Heart health needs assessment: identifying priorities for primary and secondary prevention of CHD in Filwood

Conducted by Paul Pilkington, on behalf of the Knowle West Neighbourhood Renewal Health and Well-Being Group and Bristol South and West Primary Care Trust

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Glossary

AHA	Avon Health Authority
BCC	Bristol City Council
BSWPCT	Bristol South and West Primary Care Trust
CABG	Coronary Artery By-Pass Graft
CHD	Coronary Heart Disease
HLC	Healthy Living Centre
HSE	Health Survey for England
HWG	Knowle West Neighbourhood Renewal Health and Well-Being Group
IHD	Ischaemic Heart Disease
KW	Knowle West
KWHP	Knowle West Health Park
KWNRG	Knowle West Neighbourhood Renewal Group
LBW	Low Birth Weight
LSP	Local Strategic Partnership
NR	Neighbourhood Renewal
NSF	National Service Framework
PTCA	Percutanerous Transluminal Coronary Angioplasty
WBHC	William Budd Health Centre

Report Outline and Acknowledgements

Outline

This report outlines the results from the heart health needs assessment in Filwood (Knowle West) and discusses the process and implications of the work. It identifies priorities for primary and secondary prevention of CHD. The work provides examples of mainstream services that might be "bent", to better address local needs.

Acknowledgements

I am grateful for the advice and support of Dr Chris Hine during the needs assessment, and the advice of Dr Brendan Yates during the write up. Thanks also to the members of the Knowle West Health and Well-Being Group, especially Mike Shepherd and Fiona Andrews.

Thanks also to Professor Jenny Donavan and all the local workers and residents who participated in the interviews and focus groups.

Abstract

Background: The Knowle West Health and Well-being Group (HWG) wanted to assess heart health needs in Filwood, in order to inform local neighbourhood renewal (NR) activity.

Aim:

- Identify priorities for primary and secondary prevention of CHD in Filwood and present proposals for change.

Methods:

- Epidemiological and comparative needs assessment.
- Corporate needs assessment.
- Service mapping exercise.
- Development of proposals for change, based on the needs assessment and evidence of effectiveness.
- Dissemination of the needs assessment and assisting in funding bids.

Results:

- Filwood has higher than PCT average levels of CHD mortality.
- Filwood has high estimated and measured levels of CHD risk factors.
- Research identified gaps in services and common needs of local workers and residents.
- Sixteen proposals for change were formulated and used to inform local CHD and NR activities.
- A number of heart health bids were made, including a bid to Sport England for a community gym and sports room.

Conclusions:

- The needs assessment aided the local HWG by identifying local heart health needs.
- The work demonstrated how public health specialists can provide a valuable input into NR.

1 Introduction

The Knowle West Neighbourhood Renewal Health and Well-Being Group (HWG) is charged with developing activities to tackle local health issues in Filwood. It is a sub-group of the Knowle West Neighbourhood Renewal Group (KWNRG), which formulates and assesses bids for neighbourhood renewal (NR) money.

I joined the HWG in March 2002 to provide public health input. I conducted a health profile of Filwood and presented the results.[1] As a result of the findings from the health profile the HWG identified heart health as a priority.

There was however a gap in knowledge of what the precise health problems were, what heart health activities existed in the area and what the solutions could be to local health needs. This lack of local intelligence was hindering the group's ability to develop appropriate heart health improvement strategies. I was asked to undertake a heart health needs assessment, between May-October 2002, focussing on:

- healthy eating and access to food,
- smoking,
- physical activity,
- reducing overweight and obesity,
- management of risk in primary care (including blood pressure).

These areas also reflect the primary and secondary prevention priorities of the National Service Framework (NSF) for Coronary Heart Disease (CHD).[2,3]

I was asked to use the needs assessment findings to present proposals for change that would aim to improve heart health in Filwood through primary and secondary prevention of CHD. The proposals would help to prioritise funding bids and also seek to demonstrate how mainstream funding could be "bent" to better respond to local needs. The work also linked with the CHD Steering Group of Bristol South and West Primary Care Trust (BSWPCT).

2 Background

2.1 The importance of CHD in the UK

CHD is the commonest cause of premature death in the UK.[2,3] 1.4 million people suffer from angina, and each year around 300,000 have heart attacks and 110,000 die from heart problems in England.[2] There are clear health inequalities associated with CHD, with people living in deprived areas, and those from lower social classes experiencing greater levels of mortality and morbidity.[2,3,4,5,6] Although CHD death rates in the UK fell by 38 percent between the 1970s-1990s, rates are still higher than in many other Western European countries.

Risk factors for CHD are well recognised.[2,3,7] There is also increasing evidence around the effectiveness of interventions to prevent CHD. Several reviews of the evidence have been conducted.[8,9,10,11] Evidence on risk factors and evidence of effectiveness was used to inform the needs assessment.

2.2 National policy context

CHD is a government priority. The NSF for CHD, and Saving Lives: Our Healthier Nation, include targets to reduce the death rate from CHD in those under 75 by two-fifths by 2010.[2,3]

The needs assessment focused on standards 1-4, relating to primary and secondary prevention (Table 1). It was in these areas that the HWG had both an interest and a remit to bid for funding. Needs relating to the treatment of those with existing CHD (beyond secondary prevention of risk factors) was not the focus of this needs assessment.

Table 1: NSF Standards 1-4

NSF Standard	Description
Standards 1 and 2: Reducing heart disease in the population	The NHS and partner agencies should develop, implement and monitor policies that reduce the prevalence of coronary risk factors in the population, and reduce inequalities in risks of developing heart disease.
	The NHS and partner agencies should contribute to a reduction in the prevalence of smoking in the local population.
Standards 3 and 4: Preventing CHD in high risk patients	General practitioners and primary care teams should identify all people with established cardiovascular disease and offer them comprehensive advice and appropriate treatment to reduce their risks.
	General practitioners and primary care teams should identify all people at significant risk of cardiovascular disease but who have not developed symptoms and offer them appropriate advice and treatment to reduce their risks.

Source: [2 3]

The *National Action Plan for Neighbourhood Renewal* aims to tackle the problems in the poorest neighbourhoods in the country. Its health target is to "reduce by at least 10% the gap between the one in five areas with the lowest life expectancy at birth and the population as a whole by 2010".[12 13]

The aims of the strategy overlap with the national inequalities targets (which aim to reduce inequalities in infant mortality and life expectancy) and the targets of the CHD NSF and Saving Lives: Our Healthier Nation.[2 3 14 15] It is therefore highly relevant to public health aims and objectives.

The strategy is about "bending" mainstream services (mainstreaming), so that they can be more effective in responding to local needs. It is about skewing mainstream resources to better target deprived areas.[16] The aim is to pump prime changes in service delivery that can then be sustained by mainstream funding.

2.3 Local context

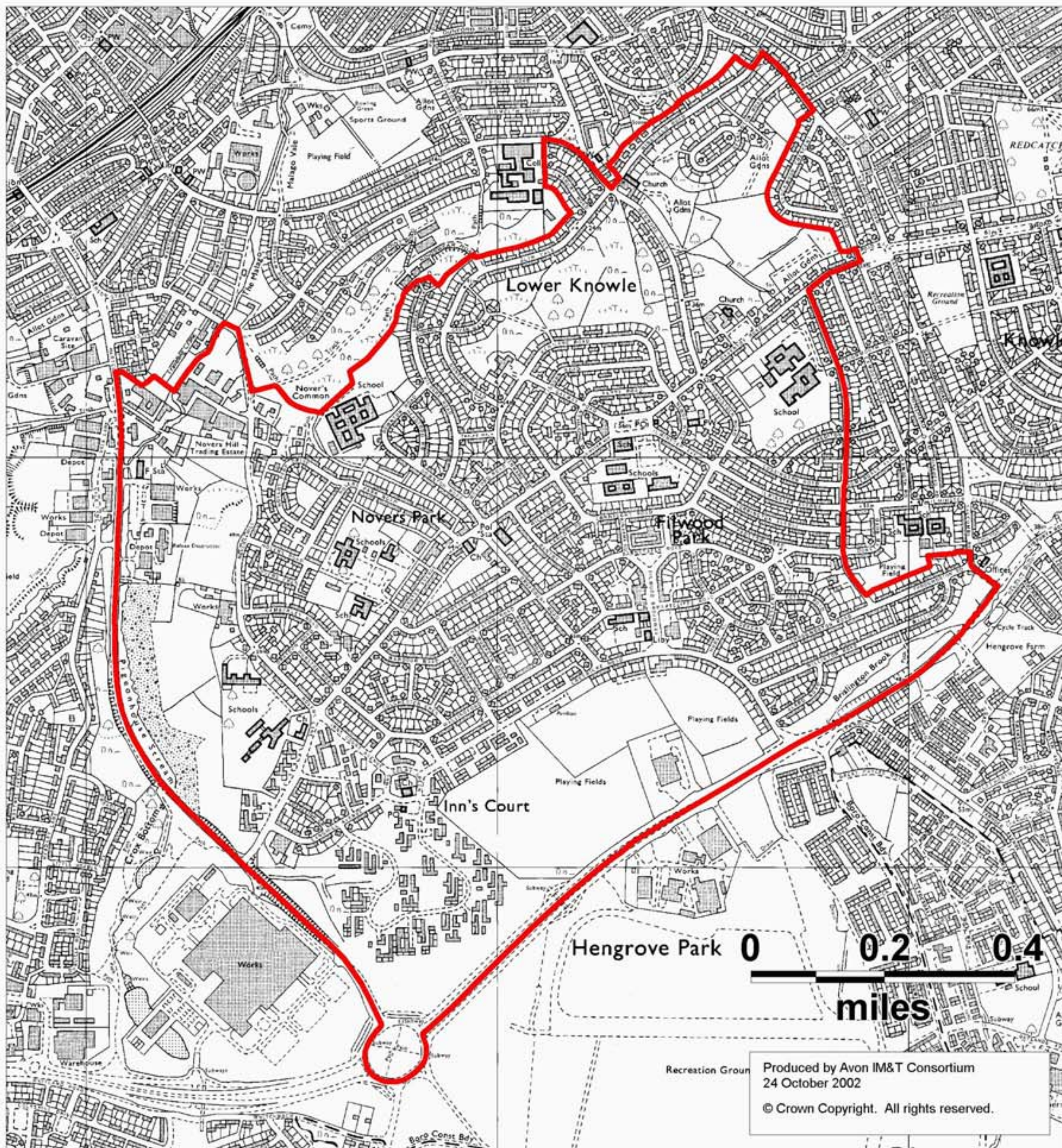
2.3.1 Geographical setting

Filwood (Figure 1), built in the 1920-40s to re-house families from Bristol's inner city, was one of Bristol's first council estates. Filwood is a Sure Start area and is one of ten NR areas in Bristol.[17]

Throughout this report the names Knowle West (KW) and Filwood are used interchangeably. Local people prefer KW, whilst the official ward name is Filwood. Filwood does not include the Knowle ward: this is a geographically distinct area.

Filwood was for many years the location of the Wills Tobacco Factory, and this was a major local employer. The company used to give out free cigarettes to its workers, and this is believed to have contributed to higher than average local levels of smoking and CHD. The factory closed at the end of the 1980s but its legacy on health is thought to live on.

