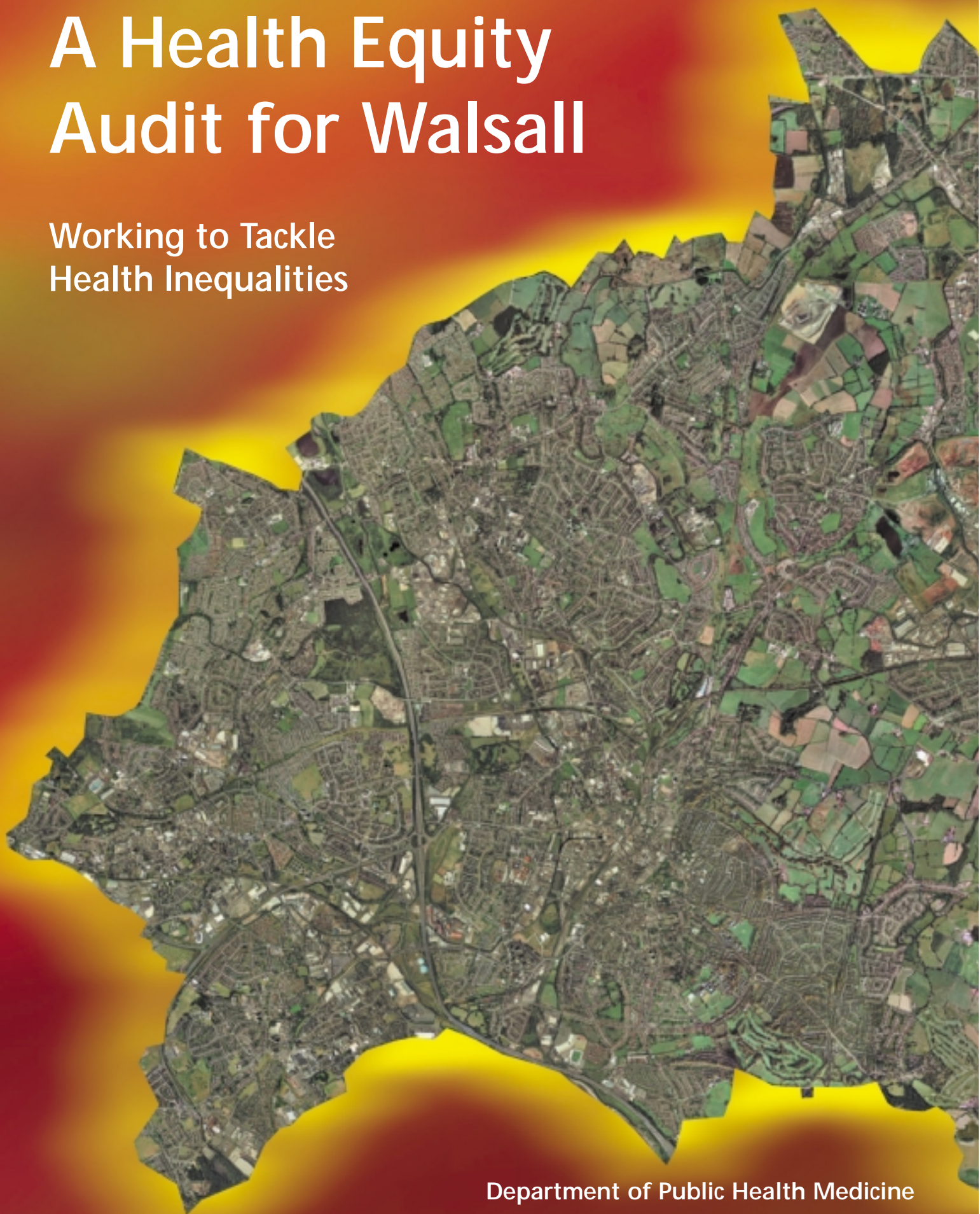


The 2004 Annual Report of the  
Director of Public Health

Walsall **NHS**  
Teaching Primary Care Trust

# A Health Equity Audit for Walsall

Working to Tackle  
Health Inequalities



Department of Public Health Medicine

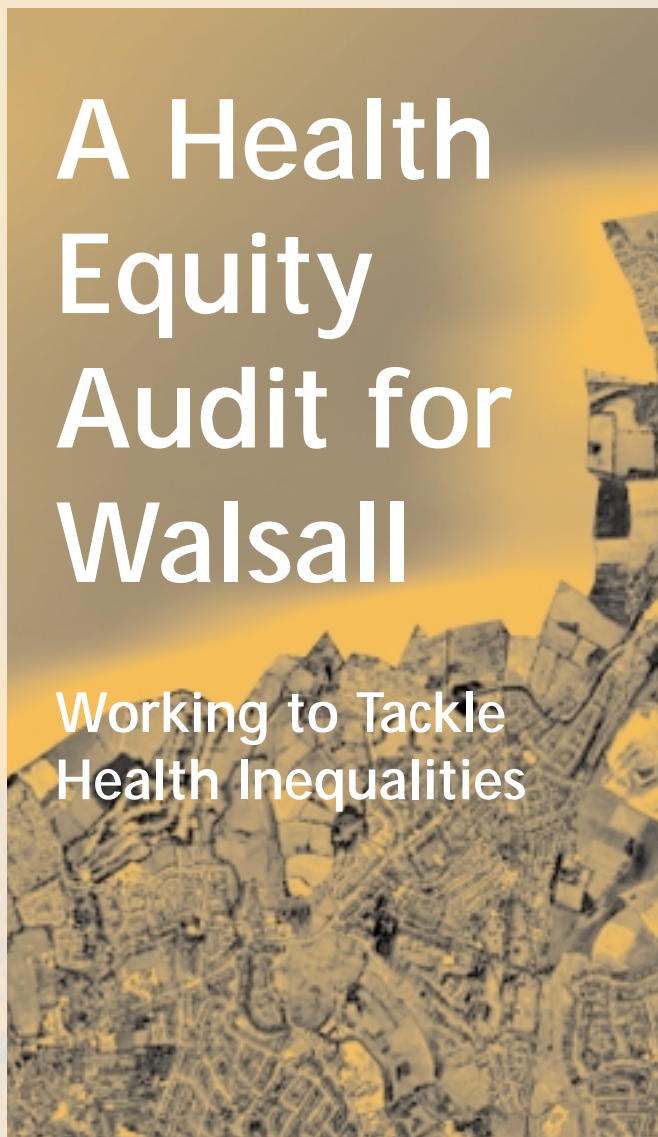




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# A Health Equity Audit for Walsall

Working to Tackle  
Health Inequalities



Over the last 20 years the life expectancy of people living in Walsall has continued to increase as death rates have fallen. Many of my past annual reports have looked at these issues in more detail. However, despite these significant improvements large inequalities still exist both within Walsall, and between Walsall and other regions.

Inequalities in health is not confined to Walsall. In 2003 the Government published '*Tackling Health Inequalities – A Programme for Action*'. This focuses on action to achieve two national health inequalities targets by 2010. These 'headline targets' are based on reducing inequalities in infant mortality and life expectancy. To supplement these, there is a series of sub targets and indicators covering those areas expected to make a significant impact on achieving the headline targets. These indicators are wide ranging and include underlying influences on health such as child poverty and educational attainment, as well as health indicators such as access to care and mortality from the major killer diseases such as coronary heart disease, stroke and cancer.

In addition, the Wanless Report '*Securing Good Health for the Whole Population*' (2004) recommends a shift of focus from treating disease to promoting the maintenance of good health, including by tackling health inequalities. The subsequent *Choosing Health?* consultation stimulates this debate further by seeking views on priorities for action as inputs into a forthcoming White Paper.

It is therefore appropriate and timely to devote my annual report this year (and this second Public Health LEC report) to tackling health inequalities in Walsall. This Report aims to analyse and review health inequalities in Walsall, and how these are being addressed, within the framework of the '*Programme for Action*' and examines the targets and indicators in Walsall, collating local and national data to assess Walsall's relative position. Variations within Walsall are also explored. Finally local interventions are summarised and areas highlighted where further action is warranted.

