  Cancer projects indicate which projects are local/network/national etc. in the table

<table>
<thead>
<tr>
<th>Name</th>
<th>Provider</th>
<th>Timeframe</th>
<th>Objectives</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Be Clear on Cancer – Bowel</td>
<td>DH</td>
<td>30 January to end of March</td>
<td>• Increase cancer awareness and early presentation.</td>
<td>The campaign advertisements featured on TV and the radio and in other national media. The campaign message is that ‘loose poo’ and ‘blood in poo’ for more than three weeks can be symptoms of bowel cancer and anyone with these symptoms should visit their doctor; and that catching cancer early makes it more treatable.</td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
<td>2012</td>
<td>• Contribute to early diagnosis.</td>
<td></td>
</tr>
<tr>
<td>Be Clear on Cancer – Lung</td>
<td>DH</td>
<td>8 May to 30 June, 2012</td>
<td>• Increase cancer awareness and early presentation.</td>
<td>Adverts on national TV and radio, and in publications aimed at specific communities, for example Asian radio stations. Events in public areas, like shopping centers, to raise awareness and prompt people with possible symptoms to see their GP.</td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
<td></td>
<td>• Contribute to early diagnosis.</td>
<td>Campaign message was if you have a cough for 3 week see your GP.</td>
</tr>
<tr>
<td>Name</td>
<td>Provider</td>
<td>Timeframe</td>
<td>Objectives</td>
<td>Comment</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>-------------------------------</td>
<td>-------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Bowel Cancer Screening Awareness Heart in the community | Social Action for Health (SAFH) | April 2012 to March 2013 | 1. Community Health Champion Recruitment and Training  
2. Holding awareness raising stalls  
3. Identification of community groups  
4. Deliver community awareness sessions  
5. Work with clinical teams and GPs to determine their needs around bowel cancer screening and support them in how best to disperse the messages to local people  
6. Evaluation of the impact of the intervention | April – September 2012 the focus has been on delivering the first three delivery objects and setting up plans for the objectives 4-6 to be delivered in October 2012 – March 2013 |
| Bowel stretch campaign                    | BIG Bowel                     | Sept 2012 to March 13 | Raise awareness of bowel cancer  
Increase uptake of screening  
Increase early diagnosis | Deliver two events: in Leyton Orient Football Club Selborne mall |
<p>| Be clear on cancer                        | DH                            | Jan 2012           | Raise awareness in bowel and lung cancer and increase early diagnosis | Deliver six small events in the community |</p>
<table>
<thead>
<tr>
<th>Name</th>
<th>Provider</th>
<th>Timeframe</th>
<th>Objectives</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Know 4 sure</td>
<td>DH</td>
<td>Jan 2013</td>
<td>Raise awareness in all cancers</td>
<td>Work with GPs and pharmacies</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Increase early diagnosis</td>
<td></td>
</tr>
<tr>
<td>Practice Visit</td>
<td>CRUK</td>
<td>Ongoing</td>
<td>Cancer Research UK (CRUK) primary care engagement facilitator for Waltham Forest visit practices to embed best practice in cancer screening and engage clinicians in early diagnosis.</td>
<td></td>
</tr>
</tbody>
</table>

**National cancer outcome indicators**
Cancer outcomes are mentioned as indicators in both the NHS and public health outcomes framework. This includes:

- Public Health Outcomes Framework:
  - Cancers diagnosed at stage 1 and 2
  - Mortality from cancer.

- NHS Outcomes Framework:
  - Under 75 mortality rate from cancer
  - One and five-year survival from all cancers
  - One and five-year survival from breast, lung and colorectal cancers.

**Risks to local delivery**
With the restructuring of the NHS the main risk to service delivery is financial constraints and loss of staff. The merging of Whipps Cross with Barts Health will also influence how services are commissioned and delivered in the future; which might include some of local services being provided in a more centralised location.

**Priorities for the next five years**
The priority for cancer commissioning should be to improve survival through early presentation and early detection. This is a three pronged approach:

1. Targeting the public to increase awareness of cancer symptoms.
2. Support primary care improve access to diagnostic services, GP awareness of symptoms and referral pathways.
3. Building capacity and quality of services in secondary care.
There are a number of challenges in reducing cancer morbidity, mortality and increasing survival. These include:

- Increasing screening coverage/uptake in the breast, bowel and cervical cancer screening programmes
- Tackling lifestyle-related cancer risk factors particularly smoking, obesity, physical inactivity and excessive alcohol consumption
- Addressing factors that contribute to late presentation for diagnosis and limited awareness of cancer symptoms amongst front line clinicians
- Implementing age extension for both bowel and breast screening programmes.

**Recommendations**

- Continued investment in early diagnosis through targeted community outreach work, GP training and increasing access to diagnostics e.g. flexible sigmoidoscopy and x-ray
- Develop targeted interventions for those who do not participate in screening programmes to increase screening uptake e.g. active follow up of DNAs through telephone calls, text messaging, letters offering second time appointments or recommending screening when eligible persons attend clinics
- Address cancer risk factors such as smoking, obesity, physical inactivity and excessive alcohol consumption e.g. by ensuring GPs and hospital clinicians have easy access to stop smoking services, why weight programme to refer patients; provide IBA training for frontline staff and encourage people to use leisure centres that provide a wide range of physical activities
- Implementing age extension for both bowel and breast screening programmes
- Implement systems to facilitate completes in recording stage of diagnosis.

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315 Approaches to improving breast screening uptake: evidence and experience from Tower Hamlets; KW Elbert, K Carroll, J Peach, S Khatoon, I Basnett and N McCulloch; British Journal of Cancer 101(S2), S64 – S67 (2009).
6.3 Cardiovascular disease (CVD)

Executive summary
CVD is the biggest killer in the London Borough of Waltham Forest and causes 24% of premature deaths (75 years and under). It is the main contributor for health inequalities between Waltham Forest and England. The borough has a higher burden of lifestyle risk factors for circulatory disease which includes smoking, physical inactivity, higher level of alcohol intake, unhealthy eating and obesity. Up to 19 in every 100 deaths from Coronary Heart Disease (CHD) are associated with smoking. Socio-economic deprivation is strongly associated with CVD prevalence and outcomes. There are significantly higher death rates in the most deprived wards compared to other parts of the borough. The premature (under 75 years) death rate for women in Waltham Forest is 56% higher than the national rate for CHD, and is fourth highest out of all London boroughs. As the local population ages, increasing demands will be made on health and social care needs. It is predicted that the highest increase in population over the next 20 years will be for men and women over the age of 50 with an estimated increase of 34% from 57,900 to 79,100 people.

Introduction
CVD, also called circulatory disease, describes a group of diseases which are caused by blockage or rupture of blood vessels. CVD embraces a range of conditions including atherosclerosis (blocked arteries), high blood pressure (hypertension), atrial fibrillation (AF), cerebro-vascular disease (stroke), aortic aneurysm (ballooning of the main artery) and peripheral vascular disease (PVD), which usually involves blockage of the blood supply to the legs. CVD is the number one killer and the main cause of premature deaths nationally and locally. It is also the main contributor to the health inequality gap between Waltham Forest and England accounting for 34% of the life expectancy gap for men compared to 29% for women. Socio-economic deprivation is strongly associated with CVD prevalence and outcomes. Hypertension is one of the most important predictive risk factors in the development of CVD particularly CHD and stroke. Atrial Fibrillation and Type 2 Diabetes (T2DM) are also well known risk factors.

The two most important causes of CVD death are CHD and stroke. The precursors of these include angina (chest pain) and hypertension (high blood pressure). The main risk factors for CHD and stroke are high blood lipid levels, smoking, obesity, hypertension, diabetes, physical inactivity and high alcohol intake. People aged over 65 years are most at risk, but strokes and heart attacks can affect people of any age, including children. Some ethnic groups such as South Asians and the Black African and Black Caribbean groups have a higher risk due to a genetic predisposition towards some of the key risk factors such as diabetes and hypertension.

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317 http://www.nhs.uk/conditions/Cardiovascular-disease/Pages/Introduction.aspx
319 http://www.lho.org.uk/LHO_Topics/Analytic_Tools/HealthInequalitiesInterventionToolkit.aspx
Local picture

Demographic predictions
Increasing numbers of older people over the next decades will mean more complex health and social care needs. By 2031 42% of all people aged over 50 are projected to be of minority ethnic background. This has significant implications for the health and social care economy as these groups are at a greater risk of developing CVD compared to the general population.

These will lead to significant increase in the numbers of people with long-term limiting illnesses such as cardiovascular disease and diabetes. Data indicate that females survive longer and outnumber males from the age of 65 onwards in the local population. This has implications as older women are more at risk of poverty, given shorter employment histories and pension contributions.

Mortality rates

CVD all age mortality rates
All age CVD mortality rate in Waltham Forest (2009–11) was 170.6 per 100,000. This is significantly higher than England (155.6) and London (151.3). Male CVD mortality rates in Waltham Forest are significantly higher than female CVD mortality rates (217.7 and 135.7 respectively). The mortality rate in 2009–11 for persons who live in the most deprived areas of Waltham Forest was 230.7 per 100,000. This is 1.9 times greater than the mortality rate for persons who live in the least deprived areas of Waltham Forest. The variation observed in England and London are lower at 1.8 and 1.6 respectively.322

CVD related premature mortality in Waltham Forest
The Public Health Outcomes Framework has an objective of reducing the numbers of people dying prematurely, while reducing the gap between communities. One of the key indicators for this objective is early mortality from CVD.

CVD accounts for nearly one-fourth (23.7%) of all premature deaths in Waltham Forest which is not significantly different from England average. Similarly, the premature CVD death rate under 75 (directly standardised) in Waltham Forest is 58.0/100,000 not significantly different from England in 2009–11.323 However, the equivalent figure for over 75 is significantly higher than England.

• In 2014 the early CVD mortality rate in Waltham Forest for persons under 75 years is predicted to be 62.8, which would be a 10 year decrease of 45.3% from 2004. The early CVD mortality rate for England is predicted to be 50.1, a ten year decrease of 44.2% and the London rate is predicted to be 51.2, a 10 year decrease of 46.6%. Local initiatives need to be in place to achieve these outcomes considering the groups who are most affected.324

• Waltham Forest experienced 62.2% decline in under 75 CVD death rate from the baseline (1995–97). However, the inequality gap in mortality rates widened by 42% between 2001–09. Figure 6.11 below demonstrates the continuing gap between the rich and the poor in Waltham Forest where Most deprived wards, Leyton, Lea Bridge and Higham Hill experienced rates twice that of the least deprived wards including Larkswood and Endlebury.

322 Cardiovascular disease health profile for Waltham Forest 2013; SEPHO.
323 Cardiovascular disease health profile for Waltham Forest 2013; SEPHO http://www.sepho.org.uk/NationalCVD/atlas/atlas.html
324 Cardiovascular disease health profile for Waltham Forest 2013; SEPHO.
CHD and stroke related premature death rate (directly age standardised) in Waltham Forest during 2009/2011 is 65.7/100,000 and not significantly different from the national rate. However, mortality rate within 30 days of an ST elevated Myocardial Infarction (STEMI) is significantly higher than the national rate 15.1 vs 8.7/100,000 for 2009-2011 within LBWF. Premature death rate for stroke in Waltham Forest is similar to the rate reported for England in 2011 (DSR per 100,000 Persons less than 75: England – 34.5; Waltham Forest – 36.3).325

**Detection of CVD in Waltham Forest**

Lower rate of detection of most CVDs including CHD, TIA/stroke, hypertension, atrial fibrillation (AF) and heart failure across the borough (compared to estimated number) in 2009/10 is an important public health concern:

- Only 34.5% % of CHD is detected and is significantly lower than the detection rate of 58.2% in England and 47.0% for London
- Only 34.1% of TIA/stroke are detected locally and is almost half of the rate of England and much lower than London (52.6%)
- Only 38.8% of hypertension is detected locally and compares to 46.0% for England and 41.5% for London.

Waltham Forest has a higher burden of main lifestyle risk factors for circulatory disease which includes smoking, physical inactivity, higher level of alcohol intake, unhealthy eating and obesity.

325 National Clinical Health Outcomes Database.
Specific CVD conditions

Coronary Heart Disease (CHD)

CHD is a condition where the arteries of the heart muscle become narrowed and blocked, starving it of oxygen. CHD manifests as angina and heart attack. CHD accounts for the majority of circulatory diseases and is the single most common cause of premature death in the UK326.

Chest pain-related service use

In the UK, up to 1% of visits to a GP are because of chest pain. Approximately 5% of visits to the emergency department and up to 40% of emergency hospital admissions are because of chest pain. Conditions causing chest pain, such as acute coronary syndrome (myocardial infarction or unstable angina) or stable angina, have a potentially poor prognosis. Fast and accurate diagnosis of chest pain or discomfort caused by these conditions is essential so that treatment can be offered quickly. Quick recognition of the symptoms followed by calling 999 means that heart attack survivors can be treated faster, which is an imperative as that results in better outcomes. This means that heart attack survivors are likely to return to their normal day-to-day activities.

Public Health England (PHE) is working to raise awareness of the signs and symptoms of heart disease to educate the public by running campaigns such as Act FAST and trialling new campaigns327. This is timely as the qualitative research undertaken locally showed that most people were not aware of other signs and symptoms of heart attack other than chest pain.

CHD related premature death rates in Waltham Forest

Figure 6.12 Standard mortality ratio (SMR) 2006–10 CHD at ward level (deprivation ranking) in people less than 75 years

Similar to the gap in mortality between most deprived Cathall, Lea Bridge and Higham Hill experienced around 70% higher rates compared to less deprived Hale End and Highams Park (Figure 6.12 above).

327 Cardiovascular Disease Outcomes Strategy (DH) March 2013.
Local picture of CHD

The incidence of CHD is higher amongst men, the elderly and in the more deprived areas. Based on GP registers, there are 6114 CHD patients with a prevalence of 2.1% (QOF 2011/12).328

### Table 6.11  Actual prevalence (QOF 11/12) of CHD in NHS Waltham Forest by localities

<table>
<thead>
<tr>
<th>Waltham Forest</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chingford</td>
<td>1,790</td>
<td>2.8%</td>
</tr>
<tr>
<td>Leytonstone</td>
<td>1,981</td>
<td>1.8%</td>
</tr>
<tr>
<td>Walthamstow</td>
<td>2,343</td>
<td>2.0%</td>
</tr>
<tr>
<td>Waltham Forest</td>
<td>6,114</td>
<td>2.1%</td>
</tr>
</tbody>
</table>

Source: HSCIC Health and Social Care Information Centre, QOF 2011/12.

There is a wide variation in the prevalence across practices, ranging from 0.3% to 4.7%.329 Detected prevalence across the borough (3.4%). Patients with CHD who are not diagnosed are more likely to suffer disease progression and premature death.

CHD related premature death rate in Waltham Forest is similar to the national average for both males and females (67.47 vs 26.26, 2008–10). There has been a decline in the premature deaths due to CHD from 1993 to 2010330 in both sexes. The rate of decline is however slower than London and national rates.

