115th ANNUAL
MOH REPORT
Bailiwick of Guernsey

Special themes:

"Health Surveillance and Priority Setting"

Report for Year 2013/14

STATES OF GUERNSEY

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ISBN No: ISBN 978-1-899905-15-7
Published by Public Health Directorate, HSSD, States of Guernsey
Date of publication: February 2015
Version: 1.0 (13 Feb)

Bridgman, S.A. (2015) *115th Annual Bailiwick of Guernsey MOH Report for Year 2013/14.* Special themes "Public Health Surveillance, and Priority-Setting in Health and Social Care", Guernsey: States of Guernsey.

CONTENTS

SUMMARY

Thank you for your interest in this, the 115th Medical Officer of Health Annual Report for the Bailiwick of Guernsey. The special themes in this report are Public Health Surveillance, with particular reference to the Guernsey and Alderney Health Profile and the 6th Guernsey and Alderney Healthy Lifestyle Survey, and Priority-Setting in Health and Social Care.

Public Health Surveillance:

Guernsey and Alderney Health Profile 2010-12

Guernsey and Alderney life expectancy increased 4-5% over the last 20 years, and is now one of the highest in the world.

In a third of islander deaths the underlying cause was cancer, in a third circulatory disease, and in a tenth respiratory disease. Suicide and undermined cause, and accidents both accounted for more years of life lost under 75y than lung cancer or coronary heart disease, reflecting the relatively young age of people who die from these causes. About 17% of deaths were attributable to tobacco smoking. Infant and perinatal death rates in 2010-2 tended to be a little lower than those in England and Wales and Jersey, but small numbers mean this difference may well be a chance finding.

Malignant melanoma incidence rates were over twice that of England, with an average of 27 people diagnosed each year, and 3 deaths. The major risk factor for melanoma disease is excessive ultra-violet light exposure. Strong campaigns were held in 2013 and 2014 to raise awareness of prevention and early detection of this disease.

Under 18y conception rates are similar to the UK, but twice that of Jersey, while UK rates of teenage births rates are four times that of Denmark and Holland. Teenage births are associated with a greatly increased risk of child and parental poverty.

6th Guernsey and Alderney Healthy Lifestyle Survey 2013 (adults 18y and over)

Smoking prevalence decreased to the lowest recorded, 13%, but there remains a big challenge as there are large variations between groups with about a quarter of those on lower incomes and in rented housing smoking. While 50% of us drank alcohol at least twice a week and a fifth binge drank in the week prior to the survey, a quarter of adults were “increasing risk” drinkers. Alcohol abstention increased to 10%. Those on the lowest income had the highest rates of both abstinence (33%), and higher risk or dependent drinking (10%).

The prevalence of overweight or obesity was 47% in women and 57% in men, and while the rate in women over the last decade has not increased, in men it has risen to the highest level on record. The problem was worst in men aged 65-74y, where, shockingly, a quarter were obese. Rates varied little by income or housing tenure. Only 20% of adults ate 5 portions of fruit and vegetables a day. While 30% of adults met recommended physical activity levels, a fifth reported no moderate exercise at all in the last week. While, obesity represents an increasingly serious health burden, and will be costing the islands dearly in regards to preventable disease, most of the prevention solutions lie outside the health sector, for instance in active transport.

A quarter of the population reported a large amount of stress, with similar proportions of men and women. While work, family health and money worries were the most frequent causes, stress from housing cost and quality jumped from 8 to 13%. Twice as many smokers as others reported a history of depression, and only 5% of smokers were in the high mental well-being category compared to 15% of others. Obese adults were more likely to have low mental well-being and have suffered a large amount of stress or pressure. Increasing risk and higher risk drinkers identified alcohol as making it easier for them to enjoy social events. The evidence based "*Five Ways to Wellbeing*", relevant to us all, was locally launched in "*Elephant Week*" as one measure to help highlight and address the massive, but Cinderella and stigmatised, issue of population mental health and well-being.

Recommendations include: A public health surveillance programme to include a new health profile every three years, and a new healthy lifestyle survey every five years: A public health strategy review and development programme to include; implementation of the new Drug and Alcohol, and Tobacco Control Strategies; finalisation and implementation of a sexual health strategy; review and update the obesity strategy; a cross Government Action plan to promote public mental health.

Priority-Setting

The scope and quality of health and social care services have a huge impact on public health. No public health service has enough money to meet all needs. For the foreseeable future there will be increasing pressure on public finances. The States has a responsibility to balance the needs of all people it serves. As a decision to fund a service is accompanied by a, often unrecognised, decision not fund other services every effort needs to be made to avoid making decisions in isolation, or singular decision making.

While Guernsey has made significant progress in the past few years on developing a range of evidence based commissioning policies to help it make better choices in health and social care (http://www.gov.gg/hssdpriorities), considerable further development is still needed. In addition, public and professional engagement needs

to be developed so that those hard choices, while likely not being popular, are seen as fair and rational. Few jurisdictions are good at priority setting. Guernsey and Alderney have the potential to be world leaders.

Recommendations include; the development and adoption of an overarching priority setting policy for health and social care investments; and the further improvement in professional patient and public engagement in priority setting.

Dr Stephen Bridgman,
Medical Officer of Health, Guernsey,
February 2015

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PUBLIC HEALTH SURVEILLANCE

Public Health Surveillance[1] is the systematic collection, analysis and interpretation of health-related data, and is important for planning, implementation and evaluation of public health and public health programmes. It is an important function for the role of Medical Officer of Health.

The first Health Profile for Guernsey, for the years 2008-10[2], was published in 2012, and was followed by the second for the years 2010-12[3] published in 2014 The Profile tells us about life expectancy, the top causes of death, rates of death from selected causes, and preventable deaths. It gives detail of cancer incidence and prevalence, rates of sexually transmitted infections, and a summary of some lifestyle information. The Profile compares Guernsey deaths and ill-health, where it is possible, with Jersey and the UK. This report will look at some of the key findings of 2010-2012 Health Profile.

The Guernsey and Alderney Healthy Lifestyle Survey 2013 is the sixth in a series of Lifestyle surveys which have been carried out every five years since 1988. The survey tells us about those behaviours of Islanders which are likely to affect their health. It tells us how Islanders assess their own health, both physical and mental. It gives an indication of smoking prevalence; healthy or unhealthy weight status; Islanders' activity, diet and alcohol consumption levels. This is particularly important since the majority of the preventable deaths and years of life lost which are shown in the Health Profile are preventable through positive changes in these behaviours. This report will look at some of the principal findings of the Healthy Lifestyle Survey 2013.

Because decisions which affect the health of all of us are not only made by HSSD but by other States Departments such as Education, Environment, Social Security and Treasury and Resources, the Voluntary Sector, Private Sector and individuals, public health surveillance data will be of interest to a wide audience.

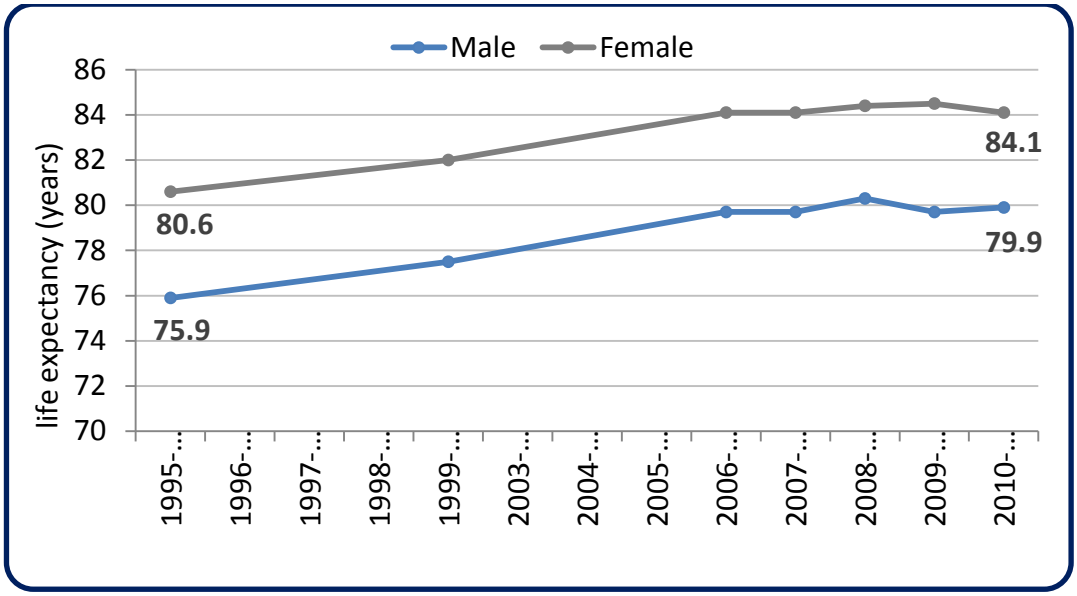
The Health Profile for Guernsey and Alderney 2010-12

Life Expectancy

Guernsey and Alderney life expectancy at birth has improved by 4-5% over the last 15-20 years and is now at an all time high. Guernsey and Alderney now have one of the highest life expectancies in Europe, at 84.1y for females and 79.9y for males (Figure 1).

[1] Public health Surveillance, http://www.who.int/topics/public_health_surveillance/en/
[2] Cataroche, J. and Bridgman, S. 2012. *2008 Health Profile for Guernsey & Alderney*. Guernsey, States of Guernsey.
[3] Public Health and Strategy Directorate, HSSD, 2014. *Health Profile for Guernsey and Alderney 2010-2*, Guernsey, States of Guernsey.

Figure 1: Change in life expectancy over time, Guernsey/Alderney 1995–1997 to 2010–2012. (Source Health Profile, 2010-12).



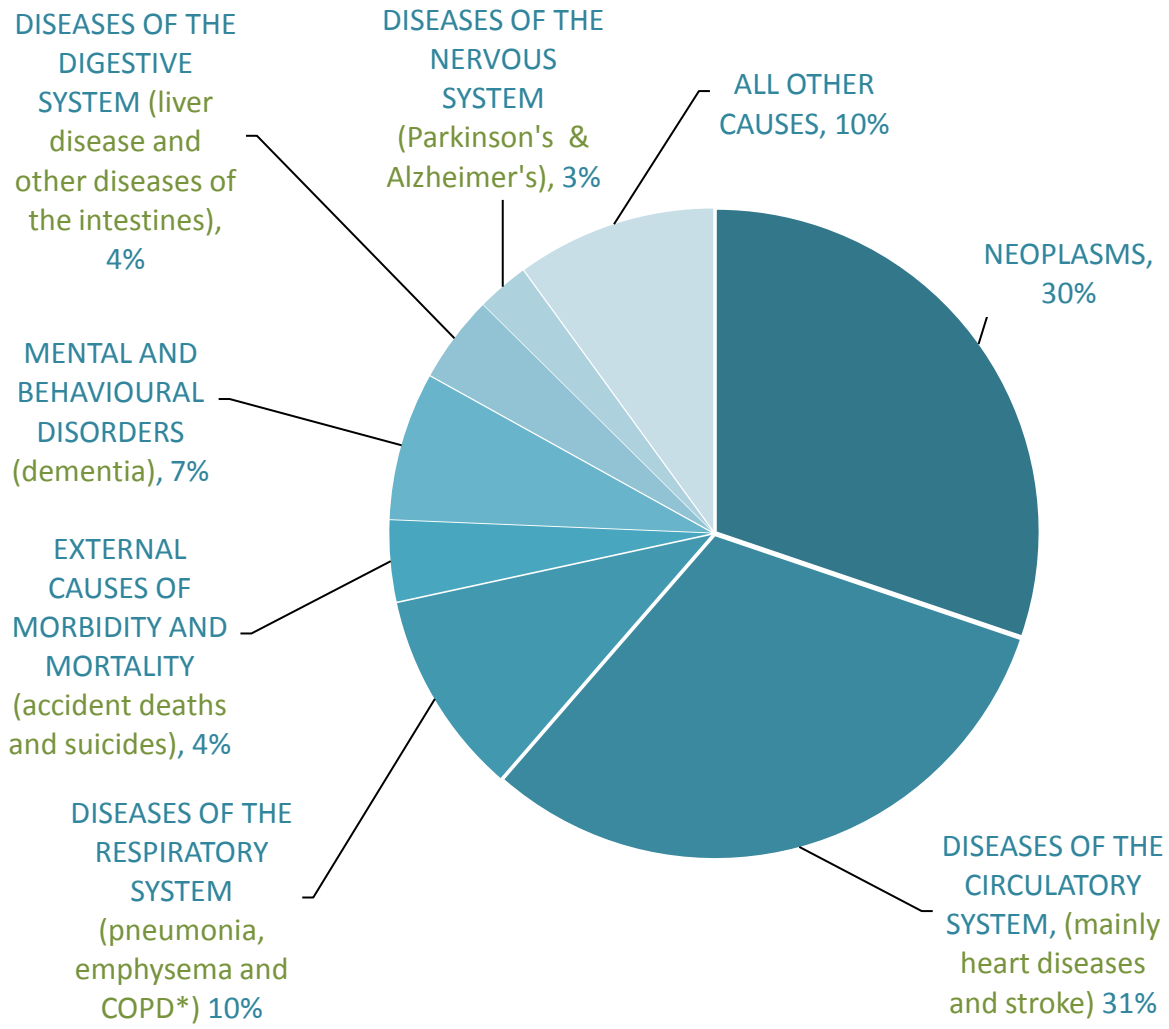
While it is good news that people are living longer healthier lives, longer lifespans and aging of the population bulge of the "baby boomer" generation born between 1946 and 1964 presents a future challenge as people over 65y account for the highest activity and spend across primary, secondary and social care. These population changes suggest that if the public wish to enjoy the current breadth and quality of public health and social services as they do today, despite continued efforts to improve efficiency, some increased resources are likely to be required for a period too.

Deaths – Numbers and Causes

About 570 deaths per year were recorded between 2010 and 2012. Circulatory disease (mainly heart disease and strokes) and cancers were the underlying cause in about 30% each of these deaths, and respiratory disease in about 10% of deaths (Fig 2). Many of these non-communicable diseases are potentially avoidable. They are primarily linked to the four common risk factors of tobacco use, alcohol use, diet, and physical inactivity, for which Guernsey has strategies to address. There are also some other important factors too, such as high blood pressure, salt, and access to key medical treatments that also need to be considered[4].

[4] WHO (2014). Global status report on non-communicable diseases 2014. http://apps.who.int/iris/bitstream/10665/148114/1/9789241564854_eng.pdf?ua=1, accessed 24th Jan 2015.

Figure 2: Leading causes of death in Guernsey/Alderney, 2010–2012, men and women combined (chapter group level of the ICD-10). (Source Health Profile, 2010-2).