This report will inform and assist the tPCT, its two LECs (North and West Walsall and South and East Walsall) and its partner agencies, to develop their policies and strategies to address these issues.

**Dr Sam Ramaiah**  
Director of Public Health, June 2004

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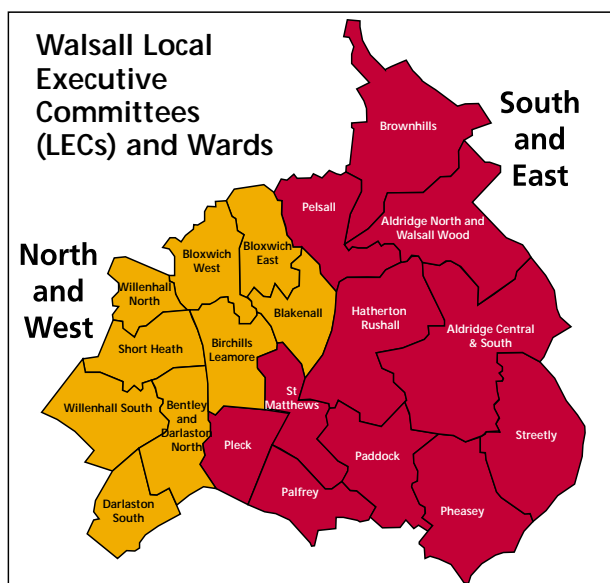
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[www.walsall.wmids.nhs.uk/pct/publichealthweb](http://www.walsall.wmids.nhs.uk/pct/publichealthweb)

The wards comprising North and West Walsall Locality and South and East Walsall Locality are shown in the map below



Inequalities prevent people from achieving their full potential in life. The Acheson Report published in 1998 highlighted the large inequalities in health across England and made 39 recommendations to address these. Subsequent documents, including the recent Government Report *'Tackling Health Inequalities – A Programme for Action'* have drawn on the work in the Acheson Report, looking at ways to reduce inequalities and to monitor the progress towards this aim. These Reports have highlighted the variation in infant mortality across the country and the widening gap, in recent years, between the areas with the highest and lowest life expectancy. For example "by the early 1990s, death rates were almost 3 times higher among unskilled groups. There are regional differences too. In 1999/2001, the difference between areas with the highest (North Dorset) and lowest (Manchester) life expectancy at birth was 9.5 years for boys and 6.9 years for girls. In small communities differences can be even greater".

The situation in Walsall is no different. In 1998/99 the infant mortality rate was 25% higher in Walsall than in England and Wales. Within Walsall there was also a large variation. The wards with the lowest rate, for example, had a crude infant mortality rate of zero while the ward with the highest rate was 13 infant deaths per 1,000 live births. The life expectancy of men in Walsall was 1½ years lower than men in England and Wales and ½ a year lower in Walsall women. Within Walsall, life expectancy varied substantially across the borough, from 71 to 81 years in men and 76 to 83 years in women, a difference of 10 years and 7 years respectively.

This Report therefore attempts to review inequalities in Walsall and the actions being taken to tackle these. However, the Report is not comprehensive as it focuses only on those areas for which there are specific targets/indicators in *'Tackling Health Inequalities – A Programme for Action'*. This means that some issues influencing health inequalities are not discussed in the Report. For example, unemployment, environment and transport.

The Report is divided into two main parts infant mortality and life expectancy. These are also the two 'headline targets' set by the Government and outlined within *'Tackling Health Inequalities – A Programme for Action'*. Each of the two chapters contains several subsections comprising those targets and/or indicators, which will contribute to the

achievement of the infant mortality and life expectancy targets. Data has been collected and calculated wherever possible to monitor accurately the targets. However, where data is not available, proxy measures have been used. These are outlined in more detail in Appendix 1.