CHD mortality is not distributed evenly across Waltham Forest where the more deprived wards experience higher mortality. CHD premature mortality (171.6 per 100,000) in Cathall and Lea Bridge wards were the highest across the borough and significantly higher than the national rate. Compared to less deprived Hale End and Highams Park (96.8) and Hatch Lane (96.8) Wards, the rate reported for both Cathall and Higham Hill were around 75% higher.

### Mortality for Acute Myocardial Infarction (AMI)

In 2008–10, the premature death rate significantly higher locally compared to the national rate (24.76 and 15.2 per 100,000 population respectively).331

### QOF performance 2011/12 provisional

PCT targets have been achieved for all the CHD related QOF indicators. However, there is wide variation across practices. Higher exception rates reported by some practices also influence clinical outcomes for some groups of patients. The outlier practices need to be supported to improve quality of care and reduce inequalities. Work is already underway through the Waltham Forest CVD Board to visit and support practices to reduce variation.

### Local progress

In the UK, up to 1% of visits to a GP are because of chest pain (Nilsson et al. 2003). Approximately 5% of visits to the emergency department and up to 40% of emergency hospital admissions are because of chest pain.

A rapid access chest pain clinic is run at Whipps Cross University Hospital where GPs could refer patients directly to avoid the delay in treatment. Development of evidence-based user friendly referral protocols and increased awareness among GPs combined with public awareness of symptoms of heart disease are likely to improve efficiency and outcomes.

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328 HSCIC – Health and Social Care Information Centre, QOF data 2011/12.
329 HSCIC – Health and Social Care Information Centre, QOF data 2011/12.
330 National Clinical Health Outcomes Database.
331 Ibid.
**Emergency admissions rate for CHD**

The emergency (or non-elective) admission rate for CHD in Waltham Forest has decreased by 19.7% between 2004/05 and 2011/12. This rate of decline is lower compared to London and national rates. Similar to previous years, the rates for males and females in 2011/12 were 313.1 versus 146.5 per 100,000, which was significantly higher compared to the national rate of 279.9 versus 124.6. Cathall had the highest emergency admissions for CHD and MI across all wards in the borough in 2011. High percentage of emergency admissions may reflect some patients not accessing or receiving the care most suited to managing their conditions. This indicates the need for timely diagnosis of undetected patients in the community.

**Angiography and surgical procedures for CHD**

Angiography is the radiographic visualization of the blood vessels after injection of a radiopaque substance. This is undertaken to identify blocked heart arteries before corrective surgery as part of management. Heart conditions that are too complex to manage through lifestyle change and condition management require surgical procedures. The two main interventions (referred to as revascularisation) for treating heart disease are Coronary Artery Bypass Graphs (CABGs) and angioplasty, which is also known as a Percutaneous Coronary Intervention (PCI). Complex cases in which one or more arteries are blocked are commonly treated using CABG, rather than a PCI, which is a less invasive procedure. Both angiography rates revascularisation rates in Waltham Forest were significantly higher compared to national rate. Revascularisation rates for persons who live in the most deprived areas of Waltham Forest are 1.4 times greater than those who live in the least deprived areas. This indicates the relatively higher occurrence of cardiac events among more deprived communities incurring extra cost to the local health and social care economy.

**Trend in non-elective angioplasty and CABG**

Non-elective angioplasty rates in Waltham Forest have increased by 88% between 2004/05 and 2011/12. Elective procedure rates have decreased by 0.1%. In England and London non-elective procedure rates have increased by 74.8% and 19.1% respectively. Elective procedure rates have decreased by 15.7% and 18.4% respectively.

CABG procedure rates in Waltham Forest have increased by 21.8% between 2004/05 and 2011/12. In England and London CABG procedure rates have decreased by 25.4% and 18.1% respectively.

**Cardiac rehabilitation**

Waltham Forest residents benefit from a dynamic cardiac rehabilitation service that operates through Whipps Cross University Hospital and provides a range of specialist exercise programmes. Patients are contacted within 48 hours of receiving the referral from the specialist tertiary centres. All clients are invited to the Phase 3 programme within 6 weeks post surgery, 4 weeks after a Myocardial Infarction, and 2 weeks after a PCI (angioplasty).

Patients with acute coronary syndrome, myocardial infarction and CABG are the most common types of patients participating in the programme. Approximately 50 patients receive home-based programmes. The service currently accepts patients with varying levels of heart failure. Numbers are limited as this client group require greater vigilance during exercise sessions. The service would need to expand its staffing and resources to enable the greater vigilance required of this group of patients with heart failure. Limited accessibility to heart failure is a national issue as well and is highlighted in the CVD Outcome Strategy as an important unmet need that needs to be addressed.

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332 Cardiovascular disease health profile for Waltham Forest 2013; SEPHO.
333 Ibid.
334 Ibid.
335 Cardiovascular Disease Outcomes Strategy (DH) March 2013.
Evidence-based interventions
Waltham Forest CVD Board developed and agreed the local care pathway for chest pain to align with the NICE clinical guideline CG95 on Chest pain of recent onset on assessment and management of patients with Chest Pain of recent onset published in October 2011. The current outpatient referrals on chest pain are being benchmarked across practices to reduce variation and ensure adherence to pathway when making referrals to acute care:

- Studies have shown that if lifestyle targets for primary prevention of CHD are met, approximately 75,000 CHD events would be prevented per year nationally, with the greatest gain coming from reduced blood pressure levels. Therefore, reducing hypertension (elevated blood pressure) is a prime prevention target for reducing CHD.

Stroke
A stroke occurs when the blood supply to a part of the brain is suddenly cut off. This may be due to a blockage in a blood vessel or when a blood vessel in the brain bursts, spilling blood into the spaces surrounding the brain cells. This can leave lasting damage, affecting mobility, cognition, sight or communication.

A transient ischaemic attack (TIA) is a minor stroke lasting less than 24 hours, which is often an important warning sign of a more serious stroke, heart attack or other vascular event. The risk of stroke in the first 24 hours after TIA is higher than the risk of a heart attack after an episode of chest pain.

The risk of stroke increases with age but the most important risk factor amenable to intervention is hypertension. Other important risk factors include a previous TIA, atrial fibrillation, diabetes, smoking, obesity, poor diet (including high salt intake) and high alcohol intake.

People aged over 65 years are those most at risk. There is also a higher risk of stroke for people in the black African and black Caribbean ethnic groups due to a genetic predisposition towards some of the key risk factors such as hypertension and diabetes. Stroke rates for this group are twice that for whites. On average black people experience their first stroke at 61 years, while White people about twelve years later at aged 73.

Stroke: the local picture
In Waltham Forest there are estimated to be 370 strokes per year. In 2011/12, the prevalence for stroke/TIA in Waltham Forest was 0.91% compared to the national prevalence of 1.74%. The observed prevalence for stroke in Waltham Forest is 34.1% of the estimated prevalence. This compares to 68.4% for England and 52.6% for London.

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342 ASSET for Commissioners Version 2.00b Sep 2009 (www.dh.gov.uk/stroke/ASSET).
344 National Clinical Health Outcomes Database.
345 Cardiovascular disease health profile for Waltham Forest 2013; SEPHO.
Table 6.12  Actual prevalence (QOF 2011/12) of TIA/stroke in NHS Waltham Forest by Clinical Commissioning Groups (CCGs)

<table>
<thead>
<tr>
<th>CCG</th>
<th>Number</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chingford</td>
<td>874</td>
<td>1.4%</td>
</tr>
<tr>
<td>Leyton Leytonstone</td>
<td>795</td>
<td>0.7%</td>
</tr>
<tr>
<td>Walthamstow</td>
<td>997</td>
<td>0.8%</td>
</tr>
<tr>
<td>Waltham Forest</td>
<td>2,666</td>
<td>0.9%</td>
</tr>
</tbody>
</table>

Source – HSCIC, Health and Social Care Information Centre.

A high level of under detection of stroke/TIA is a significant unmet need. Given the high level of deprivation and a higher percentage of black Caribbean, black African and South Asians in Waltham Forest, one would expect a higher prevalence.

Gaps in knowledge of signs and symptoms of CVD

Focus groups with local communities that discussed CVD prevention in July 2011 highlighted that the high risk groups were not only unaware of the term TIA or mini-stroke but also have not heard of the signs or symptoms of TIA. However, they were well informed about the stroke signs and symptoms as a result of the FAST national campaign.

The estimated number of people living with moderate or severe disability following a stroke in 2010 is between 878 and 960, which demonstrates long-term impacts on the quality of life for those affected and their families and also on the social care budget.

Stroke is the third biggest killer in England and the main cause of adult disability. A similar picture exists in Waltham Forest. In 2011, the indirectly standardised mortality rate (SMR) in persons under 75 years for was 36.3 per 100,000 population, which was similar to the rate reported for England (34.5). This is an improvement since 2007–09 reported rates.

Figures 6.13 and 6.14 show an overall downward trend in the mortality rates reported from 1993 to 2009 for England and London. Small numbers make it difficult to establish a trend in Waltham Forest, although it is generally going down.

Figure 6.13  Stroke-related mortality among men 1998–2011

Source: SEPHO Cardiovascular Disease Interactive Atlas.

347 Health and Social Care Information Centre (HSCIC).
Stroke of the optic nerve (eye stroke)
An eye stroke, or anterior ischemic optic neuropathy, is a dangerous condition in which blood flow either becomes blocked or reduced to the tissues of the front part of the optic nerve. An eye stroke can cause sudden loss of vision.

Causes of eye stroke
Eye stroke is caused by poor circulation in the blood vessels that supply the front portion of the optic nerve.

Risk factors of eye stroke
Eye stroke is more common in middle-aged people and the elderly. Approximately 10% of patients that are affected with anterior ischemic optic neuropathy are under the age of 45. Cardiovascular disease raises your risk for developing the disease. Therefore adequate management of risk factors including high blood pressure, cholesterol and diabetes become key to prevention of eye stroke.

Primary Care Service provision related to stroke in Waltham Forest
The quality of care a patient receives in primary care has a direct impact on his/her risk of developing another stroke or cardiovascular event. Approximately 25% of people who recover from their first stroke will have another stroke within five years. The risk of having a second stroke is greatest within 30 days of the first one. A third of recurrent strokes take place within two years of the first stroke. Recurrent strokes are a major contributor to disability and death. The risk of severe functional restriction or death increases with each stroke recurrence348. Therefore secondary prevention interventions following a stroke event are crucial to prevent further events. A number of QOF indicators are in place to monitor the quality of these interventions delivered through primary care.

Emergency admissions for stroke
Stroke related emergency admissions rate in Waltham Forest in 2011 was 127.3 a reduction from 2009. However, this rate remains to be significantly higher than the figure of 89.5 observed nationally and in London (100.3 per 100,000). Effective interventions such as detection and management of high risk groups for CVD and proactive referral of suspected TIA to well equipped TIA clinic at Whipps Cross University Hospital for timely management need to be strengthened within the borough through the CVD board and multi-stakeholder partnership. These are significant partially met needs locally.

Figure 6.14 Stroke-related mortality among women 1998–2011

Source: SEPHO Cardiovascular Disease Interactive Atlas.

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Stroke Rehabilitation in Waltham Forest

Rehabilitation services following a stroke is an evidence-based intervention that improves the quality of life and reduces mortality due to stroke. Local stroke rehabilitation for many patients begins in secondary care on an inpatient basis. Waltham Forest stroke care specialists participate in a sector wide initiative to maintain and raise rehabilitation standards, ensuring that residents who have had a stroke receive inpatient rehabilitation that meets 17 quality of care indicators. The Waltham Forest service performs extremely well against these indicators assessed in 2011, ensuring that patients will:

- Have access to a specialist inpatient rehabilitation unit with specialist multi-disciplinary teams
- Are assessed by all relevant members of the rehabilitation team including Occupational Therapists, Speech and Language Therapists, and receive psychological assessment
- Be involved in negotiating their rehabilitation goals and receive a copy of the goals within five days of admission
- Receive appropriate seating, posture and position advice within 24 hours of admission to the stroke unit
- Be allocated a named key or support worker within seven days of admission
- Offered a minimum of 45 minutes active therapy for a minimum five days a week if appropriate
- Have a joint care plan on discharge from hospital.

Stroke discharged to place of residence

In Waltham Forest, the percentage of stroke suffers who were discharged from hospital to their usual residence was significantly lower (60.3%) than the national rate of 77.9%.

Follow up of patients with stroke after discharge

Following their discharge from the Whipps Cross University Hospital (WXUH) Stroke unit all patients are reviewed by the team at 6 weeks and at 6 months. The Stroke Service runs a multidisciplinary Spasticity service, wherein a Stroke Consultant Physician assesses the patient along with his Multi Disciplinary Team and optimises their spasticity management which includes Botulinum toxin injections into spastic muscle groups. Following their Botulinum toxin injections patients are reviewed by the treating therapist for further rehabilitation including consideration for splints and training for suitable set of exercises. This care pathway needs to be developed further to improve access to all eligible people.

Hyper Acute Stroke Unit (HASU) pathway for acute stroke in Waltham Forest

Residents in Waltham Forest benefit from the North East London HASU pathway available 24 hours a day, 7 days a week. HASU Referral pathway is available for urgent referral to The Royal London Hospital's HASU for acute stroke patients.

Early supported discharge

Early supported discharge (ESD) is proven to improve outcomes in stroke survivors. QIPP evidence supports the development of ESD services as recommended interventions to improve quality and cost-effectiveness. A community stroke rehabilitation team currently operates through the acute stroke unit at Whipps Cross University Hospital to support stroke survivors immediately following discharge from hospital. The Community Stroke Team service has been redeveloped and now provides full Early Supported Discharge and appropriate six month follow-up. This includes a Community Clinical Stroke Nurse Specialist and project management support. Long-term support is also required following initial home or community-based rehabilitation. Estimates for the people with long-term conditions due to stroke indicates a high level of need. This needs to be further developed and agreed pathways agreed with the specialist Stroke Team at WXUH.

Table 6.13  Number of people aged 18–64 predicted to have a longstanding health condition caused by a stroke

<table>
<thead>
<tr>
<th></th>
<th>2012</th>
<th>2014</th>
<th>2016</th>
<th>2018</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number (aged 18+) predicted to have stroke</td>
<td>408</td>
<td>422</td>
<td>435</td>
<td>445</td>
<td>455</td>
</tr>
</tbody>
</table>


**Support to stroke survivors and carers in the community**

*Life After Stroke Service* – Stroke Service Stroke Navigator and Communication Plus Services provide a single point of access for stroke specialist advice, support, reviews and help to coordinate complex discharges. The service also provides 1:1 community-based support to Aphasia.

**Supported activities to disabled, socially isolated and vulnerable adults/older people in Waltham Forest**

The activities provided include sports, health and wellbeing activities, Independent living skill training, Arts and Crafts. In 2012/13 over 143 stroke survivors were supported in the community to improve their quality of life and personal dignity both the stroke navigator and communication plus support services.

Service is based at the North Resource Hub, however, activities take place at different location throughout the borough. Stroke Navigators also visit service uses in their own home to over personalised support.