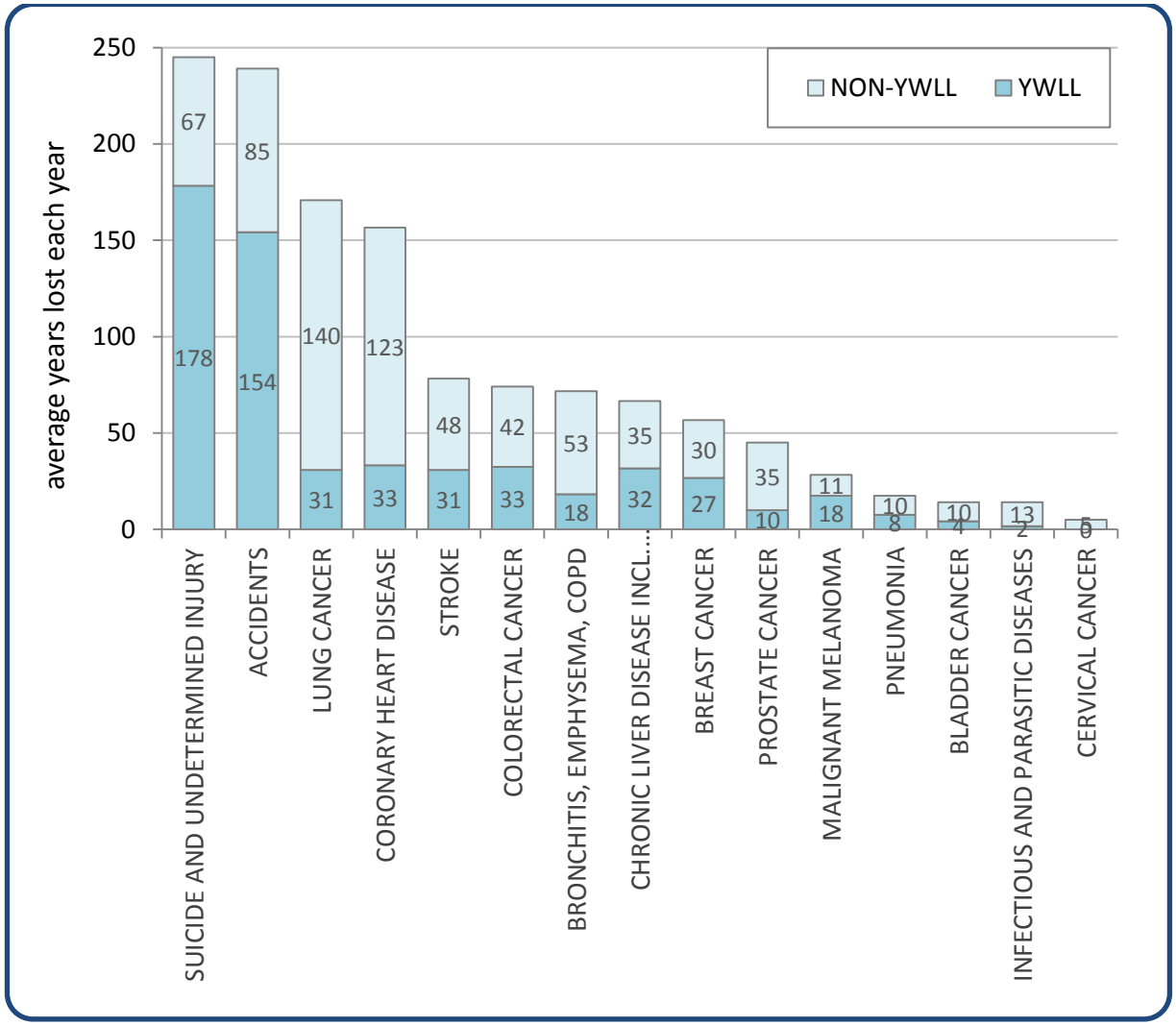


Deaths -Years of Life Lost

Under this method, if you die at 40y then you are counted as having lost 35y of life lost (YLL) which assumes you should live to 75y, and 25y of working life lost (YWLL) which assumes you should work to 65y (Fig 3). Of 2100YLL between 2010 and 2012, 43% were in those under 65y. Over 10% of YLL were from suicide and undermined injury and 10% from accidents, contributing an average per death of 37YLL and 15YLL respectively, reflecting the burden of suicides and accidents in the relatively young. The other cause of death tending to affect young people is liver

disease, which contributed an average of 17YLL per death and which I discussed in the 114th MOH report.

Figure 3: Years of life lost by cause in Guernsey/Alderney 2010–2012. Shown as average years lost per year to the nearest whole year



YLL = years of life lost under 75y. YWLL = years of working life lost, under 65y.

While key preventative strategies are in place, there is a need for cardiovascular and cancer strategies to be developed as these are a major causes of death.

Recommendation 1 :	Develop cardiovascular, and cancer clinical strategies.

Suicide is preventable[5], but is only the tip of the mental ill health iceberg. In the 2010 Guernsey Mental Health and Well-Being survey 21% of the Guernsey/Alderney population were recorded as having met the cut-off for experiencing anxiety and/or depression to clinical levels, which represents 5-10,000 islanders.[6] People with mental illness suffer more stigma and discrimination than any other disease[7], and this affects most who are ill[8]. This can blight lives and make mental illness worse. Stigma may lead to feelings of, shame, blame, hopelessness, distress, and reluctance to seek and/or accept necessary help[9].

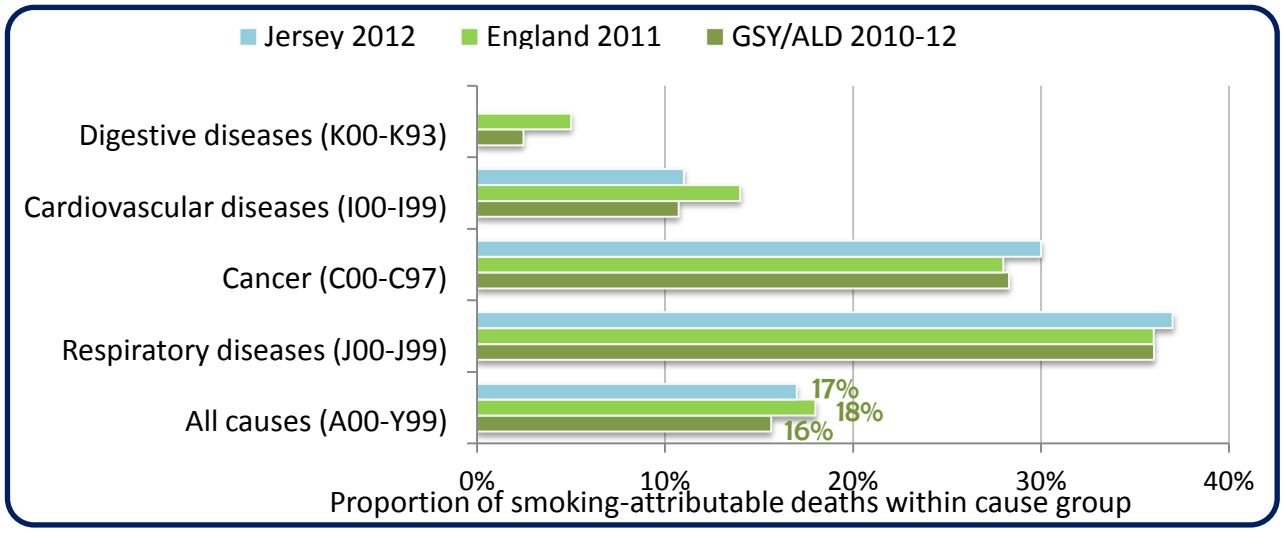
Given the massive problem of mental health, we will all know people who are suffering and so can all help improve public mental health through our attitudes and social interactions. Improvement of population mental health and well-being should be an important and long-term priority.

Deaths –Tobacco Smoking Attributable

Tobacco smoking kills up to half its users[10] and world-wide around 6million people a year die from tobacco smoking, about 10% of them from second-hand smoke. There are more than 4000 chemicals in tobacco smoke, of which at least 250 are known to be harmful and more than 50 are known to cause cancer. A significant minority of islander deaths, 17%, are attributable to tobacco smoking (Fig 4). There is no safe level of exposure to second-hand tobacco smoke.

[5] WHO (2014). http://www.who.int/mediacentre/news/releases/2004/pr61/en/, accessed 17th Jan 2015.
[6] Public Health and Strategy Directorate, HSSD. 2010. The Guernsey Emotional Wellbeing Survey. Guernsey, States of Guernsey.
[7] BMA (2015). Mental health issues carry greatest stigma, poll finds. BMA News 17th Jan 2015.
[8] Mental Health Foundation (MHF 2015). Stigma and discrimination. http://www.mentalhealth.org.uk/help-information/mental-health-a-z/s/stigma-discrimination/, accessed 17th Jan 2015.
[9] Western Australia Government, Mental Health Commission (WA 2010). What is stigma. http://www.mentalhealth.wa.gov.au/mental_illness_and_health/mh_stigma.aspx, accessed 17th Jan 2015.
[10] WHO tobacco factsheet, May 2014, http://www.who.int/mediacentre/factsheets/fs339/en/, accessed 24th Jan 2015.

Figure 4: Proportion of smoking-attributable deaths within each major cause group, Channel Islands and England compared. (Source Health Profile, 2010-2).

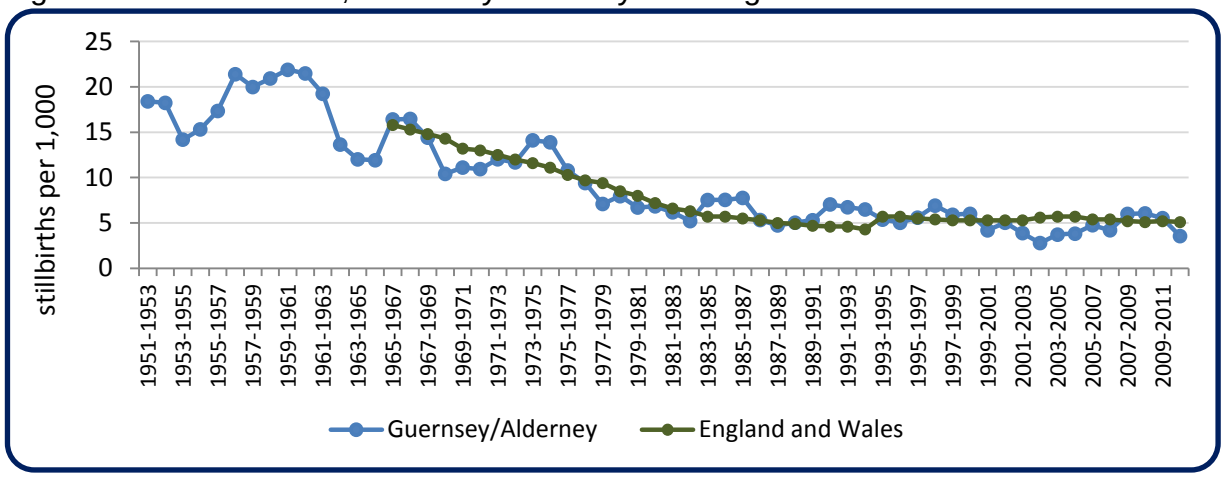


Stillbirths and Infant Deaths

The stillbirth rate has gradually reduced over several decades such that they are now relatively uncommon events, averaging 2-3 per year (Fig 5). The infant death rate is lower than the stillbirth rate, and in the twelve years to 2012 there was an average of one infant death each year (Tab 1).

Since 2008, the rate of perinatal deaths (stillbirths plus infant deaths in the first week of life) averaged over three year periods has fluctuated around that of England with in the first two periods a higher rate and in the most recent period a lower rate. In 2010-2, while our rates are lower than those in England and Wales (Fig 6) the number of events is small and sensitive to random year to year variation, so caution is needed in interpretation. Comparison data are only available up to 2010-12.

Figure 5: Stillbirth rates, Guernsey/Alderney and England and Wales



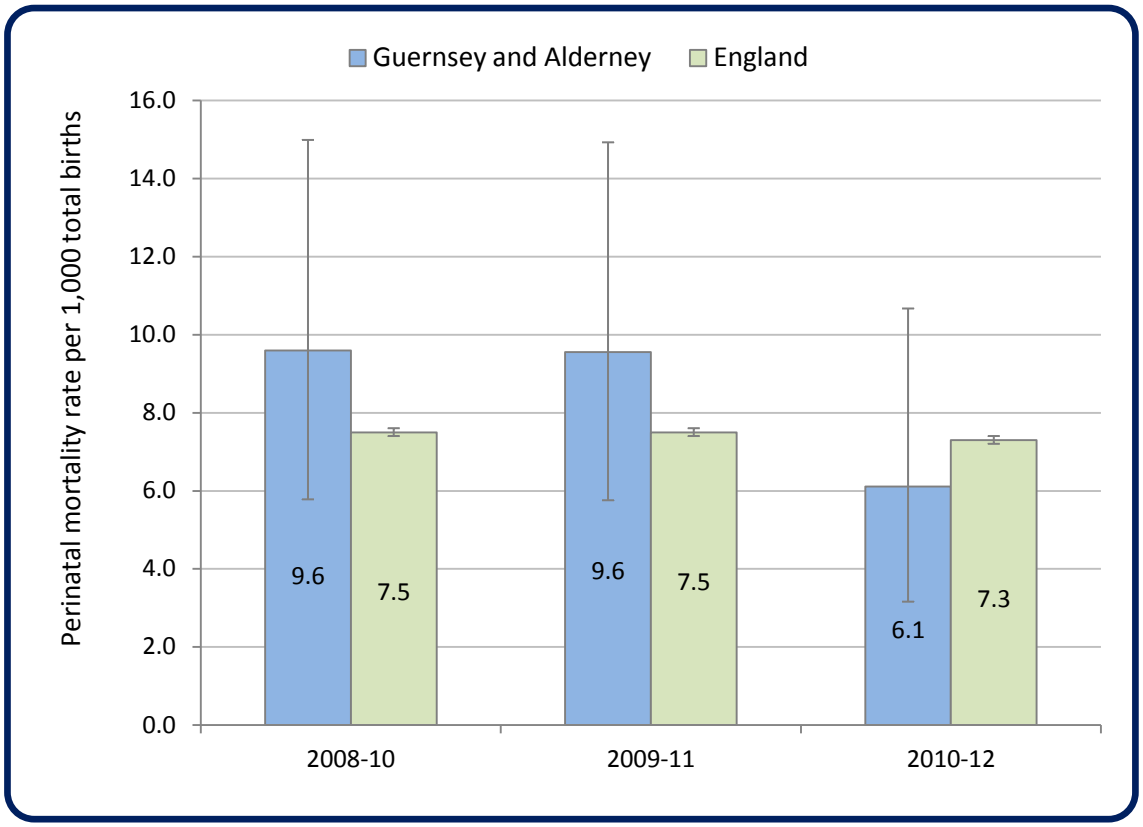
NB. Guernsey/Alderney rates are plotted as three-year averages. England and Wales rates are published figures for the first year in each three-year period. Source: Guernsey Greffe registrations to 2006. Guernsey and Alderney Greffe registrations 2006–2012; ONS Stillbirth rates 1965–2010, 12th April 2013. www.ons.gov.uk.

Table 1: Infant death rates in Guernsey and Alderney, England and Wales, English Regions, and Jersey, with 95% confidence intervals.

	Infant deaths/ 1,000	95%CI (LL)	95% CI (UL)
West Midlands	6.0	5.5	6.6
Yorkshire and the Humber	4.9	4.4	5.5
North West	4.7	4.3	5.2
England and Wales	4.3	4.2	4.5
England	4.3	4.2	4.5
East Midlands	4.3	3.8	4.9
East of England	4.1	3.6	4.5
London	4.1	3.8	4.5
South West	3.7	3.3	4.3
North East	3.6	3.0	4.3
South East	3.5	3.2	3.9
Jersey 2010-2012 *	3.4	1.9	6.1
Gsy/Ald 2010-2012 *	2.6	0.8	6.0
Gsy/Ald 2010-2012 on-island only	1.0	0.1	3.7

* includes deaths in England and Wales

Figure 6: Perinatal (stillbirths + infant deaths less than 7 days old) mortality rates, Guernsey and Alderney compared to England, with 95% confidence intervals.