Chapter 3 focuses on Infant Mortality. Chapter 4 includes subsections on teenage conceptions, smoking in pregnancy, breastfeeding, access to services and child poverty.

Chapter 5 provides an overview of life expectancy in Walsall whilst Chapter 6 examines a wide range of issues contributing to life expectancy. This includes some of the underlying determinants, lifestyle issues, access to health services and deaths from major killers such as circulatory diseases, cancer and accidents.

There is also significant inter-linkage between targets. For example, achievement of the 'Five-a-Day' target will help reduce the prevalence of obesity as well as contributing to the reduction in incidence (and mortality) of CHD and Cancer. It could also contribute to a reduction in infant mortality. Inter-linkages are illustrated in the chart in Chapter 2.

Many of these targets are contained within the Local Delivery Plan (LDP) (see Appendix 2). The LDP forms the basis of the agreement between Walsall tPCT and the Government and outlines how NHS resources will be spent. These targets are also part of the Commission for Health Improvement (CHI) assessment criteria used to decide the star status of the tPCT (see Appendix 3).

As well as reporting on current and future activity, each section briefly summarises the role of primary care professionals in addressing the inequalities targets, underlying the importance of 'shifting the balance' to primary care in driving forward health improvement programmes.

The report also contains an Executive Summary and recommendations.










## Executive Summary





The current position (most recent data) and targets to address health inequalities in Walsall are summarised below. More detailed information with regard to target definitions and baselines are given in the respective sections in the main body of the report.









High risk of not meeting target

Good progress, but some risk of not meeting target

High probability of achieving target

Target	Current Position	Target	Will Target be met?	Comments
Reducing Infant Mortality	5.6 per 1,000 births	5.7 per 1,000 births		At a borough level the target should be met but the rate can fluctuate widely because of small numbers and there is still wide variation within the borough.
Reducing Teenage Conceptions	63.2 per 1,000 births	30.8 per 1,000 births		There is a need to develop access to more young people centred, friendly services in Walsall.
Reducing Smoking in Pregnancy	578 women smoking	439 women smoking		Good progress is being made but there is some risk that improved accuracy of data being collected may distort recorded progress towards the target. Staff retention problems may also hinder progress.
Increasing Breastfeeding	46% breastfeeding	52% breastfeeding		Improved accuracy of data collection from 01/04/04 may distort recorded progress by increasing initiation rates and thus showing greater decline in breastfeeding at 2 weeks.
Improving Access to Antenatal and Child Screening Services	89% HIV uptake	90% HIV uptake		The overall aim is a coordinated approach to screening, with high quality information available to all women to enable them to make an informed choice regarding which tests to have.
Reducing Child Poverty	National Target and Indicator			Child poverty in Walsall remains well above the national average and there is a wide variation across the borough. Several initiatives are targeting this.
Increasing Life Expectancy	Men 74.1 years Women 79.6 years	Men 76.9 years Women 81.1 years		Life Expectancy in Walsall varies substantially across gender, social class and areas of residence. Improvements are dependent on success in tackling the key influencing factors including mortality rates from the main killer diseases, access to services and lifestyle issues.
Improving Housing	17% ex council private owned homes decent	100% of homes decent		Several initiatives and plans, backed by substantial investment, are targeting achievement of the decent homes standard by 2010 in both the Housing Association and private sectors.