Patients also benefit from the Waltham Forest Stroke Support Group at Longfield House, in Walthamstow. In addition older patients receive support from the LBWF including meals on wheel.

**Evidence-based interventions**

There is considerable scope for preventing strokes by addressing the key risk factors such as smoking, hypertension and excessive salt consumption.

The National Stroke Strategy sets out a framework of quality markers for raising the quality of stroke prevention, treatment; care and support over the next decades. This includes 11 key themes relating to prevention, early identification, acute care, rehabilitation and involvement of service users.

Most recent NICE Guidance (June 2013) offers evidence-based advice on the care of adults and young people aged 16 years and older who have had a stroke with continuing impairment, activity limitation or participation restriction. It makes emphasis on rehabilitation care, and to further improve outcomes350. There is ongoing work relating to redesign the spasticity pathway in order to further improve clinical and patient outcomes. This is likely to reduce the social care needs of people by preventing long-term disability and investment to undertake service changes need to be considered a priority.

**Heart failure (HF)**

Heart failure is a clinical syndrome caused by a reduction in the heart’s ability to pump blood around the body. The prognosis is poor and survival rates are worse than, for example, breast and prostate cancer, with a high risk of sudden death. Up to 40% of patients die within the first year of diagnosis. Most cases of heart failure in the UK are due to CHD and about a third result from hypertensive heart disease.351

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350 Stroke rehabilitation, Long-term rehabilitation after stroke(June 2013) NICE clinical guideline 162.

351 Pushing the boundaries, improving services for patients with heart failure, Commission for Healthcare Audit and Inspection 2007.
Heart failure (HF): the local picture

Table 6.14  Actual prevalence (QOF 2011/12) of HF in NHS Waltham Forest by locality

<table>
<thead>
<tr>
<th>Locality</th>
<th>Number</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chingford</td>
<td>463</td>
<td>0.7%</td>
</tr>
<tr>
<td>Leyton Leytonstone</td>
<td>431</td>
<td>0.4%</td>
</tr>
<tr>
<td>Walthamstow</td>
<td>571</td>
<td>0.5%</td>
</tr>
<tr>
<td>Waltham Forest</td>
<td>1,465</td>
<td>0.5%</td>
</tr>
</tbody>
</table>

Data source: The Health and Social Care Information Centre QOF 2011/12.

Heart failure-related admissions

It is important to note that rates of emergency admissions related to heart failure in Waltham Forest were higher than the national rates from 2007/08. In 2011/12 the emergency admission rate for heart failure, all persons, in Waltham Forest was 98.4 per 100,000 (229 admissions). This is significantly higher than England (60.7 per 100,000) and London (80.3 per 100,000).

Figure 6.15  Heart failure emergency admission rates (DSRs), for all ages, 2011/12

Male heart failure emergency admission rates are significantly higher than female heart failure emergency admission rates. The emergency admission rate for heart failure in 2011/12 for persons who live in the most deprived areas of Waltham Forest was 2 times greater than the emergency admission rates for persons who live in the least deprived areas of Waltham Forest (66.2).

Evidence of effectiveness

NICE Guidance, Chronic heart failure provides evidence-based guidance relating to heart failure, which is being implemented in Waltham Forest. In addition NICE Quality Standards on heart failure provide quality standards that needs to be achieved in delivering heart failure related care. QS9 (June 2011). It is important to benchmark the current service to identify areas for improvement across the care pathway.

Guidance Chronic heart failure (CG108 NICE).
Progress made in heart failure service delivery since the previous JSNA

Significant achievements have been made across the heart failure care pathway in Waltham Forest to improve productivity, efficiency and effectiveness as a result of highlighting the need for change in the previous JSNAs (2010/11, 2011/12). These include:

- Establishment of the community-based heart failure specialist service in Waltham Forest
- Introducing Serum Natriuretic Peptides (Serum NP) for suspected heart failure patients to rule out other causes to align with recent NICE Guidance on HF.\textsuperscript{354}

CVD-related risk factors

The main risk factors for CHD and circulatory disease are smoking and obesity and higher levels of disease are associated with areas of deprivation\textsuperscript{355}. It is estimated that about 5% of deaths from CHD in males and 6% of deaths from CHD in females are due to obesity\textsuperscript{356}. Up to 19 in every 100 deaths from CHD are associated with smoking\textsuperscript{357}. Excessive alcohol consumption has been associated with an increased risk of CHD\textsuperscript{358}. Hypertension is one of the most important predictive risk factors in the development of CHD\textsuperscript{359}.

Hypertension

Hypertension is the most common cardiovascular condition nationally and locally. It is the single biggest risk factor for stroke. It also plays a significant role in heart attacks. It can be prevented and successfully treated but only if it is diagnosed and managed appropriately. The Health Survey for England found that Black Africans and Black Caribbean have above average prevalence of hypertension compared with the general population\textsuperscript{360}.

Hypertension (high blood pressure (HBP)): the local picture

Modelled estimates show that prevalence of hypertension across Waltham Forest is about 28\%\textsuperscript{361}.

Recorded prevalence of hypertension in Waltham Forest according to QOF 2011/12 is 10.9\% with 32,173 registered patients in GP registers. The prevalence ranged from 2.1\% to 19\%.\textsuperscript{362} Recorded prevalence in the borough reflects less than 50\% of the modeled prevalence for Waltham Forest.

Hypertension is also linked to diabetes, which is more prevalent among ethnic minorities. However, good management can produce large reductions in Coronary Heart Disease as well as stroke. Additionally adequate control of hypertension is important to prevent heart failure, aortic aneurysm and peripheral vascular disease and chronic renal failure\textsuperscript{363} and visual impairment.

\textsuperscript{354} NICE Guidance on Heart Failure (2010).
\textsuperscript{356} National Heart Forum, 2009.
\textsuperscript{357} National Heart Forum, 2002.
\textsuperscript{358} Poikolainen, 1998.
\textsuperscript{359} (Wilson et al., 1998).
\textsuperscript{360} Health Survey for England 2004.
\textsuperscript{361} Estimates are based on two separate models derived from the Health Survey for England (HSE). These estimates have been produced for APHO by collaboration between the Yorkshire and Humber and Eastern Region Public Health Observatories and Doncaster PCT.
\textsuperscript{362} HSCIC, Health and Social Care Information Centre, QOF, 2011/12.
\textsuperscript{363} Easing the pressure: tackling hypertension: Hypertension: public health burden (HDA 2005).
Uncontrolled hypertension (HBP) can lead to vision loss

- **HBP can strain the vessels in the eyes and the optic nerve**
  High blood pressure can place a strain on the blood vessels in the eyes. HBP can cause the blood vessels to either narrow or bleed when they are subjected to too much blood pressure force. Also, the optic nerve may swell, reducing the ability to see well.

- **Untreated HBP can cause permanent vision problems**
  Using an ophthalmoscope, a healthcare professional can look at the network of tiny capillaries on the retina to evaluate the condition of the blood vessels in the eyes. Managing blood pressure is the only way to treat hypertensive retinopathy. HBP damage is cumulative, so the longer it goes untreated, the higher the likelihood of permanent damage.

- **HBP can cause a stroke which may lead to brain damage causing vision loss**
  High blood pressure can lead to stroke, which, in turn, can impair the optic nerve or damage the area of the brain responsible for processing images.

- **Uncontrolled high blood pressure increases a person’s stroke risk by four to six times. Over time, hypertension leads to atherosclerosis and hardening of the large arteries. This, in turn, can lead to blockage of small blood vessels in the brain. High blood pressure can also lead to weakening of the blood vessels in the brain, causing them to balloon and burst. The risk of stroke is directly related to how high the blood pressure is.**

As mentioned previously, keeping hypertension to a level below 140mmHg systolic BP could prevent 34 strokes in Waltham Forest per annum.

### Atrial fibrillation

Atrial fibrillation (AF) is the term used for a common type of irregular heartbeat and is an important risk factor in stroke, accounting for 14% of all strokes. The annual risk of stroke is five to six times greater in AF patients than in people with a normal heart rhythm. Early treatment of AF with Warfarin, an anticoagulant, reduces risk of stroke by 50 to 70%.

The prevalence of AF in Waltham Forest is 0.7% (same – no change) (2,128 patients in GP registers) with a range of 0.1% to 2.1%.\(^{364}\) This prevalence is lower than the national recorded prevalence resulting in AF going untreated in the population.

**Table 6.15  Actual prevalence (QOF 2011/12) of AF in NHS Waltham Forest by locality**

<table>
<thead>
<tr>
<th>Locality</th>
<th>Number</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chingford</td>
<td>889</td>
<td>1.4%</td>
</tr>
<tr>
<td>Leyton Leytonstone</td>
<td>476</td>
<td>0.4%</td>
</tr>
<tr>
<td>Walthamstow</td>
<td>763</td>
<td>0.6%</td>
</tr>
<tr>
<td>Waltham Forest</td>
<td>2,128</td>
<td>0.7%</td>
</tr>
</tbody>
</table>

Source – HSCIC, Health and Social Care Information Centre.

\(^{364}\) HSCIC, Health and Social Care Information Centre, QOF, 2011/12.
Improved detection and management of patients with AF was a key factor in reducing the burden of stroke in the borough. Detection and treatment of AF in primary care is a published QIPP case study identified as a highly recommended intervention by their peer review process. The programme recommends that opportunistic screening for pulse palpitations of patients over the age of 65, and subsequent treatment using anticoagulation supported by the GRASP tool. A proportion of Waltham Forest residents experience stroke and atrial fibrillation at a younger age, and GP recommend pulse checks to all adults over the age 40 to ensure optimal screening results.

**Evidence-based interventions**

In order to prevent AF related strokes, the recommended course of action is to initiate anticoagulation therapy. When this therapy is appropriately used and monitored, it is highly effective, lowering stroke risk by about two thirds. However, despite the clear benefits of Warfarin and the presence of guidelines for its use and management in stroke prevention, current data indicate that the management of AF is still suboptimal, with many of those receiving anticoagulation not consistently in the optimal therapeutic range.

It is evident from the recorded prevalence of AF that detection occurs at a lower rate than would be expected. The recorded prevalence is currently at 0.7% (same), compared to a recorded prevalence of 1.5% for England. Although the prevalence has remained the same over the past 3 years, the actual number of residents diagnosed with AF has increased from 1,782 in 2006/07 to 2,128 in 2011/12.

**Evidence of effectiveness**

- The treatment of AF with Warfarin reduces risk of stroke by 50 to 70%
- The estimated total cost of maintaining one patient on Warfarin for one year, including monitoring, is £383
- The cost per stroke due to AF is estimated to be £44,000 in the first year after stroke occurrence.

Current anti-coagulant management of AF is sub-optimal. NICE estimate that 46% of patients that should be on Warfarin are not on Warfarin in Waltham Forest:

- 630 is the estimated additional number requiring Warfarin according to NICE guidance
- 25 strokes would be prevented if fully compliant with NICE guidance for prescribing Warfarin to patients with atrial fibrillation.

**NHS Health Checks (NHSHCs)**

Public Health England states that the NHSHC programme is a great opportunity to tackle avoidable deaths, disability and reduce health inequalities in England (PHE 2012). It is a mandated public health programme and the regulations state that LAs must achieve a 100% offer rate in their eligible populations after five years. Recently published National CVD outcome strategy 03/2013 sets out outcomes for people at risk of CVD and the programme will contribute to achieve the following outcome indicators of the NHS Outcome Framework and the public health outcome framework (PHOF).

- Life expectancy at 75*
- less than 75 mortality rate from cardiovascular disease (including CHD and stroke)*
- % of eligible offered Health Check (20% each year).

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366 HSCIC, Health and Social Care Information Centre, QOF, 2011/12.
367 Guidance Chronic heart failure (CG108 NICE).
• Take up rate of 75% by those offered**
• Demonstrate annual improvement in recorded diabetes**
• Smoking Cessation targets**.

* NHS Outcome Framework.
** PHOF.

**Systematically target top seven causes of preventable mortality (Figure 6.16)**
High blood pressure, smoking, cholesterol, obesity, poor diet, physical inactivity and alcohol consumption.

**Figure 6.16 Burden of disease attributable to 20 leading risk factors for both sexes in 2010, expressed as a percentage of UK disability-adjusted life-years**

In addition, NHSHC programme helps to prevent the onset of vascular disease and vascular dementia by supporting changes to and management of behavioural and physiological risk factors.
Local performance on NHSHC programme (uptake as a % of those invited)

Figure 6.17  NHS Health Check programme (uptake as a percentage of those invited)

As shown in Figure 6.16, Waltham Forest did not perform well on outcomes due to a number of gaps in the delivery leading to inequality of access (Figure 6.17). This is likely to further widen continuing inequalities unless appropriate measures are taken to deliver a robust programme with clinical leadership and consultation:

- Not establishing an agreed care pathway locally
- Lack of resources to support practices in smooth implementation of the service
- A number of practices did not sign up to the LES
- Targeted approach to communities living in wards with higher premature death rates and emergency admission rates
- Inconsistency in use of inviting people for checks inequity – not agreed initially
- No process to report or monitor lifestyles referrals and outcomes
- No process to ensure quality (audit/CG element).
Supporting people with cardiovascular disease – what is being done locally to address this issue?

Cardiovascular disease (CVD) is the main cause of long-term disability in adults. The needs and support required varies depending on the needs of the individual. The London Borough of Waltham Forest works with local groups to provide a range of support for people living with CVD and for those who provide their daily care needs, paid and unpaid. POhWER is an advocacy organisation that provides information and advice to help people plan, choose and manage their care needs. Age UK, the Stroke Association and range of local community groups offer services to help people live at home, facilitate rehabilitation and support independence. There are financial planning support services available for people who have been assessed as needing help and decide to pay for their own care and services or have Personal Budgets available to them. These services provide advice and information on how to plan and spend money to achieve the outcomes residents with care needs require.

The local authority has prioritised the needs of people who care for others through the development of single access resource hubs. The hubs will be open in four areas support carers to access independent information, advice and advocacy support, provide emotional support and training to enhance the general wellbeing and independence of carers. Many of the services mentioned above are accessible through the hubs.

Recommendations

Data

- Use Health Analytics to obtain timely data to plan and monitor equity and quality of NHS Health Checks delivery, Atrial Fibrillation, heart failure and TIA/stroke care pathways
- Undertake an in-depth analysis of exception reporting related to CVD to plan appropriate interventions
- Undertake an audit of patients readmitted for cardiac surgical interventions to assess the management of underlying conditions and risk factors
- Establish a process to combine health and social care data for effective and efficient use of resources to deliver specific services.
Quality

- Develop a joint cardiovascular strategy to align with national and London policy/guidance underpinned by local needs and service gaps
- Implement NHS Health Checks with particular emphasis on areas of high mortality and deprivation as a priority with a 6-months review to assess the model of service delivery
- Improve AF care pathway to promote proactive case finding, identify and appropriately manage high-risk patients to improve prescribing of anticoagulants adhering to NICE guidance
- Proactive detection of undiagnosed patients with high blood pressure and improve the percentage of people with controlled blood pressure using targeted outreach work-based on actual/estimated ratio in primary care
- Reduce variation in quality of primary care in CVD by supporting selected practices through benchmarking practices and continuing to support selected practices through practice visits
- Develop a robust plan for education and training of primary care clinicians (sharing best practice that exists within the borough) on a regular basis on identified priorities
- Invest in the development of stroke specific Early Supported Discharge service that incorporates all NICE recommendations, ONEL stroke quality standards and includes the provision of 6-month post-discharge review in appropriate settings
- Develop and agree a local model for improving end of life care pathway for heart failure in partnership with key stakeholders.