Following a series of external reports concluding island services were acceptably safe, and Guernsey HSSD receiving external accreditation for its health services, there have been recent public concerns highlighted involving interventions from UK professional regulators. Guernsey has developed an action plan to address the issues raised by regulators.

Although both stillbirths and infant deaths are uncommon, when they do occur they are tragic events. The UK has a rate of infant mortality about 25% above the European average[11]. In January 2015, The Royal College of Obstetricians and Gynaecologists (RCOG) instigated a national quality improvement programme "Each Baby Counts" (RCOG 2014)[12], which aims by 2020 to half the 500 infants per year in the UK who die or who are left with severe brain damage because

[11] Eurostats. Infant mortality rates. http://ec.europa.eu/eurostat/help/new-eurostat-website?p_auth=x4qGhbu3&p_p_id=estatsearchportlet_WAR_estatsearchportlet&p_p_lifecycle=1&p_p_state=maximized&p_p_mode=view&_estatsearchportlet_WAR_estatsearchportlet_action=search&text=Infant+mortality+rates

[12] RCOG (2014). Each baby counts. https://www.rcog.org.uk/eachbabycounts, accessed 17th Jan 2015.

something has gone wrong in labour. Pro rata for Guernsey this would equate to a reduction from one event every second year to one event every fourth year, a difference too small to reliably detect a statistically significant difference locally. However, Guernsey has a longstanding policy to participate in UK national quality initiatives, and will be submitting any relevant local data to this important RCOG study.

Guernsey also participates in the Mothers and Babies Reducing Risk through Audit and Confidential Enquiries initiative (MRRACE-UK) which studies and makes recommendations on reducing maternal and peri-natal deaths across the UK[13].

All health services carry risk of untoward outcomes, and it is important that Guernsey takes a methodical risk-based approach to service change to ensure its services are acceptably safe for the public and affordable.

Skin Cancer

Around 27 people in Guernsey and Alderney are diagnosed with malignant melanoma each year, and an average of 3 people a year die from the disease. With an age-standardised incidence rate of 51 per 100,000, local skin cancer rates are twice the English average (Fig 7).

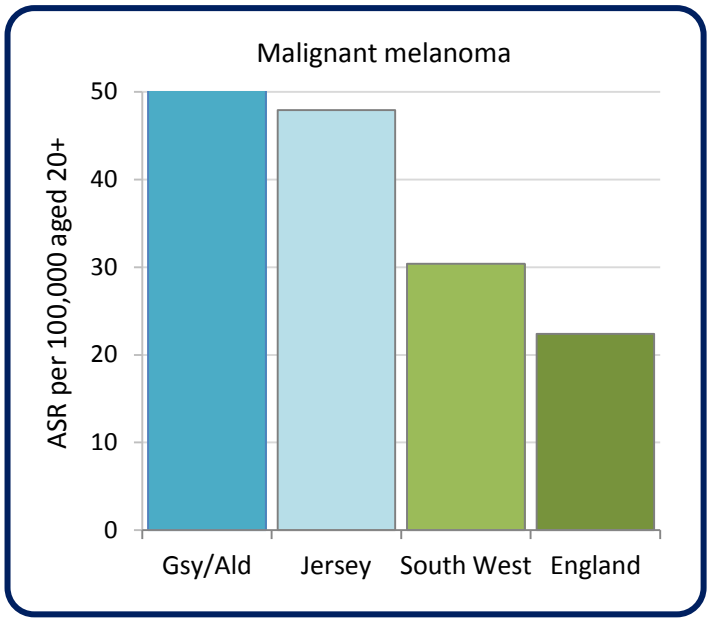
The major risk factor for skin cancer is Ultra-Violet light exposure through sunlight or sunbeds. Early childhood sunburn that causes blisters, sunburn later in life, and cumulative exposure are all risk factors. People who have a first degree relative with melanoma, people with lots of moles or freckles, red or fair hair, and those who have had skin cancer before are also at increased risk.

The key messages for the prevention of skin cancer are; spend time in the shade between 11am and 3pm; wear a T shirt, hat and sunglasses; cover up in the sun if there is no shade, wearing at least a T shirt, hat, and sunglasses; use sunscreen, at least factor 15, the higher the better.

In the 2013 Healthy Lifestyle Survey two-thirds of people reported they used factor 15 or above sunscreen, and 60% had not had sunburn in the last 12 months. Therefore, while there is good news in that the majority of islanders are acting sun-safe, there is still considerable room for improvement.

[13] https://www.npeu.ox.ac.uk/mbrrace-uk

Figure 7: Malignant melanoma, age-standardised rates (ASR) Guernsey and Alderney compared to Jersey, South-West England and England.



Local skin cancer prevention strategy has focussed on raising awareness of what to do to prevent sunburn, and the detection of the early signs of skin cancer. Specific initiatives have included;

- Talking to and educating the public on beaches
- Raising awareness of prevention through a "MUG" sponsored "*Louis the Lobster*" and Sun-Safety Campaign (Photos 1 and 2). Louis has been a tremendous campaign 'hook', introduced in summer 2014, which has helped engage both children and adults.
- Working with Amherst Primary School.
- Advertising campaign in August in Guernsey Press designed by the Partnership Agency.
- Creation and distribution of sun-safety and early diagnosis leaflets to the public.
- Advertising Campaign with Island FM, who talked with the public, and made regular posts on Facebook.
- Social media through Island FM, MUG, Guernsey Arts Commission Facebook pages.
- Raising awareness at community events such as Torteval Scarecrow festival.
- Media and public work with our local dermatologist to raise awareness of the early detection of skin cancer.
- Training beauty therapists to detect skin problems, as these professionals see a lot people's bodies during massage/waxing

Photos 1 and 2: "Louis the Lobster" at Torteval Scarecrows and our Dermatology consultant with Louis

In 2015, the focus of the awareness work will be working with schools to ensure that they all have a comprehensive sun-awareness policy, and for schools to use Louis the Lobster to raise awareness.

Teenage pregnancies

Conceptions are defined as the sum of live births, still births and legal abortions. The under 18 conception rate in Guernsey is 10% below the England and Wales average, and similar to that in the South-West of England and London but more than twice that in Jersey.

In Europe, teenage births (aged 15-19y) is the statistic used as an international comparator. The UK has a teenage birth rate 50% higher than the European average, and 4 times that in Denmark, Holland, and Switzerland[14,15]. Given that this is a European wide indicator, the Public Health Directorate plans to include local teenage births in the next health profile.

Teenage pregnancy is an important public health issue because both teenage parents and their children are at higher risk of poor health. In addition teenage parents are at risk of not finishing their education, not finding a good job, ending up single parents, and having to bring up their children in poverty. Rather than the biological effects of young maternal age, poor outcomes are because of social and economic disadvantage before and after pregnancy.

A sexual health strategy is in development that will be proposing a range of measures including free hormonal contraceptives for the under 21s in addition to the

[14] ONS http://www.ons.gov.uk/ons/rel/vsob1/births-by-area-of-usual-residence-of-mother--england-and-wales/2012/sty-international-comparisons-of-teenage-pregnancy.html, accessed 24th Jan 2015

[15] Statitistic Netherlands. http://www.cbs.nl/en-GB/menu/themas/bevolking/publicaties/artikelen/archief/2013/2013-3883-wm.htm

currently free condoms, with the aim of a reduction in the numbers of our teenagers who become pregnant. If implemented, this would have a knock-on effect on reducing child poverty, an improvement in well-being of mothers, and reduced societal costs. It is crucial sexually active young people have access to confidential evidence-based advice on contraception and safe and fulfilling sexual relationships that they can trust.

Dutch professionals have argued England has a much higher rate of teenage pregnancy than Holland partly because of culture and attitude,

"*Here sex is a normal daily part of life, like shopping or football. In England it is a joke or a nudge*." "*The English are embarrassed to talk about sex. They are too squeamish*." [16]

However, the fact some teenagers feel there is a need for a confidential service because they are fearful that if they go to their family doctor their parents may find out when they receive a bill and disapprove, indicates a local cultural issue about sex and relationships that may be a root cause behind the relatively high rates of teenage pregnancy, compared to European standards, in Guernsey and Alderney.

Recommendation 2:	To agree and implement a sexual health strategy, which includes evidence-based measures to reduce teenage pregnancy rates.

Health Profile in future

The Guernsey and Alderney Health Profile has been a very important public health product to demonstrate areas in which Guernsey and Alderney are faring well, areas for improvement, and in providing public health intelligence to underpin evidence-informed decision making and planning.

Recommendation 3:	To produce a Guernsey and Alderney Health Profile every three years, as part of the local Public Heath Surveillance programme

[16] Independent. Why are teenage pregnancy rates so high. http://www.independent.co.uk/extras/big-question/the-big-question-why-are-teenage-pregnancy-rates-so-high-and-what-can-be-done-about-it-1623828.html#

The Guernsey and Alderney Healthy Lifestyle Survey 2013

There is very strong evidence that our lifestyles are a major factor in our chances of living a long and healthy life. A healthy lifestyle can reduce our risk of common causes of death such as heart disease, stroke, cancer, and common causes of ill-health such as dementia, diabetes, and fragility fractures of the hip. The Healthy Lifestyle Survey tells us about those behaviours of Islanders which we know are likely to affect their health.

The Healthy Lifestyle Survey 2013 also included an assessment of mental health and wellbeing. This repeated (in part) the Guernsey Emotional Wellbeing Survey (GEWS) which was undertaken in 2010 with the aim of measuring mental wellbeing and the prevalence of two common mental health disorders, anxiety and depression, in Guernsey and Alderney.

What the Survey shows us that we are doing well?

Self-rated Health

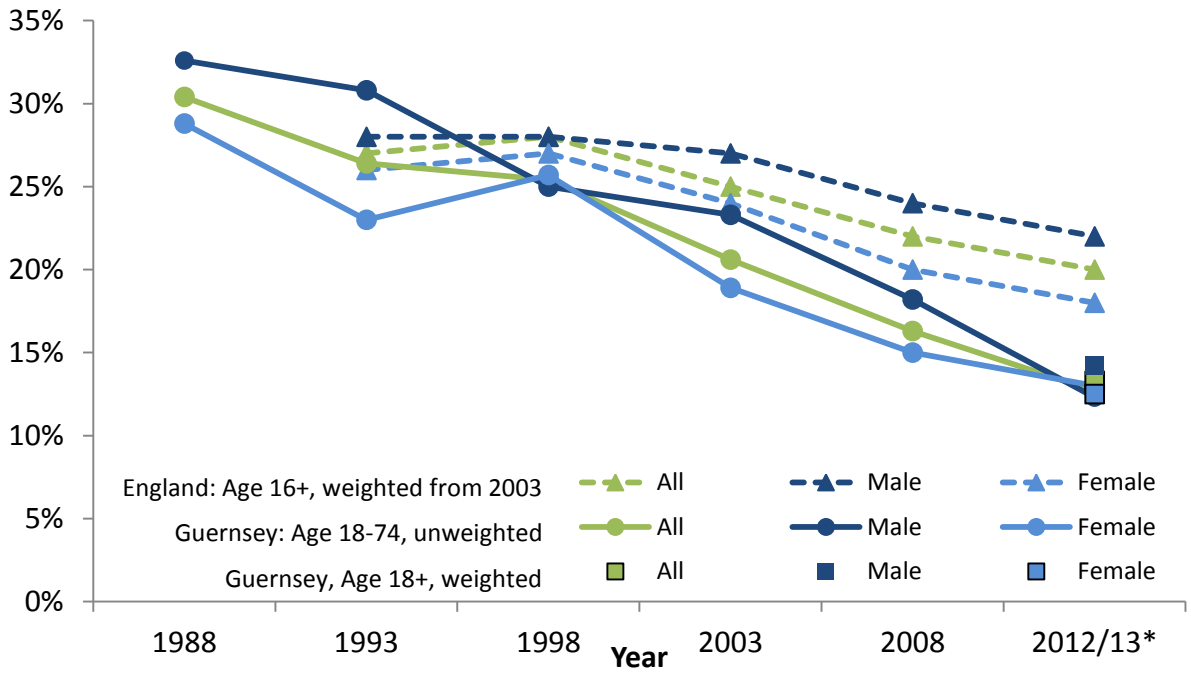
The Health Profile tells us that people in Guernsey are living longer. The Lifestyle Survey tells us that 80% of respondents reported their general health as good or very good. This good news reflects some improvements in healthy behaviours, but it also reflects personal circumstances which support good health. There was a clear relationship between self-rated health and household income, with the proportion of adults who rated their health as 'very good' increasing with income.

Tobacco Smoking

The great success story shown in the Healthy Lifestyle Survey 2013 is the reduction in prevalence of smoking. Using unweighted data, only 13% of survey responders recorded they smoked tobacco, down from 30% in 1988, and the lowest since the survey began. For decades Guernsey and Alderney have adopted and implemented strategy to control the use of tobacco, and this hard work continues to bear fruit. It can take many years for tobacco related disease to develop, but this low prevalence of tobacco smokers is likely to translate to considerably fewer tobacco related preventable deaths in future. It is also the case that the risk of premature death can decrease within months of giving up smoking[17].

[17] Capewell S & O'Flaherty (2011). Rapid mortality falls after risk-factor changes in populations. Lancet 378, 752-3, August 2011.

Figure 8: Trends in prevalence of current tobacco smoking, Guernsey/Alderney and England.



*2012 for England, 2013 for Guernsey.

This continued success in reducing smoking rates is associated with a range of evidence-based interventions which have been introduced or maintained over the last five years, led by HSSD and its partners to protect and improve the health of Islanders. These have included:

- An efficient and cost-effective Quitline service to support smokers who wish to become Smoke-free, including 'Stoptober' and National No-Smoking Day campaigns
- The introduction of evidence-based peer intervention in schools (ASSIST)
- Continuation of support for personal, social, health and economic education in schools (PSHE), support for the Healthy Schools Programme, and support for the tobacco education charity GASP until 2013, when the education aspects of GASP were taken on by the Health Promotion Unit with the appointment of a Children and Young People's healthy lifestyle worker
- Introduction of a Smoke-free prison policy, (which has led the way in Europe (http://www.bbc.co.uk/news/uk-30596976, accessed 30th Dec 2014)
- Introduction of largely Smoke free-sites in HSSD, such as at Princess Elizabeth Hospital

- Agreement of a licensing system for tobacco retailers which, commencing later in 2015, will protect children by
    - Banning display of tobacco products, including those in duty free outlets
    - Banning advertising of Tobacco and Tobacco products at the point of sale

Photos 3 and 4: St Sampson's High Year 8 pupils, ASSIST training, October 2014. (ASSIST is a NICE approved effective school based peer programme, introduced locally in 2013).

The challenge over the next five years will be to maintain this momentum and continue to reduce the prevalence of smoking and consequent preventable deaths and ill-health. Over the last 18 months a new, evidence-based Tobacco Control strategy has been developed, led by the Public Health Directorate, and involving partners and the public through initial engagement and later consultation.

