



Isle of Wight Public Health Annual Report 2008



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Foreword

2008 is the 60th anniversary of the National Health Service and this is reflected in the content of this report. Since 1948 much has been achieved in terms of improvement in the health of people on the Isle of Wight and elsewhere. Further improvement will require individuals to take responsibility for adopting healthier lifestyles, commissioning to procure services so as to minimise mortality and morbidity arising from the most common diseases and health service providers to ensure they adhere to the highest standards of service provision.

This report, together with that from previous years and the data of the Joint Strategic Needs Assessment shows that the focus of attention should be on cardiovascular disease, cancer, respiratory disease and mental illness. This was emphasised through the development of the World Class Commissioning Strategy and investment has been made accordingly.

The Isle of Wight NHS PCT is a key partner of the Island Strategic Partnership which has developed the Eco Island sustainable community strategy 2008 - 2020.

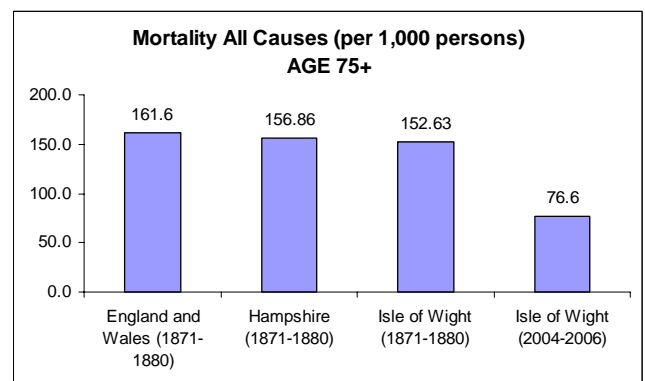
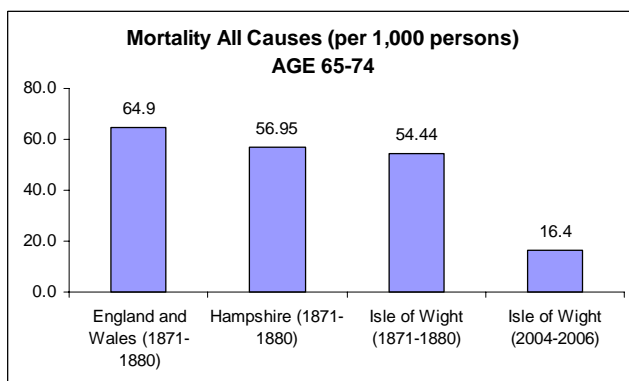
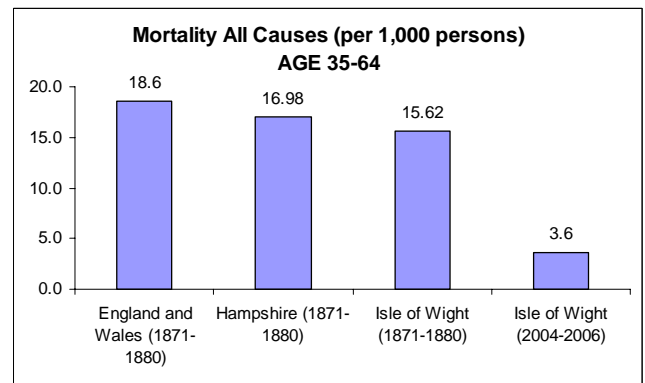
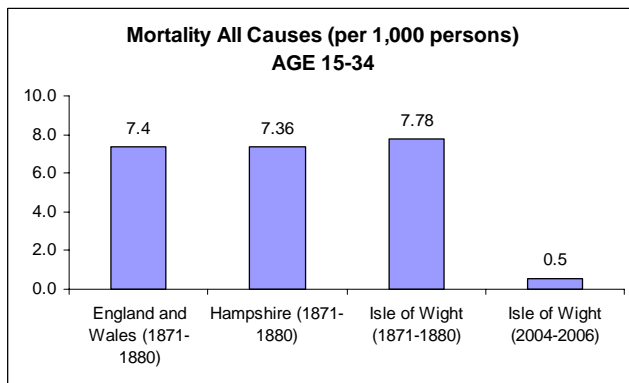
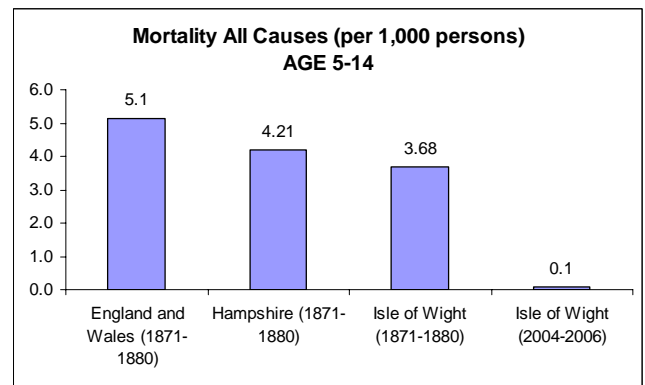
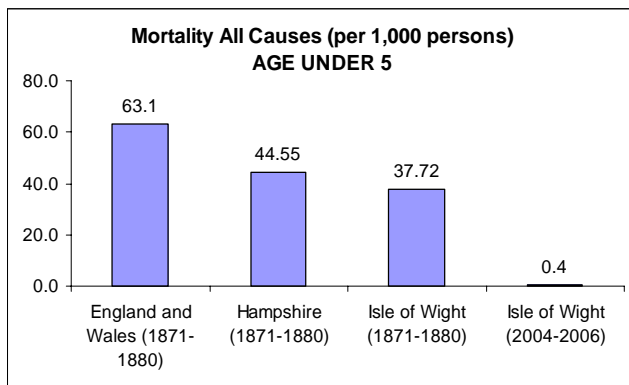
The strategy seeks to assure our future as an Island which is under four themes. Thriving; Healthy and Supportive; Safe and well kept; and Inspiring.

Within the overall framework the PCT must work in partnership to build stronger, healthier communities, with more opportunities for individuals and families to engage in lifestyle changes in their local communities and increase their quality of life and well-being. Public Health has a positive contribution to make throughout and I look forward to accept the challenge this brings in improving the health and well-being of our communities.

Dr Jenifer Smith
Director of Public Health & Chief Medical Adviser

Previous annual report topics, 2003 to 2006

Ageing	2003	Influenza	2006
Defining public health	2003, 2005	Obesity	2005, 2006
Demography	2005	Screening	2003
Deprivation	2003, 2004	Sexual health	2006
Emergency planning	2003	Smoking	2004
Health inequalities	2006	Suicide	2005
Health promotion	2003	Teenage pregnancy	2003
Health protection	2003	Vaccination	2004
Housing	2004		



Chapter 1 NHS 60: Drawing lessons from the history of the Isle of Wight Statutory Public Health Service

Executive summary: key points

- A central Isle of Wight Public Health Department is important in maintaining an overview of the Island's health while the delivery of public health programmes requires close/local working with communities.
- Health inequalities have always been present. In recent years they have again widened and proactive measures are required to close the gap (see chapter 2).
- Interpreting epidemiological data requires great care.
- Public health should not underestimate the importance of the environment to health.
- There is increasing public interest in things historical. The history of public health can be employed to promote current public health issues.

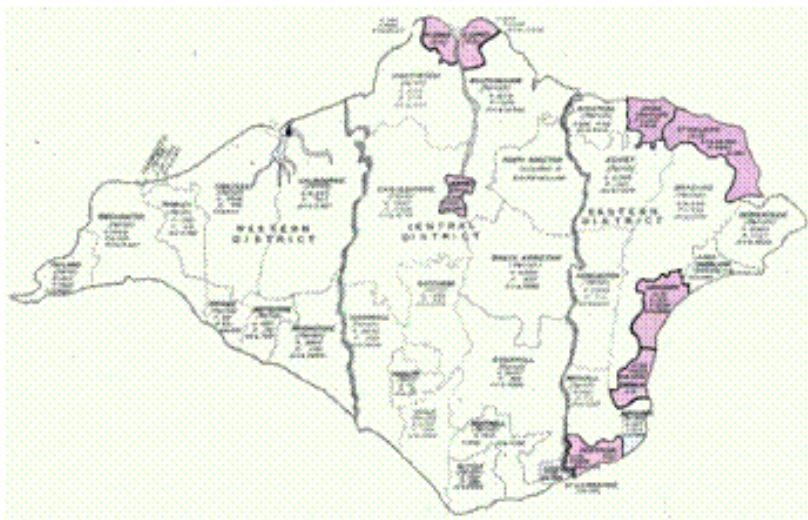
1. Introduction

This annual report is being published in the week leading up to the 60th anniversary of the inauguration of the NHS - a proud achievement. A separate booklet has been written about the start of the NHS on the Island, highlighting the role played by the Director of Public Health of the day. This chapter takes a brief look at the history of the statutory public health service of the Isle of Wight that can trace its origins back to the 1872 Public Health Act.

2. One Island, 9 sanitary authorities and 17 medical offices of health

The 1872 Public Health Act ensured nationally that within each district there was only one authority responsible for different threats to public health. However, for the Island it failed to administratively unite its divided communities.

Modern local government on the Island has its origin in a number of private acts of parliament and other measures that created eight town commissions/boards of health: Newport 1786, Cowes 1816, Ryde 1829, Ventnor 1844, East Cowes 1859, Sandown 1869, Shanklin 1863 and St Helens 1872. On 10th August 1872 these eight bodies became Urban Sanitary Authorities (USAs) and the remainder of the Island became the Rural Sanitary Authority (RSA). Each of the 8 USAs appointed a medical officer of health (MOH), but the RSA appointed 9 MOsH, one for each of its poor law patches - making 17 MOsH in all. The Island did not have one unifying County Medical Officer until 1912.



Map of the Isle of Wight included in Dr Groves' 1906 Annual Report (USAs are shaded)

Early handwritten annual reports produced by the various Isle of Wight MOsH are to be found in the records of the Local Government Board (LGB) now deposited at Kew. These are detailed contemporaneous accounts of circumstances then existing on the Island (see example of the report produced in 1876 for Shorwell by its MOH Dr Castle). Entertainingly, these reports also include the 'marking' (underlining and occasional derogatory comments) of LGB officers and exchanges of correspondence between these officers and the MOsH:



1876 Annual Report for Shorwell (Dr Castle)

LGB Officer: *'I am to enquire whether you have made the systematic inspection of your district required under... (then a long quote of a regulation).'*

MOH: *'I have to state that I am perfectly acquainted with every detail of the sanitary condition of my district.'*

Another MOH: *'I have a personal acquaintance with every house, cottage, pigsty and privy in the district.'*

Although the Island had 19 MOsH with very small districts, and inevitably there were differences of opinion, the majority of the MOsH served for many years and local newspaper obituaries record for prosperity the high regard in which they were held by their local communities. At the funeral of Dr Joseph Groves in 1907 it was said: *'Every house and shop in Newport had blinds down and shutter up; pavements were lined with crowds of poor persons, chiefly men, with bared heads'. 'He was simply worshipped by the poor, attending many for years (as a GP) without fees.'*



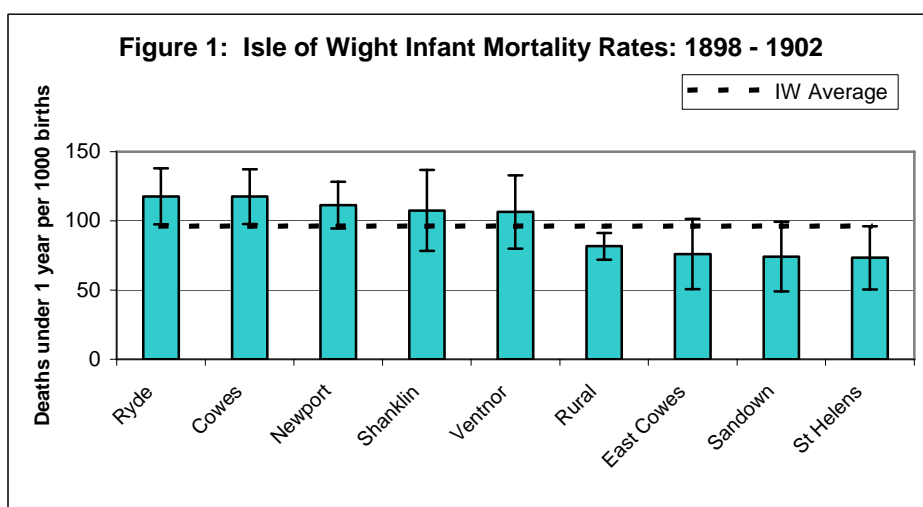
Dr Groves RSA MOH, 1883-1907

3. Improved life expectancy but little apparent concern over health inequalities

The death rate of residents of the Isle of Wight in the 19th and early 20th centuries was consistently less than the average for England and Islander's life expectancy will have exceeded that for England.

Lower than English average death rates for the Island's town and the fact that each MOH was employed only for their district appears, however, to have negated any incentive to critically compare death rates. A retrospective comparison is most easily made for infant mortality (the number of deaths under the age of one per 1,000 births) and this has been reconstructed in figure 1 for the nine Isle of Wight Sanitary districts for the five years 1898 to 1902.

Here it can be seen that the average district infant mortality rate varied widely between 69 and 130 per 1,000 births. Confidence intervals have been calculated and these show that the differences are unlikely to be due to chance (basically small number effects).



Confidence intervals have been calculated and these show that the differences are unlikely to be due to chance (basically small number effects).

The reasons for these particular inequalities in health are lost in the mists of time but it is inconceivable that Island residents in the twenty first century would tolerate such a difference in the rate of infants dying between two parts of the Island. (The average Island infant mortality rate in the 3 years 2004 to 2006 was 2.2 deaths among infants aged under one per 1,000 live births and there is no clear difference between the Island towns). Nevertheless, modern differences in all age mortality rates persist and the gap has been getting wider. Initiatives to reduce current health inequalities are discussed further in chapter 2.

4. Evaluation of the benefits of Isle of Wight isolation hospitals

During the 19th and early 20th centuries, the work of the Isle of Wight MOsH was dominated by communicable diseases such as tuberculosis, diphtheria and whooping cough, that all too often killed the vulnerable and especially young children.

The only available effective preventative measure was smallpox vaccination (vaccination against other common communicable diseases were not available until much later). Diphtheria antitoxin, that became available on the Island in about 1900, was for some time the only effective counter measure against a complication of established infection.

Faced with such a high incidence of communicable disease, all the Isle of Wight MOsH advocated isolation hospitals where notified cases of clinical illness could be accommodated; by compulsion if necessary. The Island sanitary authorities adopted this recommendation with different degrees of enthusiasm. Sandown and Shanklin commissioned a Joint Isolation Hospital in 1899, while Cowes did not have beds available until some time after 1925 (by purchasing beds at the Fairlee Hospital, Newport).

In 1925, Dr Fairley the County Medical Officer, published in his annual report a significant piece of work reviewing, for scarlet fever and diphtheria, the numbers of notifications and deaths that had occurred between 1900 and 1925. The years when districts had an isolation hospital were compared with years when a hospital was not available (see Table 1).

Table 1: Comparison, 1900 - 1925, of years in which an isolation hospital was available with years in which an isolation hospital was not available. (Rates per 1,000 resident years.)

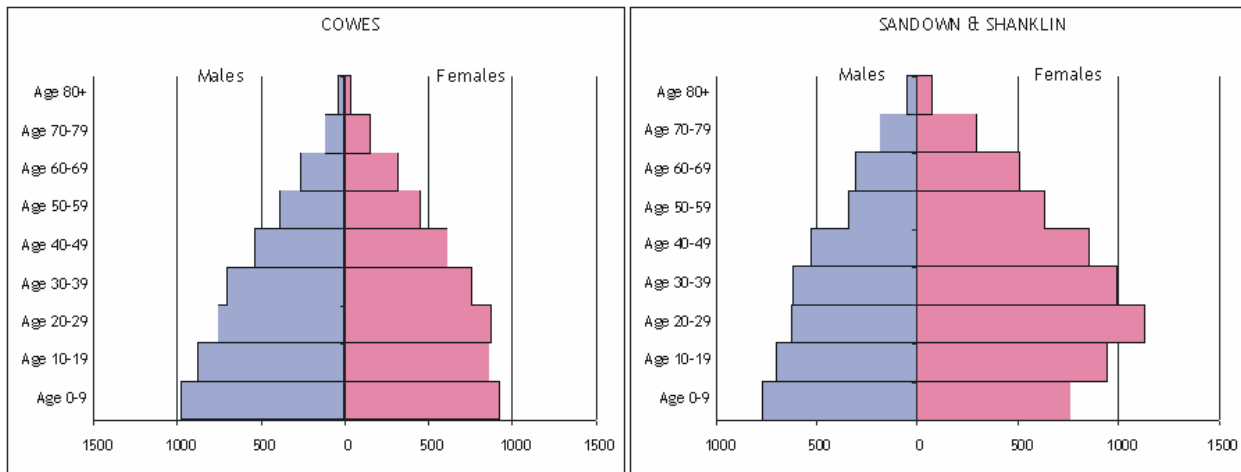
	Scarlet Fever		Diphtheria	
	Notification rate	Death rate	Notification rate	Death rate
Years in which an isolation hospital was not available	1.88	0.02	1.98	0.23
Years in which an isolation hospital was available	1.78	0.02	0.98	0.09

Dr Fairley's conclusion was that isolation hospitals made no difference for scarlet fever but did reduce the notification and death rate for diphtheria. However, we now know that individuals with diphtheria are infectious before they develop symptoms, and in a community where the condition is common, there are many asymptomatic carriers (individuals who have the organism but are not unwell). In such a setting, confining clinical cases in an isolation hospital is unlikely to reduce the incidence/notification rate of the disease.