Target	Current Position	Target	Will Target be met?	Comments
Reducing Homelessness	National Indicator			Priorities for action have been agreed and set out in Walsall Council's homelessness review and strategy.
Increasing Educational Attainment	43% obtaining 5 or more A-C grades	48% obtaining 5 or more A-C grades		Year on year improvement in the number of pupils obtaining 5 A-C grades leads us to believe that this target will be achieved. However, there is substantial variation between schools.
Reducing Smoking in Manual Groups	20% smoking prevalence	26% smoking prevalence		More accurate data on smoking prevalence will be obtained from practice registers in 2004.
	620 quitters	1814 quitters		Excellent progress is being made towards this target with a substantial increase in the number of quitters. Walsall currently has the 2nd highest quitters in the BBC StHA. However, recent inflation of the targets by 170% is a cause for concern.
Improving Diet	24% consuming 5 a day	National Indicator		A range of local activities has been developed to improve diet, but these focus largely on small geographical areas of Walsall and there is a need to develop coordinated borough-wide programmes.
Reducing Obesity	18% men obese 15% of women	14% men obese 10% of women		An extra dietitian is needed to roll out the dietary aspect of 'Time to Change' to all GP practices. Work is needed to encourage Primary Care staff to highlight problems relating to diet and weight and motivate patients to make changes and seek help. Concern has been expressed about the accuracy of local obesity data, which does not reflect national patterns and trends.
Increasing PE and Sport in Schools	National Indicator			The Walsall PE and schools sports network is established and together with its partners, is in a good position to move forward on this indicator. Within this, primary care has a key role in promoting and helping people achieve lifelong active lifestyles.
Improving Access to Coronary Interventions	Indicator			A local indicator has been agreed as part of the LDP, which states that access to interventions will reflect need with regard to ethnicity and age.

Target	Current Position	Target	Will Target be met?	Comments
Improving Access to Breast and Cervical Screening	Breast screening 70.8% uptake	Minimum of 70% uptake		Work needs to be carried out in marginalised communities which do not participate in screening programmes. The Primary Care Team need to be fully engaged and follow up messages to patients
	Breast Units 50%	Uptake of over 70% all sites		
	Cervical screening 81% uptake	Minimum of 80% uptake		Good progress has been made towards this target. However resources need to be targeted at poorly performing practices.
Improving Access to Sexual Health Services	21% of abortions undertaken at and up to 9 weeks gestation	44% of abortions undertaken at and up to 9 weeks gestation		The DPH is currently leading on a major review of sexual health services. The appointment of a new Consultant Community Gynaecologist will also raise the profile of this issue.
Increasing Influenza Vaccination Uptake	70.2% uptake	70% uptake		The borough-wide target is being achieved, but support needs to be given to increase uptake rates in those practices remaining well below target.
Improving Equity in Staffing Levels	No data available			Reviews of the District Nursing and Health Visiting services are being carried out and aim to modernise the services, meet community needs, ensure appropriate skill mixes and equitable service provision.
Reducing Deaths from Cancer	135.0 age standardised rate	113.1 age standardised rate		Good progress has been made. However, for long term results a comprehensive primary prevention strategy with sustained and focused emphasis on anti-smoking, healthy diet and exercise is required.
Reducing Deaths from Circulatory Disease	141.2 age standardised rate	84.8 age standardised rate		Overall performance in this area has been systematic and sustained over the last 3 years. This approach will deliver the targets set by the Government.
Reducing Deaths from Accidents	50 deaths annually	37 deaths annually		Walsall is implementing systematically the national priorities for accident prevention identified by the Government's Accidental Injuries Task Force.



# Recommendations

1. A comprehensive, coherent primary prevention strategy is required to ensure that all NHS professionals in Walsall and our partner organisations address inequalities in a focused fashion.

2. Many of the preventative activities detailed in this report depend on funding from special initiatives and short-term projects. There is an urgent need to mainstream the key programmes to deliver primary prevention in Walsall.