The great value of the breadth of data collected in the Healthy Lifestyle Survey is that it allows us to cross-reference health behaviours with age, gender, housing status and household income, and in this way we are able to identify those groups who are most in need of help to change their behaviours, and move to help them in the ways that they find most useful. This is especially relevant in tobacco control, as the data shows that the distribution of tobacco smokers is not evenly spread across our population. Around a quarter of those in rented accommodation smoke compared to around 8% of owner occupiers. A quarter of adults in households with incomes under £20,000 a year smoke compared to around 3% of those households

earning more than £100,000 a year. The recently published Guernsey Household Expenditure Survey also showed that smoking was negatively associated with income.[18]

These differences are highly likely to translate into health inequalities of premature death and ill health between those on lower and higher incomes, which would mirror observations in the UK.

The Healthy Lifestyle Survey 2013 shows us that in the Bailiwick, three quarters (75.3%) of all current smokers indicated that they would like to give up, either soon or in the future. However, smokers living in low income households (<£20,000 per annum) were less likely to want to give up than those living in higher income households. Research tell us that disadvantaged smokers face a number of barriers to accessing services including fear of failure, fear of being judged and lack of knowledge[19], and other pressures from poverty.

The challenge for Guernsey in the next Tobacco Control strategy is not to blame or judge people who smoke, but to look at ways of tailoring our services to better meet the needs of the many people in lower income groups and in the rented sector who would like to give up. Family-based interventions, delivered in or near schools where a high proportion of children have a parent or carer who smokes; working in partnership with the Housing Association and residents, and recruiting Health Trainers from within those communities where smoking rates are highest will all contribute to this. (The Health Trainer service is a holistic 'person to person' intervention designed for people who need help to reach the point of readiness to change, and help to make and maintain those positive changes). In addition to the health yield for people on low incomes, going smoke-free is likely to give extra disposable income that will reduce effects of poverty.

The World Health Organisation 'best buys' for Tobacco Control (i.e. the most cost-effective measures for a jurisdiction to put in place)[20] are increasing price through taxation, and legislation to protect adults and especially children from beginning and continuing to smoke. These measures help to protect children and adults, smokers and non-smokers alike, from the effects of second-hand smoke. Recommendations for the new Tobacco Control Strategy have therefore also included regular above inflation increases in tobacco taxation; the introduction of legislation to prevent adults from smoking in cars carrying children; and increased provision of smoke-free outside areas for playing and eating.

[18] Guernsey Household Expenditure Survey, 2012-3. http://www.gov.gg/hes

[19] Bauld Letal (2007). Assessing the impact of smoking cessation services on reducing health inequalities in England. Tob Contr'16, 400-4

[20] World Health Organisation (2010) Global status report on non-communicable diseases: chapter four http://www.who.int/nmh/publications/ncd_report_chapter4.pdf, accessed 24th Jan 2015.

The experience of prisoners who have been obliged to give up smoking on entry into the Smoke-free Prison in Guernsey is that this is made much easier when you live in an environment where no-one else smokes. Many of these young ex-smokers want to remain smoke-free on release; support for them, combined with an increase in the number of smoke-free environments where they can eat and take their children to play will help them and their families to stay healthy and build self-esteem.

Recommendation 4:	The States to agree and implement a proposed Tobacco Control strategy based on best evide**n**ce of effectiveness, and that has been developed with partners and the public.

Alcohol

While there has been some success in controlling alcohol related harms, the drinking of alcoholic beverages remains a major health issue for the islands.

In 2013 and 2014, the Public Health Directorate of HSSD supported the Home Department by leading an assessment of needs for drug and alcohol services in the Bailiwick, working with Service Providers, Service Users, Police, and HSSD clinicians. One of the principal findings of that process was that the premature death and ill-health caused by misuse of alcohol far outweighed the damage caused by drugs in the Bailiwick.

The topic of alcohol-related harm was comprehensively covered in my last MOH report about Liver disease (114th report), and I do not propose to revisit this here, other than to re-iterate that liver disease causes 1-2% of deaths of islanders, but 7% of the years of life lost under 75 years, with half of island liver deaths attributable to alcohol and …

”*drinking alcohol can cause at least seven types of cancer: those of the mouth, gullet (oesophagus), throat (pharynx and larynx), liver, large bowel (colon and rectum), and breast. Consumption of any amount of alcohol increases your cancer risk. The more alcohol you drink, the higher the risk of developing cancer. Reducing your consumption or – even better – avoiding alcohol completely will help reduce your cancer risk*.” [21]

The results of the Healthy Lifestyle Survey 2013 did not bring any great surprises or data that differed substantially from that which had emerged in the drug and alcohol needs assessment. The Survey showed that 90% of adults reported drinking at

[21] International Agency for Research Against Cancer (IARC), of the WHO (IARC 2014). Questions and Answers about Alcohol and Cancer. http://cancer-code-europe.iarc.fr/index.php/en/ecac-12-ways/alcohol-recommendation/28-limiting-alcohol, accessed 29th Dec 2014.

least occasionally and over 50% drink alcohol at least twice a week. The percentage of adults who abstained from drinking alcohol altogether increased from 8% in 2008 to 10.4% in 2013 (unweighted data). In the week prior to the survey, 21% of adults consumed more than 6 units for females or 8 units for males on a day (binge drinking).

UK national guidance on alcohol consumption currently recommends that males should not regularly exceed four units of alcohol per day and females should not regularly exceed three units[22] (see also Bridgman, 2009). Drinking more than double these recommended maximums (i.e. over 6 units for females and over 8 for males) is commonly defined as binge drinking[23]. There should also be two alcohol free days a week.

Of responders, 24.5% were classed as "increasing risk" drinkers, 2% "higher risk" drinkers, and 1% possibly alcohol dependent. Over 80% of higher risk and dependent drinkers responded that they would like to drink less alcohol, compared with just 23% of increasing risk drinkers.

The 114th MOH report and the needs assessment, together with partnership working across departments and involvement of service users and the public through consultation, have underpinned development of a new evidence-based Drug and Alcohol Strategy, recently approved by the States of Deliberation, which will give increased emphasis to working with those who misuse alcohol. Performance measures used in the new Strategy use existing Healthy Lifestyle data as a baseline, and will use future surveys as a method to measure our communities success, or otherwise in tackling this issue.

The Healthy Lifestyle Survey 2013 showed divergence in drinking habits across age groups and across income categories, but these were not simplistic. Using weighted results, 27% of adults living in low income households abstained altogether from alcohol compared to 6.5% in higher income households. Adults from the lowest income category (<£10,000 per year) had both the highest level of abstinence (33%), and the highest level of higher risk drinking (8%) and possible dependence (2%). The Drug and Alcohol Strategy Co-ordinator will be able to use the detailed data in the Healthy Lifestyle Survey to inform the targeting and tailoring of programmes to reach those who are most at risk from alcohol-related harm, working in partnership with the Health Promotion Team at HSSD to raise public awareness of the health risks. Working in this way, coupled with other strategic work streams relating to price and taxation, education and supply reduction, has potential to show improvement in these figures in the 2018 Healthy Lifestyle Survey.

[22] Department of Health, Sensible drinking: report of an inter-departmental working group. London: Department of Health, 1995. A unit is 8mg of pure alcohol.
[23] NHS Choices. Binge Drinking http://www.nhs.uk/livewell/alcohol/pages/bingedrinking.aspx, accessed, 25th Jan 2015.

Recommendation 5:	The States to continue their ongoing support for the development and implementation of the Drugs and Alcohol Strategy over the next five years, which is based on best evidence of effectiveness.

What the Survey shows us that we are doing less well?

Weight

In the 2013 Lifestyle Survey, 52% of responders were classed as overweight or obese from self-reported height and weight (Tab 2), a similar proportion to that reported in 2008 (Fig 9).

Table 2: Responders (%) in the 2013 Healthy Lifestyle Survey by World Health Organisation (WHO) BMI weight categories[24]

WHO BMI cut-offs (kg/m^2)	% for weighted sample
Underweight (<18.5)	2.3
Normal (18.5 to 24.99)	46.1
Overweight (25-29.99)	33.2
Obese class 1 (30-34.99)	11.8
Obese class 2 (35-35.99)	4.8
Obese class 3 (>40)	1.8

A higher percentage of men (57%) were overweight or obese than women (47%) (Figs 10 and 11). Using unweighted data, shows that levels of overweight and obesity (combined) in men aged 18-74y in 2013 were the highest ever recorded (Fig 10). The age-gender group with the highest prevalence of overweight and obesity combined (74%, weighted data) were 65-74y men, with 26% obese. In women, obesity varied between 15% in those aged 35-44y to 23% of those aged 18-24y. These are very disturbing findings, and they show that a huge amount of work is still required to improve the situation.

[24] WHO Expert consultation. Appropriate body-mass index for Asian populations and its implications for policy and intervention strategies. Lancet 2004; 363: 157–63http://www.who.int/nutrition/publications/bmi_asia_strategies.pdf

Figure 9: Level of obesity in Guernsey by BMI category (2008 compared to 2013). (Source: Guernsey and Alderney Healthy Lifestyle Surveys 2008 and 2013).

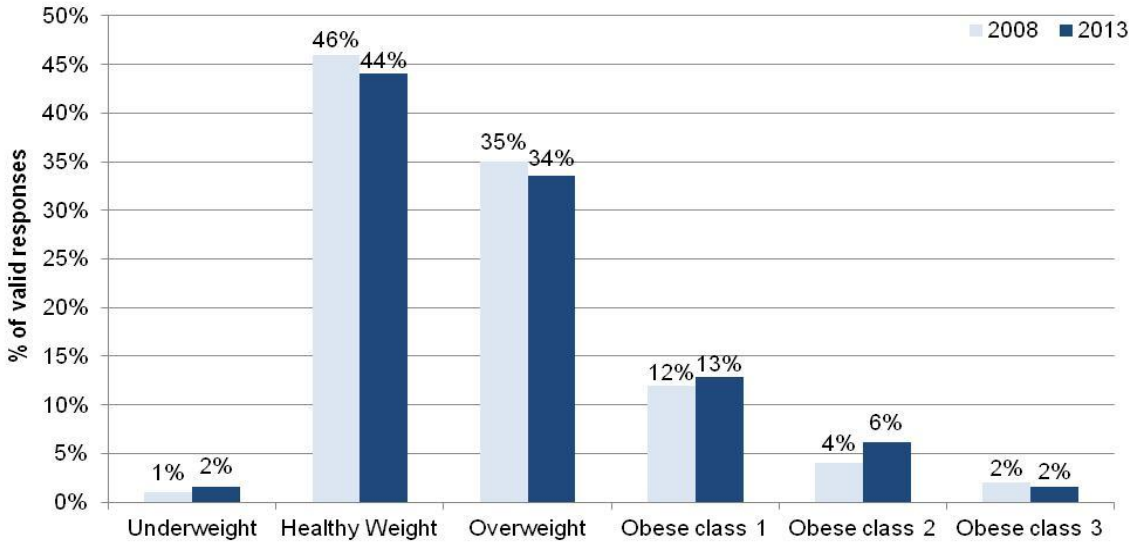


Figure 10: Overweight and obesity (%) in men,2013 Guernsey and Alderney Healthy Lifestyle Survey, and England.

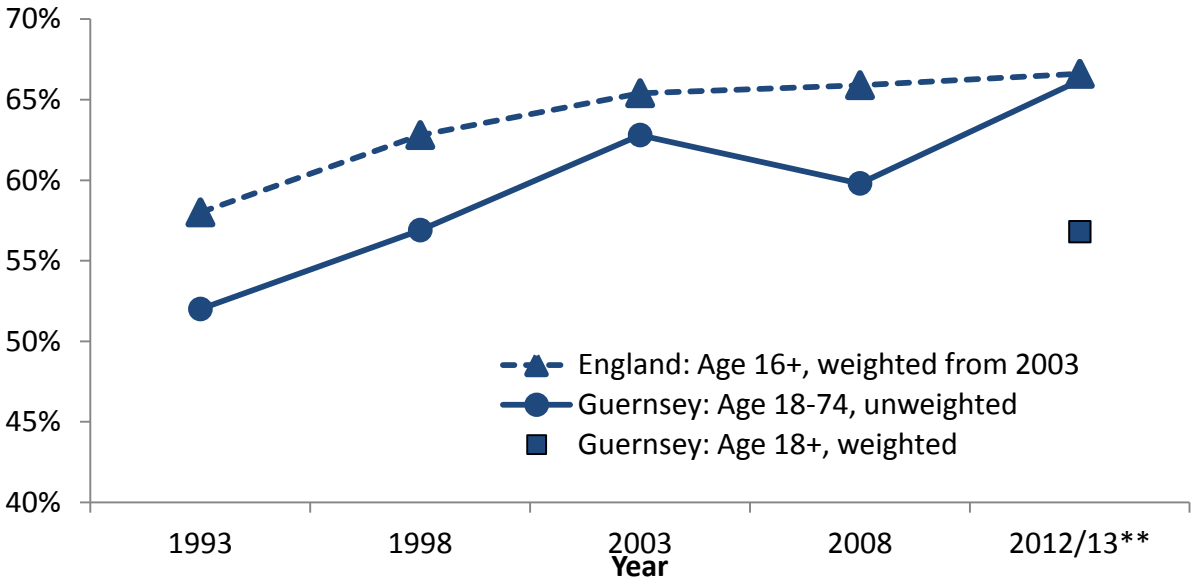
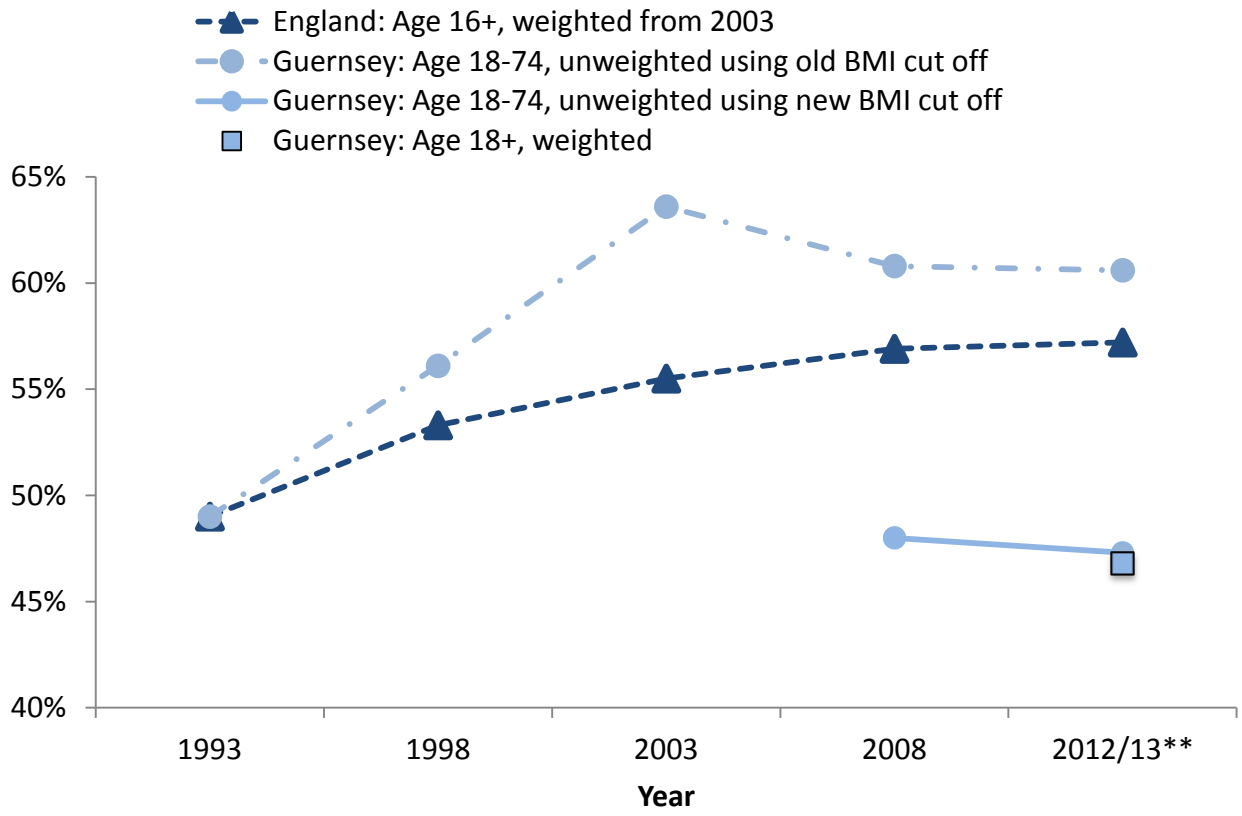


Figure 11: Overweight and obesity (%) in women, Guernsey and Alderney Healthy Lifestyle Survey, and England.