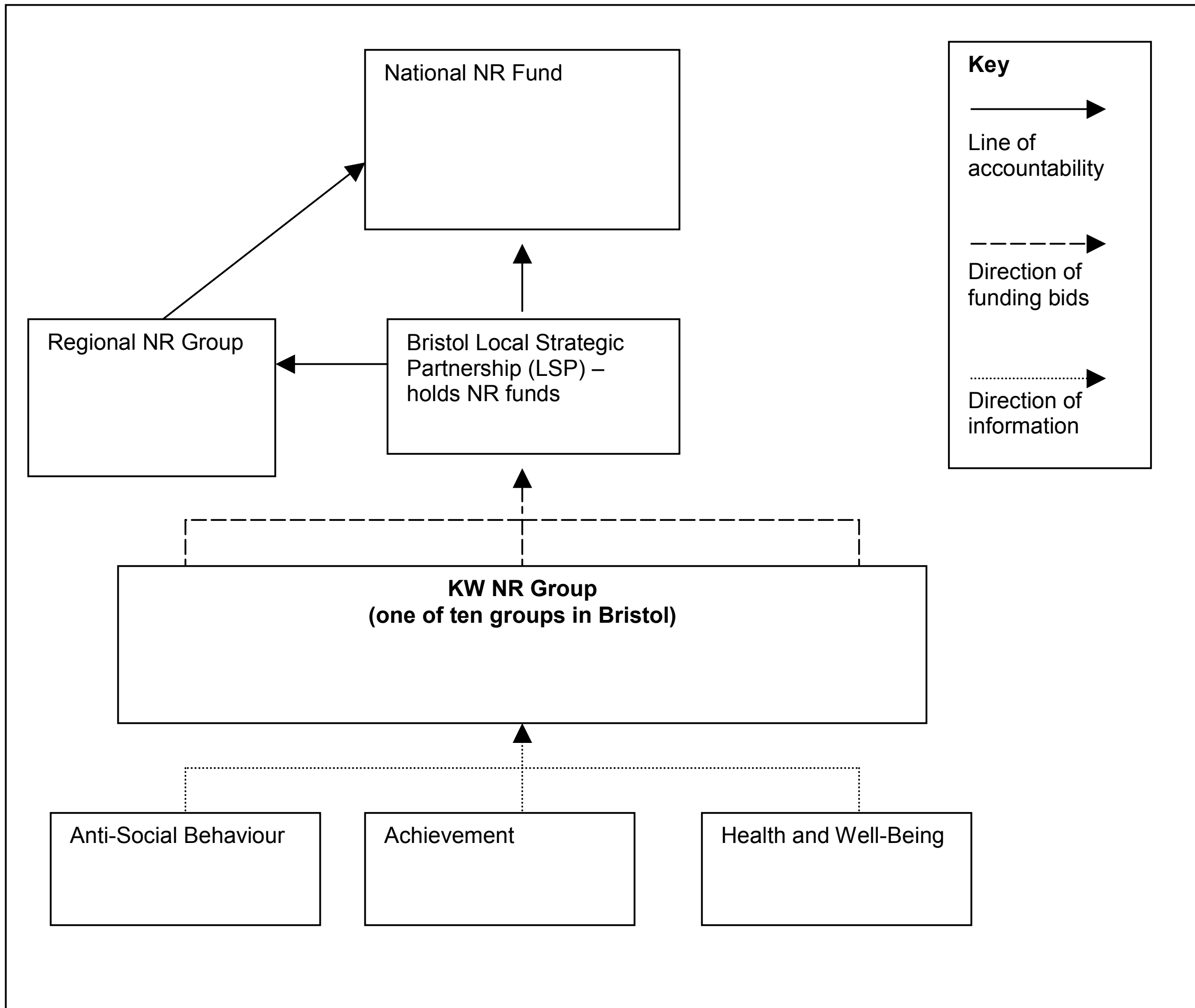
Figure 1: Filwood ward



2.3.2 Local policy context

Figure 2 outlines the NR structure in Bristol.

Figure 2: NR in Bristol



2.3.3 Previous health needs assessments in Filwood

I identified three studies that involved some assessment of health needs in Filwood, but none that focussed on CHD. Comparisons with my report are made in section 8.

3 Aims and Objectives

Aims

To assess heart health needs in Filwood, and present proposals for change that can be used to prioritise health activity and develop bids for funding.

Objectives

1. Use epidemiological, comparative and corporate approaches, to assess need for primary and secondary prevention of CHD in Filwood.

2. Map existing local heart health activities, comparing them against those outlined in the CHD NSF.

3. Use the findings from the needs assessment to formulate proposals for change that can aid the work of the HWG and BSWPCT in improving heart health in Filwood.

4. Work with the HWG and BSWPCT to develop bids for funding.

4 Methods

4.1 Approach to the needs assessment

The needs assessment utilised the Health Development Agency's *Health Needs Assessment Workbook*.[18] This defines health needs assessment as:

> '…a systematic and explicit process which reviews the health issues affecting a population. The process aims to improve health, and reduce health inequalities, by identifying local priorities for change and then planning the actions needed to make these changes happen.'

I followed a traditional approach as documented by Stevens and Raftery[19], consisting of:

a) Epidemiological;

b) Corporate; and

c) Comparative assessments of need.

I drew up a detailed project plan during May 2002. It included aims and objectives, proposed methodologies and timescales. The plan was agreed by the HWG whom I reported to at regular intervals. Sections 4.2-4.6 outline the methods in greater detail.

4.2 Epidemiological and comparative

I identified potential data sources following discussions with the public health information analyst. I identified risk factors for CHD from the NSF. Table 2 outlines the details, strengths and weaknesses of the data I used.

Table 2: Data sources for epidemiological and comparative needs assessment

Data source	Details	Strengths	Weaknesses
Population estimates	Estimates calculated by the local information department.	Provides estimates of age and sex by ward. Allows comparisons with city average.	Only estimates.
1991 Census	Collected every ten years, providing data at ward level.	Provides data on ethnicity and deprivation. Standardised collection of data.	Ten years out of date. 2001 data not yet available. Limitations to ethnicity measurements.
Mortality and hospital admissions data, 2000-2001 (ICD-9 codes 410-414)	Local LAPIS database (Locality and Practice Information System) provides epidemiological data by ward and GP practice in BSWPCT. Based on ONS death registrations and HES data. Mortality data includes all deaths, premature deaths and CHD mortality. Admissions data includes hospital rate for CHD, Myocardial Infarction (MI) and Coronary Artery By-Pass Graft (CABG) and Percutanerous Transluminal Coronary Angioplasty (PTCA) operations.	National, routinely collected data provides accurate picture of mortality and admissions. Mortality standardised by age and sex. 95% confidence intervals applied. Allows comparison across wards and GP practices in BSWPCT.	Analysing data at the ward level means that because of small numbers statistically significant differences between wards may not be detected. Admissions are based on completed consultant episodes: can be double counting when more than one consultant has been involved.
Smoking cessation database, 2001/2002	Database managed by Avon Smoking Cessation Service. Has number of people setting quit dates and quit at four weeks after by GP practice.	Provides local data on cessation activity. Allows comparison of cessation activity and outcomes across GP practices.	Did not provide rates. I calculated crude rates per 1000 registered practice population. But this does not take into account smoking prevalence by practice. Activity levels may reflect supply of services, not need.
Smoking in pregnancy data, 2001	Local data collected by health visitors.	Provides locally collected data on smoking status, rather than estimates from national figures. Provides data across ward level, allowing comparison.	May underestimate continued smoking through responder bias as data accuracy relies on honesty of the respondents i.e. Self-selected and self-reported data.
Breastfeeding data, 1999/2000	Percentage of mothers breastfeeding 8 weeks after the birth. Data collected at 8 week post natal check.	Provides actual data on breastfeeding.	May overestimate breastfeeding as it does not take into account mothers who failed to attend the 8 week check (who may be more likely not to be breastfeeding). Also accuracy of the data relies on honesty of responders (self-selected and reported data).
Low Birth Weight,	Data collected by ONS and available at ward	Routinely collected data. Good	Small numbers involved at ward level

Data source	Details	Strengths	Weaknesses
1996-2000	level in the LAPIS system.	validity. Allows comparison between wards. 95% CI applied.	mean that statistically significant differences are difficult to detect.
Health Survey for England (HSE) prevalence estimates, 1998[20]	Risk factor and disease prevalence by ward, estimated from national prevalence gained from the HSE 1998 (a cross sectional survey of 16,000 adults in the UK).	Provides an indication of prevalence for a number of CHD risk factors that can complement locally collected data. Standardised by age, sex and social class (using Townsend Score at the ward level). Data derived from national study. 95% CI are applied.	Small numbers involved at ward level means that statistically significant differences are difficult to detect. Social class data for each ward is from 1991 – 2001 figures not yet available. Figures are just estimates, and may not reflect actual prevalence.
BSWPCT CHD Audit, 2002[21]	Audit of health status of, and prescribing for IHD patients (those with doctor diagnosed heart attack or angina, aged 35-74) on the CHD register in BSWPCT across 28 practices (n=3234).	Comparable data relevant to CHD available across GP practices in BSWPCT.	Problems with data accuracy and completeness of CHD registers in some practices. Prescribing data may reflect differences in prescribing behaviour between practices.
Knowle West Health Park (KWHP) evaluation, 2001[22]	Health assessment of 181 people registered with the William Budd Health Centre in KW (Practices A and B). Included medical checks and analysis of patient records.	Provided local data on blood pressure, cholesterol, smoking status, physical activity and food intake.	There was limited details about the methodologies used and how participants were selected. Validity and accuracy of data unclear. Statistical tests of significance were not used. Small numbers.
Bristol City Council (BCC) Quality of Life survey, 2001[23]	12000 residents randomly selected from electoral register with 4000 responses. Provides information by ward on behaviour, including exercise and diet. Uses new ward boundaries (1999 Wards), different from those in LAPIS (1998 Wards), but only some ward boundaries are affected. Filwood remains the same.	The only data source on physical activity and diet that allowed a comparison across wards.	Response rate was 33% overall and 25% in Filwood (89 people). Small sample size at ward level means confidence intervals are large. Postal survey: self-reporting could result in responder bias. Survey asks about 4+ fruit and vegetables per day when recommended level is 5+.
KW Sure Start. KW Report, 2001.[24] Bristol Children's Fund. KW Geographical Area, 2000.[25]	Includes a review of data relevant to children in KW: economic, social and some health.	Provided easy to understand profiling of Filwood.	Of little use as data was limited and out-of-date. Did not compare across areas.

I assessed the accuracy, validity and reliability of the data. The comparative aspect of the needs assessment involved a comparison of CHD risk factors and health in Filwood with the other wards in BSWPCT and the BSWPCT average. This helped to recognise issues of inequality across BSWPCT.

I considered conducting a community survey, but given time and resource restrictions I decided that this would not be feasible. KW had also been extensively researched. Therefore I concentrated on utilising existing data and reports.