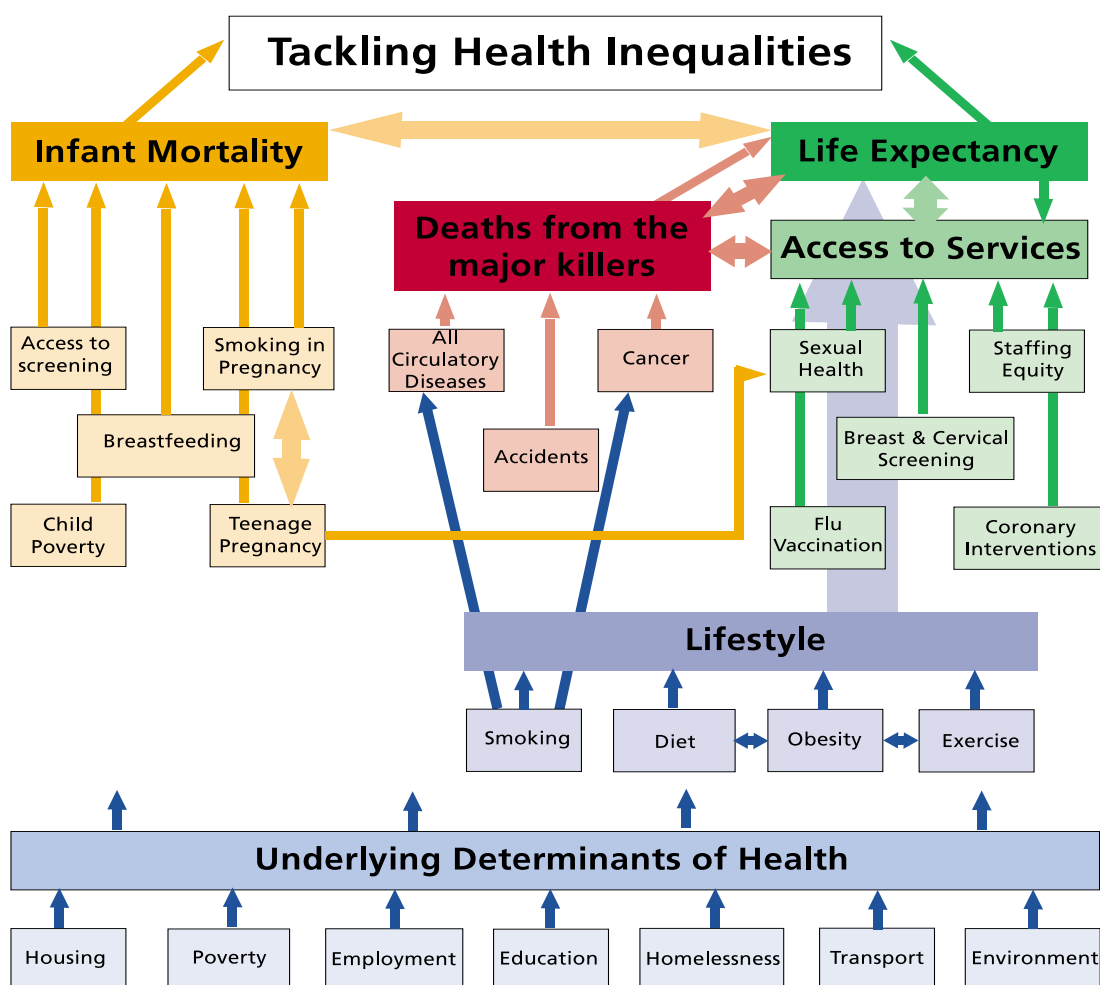
3. Along with the rest of the UK, Walsall is now clearly demonstrating the effects of poor diet and a sedentary lifestyle, which results in high levels of obesity. Accurate local data on the levels of obesity are required as well as a comprehensive strategy to tackle obesity in Walsall.

4. There is a need to develop information systems to ensure ongoing review and monitoring of inequality targets. These are important both to ensure Walsall tPCT can address LDP as well as CHI targets.

5. The role of primary care needs further development particularly with regard to prevention and the need to ensure that the preventative aspects of ill-health form part of all integrated care pathway developments.

6. The writing of this report has shown that there are significant initiatives being developed across a wide range of partner organisations, which have implications for health. It is recommended that a supplementary report addressing particularly the key areas around poverty, transport, physical activity and the environment is undertaken.

## Inter-Linkage Between The Inequalities Targets



# chapter 3

## Infant Mortality

### National Headline Target

Starting with children under one year, by 2010 to reduce by at least 10% the gap in mortality between manual groups and the population as a whole (baseline period 1998/2000).