Services

- Implement and monitor the community-based specialist HF service combined with appropriate publicity and agreed process of monitoring of referrals to maximise effectiveness of this service
- Tailor long-term support services that assist stroke survivors and their carers to improve confidence, mobility and independence
- Provide support and contribute to the ONEL QIPP integrated care model related to CVD to reduce high impact users i.e. Heart Failure and CHD
- Invest in targeted innovative culturally appropriate social marketing to raise public awareness of early signs/symptoms of heart disease, TIA/stroke, AF and hypertension to encourage seeking early treatment
- Use the findings of the qualitative research undertaken among high risk communities in July 2011 on CVD prevention to inform the above recommendation
- Continue to designate smoking as a priority particularly aimed at deprived communities and those with higher smoking rates
- Work with relevant leads to develop a co-ordinated programme of personalised advice and support services to encourage quit smoking, promote physical activity and sensible drinking and reducing overweight/obesity based on assessed needs.
Priorities for the next five years: gaps and challenges

1. Reduce the continuing inequalities and increasing demand related to CHD and stroke through:
   - provision of a combination of proactive, innovative and culturally appropriate social marketing to address CVD risk factors particularly smoking, hypertension, physical inactivity and high cholesterol targeting wards with higher mortality and admission rates.

2. Address under-detection of CHD, TIA/stroke, hypertension, atrial fibrillation and heart failure which is an unmet need across GP practices through a proactive targeted approach through clinical leadership and community engagement.

3. Ensure NHS Health Checks are implemented with a robust call/recall function and an additional outreach initiative to reduce inequity in service access targeting wards with highest needs.

4. Reduce variation in quality of care for CVD reflected through QOF performance and high exception reporting in certain practices warrants further analysis of exception reporting and appropriate interventions.

5. Redesign the stroke rehabilitation pathway with emphasis on improving timely provision of care for people with spasticity following stroke.

6. Mainstream the community-based specialist heart failure service to sustain improved quality of care and outcomes.

8. Address wider determinants related to CVD to reduce the deprivation related inequalities.

Challenges

- High level of deprivation and cultural diversity remain as big challenges in providing equity in access to services in primary, secondary and community care. Language appears to be a barrier in communicating with health care professionals particularly among unregistered recent migrants.

- Higher level of CVD risk factors (smoking, obesity, physical inactivity) and poor health literacy relating to CVD

- High level of exception reporting in primary care relating to CVD.
6.4 Learning disabilities

Executive summary
People with learning disabilities are among the most vulnerable and socially excluded people in Waltham Forest. They are more likely to:

- have poorer physical and mental health
- have difficulties in accessing health care
- be at risk of abuse and suffer discrimination
- need support to access housing and employment, as more likely to be unemployed compared to the general population
- be at a greater risk of ending up in prison.

There are an estimated 4,514 people with learning disabilities resident in Waltham Forest. Of these, 1,028 have moderate/severe learning disabilities and 78 have challenging behaviours. Also, 741 are currently receiving services from the Community Learning Disability Team.

There is a forecast of an increase in the prevalence of people with learning disabilities over the next 10 to 15 years, with the highest increase being among those with the most severe learning disabilities and additional complex needs. In addition, there is a forecast of an increase in the number of young people with learning disabilities reaching adulthood that will require support from health and social care services between now and 2020.

Data recording in both health and social care are not consistent and this makes it difficult to estimate the number of people with learning disabilities in Waltham Forest who have a specific diagnosis or type of learning disability (i.e. complex needs, including behavioral issues, mental health condition, dual diagnosis and complex physical needs) to enable commissioners to map future needs and plan accordingly.

Health and Social Care commissioners require robust data in order to develop a more holistic knowledge and understanding of the current and the future trends of the learning disability population in Waltham Forest.

The following are the strategic priorities for the Learning Disabilities Service:

- Personalization – Access to good information, advocacy and person centered planning, choice and control to access to self-directed support, and promoting the use of community-based resources
- Supporting Carers to continue in their caring role and to be engaged in development of services
- Ensuring that transition into adult life is smooth and person centered and to improve on the good practice which already exists. A multi-disciplinary transition team was established this year which is working with young people from the age of 14 years, this help to improve the transition pathway for young people
• Protecting people from harm ensuring that the process for safeguarding adults at risk is robust and the needs of people with learning disabilities is recognized with regards to Community Safety. An action plan has been developed in relationship to the Winterbourne View recommendations

• People living in settled accommodation in the community

• Supporting people to gain meaningful employment

• Good Health and access to health services. A joint report by the learning disability service and Public Health has been written; this considers the findings from The Confidential Enquiry in to the Premature Deaths of People with a Learning Disability and makes recommendations for improving health services for people with learning disabilities

• Reducing the number of out of borough placements and increasing the opportunity of accessing housing and support locally.

Recommendations

• To commission services in line with the expected increase in the prevalence of people with learning disabilities over the next 10-15 years

• To work closer with GPs to improve health outcomes for people with learning disability and continue to commission the Learning Disabilities Direct Enhanced Service (DES) to ensure that practices are offering high-quality annual health checks to those who are eligible. To also consider alternative methods of delivering health checks to people with learning disabilities who are registered at practices but have not signed up to the DES. The Community Learning Disability team offer support to GP practices, this is by supporting individuals to access services and by advising GP and associated health staff to make reasonable adjustment to improve health access for people with a learning disability, this work will continue

• Complete and implement the Autism and Learning Disability Strategies

• To complete the Health Self Assessment and have a clear action plan to take forward which ensures that access to health services improves for people with a learning disability

• To complete Autism SAF and develop and action plan

• To ensure that preventive services are available to people with a learning disability

• To continue to stimulate the local market to ensure appropriate/relevant provisions is available locally to meet the needs of people with challenging behavior and autism. Also, including the need for autism awareness training to be covered in the contractual arrangements for commissioned services

• Care pathways including diagnostic pathway for people with autism spectrum disorder to be integrated in service planning. North East London Mental Health Trust are developing an autism care path and this will be implemented across the partner agencies

• To understand the demand for and the costs of specialist services to ensure that service provision is delivering value for money

• Ensure that robust reviews and ongoing monitoring of both health and social care ‘Out of Borough Placements’ with specific focus on people with challenging behaviour; people in high-cost placement; people with mental health needs; and people with complex needs and people in health funded inpatient units,(as recommended by the Winterbourne View report)

• To work with wider voluntary sector providers to create volunteering opportunities and support people with learning disabilities to get into employment

• To increase the opportunities for people with a learning disability to access community-based resources
• Ensure that joint health and social care commissioning strategies and protocols for young people reflects the demographic information relating to the increase needs for services for people with complex needs

• The population of people with a Learning Disabilities and dementia is increasing; dementia strategies and care pathways need to reflect the increase demand on services for people with an LD

• To understand the distinctive needs of people with profound and multiple learning disabilities and ensure that appropriate health and social care service provision is in place locally to meet needs whilst delivering value for money

• Review community care for people with learning disabilities to identify ways of reducing rate of emergency admission in this group and provide a service which promotes a preventative and enabling model

• Ensure that Waltham Forest keeps abreast of any other developments as a result of the recommendations made by the Confidential Enquiry, for example the resuscitation guidelines.

What are learning disabilities?

A ‘learning disability includes the presence of a significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence) with a reduced ability to cope independently (impaired social functioning); which started before adulthood with lasting effect on development’. This definition includes people with autism who also have learning disabilities, but not those with a higher level of autistic spectrum disorder who may be of an average or even above average intelligence, such as some people with Asperger’s syndrome (Valuing People (2001).

This definition encompasses people with a broad range of disabilities. The presence of a low intelligent quotient, for example an IQ below 70, is not, or in itself a sufficient reason for deciding whether an individual should be provided with additional health and social care support.

The World Health Organisation also defines learning disabilities as ‘a state of arrested or incomplete development of mind’. Somebody with a learning disability is also said to have ‘significant impairment of intellectual functioning’. The presence of a low intelligence quotient [IQ] below 70 is one of several indicators of learning disability, and ‘significant impairment of adaptive/social functioning’. This means that the person will have difficulties understanding, learning and remembering new things, and in generalising any learning to new situations. The term learning disability does not include all those who have a ‘learning difficulty’ which is more broadly defined in education legislation.

People with learning disability have a range of development needs. Learning disability affects the way a person learns and copes with new things in any area of life. It means it is harder for the person to learn, understand and communicate when compared to other people and it may also mean the individual is more vulnerable to exploitation and abuse. In addition, there may be other needs because of physical disabilities and or sensory impairments.

Due to the wide range of possible needs, people can be assessed with mild, moderate, severe and profound/complex disabilities. The difference between these assessments is the level of help that they need with their daily living.
What is the local picture?

Prevalence of learning disabilities
It is difficult to estimate the number of people with learning disabilities in England. Statistics that are collected tend to relate to the numbers of adults receiving services. Emerson and Hatton estimates 2% of the total population have learning disabilities. Less than 0.5% of these are likely to be known to local health and social services. But these numbers vary with age. In Waltham Forest, it is estimated there are 4,514 people with learning disabilities but only 1,056 are known to health and social care services.

Increasing prevalence
Factors that are likely to lead to an increase in the prevalence rates for adults with learning disabilities over the next two decades are:

- An increase in proportion of younger adults from South Asian communities (as evidence suggests a two to three-fold increase in severe learning disability)
- Increase in the survival rates among young people with severe and complex disabilities
- Reduction in the mortality rate among older adults with learning disabilities.

The Department of Health website – Projecting Adults Needs and Service Information (PANSI) provides an estimate of the number of people in Waltham Forest affected by different levels of learning disabilities.

www.pansi.org.uk.

Table 6.16 Estimated number of people affected by different levels of learning disabilities

<table>
<thead>
<tr>
<th>Age 18 to 85</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>LD Waltham Forest baseline</td>
<td>4,813</td>
<td>4,861</td>
<td>4,915</td>
<td>4,961</td>
<td>5,012</td>
</tr>
<tr>
<td>Severe learning disability (18-64)</td>
<td>259</td>
<td>262</td>
<td>265</td>
<td>268</td>
<td>271</td>
</tr>
<tr>
<td>Moderate/severe learning disability</td>
<td>1,028</td>
<td>1,040</td>
<td>1,054</td>
<td>1,067</td>
<td>1,081</td>
</tr>
<tr>
<td>Challenging behaviour (18-64)</td>
<td>78</td>
<td>79</td>
<td>80</td>
<td>81</td>
<td>82</td>
</tr>
<tr>
<td>Autism spectrum (18-64)</td>
<td>1,761</td>
<td>1,784</td>
<td>1,809</td>
<td>1,833</td>
<td>1,853</td>
</tr>
<tr>
<td>Down’s syndrome (18-64)</td>
<td>109</td>
<td>110</td>
<td>111</td>
<td>112</td>
<td>113</td>
</tr>
<tr>
<td>People with learning disability living with a parent (18-64)</td>
<td>390</td>
<td>395</td>
<td>399</td>
<td>403</td>
<td>407</td>
</tr>
</tbody>
</table>

Source: PANSI 2012.

Age profile
The largest number of people with learning disabilities (PLD) in Waltham Forest is between the ages of 25 and 54 (See Figure 6.19 below), indicating a future increase of older people with learning disabilities. An increase in age related illness in the next 10 to 20 years can therefore be predicted.

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There were 798 with learning disabilities aged 18+ years recorded on GP practices’ QOF registers in 2011/12. GP practices’ records of prevalence of learning disabilities shows that the largest number of PLD is in Leyton/Leytonstone (385), followed by Walthamstow (304) and Chingford (109).

**Transition**

Research by Lancaster University shows that there will be an increase in young people reaching adulthood with complex needs over the next few years with a peak between now and 2020. Local evidence for Waltham Forest over the last 3 years based on the number of people transferring to adult services has shown that approximately 80% of the people requiring adult Health and Social Care services are likely to be young people with a significant learning disability with additional complex needs such as challenging behaviour, complex health and physical needs.

Fifty-seven young people who reached 19 years transferred to adult services in 2011/12 with 32 of them having a significant learning disability and requiring input from Health and Social care. In addition to this 87 young people known to children’s services with an education statement reached the age of 18 years.

A decision was made by the Borough of Waltham Forest to transfer people to adult services at 18 years rather than the old arrangements of 19 years and 2 terms, this has created an additional pressure in adult services.
A transition team comprising of career advisors, social workers, a health facilitator and a manager has been established and is working with young people from the age of 14 years, this is the point when the transition planning commences.

New SEN reforms mean that young people will cease to have an education statement and there will be a requirement to develop a single health, education and social care plan for children from 0 to 25 years. This will require Health, education and social care services to work in a more integrated way when supporting children and young people with a disability.

The borough are required to develop a Local Offer which all key agencies will be responsible for implementing.

**Mortality**

People with learning disabilities die at younger ages than other people.

The median age at death for people with learning disabilities in Waltham Forest between 2008–11 was 26 years, which is significantly worse than England average 56 years, London average 49 years and both our statistical comparators Croydon 54 years and Greenwich 56 years. Again there has been a drop in age at which people with learning disabilities are dying in Waltham Forest from 33.5 years in 2006–10 to the current age of 26 years.

Nationally, respiratory disease accounts for 46% to 52% of deaths among PLD, which is higher than that of the general population between 15% and 17%. It is the highest cause of death among PLD. People with Down’s syndrome are particularly at risk because they have a predisposition to lung abnormalities, a poor immune system and a tendency to breathe through their mouth.

CHD is the second most common cause of death among PLD. PLD are more likely to develop hypertension and obesity and they also suffer from lack of exercise, all of which increase the risk of Ischaemic heart disease (14%-20%). Between 40 and 50% of people with Downs’ syndrome are affected by congenital heart defects. In Waltham Forest 6% of those who had annual health checks were found to have heart disease.

Smoking rates among PLD have been reported to be comparable to those in the general population or even higher. Smoking is higher among people with mild/moderate learning disabilities and this is mostly among those who live in private households.

**Long-term conditions among PLD**

PLD experience a higher prevalence of health conditions/risk factors compared to the general population. For example in PLD:

- Obesity – 1 in 3 PLD
- CHD – 2nd most common cause of death
- Respiratory disease – 3 times higher than the general population
- Dementia – 4 times higher than the general population
- Epilepsy – 20 times more common among PLD
- Sudden unexplained death in epilepsy – 5 times more common in PLD than in others with epilepsy.

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Other major health problems among PLD include:

- Sensory impairment
- Osteoporosis
- Hypothyroidism (particularly in Down’s syndrome)
- Mental illness and challenging behaviours and early onset of dementia
- Poor oral health
- Gastrointestinal disorders (e.g. gastro-oesophageal reflux disease)
- Cancer (particularly gastrointestinal cancers).