**2012 for England, 2013 for Guernsey. N.B.WHO revised BMI cut-offs for females were adopted from 2008 onwards, with overweight defined as 25 to 29.9 (as for men) instead of 23.8 to 28.6, and obesity 30 and over instead of over 28.6 (see 2008 Lifestyle Survey, Jenkins & Bridgman 2010, or Bridgman 2014 p97/98 for details).

Carrying this extra fat leads to an increased risk of cardiovascular disease (heart disease and stroke), type 2 diabetes, musculoskeletal disease (especially osteoarthritis), and some cancers (endometrial, breast, and colon)[25]. The risk increases with the degree of overweight or obesity. Further, obesity adds large costs to our economy, for example in the cost of drugs for diabetes which were £572,000 for the Social Security Department in 2013, and much of which will be attributable to obesity.

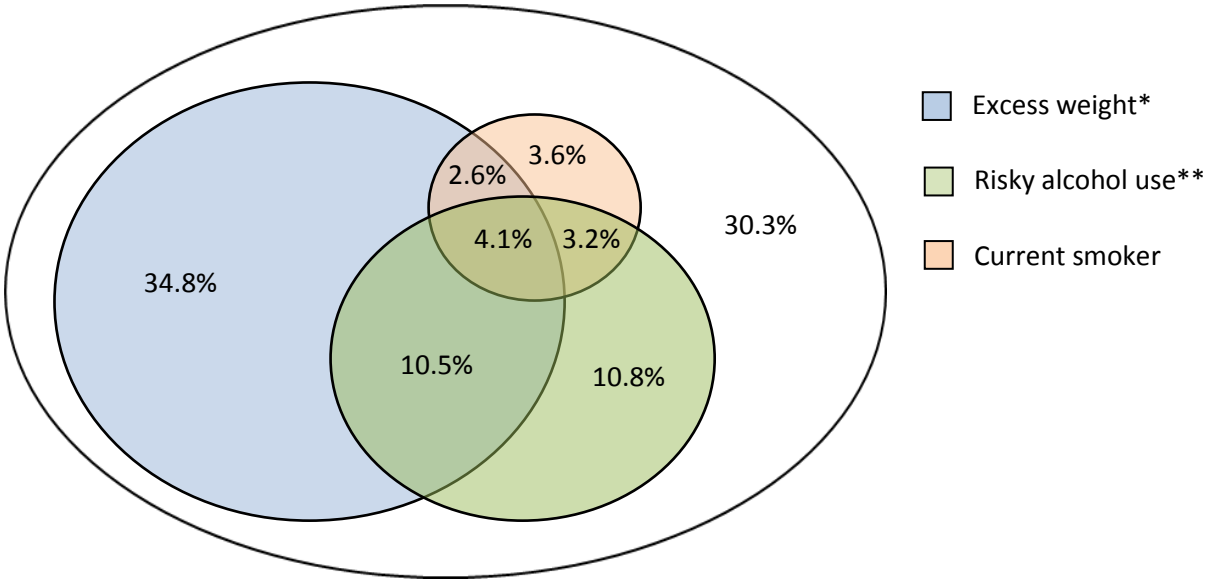
So what does this mean in terms of relative risk and where work should focus? Looking at the analysis of data relating to income groups and housing status, in contrast to smokers, there is no significant correlation between these groups and overweight and obesity. The overall rate of overweight and obesity combined (men

[25] WHO (2015). Obesity and overweight, Factsheet 311, updated Jan 2015. http://www.who.int/mediacentre/factsheets/fs311/en/, accessed 25th Jan 2015

and women) has not reduced over the last five years, and levels in men between 65-74y reached record levels. What may be influencing this?

Looking at combined data for obesity and overweight, smoking and unhealthy use of alcohol, the following diagram shows the crossover of responses for excess weight, risky alcohol use and smoking in the Survey.

Figure 12: Crossover between excess weight, risky alcohol use and smoking, all adults



*BMI weight group of overweight or obese
**AUDIT category of increasing risk drinker, higher risk drinker or possible dependence
NOTE: diagram is not to scale.

Only 30% of adults were neither overweight nor obese, nor smokers, nor a higher risk drinker or greater.

10.5% of responders were overweight or obese and increasing risk, higher risk or possibly dependent drinkers. 4% of responders were smokers, had excess weight and risky alcohol use. Now, looking back at the alcohol consumption data in the Healthy Lifestyle Survey 2013 again, we find that men drink more than women, and drink more with age. Also, compared with other drinkers, more adults in the higher alcohol risk/possible alcohol dependence categories were either overweight or obese[26], which again suggests that this may be a relevant link.

[26] Very small numbers in these drinking categories mean findings should be treated with caution.

Figure 13: Frequency of alcohol consumption by survey year and gender

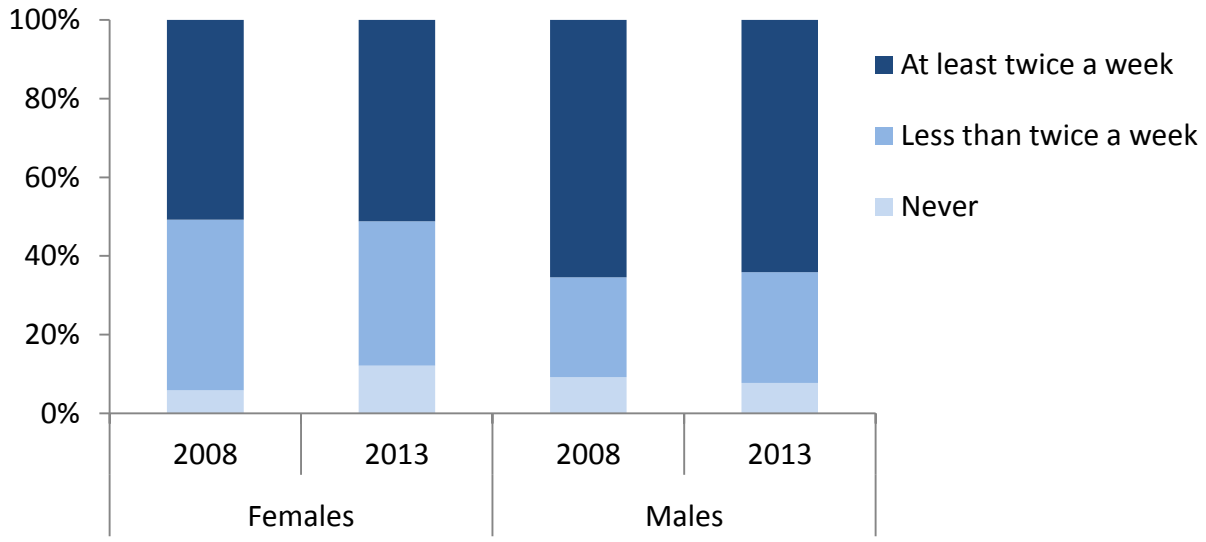
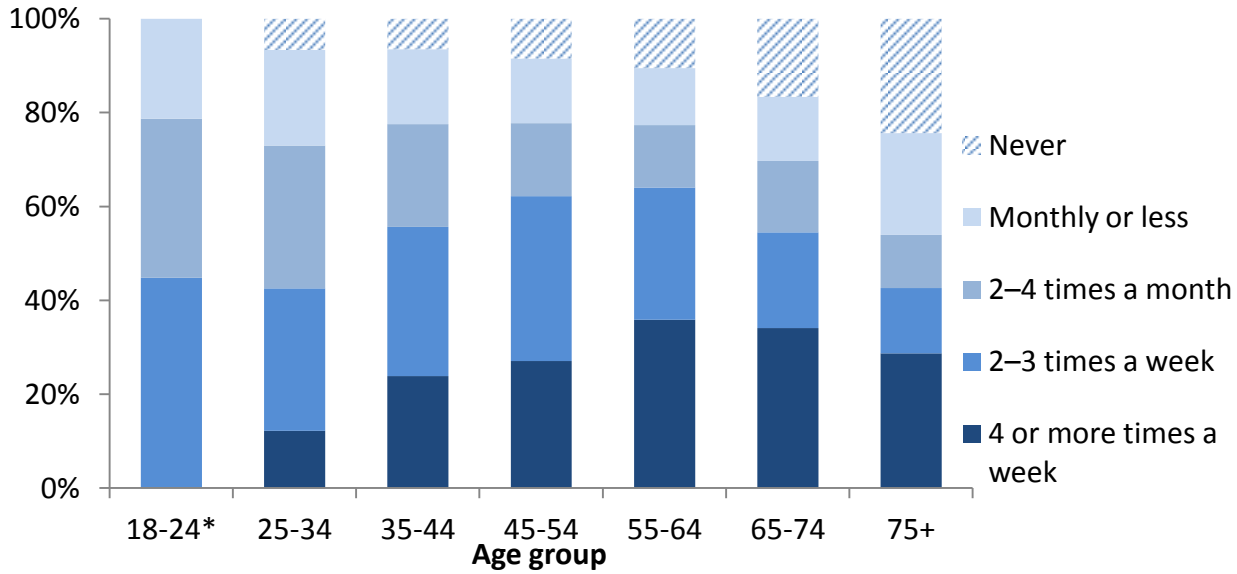


Figure 14: Frequency of alcohol consumption, by age group



*The number of 18-24 year olds participating in the survey was low.

The calorie content in alcohol may be contributing significantly to the struggle with overweight and obesity in Bailiwick men.

It is clear that, following the completion of work on the Tobacco Control and Drug and Alcohol Strategies, the next Strategy for urgent review is the Obesity Strategy. This has already been identified on the work—plan of the Public Health Directorate as part of a rolling programme of strategic reviews, following my recommendation in the 114th MOH report.

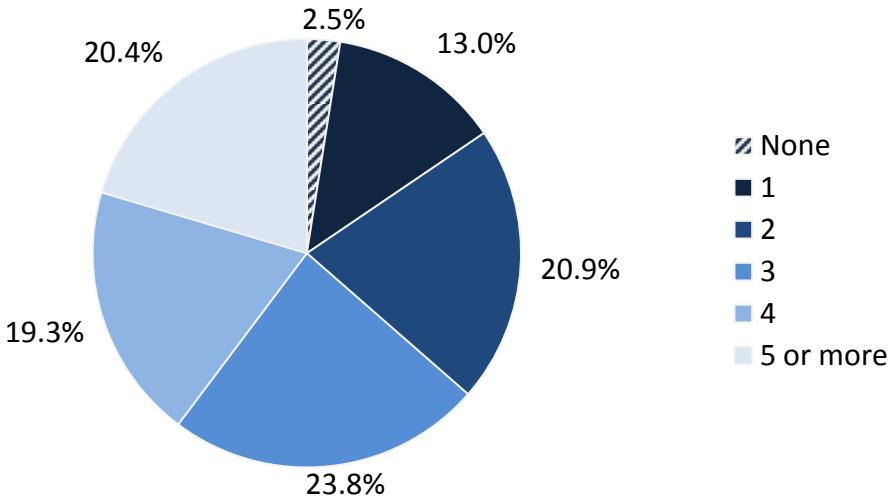
It should be noted that the Obesity Strategy of 2009[27] was not funded until 2011, and then only the first phase was funded. This allowed recruitment of a Specialist School Nurse for Weight Management to lead family-based programmes for obese children, a Community Dietitian to provide services for obese clients and design weight management pathways from Primary Care into specialist services, and the Sports Commission to provide additional physical education in schools. In addition, the Obesity Strategy funded Health Trainers to help people to move towards lifestyle change. Further, the Culture and Leisure Department run a very helpful Lifefit Exercise on Prescription Referral scheme at Beau Sejour for those with health issues who need to increase their levels of physical activity. All of these initiatives are strongly evidence-based, and my previous report shows that they have been effective for those service users who receive their help, but they are not enough to meet the increasing numbers who need assistance.

However, overweight and obesity are preventable. The key to successfully preventing the problem is firstly to reduce energy intake through limiting sugar and fat intake: and eating more fruit, vegetables, legumes, whole grains and nuts. Secondly to increase physical activity to the recommended levels of at least 30 minutes of moderate physical activity on most days.

The Healthy Lifestyle Survey shows us that in 2013, only one in five respondents (20%) consumed the recommended five portions of fruit and vegetables a day. This varied from about 11% of the under 35y respondents to about 25% of the over 35y old respondents. A higher percentage of women (22.1%) than men (18.6%) met the recommended guidelines.

[27] Billet D'Etat XXX1 2009 vol 2 http://www.sustainableguernsey.info/blog/wp-content/uploads/2010/09/2009-M11-Guernsey-Obesity-Strategy-Billet-dEtat-XXXI-Vol-2.pdf, accessed 25th Jan 2015

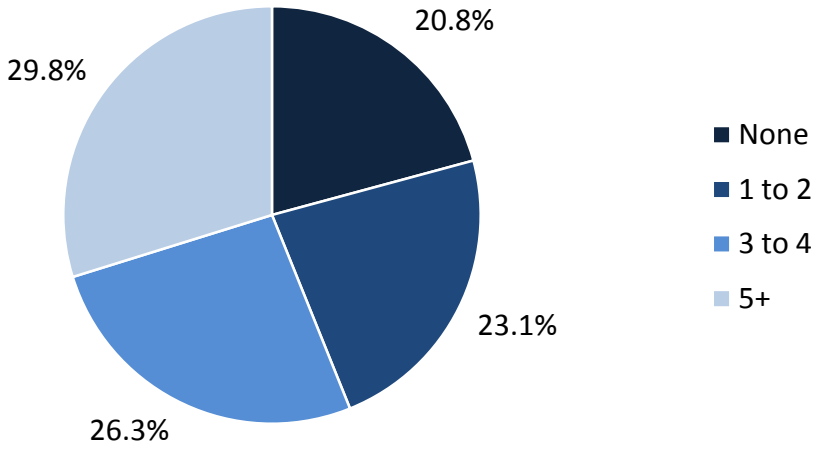
Figure 15: Portions of fruit and vegetables consumed by adults on a normal day



The vast majority of people consumed some fruit and vegetables every day, and the most common foods consumed on a daily basis were vegetables (38%), fruits (35%) and high-fibre breakfast cereals (29%). Over half of respondents reported that they were eating as healthily as possible. Of those who were not eating as healthily as possible, the most common reasons preventing them were lack of will power; healthy foods are expensive; and healthy foods take too long to prepare. Eating healthily was linked to income with 36% of those with a household income greater than £100,000 per year eating 5 or more portions of fruit and vegetables, and only 13% of those with a household income less than £20,000 per year.