4.3 Corporate

Local workers

I liaised with the HWG to identify key informants in Filwood. I contacted the informants and arranged interviews. I ensured that the purposive sample of informants was representative in terms of topic areas covered and their professional and organisation background. The informants were all workers "on the ground": I wanted to get views from those who interacted with the community. I interviewed twenty-three local workers (see appendix 1). Interviews were semi-structured, with prepared questions allowing for an exploration of views and experiences. I recorded and transcribed all the interviews. I prepared for the interviews by utilising key texts of qualitative research techniques and through discussions with my academic tutor.[26] [27] [28] [29] [30] [31] I focussed questions around particular areas of concern, highlighted in the epidemiological needs assessment (which I had already completed). I also conducted a focus group with seven health visitors in Filwood.

Local residents

Much work investigating residents' views has been done in Filwood. Therefore I drew on earlier work. I also helped to organise a health and well-being workshop and ran three focus groups with local people (Table 3).

Table 3: Sources of residents' views on need.

Source	Details	Strengths	Weaknesses
Healthy Living Festival (1999)[32]	Local views gained from taped interviews (n=135) and questionnaires (n=69) at event in Filwood.	Provided useful comments about heart health issues that I could follow up in my own research.	Did not detail the methodology (not clear who was questioned).
Health and Well-Being Workshop	Event attended by fourteen local residents. Views gathered in groups.	Workshop was open to all, advertised by mail shot to all local houses. Views sought on variety of topics.	Residents may have been unrepresentative of Filwood community. Low turn out considering numbers targeted.
Focus group with four local residents (key informants)	I identified four key local residents who were engaged with health and NR issues in Filwood.	Individuals had a good knowledge of local issues and are seen as representatives of the local community. Relatively easy to organise the group because they are motivated.	Residents may not be typical of the community.
Focus group with ten local mothers at Sure Start group	I attended a Sure Start children's activity session and ran a focus group with the mothers present.	Engaged with mothers, who have distinct heart health needs. Targeted those who may not attend community days such as the workshop.	Participants not used to engaging at first found it difficult to be open about their views.
Focus group with seven local residents in the walking group	I ran a focus group with local walkers.	Engaged with older members of Filwood.	People can feel uncomfortable in group situations. Walkers were not representative of more immobile older people, who may have greater needs.

See Appendix 2

I prepared for the focus groups by reading key texts.[26 31] I recorded and transcribed all focus groups.

4.4 Service mapping

I worked with the HWG and the local workers I interviewed to map local heart health-related services against those services outlined in the CHD NSF. I designed an "expected heart health service activity" model based on the NSF. This was compared to local activities. I circulated the mapping document to the local workers and the BSWPCT CHD group, to minimise missed services.

The mapping exercise sought to identify gaps, but it also formed a directory of local services: local workers wanted to know what else was happening in Filwood, and wanted a directory, with contact names and numbers.

4.5 Formulating proposals for change

I formulated proposals for change, based on the findings from the needs assessment. I used reviews of evidence of effectiveness to assess the evidence for each proposal (Table 4).

Table 4: Reviews of the evidence

Name	Details
CHD NSF.[2 3]	Reviews the evidence of effectiveness for interventions designed to prevent CHD.
H.D.A. CHD Guidance for implementing the preventive aspects of the NSF.[8]	
NHS Centre for Reviews and Dissemination, Evidence from systematic reviews of research relevant to implementing the wider public health agenda.[9]	
National Electronic Library for Health TRIP database.[33]	Searches key sources of evidence of effectiveness, including Bandolier and Clinical Effectiveness reviews. I used this site when the other sources did not have any evidence on a given proposal.

I presented each proposal in tabular form, with detailed information under the following headings:

- Proposal for change.
- Success criteria.
- Evidence from epidemiological and comparative needs assessment.
- Evidence from corporate needs assessment.
- Evidence of effectiveness of proposal.
- Points to consider.
- Potential resource implications.

I wanted to maximise the usefulness of the proposal tables as stand-alone resources for developing funding bids. Detailed cost implications were developed by topic area specialists as part of the prioritisation process. To avoid repetition the proposals in this report are presented only with success criteria and references to the needs assessment and evidence of effectiveness.

4.6 Developing bids for funding

I worked with local specialist topic groups to prioritise the proposals for change (using the nominal group process) and help develop funding bids.[34] I attended local meetings and presented the results at the groups. I created a summary report to enable those developing bids to interpret the findings without reading the full document.

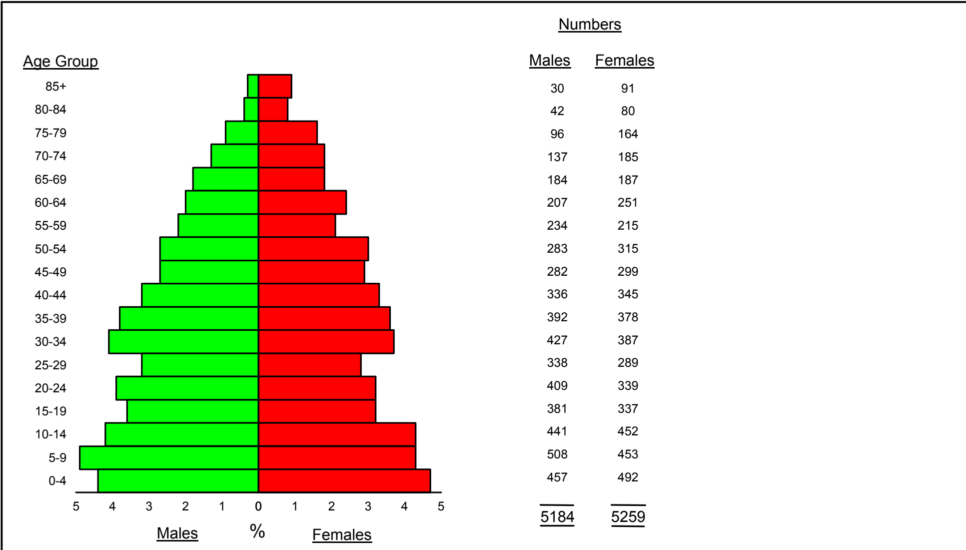
5 Results

5.1 Data on the local population

5.1.1 Age and sex structure

An estimated 10,500 people live in Filwood (2000). Figure 3 below summarises Filwood's age and sex distribution.

Figure 3: Filwood's age and sex distribution (2000)



Source: Avon Health Authority (AHA) population estimates (2000)

Those under 20 years of age make up 34% of the population, while persons over 70 account for 8%. Filwood has a younger age distribution than Bristol overall (Table 5).

Table 5: Age bands by % of total population in Filwood and Bristol

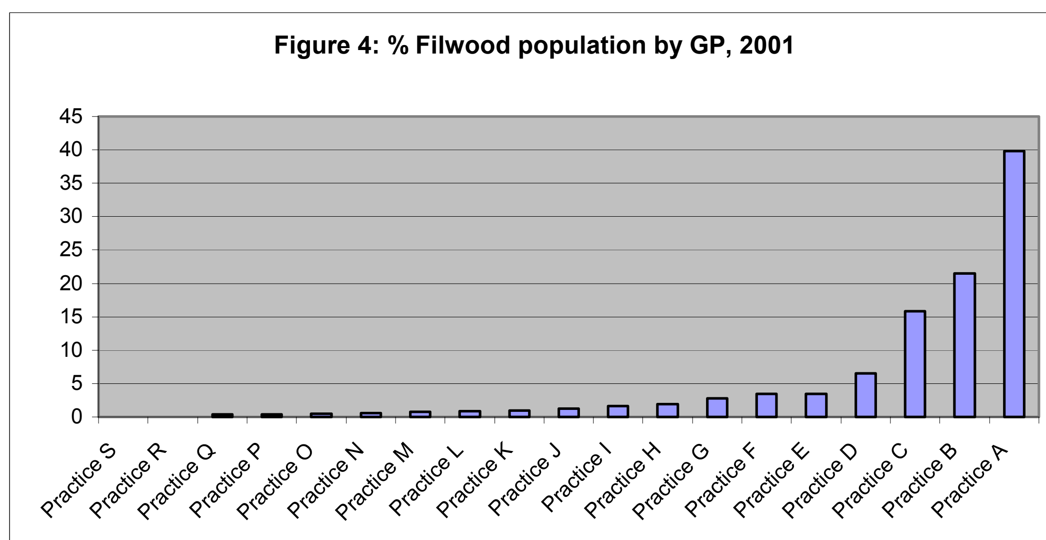
Age Group	Filwood (%)	Bristol (%)
0-4	9.1	6.1
5-14	17.7	12.5
15-24	14.0	15.1
25-44	27.7	31.3
45-64	20	20.3
65-74	6.6	7.2
75-84	3.7	5.4
85+	1.2	2.0
Total	100	100

Source: AHA mid-2000 population estimate

An above average percentage of Filwood's population is 14 years of age and under.

5.1.2 Who provides primary care to the Filwood community?

I identified the main providers of primary care locally to decide which practices' data to analyse when investigating health in Filwood (Figure 4).



Source: LAPIS.

77% of the Filwood population are registered with one of three GP practices; Practices A, B and C. The remaining residents are spread among sixteen other practices. Two of the practices (Practices A and B) are based in the William Budd Health Centre (WBHC) in Filwood.

Table 6: Filwood residents in three local practices, 2001

Practice	List size (2001)	Filwood residents on list (2001)	Percentage of registered patients from Filwood
Practice A	6267	4105	65.5
Practice B	4932	2212	44.8
Practice C	7273	1637	22.5

Source: LAPIS.

All three selected practices have a higher than average percentage of people who are 14 years of age or under, mirroring the earlier population findings.

5.1.3 Ethnic mix

The most recent data on ethnicity is from the 1991 Census (Table 7).

Table 7: % of residents from non-white ethnic groups, 1991

Area	% of residents from non-white ethnic group
Avon	2.7
South Bristol	2.5
Filwood ward	2.3

Source: 1991 Census

Filwood has a lower than average percentage of people from non-white ethnic backgrounds, but as these figures are ten years old the situation may have changed. However, I analysed local GP practice lists (based on surname), which suggests that the area still has a low proportion of people from non-white ethnic backgrounds.

5.1.4 Indicators of high health need

Filwood has the highest Townsend score in BSWPCT (9.7). The BSWPCT average is 4.2. The three local practices are in the top four most deprived in BSWPCT according to their Townsend scores.

Using the DETR's Index of Multiple Deprivation, Filwood is the most deprived ward in BSWPCT. Filwood also has high levels of health need: using the health component of the index, Filwood is second highest in the city, coming within the top 10% of English wards.