PLD have a much higher risk of developing epilepsy, particularly if they have severe learning disabilities. Nearly one in four (22%) have epilepsy compared with 1% of the general population line with the Waltham Forest findings. Of those who had an annual health check 22% were found to have epilepsy. Epilepsy is higher in Walthamstow.

PLD have a higher risk of developing dementia compared to the general population, with a significantly increased risk for people with Down’s syndrome and at a much earlier age. About 20% of people with a learning disability have Down’s syndrome. Dementia prevalence rates have been estimated at ten (with some studies as high as 25) in 100 people at 40 years of age, 36 in 100 people at 50 years and 50–65 people in 100 at age 60+. For those who have learning disabilities and do not have Down’s syndrome, the prevalence rate is increased over the general population but at lower percentages than PLD with Down’s syndrome. This approaches a level that is 4 times as great as the general population. Waltham Forest has 92 people with Down’s syndrome, 29 of those are between the ages of 45–64 and out the 29, 5 suffer from dementia.

Of the PLD who had the annual health check in Waltham Forest, 35% were having care provided by older carers. Given that PLD are living longer and most require more than 50 hours a week of care, plans will be required for a number of PLD who may need their care provided by paid carers in future.

**Challenging behaviour**

People with all levels of learning disability and complex needs may display challenging behaviour. Emerson et al. found that people identified as having challenging behaviour were more likely to have additional health and social care needs such as restricted mobility (24%), visual impairment (15%), not fully continent (38%) or a need for assistance when washing (70%).

Findings in the studies of prevalence in challenging behaviour in people with learning disability vary widely, reporting rates of between 5.7% and 14%. The overall prevalence increases with age during childhood, reaches a peak during the age range of between 15 to 34 years and then declines. The Office of National Statistics estimates that 4% of PLD between the ages of 18 and 64 in England have challenging behaviour. PLD with challenging behaviour in Waltham Forest is 4.2% of those between ages 18 and 64 and this is similar to that of England. Prevalence across age groups is fairly equal, with the exception of a small increase between 25 to 44 years.

**Complex health needs**

People who have a learning disability and complex health needs are diverse. In Waltham Forest 4% of PLD fall into the complex needs category.
Autism spectrum disorder (ASD)
From the 741 people currently receiving services from the Community Learning Disability Team there is an estimated 0.9% of people who are either diagnosed as having ASD or are known to show characteristics of autism. There are more males than females which reflects national data. The National Autism Society estimates people with autism who have a learning disability to be at just under 50%.

Waltham Forest learning disabilities 2013 profiles figures show 376 pupils with a primary diagnosis of autism spectrum disorder are known to schools.

Waltham Forest learning disabilities profile
Public Health England provides annual local learning disabilities profiles that aim at showing:

- How many people have learning disabilities
- How healthy they are
- How much health care they get
- How well social services are looking out for them

2013 learning disabilities profiles372 for Waltham Forest shows:

GPs are required to keep a register of patients on their practice list that have learning disabilities. In 2011/12 data the national average of people with learning disabilities known to their GPs is 4.54 in every 1,000. Although GPs in Waltham Forest are identifying more people with learning disabilities, our rate of 3.54 in every 1,000 is still significantly lower than England average. When compared to regional comparators, Waltham Forest rate is higher than London average (3.36) but lower than our statistical comparators Croydon (5.12) and Greenwich (3.89)373. A total of 798 adults with learning disabilities are known to GPs in Waltham Forest.

Waltham Forest rate of adults (18 to 64) with learning disabilities known to local authorities is 2.96 in every 1,000 which is significantly lower than England average (4.27), lower than London average (3.65) and also lower than our statistical comparators Croydon (4.2) and Greenwich (3.22). In 2011/12 a total of 510 adults with learning disabilities are known to local authorities. This is a drop of 8.9% from previous year (2010/11)374.

Estimates of children with learning disabilities are based on school children reported as having ‘learning disabilities’ on the 2011/12 annual school censuses. Waltham Forest rate of children with learning difficulties (specific difficulties (like dyslexia) moderate, severe and profound and multiple learning difficulties) known to schools of 36.12 in every 1,000 school pupils is significantly higher than England average (24.53) and twice as high as statistical comparators Croydon (15.22) and Greenwich (17). A total of 1,522 children with learning difficulties are known to schools in Waltham Forest. There are three specialist schools in the borough that provide education for children with a learning disability and complex needs. A transition team was set up in January 2013 to support children and young adults with an educational statement through the transition stage in to adult health and social care services. The team comprises of a health facilitator, social workers and career advisors and a team manager.

Waltham Forest proportion of eligible adults with learning disabilities having GP health check is 46.28 in every 1,000 which is significantly worse than England average (52.78). This is lower than London average (50.20) and statistical comparator Croydon (64.73) but higher than Greenwich (40.85). There has been a decline in the number of people receiving health checks in Waltham Forest, 405 in 2010/11 versus 342 in 2011/12.

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373 Self-Assessment Framework (SAF), 2012/13 data.
The most recent data (2008/09) show Waltham Forest has significantly worse emergency admission to hospital for people with learning disabilities (65.87% of all emergency admissions) compared to England average of 49.96% and London average of 97.11%. This is also higher than Croydon (44.28%) and Greenwich (41.13%). This has implication for how patients experience care as advance planning is limited and therefore staff are not able to make reasonable adjustment in anticipation.

Similarly Waltham Forest has significantly higher admission rate for non-psychiatric care sensitive conditions in people with learning disabilities (46.54 in every 1,000 adults known as having learning disabilities) compared to England average (23.27) and London average (33.74). Equally Waltham Forest rate is higher than Croydon (21.55) and Greenwich (27.3). This indicator points to poor quality of community care for gastric-oesophageal reflux disorder (GORD), epilepsy and constipations which are the three conditions common in people with learning disabilities that are more likely to cause hospital admission.

Identifying people with learning disabilities in general hospital statistics is important in making appropriate reasonable adjustment in care for the patients. Waltham Forest's identification of people with learning disabilities in hospital is 21.37% which is significantly worse than England 27.1% and London average of 22.43%.

Figures for 2012/13 show that 75.3% of people with learning disabilities in Waltham Forest known to social services were living in settled accommodation compared to the London average of 67.7%. The target for 2013/14 is 76% \(^\text{375}\).

The rate of adults with learning disabilities using day care services supported by the local authority in Waltham forest is 225.49 per 1,000, which is similar to London average 282 and significantly lower than England average of 347.2.

There are 735.29 per 1,000 Adults with learning disabilities receiving community services supported by local authorities in Waltham forest, which is similar to England average of 746.71 and higher than London average of 669.49.

In 2012/13 11.3% of people with learning disabilities in Waltham Forest were in paid employment. This is slightly better than the London average (9.4%). The target for 2013/14 is 12%.

Waltham Forest adult social care service spend significantly more per head on people with learning disabilities £41.01 compared to England average (£21.52) and London average (£26.59). There has been a significant increase in spend per head, from £26.58 in 2010/11. Waltham Forest is spending more per head compared to our statistical comparators Croydon (£34.35) and Greenwich (£30.59) and generally having poorer outcomes.

What are effective interventions?
There are several government policies and service development frameworks that influence attitudes and services for people with learning disabilities. These policies and frameworks focus on promoting and delivery advocacy, employment support, person-centred planning, quality of life, effective transitions from children to adult services, improved support for families and partnership working to improve the lives of people with learning disabilities. A few of the policy drivers are summarised below:

Valuing People (DH:2001) – White Paper sets out the Government’s commitment to improving the life chances of people with learning disabilities, through close partnership working to enable people with learning disabilities to live full and active lives.

Valuing People Now (DH:2009) – retained the principle outlined in Valuing People that people with learning disabilities are people first, and re-emphasised the need for agencies to work together to achieve the best outcomes for people with learning disabilities.

\(^{375}\) Self-Assessment Framework (SAF), 2012/13 data.

Our Health, Our Care, Our Say (DH: 2006) – sets out the Government’s idea for the future direction of health and social care community services.

Health Care for All (2008) – the report of the independent inquiry into death by indifference concluded that people with learning disabilities appear to receive less effective care than they are entitled to, with evidence of a significant level of avoidable suffering and a high likelihood that deaths are occurring that could be avoided. A total of 10 recommendations were made, all of which were accepted by the Department of Health and Valuing People Now.

Six Lives (2009) Ombudsman Report – the report of the Health Ombudsman into the cases highlighted in Death by Indifference highlighted some significant and distressing failures in health and social care services, leading to situations where people with learning disabilities experienced prolonged suffering and inappropriate care.

The Autism Act 2009 and Fulfilling and Rewarding Lives – sets a clear framework for all mainstream services across the public sector to work together for adults with autism.

The key themes and national priorities for people with learning disabilities are as follows;

**Personalisation:** to ensure that people have real choice and control over their lives and the services they receive.

**Modernised Day Opportunities:** to ensure that people are included in their communities with a focus on increased independence and being in paid work.

**Fair Access to Health:** to ensure that people have full and equal access to good quality healthcare for both physical and mental wellbeing from NHS.

**Access to housing in the community:** to ensure that people have options for housing and with a focus on home ownership and tenancies.

**Make change happen:** to ensure that partnership boards are more effective in delivering policies.

**What is being done locally to address learning disability?**

**Prevention and access to universal services:** Preventive services focus on providing information, advice and advocacy support to people with learning disabilities to enable them to enjoy independent living.

Waltham Forest commissioned Learning Disabilities Advocacy Service through a collaborative arrangement. The services commissioned included one to one advocacy, complex and high support professional advocacy, service users inclusion service (People First), Learning Disability Experience and Service Users Forum.

Waltham Forest also provides an advocacy support to young people (18–24) going through transition; these services empower young people through person-centred planning, independent and healthy living activities, community participation and development of friendships and relationships.

**Supporting carers:** Support for carers is a key part of support for vulnerable people. Support for carers also enables carers to continue with their lives, families, work and contribution to their community. Carers are able to access a range of services including low level preventive services to empower and enable them to have breaks.
Short Break (respite) Services: are available to people with learning disability through the Council’s in-house respite care service and from independent providers. Respite care describes separate periods of care for people with learning disability if they, or their carer, need a short-term break. Respite care can also be provided in an emergency such as illness.

Self-Directed Support: Self-Directed Support is seen as being at the centre of personalisation. It is about giving people who use care and support services more choice and control over the support services they require. It enables people to take control of their own individual budget from which to commission and procure the care and support they feel will meet their individual needs.

People with Learning Disabilities also have access to Support Planning and Brokerage Services that will support them to set the outcomes they wish to achieve and plan how to spend their individualised budget. The service also supports individuals to arrange the services they require through a support broker. The resources allocation system was introduced to learning disability services in October 2011. All people who are assessed as requiring support from adult learning disability social care services are offered a personal budget which is based on their assessed needs. This gives people with learning disabilities the opportunity to use individualised budget to commission more person centred support in the community.

Community Learning Disability Team: is a multi-disciplinary and multi-agency team that includes a range of professionals (including consultant psychiatrist, community learning disability nurse, social worker, physiotherapist, occupational therapist, speech and language therapist, clinical psychologist and administrative support) and acts as the gate-keeper to services for adults with a learning disability living in Waltham Forest. The team is managed by North East London Foundation Trust.

Supporting living opportunities: Housing support services are intended to help people live independently in their own homes and provide early intervention and preventative services e.g. to prevent homelessness.

Supported living offers people with learning disability the opportunity to live in their own home in the community and to lead active, socially inclusive lives. The support is designed individually, with the active participation of the person to be supported and those who know them best. It focuses on what people can do, provides support for things people cannot do, and creates opportunities for people to learn how to do things they want to do.

Most importantly supported living offers choices to people about where they live; who they live with, what support is required and who offers it. Supported living has the potential to ensure that each individual’s needs wishes and aspirations are met in a way, which suits them, and the lifestyle they want to lead. Approximately, 90 commissioning service users are currently been supported in Supported Housing in Waltham Forest.

Day Opportunities: Day Opportunities services are available for people with learning disabilities including Day Services for Asian Women, Supported Employment Project. Day opportunities are also commissioned from external providers. Day opportunities need to reflect the principles of personalisation, fit for purpose, modern and ensure that services are targeted at the people most in need. A review of day services will be completed this year for all adult services which includes resources for people with a learning disability.

Residential/Nursing Care: The policy drive at both national and local level is to move away from residential care provision for people with learning disabilities. In Waltham Forest a considerable percentage of service users are still placed in residential care partly because of the legacy of the long stay hospital which was located in the borough, the total number of both in and out of borough placements is 193. This represents approximately 26% of people receiving services from the Community Learning Disability Team.

One of our strategic priorities is to reduce the use of residential care and the strategic approach will be outlined in the commissioning strategy for people with learning disabilities which will be produced shortly.
**Equalities** It is broadly recognised that people with learning disabilities experience inequality in service provision and social outcomes when compared with people without learning disabilities. They also experience poor health, risk of early death and significant discrimination in accessing health care facilities, diagnosis and treatment as highlighted in the March 2007 Mencap report, ‘Death by indifference’. The report accused the health services of institutional discrimination that led to people with a learning disability receiving worse health care than non-disabled people. This lead to a confidential enquiry in to the premature deaths of people with a learning disability, this was published in March of this year and recommendations published in the summer. The recommendations have been incorporated in to a Waltham Forest report with local recommendations.

Waltham Forest embraces the principles of equality and celebrates the diversity of Waltham Forest’s communities. Waltham Forest therefore will:

- Monitor performance against local population to ensure that policies and work practices meet the needs of the different communities
- Reduce barriers to services in terms of gender, disabilities, race, religion, sexuality and age
- Monitor service delivery to ensure equal access for all people requiring services
- Monitor take up of services
- Train staff to recognise diversity, promote equality and inclusiveness.

Equality Analysis will be carried out as part of the development of the Learning Disability Commissioning Strategy.

**Safeguarding:** Waltham Forest and all partner agencies aim to protect and promote individual rights, independence and well-being. This also includes an assurance that vulnerable people are safe and are safeguarded against abuse, neglect, discrimination and poor treatment. And, that they are treated with dignity, respect and enjoy a high quality of life. The Safeguarding process is detailed in the Safeguarding Operational Guidance Manual. The manual outlines the roles and responsibilities of care management, commissioners, providers and other agencies.

The Winterbourne View report and recommendations have been incorporated in to a Waltham Forest action plan and will be monitored and reviewed through the Safeguarding Adults Board.

**What evidence is there that we are making a difference?**

- Health facilitators who are part of the learning disability team work with GP practices, and support people to receive annual health checks, they work with the other health and social colleagues in the team to provide a community-based service
- The LD team work with individuals around provision of ‘reasonable adjustments’ and links with the local hospital and GPs. The team also run groups for people to support their knowledge of services and prepare them for medical interventions
- Health promotion groups are run by the community learning disability nurse to promote such things as healthy eating, exercise and sexual health awareness
- People with learning disabilities and who have multiple health needs or two or more long-term conditions and are known to the social care services have a named health professional to coordinate their care
The team have developed ‘hospital passports’ (patient held note with key information about the person) for people with learning disabilities which make it easier for professionals to be aware of their medical needs and make reasonable adjustment as appropriate.