Epidemiological (population) studies like that undertaken in 1925, are prone to confounding factors that have to be identified and allowed for if valid conclusions are to be drawn.

This particular study did not allow for the decrease in mortality that will have occurred from 1900 to 1925 due to increase in the use of antitoxin or that the population profile of the various Island towns was very different. Diphtheria remained a killing disease until the introduction of a vaccination programme at the height of the war in 1942.

1911



5. A safe water supply - the importance of the rural heart of the Isle of Wight

Early annual reports underline the importance the MOsH placed on clean drinking water and safe sewage disposal. Frequently they drew attention to wells that were poorly sited and/or uncovered and pollute streams from which residents drew their water.

However, when a government medical inspector (Dr Ballard) visited the Island in 1880, he found that at least one MOH was not concerned about pollution entering a river on his patch the consequences rather being an issue for an MOH further down stream! Dr Ballard pointed out the importance of maintaining high public health standards especially within the rural part of the Isle of Wight, as this was the source, for the Island's coastal and other towns, of water, milk and other 'essentials of life'.

As the Island's resident and tourist population expanded, the MOsH were involved in local piped water work schemes where bore holes and river extraction with water treatment were utilised as an alternative to wells or individuals self collecting water from streams etc. Unfortunately however, there was little cooperation between districts and in 1890 Dr Groves wrote: *'When the subject [water supply] is considered from the standpoint of the general good, it really does seem unfortunate that each little district must have its own little waterworks when by combination all may have been supplied most abundantly and probably at less cost.'* The Island did not have a unitary Water Board until 1950 when one was imposed by the Minister of Health.

Sewage disposal was dealt with by the coastal towns by outfall pipes, occasionally with some pre-treatment. A final solution to this issue was only achieved in 2002 when a £200m scheme (Seaclean Wight) was completed by Southern Water. All of the Island's wastewater from its coastal towns is pumped to Sandham, where it is treated before being discharged via a 3km outfall pipe into the deep waters of the English Channel.

6. Isle of Wight history of public health project

The Isle of Wight history of public health project consisted of a series of seven evening workshops that concluded in April 2007. The workshops were advertised to the public and funded by the Worshipful Society of Apothecaries of London. An average of 20 people attended (range 26 to 14) and 6 of those attending undertook a mini-project (either by finding their own material or based on papers provided). Project presentations were made on the Isle of Wight experience of diphtheria, cholera, polio and TB, the link between art, x-rays and the creation of general hospitals and, finally, public health aspects of the growth of Brighthstone village around 1970. Invited speakers included Iain Blair, Fred Caws, Johanna Jones, Martyn Pearl and Virginia Berridge, Professor of History at the London School of Hygiene & Tropical Medicine.



Display boards advertising IOW history of public health project

Specific learning points from the workshops included:

- The Island was important in pioneering fluoridated toothpaste.
- The Island experienced significant outbreaks of polio in 1947 and 1950 that devastated tourism for those years. Due to vaccination, polio is now a thing of the past but we still need to maintain good uptake of childhood vaccination (including MMR).
- The Island has had its share of *all* the pandemics that have affected the mainland, e.g. Black Death, cholera and pandemic flu in 1918/1919. We are unlikely to avoid the next flu pandemic.
- The Island has several important connections with Dr John Snow, the famous doctor of the Broad Street outbreak of cholera and remover of the handle of the water pump.
- Ventnor was an important health resort and many TB patients were cared for at the Royal National Hospital. This is now the site of Ventnor Botanic Gardens.
- We have exchanged public health problems of the past for those of the present and future, such as smoking, diabetes, cardiovascular disease, obesity and suicide.

7. Conclusions

The Isle of Wight Public Health Department has 136 proud years of history to build on. Life expectancy has increased spectacularly but public health now needs to address health inequalities that it was perhaps blind to in the past (see section 3 above and chapter 2). Though the introduction of vaccination and other measures, many killing diseases are now in abeyance although re-emergence needs to be avoided through maintaining vaccine uptake (see chapter 5). Finally, public health needs to continue to champion the importance of the environment to health.

Chapter 2: Health inequalities on the Isle of Wight: Cardiovascular disease prevention project

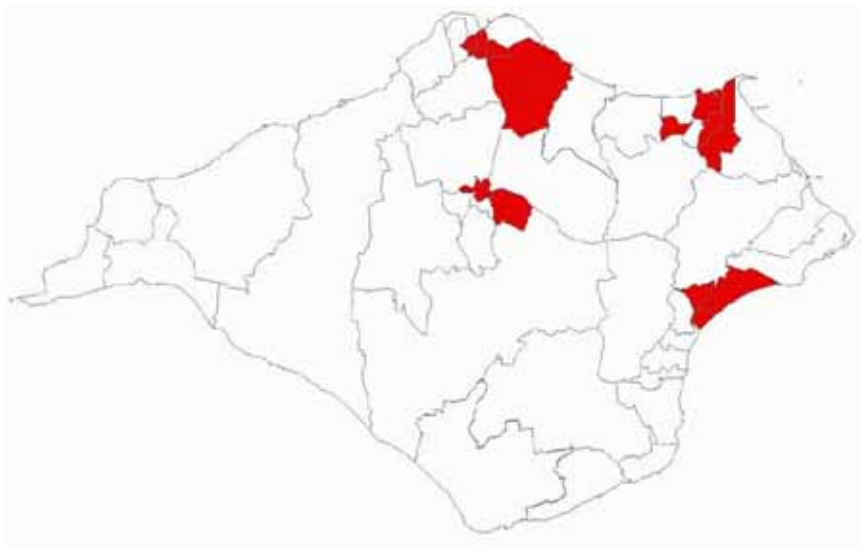
Executive summary: key points

- The 2006 Annual Report identified that the mortality rate of 12 electoral wards exceeded the mortality rate of the rest of the Island and that this inequality has been widening.
- Funding made available by the Strategic Health Authority has made possible a Cardiovascular Prevention Health Inequalities Project that started in January 2008.
- Invitation to a health check sent to individuals in 12 target wards aged 45 to 74 whose cardiovascular risk factors have not recently been assessed and offer advice, interventions and if necessary treatment.
- The project incorporates 12 elements ranging from GP/outreach screening to community development projects to increase access to physical activity and weight management.
- It is early days but initial uptake of individuals to health checks by their GP practice has exceeded that expected.

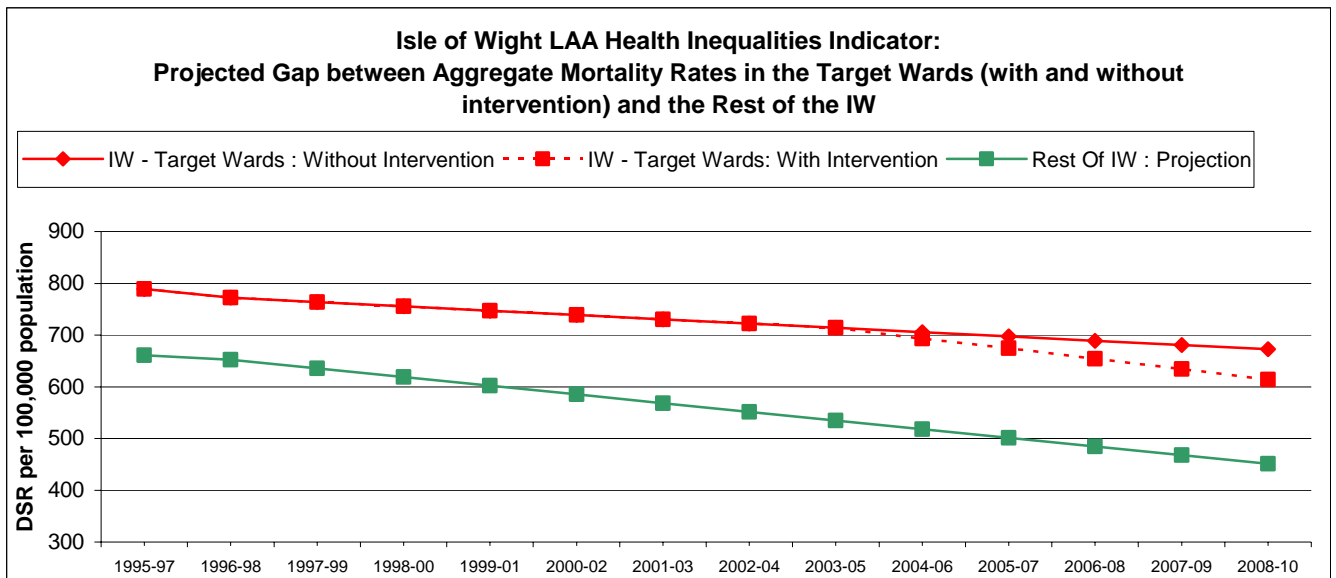
2. Introduction

The 2006 Public Health Annual Report highlighted the unpalatable fact that, along with many mainland districts, the Island has significant geographical inequalities in life expectancy. In particular, 12 of the Island's 48 electoral wards (red in the map below) have an average of nearly three years less life expectancy than the remaining 36 electoral wards. Furthermore, the gap between the mortality rate for the red (12 target wards) and the rest of the Island (36 wards) has been getting wider. Proactive action is now required to close the gap (see figure 2).

Figure 1: 12 target wards for the cardiovascular disease prevention project



Ward Name
Cowes Central
Cowes Medina
East Cowes South
Newport North
Osborne
Pan
Ryde North East
Ryde South West
St. John's East
St. John's West
Sandown North
Sandown South



The red trend lines represent the target wards:

- the unbroken line represents the predicted trend without any intervention.
- the dotted line represents the required trend to close the gap.

The green trend line represents the predicted trend for the rest of the IW.

The previous (2006) report discussed the importance of addressing health inequalities at source ('upstream'/preventative measures) "*by tackling wider determinants, such as poverty, poor educational outcomes, worklessness, poor housing, homelessness and the problems of disadvantaged neighbourhoods*". It also drew attention to the need, if health inequalities were to be narrowed in the short term, to have "*a particular focus on people who already have, or at high risk from, one of the main life threatening diseases*".

The 2006 report concluded by making recommendations for making best use of available resources, however in October 2007, the Strategic Health Authority announced special funding for tackling health inequalities. It has now become possible to build on these recommendations through the launch of the Isle of Wight's Cardiovascular Prevention Health Inequalities Project, a programme to address cardiovascular risk factors in the 12 electoral wards with the highest mortality. The remainder of this chapter is about the cardiovascular prevention project.

3. Cardiovascular Inequalities project

Programme summary

Duration of project:	January 2008 to March 2009.
Target population:	Residents aged 45 to 74 of the 12 electoral wards listed on page 8.
Personal resident invitations:	Residents of the target wards aged 45 to 74 who do not have a recent record of their cardiovascular risk factors in their GP notes are being sent a personal invitation to a health check at their practice.
Reducing individual cardiovascular risk:	All those attending for a health check will be given advice about minimising their risk of cardiovascular disease. Those at moderate risk are being offered free or subsidised access to lifestyle interventions (see pages 17 to 22). Those at significant risk are recommended treatment.
Community involvement:	Strong community involvement can help encourage individuals in taking up invitation for health checks and importantly in maintaining lifestyle changes. The project is setting out to obtain this by taking a mobile health service into the heart of communities. Engaging with community partners including local councillors, Parish councils, community and voluntary groups, local housing associations, and businesses, to assist the service to reach as many of the target group as possible through various existing networks.
Innovative features:	Working in partnership with GPs presents the most effective opportunity to use their comprehensive patient registers to send personal health check invitations to those most in need. Partnership with the business sector has enabled the project to take health checks to those otherwise unreachable by invitations. This approach affords direct entry to workplaces to offer screening services and lifestyle advice. A range of local activities is being developed, offering increased local access to lifestyle interventions.

3. Some questions and answers

- Why are residents aged 45 to 74 in other electoral wards not included in the project?

The funding for the project has been given specifically to address the electoral wards with the highest mortality. However, residents from the other 36 wards can request a health check from the GP and non target ward individuals will not be turned away by the outreach team.

- Why is the project time limited (due to conclude at the end of March 2009)?

Funding has been given for 15 months to be followed by a phase of analysis and discussion. Hopefully many of those in the 12 target wards will by the end of the project, have had their cardiovascular risk factors checked. Those not reached may need other subsequent approaches, however, while accepting that some will decline participation in any project.

- What assurance can be given that the project will have lasting benefits?

In addition to the individuals in the 12 target wards who participate in the lifestyle intervention and treatment, the project has already been of benefit in providing standardised training to practice staff in assessing and calculating cardiovascular risk and in motivational interviewing. Links made between public health/practices and clusters will be maintained and if further inequalities monies become available, the Island will be well placed to bid for funding to take innovative features of the project that will have been piloted, further forward.

4. Programme elements

GP Locally Enhanced Service (LES)

GP practices with patients in the 12 target wards have been commissioned to provide a locally enhanced service for cardiovascular disease. This consists of checking the notes of individuals aged 45 to 74 living in the target wards. If there is no recent record of cardiovascular risk factors, individuals are being sent a personal invitation to a health check at their practice. If there is no response (individuals are able to decline further involvement at any point), phone contact is attempted by a practice nurse or healthcare assistant.



Dr John Partridge
GP St Helens and Governance Lead

Practice staff have been trained by the project in the initial record search algorithm, in assessing cardiovascular risk and in calculating a summary risk score. This is then the basis for offering advice, lifestyle interventions, and treatment. Four GP Practices have adopted an added option to extend identification of patients, increasing the numbers to 6,000 invited for assessment to 6,000 in total.

Outreach Service

For various reasons many of those sent a personal invitation will not attend their GP practice for a health check. In order to reach as many of these individuals as possible, the project has commissioned the Isle of Wight Chamber of Commerce to provide an outreach service run by two specialist nurses. By arrangement, the outreach team will visit workplaces where a high proportion of the workforce are from the 12 target wards and offer the same health check and interventions available under the LES from GP practices. If individuals are found to be high risk and require treatment, they are referred back to their GP. The outreach service will also visit other non-workplace sites within the target wards to offer health checks. These sites will be selected and advertised in association with local groups.

The outreach service has begun conducting health check sessions in workplaces and at local community venues. Their first session in a workplace saw 40 people attending, 23% within the target group. The service will be enhanced during June when a specially equipped mobile unit is delivered. The mobile unit will target those areas where the best response is obtained and where GP returns show that the response to invitations have been poor.



Tracie Sacre & Jenny Edgington

Medicines management

Minimising cardiovascular risk (and reducing mortality so the dashed line shown in figure 2 is approximated) consists not only in offering health checks and advice/lifestyle interventions but in also ensuring that the drug treatment that is already being prescribed is optimally maintained.

The inequalities funding has allowed the appointment of a full-time Nurse Prescriber within the medicine management team who will identify patients already receiving prescribed medicines to reduce cholesterol, working with GP's and patients to maximise their health and embed more effective prescribing practice.



Sue Ward & Julie Packer

The Clinical Lead Nurse has analysed all statin (lipid/fat lowering drugs) prescriptions for target age range patients within the 4 clusters, making comparisons with the whole population. Risk score assessments for housebound patients and carers are also being offered within the 12 target wards.

An enhancement to the smoking cessation service is possible as Champix prescriptions for smoking cessation clients will be issued, monitored, and supported by the Nurse lead.

Enhanced pharmacy smoking cessation capacity



Smoking is the major cause of health inequalities in England killing an estimated 87,000 every year and 100 annually on the Isle of Wight.

Smoking continues to be most prevalent among the most disadvantaged in society and targeted health improvement measures are required to affect change. A reduction of smoking prevalence, particularly amongst smokers in routine and manual groups, is dependent on a range of effective interventions.

The cardiovascular disease prevention project monies have enabled two initiatives to take place. The first initiative has been a Locally Enhanced Service with 11 Community Pharmacies serving the target wards to provide one to one smoking cessation support. It is recognised that community pharmacies have the potential to reach and treat large numbers of smokers. These pharmacies are providing three hours per week one to one support and advice. Funding from the project has also enabled General Sales List Nicotine Replacement to be supplied direct to quitters. To date 42 smokers have engaged with the service, 2 of which are now 4-week quitters.