5.2 Local heart health status

5.2.1 General health

Table 8 summarises some of the general health indicators:

Table 8: Summary of general health

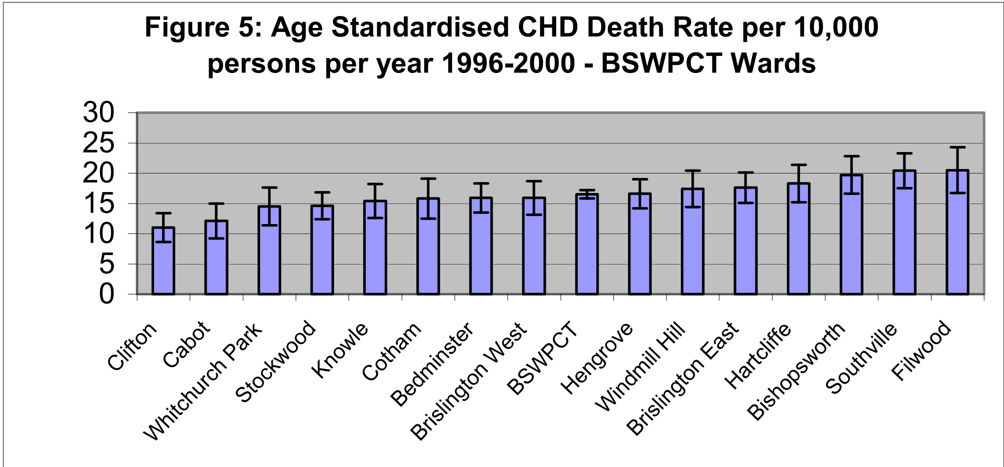
Indicator	**BSWPCT average**	**Filwood**	**BSWPCT Rank**	**p<0.05?**
Death rate (all causes) (per 10,000 persons per year, 1996-2000).	70.1	85.6	Second highest	Yes
Premature death rate <75 and <65 (all causes) (per 10,000 persons per year, 1996-2000).	38.4 and 20.9	51.2 and 28.4	Highest	Yes
Hospital admissions (all causes), elective and emergency (2000-2001).	1906	2612	Highest	Yes

Source: LAPIS

Filwood has significantly higher than BSWPCT average death and hospital admission rates.

5.2.2 Deaths due to heart disease

Filwood has the highest death rate for CHD in BSWPCT (Figure 5).



Source: LAPIS system

Whilst Filwood is not significantly different to the BSWPCT average, the differences in death rates between Filwood and the more affluent wards of Clifton and Cabot are significant ($p<0.05$). This demonstrates inequalities across BSWPCT.

Figure 6 shows the premature death rate for CHD among BSWPCT wards.

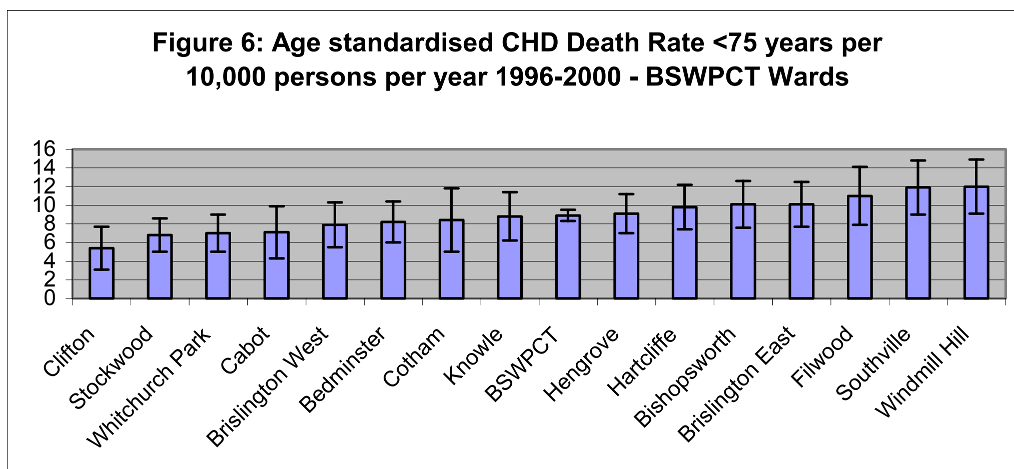


Figure 6: Age standardised CHD Death Rate <75 years per 10,000 persons per year 1996-2000 - BSWPCT Wards

Source: ONS. AHA 1998 population estimates

* ICD-9 codes 410-414

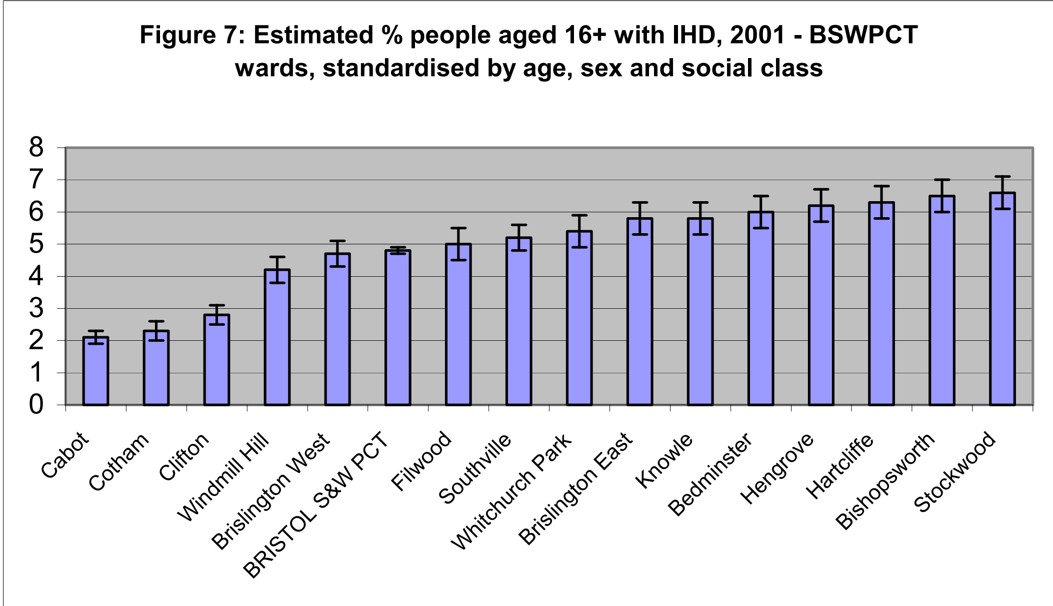
Filwood has the third highest premature death rate for CHD in BSWPCT. The difference between Filwood and the BSWPCT average is not statistically significant, but differences between Filwood and Clifton are significant ($p<0.05$), again highlighting inequality.

5.2.3 Prevalence of CHD

No CHD prevalence surveys have taken place in Filwood. Because of time and resource restrictions I used alternative data sources to estimate prevalence.

The BSWPCT Audit identified that in BSWPCT Practice C had the second highest percentage of its patients who were on the CHD register (11% of its patients). Practice A had 9% (fifth highest) and Practice B 5.5% (twenty-third highest). The BSWPCT average was 6.8%.

I also used the HSE to estimate prevalence (Figure 7).



Source:[20]. AHA 2001 population estimates. 1991 census.

Results in Figure 7 differ from the local audit. The audit estimates a prevalence between 6.8% -11% compared to the 5% from the national survey. The 5% estimate equates to 374 people having Ischaemic Heart Disease (IHD) locally. These differences could be due to a real change in prevalence between 1998 (when national IHD estimates were gained) and 2001 (when local data was collected). Differences could also be because the HSE figures do not take into account the prevalence of risk factors such as smoking. This may underestimate heart disease in areas that have high prevalence of risk factors: the audit does suggest that the HSE may underestimate prevalence.

5.2.4 Heart health service activity

Numbers of hospital admissions were too small at the practice level to be useful, so I compared admissions for CHD and Myocardial Infarction (MI) across wards (Figures 8-9).

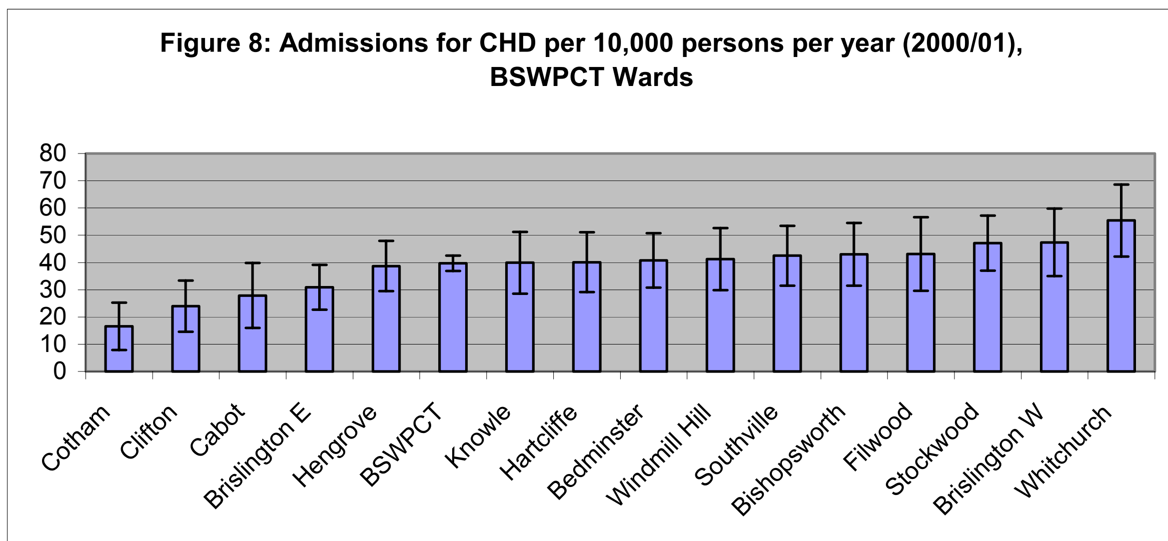


Figure 8: Admissions for CHD per 10,000 persons per year (2000/01), BSWPCT Wards

Source: LAPIS

Filwood has the fourth highest CHD admission rate in BSWPCT: although not significantly greater than the average, it is significantly greater than Cotham ($p<0.05$).

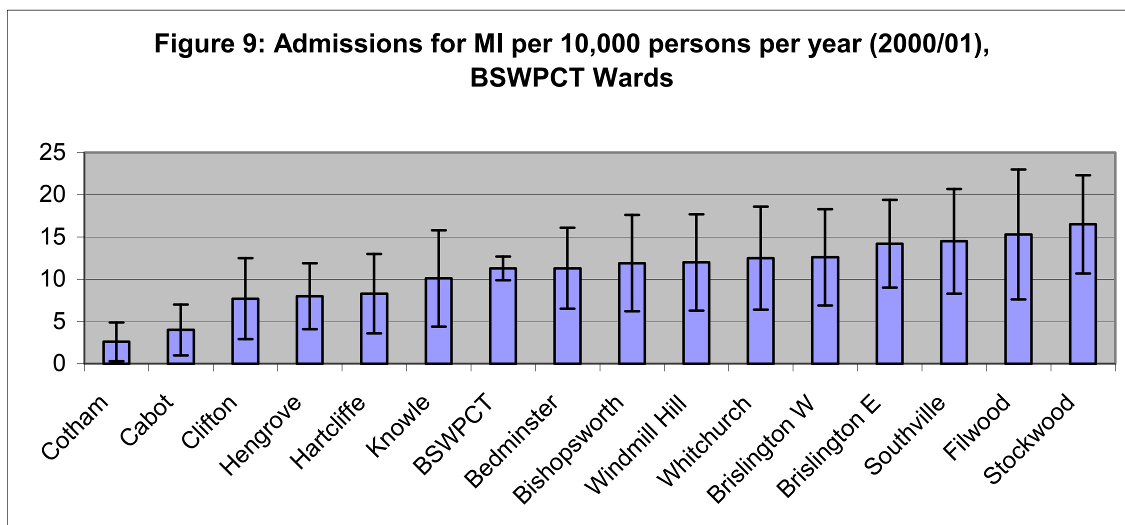


Figure 9: Admissions for MI per 10,000 persons per year (2000/01), BSWPCT Wards

Source: LAPIS

Filwood has the second highest MI admission rate in BSWPCT, but it is not significantly different than the BSWPCT average. Filwood is significantly different ($p<0.05$) to the more affluent wards of Cabot and Cotham.