The team works with GP through Directly Enhanced Service (DES) scheme for annual health checks and develop health action plans.

The team provide Specialist OT, Physiotherapy, speech and language, occupational therapy, psychiatry, psychology and community nursing services.

The team assess people for continuing health care funding.

Health and social care cases known to the team are prioritised using a RAG rating, red and amber cases are discussed at a weekly zoning meeting. People with complex health needs, presently in inpatient beds, at risk of hospitalisation or due for discharge will be discussed at the weekly meeting.

The impact of service provision for people with learning difficulties is measured against a number of key targets and indicators. Key national-level indicators include:

- National Indicator 145: Adults with learning disabilities in settled accommodation 439 users in 2012/13
- National Indicator 146: Adults with learning disabilities in employment 66 users in 2012/13
- National Adult Social Care Outcome 1E: Proportion of Adults with a Learning Disability in paid employment: 11.3% (66/583)
- National Adult Social Care Outcome 1G: Proportion of Adults with a Learning Disability living in their own home or with family: 75.3% (439/583).

In 2012/13 performance data showed only 439 of adults with learning disabilities in settled accommodation out of the recorded data on Framework (social care database). During the same period, only 66 adults with learning disabilities were in employment, this figure represents approximately 11.3% of those known to the Community Learning Disability Team.

As part of the health services Direct Enhanced Services (DES) scheme GPs have the option to sign up to the direct enhances service for learning disabilities. Requirements under this scheme are that GP practices will keep a register of all people with learning disabilities that are known to Social Care and Health Services. In addition the clients on the Learning Disability register will be offered an annual health check.

The community Learning Disability nurses monitor this process, validate the learning disability registers, provide learning disability awareness training and visit GP practices to monitor outcomes of the health checks and health action plans.

In 2011/12 342 health checks were completed for adults with learning disabilities within Waltham Forest. This is a reduction from the previous year and the community Learning disability nurses are continuing to promote the importance of annual health checks with GP practices and offer support to raise awareness of the importance of health checks to hard to reach patients.

Table 6.17 below shows the type and number of people with learning disabilities who received services in 2013/14.
Table 6.17  Number of PLD who received specific services in 2013/14

<table>
<thead>
<tr>
<th>Service type</th>
<th>Number of people</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Nurses</td>
<td>109</td>
</tr>
<tr>
<td>OT</td>
<td>49</td>
</tr>
<tr>
<td>Home care (brokerage)</td>
<td>15</td>
</tr>
<tr>
<td>Residential care (out of borough)</td>
<td>121</td>
</tr>
<tr>
<td>Residential care (in borough)</td>
<td>72</td>
</tr>
<tr>
<td>Day opportunities (in-house)</td>
<td>110</td>
</tr>
<tr>
<td>Day opportunities (spots)</td>
<td>85</td>
</tr>
<tr>
<td>Supported living accommodation (in borough)</td>
<td>122</td>
</tr>
<tr>
<td>Supported living accommodation (out of borough)</td>
<td>15</td>
</tr>
<tr>
<td>Floating support</td>
<td>44</td>
</tr>
<tr>
<td>Direct payment/individual budget</td>
<td>102</td>
</tr>
</tbody>
</table>

Sources of Data: The data has been collated from various sources, these include LP12 Review reports; activities returns for NI145 and 146; Finance database; service area records; and GP registers.

What is the perspective of the public on support available to them?
The Learning Disability Partnership board provides a platform for a regular dialogue with people with learning disabilities and their carers to inform the board about their experiences and to discuss issues they face in accessing services.

It is also a local forum to enable users and carers to have a say and for commissioners to gain insights into their needs and aspirations.

What more do we need to know?
Waltham Forest signed up to the Learning Disabilities Self-Assessment Framework which requires all providers to evidence how they identify and effectively engage with people with learning disabilities and where there are poor performance to demonstrate how they will improve. This is independently validated by NHS London.

The Self-Assessment Framework (SAF) outlines four main Top Targets and Key Objectives to be assessed. These include:

1. People who are or who were formally in NHS-provided long-term care have settled accommodation that reflect their Person-Centre Plans and there is a system in place to ensure minimum annual review.

2. Health and Social Care commissioners are working closely with local Partnership Boards, statutory organisations and other partners to address the health inequalities faced by people with learning disabilities.

3. People with learning disabilities who are in services that the NHS commissions or provides are safe.

4. Progress is being made in developing local services for those needing more help with their health.

Every year the NHS holds local events to assess the experiences of people with learning disabilities and their carers. The outcomes of these events inform the performance of Waltham Forest on the four top key targets and objectives areas listed above. These are submitted to NHS London who validate and confirm the local scoring.
In 2010, Waltham Forest scored one RED and three AMBERS; the RED score was due to one person still living in a long stay NHS bed. However, in 2011, the scoring has improved to one GREEN and three AMBERS. This shows that Waltham Forest still has areas that need improvement as shown in Table 6.18 below.

For 2012 the LD SAF return changed from four target areas to three. In addition the questions that were asked of providers and commissioners changed. This resulted in less evidence being available for specific target questions as there was no prior warning of the changes resulting in providers and commissioners not having adequate time to change their monitoring parameters to accommodate the changes. This resulted in a drop of scoring to all ambers, which NHS London at the time were expecting across the London region.

The LD SAF for 2012/13 has not yet been completed. Due to further significant changes to the document and the evidence is required the submission date for this return has been moved from July 2013 to 30 November 2013. Within the present LD SAF greater evidence is being requested from commissioners to monitor their awareness of how provider services perform.

Table 6.18  Waltham Forest’s performance on the four top key targets and objectives areas

<table>
<thead>
<tr>
<th>Target</th>
<th>2011 validated outcome</th>
<th>2012 validated outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target 2: Being Safe (2012)</td>
<td>Amber</td>
<td>Amber</td>
</tr>
<tr>
<td>Target 3: Governance and Quality (2012)</td>
<td>Amber</td>
<td>Amber</td>
</tr>
<tr>
<td>Target 4:</td>
<td>Amber</td>
<td>N/A</td>
</tr>
</tbody>
</table>

For the 2011/12 the SAF changed putting great emphasis on health commissioners to demonstrate that their strategies, reasonable adjustments and commissioning activity reflects the need of the local learning disability population.

What are the priorities for improvement over the next 5 years?
Estimates suggest that the prevalence of people with learning disabilities will increase in the next few years; this is driven by four main factors (Emerson and Hatton 2004):

1. The increase in proportion of younger adults who belong to South Asian communities, as these communities have a higher prevalence of severe learning disabilities. Waltham Forest has a large population of people from these communities.

2. Increased survival rates among young people with severe and complex disabilities.

3. Increased longevity among adults with learning disabilities, due to improvements in medical care and reduced mortality.

4. The number of older people with older age related illness is increasing.

With this in mind, the priorities for the next five years include:

- To commission services in line with the expected increase in prevalence of people with learning difficulties over the next five years and develop services to meet the needs of people with learning disabilities locally

- Improve the quality of primary care learning disability register, ensuring that there are systems in place to ensure more people with learning disabilities are identified and added to the register; services are reasonably adjusted to meet the health needs of people with complex needs
• To ensure that all the key targets and objectives in the Self-Assessment Framework are met and to ensure that there is continued improvement in services for people with learning disabilities
• To help people with learning disabilities to understand personalisation and individualised budget, how to spend their budgets and what choice and control mean to them
• Partnership working to address health inequalities and engaging with people with learning disabilities who have complex needs and involving them in making choices about their health
• Encourage uptake of annual health checks and improve access to screening services and other services in line with Valuing People, Six Lives and Health Care for All recommendation
• To continue to work positively with local sexual health services through the provision of regular appointments and follow-up, support and education
• Strengthen partnership working and develop closer relationship with the voluntary sector to promote health and the wellbeing of PLD
• Continue to develop better well-co-ordinated systems to plan for young people going through transition to adult services
• Review community care for people with learning disabilities to identify ways of reducing rate of emergency admission in this group and provide a service which promotes a preventative and enabling model
• Ensure that Waltham Forest keeps abreast of any other developments as a result of the recommendations made by the Confidential Enquiry, for example the resuscitation guidelines
• To ensure that social care and health policy include the needs of people with a learning disability
• To embed the recommendations of the Health and Care Bill and the Children and Family Bill and incorporate the needs of people with a learning disability.

Autism
The Autism Act 2009 and the National Strategy for Autism ‘Fulfilling and rewarding lives, is the first disability specific strategy for adults with ASD in England. This legislation requires local authorities and NHS to implement a local autism plan to meet the needs of those people on the autism spectrum.

Waltham Forest has developed a Joint Children and Adults Autism Strategy and is expected to present this to Cabinet in December/January to agree it’s implementation.

What is autism?
Autism is defined as: ‘A disorder of neural development characterized by impaired social interaction and communication and by restrictive and repetitive behaviour’.

There are three main types of ASD:
• autistic disorder, sometimes known as ‘classic autism’
• Asperger syndrome
• pervasive developmental disorder – not otherwise specified (PDD-NOS), also known as ‘atypical autism’.
People with autism have a wide spectrum of needs and are unique with no two people are the same. There are three key areas of difficulty known as the ‘triad of impairments’ that all people with autism are likely to experience:

- Ability to understand and use non-verbal and verbal communication
- Ability to understand social behaviour and to interact with other people
- Ability to think and behave flexibility.

In addition, many people with autism are over-sensitive or under-sensitive to particular things such as smells, tastes, colour, sounds, balance or touch.

Autism is a lifelong developmental that affects the way a person communicates with, and relates to, people and the world around them. Those with higher functioning autism or Asperger Syndrome feel they have a ‘hidden’ condition not easily recognised or understood by professionals or the general public.

Some people with ASD may have accompanying conditions such as Learning Disabilities, Mental Health, ADHD and/or epilepsy. For some people with ASD they may find themselves in a position where they do not fit easily into Learning Disability or Mental Health services and therefore may not have access to appropriate services to meet their needs.

**Research**

Data from the PANSI website (2013), a system developed by the Institute of Public Care (IPC) to assist local authorities to gather data predicts that there are 1,784 people living in Waltham Forest with Autism Spectrum Disorder; with this number predicated to increase to 1,833 by 2015.

Recent prevalence estimations of autism spectrum conditions shows the overall prevalence of autism, combining data from the Adult Psychiatric Morbidity Survey (APMS) 2007 and learning disability study, was 1.1 per cent (95 per cent confidence interval 0.3 per cent to 1.9 per cent). The prevalence of autism was higher in men (2.0 per cent) than women (0.3 per cent). If this data is applied to the population of Waltham Forest, it would suggest there are 2,840 people with ASC locally.

Currently local data is not clearly documented, including BAME data on the number of Children and Adults with Autistic Spectrum Disorder in Waltham Forest. The delivery plan in Waltham Forest’s draft joint autism strategy seeks to address this gap and improve current systems. Other factors that may contribute to the lack of data of those with ASD may be:

- lack of early diagnosis and clear pathways
- those with high functioning ASD not meeting eligibility criteria.

Table 6.19 provides data based on open referrals between April 2012 and March 2013.

**Table 6.19  Open referrals April 2012 to March 2013**

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of adults with a diagnosis of autism:</td>
<td>65</td>
</tr>
<tr>
<td>Number of adults open to LD services only</td>
<td>42</td>
</tr>
<tr>
<td>Number of adults open to LD and mental health services</td>
<td>7</td>
</tr>
<tr>
<td>Number of children with a diagnosis of autism and open to CAMHS services</td>
<td>65</td>
</tr>
</tbody>
</table>
Below are figures relating to people with a diagnosis of Asperger’s.

Table 6.20 **People diagnosed with Asperger’s syndrome**

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of adults with a diagnosis of Asperger’s syndrome</td>
<td>29</td>
</tr>
<tr>
<td>Number of adults with Asperger’s open to LD services only</td>
<td>1</td>
</tr>
<tr>
<td>Number of adults with Asperger’s open to LD and mental health services</td>
<td>6</td>
</tr>
<tr>
<td>Number of children with a diagnosis of Asperger’s syndrome, open to CAMHS services</td>
<td>22</td>
</tr>
</tbody>
</table>

Current data shows 7 people who have autism and accompanying learning disabilities are in receipt of Direct Payments.

It is important for those people with ASD who do not meet the eligibility criteria for adult social care, that they are signposted to other services so they are not left without appropriate support, this includes advocacy services. The Government guidance for local authorities emphasises to focus on prevention rather than crisis management.

The National Audit Office (NAO) investigated public spending for adults with autism and found if local services identified and supported just 4% of adults with High Functioning Autism and Asperger syndrome the outlay would become cost neutral over time. Furthermore, they found if they did the same for just 8% the Government could save £67 million per year. Although an initial cost with identification will be placed on the NHS – estimated to be around £28 million for an eight per cent identification rate – the saving for local authorities would potentially be around £105 million.

Research has shown only 15% of adults with autism in the UK are in full-time paid employment, with 51% of adults with autism in the UK having spent time with neither a job, nor access to benefits.

NAS website states some people with autism may be vulnerable to criminal acts against them because of their social difficulties. It is therefore vital that appropriate support needs to be in place in order that victims are understood and appropriately represented and supported.

**Waltham Forest priorities**

Key priorities for Waltham Forest is raising awareness, training, establishing clear diagnostic pathways, transition, housing, employment, personalisation, carer support and support in the criminal justice system.

As autism awareness becomes more ingrained and professionals and key agencies become more aware of the needs of individuals with autism spectrum disorder, the demand for services is likely to grow.

Both Social Care and Health will need to be able to meet this demand and commission services that have skilled workers who can deliver good quality, and offer value for money.

Waltham Forest has a range of services provided in-house and commissioned from the voluntary and independent sector that children, young people and adults including those with Autism Spectrum Disorder can access. Mapping of these services are currently underway to understand what the demands are for specific/specialised services, the costs of these and to ensure that service provision is delivering good quality and value for money.

We anticipate that gaps are more likely to be apparent for those people with ASD who are high functioning, compared with those people with lower functioning levels.
Executive summary

This section considers four long-term neurological conditions; Epilepsy, Parkinson’s disease, Multiple Sclerosis and Motor neurone disease.

- Among those aged 18 or over and registered with a GP in Waltham Forest, there are 1,228 people who have diagnosed epilepsy. This is a local rate of 0.5% (crude rate), and compares to a London rate of 0.6% and an England rate of 0.8%. There is little or no breakdown of ethnicity of patients available.

- It has not been possible to obtain data on the number of people in Waltham Forest with Parkinson’s, Multiple Sclerosis or Motor neurone disease, however national rates were applied to the local population, resulting in the following estimates for Waltham Forest:
  - Parkinson’s – a rate of 195 per 100,000 or 506 individuals
  - Multiple sclerosis – a rate of 161 per 100,000 or 418 individuals
  - Motor Neurone disease – 7 per 100,000 or 18 individuals.