Smoking cessation tier 3 specialist adviser

The second initiative has been the provision of funding for a specialist smoking cessation advisor. The specialist advisor is working within the core Island Quitters Team. This role is helping to establish a comprehensive infrastructure of advice, support, and pharmacotherapy to provide smokers with an accessible and responsive smoking cessation service.



Island Quitters Office

Health Trainer Service

Although not funded or commissioned by the inequalities project the IOW Health Trainer Service (HTS) is supporting the project by taking referrals from all elements of the programme. The IOW HTS is part of a nationwide initiative launched by the White Paper '*Choosing Health: Making Healthy Choices Easier*'. A Health Trainers' role is to provide easy access to health information and health services to adults over the age of 18 years. This includes individually tailored support to those who want to improve their health, wellbeing, and lifestyle and involves Health Trainers holding one to one meetings to help individuals improve their health in positive and manageable ways using recognised behaviour change approaches. In this way client needs are identified so that realistic personal goals can be set that are achievable and measurable.



Cllr. Abraham &
Becky Hunter

Health Trainers provide support for up to 6 sessions over a period of about 3 months to help people achieve their goals. Health trainers work part time or are volunteers working in their own communities.

Inequalities project funding has enabled Behaviour Change Management training to be provided for all participating practices. This is the beginning of working with individuals on the process of change when lifestyle issues are identified; facilitating referral to the Health Trainer Service when in depth and sustained support is indicated.

CVD nutrition



Paul Rogers

This element involves a partnership that has been commissioned from the voluntary sector through the Rural Community Council, to produce a full Food Mapping survey of target areas, a Community Food Worker/Home Economist to deliver community-based food and health interventions and delivery of Supermarket Safaris within all target areas.

Weight management

Individuals with a significant weight problem will be able to take advantage of joining commercial weight management groups for a number of weeks with free vouchers.

They will have a choice of 2 commercial groups in their area, which will start them on a programme of support to manage their weight. One group combines weight management with an exercise programme. To date 10 people have been referred.



Public awareness campaign



This will highlight when to use emergency services in the event of chest pain and abnormal heart rhythm.

This is being developed through the Outreach Service, with the cooperation of the Ambulance Service, British Heart Foundation, and local business sector. Partnership working will take full advantage of existing marketing potential.

Cardiac rehabilitation

Cardiac rehabilitation is where those who have suffered heart disease engage in a phased programme of recovery. There are 4 phases, two of which are after discharge from hospital.

To ensure robust data collection of all those participating in all 4 phases, an IT software package has been installed. This will enable a greatly enhance service and will record all patients attendance and progress through all the phases. Data Analyst support has been provided by the Public Health team for data input, now all new patients from 1 April 2008 will be entered onto the system directly. Engagement of a physiotherapist in assessing the wider menu of activities through phase 3 and 4 has begun. There is greater scope for heart patients to access and



Helen Young

attend existing community activities where they live. To help with the uptake of these activities, the Heart Care Club (a long-standing heart patient's support group) is engaging in providing volunteers to train as mentors. The training will be conducted through Health Improvement/Public Health established trainers.

Physical Activities Co-ordinator



Louise Gray & walkers

A Physical Activities Co-ordinator will be working with referrals from participating surgeries and outreach nurses signposting patients/clients to activities to suit their requirements. The aim is to encourage people to carry out the Chief Medical Officer's recommendations for adults of at least 30 minutes a day of moderate intensity physical activity on 5 or more days of the week.

The post is a secondment post from the Local Authority, bringing expertise and knowledge of local activities available. It also provides support and advice on most appropriate activities including facilities available at fitness centres and within local communities.

As required this may involve the extension or enhancement of existing programmes/classes in each of the ward areas. Opportunity to extend and develop appropriate activities and widen engagement of adults in Physical Activity including Health Walks will be established.

Local Authority's leisure services

To extend gym services available at the Westridge Centre, Ryde. This will include increasing staff capacity and specialist training to facilitate referral to exercise through general practice. It will also offer access to all local authority leisure centres through the existing 'One Card' (concessional rate card) system.

In total 150 'One Cards' have been purchased for distribution to clients participating in activities at Local Authority venues in the target areas. Use of the 'One Cards' will be monitored to ensure maximum benefit. Since January 2008, 25 people have been referred to a range of physical activities.



Evaluation



A comprehensive evaluation of the GP LES and Outreach Service will be conducted by Portsmouth University. Questionnaires and protocols are being submitted to Southampton Ethics Committee.

Cluster development

The 12 target wards for the project (see figure 1) are broadly clustered in four parts of the Island. A variety of meetings have already taken place with local Cluster Intervention Groups, Housing Associations etc within cluster target area. A joint Neighbourhood Day with Medina Housing Association will take place in the Cowes area in July 2008. Joint venues will be used by the Outreach Service in the Pan and Ryde areas, utilising local contacts to maximise community engagement. Marketing will be as localised as possible to ensure maximum engagement of the target population. This can be achieved by using local lines of communication and newsletters.



5. Conclusion

It is still early days for the project but GP Practices are reporting that the number of patients wishing to attend for assessment has been higher than expected. The project has enabled GP Practices, particularly to see people with lifestyle change needs that would not have otherwise been brought to their attention. Direct conversations with individuals taking part in the project have been very positive with many appreciative of the opportunities made available to improve their health. A greater understanding of health inequalities is being achieved. GP's, Allied Health Professionals, partners and individuals are being made aware of how inequalities impact on our communities, and the benefits that can be made on the health and wellbeing across the target groups by increasing access to services.

Chapter 3: Screening

Executive summary points

- The Island has a proud history of high quality, pioneering screening services. Cervical screening has been in place for 42 years and this year sees the 20th anniversary of breast screening service on the Island, the first in Wessex.
- With the expansion of screening services - bowel cancer screening will start in 2009, the PCT needs to adopt a more strategic approach to programme monitoring and planning.
- The main public health challenge for screening is maintaining the uptake of established services (e.g. cervical screening) while promoting uptake of new services as they are introduced (eg chlamydia and bowel cancer screening).

1. Some key questions answered

- What is screening?

A public health service in which members of a defined population (eg the Isle of Wight) who do not necessarily perceive they are at risk of or already affected by a disease or complications are offered a test or asked a question, to identify those individuals who are more likely to be helped than harmed by further tests or treatments to reduce the risk of disease or its complications.

- How are NHS screening programmes determined?

At first, all potential screening sounds like a good idea (prevention is better than cure) but for example, there would be no point in detecting a condition for which there is no treatment. In global terms, benefits must exceed disbenefits (including net costs, as NHS screening monies could be put to alternative uses). The NHS programme is determined by the UK National Screening Committee (www.screening.nhs.uk).

- Why do screening programmes need to be high quality and how can this be assured?

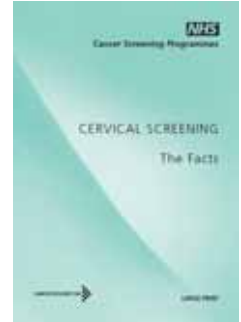
As well as doing good (eg stopping the development of a cancer or diagnosing an established cancer at an early stage), screening programmes can potentially do harm. Harm can include anxiety while patients await initial test results; some patients are suspected of having an abnormality that turns out not to be the case, while some cancers and other conditions are not detectable by the screening test (e.g. some breast cancers are not visible on a mammogram) or are not detected due to technical or human error. For these reasons, screening programmes have to be of the highest possible quality and all parts of the programme are assured by internal and external audit (for example for cervical and breast screening by the South Central Quality Assurance Reference Centre www.ociu.nhs.uk).

2. NHS screening programmes

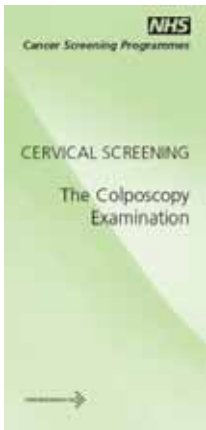
2.1 Cervical screening

- Purpose of the programme

The national cervical screening programme has been established to prevent the development of uterine cervical cancer (cancer of the neck of the womb) by testing samples of surface cells collected at cervical screening internal vaginal examinations. These examinations are most frequently undertaken in a GP's surgery by a practice nurse trained to cause minimum discomfort. A leaflet explaining the examination is enclosed with every invitation letter sent by the programme so that women can make an informed choice.



If insufficient cells are obtained for interpretation by the laboratory, then a repeat smear will be requested (although the frequency of repeats has recently been decreased - see below). A repeat test in 6 or 12 months may be requested if minor abnormalities are found in the cervical cells.

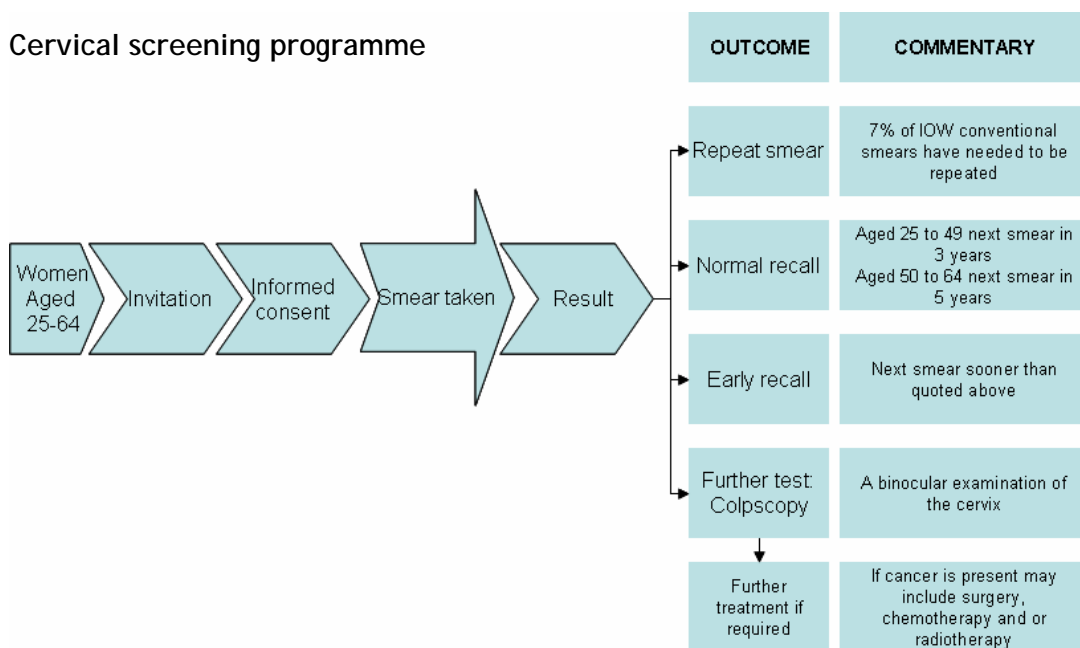


If the abnormal cells persist or if the abnormalities are more significant, the woman is requested to attend the colposcopy clinic at St Mary's, where the cervix is visualised under magnification during an internal vaginal examination. Abnormal cells can sometimes be treated under a local anaesthetic at the first visit to colposcopy, without requiring further appointments. If colposcopy is advised, an explanatory leaflet is sent to the woman and GP practice staff are very willing to answer questions and give reassurance.

(The following website (www.cancerscreening.nhs.uk/cervical) may also be found useful.

It is important to note that *'research has shown that cervical screening has prevented an epidemic in the UK that would have killed about one in 65 of all British women born since 1950 and culminated in about 6,000 deaths per year in this country. 80% or more of these deaths, up to 5,000 per year, are likely to be prevented by screening.'*

- Cervical screening programme



- **Origins of the Isle of Wight Cervical Screening programme**
- 1966 Start of Isle of Wight campaign for the Prevention of Cancer in Women.
- 1987 IOW colposcopy service established.
- 1988 Implementation of the national NHS Cervical Screening Programme based on computerised call-recall and set quality standards.
- 1991 Laboratory service moved from Ryde County Hospital to St Mary's, Newport.
- 2008 1st April - Liquid based cytology implemented and laboratory service moved to Portsmouth.

Population Screening for Cancer of the Cervix.

In conjunction with the Island Campaign for the Prevention of Cancer in Women, clinic sessions commenced at County Hall in October 1966.

Three thousand, six hundred and seventy-five women wished to be seen at the Clinic. During the period January to October 1967 the number of smears taken was as follows:—

At Clinic Sessions	...	...	...	891
By General Practitioners	...	...	...	1208
By Local Hospital Authority	...	...	...	724
By Family Planning Association	...	...	...	138
Others	...	...	...	65
				3026

and the response to Clinic appointments was as under:—

Number of notices sent	...	...	...	1424
Actual attendances	...	...	...	819
Appointment changed or reason given for				
failure to attend	...	...	...	463
Defaulters	...	...	...	142

From October 1966 to December 1967 twenty-eight sessions were held and a total of 1,056 women received a smear test. In addition, 11,025 women preferred to be seen by their General Practitioners, and appointments with family doctors and at the Clinic are being arranged according to the rate at which slides can be accepted by the Pathology Laboratory, with initial priority being given to the 35 to 45 year age group.

All suspicious results have been referred back to family doctors for further investigation and treatment. It is important to realise that any woman of any age with symptoms can, of course, be referred through her family doctor in the usual way and does not need to await an appointment within her age group for a smear to be taken.

During the period January to October 1967, 45 of the 47 Island family doctors dealt with smears.

My thanks are due to Dr. D. Edwards, Chairman, Mrs. A. B. Oliveira, Secretary and all members of the Island Campaign, whose hard work and enthusiasm have made this service possible.

Extract from Dr Machell's 1967 annual report

- **Recent developments**



Linda Twisleton
Screening Co-ordinator

From the start of the national NHS Cervical Screening Programme in 1988 until 1st April 2008, cervical smears taken from Island women were processed and read in the Island's pathology laboratory. The laboratory consistently achieved good performance figures and a small team of committed and experienced staff provided a very good service to local women.

On 1st April 2008, a new method of processing cervical samples known as liquid based cytology or LBC was introduced as part of the roll out of a national programme.

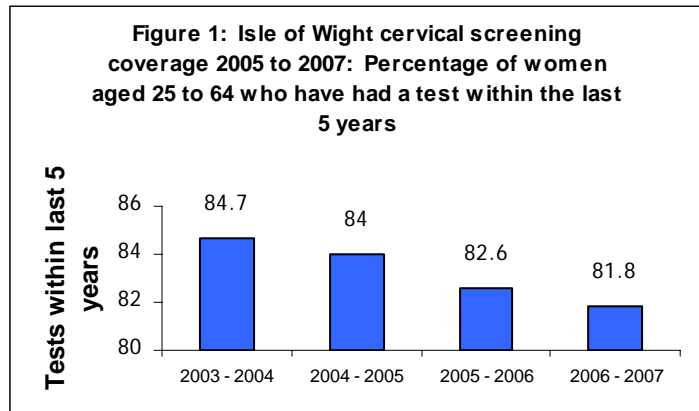
This is unlikely to be noticed by women having a test in that the vaginal examination to collect a sample is basically the same. However of great benefit, the rate of calling women back for repeat smears is set to drop from 7% to 2%.

Investment in new laboratory equipment for LBC requires a minimum throughput of 35,000 slides a years to make the investment cost effective and to meet quality assurance requirements (the recent throughput of the Island's laboratory had been of the order of 10,000 slides per year). Consequently from 1st April 2008, St Mary's cervical cytology department laboratory department closed and amalgamated with the laboratory at Queen Alexandra Hospital, Portsmouth.

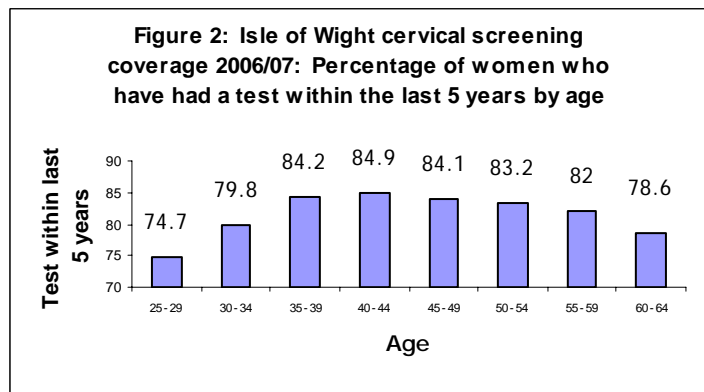
It has been known for some time that 70% of cases of cervical cancer are caused by 2 strains of the Human Papilloma Virus (HPV). From September this year, vaccination (3 doses are required over 6 months) will be offered to girls in school year 8 by a school based programme. A catch up campaign will subsequently be promoted for females up to the age of 18 (for further details see www.immunisation.nhs.uk/hpv). Vaccination against HPV will not eliminate the need for cervical screening but will further reduce the risk of cervical cancer.