Initial examinations of CABG/PTCA operations suggest that numbers may be too small at the practice and ward level to be meaningful. A detailed examination of rates of CABG/PTCA operations was outside the remit of the report. However I intend to examine CABG/PTCA patterns in greater detail as a follow-up piece of work.

5.2.5 Heart health-related prescribing

Heart health related prescribing is outlined in Table 9.

Table 9: Heart health-related prescribing – selected practices vs BSWPCT

The interventions that patients at high risk of CHD should receive, unless contraindicated, are:	CHD Audit performance measure	Practice A	Practice B	Practice C	BSWPCT average
Advice and treatment to maintain blood pressure below 140/85 mmHg	% Patients with IHD - BP record in the last 12 months	88.15	81.82	83.66	79.85
Low dose aspirin	% Patients with IHD on low dose aspirin	85.93	68.83	88.89	86.27
Statins and dietary advice to lower serum cholesterol concentrations either to less than 5 mmol/l (LDL-C to below 3 mmol) or by 30% (whichever is greater).	% Patients with IHD on Statins in the last 12 months	63.70	66.23	64.05	71.23
Beta-blockers for people who also have had a myocardial infarction	% Patients with MI on BB in last 12 months or contraindication	46.34	92.50	91.30	63.36

Source: [21]

Practice B has a low percentage of patients on low dose aspirin, despite it being cheap and effective. Practice A has a low percentage of patients on beta-blockers, which are an effective secondary prevention intervention. The BSWPCT CHD Group will examine these issues further.

Summary

- Filwood has the highest all causes premature death rate in BSWPCT.
- Filwood has the highest death rate and third highest premature death rate for CHD in BSWPCT.
- Prevalence of CHD in Filwood is unclear. Estimates from HSE suggest that the percentage of people with IHD in 2001 would be close to the BSWPCT average. However no account is taken of local risk factor prevalence (see Section 5.3).
- Filwood had the fourth highest admission rate in BSWPCT for CHD and second highest for MI (2000-2001).
- There may be an under-usage of low dose aspirin by Practice B and beta-blockers by Practice A.
- Inequalities exist across BSWPCT with Filwood having significantly higher rates of CHD mortality than more affluent areas.

5.3 Heart health risk factors in Filwood

5.3.1 Smoking

Table 10 summarises measures of smoking prevalence:

Table 10: Smoking prevalence

Measure	Filwood	BSWPCT average	National average
% people 16+ smokers, 1998*	33.5%, significantly above average.	29.6%	28%
% people 16+ registered with Practice B and Practice A who are smokers, 2001**	44% males 42% females	N/A	29% males 28% females
% Women who continue to smoke whilst pregnant, 2001***	43.9%	25.3%	19%*****
% people with established IHD who continue to smoke, 2002***	40-45% in local practices	30%	N/A
Smoking cessation quit set rate per 1000 registered practice population, 2001****	Practice A (5.1) Practice B (3.65) Practice C (7.84)	6.22	N/A

* Estimated from [20] ** [21] *** Health visitors database
**** Smoking cessation service database ***** [35]

We can estimate that there are between 2505 and 3547 smokers in Filwood over 16 years old. In Filwood, all smoking measures except quit set rates are above the BSWPCT and national averages. This suggests that while prevalence is higher than average, service usage is lower.

5.3.2 Blood Pressure

Estimates of high blood pressure are summarised in Table 11:

Table 11: Estimates of high blood pressure

Measure	**Findings**	**BSWPCT average**	**Different to BSWPCT at p< 0.05?**
IHD patients registered with local practices with BP >150/90*	Practice A 7 (5.2%) Practice B 6 (7.8%) Practice C 15 (9.8%)	757 (22.1%)	Yes.
Patients registered with Practice A and Practice B with BP >160/90 (out of sample of 210)**	70 (33%)	N/A	N/A
Estimated number of residents in Filwood aged 16+ with BP >140/90***	2239 (29.9%)	45955 (30.5%)	No

* BSWPCT CHD Audit 2002. % patients with BP reviewed in last year ranged from 81-88% (BSWPCT average is 80%).
** [21] *** Estimated from [20]

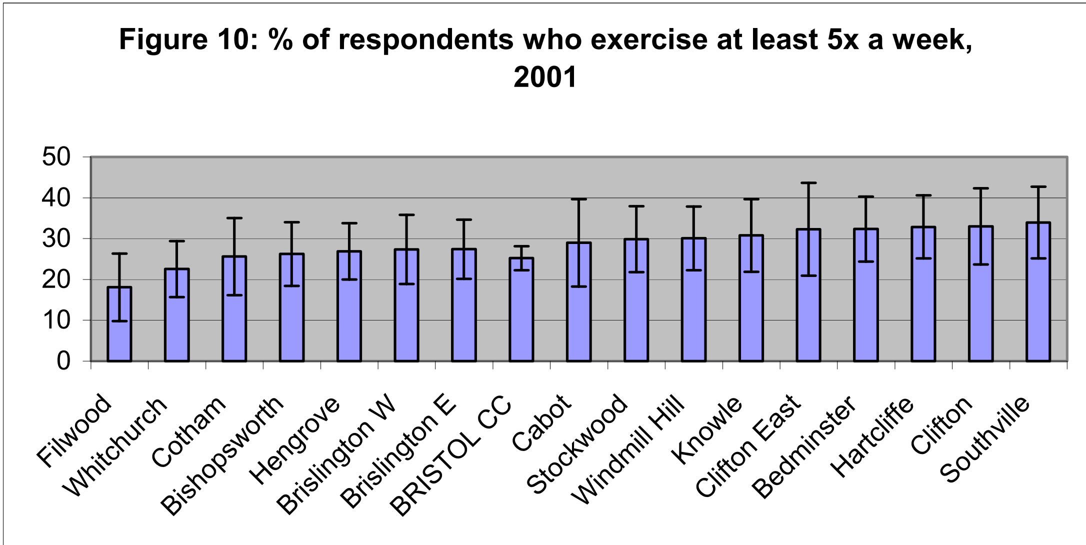
Estimates suggest that Filwood has average prevalence of high blood pressure. Using the >140/90 definition, an estimated 2239 in Filwood have high blood pressure. In the absence of a local prevalence survey in the general population, true prevalence of high blood pressure in the community is unclear.

The CHD audit indicates that blood pressure amongst those with diagnosed IHD is being much better controlled in local practices than elsewhere in BSWPCT.

5.3.3 Physical activity

Local data on levels of physical activity is sparse. The KWHP evaluation found that 12 (19.2%) men and 20 (16.8%) women of those surveyed reported at least one period of moderate exercise in the previous week and 36 (59.6%) men and 61 (51%) women reported only light exercise. Comparisons against the HSE (1998) suggested that local people took less exercise than the national average.

The 2001 BCC survey[23] asked residents "How often do you take moderate exercise?" (Figure 10).



Moderate exercise i.e. a brisk walk or heavy housework

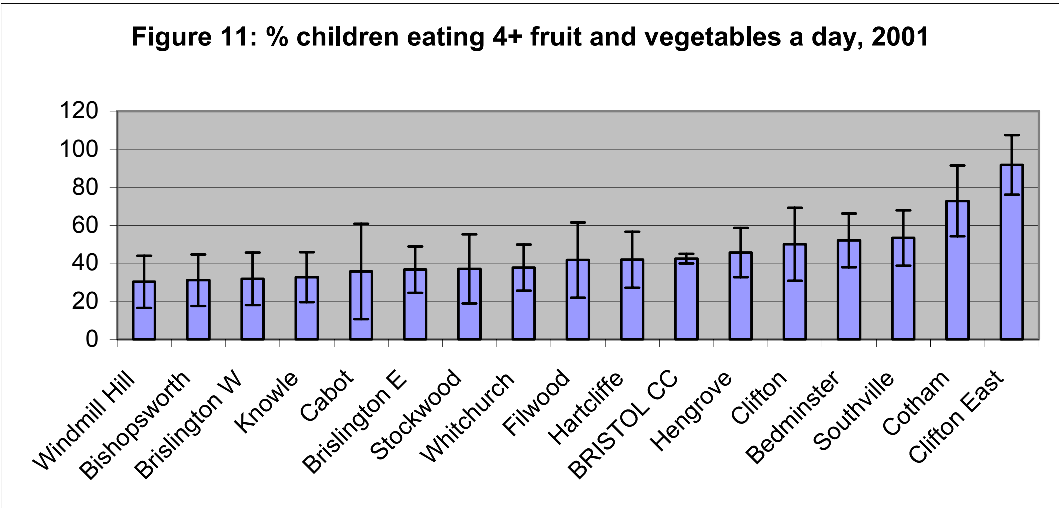
Filwood has the lowest percentage exercising at least five times a week (18%). The Bristol average is 29%. Due to small sample sizes at the ward level, confidence intervals are large, and Filwood is not significantly different to the other wards or the BCC average.

An above average percentage of primary school children walk to school (67% in Filwood compared to 56% BCC average). But a below average number of residents walk or cycle to work (8.8% compared to 23.2%). Car usage is around the city average while bus usage is above average (19.1% compared to 13.6%).

5.3.4 Healthy Eating and diet

The KWHP evaluation used the DINE questionnaire, which produces scores based on food intake during the previous week.[22] [36] It found high levels of unsaturated fat consumption among those surveyed: the mean score was 10.3 (<5 was classified as low, 6-9 moderate and high as 10+).