Waltham Forest’s spend per head for neurological conditions was £74 for 2011/12. This is compared to £64 per head of population for our ONS cluster (London suburbs).

Recommendations

- Provision of a specialist nurse for those with Parkinson’s disease
  The neurology consultants support the view that a community nurse specialist for Parkinson’s and MND patients would not only improve the care provided for these groups but would also relieve the burden on hospital services, improve the numbers of people treated within the borough and help with issues faced by those suffering from these conditions before they escalate. Parkinson’s UK has offered to seed-fund a post using a patient legacy: the option for this funding should be explored.

- A paediatric epilepsy nurse specialist based at Whipps Cross
  Whipps Cross has a paediatric neurology clinic and an epilepsy clinic but no paediatric epilepsy nurse specialist. The number of young people with epilepsy seen at Whipps Cross (emergency and other admissions) should be compared to other similar boroughs, to explore this need further.

- Increased communication (2012/13 recommendation)
  Although a specialist nurse for MS is now in place, some cases are not being referred on from the GPs for extra support provided by the nurse. When patients with neurological conditions are admitted to hospital, there can be a delay where hospital staff are not aware of the diagnosis, therefore appropriate medication may be delayed.

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376 Health and Social Care Information Centre (HSCIC), QOF 2011/12.
377 Parkinson’s UK, http://www.parkinsons.org.uk/content/about-parkinsons
378 Multiple Sclerosis Society, http://www.mssociety.org.uk/
Assessment of available mental health services (2012/13 recommendation)
Current provision within the borough is not sufficient for those with long-term neurological conditions. Those with MS are at particular risk of depression and even suicide. As there is an overlap between Parkinson’s disease and Lewy Body Disease there is an accompanying need for review by old age psychiatry/memory services.

A mental health strategy is in development in the public health team and the needs of patients with long-term neurological conditions should be picked up in this strategy.

What is a long-term neurological condition?
A long-term neurological condition results from damage to or disease of the body’s nervous system. These can be broadly categorised as follows:

- **Sudden onset conditions** – e.g. stroke or T.I.A
- **Progressive conditions** – e.g. motor neurone disease, Parkinson’s disease
- **Intermittent/unpredictable conditions** – e.g. multiple sclerosis, epilepsy
- **Stable neurological conditions** – e.g. cerebral palsy, post-polio syndrome.

These can cause a range of problems for the individual, including impaired movement, muscle weakness, coordination problems, seizures and paralysis.

This section focuses on four key long-term neurological conditions:

**Epilepsy**
Epilepsy is the most common chronic disabling neurological condition in the UK. It is characterised by recurrent seizures, and classified as an intermittent condition. Epileptic seizures are the clinical manifestation of abnormal, excessive or synchronous neuronal activity in the brain. Epilepsy can have many causes and should be seen as a symptom of different neurological disorders, rather than a single disease entity. Epilepsy affects the brain and causes repeated seizures, also known as fits. Epilepsy usually begins during childhood, although it can start at any age.

Epilepsy can be caused by a head injury, an infection (for example meningitis) or a stroke, and it can also be inherited. Much of the time, however the reason a person develops epilepsy is unknown.\(^{381}\)

Epilepsy affects around about 1 in 100 people in the UK, totalling approximately 500,000 across the country.

**Parkinson’s disease**
Parkinson’s disease is a progressive neurological condition in which part of the brain becomes damaged over many years. The cause of Parkinson’s remains unknown, but the disease is characterised by a lack of dopamine-containing cells in the movement-centre of the brain, resulting in three main symptoms related to movement:

- Involuntary shaking of particular parts of the body (tremor)
- Muscle stiffness that can make everyday tasks such as getting out of a chair very difficult (rigidity)
- Physical movements become very slow (bradykinesia).

\(^{381}\) Epilepsy Society, http://www.epilepsysociety.org.uk/epilepsy-did-you-know
It is not known why people get Parkinson’s disease. Most people are aged over 50 when symptoms first manifest, however one person in 20 is under the age of 40 [Parkinson’s UK]. There is currently no cure for Parkinson’s disease.

The prevalence of Parkinson’s disease in the UK is estimated at 195 per 100,000, which equates to around 127,000 people.\(^{382}\)

**Multiple sclerosis**

Multiple sclerosis (MS) is a disease affecting nerves in the brain and spinal cord, causing problems with muscle movement, balance and vision. In those suffering from MS the protective myelin sheath surrounding the nerves in the brain breaks down, disrupting the transfer of nerve signals. This causes a wide range of potential symptoms, such as loss of vision, ataxia and fatigue. MS is more common among women than men, with the most likely time for diagnosis between 20 and 40 years of age.

The rate of MS in the UK is around 161 per 100,000, which equates to 100,000 people living with the condition in the UK.\(^{383}\)

**Motor neurone disease**

Motor neurone disease (MND) is a rare condition that progressively damages the nervous system, causing the muscles to waste away. As the condition progresses, people with motor neurone disease will find walking, speaking and even breathing and swallowing increasingly difficult, and eventually impossible. The cause of this condition is currently unclear, although there are a number of theories.

Men are slightly more likely to acquire MND as women, with the majority of people being over 40 years of age at diagnosis, and the highest incidence between the ages of 50 and 70.

The rate of MND in the UK is 7 per 100,000, which equates to around 4,400 people with the condition.\(^{384}\)

**What is the local picture?**

**Epilepsy**

The proportion of patients with epilepsy on drug treatment and convolution free is 75.38 (72.61%–77.95%) in Waltham Forest, compared with 72.63% (72.14%–73.11%) in London and 74.68% (74.52%–74.84%) in England.\(^{385}\)

**Parkinson’s disease**

The rate of Parkinson’s disease in the UK is 195 per 100,000. Applied to the population of Waltham forest, this results in an estimate of 506 individuals with Parkinson’s disease locally.\(^{386}\) As shown in Table 6.21, this can be split into the following phases:

<table>
<thead>
<tr>
<th>Parkinson’s disease phase</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis</td>
<td>55</td>
</tr>
<tr>
<td>Maintenance</td>
<td>205</td>
</tr>
<tr>
<td>Complex</td>
<td>171</td>
</tr>
<tr>
<td>Palliative</td>
<td>75</td>
</tr>
</tbody>
</table>


Between 2009 and 2010 there were 19 deaths attributable to Parkinson’s in Waltham Forest (see Figure 6.22 below).

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\(^{382}\) Parkinson’s UK, http://www.parkinsons.org.uk/content/about-parkinsons

\(^{383}\) Multiple Sclerosis Society, http://www.mssociety.org.uk/

\(^{384}\) Motor Neurone Disease Association, http://www.mndassociation.org/what-is-mnd/Brief+guide+to+MND.htm

\(^{385}\) Health and Social Care Information Centre (HSCIC), https://indicators.ic.nhs.uk/webview/

\(^{386}\) Parkinson’s UK, http://www.parkinsons.org.uk/content/about-parkinsons
Multiple sclerosis
The rate of MS in the UK is 161 per 100,000. Applied to the population of Waltham Forest, this results in an estimate of 418 individuals with Multiple sclerosis locally. As shown in Table 6.22 below, this can be split into the following phases:

Table 6.22  Multiple sclerosis phase

<table>
<thead>
<tr>
<th>Multiple sclerosis phase</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis</td>
<td></td>
</tr>
<tr>
<td>Minimum-moderate impairment</td>
<td></td>
</tr>
<tr>
<td>Complex</td>
<td></td>
</tr>
<tr>
<td>Palliative</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>174</td>
</tr>
<tr>
<td>216</td>
<td>10</td>
</tr>
<tr>
<td>418</td>
<td></td>
</tr>
</tbody>
</table>


Between 2009 and 2010 there were 19 deaths attributable to MS in Waltham Forest. See comparison figure below.

Motor neurone disease
The rate of motor neurone disease in the UK is 7 per 100,000. Applied to the population of Waltham Forest, this results in an estimate of 18 individuals with motor neurone disease locally. Local services report they are currently treating 10 patients in Waltham Forest with this condition.

Between 2009 and 2010 there were 15 deaths attributable to MND in Waltham Forest (Figure 6.20 below).

Figure 6.20  Age standardised death rates per 100,000 population, by neurological condition and area of residence, 2009/10 pooled data

Admission to hospital
Data from the London Health Observatory is available for years up until 2009/10. This shows that from these four conditions, epilepsy causes by far the greatest number of hospital admissions (886 for 2009/10). No further data has been made available since 2013/14. See Figure 6.21 below.
**What are the effective interventions?**

**Epilepsy**

The NICE guidelines for epilepsy were updated in 2012. Some detail was given in last year’s JSNA and the guidance can be accessed at:

http://guidance.nice.org.uk/CG137

**Parkinson's disease**

NICE issued guidelines for Parkinson’s disease in 2006 and some detail of the guidance was provided in last year’s JSNA. The guidance can be accessed at:

http://publications.nice.org.uk/parkinsons-disease-cg35

**Multiple sclerosis**

NICE issued guidelines for multiple sclerosis in 2003, and there are updated guidelines due out in 2014. Some detail of these guidelines was provided in last year’s JSNA.

http://publications.nice.org.uk/multiple-sclerosis-cg8

**Motor neurone disease**

NICE guidance is at http://publications.nice.org.uk/motor-neurone-disease-cg105

There is also good practice guidance from the MND Association:

- Rapid and accurate diagnosis
- Earliest possible assessment by a neurologist
- Appropriate emotional/psychological support
- Appropriate information is made available, in a timely manner
- Immediate identification of a single point of contact (key worker/case manager)
- Access to appropriate expertise and services at the appropriate time
- Timely referral to specialist palliative care and respite care
- Regular monitoring and review.
What is being done locally to address the needs of patients with neurological conditions?

Spend/outcome
Total spend for learning disabilities, neurological conditions, hearing, trauma and injuries and social care needs was slightly lower relative to other PCTs in 2011/12, however the overall outcomes for this category are equal to that of other PCTs\(^ {387}\).

Waltham Forest’s spend per head of population for neurological conditions was £74 for 2011/12. This is compared to £64 per head of population for our ONS cluster (London suburbs).

GP referral
GPs refer suspected cases of neurological conditions to consultants at Whipps Cross or other hospitals (mainly Royal London or Queens Hospital). For complex neurological problems it can sometimes be a long period before a problem is suspected and referred on. The specialist nurse services are advertised to all the GPs in the borough.

Secondary care
There are three half time consultants for neurological conditions based at Whipps Cross Hospital (time split between Whipps and the National Hospital) and one sessional consultant providing an outpatients clinic. The clinic is busy and it has been reported that waiting lists are long for non-urgent cases.

Specialist nurses
In 2009, a specialist nurse for MS post was created in Waltham Forest, conducting clinics, and home visits for regular reviews of patients. This has greatly increased the support to those with MS resident in Waltham Forest. Clinics are held at Chingford Health Centre (monthly), Whipps Cross (monthly) or the Comely Bank Clinic (weekly), and patients are referred on for other services as appropriate.

At present there is no specialist nurse to serve the needs of those with Parkinson’s disease or MND. As well as providing community support, a specialist nurse would relieve the caseload for the hospital consultants. Parkinson’s UK has offered some seed-funding for a nurse from a patient legacy: the CCG should explore this offer.

The Epilepsy Society and Whipps’ consultants endorse the establishment of a paediatric epilepsy nurse specialist post.

Other services
Community rehabilitation – Intercare – provides rehabilitation for those in Waltham Forest. This can be provided in people’s homes or in the Ainslie Rehabilitation Unit, which also takes inpatients.

Mental Health Services – cited by multiple sources as a potential gap, patients can be referred for counselling at Whipps Cross Palliative care centre, however that service is sometimes not sufficient for those with complex needs.

Family/carer support – apart from volunteer agencies, there is no particular support for children of those with MS. There is also little support available for carers of those with neurological conditions.

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\(^{387}\) Spend and outcome factsheet 2010/11, Waltham Forest PCT. Yorkshire and Humber Public Health Observatory, Right Care and Department of Health.
Voluntary agencies
There are many voluntary agencies for those with neurological conditions working in Waltham Forest. The MND Association provides community support for sufferers of MND.

Parkinson’s UK provide monthly drop in groups for those with Parkinson’s and their carers. They have said they may be willing to part fund a Parkinson’s specialist nurse if an appropriate business case were submitted.

The Epilepsy Society identifies need in the borough through work with patients and carers and health professionals, and via community education workshops.

The MS Action Therapy Centre in Walthamstow has a weekly drop in clinic, and caters for people with all kinds of neurological conditions.

What is the perspective of the public on support available to them?
The Waltham Forest Local involvement network (LiNK) conducted a review of neurological services in 2010, in which the following points were highlighted:

- Neurological conditions are not explicitly mentioned in the Waltham Forest Joint Commissioning Strategy, meaning that these service areas may be neglected against other priority areas. Neurology is discussed in the CCG CSP for 2014/15
- Specialist nursing services are currently limited to one MS nurse, and this service has only been operational since 2009. Budget pressures have prevented further commitments for specialist nursing services. This was highlighted as the main gap in services
- Relationships around commissioning and the Local Authority are good, however there needs to be more joint commissioning arrangements between social and neurological services to better integrate care
- Recommendations identified by previous PPI forum research into neurological services in the borough remain to be fully implemented. These include the establishment of person-centered services, set of multi-disciplinary teams working across neurological conditions, delivery of specialist nursing services and provision of support and assistance to carers.

What more do we need to know?
Epilepsy data is available through the primary care database (QOF) but is more difficult to obtain for other conditions, and is mainly estimated from national rates or from the number of cases being treated by specialist nurses. There is a paucity of data on the ethnicity of patients.

What are the priorities for improvement over the next five years?
Comments from those working in this sector have been that with the exception of the recruitment of a specialist nurse for MS, very little has changed in the service provision for those with neurological conditions for many years.

Provision of a specialist nurse for those with Parkinson’s disease
The specialist nurse has greatly increased support for those with MS, and having this service for those suffering from Parkinson’s and MND would not only improve the care provided for these groups but would also relieve the burden on hospital services, improve the numbers of people treated within the borough and help with issues faced by those suffering from these conditions before they escalate. NICE guidelines specify that those with Parkinson’s should be reviewed regularly and have access to a specialist nurse, and unless they seek treatment out of borough, this is not available. Improvement of follow-up and maintenance of those with MND and Parkinson’s should be a priority for the borough. Funding for the MS specialist nurse is only secured until December, and every effort should be made to ensure that this post continues in the borough.
Increased communication
Although a specialist nurse for MS is now in place, some cases are not being referred on from the GPs for extra support provided by the nurse. Also, when patients with neurological conditions are admitted to hospital, there can be a delay where hospital staff are not aware of the diagnosis, and there is no one to contact, therefore appropriate medication may be delayed.

Assessment of available mental health services
Current provision within the borough is not sufficient for those with long-term neurological conditions. Those with MS are at particular risk of depression and even suicide. Inclusion of this need in the mental health strategy in development (October 13) is essential.
6.6 Respiratory diseases

Executive summary
Respiratory disease is the third main cause of death in Waltham Forest and contributes to significant health inequality in the borough. Asthma is a long-term respiratory condition that can be debilitating in some individuals chronic obstructive pulmonary disease (COPD) is a progressive and debilitating respiratory disease that is a leading cause of health inequality in men in Waltham Forest, particularly from areas of high deprivation.