Current programme performance

From an Isle of Wight public health perspective, the major concern with the cervical screening programme is a fall in population coverage (the percentage of women aged 25 to 64 who have had a test within the last 5 years). In the past the Island has had coverage rates among the best in the South Central region but in line with a national trend, coverage on the Island has been falling.



Coverage is least good among younger women which is of considerable concern as if a regular routine of cervical smears is not established, the coverage rate in 5 to 10 years time will be very low indeed.



4 of the 17 IOW GP practices have a coverage of less than 80% while 9 have a coverage of 82% or better. Factors that could account for the differences include small numbers, local custom, and practice, different age profiles (although the denominator is women aged 25 to 64) and different degrees of deprivation. The latter has been examined in figure 4.

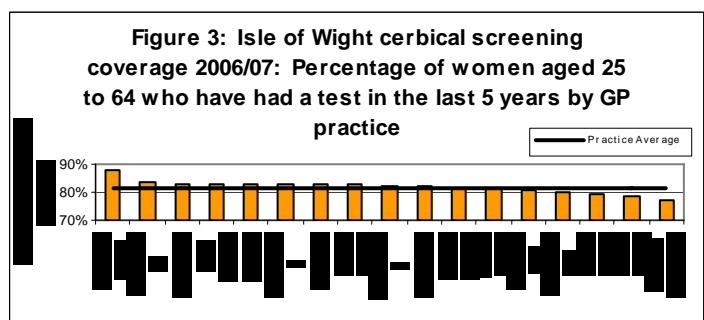
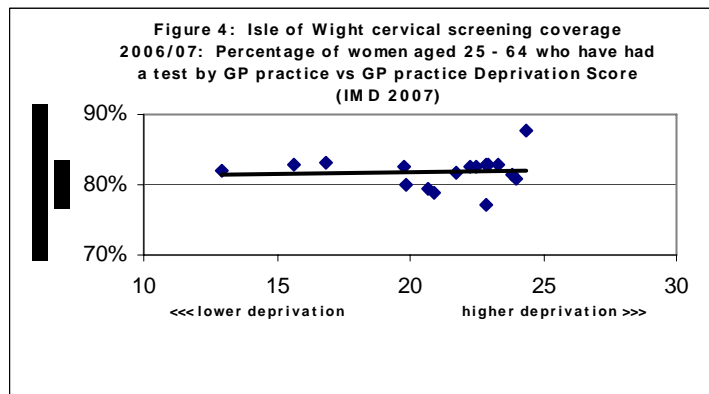


Figure 4 shows no linkage between the average deprivation score (2007 index of multiple deprivation) of a GP practice and cervical screening coverage, suggesting that deprivation is not a factor at that level.



- **Future opportunities and challenges**

By 2010, it will be a requirement that women wait no longer than 2 weeks from their cervical sample being taken to the letter containing their results being sent to them. This will require all those involved in the screening service including practice nurses, GPs, laboratories and others to work together to ensure there are no delays in the system.

The major public health challenge facing cervical screening for the Island is maintaining coverage above the target of 80%, in spite of national falling rates. Nationally, work has been commissioned by the NHS Cancer Screening Programme of the Improvement Foundation to address falling participation in cervical screening by younger women aged 25 to 35 but this will not be available until 2009. During the coming months, public health will:

- Undertake further work on examining the correlation between cervical screening coverage and deprivation at electoral and sub electoral ward level.
- Work with commissioning and others on making general practice cervical screening appointments more accessible.
- Ensure that available national posters and leaflets are used to best effect.
- Include the promotion of cervical screening uptake in future targeted inequalities initiatives.
- By working with Wish-Net, the IOW Integrated Sexual Health Network will ensure that enquiring about the most recent cervical smear is a routine part of taking a sexual history and that smear taking is part of a one stop service for contraception and STI screens.

2.2 Breast screening

- Purpose of the programme

The NHS breast screening programme has been established to detect breast cancer at an early stage through mammography (x-ray examination of the breasts). On the Island, mammograms are undertaken at the Breast Screening Unit located at St Mary's Hospital Newport.

Women are invited in batches according to their GP practice of registration in a three year cycle.



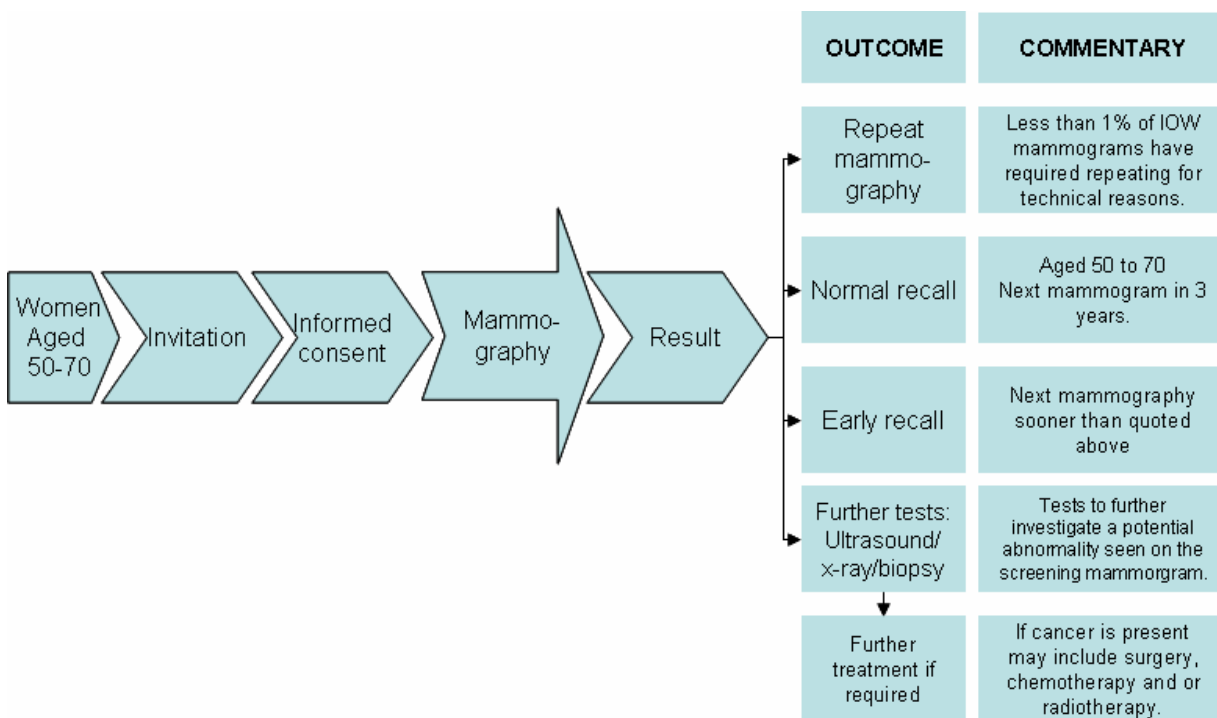
IOW Breast Screening Unit



If an abnormality is detected in a mammogram, the woman is invited for further assessment. This may consist of further mammography or 'triple assessment' may be undertaken. This includes clinical examination, imaging (frequently using ultrasound) and needle biopsy. The intention is to see all women for assessment within 3 weeks of an abnormal mammogram (see figure 9). The results of all assessment investigations are reviewed by a weekly multidisciplinary screening meeting and a clear management decision is reached.

'In February 2006, the Advisory Committee on Breast Cancer Screening concluded that breast screening is saving 1,400 lives a year in England.'

- Breast screening programme



- **Origins of the Isle of Wight Breast Screening programme**

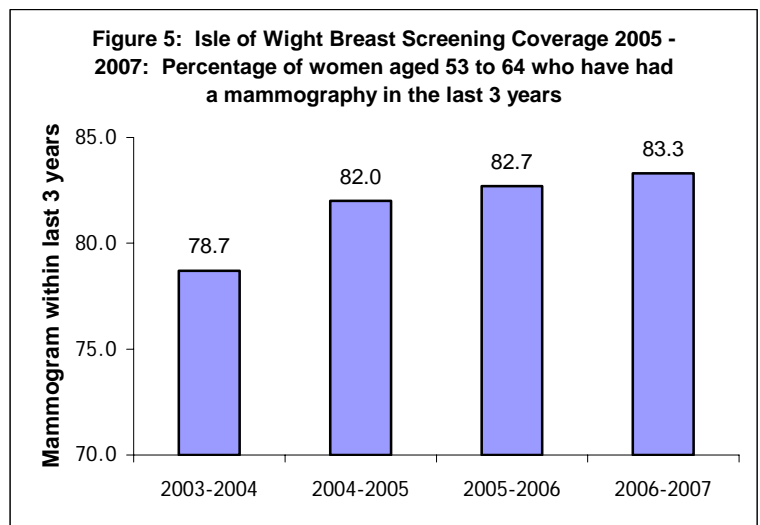
- 1988 8th May - Implementation of national NHS Breast Screening Programme.
- 1988 16th June - Breast screening started on the Isle of Wight.
- 1993 Date; purpose built IOW Breast Screening Facilities opened.
- 2000 Breast care nurses move to adjoining Applegate bungalow.
- 2003 First unit in Wessex to implement routine 2-view mammography for each breast.
- 2004 Extension to main Breast screening unit building. Age for calling women extended from 50 to 64 to 50 to 70.
- 2007 Merger with the Southampton and Salisbury Breast Screening Service

- **Recent developments**

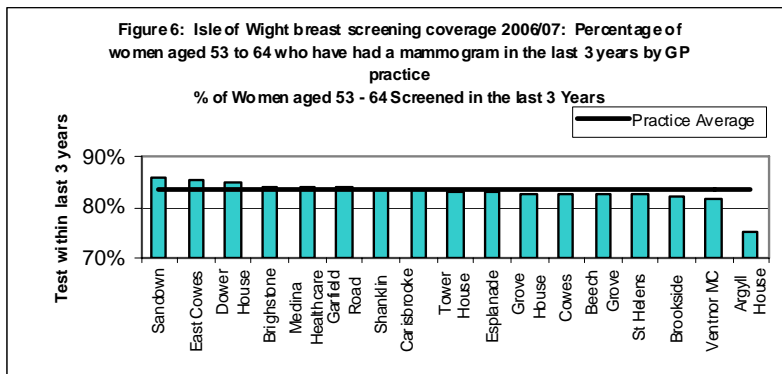
As can be seen above, the Island's breast screening service was one of the first in the UK to start. The unit has always achieved very good results, but as with the cervical screening programme, has been dependent on a small number of dedicated staff. In October 2007 the Isle of Wight breast screening programme was merged with the Southampton & Salisbury screening services, with Dr Rubin as programme director. This is in line with the national trend for larger units led by programme directors who specialise in breast screening.

- **Current performance**

In contrast to cervical screening, breast screening has managed to maintain coverage above 80%.

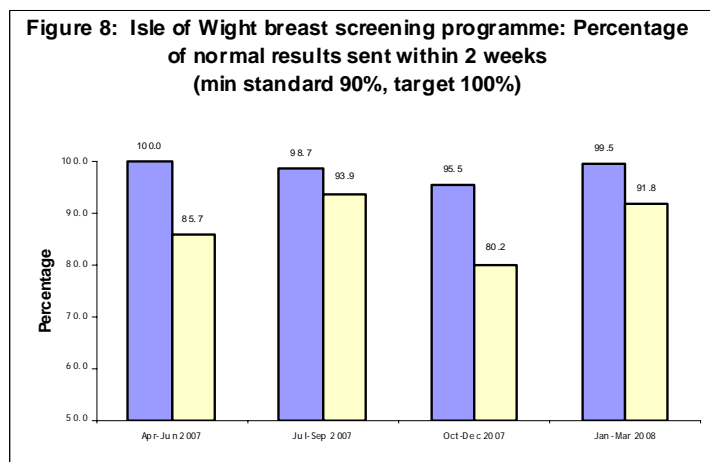
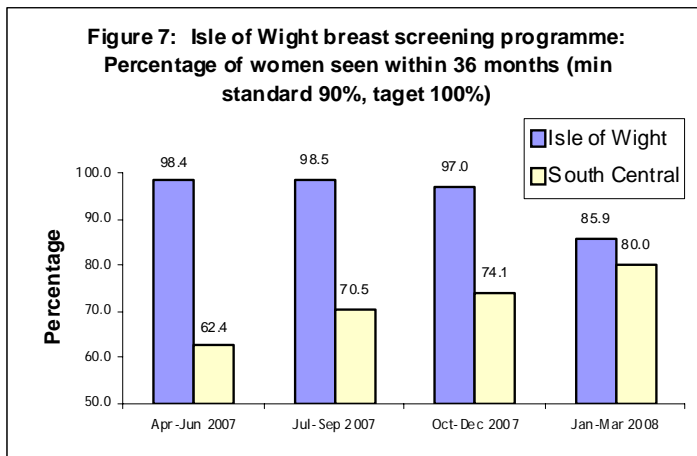


Only 1 of the 17 IOW GP practices has a coverage of less than 80% and is such an outlier that explanatory factors are being sought - eg was this practice affected by the breast screening staffing problem encountered in January to March 2008 (see figure 7).

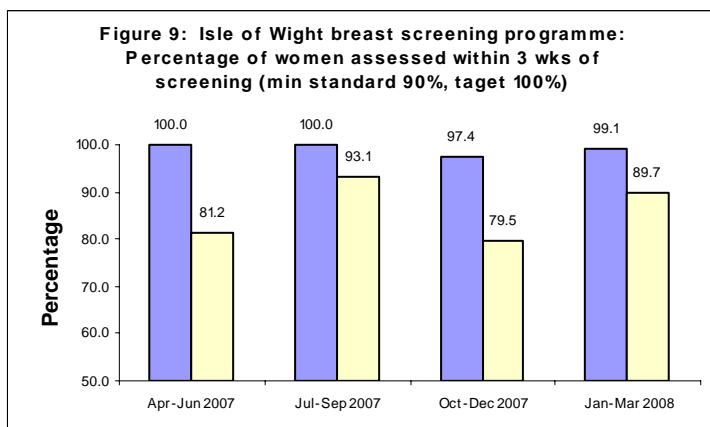


The Isle of Wight Breast Screening Unit continues to better NHS minimum standards. Three parameters in particular are monitored on a quarterly basis.

The Isle of Wight has consistently performed well in keeping up to date with 3 yearly calls of women aged 50 to 64 for screening. The fall off in performance in January to March 2008 was due to changes in staff timetabling. Reorganisation and some extended working has brought this back on track.



The Isle of Wight programme has consistently performed well in sending normal results to women following screening. This is important, as noted on page 19, as awaiting a result is an anxious time.



Finally, the Isle of Wight programme also has a good performance in seeing women for assessment following an apparently abnormal mammogram (see page 23).

- **Future opportunities and challenges**
- Sustainable solution to the increase in screening from extension of call to women aged 47 to 73.
- At present, women are invited for breast screening seven times at three yearly intervals between 50 and 70 years. By the end of 2012, this should have extended to nine screening rounds between 47 and 73 years with a guarantee that women will have their first screening before age 50 - at present some women wait until nearly their 53rd birthday before they receive their first invitation. There is increasing evidence of the clinical and cost-effectiveness of screening women up to age 73.
- Replacement of conventional with full field digital mammography.
- Screening of women at high genetic risk of breast cancer with MRI scanning (at Southampton).
- Assessment of screen detected lobular cancer with MRI scanning (at Southampton).
- Provision of vacuum assisted breast biopsy.

2.3 Ultrasound scanning in pregnancy

- **Purpose of the programme**

Ultrasound examination of the developing baby can be undertaken for a number of purposes other than screening eg dating the pregnancy, determining if there is more than one baby etc. In respect to screening, ultrasound is undertaken at 11 to 13 weeks of pregnancy as part of a programme to detect Down's Syndrome. It is also used mid-pregnancy (15 to 21 weeks of pregnancy) to detect fetal anomalies.

Deciding whether to opt for various screening tests in pregnancy is a difficult decision for parents. A booklet has been written by the UK National Screening Committee to assist subsequent discussion with midwives and doctors.