The Survey tells us that only 30% of respondents exercised at levels of moderate physical exercise for 30 minutes at least five times a week, while 21% reported no moderate physical exercise at all in the last week.

Figure 16: Number of times adults had engaged in the last week in moderate physical exercise (sport or recreational activity, for at least 30 minutes, which had made you at least slightly breathless and warm).



Men and women had similar levels of moderate physical exercise. While 8% of respondents in the 18-24y old age group were physically inactive, (engaged in no moderate physical exercise in the last week), this increased to around 20% of those aged 25-74y, and 37% of respondents aged over 75y.

In respect of human evolution, people now adopt lifestyles in industrialised countries that were unknown until recently. The rapid increase of obesity in Western Countries in recent years has been considered to be a consequence of both an increased intake of energy-dense highly processed foods that are high in fat and sugar; and a decrease in physical activity due to the sedentary nature of much modern work, changing modes of transportation as people move to motorised door to door methods, and more time in sedentary leisure pursuits such as television and computer games, (WHO 2013).

I explored research into the causes of obesity in the 114th MOH report…

"The causes of the rising rates of obesity in the UK were modelled by the Foresight Programme (2008) and a complex, multifaceted system was identified which locks individuals and societies into an unequal balance between energy intake of food and energy expenditure through exercise. The four key determinants of obesity were identified as physiological factors, eating habits, activity levels and psychosocial influences, with additional attitudinal drivers including ambivalence and lack of personal identification with the agenda. It appears likely that the same influences are affecting the population of Guernsey and Alderney."

Changes in diet and physical activity are not down to one change, but to a combination of changes in different sectors such as health, agriculture, transport, urban planning, environment, education, food processing, distribution and marketing[28]. The solution therefore also needs to be across sectors (government, private and voluntary), multi-faceted and implemented at the individual, family, community and national levels. These are principles which must underpin the review of the Obesity Strategy.

The World Health Organisation has urged Governments to set voluntary national targets for 2025, including a 10% relative reduction in prevalence of insufficient physical activity, and a halt in the rise of obesity by 2025[29]. These would be appropriate long-term key performance indicators for the new Strategy if agreement can be reached to make the necessary improvement in expectations across sectors, with the States taking a lead, and including the voluntary sector and private sector

[28] WHO (2014). Global status report on non-communicable diseases 2014. http://apps.who.int/iris/bitstream/10665/148114/1/9789241564854_eng.pdf?ua=1, accessed 24th Jan 2015.

[29] WHO (2013). Global action plan for the prevention and control of noncommunicable diseases 2013-20. http://apps.who.int/iris/bitstream/10665/94384/1/9789241506236_eng.pdf, accessed Dec 28th 2014.

employers. Most action required to prevent obesity will be outside the health service. Key partners will include the Sports Commission, who are already core group members in the Obesity Strategy Working Group and have started a plan to tackle physical inactivity, other Government Departments such as Culture and Leisure, Education and Environment, and the business and voluntary sectors.

Over the next five to ten years, we should aim to halt the rise in levels of overweight and obesity and increase the proportion of people who consume recommended levels of fruit and vegetables. We should aim to see an increase in the proportion of people that meet physical activity recommendations and a decrease in those who are not undertaking any moderate physical activity at all. It is also important that policies are implemented that give everyone a fair chance of accessing healthy foods, so a specific aim should be to increase the fruit and vegetable consumption of our residents who manage on the lowest incomes.

"*Ambivalence and lack of personal identification with the agenda*" may be the biggest obstacles to addressing the problem of overweight and obesity in Guernsey – there are hundreds of excellent restaurants serving food of high quality at affordable prices by comparison with income. A high proportion of people eat out on a regular basis; we eat healthy foods but the overweight and obesity figures tell us that we do not always eat in healthy quantities. The Survey tell us that more adults agree than disagree that it is easier to enjoy a social event if you've had a drink, and that people in some other parts of Europe tend to drink alcohol more sensibly than people in the Bailiwick of Guernsey. Employment in Guernsey consists primarily of sedentary work; we do not programme physical activity at moderate levels into our daily lives and many of us do not think we have a problem.

Both the States and private Employers would see business benefits from a workforce encouraged and incentivised to be more active and eat more healthily at work. The relevant NICE guidance on workplaces and physical activity gives a clear steer on what is effective[30]. The benefit would manifest itself in terms of reduced sickness absence, increased loyalty and better staff retention. This will require investing in the health of employees through integrated health policy for its staff and visitors.

Recommendation 6 :	Review the obesity strategy and develop a new Weight Management Strategy involving partners and the public based on best evidence of effectiveness and that uses data from the Health Profile and the Healthy Lifestyle Survey to measure progress.

[30] NICE (2008b). Promoting physical activity in the workplace. (NICE PH guidelines 13). https://www.nice.org.uk/guidance/ph13/resources/guidance-promoting-physical-activity-in-the-workplace-pdf, accessed 27th Dec 2014

What does the Survey show us about a holistic view of health?

Mental Health and Well-Being

The World Health Organisation considers good mental health to be a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community[31]. The broad factors that influence it are also well recognised…

"*(there is)... a strong link between the protection of basic civil, political, economic, social, and cultural rights of people and their mental health. In these times, when conflicts between individuals and communities are on the increase and economic disparities are widening, this message is especially relevant. Good mental health goes hand in hand with peace, stability and success."* Herrman[32]

The Bailiwick Mental Health and Wellbeing Strategy was approved by the States of Guernsey in 2013. This was envisaged as an island-wide integrated strategy. A magnificent new custom-built building for the treatment of those with mental illness will open on the Princess Elizabeth Hospital site in 2015.

In the 110th MOH report, I noted that mental health issues were the largest cause of loss of disability adjusted life years.[33] As there was no local data on population mental health and well-being to give an indication of the size of the problem, or to provide a baseline measure for progress, the HSSD Public Health Directorate in partnership with HSSD Mental Health Services carried out the first Guernsey Emotional Well-Being Survey (GEWS) 2010[34]. The data showed that around one in five Islanders (21%) experience anxiety or depression to a clinical level. This was somewhat higher than in Jersey (15%) and in the UK (17.6%). In addition, a validated population measure of mental well-being (as opposed to mental ill-health) was used in the Guernsey survey, the Warwick-Edinburgh Mental Well-Being Scale (WEMWBS). In that survey we found that low mental well-being was associated with low income, living in rented housing, being sick and disabled, and not working. Higher mental well-being was associated with older age. I note that England has followed Guernsey's lead and adopted WEMWBS as a public health measure of mental well-being.

Both the GEWS and the Healthy Lifestyle Survey show that many Islanders' lives are affected by poor levels of mental wellbeing, and demonstrate that the high years

[31] WHO (2013b). Mental health action plan 2013-20. http://apps.who.int/iris/bitstream/10665/89966/1/9789241506021_eng.pdf, accessed 29th Dec 2014.

[32] Herrman H, Saxena S, Moodie R (2005) Ed. WHO. Promoting Mental Health. Concepts, emerging evidence, practice. A report of the WHO and University of Melbourne. WHO.

[33] DH (2011) https://www.gov.uk/government/publications/mental-health-promotion-and-mental-illness-prevention-the-economic-case

[34] Johnson S, Cataroche J, Hinshaw T, Bridgman S (2010). Guernsey emotional wellbeing survey 2010: a cross-sectional survey of mental wellbeing and common mental health disorders in Guernsey and Alderney. Public Health and Strategy Directorate, HSSD, Guernsey.

of life lost from suicide and undetermined injury, noted earlier in this report, are just the tip of the mental health iceberg.

Mental health and well-being are an issue for every one of us individually. The data above indicates what a huge issue mental ill-health and low levels of well-being is for our community too. So what has been done? And what does our survey tell is yet to do?

One very important local advance has been the introduction in 2011 by HSSD and SSD, in close collaboration with primary care and mental health services, of a primary care mental health and wellbeing service (http://www.gov.gg/pcmhwsove). This service is aimed at people with mild to moderate mental health problems: depression, stress, anxiety and other mental health issues. The website also gives links to self-help/health promotion materials for a range of mental health issues such as anxiety and depression.

The WEMWBS tool was used again in the 2013 Guernsey Healthy Lifestyle Survey, and the data shows similar population mental well-being scores to those found in 2010. In the Lifestyle Survey, we also used questions about stress and anxiety. About a quarter of the population reported a large amount of stress, with a similar proportion of men and women, but a lower proportion of older adults reporting high stress. The most common factor frequently or always causing anxiety or stress in 2013 were pressures at work (28%); family's health (20%); money worries (19%); staffing levels at work (16%); family relationships (15%); own health (14%) and housing condition/affordability (13%). The distribution of factors causing stress was similar between 2008 and 2013, and these factors chime with the "*civil, political, economic, social, and cultural"* concerns identified by the World Health Organisation as influencing mental health and wellbeing. The only major change was an increase from 8% in 2008 to 13% in 2013 in people who reported housing condition/affordability frequently or always caused them anxiety or stress.

In addition to this basic data, the 2013 survey analysed mental health and wellbeing cross-referenced with lifestyle behaviour factors. This analysis showed that smokers reported higher levels of stress than those who had never smoked and ex-smokers. 37% of smokers reported being told by a doctor or nurse they had depression at some point in their lives, compared to 17% of those who had never smoked. Only 5.2% of current smokers were in the high mental wellbeing category compared with about 15% of both those who had never smoked and ex-smokers.

In the analysis of weight and health, obese adults were more likely to have low mental well-being, although overweight and obesity was not significantly related to income group or housing status. Adults who were categorised as obese were more likely than those in lower weight groups to report having suffered a large amount of stress or pressure in the past 12 months. Adults who were classed as obese were

also more likely to have had lower levels of mental wellbeing than those in other weight groups.

The Healthy Lifestyle Survey 2013 showed that people felt well-educated about the risks, and worried about their own health, but found it difficult to get into the mind-set to make the changes they wanted to make in their lives. Smokers identified this as needing will-power; those who know they should be eating a healthier diet said the same. Those who don't exercise enough talked about a lack of incentive, as well as insufficient leisure time; this may be linked to the stressors of pressures at work and staffing levels at work as shown above. Finally, the local culture can be a sharp brake on behaviour change, for example increasing risk and higher risk drinkers identified alcohol as a major part of the local way of life and a way to make it easier to enjoy social events.

A high proportion of people would benefit greatly from strengthening their mental health and wellbeing to become more resilient and feel more in control of their own lives: and it is likely that this will also help to move them towards a mind-set where they feel more confident to contemplate change. I have already mentioned the very important role of Health Trainers (a holistic 'person to person' intervention designed for people who need help to reach the point of readiness to change, and help to make and maintain those positive changes). Those people who are struggling to make the changes in their lives that put their health at risk are able to access this excellent free service by self-referral or referral from their GP or other services. However, where clinically significant anxiety and high levels of stress are as widespread as they appear to be in Guernsey, an ounce of prevention is better than a pound of cure and there is a simple, evidence-based way of getting 'five a day' for mental health and wellbeing, just as we aim for a fruit and veg 'five a day' to stay fit and healthy.

These are the **Five Ways to Wellbeing**[35]. All of the 5 ways are free, achieved easily and can apply to everyone - no matter what the circumstances. Doing these things is an evidence-based way to make a real difference to our thoughts and feelings.

[35] NEF. Five ways to well-being: the Evidence. http://www.neweconomics.org/publications/entry/five-ways-to-well-being-the-evidence, accessed 24th Jan 2014

Figure 17**:** Five Ways to Well-Being Poster Headings

To put it another way, this is what you need to do to make you feel good:

- **Connect** - With the people around you. With family, friends, colleagues and neighbours. At home, work, school or in your local community. Think of these as the cornerstones of your life and invest time in developing them. Building these connections will support and enrich you every day;
- **Keep Learning** - Try something new. Rediscover an old interest. Sign up for that course. Take on a different responsibility at work. Fix a bike. Learn to play an instrument or how to cook your favourite food. Set a challenge you will enjoy achieving. Learning new things will make you more confident and be fun;
- **Be Active** - Go for a walk or run. Step outside. Cycle. Play a game. Do some gardening. Dance. Exercising makes you feel good and improves your physical health too. Make sure you find an activity you enjoy and that suits your level of ability and fitness;
- **Take notice** - Be curious. Catch sight of the beautiful. Remark on the unusual. Notice the changing seasons. Savour the moment, whether you are walking to work, eating lunch, or talking to friends. Be aware of the world around you and your feelings. Reflecting on your experiences will help you appreciate what matters to you;
- **Give** - Do something nice for a friend, or stranger. Thank someone. Smile. Volunteer your time. Join a community group. Seeing yourself linked to the wider community can be incredibly rewarding and creates connections with the people around you.

Just like learning any new skill, users need to practice the 5 ways and make a conscious effort to keep doing them regularly. Further information is available at http://www.gov.gg/mentalhealthandwellbeing along with an excellent leaflet

produced by the Health Promotion Unit which can be downloaded, or otherwise obtained by telephoning the Health Promotion Unit on 01481 707311.

The Healthy Lifestyle Survey 2013 shows a concrete example of how at least one of these actions works for people in Guernsey. Those people who met the recommended physical exercise levels generally reported lower stress levels than those exercising at lower levels. Over a third (34.0%) of adults who reported no physical exercise in the past week stated they had experienced large amounts of stress over the past 12 months compared with 20.2% of those that met the recommended five or more physical exercise sessions. Further, the people who had not engaged in any physical exercise were more likely to have low mental wellbeing than those that did any level of physical exercise.

The World Health Organisation has launched a Mental Health Action Plan 2013-20, in which it calls upon Governments to implement strategies for prevention of mental ill health, and promotion of mental health and wellbeing[36]. Guernsey HSSD mental health services and Health Promotion Unit (from within existing resources), in collaboration with partners such as Guernsey MIND, marked World Mental Health Day in October 2014 with its first ever full week of awareness. This was called Elephant Week, and was seen as part of the implementation of the Mental Health Strategy.

Photos 5 and 6**:** Guernsey Mental Health Awareness Elephants. Mental health is seen as the 'elephant in the room'. (Schoolchildren were asked to decorate the elephant with which represented one of the 'Five Ways to Wellbeing' – dubbed 'CLANG' – Connecting, Learning, being Active, taking Notice and Giving. La Houguette's elephant is blue, Amherst's red.)

[36] WHO (2013). Mental Health Action Plan 2013-20. http://www.who.int/mental_health/action_plan_2013/bw_version.pdf?ua=1, accessed 24th Jan 2015

Elephant Week was an opportunity for us to discuss and change our thinking about mental health and wellbeing and promote the Mental Health Five–a-Day message. For a week, Guernsey Posties wore Elephant Week hi-vis vests, whilst they delivered a flyer to every household in the Bailiwick; elephants were being decorated to raise awareness of mental health by school students in 10 primary schools and 2 secondary schools, and these were displayed during the Tea & Talk events held every day at the Town Church (Photos 3 and 4).