Both asthma and COPD are considered ambulatory care sensitive conditions (where admission to hospital is potentially avoidable through good quality primary and preventive care) but they result in high levels of hospital admissions locally. This indicates a weakness in primary care. Asthma and COPD are clinically different diseases but share similar risk factors, notably smoking and exposure to second-hand smoke. Deprivation is a key factor in poor health outcomes for both conditions. They are conditions that can be improved through similar objectives:

- Ensure people are aware of the importance of good lung health, what the risk factors are and how to avoid them
- Reduce early deaths through proactive, accurate early diagnosis and interventions
- Enhance the quality of life for people with poor lung health across all social groups, with a positive and enabling experience of care and support
- Ensure people with asthma are free of symptoms, and people with COPD experience minimal disease progression, through accurate diagnosis, shared decision making, and ongoing support.

Recommendations
- Establish healthy workplace schemes in the largest employers in the borough (Local Authority and NHS). The schemes should address healthy living, early detection, and wellbeing initiatives that educate and de-stigmatise lung disease. Evidence shows that targeted schemes can result in a 34% return on investment
- Implement a two tier smoking prevention curriculum in local schools that address all students aged 13-14 through multi-media learning, and followed by a targeted programme of peer support and intervention for students in high need schools.

What is asthma?
Asthma is a chronic disorder of the airways, caused primarily by inflammatory processes and constriction of the smooth muscle in airway walls (bronchoconstriction). It is characterised by airflow obstruction and increased responsiveness of the airways to various stimuli. Symptoms include recurring episodes of wheezing, breathlessness, chest tightness and coughing. Typical asthma symptoms tend to be variable, intermittent and worse at night. Asthma is commonly triggered by viral respiratory infections, exercise, smoke, cold and allergens such as pollen, mould, animal fur and the house dust mite.

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388 A national outcomes strategy for COPD and Asthma 2011; Department of Health.
Prevalence
The prevalence of asthma in England is one of the highest in the world, with approximately 5.9% of the population with diagnosed asthma (2008)390.

Mortality
Nationally, the number of deaths from asthma has remained level since 2000, and it is estimated that 90% of those deaths are associated with preventable factors.

Risk factors
WHO391 recommends that the fundamental causes of asthma are not completely understood. The strongest risk factors for developing asthma are a combination of genetic predisposition with environmental exposure to inhaled substances and particles that may provoke allergic reactions or irritate the airways, such as:

- indoor allergens (for example house dust mites in bedding, carpets and stuffed furniture, pollution and pet dander)
- outdoor allergens (such as pollens and moulds)
- tobacco smoke
- chemical irritants in the workplace
- air pollution.

What is COPD?
Chronic obstructive pulmonary disease (COPD) is a general term that includes chronic bronchitis and emphysema, and is characterised by airflow obstruction. The airflow obstruction is usually progressive, not fully reversible and does not change markedly over several months.

COPD is common, it is estimated that three million people are affected by COPD in the UK, equivalent to 2-4% of the population. An estimated two million people have COPD but much has not been diagnosed. Of those with undiagnosed COPD, 5% will have be at the mild end of the spectrum (see NICE).

Mortality
COPD is the fifth leading cause of death in the UK, accounting for 30,000 deaths each year, more than 90% of which occur in the over 65 age group.

Risk factors
- Most COPD cases are caused by smoking or exposure to second hand smoke. The lifetime risk of developing COPD as a smoker is 10 to 25%
- COPD cases caused by other risk factors such as air pollution, or polluted working conditions, are rarer in the UK than in other countries
- COPD is closely associated with levels of deprivation
- COPD mainly affects people over the age of 40 and becomes more common with increasing age.

Impact on the individual
Symptoms include cough, shortness of breath, and excessive sputum production. Chest infections are common. Exacerbations can result in hospital admissions. Breathlessness has a significant impact on quality of life.

Impact on business
COPD accounts for more time off work than any other illness.

391 WHO, Chronic Respiratory Disease: http://www.who.int/respiratory/asthma/causes/en/index.html#
Impact on NHS
Direct health care costs for COPD are an estimated £800 million\textsuperscript{392}.

The local picture – asthma

Prevalence
The recorded prevalence of asthma in Waltham Forest (as a percentage of GP practice list) was 4.5% in 2011. This is significantly better than the England average (5.9%) for the same year, and lower than the London average (4.9\%\textsuperscript{393}). The expected prevalence in the borough is 9\%, similar to the expected prevalence nationally and regionally. The gap between recorded and expected prevalence may represent under diagnosis. Refer to Maternal and Child Health section for asthma in children.

The local picture – COPD
(Unless stated, the following data has been supplied by the Interactive Health Atlas for Lung Conditions in England (INHALE)).

Prevalence
Between 2008–10, the recorded prevalence of COPD in Waltham Forest was 0.9\%. In 2011 the recorded prevalence as a percentage of patients registered with local GP practices was 1\%, equal to other London suburbs. Compared to England and London as a whole, recorded prevalence is lower. The expected prevalence of COPD is 3.2\%. The gap between recorded and expected prevalence is bigger in Waltham Forest compared with the England average. The gap between recorded and expected prevalence is a measure of undiagnosed disease.

Mortality
The COPD mortality rate per 100,000 population under the age of 75 is reported as not significantly different from the England average. Mortality in those aged 75 and under is considered premature or early death. Whilst the average rate of early death is not significantly different to the national average, local level data (2008–10) indicates that men in the borough have a higher early death rate due to COPD than their national counterparts. This is a similar profile to London as a whole and is compatible with higher smoking prevalence in men in the borough and London.

Figure 6.22 Under 75 mortality from COPD (2008–10 pooled)

\textsuperscript{392} COPD An Outcome Strategy for Chronic Obstructive Pulmonary Disease (COPD) and Asthma in England July 2011; Department of Health.

\textsuperscript{393} INHALE data report/spinechart.
**Health care services**

**Primary care**
The majority of asthma and COPD management is done in primary care, including diagnosis, prescribing, monitoring, patient education and continuity of care. Good quality management of symptoms is essential to avoid admissions into hospital and to maintain quality of life.

Asthma and COPD are clinically different diseases that share some symptoms and risk factors. Accurate diagnosis is one of the most important tools for optimal treatment of both diseases.

The percentage of patients on asthma registers with Asthma diagnoses with Measures of Variability or Reversability was 88.5% in Waltham Forest, this is higher than local and regional averages (86.4% and 86.5% respectively) but not significantly higher than the England average (87.2%).

The percentage of patients on COPD registers with diagnoses confirmed by spirometry is 92.1%. This is not significantly different from the England average and higher than the London and local (London suburbs) averages.

**Hospital admissions**
Hospital admissions and emergency hospital admissions for both asthma and COPD are significantly worse in Waltham Forest compared to England, London and London suburb averages. High hospital admission rates could be due to overall poor health of the population, poor management in primary and community care settings, or referral thresholds and practice particular to the local area. See INHALE profile online.

**Health inequality**
In 2012, an assessment of local data sources looked at cases of COPD by demographics. The results indicated that more cases were identified in people from White ethnic backgrounds compared with other ethnic backgrounds. Modelling suggests that the expected prevalence should be 3.36% for BAME population group in Waltham Forest\(^{394}\). The recorded prevalence is 0.3%, compared to a recorded prevalence of 1.3% for the White population who have a 4.26% expected prevalence. The difference in ratios of modelled to recorded prevalence suggests that diagnosis in BAME groups should be assessed for possible under-diagnosis. Expected and recorded prevalence has changed since this assessment took place and a refresh of this data is required.

**Figure 6.23  Number of COPD cases in Waltham Forest, 2012**

\(^{394}\) HNA Toolkit 2011.
The highest proportion of patients admitted to hospital for COPD in 2011/12 lived in the most deprived areas of the borough.

Evidence of effective interventions

Prevention and early detection

Current and ex-smokers are most at risk of contracting COPD. People exposed to dust and gases in the workplace are also at risk. The most effective intervention for preventing COPD is by not starting or stopping smoking, avoiding and controlling risks in the workplace.

Reducing smoking prevalence is one of the major health programmes in Waltham Forest. Evidence shows that educating young people to the dangers of smoking is an effective intervention to prevent taking up smoking. The government strategy to improve COPD outcomes identifies stigmatisation of lung disease as being ‘self-inflicted’ as a barrier to prevention and early detection activities. Health professionals and the public should work together to overcome this preconception. Better public awareness of lung disease can also improve early detection rates.\(^{395}\)

Health care

A review of case studies of evidence-based best practice in quality and innovation showed that the most cost-effectiveness services are those that prevent patients from being admitted to hospital, provide services at or close to home, and address issues of anxiety through community-based care, and treat psychological conditions.

What is the public perspective?

The results of a patient survey conducted in 2008\(^{396}\) suggest that the phase leading to an emergency admission can be quite long, implying there are opportunities to intervene earlier to prevent hospital admissions in patients. Just over half (57%) of these patients stated that they sought advice from their GP, respiratory nurse or hospital doctor by phone. Most respondents (85%) knew what COPD meant and 79% knew that they already had it. Only a quarter (25%) had been given a written plan for what to do when their chest symptoms worsen. The respondents made the following suggestions for service improvement:

- More care and help at home
- Greater access to respiratory nurses.

\(^{395}\) An outcomes strategy for Chronic Obstructive Pulmonary Disease (COPD) and Asthma in England.

\(^{396}\) The National Chronic Obstructive Pulmonary Disease Audit 2008: Patient Survey.
What we are doing to address the issues

Prevention
Tobacco control and stop smoking services are key services in Waltham Forest. A recent analysis of smokers and service users identified that men have significantly lower rates of stopping compared to women, and compared to the national average for men. The local stop smoking service has undergone a service redesign to improve accessibility and quality of services. More work is needed to engage in high risk groups, reduce supply of cheap cigarettes and other tobacco products.

Health care
Primary and Secondary care services have worked together on a range of improvement projects since 2009. Since 2011, a project to improve COPD care across the pathway has operated in the borough. The objective of the project has been to integrate aspects of primary, community and acute care in order to improve COPD care in Waltham Forest and align it further toward NICE Gold Standard and COPD Outcomes Standard. These state (among others) that patients should have a positive experience of care, are helped to recover from episodes of ill-health, that their quality of life should be enhanced and that they should be prevented from dying prematurely.

Additional types of respiratory clinic have been introduced to the community pathway to achieve the improved management of patients with COPD in primary and community care. This also involves enabling patients to better self-manage their condition. The anticipated outcome of these clinics is reduced admissions to A&E by patients suffering an exacerbation.

Whipps Cross Hospital has introduced a ‘discharge bundle’. This has five elements of care: a) the patient is offered a smoking cessation referral; b) inhaler technique is checked and (if necessary) corrected; c) a self-management plan is issued and checked that it is understood by the patient; d) a rescue pack is issued and the patient is instructed how to use it; e) a follow-up by the community respiratory team is planned prior to discharge.

This is supported by community post-discharge clinics which offer a follow-up appointment to the patient within two weeks. These clinics check the elements of the discharge bundle and assess the patient for pulmonary rehabilitation. It provides the patient with a face-to-face contact with the community respiratory team. They can be confident to use this service as their first point of call when they are next unwell with their COPD. Administration and communication between the community team and the hospital has been improved. Patients are now handed over on a daily basis between the Whipps Cross clinical team and nurse within the community respiratory team. Discharge summaries are now electronically transferred by e-mail rather than paper. Discharge summaries and communication with the patient is recorded on RiO.

Diagnostic spirometry clinics provide validated diagnoses of COPD to the NICE Quality Standard. These tests are conducted by health care assistants with oversight from a respiratory nurse. General practitioners can refer to these clinics.

What evidence is there where we are making a difference?
The following recommendations from previous JSNA’s have been put into place:

• Provide a high quality, evidence-based package of early detection and care for all patients with asthma and COPD. In particular focus on COPD diagnosis using spirometry, ensuring smokers receive stop smoking support from NHS Stop Smoking Services, and provide all diagnosed COPD patient with Pulmonary Rehabilitation
• Embed new pathways including self-management
• Increase improvements in diagnostic spirometry and severity recording with community and prescribing support
• Reduce emergency admissions and readmissions with more effective use of community resources
• Redesign pulmonary rehab provision.
Progress will be assessed and evaluated to assess how well these recommendations are improving outcomes for local residents.

**Priorities for the next five years**
- Full implementation of the Waltham Forest Health and Wellbeing Strategy, Enterprise Employment and Skills Strategy, and Housing Strategy to reduce the number of people living with a life-limiting illness
- Invest in school-based programmes proven to prevent young people from taking up smoking that address the general school population and targeted interventions
- De-stigmatise lung disease to increase public engagement with early detection programmes and risk-limiting services for stopping smoking and increasing exercise
- Continue to improve, through primary care transformation, diagnosis and management of COPD in primary care to reduce the number of emergency admissions
- Provide high quality patient education and rehabilitation services that enable COPD patients to maintain good mental health, mobility, and reduce social isolation.
6.7 Ambulatory care sensitive conditions

An ambulatory care-sensitive condition (ACSC) is one where admission to hospital is potentially avoidable through good quality primary and preventive care. Most chronic conditions such as asthma, diabetes, and COPD are considered ACSCs. Detecting ACSCs early when there is a possibility of cure or of management in the community could delay not only hospital admissions but also mortality.

As well as treatment, ambulatory care also includes preventive measures such as screening and the management of risk factors such as cholesterol and blood pressure. When patients are admitted to hospital for treatment of an ACS condition, this can be thought of as an avoidable hospital admission or failure in primary care delivery. Rates of ACSC admissions are therefore often used as a measure of the quality of primary care in a local area.

The North East Public Health Observatory classified the ACSCs into three categories:

1. **Chronic conditions**, i.e. those long-term conditions for which rate of progression and incidence as acute episodes requiring hospital admission can be reduced by effective primary and community care (e.g. asthma, chronic obstructive pulmonary disease, congestive heart failure, angina, hypertension, diabetes, musculo-skeletal disorders such as rheumatoid arthritis, anaemia and nutritional deficiencies). Waltham Forest has higher unplanned admissions than London as shown in Table 6.23.

2. **Acute aggravated conditions**, i.e., those where failure to provide timely and efficacious primary care interventions aggravate the condition and thus produce the need for hospital admission (e.g., cellulitis, convulsions and epilepsy, dental conditions, ear-nose-throat infections, gangrene, gastroenteritis, pelvic inflammatory disease, perforated/bleeding ulcer, pyelonephritis).

3. **Immunisable conditions** i.e., those where immunisation can prevent the onset of the condition and hence the need for a hospital admission (e.g., influenza, pertussis, rheumatic fever, tetanus and the range of conditions for which we usually provide population wide vaccination programmes)\(^{397}\).

The ambulatory care sensitive conditions discussed in the 2012/13 JSNA include diabetes and respiratory diseases chronic obstructive pulmonary disease and asthma.

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