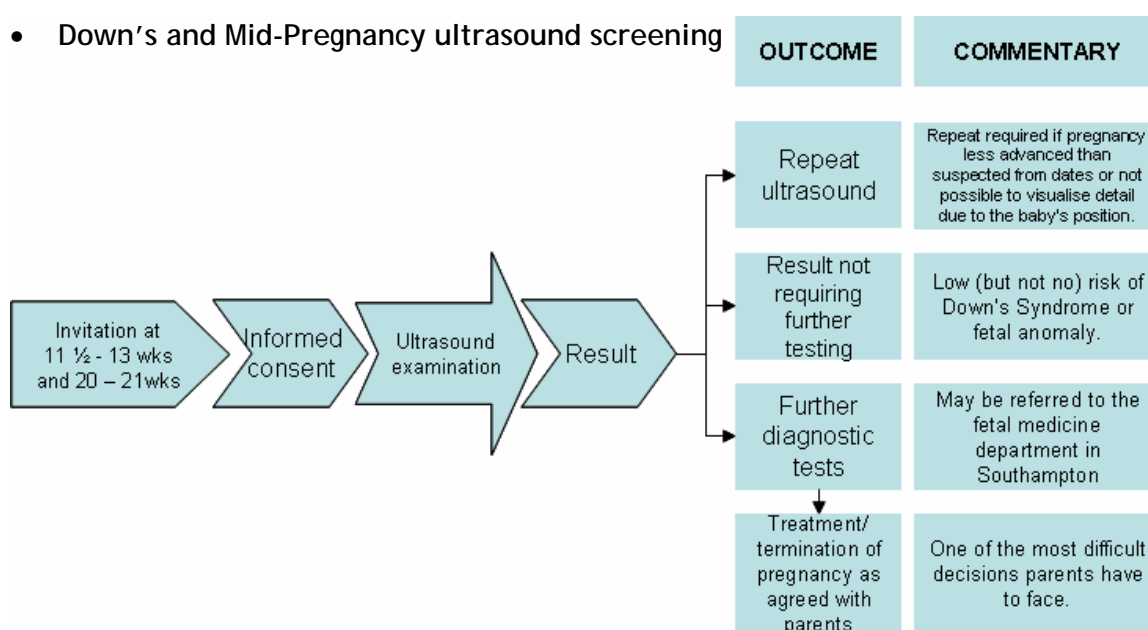
As with all screening programmes, Down's Syndrome screening and mid-pregnancy ultrasound scanning have limitations and not all anomalies will be detected (see figure 10). Overall, about a quarter of babies with Down's Syndrome are not detected by screening tests.



Figure 10: If present, chances that an abnormality will be detected by mid pregnancy ultrasound scanning.

Description	Chances of being detected
Defect of the skull (Anencephaly)	99%
Open spinal cord (Spina bifida)	90%
Missing limbs/long bones	90%
Excess fluid within the brain (Hydrocephalus)	60%
Structural heart defect	25%
Cerebral palsy	Cannot be seen on scan
Autism	Cannot be seen on scan

• Down's and Mid-Pregnancy ultrasound screening



• Origins of the programme

1979 *Diagnostic* obstetric ultrasound service became available.

1982 Ultrasound screening at 18 weeks gestation started.

1998 Nuchal translucency screening (for Down's syndrome) started.



Presentation of cheques for the Baby Scanner Appeal 1981

• Recent developments

In May 2007, in line with national standards, the Isle of Wight Down's syndrome screening programme was extended to include not just nuchal translucency screening but also a blood test taken on the same day as the scan at 11 to 13 weeks of pregnancy. A combined adjusted risk is then calculated and the woman is informed of the result and supported in its interpretation.

- **Current performance**

The performance of the Isle of Wight obstetric ultrasound scanning programme is high and is monitored by the Wessex Ante-Natal Detected Abnormalities Register that is operated by the Wessex Clinical Genetics Service based at Princess Ann Hospital, Southampton.

- **Future opportunities and challenges for obstetric ultrasound screening**

Cervical length - this is undertaken on women who have had a previous mid-trimester miscarriage or significant cervical surgery. A normal scan can avert the need for an intervention such as cervical cerclage.

Middle Cerebral Artery Doppler can be used to detect anaemia in a fetus at risk. At present the Island staff are learning the technique and it is hoped to offer the service shortly.

2.4 Bowel cancer screening

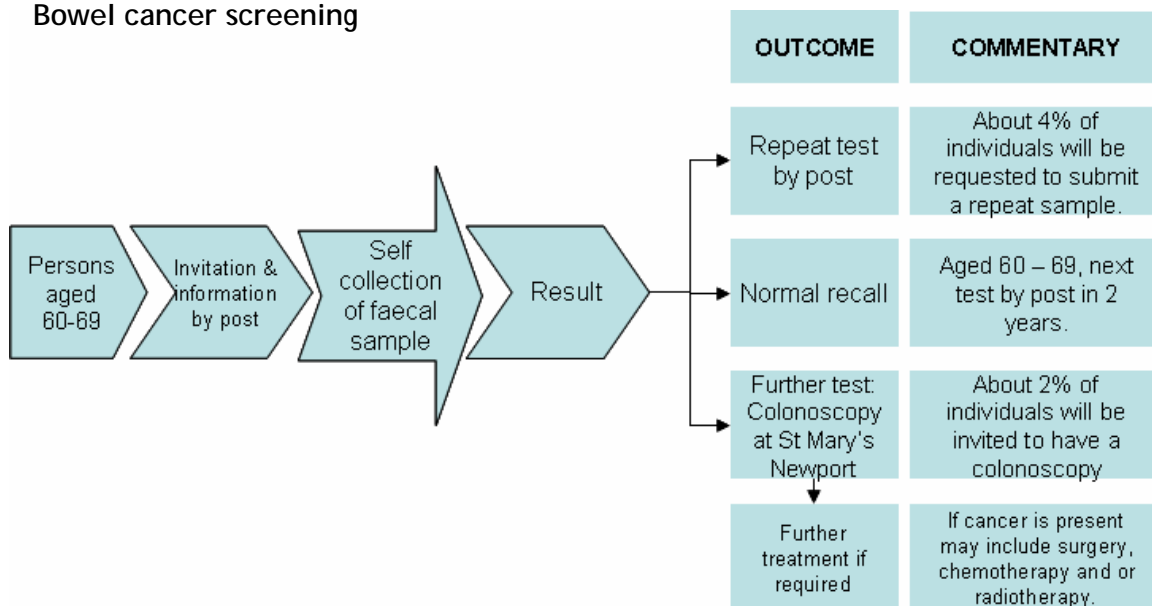
- **Purpose of the programme**

The NHS Bowel Cancer Screening Programme is being rolled out across England to detect bowel cancer at an early stage when it is more effectively treated and to detect polyps in the bowel that could develop into cancer (see www.cancerscreening.nhs.uk/bowel).

The programme will start on the Isle of Wight in 2009. Residents aged 60 to 69 will be sent faecal sample collection kits to be returned by post to a mainland laboratory specialising in bowel cancer screening. The programme will be extended to residents up to age 75 from 2010.

If a trace of blood is detected (by the hub laboratory) in a faecal sample, a repeat sample will be requested by post. Where samples are abnormal, individuals will be invited to attend St Mary's Hospital Newport for colonoscopy (a telescope examination of the bowel).

- **Bowel cancer screening**



- **Challenges**

Establishing the colonoscopy service to NHS screening standards.
Obtaining high uptake of the programme.

- **Future opportunities and challenges**

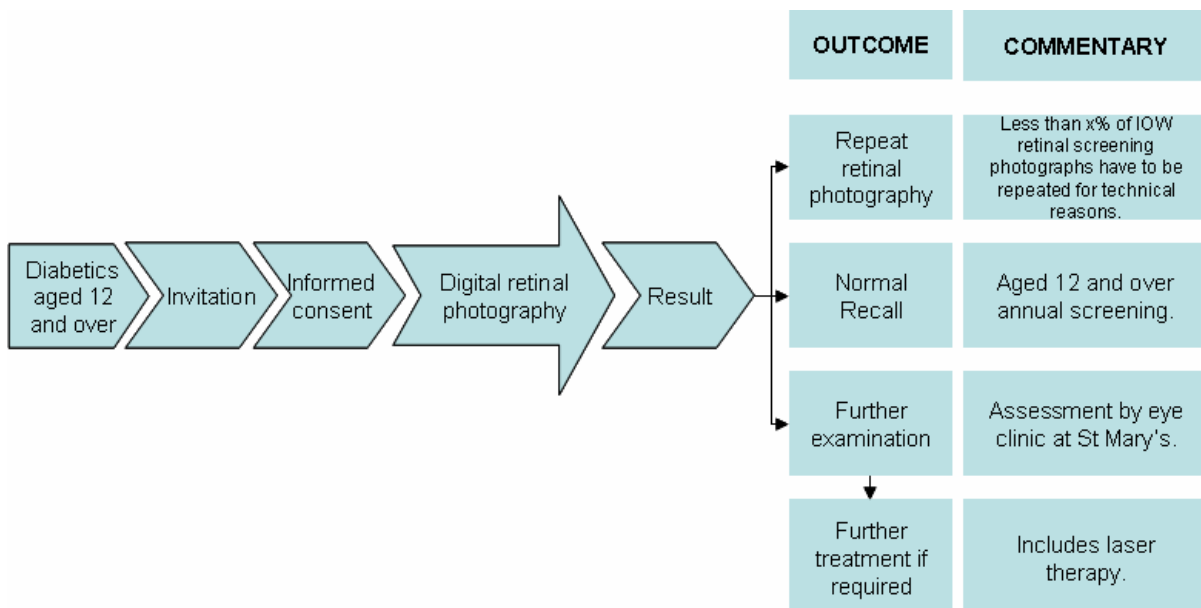
In order to be able to provide further test colonoscopies on the Isle of Wight, St Mary's needs to meet new screening programme accreditation criteria for facilities, equipment and staff. Work is underway but much remains to be done to meet the end of 2009 deadline.

2.5 Diabetic retinopathy screening

The NHS diabetic retinopathy screening programme has been established to detect proliferative diabetic retinopathy (abnormal formation of new blood vessels at the back of the eye) that untreated can bleed and lead to blindness. Early detection and treatment (usually with laser therapy) halves the risk of sight loss.

Screening consists of taking digital photographs of the back of each eye usually once the pupils have been temporarily dilated with drops. This wears off after a couple of hours but means the screened individual cannot drive home from the appointment. On the Island screening takes place in a mobile van that is parked at GP surgeries and at the (Ophthalmic) eye department at St Mary's Hospital, Newport. The digital photographs are read by a Retinal Screening Service that includes staff who work at St Mary's and the Southampton University Hospital NHS Trust. If laser therapy is required by Island residents, this is generally undertaken in the ophthalmic department of St Mary's Hospital.

- **Diabetic retinopathy screening programme**



- **Recent developments**

In line with the NHS diabetic retinopathy screening programme, central call and recall from a computer based with the service in Southampton was started in April 2008. GPs securely upload details of their patients known to have diabetes and postal invitations for screening are issued either to attend the screening van parked at the patients GP practice or the 'static' camera that is located in the eye department at St Mary's.

- **Current programme performance**

In January 2008, 5,714 Island residents were known to have diabetes and the target for screening (80% coverage) for the year was set at a minimum of 4,500. However, since April several technical problems have been encountered and the numbers screened has fallen behind that required to meet the target.

Additional screening sessions are being arranged but currently up to 30% of the screening shots offered to patients are not being taken up. Further work is being undertaken to investigate the reason for this. From July evening screening sessions will be offered at the eye department at St Mary's.

- **Future opportunities and challenges**

- Improving access for those who are housebound and to those in residential and nursing homes.
- Providing a service equivalent to that available in the community to prisoners.
- Ensuring that the interval between screening and a normal results letter or between screening and assessment does not exceed target times.

4. Recommendations

- The PCT should establish a district screening committee to meet quarterly and maintain an overview of the performance of established screening programmes and of plans to implement new programmes.
- Informed by forthcoming national research, public health together with primary care commissioning should formulate a plan for equalling or exceeding national screening uptake/coverage targets.

Chapter 4: Children & Young People

Executive summary: key points

- The Isle of Wight Children and Young People's plan has identified the five priority areas for the 24,000 0 - 18 year olds who live on the Island.
- Local Authority and the PCT have joint targets for all five-priority areas of the plan. Under the Local Area Agreement they will work together to ensure target delivery.
- This chapter reviews a range of existing programmes that address health and wellbeing issues. With recommendations to review, re-design and take forward in partnership work to tackle the identified priorities.
- Key concerns - Educational achievement, Smoking, Teenage Pregnancy, Alcohol, and Obesity.



1. Introduction

After exploring data on some of the most vulnerable of the Island's children and young people, this chapter details for six health improvement programme areas the national policy drivers, local prevalence data and initiatives currently being taken on the Island. Finally future recommendations are made.

The key local policy framework for delivering these health improvement programmes is the Local Area Agreement within the Children and Young Persons plan.

The Isle of Wight Children and Young People's Plan (www.iwight.com/childrenstrust) sets out five clear objectives:

- Raise educational achievement.
- Improve general health and mental well-being (by reducing bullying, alcohol and substance misuse).
- Increase support and employability for those of aged 14 to 19.
- Help more young people get in their community.
- Develop more support for parents, carers, and families.

Core policy drivers for the improvement of children's health and well-being

- Children and Young People plan (IOW Childrens Trust:2006)
- Choosing Health - making healthy choices easier (DH:2004)
- Every Child Matters: Change for Children (DfES:2004)
- Every Child Matters: Aiming high for disabled children (HM Treasury/DfES:2007)

- National Service Framework for Children, Young People and Maternity Services (DH/DFES:2004)
- Tackling Health Inequalities - a programme for action (DH:2003)

2. Vulnerable children and young people on the Island

Vulnerable children include:

- Children at risk from harm (those subject to a child protection plan).
- Looked after children (in the care of Children's Services).
- Children with a disability - including a learning disability.
- Young People offending
- Children excluded from school

Children in need of protection

In March 2008, 70 children are subject to a child protection plan, which is an increase of 13 from last year and slightly above the national average. The increase is centred on the age range 10-15 and those under 1 year old. Of note, however, the number under the age of 1, compared with the national average is low.

4 children have a child protection plan because of likelihood/actual sexual abuse, 5 children for likelihood/actual physical abuse, 13 for neglect and the remaining majority for emotional harm. This overrepresentation of children in the emotional harm category is probably linked with increasing awareness/concern for children living within environments where they experience/witnesses domestic abuse. This change is also in line with the national picture.

The registrations on the child protection register (or equivalent) are high at 25.6%. This is a volatile indicator because of the size of the cohort. Monthly analysis is undertaken by senior managers to understand reasons for re-registration.

Children looked after

At the end of March 2008, there were 198 children looked after, the majority of whom are between the ages of 10-17 (124). In comparison with the national average the number is high. However, a higher proportion than the national average are cared for by family/friends/parents rather than local authority carers. This usually contributes to a better outcome in terms of placement stability.

The profile of the legal status of children looked after is changing with far more subject to court imposed Care Orders or Interim Care Orders. This reflects the growing number of families with complex needs on the Isle of Wight. This is against the national trend, which is seeing a reduction in numbers of cases where statutory orders are being sought.

There has been a significant improvement in achieving permanency for Isle of Wight looked after children, with an increase of numbers of children adopted, and those where residence orders or special guardianship orders have been granted.

There is a statutory obligation to review the cases of looked after children first within 28 days of becoming looked after, then within a further 3 months and subsequently at intervals of no more than 6 monthly. The number of looked after children who participate in their statutory reviews has dropped this year from 96% in 06/07 to 84.5%.

The ratio of the percentage of care leavers in Employment, Education, and Training at age 19 years has slightly decreased this year to 0.64% from 0.83% last year. This represents a very small cohort of 19 young people, which disproportionately affects percentage outturns. However Isle of Wight performance for Care leavers at age 19, who are living in suitable accommodation, remains higher than the national average.

Children with disabilities

- There are 592 children with statements of special educational needs. Whilst a high number of these children attend our 2 special schools (177), 97 attend 37 of our primary/pre schools, 122 attend 15 middle schools and 142 attend 5 high schools. 6 are educated at home, with the rest attend other special schools, tuition centres or mainland residential schools.
- There are approximately 1600 disabled children on the IW, of whom at end of March 2008 about 200 were receiving targeted services from Social Care Teams
- The prospect is that there will be a growing number of disabled children as increasing numbers of premature children are surviving. There is an interesting differential in the gender of these children, 1½ times more girls than boys. This data has to be used with caution because currently there is no centralised system of recording children with disabilities.
- There are significant differences between authorities in terms of definitions, disability eligibility criteria and the way information is collected and managed. This makes benchmarking unreliable and extremely difficult.
- Transitional planning for young people with disabilities aged 14+ to support their move from Children's Services to Adult Services, has been a key priority for the Local Authority. Our performance has improved considerably, in line with the national average.
- Respite placements for children with disabilities are insufficient to meet current needs.

Young people offending

- The 07/08 Outturn was that there were 257 first time entrants to the criminal entrants system and criminal justice. This is a 26.6% reduction on the 2005 baseline, far exceeding the 5% target.
- Effective partnerships have been maintained to reduce offending behaviour.
- Mental Health assessments are undertaken on all young people who are referred to the Mental Health Worker in the team.
- We had higher than the national average of children who were looked after who had been given a final warning, reprimand or convicted in the year 05/06 and 06/07. Figures are still being validated for 07/08 but the early indication is that this has improved in line with the Island target. Offending is a factor in the past history of a significant number of children who become looked after. It can also be a measure of the quality of the care and support

children receive once in Care. In addition there is often a relationship between offending and educational attendance and attainment.