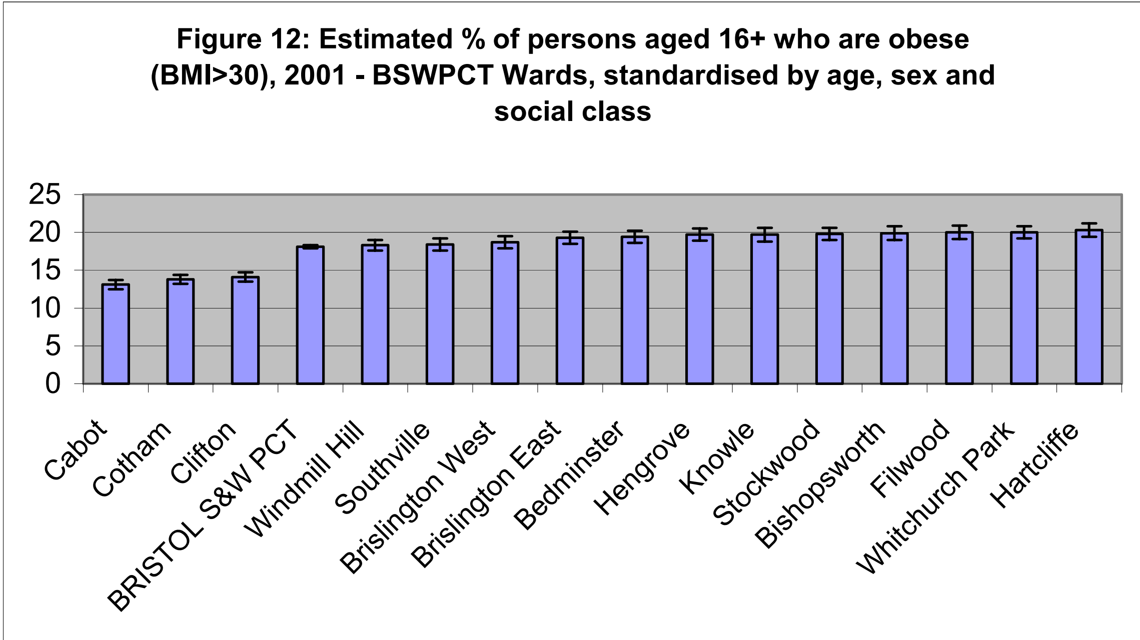
The Bristol Quality of Life survey asked responders about the amount of fruit and vegetables eaten by their children (Figure 11).



Filwood is around the Bristol average (41.7% compared to 42.4%). Due to small sample populations per ward confidence intervals are large and differences between Filwood and other wards are not significant (p>0.05), except Clifton East.

5.3.5 Overweight and Obesity

Filwood has the third highest estimated number of obese people in BSWPCT (Figure 12). Differences between Filwood and the BSWPCT average are statistically significant (p <0.05).



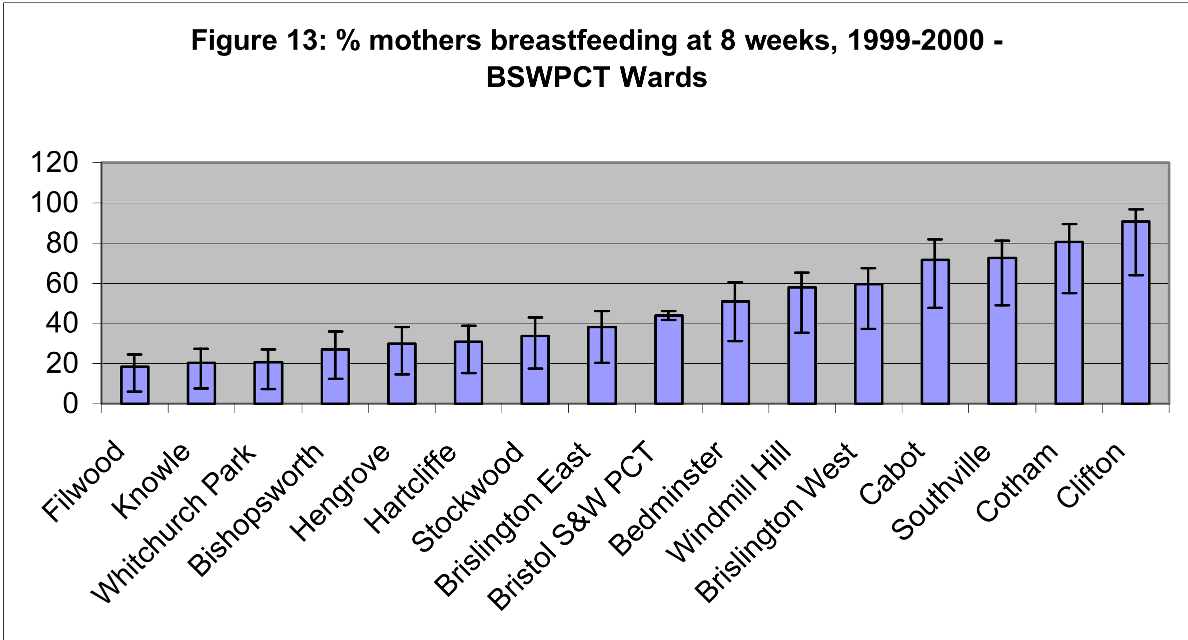
Source: Estimated from [20]. 1991 Census.

The percentage estimate equates to an estimated 1497 people aged over 16 living in Filwood who are obese. Filwood rates are significantly higher than those in six other wards (p<0.05), highlighting inequalities in estimated prevalence across BSWPCT.

The CHD audit revealed that Practices A and C have the highest percentage of patients with established IHD who are obese (Body Mass Index (BMI) >30 on their last reading). The figures being 34% and 48% respectively, compared to the BSWPCT average of 23%. Practice B has a figure of only 7.7%, but only 20% of his patients on the CHD register had ever had their BMI measured, compared to 90%+ in the other two practices.

5.3.6 Breastfeeding

The percentage of mothers breastfeeding in Filwood eight weeks after birth (18.4%) is the lowest in BSWPCT (Figure 13).



Source: Child Health Surveillance Data, 1999-2000

Filwood's figure is statistically significantly lower than the BSWPCT average ($p<0.05$) and there are significant differences between Filwood and seven other wards, indicating inequalities in breastfeeding across BSWPCT.

5.3.7 Low Birth Weight

Filwood has the second highest percentage of Low Birth Weight (LBW) babies in BSWPCT between 1996-2000 (Figure 14).

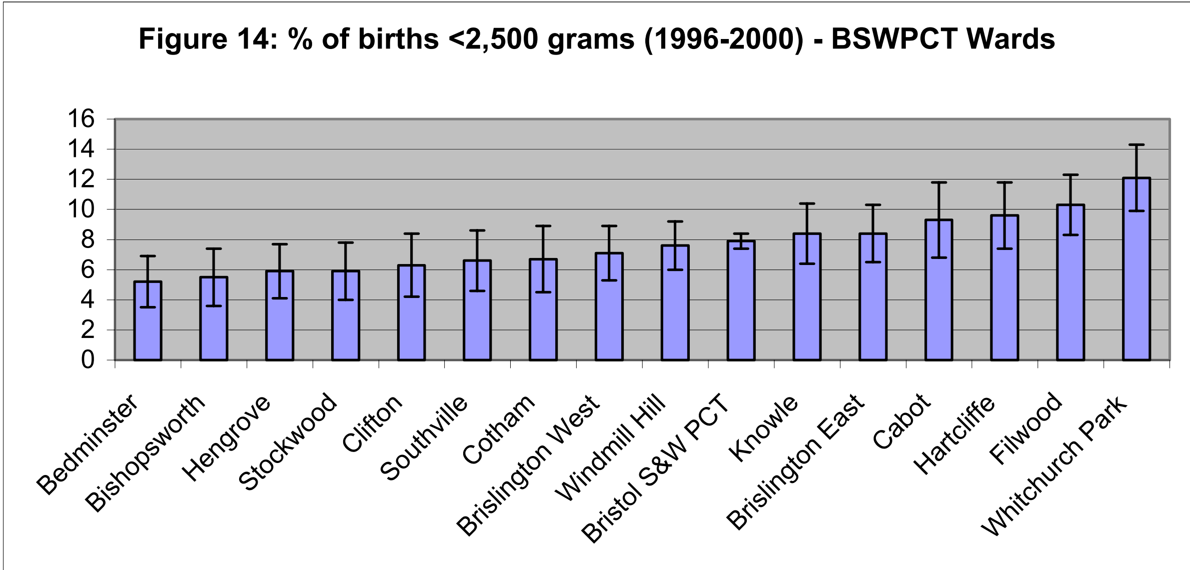


Figure 14: % of births <2,500 grams (1996-2000) - BSWPCT Wards

Source: ONS Birth Registrations, 1996-2000

Filwood's figure of 10.3% is higher than the BSWPCT average of 7.9%, but differences are not statistically significant. There are however significant differences between Filwood and four other wards in BSWPCT ($p<0.05$), highlighting inequalities in LBW across BSWPCT.

5.3.8 Raised cholesterol prevalence

Table 12 summarises estimates of raised cholesterol.

Table 12: Estimates of raised cholesterol

Measure	BSWPCT average	Estimate	P<0.05?
Estimated % aged 16+ with raised cholesterol (>6.5mmol/l)*	27854 (17.4%)	1344 (18%)	p>0.05
IHD patients registered at local practices with cholesterol >5 mmol/l**	1340 (39%)	Practice A 38 (49%)	p<0.05
		Practice B 73 (58%)	p<0.05
		Practice C 56 (34%)	p>0.05

*** Estimated from** [20]
** [21]

The BSWPCT CHD audit suggests that the prevalence of high cholesterol among IHD patients is significantly higher than the BSWPCT average in two of the local practices (A and B). Only estimates of prevalence in the general population are available. Estimates are not significantly different from the BSWPCT average. Without a local prevalence survey it is not possible to assess prevalence in the general population.

Summary

- A lack of ward-level data means that many CHD risk factors have been estimated from the HSE.
- Filwood has a high prevalence of a number of CHD risk factors.
- Smoking is a big problem, with around 44% of males and 42% of females smoking. Filwood has the highest estimated percentage of smokers in BSWPCT. Rates are high in pregnant women and those with IHD.
- The CHD audit suggests that of those who are known to have high blood pressure and CHD it is being well controlled. The KWHP evaluation concluded that a high proportion of the local population had high blood pressure, but estimates from the HSE were lower than average.
- There is a lack of data on physical activity and healthy eating/diet. Local surveys suggest that local people take less exercise than the national and BSWPCT average and eat less healthily, but sample sizes were small.
- Filwood has a higher than BSWPCT average estimated number of people who are obese.
- Filwood has the lowest percentage of mothers breastfeeding in BSWPCT (2000).
- Filwood had the second highest percentage of LBW babies in BSWPCT, 1996-2000.
- Data suggests that cholesterol among those with IHD is higher in Filwood than elsewhere in BSWPCT. Estimates of high cholesterol prevalence in the general population are around the BSWPCT average.
- Inequalities across BSWPCT exist, with Filwood having a significantly higher prevalence of a number of CHD risk factors than other more affluent wards.

5.4 Views of local workers and residents

Common needs were expressed among local workers and residents (Table 13). In the service report, tables containing key quotes from local workers and residents that relate to each proposal were used to validate the choice of proposals. They are excluded here due to word count restrictions.

Table 13: Views of local workers and residents.