Events organised during Elephant Week included talks and seminars on Life skills for business; Post-Traumatic Stress Disorder; Anxious Parents raising Confident Children and How Mental Wellbeing is influenced before Birth. This gave a tremendous boost to public awareness and encouraged open discussion of a whole range of mental health and wellbeing issues, to the benefit of sufferers and families, and increased understanding in many. Guernsey MIND have also been active in working with businesses using a preventative approach for mental health[37] and are indeed a valued and expert partner for change for the better. The Guernsey Sports Commission have been advocating evidence-based techniques to improve our mindsets, in particular encouraging us to adopt "*Growth*" rather than "*Fixed*" mindsets to help us and those around us reach our potential.[38]

Given the decades it has taken to reduce smoking prevalence, I would also anticipate that demonstrably improving population mental health and well-being will take many years. It will need a cross-government action on the wider determinants of mental health and wellbeing (e.g. employment, housing, accessibility of services) as well as a programme of mental health promotion. I recommend a cross-Government Mental Well-Being Strategy Implementation Group is set up to develop and implement an evidence-based Action Plan to improve Public Mental Health. Further population based surveys of public mental health will be required to monitor progress.

Recommendation 7:	Cross-Government Public Mental Health and Well-Being sub-group is set up to develop and implement an action plan to improve Public Mental Health

Recommendation 8:	A repeat population survey of public mental health and well-being is carried out to monitor progress.

[37] http://www.guernseymind.org.gg/about-guernsey-mind/what-we-do/employment-project

[38] Dweck CS, (2006). Mindset, the New Psychology of Success. Ballantine Books.

Healthy Lifestyle Survey Future

The healthy lifestyle survey is a crucial source of local data on behaviours that are important for health. It helps us identify local health needs, measure changes over time, and provides data for public health intelligence to help our priority-setting and strategic planning.

Recommendation 9 :	To produce a local Healthy Lifestyle Survey every five years as part of our local Public Heath Surveillance programme

Recommendation 10 :	To continue the Public Health Strategy Review and development, programme guided by the principal issues identified in the Health Profiles, and Healthy Lifestyle Surveys.

PRIORITY SETTING IN HEALTH AND SOCIAL SERVICES

Background

"*Difficult and agonising judgements have to be made as to how a limited budget is best allocated to the maximum advantage of the maximum number of patients*." Sir Thomas Bingham[39].

I considered priority setting in the 110th MOH report and briefly again in the 114th MOH report. In this section I consider some of the background pressures, progress that has been achieved, and further work to be done.

The scope, quality and cost of health and social care services are very important factors in the health and well-being of the public. From a public health or population perspective the objective is to obtain the greatest health and well-being of the population for the resources (money, time, facilities) available, in a fair way.

Guernsey has no statutory obligation, to provide health services unlike the NHS in the UK. The source of its obligation to provide health services comes from its Corporate Governance responsibilities. The Health and Social Services Department is required by the States of Deliberation to be responsible for (http://www.gov.gg/HSSD);

(i) *Promoting, protecting and improving personal, environmental and public health;*
(ii) *Preventing or diagnosing and treating illness, disease and disability;*
(iii) *Caring for the sick, old, infirm and those with disabilities;*
(iv) *Providing a range of social services to all age groups including ensuring the welfare and protection of children, young people and their families and ensuring that the best interests of the child shall be a primary consideration.*

HSSD is expected to operate within the cash limited budget allocated to it by the States. However the very nature of health and social care services, and the relatively unpredictable nature of demand, is such as to make it hard to precisely predict calls on resources year to year. A particular challenge in Guernsey and Alderney is that the population catchment is only around 65,000, and yet the scope of the provision on Island and off Island has to be as comprehensive as in England with a population of 53 million.

The financial challenge has also been sharpened for all States Departments as a result of the Economic and Taxation strategy of 2006 which led to the 'zero-ten structure' for corporate taxation leading to less public revenue income[40]. The global

[39] Court of Appeal Ruling, R v Cambridge Health Authority ex parte B [1995] 1WLR 898 (CA).
[40] T&R Board (2014). 2015 Budget Report, http://www.gov.gg/CHttpHandler.ashx?id=92601&p=0, accessed 1st Jan 2015.

financial crisis of 2007, perhaps the worst since the Great Depression, made the situation worse[41].

After six years with a budget deficit, and with a huge amount of effort by many people, the positive situation is that Guernsey's Treasury and Resources Department consider that in 2015 a balanced budget is achievable through both targeted increases in indirect taxation, and the real-terms reduction in revenue expenditure that has been achieved in recent years.

However, Guernsey will need to continue to work hard and make difficult choices in order for it to maintain a balanced budget and obtain the greatest public health improvement from its resources.

Along with the financial constraints, it is well recognised that Guernsey, faces a range of pressures driving up the costs of and demands on health and social care, such as;

- Growth in available technology, in diagnostics, curative and palliative treatments
- Increase of proportion of older people particularly those over the age of 80y
- Decrease in the proportion of people of working age
- Growing prevalence of chronic diseases related to lifestyle
- Increased public expectations in relation to the both the extent and quality of care they want
- Recruitment and retention of health and social care professionals, especially with the relatively high cost of living
- Increased internal monitoring and quality assurance systems
- Increased external regulation

Priority Setting Processes

Priority setting is the process (or in reality processes) by which choices are made about resources; whether this is money, manpower, how time is spent, use of facilities, or training.

It is a reality that every budget holder, whether they are an individual, a business, a charity or a public body, has to make difficult and often uncomfortable choices about how to spend their money.

The values and process of decision making will vary household to household, business to business, and charity to charity. Most budget holders have

[41] World Bank (2009). Protecting pro-poor health services during financial crises. Lessons from experience. Washington, DC, World Bank. http://siteresources.worldbank.org/HEALTHNUTRITIONANDPOPULATION/Resources/ProtectingProPoorFC.pdf, accessed Jan 11th 2015.

considerable discretion how to spend their money. Public bodies that look after taxpayers' money, however, have certain duties placed on them which restricts the types of choices they can make and how they make their decisions.

Priority setting is done through a series of decisions. In an organisation such as HSSD there are five key processes which involve priority setting:

1. **Strategic Planning**
   This is a slow process by which organisations come to an understanding about the needs of their population, their services and determine the scope, level, and quality of services that will be provided to their population. Shortfalls in services or service quality are assessed and then a priority order created in which they should be addressed. This is the most important process for carrying out priority setting and it has the potential to engage clinicians, patients and the public in that process.

2. **Operational planning**
   This is the process by which organisations develop short term plans to implement their strategies about 1 to 3 years ahead. This determines the pace at which strategic plans are implemented and is very much determined by the financial climate year to year. It is important that the operational plan reflects the agreed priorities of the organisation.

3. **In-year service developments**
   In general an organisation should only invest in pre-agreed priorities. It is, however, the nature of healthcare that new developments are introduced throughout the year. Organisations generally deal with these by reviewing their strategic priorities to see if new developments are more important than those that have already been agreed. Potential new service developments therefore should be managed through the revision of the operational plan. However there will be times when urgent unpredicted funding is required during a financial year to either deal with pressing matters, such as an outbreak of pandemic flu, to manage a major risk to patients/users' health and well-being or to fund a new service development which is considered so important that its implementation should not wait.

4. **Contracting**
   When placing a contract with a provider of healthcare the better an organisation can set out the details of how it expects patients to be managed and to what standard the better. However the process of standard setting also requires priority setting as many of the service standards which have been developed by professional, regulatory and patient bodies cannot be fully afforded. So the organisation paying for the service has to determine what is

essential, what aspects of quality improvement will be delivered over the coming 1 to 3 years and what will have to await future development.

5. **Funding decisions at the individual level.**
   There are a number of ways in which funding decisions are taken at the level of the individual. This is particularly so in social care, where individual's needs are assessed and packages of care determined. On the health care side there is also a process called the individual funding request process which deals with decisions about care not normally funded.

In the last twenty years much progress has been made in many health care systems to develop the above processes to create more robust, fair and open choices. In the UK for example some core principles which shape decision making have emerged and there is a general consensus over the factors which should commonly be used when making choices between competing health care developments, although the priority setting field in social care is less well developed.

In Guernsey, also, work has been done in the last few years to develop better decision making, most notably in the area of individual funding requests, the development and adoption of an ethical framework and the development and adoption of a range of priority setting policies. HSSD has made information about aspects of its priority setting available to the public on the States website (http://www.gov.gg/hssdpriorities and http://www.gov.gg/ifr).

There is more to be done in developing the other processes and in particular:

1. Developing priority setting at the strategic level, particularly at the healthcare programme level.
2. Improving the link between the macro decisions and the micro decisions.
3. Developing professional, public and patient engagement.

Developing priority setting at the strategic level

Poor strategic planning leads to poor choices because reactive decisions are not always the best ones, and this will negatively affect public health.
To improve priority setting the Health and Social Services Department and the Social Security Department may benefit from strengthening and clarifying their priority setting processes across the healthcare services they are responsible for. This will need to be documented in an overarching policy for priority setting which would incorporate the key processes in priority setting set out above.

Improving the link between the macro decisions and micro decisions

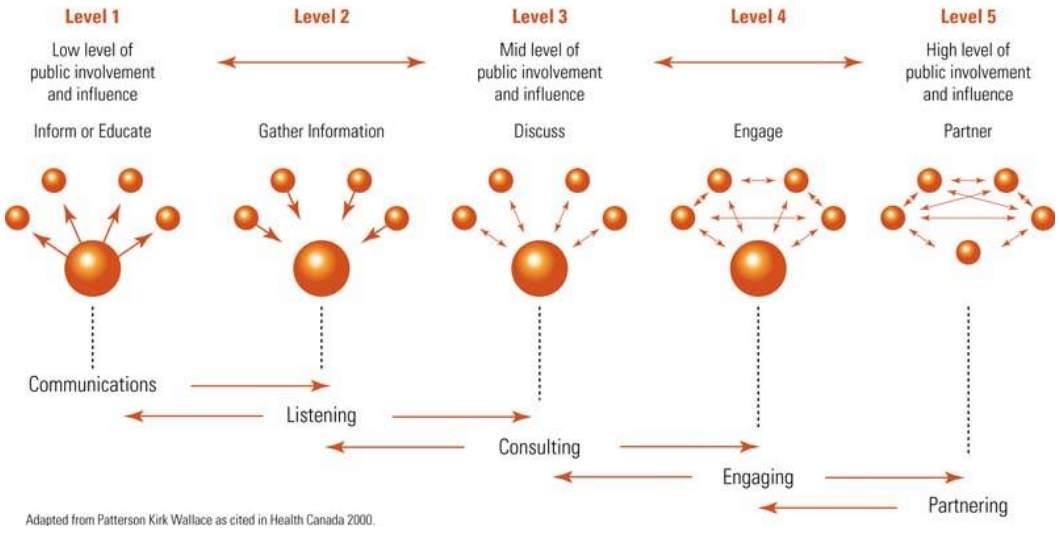
It requires considerable organisational effort to ensure that there is a strong link between agreed strategic goals and what happens on the ground by way of activity and also funding. The systems put in place to ensure this coherence form part of the priority setting processes. This also ensures that the most important decisions are taken in a planned and informed way.

Developing professional, public and patient engagement

If the States are to make the best choices they can and increase public and professional understanding and confidence in its decisions about resources, then wider engagement is needed. This is particularly important during strategic planning as each group, patients/users/carers, professionals, public health, management and those with overall responsibility for the budget, have different information and bringing them together is very powerful.

Professional, public and patient engagement is not something that can be done easily but needs time and effort to progressively develop. This is because it demands individuals and groups to participate in a decision which does not come easily to them and which can be uncomfortable (making choices between competing needs either within their service area or between service areas). To engage fully requires maturity and trust on both sides, and this cannot develop overnight. The Canadians for example have a 15 year programme of public engagement to improve this aspect of decision making. They are developing capacity stage by stage.

Figure 18: Canada's continuum of public engagement



Canada has produced a useful framework for public engagement which can readily be applied. Many health care organisations have started with level 1 and are developing capacity for engagement both internally and with the public along the continuum.

Guernsey should be well placed to develop this aspect of priority setting because of its small population, its straightforward administration, and the small distance between politicians in power, the public and professionals. It is therefore quite possible that The States of Guernsey could be a world leader in this field if it chose to be.

At the very least some engagement is required to overcome the view that priority setting can be avoided. It is understandable that so many find the very idea of having to choose between patients or users difficult, and for some morally unacceptable. But believing this will not make the fact go away and avoiding making explicit choices has serious consequences for Society. Denial of the need to make choices leads to poor decisions being made.

In order to begin meaningful engagement there are some basic obstacles that need to be overcome.

Making choices explicit

The first is for all to understand the fact that every decision made is a choice. In fact one of the most important ethical principle bodies like HSSD follow is that they should make all their decisions knowing the full implications of their decision. In the 110th MOH Report, I discussed the way in which funding decisions were played out in the public domain, and made some recommendations for improvement. All too often the public, patients and healthcare professionals see the funding decision played out as a choice of whether or not to ration. When a new cancer drug comes along, it is presented as a choice over whether or not to ration the drug. This presentation of the decision is misleading. It suggests that saying yes will avoid rationing and depriving patients of a treatment they need or want. It does not. It displaces the rationing to another group of patients. Because that group of patients are not in the public domain – everyone can pretend they are not being denied care. There is a natural tension between the 'population perspective' that drives the decision maker to obtain the most population health and wellbeing for the money available and the clinical or individual view of doing the very best for the individual at any point in time. But ultimately, the task in hand is the fair distribution of scarce resource.

When patients do not get the care they need, they may feel that the State does not care about them, that their life and contribution is not valued and that the State does not think 'they are worth the money'. But when considering how to distribute scarce resources, a public body such as HSSD, cannot solely consider whether it is a good

thing or not to provide a particular treatment. In addition, the public body must aim to do two further things:

1. To find the best way to invest resources across all the patient/user groups for whom it has responsibility; and

2. To strive to provide a balanced range of health and social care – prevention, diagnosis, treatment or care, rehabilitation and palliation.

As a result the organisation has to design and operate decision making principles and policies which are designed to answer the question: '*Which, of all the possible options that are available is the next most important investment for the population/patient-user groups we are responsible for*?'

Within a restricted budget the public body will need to disinvest in lower priority interventions in order to generate funding for higher priority ones. Because of this, the question then becomes 'How can we disinvest in services with the least negative impact across the population / patient groups for whom we are responsible?'

Only prioritisation as a method of decision making can answer these questions. The alternative is known as singular decision making. Singular decision making in the context of health and social care funding describes a situation in which the decision maker makes a choice as to whether or not to fund a single treatment or service, without regard to how else that funding might be used.

A way to illustrate why singular decision making leads to not only poor choices, but is unethical is as follows:

> *Imagine there are 50 people in a room and each individual represents a new treatment or service development for a particular disease. You can only afford to fund 3-5 service developments. Prioritisation can be represented as selecting people from a crowd. Here you have all 50 people in front of you. You are aware of all the competing needs. You can choose the highest priority needs and also understand (and take responsibility for) which patients groups you will not fund (referred to as the opportunity cost). All those competing for funding have a fair chance of being considered.*
>
> *Singular decision making has not all the patients standing in front of you at once but they are standing in line. You can only see the person at the front of the queue. So you make your decision one at a time. You make your decision person by person without any idea of the needs of the people further down the line. It is human nature that you will be more generous because you are not making a choice between two or more people and so are likely to run out of money well before you approach the end of the queue. The most*

important need or best value for money treatment might be for the person at the back of the queue.