Children excluded from school

There are 1,200 children and young people with fixed term exclusions from mainstream education provision on the Island. This is a declining figure, achieving 10% reduction each year, whilst there is Pupil Referral Unit provision these can be children and young people who sometimes may otherwise have no engagement with services.

3.1 Oral health improvement

National Context

Nationally, in the last 30 years, oral health among children has improved significantly. However 40% of children still enter school with some experience of tooth decay.

Programme area policy drivers

- Choosing Better Oral Health: An oral health plan for England (2005).
- Valuing Peoples Oral Health: A good practice guide for improving the oral health of disabled children (2007).

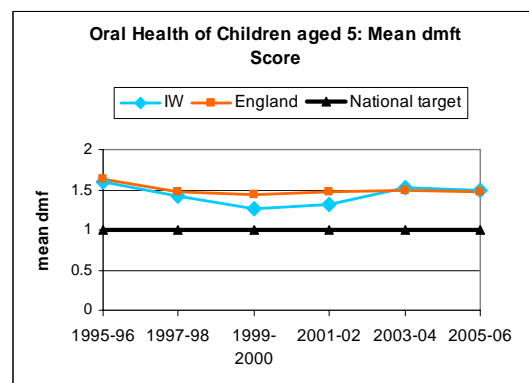
Oral health indicators on the Isle of Wight

There are two main indicators of oral health in children:

1. **dmft score:** this is the average number of decayed, missing or filled teeth

The chart alongside compares the average dmft score for children aged 5 on the Island with that for England, together with the national dmft target. It shows that the increase in dmft on the Island since 1999-2000 has been halted, but has not been reversed. The Island dmft is very similar to the England average, but is well above the national target.

(Data source: British Association for the Study of Community Dentistry Surveys)



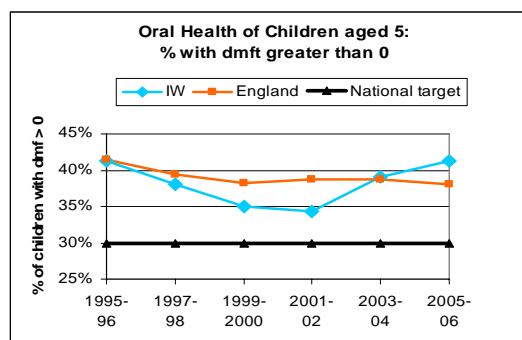
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2. % of dmft scores that are greater than 0: i.e. the % of children with any decayed, missing, or filled teeth.

The chart alongside shows the % of children aged 5 whose dmft is greater than 0 (i.e. they have 1 or more decayed, missing or filled teeth).

The chart shows that the % of children on the Island with at least 1 decayed, missing or filled tooth is continuing to increase. The IW is above the England average, and is well above the government target.

(Data source: *British Association for the Study of Community Dentistry Surveys*)



desired direction ▼

Model of programme delivery

Health Improvement Services within Public Health have a part-time Oral Health Promotion Practitioner post dual funded by the Children's Fund and the Personal Dental Service (PDS). Oral health programme service delivery takes place within schools, Children's Centres, and early years settings, partnering Local Authority, voluntary and community organisations. This work brings together oral health issues, and nutrition/healthy eating.

Key risk factors

The key risk factors for poor oral health in children are diets high in sugary foods and drinks, inappropriate infant feeding practices and poor oral hygiene. There is particular concern about the high levels of consumption of sugars among pre-school children¹.



Current IOW measures to improve the oral health of children and young people

In Early Years:

- Work has been established with the Early Years Unit of the IW Council and all Children Centres to build strong links in delivering oral health promotion to children and families.
- A programme for training oral health motivators within each pre-school setting has been developed and delivery has commenced. Training and support is being offered in all children's centres in line with latest oral health new recommendations and raising awareness of oral health issues.
- General promotion of oral health awareness messages to increase knowledge among appropriate agencies, parents, and communities within early year's settings is well established.
- Midwives and health visitors are being offered regular oral health up date training and information.
- Regular visits of oral health promotion to support parents and toddlers in baby clinics and new parent groups are established.
- Support through geographical cluster groups, childminder networks and parent toddler groups are in place.

¹ Department of Health (2005) *Choosing Better Oral Health: An Oral Health Action Plan for England*

In schools:

- On-going training of oral health motivators through the '*Working Together to Protect Island Smiles*' programme continues with established strong links with all schools aiming to improve environments and encourage good oral health, nutrition awareness, and increased knowledge.
- Training is offered to support teachers, school support staff, parents, school nurses, community and youth organisations, carers of looked after children and those with special needs.
- Access to quality resources is provided to support and enhance teaching of oral health within the curriculum.



Targeted support for children with special needs:

- Tailored oral health training is being provided to staff and carers within the special needs groups, with programmes that emphasise the need for health promoting environments, encouraging good oral health, raising awareness, and increasing knowledge within homes and schools.

Support to adults working with children:

- Oral Health Promoters are currently working to establish a local accredited adult learning programme similar to the Oral Health Motivators programme with access into the National Education Board of Dental Nurses (NEBDN) course.

3.2 Improving diet, increasing physical activity and reducing obesity

Key risk factors & lifestyle recommendations

Being overweight or obese increases the risk of a wide range of chronic diseases, mainly Type 2 diabetes, hypertension, cardiovascular disease including stroke, and cancer². Obesity in childhood can increase the risk of health problems in later life³. Nationally, the prevalence of obesity and overweight among children is increasing



The causes of obesity are complex and not confined simply to individual lifestyle choices. But at the heart of the problem is an imbalance between energy intake and energy expenditure. Eating habits and physical activity are key influences on energy balance².

Physical activity in childhood has a range of benefits including healthy growth and development, psychological well-being and social interaction, as well as its role in helping prevent weight gain or helping weight loss where necessary. It is recommended that children should undertake at least 60 minutes of at least moderate intensity physical activity each day³.

² 'Foresight: Tackling Obesities – Future Choices' (Government Office for Science, 2007)

³ 'At least Five a Week: Evidence on the Impact of Physical Activity and its Relationship with Health' (Chief Medical Officer, 2004)

Consumption of five or more portions of fruit and vegetables a day is recommended as one aspect of a healthy diet.

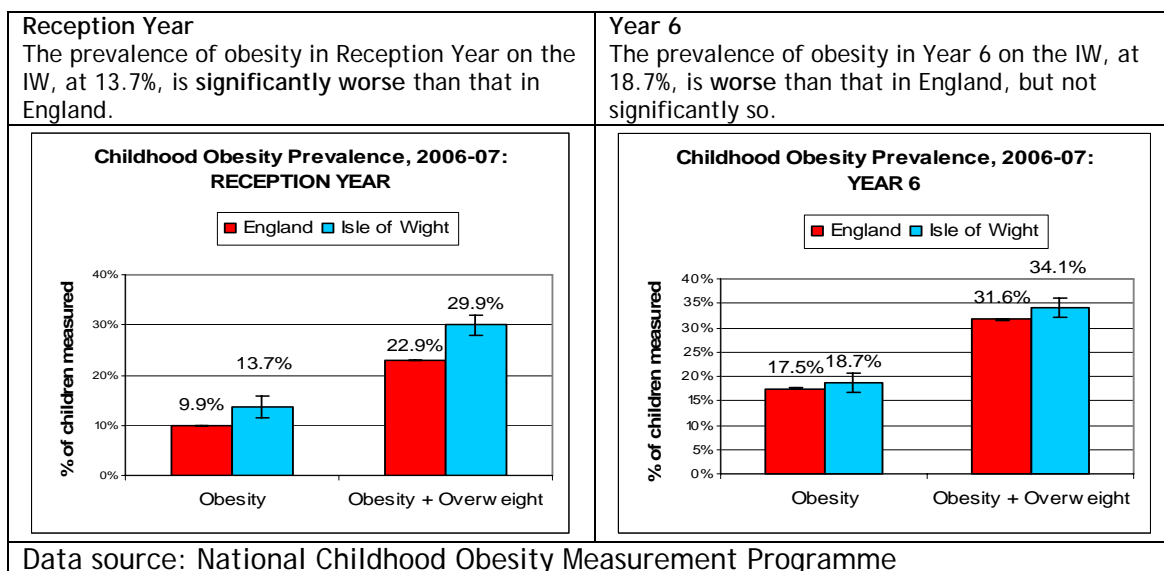
Programme area policy drivers

- Choosing a Better Diet (DH: 2005)
- Choosing Health: Choosing Activity (DH: 2004)
- Healthy Weight, Healthy Lives (DH:2008)
- Obesity: Guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children (NICE:2006)
- Improving the nutrition of pregnant and breastfeeding mothers and children in low-income households (NICE:2008)
- Move It - Framework for Physical Activity Strategy for SE England (Sport England: 2004)
- Isle of Wight Children & Young People’s Plan 2006 - 2009

Childhood obesity, physical activity and dietary indicators on IW

Local prevalence of childhood obesity

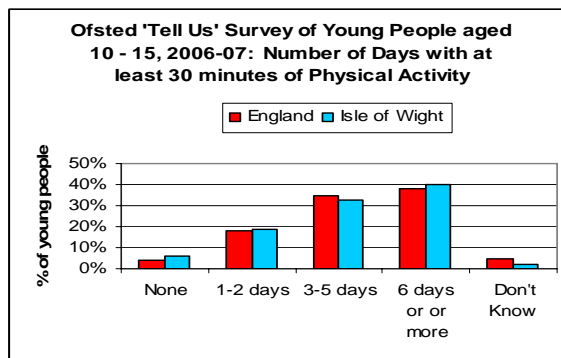
Obesity and overweight among Reception and Year 6 children on the Island were measured in 2006-07 as part of the National Childhood Measurement Exercise. The results are shown below.



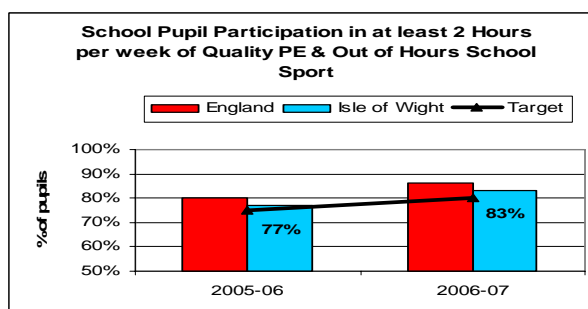
Young People's physical activity on the Isle of Wight

Information on physical activity among young people on the Island is available from the Ofsted 'Tell Us' survey of young people, which was conducted in a sample of schools in each Local Authority in England in 2006-07.

The chart alongside shows the number of days on which young people undertook at least 30 minutes of physical activity. The IW profile is similar to England's. 25% of IW young people were active on 2 days or fewer.



The chart alongside shows performance against the government target to enhance the take-up of school sporting opportunities by 5 -16 year olds. 83% of Island young people participate in at least 2 hours of school sport a week, slightly lower than in England but on course to meet the 2007-08 national target of 85%.

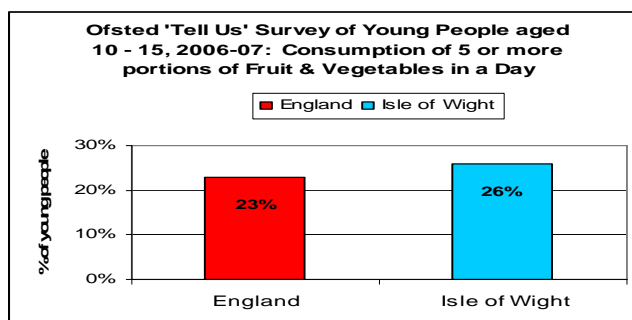


Data source: School Sports Surveys

Young People's consumption of fruit and vegetables on the Isle of Wight

Information on fruit and vegetable consumption among young people on the Island is available from the Ofsted 'Tell Us' survey of young people, which was conducted in a sample of schools in each Local Authority in England in 2006-07.

The chart alongside shows the percentage of young people consuming five portions a day. The Isle of Wight rate is slightly higher than that in England, but the difference is not statistically significant.



NB: Only 19% of IW schools participated in the survey, compared with 34% nationally, so the IW sample is relatively small.

Model of programme delivery

There is no one single service addressing these issues for children. Instead a range of multi-agency programmes contributes to this agenda and these are reflected below.

Current IW measures to increase healthy eating and physical activity in children and to reduce childhood obesity



A co-ordinated partnership approach is crucial to successfully tackling the multi-faceted drivers of obesity. Locally, a range of programmes delivered by different partner organisations to address childhood obesity have been co-ordinated and linked through the Healthy Weight Action Group. These include:

School-based programmes:

- Work through the national **Healthy School Standard** programme is a key element of this programme, with 34 of the 41 Healthy School criteria directly contributing to obesity prevention.
- The **School Fruit and Vegetable Scheme** is operating in all Island primary schools. The scheme provides a piece of fruit free of charge to all 4 - 6 year olds.
- Implementation of the new **nutritional standards for school meals** has been supported locally by a work programme with schools and catering supervisors working for pabulum and in-house school caterers.
- The Rural Community Council is hosting the second year of a grant-funded **Children's Food Worker** post, with the aim of promoting good practice and helping organisations develop and embed holistic food policies in the services they provide.
- The Rural Community Council's **Community Chef Service** continues to work with children and families in pre-school, school and community settings to offer practical opportunities to learn cooking skills and healthy recipes.
- The Healthy Eating Alliance presented their 3rd **Healthy Eating Awards** open to local organisations, community groups, & businesses who demonstrate best practice in healthy eating.
- The Consumer Protection Directorate of the IW Council have undertaken food sampling from items on **children's menus** in catering establishments across the Island to identify high levels of fat, sugar and salt.
- Time Being 7 is an **active play** 20 week arts course for young children being delivered in Newport primary school by the Healing Arts programme. The PCT's Dietetic Service now offers dedicated **paediatric clinics** for overweight children.
- The need to develop support options for children and young people with established obesity has led to the development of a pilot programme called **Trim Kids**.
- Department of Health funding has been secured to support the development of a **care pathway for childhood obesity** during 2008/09.
- The **National Child Measurement Programme** is a national survey of the height and weight of children in Reception Year and Year 6.
- The PCT's Physical Alliance Coordinator and the Council's School Travel Plan Advisor have worked with the Earl Mountbatten Hospice and the annual fundraiser to take part in the Schools "**Walk the Wight**".

- All Island swimming pools offer **free swimming in school holidays** to school aged children who have registered for a junior registration card.
- Community groups have been offered **family based everyday physical activities** over a 4-week programme.
- **Junior gym** and family gym sessions have been made available at all local IW Council run facilities to encourage families to attend gym sessions together.
- Equipment has been purchased to provide gym-based activities for children aged 4-10 yrs. **Gym kid's** sessions are available at 2 island leisure facilities.
- The Council's Sustainable Travel to School Strategy outlines how the council is promoting active and sustainable travel to school. At the core of this lie schools' **travel plans**, which are developed by parents, pupils, staff, governors, and the local community, with assistance from the local authority. Alongside reducing the carbon footprint of school sites they also aim to increase activity of all users of school premises.



3.3 Smoking and Young People

National context

Nationally, the proportion of young people who have 'ever smoked' has fallen from 49% in 1996 to 39% in 2006.⁴ However significant numbers of young people do still start to smoke.

Programme area policy drivers

- Smoking Kills a White Paper on tobacco (DH; 1998)
- Future Guidance on preventing the uptake of smoking by Children and Young People. (NICE; July 2008).



Key risk factors

Children and young people are particularly vulnerable to smoke and smoking. Exposure to second hand smoke is a major risk to child health. Those who begin to smoke young have higher rates of tobacco -related morbidity and suffer tobacco-related diseases earlier.

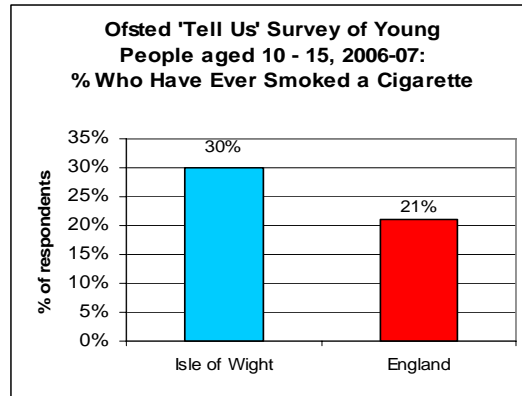
Indicators for smoking in young people on the Isle of Wight

⁴ Information Centre (2007) 'Smoking, Drinking & Drug Use among Young People in England, 2006'

Young people who have 'ever smoked'

Information on smoking prevalence among young people on the Island is available from the Ofsted 'Tell Us' survey of young people, which was conducted in a sample of schools in each Local Authority in England in 2006-07.