	Local Workers	Local Residents		
Topic	**In-depth interviews (n=23) and focus group (n=1)**	**Past reports**[32]	**Residents focus groups (n=3)**	**Health Workshop (n=1)**
Smoking cessation and control	▪ Want to train local people as cessation advisors. ▪ Want to develop smoke free areas in local cafes and pubs. ▪ Want to expand the cessation service outside of general practice to manage demand. ▪ Want to focus on pregnant women and those with IHD.	▪ Want help to quit smoking. ▪ Want smoke free areas.	▪ Want shorter waits for cessation services. ▪ Residents know little about other cessation opportunities, such as the drop-in service. ▪ Mothers want smoke free areas to take their children to.	▪ Want shorter waits for cessation services. ▪ Want more information about smoking cessation. ▪ Want smoke free areas.
Healthy eating and access to food	▪ Want to improve access to fruit and vegetables, especially for children. ▪ Encourage local schools to develop breakfast clubs and fruit tuck shops. ▪ Feel that accessibility to food is a key factor in dietary choice. ▪ Want to encourage breastfeeding and train local people to be supporters.	▪ Want a food co-op or community supermarket. ▪ Want better food shops. ▪ Want better supermarket buses.	▪ Want a co-op or supermarket ▪ Think local food shops are rubbish. ▪ Are frustrated at failed attempts to set up a community supermarket/co-op. ▪ Mothers find getting the bus difficult and expensive. ▪ Want to encourage breastfeeding and train local people.	▪ Want better access to fruit and vegetables. ▪ Want to improve children's diet in schools. ▪ Want to encourage breastfeeding.
Physical activity	▪ Want to encourage physical activity. ▪ Want to train local people to run teams. ▪ Want to develop a community gym. ▪ Want to improve cycling training and access to bicycles. ▪ Want to develop the walking group and link with primary care.	▪ Want to increase cycling and walking, especially in children. ▪ Want a gym.	▪ Want to improve access to the swimming pool, including subsidies for residents. ▪ Want an affordable gym facility.	▪ Want to encourage sport in schools. ▪ Want to expand the walking group. ▪ Want a community gym. ▪ Want improved access to the swimming pool.
Overweight and obesity	▪ Want to tackle issues of overweight and obesity. ▪ Want to develop a weight management scheme in primary care. ▪ Want to run slimming groups that combine physical activity with dietary advice.	▪ Want access to affordable slimming groups. ▪ Want advice on weight loss.	▪Want access to affordable slimming groups. ▪Want advice on weight loss.	▪ Want access to affordable slimming groups.
Identifying and managing those at high risk of CHD	▪ Want to improve awareness of blood pressure and cholesterol in the community, and training of health professionals in testing.		▪ Want to know more about blood pressure and cholesterol. ▪ Want to improve access to blood pressure testing outside of primary care.	▪ Want more access to blood pressure testing in the community.

Several key themes emerged, that have important implications for improving heart health locally (Table 14).

Table 14: Key themes

Theme	Summary
Geographical mobility	Local people are reluctant to travel even short distances: people in one area of the estate rarely venture to another area, which can have an impact on the usage of local services.
Means of engaging the local community	Posters are often not read. There are also high levels of illiteracy in Filwood that could affect the impact of visual material. Word-of-mouth was viewed as the most effective means of communication.
Training local people	Seen to offer a way of empowering the community and improving the effectiveness of projects.
Inter-organisational relations	Communication problems between local organisations, which has hindered multi-agency activity.

Summary

Local workers and residents want to:

- Improve access to, and awareness of, smoking cessation services.
- Develop smoke free areas.
- Improve access to fruit and vegetables (especially for children) by developing a co-op or box scheme, improving supermarket buses and developing breakfast clubs and fruit tuck shops in schools.
- Encourage breastfeeding and train mothers to support others.
- Encourage sport in schools including developing team sports and involving local people in the running of them.
- Expand the walking group, promote cycling, encourage use of the swimming pool and have a community gym.
- Train health professionals in blood pressure and cholesterol testing and raise awareness in the community.
- Key themes emerged around; geographical mobility, means of engaging the local community, training local people and inter-organisational relations.

5.5 Mapping local services against NSF standards

5.5.1 Smoking cessation and tobacco control

Table 15: Smoking prevention activities

Smoking prevention activities (expectations outlined in NSF)	**What services/activities exist?**	**Issues**
Development of smoking cessation services	Smoking cessation sessions run by trained advisors (nurses) at the local practice. Patients seen one-to-one for 6 weeks. Service has above average quit rates but lower than average quit set rates. Sure Start midwife provides smoking cessation sessions for pregnant women.	Long waiting times for an initial appointment, due to capacity problems in primary care.
	Group sessions are held at the Healthy Living Centre (HLC), run by the smoking cessation co-ordinator, for those on waiting lists and open invite. Drop-in clinic tried at the HLC but now is appointment based, weekly.	There is low uptake of group sessions. The drop-in was not well attended and demand is low for the appointment session.
Reducing smoking in public places	Project works in deprived areas to help pubs develop smoke-free areas. Clean air for kids co-ordinator works with local professionals and residents around passive smoking.	Only one pub in Filwood. Attempts to promote no-smoking areas not well received. One nearby pub is non-smoking, one is smoking throughout, while another two have no-smoking areas. Some work in local cafes and with health visitors and Sure Start. No money for work with schools and workplaces.
Reducing illegal sales of cigarettes	Educating traders and responding to complaints about underage sales.	Lack of staff so little test purchasing in shops.
Monitor the advertising ban, when introduced	Ban not yet introduced.	Cigarette billboard in the centre of Filwood throughout August.
Work to support any national campaigns – ie smoke free day	Cessation service support national campaigns.	Resources are limited.

5.5.2 Healthy eating and access to food

Table 16: Food and diet activities

Food and diet activities (expectations outlined in NSF)	**What services/activities exist?**	**Issues**
Be aware of the availability of foods in the local economy.	Mapping of fruit and vegetable shops in 2001 conducted by BCC revealed lower than average access in Filwood to fruit and vegetable shops (households within 500 metres of a shop).	No-one has looked at price comparisons of local food shops with supermarkets, or assessed accessibility of supermarkets, including the appropriateness of supermarket buses.
Work with retailers of fruit and vegetables to encourage increased consumption and to improve local accessibility to affordable supplies of fruit and vegetables.	No food co-op or fruit and vegetable box scheme in Filwood. Breakfast clubs run in three of the six local primary schools. Two schools have fruit tuck shops and one provides a piece of fruit with the children's milk.	Previous efforts to create a food co-op/ supermarket failed, creating disillusionment among local activists. One local school stopped running their breakfast club because of lack of demand. One school has a breakfast club in the junior school section.
Help patients to turn health education messages into practice.	Weekly breastfeeding supporters club run by Sure Start, to encourage women to breastfeed. Also trains mothers as "breastfeeding supporters". Sure Start and Health Visitor programmes have sessions on healthy eating.	The group is small but enthusiastic. No healthy eating sessions for wider population.
Help local people, especially those in low income households, to shop strategically and to improve their cooking skills.	"Cook and eat" sessions took place. Currently no local cooking clubs. Sure Start and Health Visitor programmes (for mums and dads-to-be) have short cooking sessions.	Food skills opportunities in Filwood are only available for future or recent parents.

5.5.3 Physical activity

Table 17: Physical activity activities

Physical activity activities (expectations outlined in NSF)	**What services/activities exist?**	**Issues**
A focus on promoting daily moderate intensity physical activity that can be carried out as part of their daily life.	Weekly gardening club and "Green Gym" promotes exercise through conservation.	Problems with engaging residents. Lack of funding.
The promotion of cycling and walking as modes of transport.	Walking the way to health project has group that walks each week. Cycle stands at HLC. Cycle lane circling the estate: part of national cycle network. Local cycling organisation offers cycling training in Bristol.	Lack of money for expansion of walking groups. Group does not attract younger people and is not really suitable for those who could walk at pace. No cycle lanes/paths in the estate. No cycle training for school children or bicycle recycling scheme.
The implementation of green transport plans in every NHS facility and major workplace and safe routes to school.	One school has a travel plan, one had crossing points put in, one worked with BCC to encourage walking to school.	No local employers known to have travel plans.
Programmes to improve community access to green spaces and community recreation facilities.	Swimming pool in Filwood. Junior school children go swimming once a week. Variety of parks and safe-play areas nearby. Some exercise classes run at the HLC and Health Association. Football and netball most popular team sports locally.	Pool has seen falling attendances. Due to close in next few years, replaced by a pool 10-20 minutes walk away. Problems with discarded syringes, but neighbourhood wardens are now helping to clean up the area. Exercise classes aimed mainly at women. No community gym. Few other team sports. Lack of volunteers to run teams.
Training primary care staff in counselling skills to promote	Practice Nurses use CHD template to identify those at high	Lack of knowledge among workers about local health

Physical activity activities (expectations outlined in NSF)	**What services/activities exist?**	**Issues**
physical activity and promote home-based physical activity.	risk of CHD and advise them about health promotion opportunities.	promoting activities.
Exercise referral schemes.	Healthy Practices GP referral scheme runs in parts of Bristol, but not yet in Filwood.	Not clear whether it will be extended to Filwood.

5.5.4 Overweight and Obesity

Table 18: Overweight and obesity activities

Reducing overweight and obesity (expectations outlined in NSF)	**What services/activities exist?**	**Issues**
Activities	Weight management programme developed for use in primary care. One-to- one sessions with a trained advisor. Pilot scheme ran locally that trained residents as weight loss advisors.	Scheme postponed. No money to employ advisor. No slimming groups run locally.

5.5.5 Identifying and managing those at high risk of CHD

Table 19: Advice and treatment in primary care for CHD

Advice and treatment in primary care for those with heart disease and those at high risk (expectations outlined in NSF)	What services/activities exist?	Issues
Advice about how to stop smoking, including advice on the use of NRT	See table 15.	See table 15.
Information about other modifiable risk factors and personalised advice about how they can be reduced.	Practice Nurses use CHD template to identify those with CHD or those at risk. They are invited to a CHD clinic for advice.	Targeting of at risk people is more opportunistic.
Medical treatment for those with established heart disease (including cholesterol and blood pressure control).	Prescribing of appropriate medication.	CHD audit revealed variations in prescribing between practices.

Summary

- There are long waits for smoking cessation sessions in the local GP practices, but low uptake of other smoking cessation opportunities.
- There is a lack of work around tobacco control, such as creating smoke free areas in public places, due to lack of money.
- Need to address food access issues, including supermarket buses and a food co-op or box scheme.
- Lack of healthy eating courses and cookery classes.
- No cycle lanes or gym, and problems with the local pool.
- No weight management services.
- Lack of services for older people.

6 Planning: Proposals for change

I formulated sixteen proposals for change based on the findings from the needs assessment. Tables 20-24 summarise the proposals. Asterisks (*) indicate proposals where mainstream funding (bending mainstream services to better address local need) may be able to achieve the desired change.