To answer the question: 'Is this a good thing to provide to patients?' requires only singular decision making.

To answer the question: 'Which is the best way to use this money?' requires consideration of all the options.

At the heart of many of the difficulties and conflicts in dealing with funding questions, particularly when they focus on a single patient, is not that there are different views on the answer but that the two sides are actually trying to address different decisions – they are not answering the same question.

There is much evidence to suggest that when groups which often appear to be in conflict are asked to prioritise a number of potential investments in health care services, patients, clinicians, and those holding budgets make very similar choices. The people involved have not changed – but the nature of the decision to be made has. One of the tasks of engagement therefore is to ensure that all are focused on the same question. This does not alter the nature of the decision to be made but ensures that different experiences and knowledge are brought to bear on the decision.

Arguments that rationing can be avoided

Often it is difficult to engage in public debate about the choices to be made because there is resistance to the idea that priority setting is unavoidable. There are three common counter-arguments to the need for priority setting. Each of these arguments are important and have merit in their own right in that they can contribute to easing the level to which services are rationed, but they cannot either singly or collectively stop it happening altogether.

Health and social care funding is inadequate

All Western health care systems are experiencing pressure on health care budgets. A number of reasons are cited for this e.g a growing elderly population, new technology, rising prices. At the same time the West has also experienced changing economic circumstances which means there is less money available to the public purse to spend (see above). All public services could identify more things to spend money on whether it is education, health, the police, social services etc.

Politicians have the role of determining priorities across departments and how much tax burden to place on individuals and businesses. There are always trade-offs to be made and there is always a limit to how far cuts can be made in one department to pay for services in another, and there are limits on the taxes the public will bear. The fact is that the health care budget needs year on year growth just to stay still. If

say 100 hip replacements are needed this year, then more will be needed next year to keep up with the ageing population.

No health care system, regardless of how health care is paid for, is able to meet all demand or need and while the public often demand cuts in other services to pay for health services, when the choice becomes apparent (the crowd of options is revealed) – e.g. cutting policing or teachers, or paying more tax or social insurance contributions, the idea is often rejected.

One of the successes of local priority setting has been avoidance of significant additional costs on relatively low value for money treatments, as part of HSSD's individual funding request priority setting processes. A similar rational and evidence-based introduction of policies for service developments would also enable Guernsey and Alderney to improve the population health gain (measured in length and/or quality of life) from within the available public health resources.

Inefficiencies should be tackled first

No one could argue against addressing current inefficiencies and waste. Health and social care organisations are constantly finding ways to save money. It is not a single fix and requires considerable time and manpower resources to deliver. It is true that there are always more savings and efficiencies to be found but these alone cannot deliver the funding needed. Finding savings in an island setting is even more challenging. There are many fixed costs not incurred in other systems. The smaller the population planning base, the higher the costs of running a basic service.

Over the past few years the staff in the public sector in Guernsey have worked hard to find efficiencies. For example, clinicians standardising their use of joint replacements, our pharmaceutical advisors and GPs working together to increase the proportion of unbranded (generic) drugs used, clinicians making tough evidence-based decisions through committees such as the Drug and Therapeutics or Professional Guidance (formed in response to a recommendation in the 110th MOH report) to prevent the introduction of insufficiently cost-effective treatments.

An example of a local efficiency Guernsey introduced that has received international plaudits, is the use, for a common eye disease that can lead to blindness, of an effective unlicensed drug in preference to a much more expensive but licensed drug. The Royal College of Opthalmology President and Southampton's Professor of Opthalmology refer to "*bureaucratic hurdles that prevent its use"* so that the English NHS were unable to follow in Guernsey's evidence-informed lead with the implied hurdles being the GMC and NICE[42]. This decision, alone, has saved an

[42] Lotery A, MacEwen C, (2014). What is stopping the NHS from using bevacizumab for macular degeneration and other retinal disorders? *BMJ*2014; 349 doi: http://dx.doi.org/10.1136/bmj.g6887(Published 19 November 2014) Cite this as: BMJ 2014;349:g6887

estimated several hundred thousands pounds recurrently a year for our taxpayers, and will have enabled Guernsey and Alderney to obtain much more public health gain than England per pound spent on this service.

HSSD also have an evidence-based and ethical policy that NICE guidance is just that, guidance and not mandatory instructions, as while NICE and UK professional regulators have extremely important and valuable roles, they do not hold the local budget and therefore cannot know what the next most important priority is locally for investment in this jurisdiction, or indeed in England.

Ineffective practices should be tackled first

Similarly, no one could argue against stopping things that do not work. This however is much more challenging to deliver as it requires cultural change. An illustration of just how difficult stopping ineffective or relatively low priority practices has been nationally has been antibiotic prescribing for viral infections, although great progress has been made recently in the islands.

However, none of what is said above negates the value of a Guernsey-wide discussion about the level of funding of public services and the choices that need to be made between different public services, nor does it argue against the need to reduce waste and inefficiency. However there is nothing to be done to avoid the need to prioritise either in the short or medium term. HSSD, SSD and the States have to make decisions about what to fund and not fund now and will always be required to do so. Arguing against that fact is not constructive and is also harmful as it does not facilitate or enable engagement.

Moving Forward with Engagement

The public health and social care system in Guernsey is arguably one of the most complex businesses on the island. Guernsey has begun the first level of public engagement through informing the public about its priority setting policies, such as its ethical framework[43]. The first stages of improving engagement will be strengthening how the public, patients and professionals are informed.

Improved engagement will help in the future when tough decisions are made, as professionals and public will know and understand that those responsible for priority setting decisions have done their best, and that the decisions are fair even if they are not popular. The evidence is that the best health and social care systems are when politicians, professionals and the public work together for many years in concert.

Public and professional engagement needs to be developed so that those hard choices, while likely not being popular, are seen as fair and rational. Few

[43] HSSD, Guernsey. How we decide priorities. http://www.gov.gg/hssdpriorities, accessed 25th Jan 2015.

jurisdictions are good at priority setting. Guernsey and Alderney have the potential to be world leaders.

Recommendation : 11	To review the priority setting processes for health and social care, building on the good work to date, and to formalise them into an overarching priority setting policy.

Recommendation : 12	To continue to develop the long-term process of professional, patient and public engagement on priority setting.

BLANK

REFLECTIONS ON THE 15TH MOH REPORT (1913)

The 15th Medical Officer of Health (MOH) report was attached as an Appendix to a letter in the Billet d'Etat from the President of the Board of Health, G.E Kinnersly. The Bailiff and President of the States of Guernsey at this time was William Carey.

Dr H Y Draper Bishop MD (DB), the MOH, estimated the population of Guernsey to be 41,854, equalling the population estimate for both 1911 and 1912.[44]

The number of births recorded was 887, a rate of 21.2 per 1,000. There were 59 still-born babies, which equated to 6.6% of total births. There were 101 deaths in children under the age of 1y, a rate of 113.8 per 1,000 births. The rate for England and Wales was lower at 109 per 1,000 births. In Guernsey, 41 children died before they reached the age of 1 month. Infant mortality was especially high in the poorer classes as during labour, no medical attendance was offered. It was strongly suggested that "medical attendance for the poorer classes" must "be revised in drastic fashion" as all women should be able to secure medical attention when in labour. In addition, "mortality among the children of the working classes was 62 per cent higher than in the case of the mothers who carried out only their domestic duties". DB believed that the number of women who left home during the day to work was very high in Guernsey.

The number of deaths was 550, a rate of 13.1 per 1,000. The death rate for England and Wales at that time was 13.7 per 1,000. One in nine deaths were due to cancer after the age of 25y, and in women between the ages of 40y and 60y cancer accounted for one in every five deaths. DB highlighted that the use of radium to treat cancer was limited and had proved to be "a very uncertain remedy." It was emphasised that the public be informed that radium is not "at present a cure for cancer".

There were 72 cases of diphtheria, of which four were fatal. One fatal case "was treated with sulphur by the grandmother, who considered herself an authority upon diphtheria." No doctors were called until the child had collapsed. Forty-seven deaths occurred from tuberculosis. There were 10 cases of enteric fever, of which there was one death. Two cases were due to drinking from badly contaminated wells, with further cases being the result of people swimming near sewage outfalls.

During 1912, most of the preventable diseases were due to the lack of pure drinking water. Therefore, understandably the "greatest event of the year, from a public health point of view" was the decision from the States to begin proceedings to provide an ample supply of water to the island. With regards to public health, further progress was made with St Sampson's parish agreeing to have the refuse collected

[44] Bishop HYD (1914). 15th MOH report, 1913. Guernsey.

and destroyed in the incinerator, instead of “dumping it in the fields as was the custom in the past.” Finally, improved sanitary conditions in the island, combined with the isolation of infectious diseases in the Board’s hospitals had contributed greatly to the diminished general mortality. It was concluded that “the future is hopeful”.

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Guernsey and Alderney deaths 2013, by Gender and Cause.[45]*

	Number of deaths			
CAUSE OF DEATH (ICD-10 codes)	Male	Female	Total	% of all deaths
Cancer (C00-C97 or D00 to D48)	89	70	159	29%
Cardiovascular disease (I00-I52 or I60-I69)	66	95	161	30%
Respiratory disease (J00-J99)	38	38	76	14%
Other (any other code not included above)	65	85	150	27%
Total	**258**	**288**	**546**	**100%**
CANCER TYPE	Male	Female	Total	% of all deaths
Oesophagus (C15)	10	2	12	2%
Colon (C18)	3	5	8	1%
Pancreas (C25)	5	3	8	1%
Bronchus & lung (C34)	16	9	25	5%
Breast (C50)	0	9	9	2%
Prostate (C61)	15	0	15	3%
Other cancers	40	42	82	15%
Total	**89**	**70**	**159**	**29%**
CARDIOVASCULAR DISEASE TYPE	Male	Female	Total	% of all deaths
Acute myocardial infarction (I21)	13	13	26	5%
Chronic Ischaemic heart disease (I25)	19	20	39	7%
Cerebrovascular diseases (I60-I69)	18	34	52	10%
Other cardiovascular diseases	16	28	44	8%
Total	**66**	**95**	**161**	**30%**
RESPIRATORY DISEASE TYPE	Male	Female	Total	% of all deaths
Pneumonia (J18)	8	10	18	3%
Emphysema (J43)	5	3	8	1%
Chronic obstructive pulmonary disease (J44)	14	14	28	5%
Other respiratory diseases	11	11	22	4%
Total	**38**	**38**	**76**	**14%**
OTHER CAUSES	Male	Female	Total	% of all deaths
Unspecified dementia (F03)	12	13	25	5%
Senility ('old age') (R54)	2	6	8	1%
Chronic renal failure (N18)	1	2	3	1%
Deaths with an inquest verdict of suicide	1	0	1	0%
Accident deaths (V01-X59)	7	5	12	2%
Other 'other causes' (includes inquests pending)	42	59	101	18%
Total	65	85	150	**27%**

[45] Includes stillbirths.

*Provisional. 4 outstanding inquest deaths not yet allocated causes of death are under 'Other' causes.

2013 vital statistics by Island

Guernsey

	M	F	Total
Estimated mid-year population	31081	31651	62732
Live births registered	342	318	660
Stillbirths	2	0	2
Deaths (all ages)	245	273	518
Deaths under age 1	1	2	3

Alderney

	M	F	Total	Source
Estimated mid-year population	1009	1071	2080	Policy Council
Births in Guernsey	5	6	11	Euroking
Births in Alderney	0	1	1	Alderney Greffe
Total births	5	7	12	
Deaths (all ages)	15	11	26	Alderney Greffe
Deaths under 1 year	0	0	0	Alderney Greffe

Sark

	M	F	Total	Source
Estimated mid-year population	not known	not known	513 *	Sark doctor (Sark Chamber of Commerce and Sark Electricity)
Births in Guernsey	1	4	5	Euroking
Births in Sark	0	0	0	HM Greffier, Sark
Total births	1	4	5	
Deaths (all ages)	1	0	1	HM Greffier, Sark

*Jan 2014

Acknowledgements

I thank Linda Prickett for assistance with the health surveillance section, Dr Daphne Austin for assistance with the priority setting section, Jenny Cataroche for compiling the Guernsey and Alderney deaths and vital statistics, Dr Casey Lee for the reflection on the 15th MOH Report, Katherine Ford of the Centre for Public Health, John Moores University for undertaking some additional analyses from the Guernsey and Alderney Lifestyle Survey 2013, Steph Charlwood for designing the front and back covers, Tom Cheshire for Photos 3 and 4, and Linda Osborne for help in formatting the final document.

I thank Professor William Roche, Mark Salmon and Carol Tozer of HSSD Corporate Management Team for comments on a draft, James Murray HSSD psychologist for comments on the mental health aspects, Ed Freestone of HSSD and Eddie Pinkard of Capita for comments on the prioritisation section, Yve Le Page for comments on the Health Surveillance Section, Zoe Grainger, SHARE staff, and Dr Nikki Brink for comments on the teenage pregnancy aspects, and Andrea Nightingale for comments on the alcohol aspects.

GLOSSARY and ABBREVIATIONS

BMI	Body Mass Index
HSSD	Health and Social Services Department of States of Guernsey
Physically inactive	Engaged in no moderate physical exercise in the last week
Physical exercise moderate	Sport or recreational activity for at least 30minute (which had made you at least slightly breathless and warm).
WHO	World Health Organisation

FIGURES, TABLES AND PHOTOGRAPHS

FIGURES

TABLES

PHOTOGRAPHS

RECOMMENDATIONS

Recommendation 1: Page 12	Develop cardiovascular, and cancer clinical strategies.
Recommendation 2: Page 20	To agree and implement a sexual health strategy, which includes evidence-based measures to reduce teenage pregnancy rates.
Recommendation 3: Page 20	To produce a Guernsey and Alderney Health Profile every three years, as part of the local Public Heath Surveillance programme.
Recommendation 4: Page 25	The States to agree and implement a proposed Tobacco Control strategy based on best evide**n**ce of effectiveness, and that has been developed with partners and the public.
Recommendation 5: Page 27	The States to continue their ongoing support for the development and implementation of the Drugs and Alcohol Strategy over the next five years, which is based on best evidence of effectiveness.
Recommendation 6: Page 35	Review the obesity strategy and develop a new Weight Management Strategy involving partners and the public based on best evidence of effectiveness and that uses data from the Health Profile and the Healthy Lifestyle Survey to measure progress.

Recommendation 7*:*	Cross-Government Public Mental Health and Well-Being sub-group is set up to develop and implement an action plan to improve Public Mental Health.
Page 41	

Recommendation 8:	A repeat population survey of public mental health and well-being is carried out to monitor progress.
Page 41	

Recommendation 9:	To produce a local Healthy Lifestyle Survey every five years as part of our local Public Heath Surveillance programme.
Page 42	

Recommendation 10:	To continue the Public Health Strategy Review and development programme guided by the principal issues identified in the Health Profiles, and Healthy Lifestyle Surveys.
Page 42	

Recommendation: 11	To review the priority setting processes for health and social care, building on the good work to date, and to formalise them into an overarching priority setting policy.
Page 53	

Recommendation: 12	To continue to develop the long-term process of professional, patient and public engagement on priority setting.
Page 53	

115th ANNUAL
Medical Officer of Health (MOH) REPORT
Bailiwick of Guernsey