30% of Isle of Wight respondents responded 'Yes' to the question: 'Have you Ever Smoked?' This was higher than the England rate, but the difference is not statistically significant.

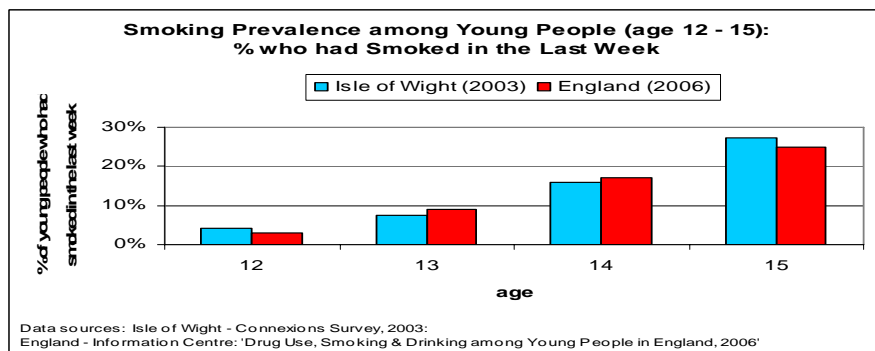


NB:

- Only 19% of IW schools participated in the survey, compared with 34% nationally, so the IW sample is relatively small.
- Only those over 12 participated in the IW survey, which is likely to inflate the 'yes' response rate compared with England's since smoking prevalence increases with age (see below).

Young smokers by age

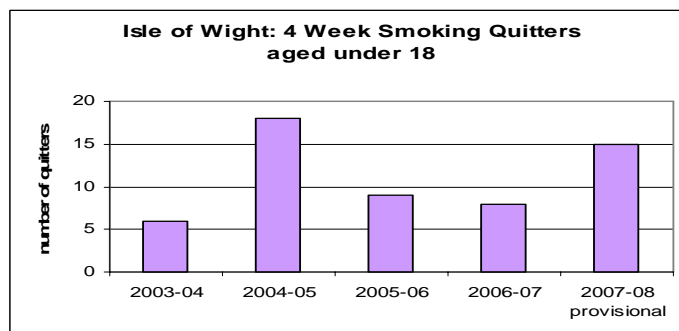
The prevalence of smoking among young people increases throughout their teenage years. The chart below shows smoking prevalence by age on the Isle of Wight compared with England, with a similar pattern apparent for each.



NB: the most recent IW data on smoking behaviour by age dates back to the 2003 Connexions Survey. It is compared here with England data for 2006, the most recent available.

Young People Quitting Smoking

The chart alongside shows the performance of the Island Quitters service together with GP Practices in supporting young people aged under 18 to quit smoking in the last 5 years.



Model of programme delivery

Island Quitters is a team of specialist smoking cessation advisors whose main aim is support those on the Isle of Wight to stop smoking. The team engages and works with young people to prevent the uptake of smoking and to support those who want to quit smoking. The Team offers

a bespoke service to schools and colleges and individual or group support can be offered. Island Quitters works in partnership with relevant services, to promote a series of measures to reduce smoking and the awareness of passive smoking for children and young people. Island Quitters are also working with many other partner agencies and services accessed by young people to discourage young people from taking up smoking or encouraging those who do to quit.

There is no simple explanation as to why children and young people take up smoking. Island Quitters anticipate that the continuation of their work will carry on raising the awareness of the harms of smoking, change attitudes towards second hand smoke, and reduce the uptake of smoking in young people.

Current IW measures to reduce smoking in young people

- Partnership working with the School Nursing Team offers educational support, enabling young people to understand the risks of smoking and promotes the importance of smoke free homes. Specialist support materials are used to support the Department of Health marketing strategy for this area.
- Stop smoke support is available at High Schools by referral from School Nurse or self-referral by student.
- Quit smoking services are available for students at one High School and for students at the Isle of Wight College. It is expected that more schools will promote young quitters in the future.
- Stop Smoke support is available by referral from specialist key workers e.g. Connexions.
- Attendance by the Island Quitters Team at young people and family orientated events to raise awareness of the harms of smoking and second hand and to encourage a smoke free home.
- Island Quitters, Trading Standards and Environmental Health work together to reduce the opportunities for young people to buy contraband tobacco and underage sales through enforcement of regulations on tobacco advertising and age requirements for sales.



3.4 Young people's substance misuse service

National context

Nationally, in 2006, of young people aged 11 - 15⁵:

- 35% had been offered drugs.
- 24% had taken drugs; 17% in the last year.
- 32% of those who had taken drugs in the last year had done so at least once a month.

Nationally, of young people aged 11 - 15⁶:

⁵ Information Centre (2007) '*Smoking, Drinking & Drug Use among Young People in England, 2006*'

⁶ Information Centre (2007) '*Smoking, Drinking & Drug Use among Young People in England, 2006*'

- Over half (55%) have drunk at least one alcoholic drink.
- Consumption increases with age, from 21% of 11 year olds to 82% of 15 year olds.
- Among young people who had drunk any alcohol in the last 4 weeks:
 - 56% had been drunk;
 - 35% had deliberately tried to get drunk.

Programme area policy drivers

- The National Drug Strategy February 2008
- National Treatment Agency (NTA) Models of Care (2002, 2005)
- Every Child Matters: Change for Children - young people achieving the five outcomes (DfES,2004)
- National Treatment Agency for Substance Misuse (2007) - Assessing Young People for Substance Misuse

Key risk factors

Substance misuse among young people has been linked to suicide, depression, conduct disorder, and educational problems⁵.

Drug misuse

Drugs affect people's inhibitions and judgement, and this can lead to risky behaviour particularly with unprotected sex that can result in sexually transmitted infections and unplanned pregnancy⁷.

Young people who had truanted or been excluded from school were more likely to have taken drugs.

Alcohol misuse

Consequences of drinking include feeling ill, having an argument, losing money, vomiting, having a fight, getting into trouble with the police and being taken to hospital.

Alcohol misuse is often associated with sexual activity. Associated risks include early and regretted sexual experiences and sexual attacks. The more alcohol consumed, the greater the risk of unprotected sex, and of the contraction of sexually transmitted infections and unplanned pregnancies⁸.

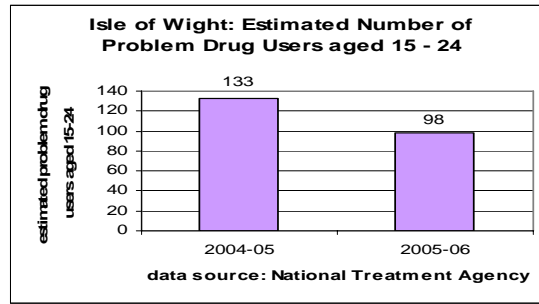


⁷ Independent Advisory Group on Sexual Health and HIV (2007) *Sex, Drugs, Alcohol and Young People*

⁸ Independent Advisory Group on Sexual Health and HIV (2007) *Sex, Drugs, Alcohol and Young People*

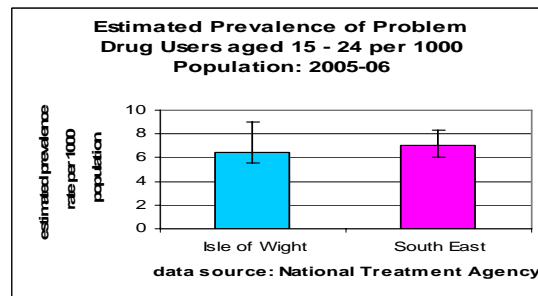
The most recent available data (from 2005-06) estimates an Island population of 98 “problem drug users” aged between 15 - 24. This represents a fall from the 2004-05 estimates of 133, but there is no statistically significant difference between these figures.

It should also be noted that small methodological changes between the two measurements mean that robust comparisons are not possible.



The IW's estimated prevalence rate of problem drug use per 1000 population in the 15-24 age groups is compared alongside with the rate for the South East region.

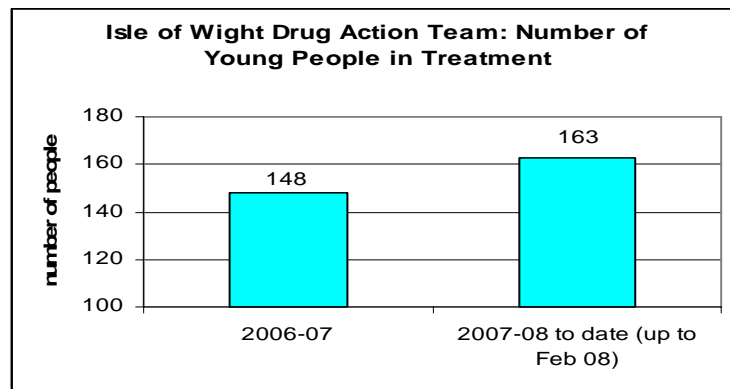
The IW's rate is slightly lower, but the difference between the two rates is not statistically significantly different.



Young Drug Users in Treatment

The Isle of Wight Drug Action Team (DAT) commissions specialist drug treatment services for young people from Get Sorted. The number of young people (defined here as aged under 18) seen for treatment over the last two years is shown alongside.

The increase in numbers of young people in treatment reflects the development and increased awareness of the service, by both young people and referring agencies.



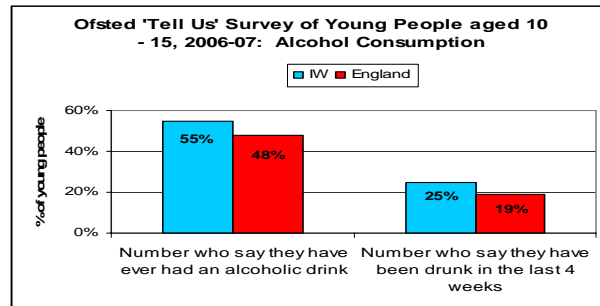
By September 2007 services had successfully attracted approximately 457 of these problem drug users (PDUs) into treatment, of which 116 were under 18 years. The main drug of choice for young people in treatment over this period was cannabis.

Alcohol Misuse

Alcohol Consumption

Information on alcohol consumption among young people on the Island is available from the Ofsted 'Tell Us' survey of 10-15 year olds⁹ conducted in 2006-07.

55% of Island young people had had an alcoholic drink; and 25% had been drunk in the last 4 weeks. These rates were higher than the equivalents for England from the same survey, but the differences are not statistically significant.

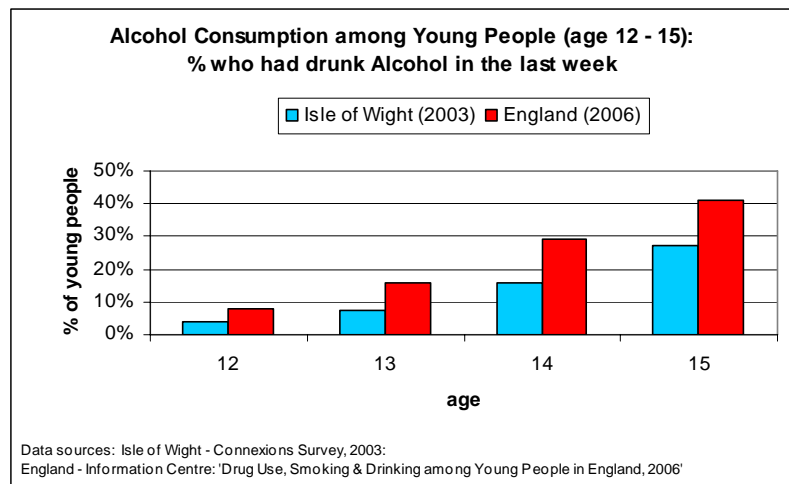


- Only 19% of IW schools participated in the survey, compared with 34% nationally, so the IW sample is relatively small.
- Only 12-15 year olds participated in the IW survey, which is likely to inflate the response rates compared with England's since alcohol consumption increases with age.

Young Drinkers by Age

The prevalence of drinking alcohol among young people increases throughout their teenage years. The chart below shows alcohol consumption by age on the Isle of Wight compared with England, with a similar pattern apparent for each.

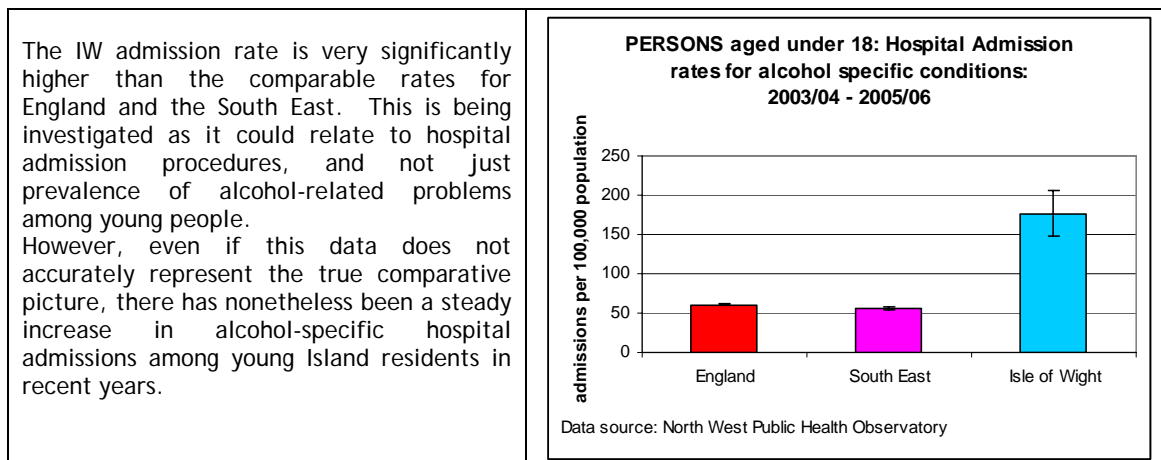
NB: the most recent IW data on smoking behaviour by age dates back to the 2003 Connexions Survey. It is compared here with England data for 2006, the most recent available.



⁹ The 'TellUs online survey was conducted in a sample of schools in each Local Authority, and asked children and young people aged 10 – 15 about their experiences and satisfaction with local services.

Young People's Hospital Admissions

Numbers and rates of alcohol-specific hospital admissions (those caused wholly by alcohol consumption) among young people aged under 18 are shown below.



Model of Programme Delivery



The Get Sorted Team is a small team with a specialist role in engaging young people with substance misuse problems to provide treatment and support. The aims of the team are to engage young people and work with them around substance and alcohol misuse, to empower them to make informed, safe lifestyle choices' using a holistic approach and to work in partnership to reduce drug related deaths and minimise harm caused by legal and illegal substances in young people.

The team offers comprehensive assessment, individualised packages of care, intervention, and treatment, based on the needs of children and young people.

Current IW measures to reduce substance misuse in young people

- Secure the well-being and health of children and young people.
- Improve the health and well-being of children and young people.
- Increase the number of children and young people on the path to Success.
- Reduce the number of first time entrants to the Youth Justice System aged 10 - 17.
- Reduce the number of young people who misuse substance.
- Increase the numbers in young people who access treatment for substance misuse .



- Increase the percentage of young people who have been retained in treatment for 12 weeks or more.

3.5 Chlamydia screening programme

National context

Genital Chlamydia trachomatis infection is the most commonly diagnosed bacterial sexually transmitted infection (STI) in genitourinary medicine (GUM) clinics in the United Kingdom. The number of diagnoses of uncomplicated genital chlamydial infection has risen steadily since the mid-1990s. In the UK diagnoses rose by 9% (95 879 to 104 155) between 2003 and 2004. In 2004, the highest diagnostic rates of genital chlamydial infection were among 16- 19 year old females (1,310/100,000) and 20-24 year old males (1,026/100,000).

As most people with chlamydia are asymptomatic, large proportions of cases remain undiagnosed. Untreated genital chlamydial infection can have serious long-term consequences, especially in women in whom it is a well-established cause of pelvic inflammatory disease (PID), ectopic pregnancy, and infertility.

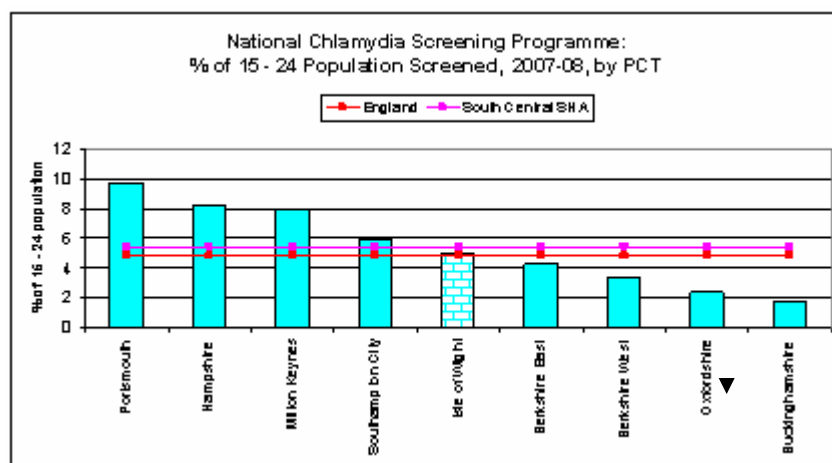
The National Chlamydia Screening Programme promotes proactive opportunistic screening of sexually active asymptomatic 15-24yr olds, with the aim of reversing the rising incidence of this generally asymptomatic STI.