6.1 Smoking cessation and control

Proposal for change	Success criteria	Evidence from epidemiological needs assessment	Evidence from local workers and residents	Evidence from service mapping	Evidence of effectiveness of proposal
Pilot and evaluate a project to train local people as smoking cessation advisors and engage them in local cessation activity, especially with pregnant women and those with established heart disease.*	Increase in number of people, especially high-risk groups, attending smoking cessation sessions. Decreased waiting times for smoking cessation advice. Increase in four week quit rate for local practices. Reduction in percentage of mothers and those with CHD who are still smokers. Reduction in local prevalence of smoking.	Section 5.3.1,	Table 13.	Table 15	Effectiveness of smoking cessation, including for pregnant women and those at high risk.[2 8 37 38]

Table 20a

Proposal for change	Success criteria	Evidence from epidemiological needs assessment	Evidence from local workers and residents	Evidence from service mapping	Evidence of effectiveness of proposal
Promote the HLC smoking cessation clinic in different ways, to maximise awareness in the community, especially among high risk groups and pregnant women.*	As Table 20a. Increase in numbers attending the clinic. Reduction in people waiting for longer than a month for smoking cessation advice.	Section 5.3.1,	Table 13.	Table 15.	Effectiveness of smoking cessation.[2 8]

Table 20b

Proposal for change	Success criteria	Evidence from epidemiological needs assessment	Evidence from local workers and residents	Evidence from service mapping	Evidence of effectiveness of proposal
Help to establish smoking policies in local schools, workplaces and other public places such as cafes.	Increase in number of local facilities with smoking policies. Changes in attitudes around passive smoking.	Section 5.3.1,	Table 13.	Table 15.	Effectiveness on behaviour and attitudes of smoke free policies in public places.[8 9]

Table 20c

6.2 Healthy eating and access to food

Proposal for change	Success criteria	Evidence from epidemiological needs assessment	Evidence from local workers and residents	Evidence from service mapping	Evidence of effectiveness of proposal
Pilot and evaluate a food co-op and/or fruit and vegetable box scheme serving KW.	Increase in number of households who subscribe to the co-op or box scheme. Increase in number of local people who eat 5 or more portions of fresh fruit and vegetables a day.	Section 5.3.4,	Table 13.	Table 16.	Evidence of impact on choice and accessibility of foods.[8] No evidence on health effects.[33]

Table 21a

Proposal for change	Success criteria	Evidence from epidemiological needs assessment	Evidence from local workers and residents	Evidence from service mapping	Evidence of effectiveness of proposal
Pilot and evaluate work with local supermarkets to ensure effective provision of free buses, suitable for mothers with small children and the elderly (which are regular and pick up at points around the whole estate).	Increase in geographical coverage and frequency of free supermarket buses. Increase in local usage of the buses. Increase in local satisfaction with the services. Increase in number of local people who eat 5 or more portions of fresh fruit and vegetables a day.	Section 5.3.4,	Table 13.	Table 16.	No evidence could be found on the effects on health, changes in shopping behaviour or diet of free supermarket buses.[33]

Table 21b

Proposal for change	Success criteria	Evidence from epidemiological needs assessment	Evidence from local workers and residents	Evidence from service mapping	Evidence of effectiveness of proposal
Establish cooking skills clubs, open to the local community, which will provide practical advice on buying and cooking healthier food. **(Pilot and evaluate the impact on adults)**	Increase in number of local residents attending cooking skills courses. Increase in number of local people who eat 5 or more portions of fresh fruit and vegetables a day.	Section 5.3.4,	Table 13.	Table 16.	Evidence on the effects of cooking clubs on attitudes and diet of children.[9 39] No evidence found on effects of clubs on adults.[33]

Table 21c

Proposal for change	Success criteria	Evidence from epidemiological needs assessment	Evidence from local workers and residents	Evidence from service mapping	Evidence of effectiveness of proposal
Encourage and support local primary schools to develop breakfast clubs and fruit tuck shops.* **(Pilot and evaluate the effects of the tuck shop)**	Increase in number of local schools providing breakfast clubs and fruit tuck shops. Increase in number of children eating 5 or more portions of fruit and vegetables a day. Increase in number of children eating breakfast. Reduction in prevalence of childhood obesity.	Section 5.3.4,	Table 13.	Table 16.	Evidence on increased breakfast consumption among children.[40] No evidence found on the health effects of school fruit tuck shops.[33]

Table 21d

Proposal for change	Success criteria	Evidence from epidemiological needs assessment	Evidence from local workers and residents	Evidence from service mapping	Evidence of effectiveness of proposal
Expand the breastfeeding mothers club and training of breastfeeding supporters. Increase the profile of breastfeeding and pilot and evaluate impact of incentives for mothers to breastfeed.*	Increase in numbers attending the breastfeeding club. Increase in number of breastfeeding supporters. Increase in % of women breastfeeding in KW.	Section 5.3.6.	Table 13.	Table 16.	Effectiveness of interventions to promote breastfeeding.[41] No evidence found on the effect of peer support for those women who had not expressed a wish to breastfeed.[33] No evidence found on the effectiveness of providing incentives for women to breastfeed.[33]

Table 21e

6.3 Physical activity

Proposal for change	Success criteria	Evidence from epidemiological needs assessment	Evidence from local workers and residents	Evidence from service mapping	Evidence of effectiveness of proposal
Increase the number of walking groups, to cater for people of differing abilities. Link these groups with referral from primary care. Train and pay for group leaders, who may or may not be local people.*	Increase in number attending walking groups, including those referred from primary care. Increase in number of local people engaged in regular physical activity.	Section 5.3.3.	Table 13.	Table 17.	Effectiveness of interventions that do not require attendance at exercise facilities.[9] Effectiveness of walking groups at increasing physical activity.[42]

Table 22a

Proposal for change	Success criteria	Evidence from epidemiological needs assessment	Evidence from local workers and residents	Evidence from service mapping	Evidence of effectiveness of proposal
Pilot and evaluate the provision of subsidised swimming sessions for local people at Filwood Pool.*	Increase in number of local residents using Filwood Pool. Increase in number of local people engaged in regular physical activity. Reduction in prevalence of obesity.	Section 5.3.3.	Table 13.	Table 17.	Evidence showing importance of cost and access for the success of health promoting activities, especially involving hard to reach groups.[8] No evidence on the health effects of subsidised swimming sessions.[33]

Table 22b

Proposal for change	Success criteria	Evidence from epidemiological needs assessment	Evidence from local workers and residents	Evidence from service mapping	Evidence of effectiveness of proposal
Pilot and evaluate the development of a community gym, which would be open access but also allow people to be referred there from primary care.	Increase in number of local people who use the gym, including those referred from primary care. Increase in number of local people engaged in regular physical activity. Improvements in cardio-vascular fitness in those referred to the gym from primary care. Reduction in prevalence of obesity.	Section 5.3.3.	Table 13.	Table 17.	No evidence could be found on the effectiveness of referral schemes to a gym, in terms of health benefit and/or uptake.[33]

Table 22c

Proposal for change	Success criteria	Evidence from epidemiological needs assessment	Evidence from local workers and residents	Evidence from service mapping	Evidence of effectiveness of proposal
Pilot and evaluate the promotion of team sports across the local community and especially in schools. Train local people to help run clubs.*	Increase in number and variety of team sports in KW. Increase in physical activity levels among general population and local school children. Reduction in prevalence of overall and childhood obesity.	Section 5.3.3.	Table 13.	Table 17.	No evidence that sports clubs affect physical activity levels or CHD mortality.[8]

Table 22d

Proposal for change	Success criteria	Evidence from epidemiological needs assessment	Evidence from local workers and residents	Evidence from service mapping	Evidence of effectiveness of proposal
Pilot and evaluate work with local people and especially schools to promote cycling (including training school children in cycling proficiency, providing cycle lanes/paths between key facilities and developing a bicycle recycling scheme).	Increase in number of local schools who have participated in cycle proficiency training. Increase in number of people cycling to school and work. Reduction in prevalence of obesity.	Section 5.3.3.	Table 13.	Table 17.	Evidence of increased walking and cycling when environment is modified to encourage walking and cycling.[8 9] No evidence found on effects of cycle training.[33]

Table 22e

6.4 Overweight and obesity

Proposal for change	Success criteria	Evidence from epidemiological needs assessment	Evidence from local workers and residents	Evidence from service mapping	Evidence of effectiveness of proposal
Provide sufficient funding for a practice nurse to do extra sessions at the health centre, acting as a weight management advisor.*	Increase of people being seen by the weight management advisor. Decrease in weight by those taking part in the programme. Reduction in prevalence of obesity.	Section 5.3.5.	Table 13.	Table 18.	Effectiveness of behavioural change strategies providing information together with personal support.[9 10 11] Evidence on effects of support on weight loss.[43 44 45 46 47]

Table 23a

Proposal for change	Success criteria	Evidence from epidemiological needs assessment	Evidence from local workers and residents	Evidence from service mapping	Evidence of effectiveness of proposal
Pilot and evaluate the establishment of a slimming club, possibly run by trained local people. Group would be open to all, but could also run for those referred there as part of a weight management scheme. Group would take a holistic approach, looking at food and exercise.	Reduction in weight of participants. Increase in number of participants who eat 5 or more portions of fresh fruit and vegetables a day. Reduction in prevalence of obesity.	Section 5.3.5.	Table 13.	Table 18.	Evidence of weight loss in group settings.[8] Evidence of weight loss in interventions that combine behaviour therapy, dietary advice and physical activity.[48] No evidence on effects of training local people.[33]

Table 23b

6.5 Management of risk in primary care

Proposal for change	Success criteria	Evidence from epidemiological needs assessment	Evidence from local workers and residents	Evidence from service mapping	Evidence of effectiveness of proposal
Raise awareness of blood pressure and cholesterol by holding a training day for local health professionals and a community awareness day where local people could be tested. **(See smoking, food, physical activity, overweight and obesity tables for other relevant proposals).**	Increase the proportion of the registered population (including those at high-risk of CHD and with established CHD) who have had their blood pressure and cholesterol taken within a specified period of time (period to be decided). Increase number of health workers who have had recent training in blood pressure and cholesterol testing.	Section 5.3.2. Section 5.3.8.	Table 13.	Table 19.	Effects of intensive programmes of hypertension detection and treatment on CHD mortality.[8 9]

Table 24

7 Recommendations

I made the following recommendations:

The HWG and BSWPCT should:

1. Consider the implications of the findings of the needs assessment
2. Prioritise the proposals for change and assess the resource implications.
3. Develop bids for funding.
4. Consider the importance of word-of-mouth and geographical mobility when developing local heart health initiatives.
5. Use success criteria to enable in-built evaluation of the proposals for change that are taken forward.
6. Encourage local organisations to network, using meetings and e-groups.

Outcomes of the needs assessment

1. The HWG and BSWPCT CHD group met in October 2002 to discuss the findings and how to move forward and develop bids. I presented the findings and circulated the document in advance.

2. The physical activity proposals were used by BSWPCT as part of a bid for Local Exercise Action Pilot (LEAP) funding. I attended a meeting to prepare the bid, which unfortunately was not successful.

3. Links have developed between the walking group and primary care. As a direct result of the needs assessment the walking group co-ordinator met with primary care professionals to discuss ways of developing a referral system.

4. The findings from the needs assessment were used to support a bid to Sport England for a new community gym and exercise room at the HLC.

5. A bid for a fruit and vegetable box scheme run from the HLC is being considered.

6. The evidence of need for smoking cessation and control contributed to the efforts to secure smoking cessation funding from BSWPCT following the end of ring-fenced funding in March 2003.

7. A paper will be written in conjunction with the Director of Public Health for BSWPCT outlining how mainstream funding could be bent to respond to local need, using my work as a case study. The paper was submitted to the Bristol LSP, the GOSW lead for NR and the BSWPCT board.

8. The directory of local services was well received by local organisations.

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