Programme area policy drivers

- Choosing health - making healthy choices easier (DH: 2004).
- Independent Advisory Group report - Why sexual health is a cross governmental issue.
- New Frontiers - National Chlamydia Screening programme annual report 2005/06.
- Testing Times HIV and other sexually transmitted diseases in the UK 2007.

Current screening activity

The chart alongside illustrates the 5.1% of young people screened in 2007/08. The screening programme to not commence fully until September 2007 so this chart does not truly reflect a year's activity.



Model of Programme Delivery

The IOW Chlamydia screening commenced in September 2007. The Island has been set the target of screening 17% of the Islands young people aged between 15 and 24 years in 2008/09. This equates to 2,632 young people.

The chlamydia screening test is a simple urine test for both young men and women. Test results are returned to the Local Chlamydia Screening Office and entered onto a database. Individuals are informed of their results according to their choice by text message, phone call, or letter. Antibiotic treatment for positive patients and their partners is available free of charge at the IOW Sexual Health Clinic.

Current IW measures to increase screening/ reduce the prevalence of chlamydia

- Extending screening provision across the Island through General Practices.
- Work with young peoples services to promote and deliver screening among the target group age.
- A website offering information and access to screening kits.
- Developing a Pharmacy led service to offer screening and treatment to positive patients and their partners.
- Close work with the local Teenage Pregnancy Coordinator to promote the screening programme within schools.
- 'Pee in a Pot' days at the IOW college.
- Working closely with the IOW Sexual health clinic to offer opportunistic screening and treatment and partner notification.
- Using local media sources to promote the screening programme.
- Offering training to a broad group of individuals who may have contact or work with young people in this age group.
- Work with the Local Authority and Business Communities to develop opportunities to offer Chlamydia screening in a variety of settings.
- Develop joint project for young people for example GUM FU DVD.

3.5 Teenage pregnancy Isle of Wight

**HELP AND ADVICE ON YOUTH ISSUES
COUNSELLING AND ADVOCACY**

Youth Trust, 1 St John's Place,
Monday to Friday 09.00 to 13.00
14.00 to 17.00 529 569

Gay and Bisexual Outreach
Worker Advice & Information
07795 126 756

Citizens Advice Service
at connexions
Weds pm - call for appointment
525 927

Housing Advice Helpline
0800 800 4444

Drug & Alcohol Advice
Get Sorted 617 660
Confidential service with Drop
In at Melville Street, Ryde.

Drop in service
@ Cowes Youth Centre.
16 years +, 292833
11 - 1pm Thurs
10 - 12am Fri

USEFUL WEBSITES

www.greengoldfish.com
www.ruthinking.co.uk
www.teenagehealthfreak.org
www.ilkelits.org.uk
www.ruthel.co.uk
www.iwyoungservice.org.uk/youth_centres/cowes

www.thesite.org
www.739sense.co.uk
(for services in Southampton
& Portsmouth)

R U Thinking free phone, 19.00 to 00.00 0800 282 930
Talk Adoption 0800 763 1234 (advice & support for under 25's)
Brook Helpline 0800 0185 023 www.brook.org.uk
Care Confidential 0800 028 2228 www.careconfidential.com
Developed in co-ordination with Teenage Pregnancy
Co-ordinator 01983 522 830

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National context

The National Teenage Pregnancy Strategy was launched in 2000. The aim nationally is reduce the National Teenage Pregnancy rate by 50% by 2010 based on the 1998 baseline. The *National Strategy for Sexual Health and HIV* (Department of Health 2001) shares the same target for reducing unintended teenage pregnancy, to improve the sexual health of targeted groups and services generally. Young people are a targeted group as the steepest rise in Sexually Transmitted Infections (STI's) is amongst young people aged 16 to 19. The *Every Child Matters: Change for Children Programme 2004* (www.everychildmatters.gov.uk) aims for positive life chances for all children and young people. It has five headline outcomes, which are 'be healthy',

'stay safe', 'enjoy and achieve', 'make a positive contribution' and 'achieve economic well-being'. Teenage Pregnancy and staying sexually healthy is part of the 'be healthy' outcome. The *Children's Act 2004* (www.everychildmatters.gov.uk) includes a duty on all services to co-operate to meet the five outcomes. The second part of the Teenage Pregnancy Strategy is Support for Teenage Parents. A target is to reduce the number of teenage parents not in education, employment, or training by 60%.

Local context



Locally the target is to reduce teenage pregnancy on the Isle of Wight by 45% in 2010 from the 1998 baseline. Each Local Authority area has developed its own Teenage Pregnancy Strategy. On the Isle of Wight an action plan is developed each year based around national evidence, guidelines, local needs assessment, and research. The following points show the key areas that the action plan is based upon.

- Strategic work within the Children's Trust and working with schools to improve and work with schools to improve Sex and Relationships policy and education.
- Implement Media strategy for sexual health, delay and safer sex messages.
- Maintain collection and collation of data.
- Improve access to contraceptive and sexual health services and advice to young men and women.
- Maintain and improve a strong delivery of Sex and Relationship Education and Personal Health and Sex Education (PHSE) within school and out of school settings.
- Develop targeted work with at risk groups of young people as identified by local data and in line with Targeted Youth Services arrangements.
- Maintain workforce training on sex and relationships within mainstream and partner agencies.
- Assisting services within school and out of school in raising aspirations.
- Work with Parents on Sex and Relationship education.
- Support teenage parents

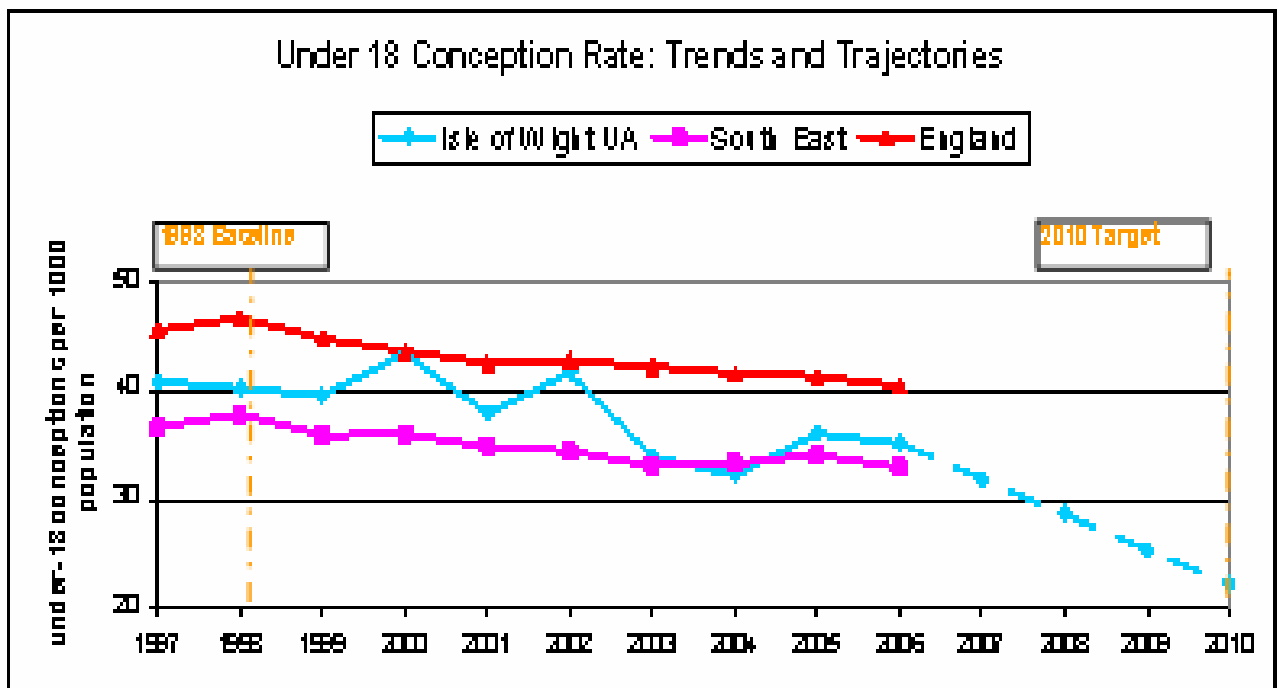
Local data

The latest available Island statistics are from 2006. This showed a reduction of the teenage conception rate of 13% from the baseline year of 1998. The data from 2006 showed that the Isle of Wight's percentage reduction is in line with the national percentage reduction, but slightly above the South East's overall reduction. The Isle of Wight's rate for 2006 is 35.1 conceptions per thousand females aged 15 - 17. The target for 2010 is for a percentage reduction of 45% from the 1998 baseline to a rate of 22.1 conceptions per thousand females aged 15 - 17. That would involve a reduction from approximately 90 to approximately 50 conceptions in this age group each year.

The target wards for Teenage Conceptions on the Isle of Wight are Newport S, Ryde N E, Ryde S E, Sandown N and Shanklin S. 35% of all teenage conceptions occur to residents of these wards that have high deprivation levels. 20.8% of Isle of Wight children live in non working families who are benefit dependent.

Current and future measures to address <18 conceptions on the IOW

- Implement teenage pregnancy and integrated sexual health service media strategy.
- Participation and consultation with young people including mystery shopper's exercise as part of FACT scheme (young people's services quality assurance scheme). Work with Girls Friendly Society to involve teenage parents in positive activities and research.
- FACT scheme to be aligned with national scheme.
- Condom distribution scheme further developed.
- Sandown, Newport and Ryde cluster primary schools further developed their Sex and R Education policies for a whole school approach.
- 6 teachers and 2 health professionals to complete the Personal Sex and Health Education Current Professional Development Certificate.
- Maintain the Added Power and Understanding in Sex Education (APAUSE) in 5 High schools.
- Teenage Pregnancy midwife connexions PA role to be enhanced and supported.





4. Future recommendations to improve the health of children and young people

Vulnerable children and young people

- To develop preventative services that looks at a whole family approach, leading to earlier intervention for children on the edge of care, and children at risk of offending.
- Respite services for children with disabilities to be strengthened.
- Develop more integrated working processes around families where domestic abuse is a factor and particularly focusing on children where registration and re-registration are linked to domestic abuse.

Oral health

- Work within the framework of the Children's Trust Preventative Strategy to develop sustainable oral health promotion programmes.

Reducing childhood obesity

- Use the Children's Trust Preventative Strategy as a mechanism for focusing multi-agency work to prevent childhood obesity.
- Support the development and implementation of a care pathway for the prevention and management of childhood obesity through effective integrated multi-agency Public Health and Commissioning programmes.

Reducing smoking in young people

- Develop a network of smoking cessation advisors to offer support to young people who smoke.
- Improve referral pathway of young people to specialist smoking cessation services.

Substance misuse

- Increase the availability of services to young people who misuse substances via generic services through increased education, awareness, good health promotion, and clear referral pathways.
- Identify improved signposting of young people by primary care services to the Get Sorted team.

Chlamydia screening

- Work with LA colleagues to develop an action plan to support the Local Area Agreement target to increase opportunistic screening across the Island.
- Develop a GP Locally Enhanced Service to reward opportunistic screening activity in the practice setting.

Teenage Pregnancy

- Target young people at risk of teenage pregnancy in conjunction with Targeted Youth Services arrangements.
- Improving access to and extending young people's sexual health services.
- Improve performance management, data collection, and analysis of data.

Chapter 5: Progress against recommendations from the Public Health Annual Report 2006

The Public Health Department should co-ordinate the production of a Health Inequalities Action Plan, to set out how the interventions recommended to reduce health inequalities will be implemented in the Local Area Agreement Target Wards.

This recommendation is being taken forward through the Isle of Wight Cardiovascular Prevention Inequalities Project (see chapter 2).

Every effort should be made to ensure that the uptake of flu vaccine on the Island during the winter of 2007/08 among those aged 65+ exceeds the average uptake for England.

Unfortunately, the national uptake of flu vaccine amongst those aged 65+ fell from 73.9% in 2006/07 to 73.5% in 2007/08 and while the Island managed to improve its uptake by one percentage point (72.6% in 06/07 and 72.7% in 07/08), this was not sufficient to exceed the average for England. Seasonal flu vaccination for those aged 65+ and others at risk continues to be an important public health measure. The PCT will undertake a winter campaign with partners to increase the uptake of flu vaccine, minimise the spread of norovirus (winter vomiting disease) and promote winter warmth for those at risk.

The NHS and local authority on the Island should implement the Department of Health recommendation to 'consider establishing regular training programmes in good hygiene to remind both existing and new staff of its importance'.

During the winter of 07/08, St Mary's hospital was affected by outbreaks of norovirus and *clostridium difficile*. As well as redoubling hand hygiene with staff, hand hygiene was promoted to the public through the media. The public were requested to rub their hands with alcohol gel before entering ward areas and relatives visiting patients being treated for *C. diff.* were requested to wash their hands with soap and water on leaving the isolation area.

The PCT/local authority should recognise the Island's success during exercise Winter Willow in running a joint control room and should endorse a joint list of staff volunteers and joint training to have taken place 31 March 2008.

The PCT and local authority continue to work closely on emergency planning and have undertaken joint training of support staff for a multiagency control room that would be used in the event of a major incident on the Island. Further development and exercising will be undertaken during 08/09.

A chapter in the 2006 Annual Report on sexual health recommended; using information technology to create a professionals network, applying consistent standards of care, continuing development of primary care based skills, roll out a chlamydia screening programme and develop services that are responsive to the needs of young people.

The Integrated Sexual Health Service (ISHS) offers a broad range of sexual health services, advice and support for both the general public and professionals through clinics, the development of a sexual health network and an annual sexual health conference. New ways of meeting the 48 hour target for access to GUM services continue to be developed including longer St Mary's GUM clinic opening times and the development of new clinics within community settings such as Connexions and the IOW College.

Professional network



Wish-Net, The IOW Integrated Sexual Health Network (www.wish-net.co.uk) has been designed to bring together Island residents and multi-disciplinary professionals from all related disciplines to improve the sexual health and well being of individuals on the IOW. The network will include information on a wide range of subjects including, Chlamydia screening, learning disability, lesbian gay and transgender young people services, links to other services and training and development opportunities.

The network is designed to:

- Increased knowledge of sexual health services and how to access them.
- Information on sexual health issues
- Advice and support on safer sex.

Professionals who register will have access to:

- An effective tool for accessing and sharing information
- Continue consistent standards of care
- Links to other organisations and professional bodies
- The network is following the department of health guidelines and Medical Foundation for AIDS and Sexual Health.

Annual Sexual Health Conference 2007



Around 100 delegates held the conference for the third year running at Northwood House Cowes. The conference is designed to share good practice across the Island as well as a networking opportunity for professionals. A full report on the conference can be accessed through Wish-Net.

Continuing the development of Primary care services

In partnership with primary care colleagues the 'Level 1' service has been developed and agreed to ensure a consistent and equitable service is available throughout General Practices on the Island. The Level 1 agreement sets out the minimum services that are available within Practices. Further services are being developed to deliver Long Acting Contraceptives; Young people services and Chlamydia Screening.

The 'SHINE' evenings have been developed to offer General practice specialist education opportunities in a wide range of sexual health issues including managing menopause, men's health and sexually transmitted infections. These evenings are responsive to the needs of local GPs and Practice Nurses in order to maintain skill levels. Further regular training is offered for Implant insertion, IUCD fitting, condom distribution, cervical screening and Chlamydia screening.



Many pharmacies across the Island now offer free condoms, emergency hormonal, contraception and Chlamydia screening. By July 2008 a number of these pharmacies will also be offering Chlamydia treatment for patients and their partners.

Chlamydia Screening

As outlined in chapter 4, section 3.5, the Island Chlamydia screening programme has now been established. Screening is offered through a variety of venues including General Practice, pharmacies, sexual health services, youth services and prisons.

The Chlamydia screening website has been very successful with an average of 450 hits per day. The website gives detailed information regarding the screening programme and allows young people to request testing kits via the post. Other promotional resources have included posters, T Shirts and pens.



Pee in the Pot days have been held at the IOW College and schools have had information sessions for students. There are more opportunities to extend the work carried out around the screening programme with schools and youth organisations in the future.

A Chlamydia screening information film was made for the service by the Streets Ahead Youth film unit. This film is available to be viewed on www.myspace.com/gumfu.

The target for 2008/09 has been set at 17% of the 15-24 year old population, this equates to 2,632 screens on the Island. This is a challenging target to achieve.