### Public Health Interpretation for a local Walsall Target

Starting at 7.1 per 1,000 live births in 1998/00, reduce the rate to no more than 5.7 by 2010. This means saving the lives of at least an additional 5 children a year by 2010.

### Introduction

In February 2001 the Government identified infant mortality (deaths under 1 year) as an important headline target for reducing health inequality. This target was introduced because there is a significant variation in infant deaths between manual and professional groups and between different areas. The target focuses on reducing this gap. However data is not available to measure this locally. Therefore it is assumed that a general reduction in infant mortality will also lead to a reduction in the gap in infant mortality between social classes and, as a result, help us achieve the target.

Many infant deaths occur within the first month of life and many of those within the first 7 days from birth. The main causes of death in these very young children are prematurity and congenital abnormalities and there is a relationship with smoking in pregnancy, poor nutrition and antenatal care. The infant mortality target aims to address infant mortality through tackling some of these causes, as well as improving the health of older babies.

Infant mortality is usually expressed as a rate per 1,000 live births. The national baseline is based on 1998-2000 data. Three-year averages are used to smooth year on year fluctuations. In the case of ward level data, 5-years averages have been used because of the small numbers. For more information on this and on how the Walsall target has been calculated, see Appendix 1.

### How Walsall Compares

*Figure 1: Infant mortality rates per 1,000 live births, Walsall, West Midlands and England and Wales, 1982 – 2002*

		England and Wales	West Midlands	Walsall
1994 - 1996	No. Rate	11205 6.1	1426 7.0	64 6.1
1995 - 1997	No. Rate	11782 6.1	1413 7.0	75 7.2
1996 - 1998	No. Rate	11419 5.9	1362 6.8	80 7.7
1997 - 1999	No. Rate	11065 5.8	1340 6.9	91 8.8
1998 - 2000	No. Rate	10639 5.7	1285 6.8	72 7.1
1999 - 2001	No. Rate	1084 5.6	1257 6.8	65 6.6
2000 - 2002	No. Rate	9834 5.5	1216 6.6	54 5.6

Source: Office for National Statistics

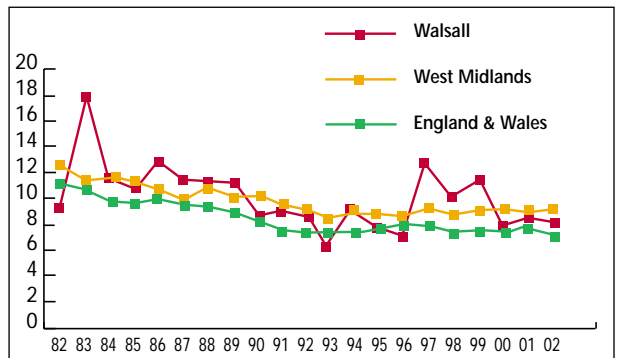
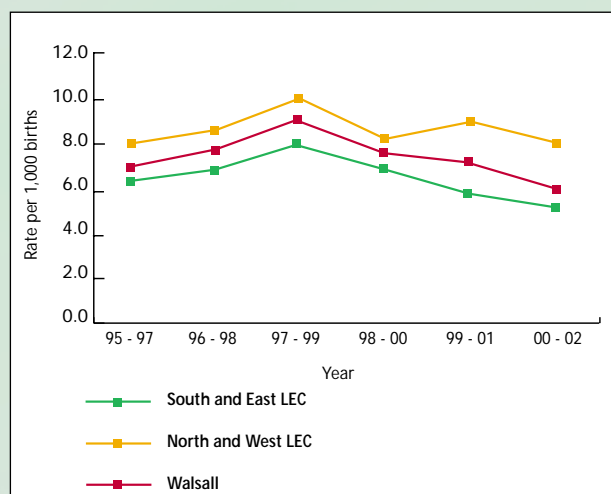


Figure 1 shows that the infant mortality rate gap between Walsall and the national rate has narrowed substantially in the last triennium (2000/02) and that Walsall appears to have met its 2010 target. However, there are considerable year on year fluctuations and there continues to be wide variations within Walsall.

## Focus on Walsall

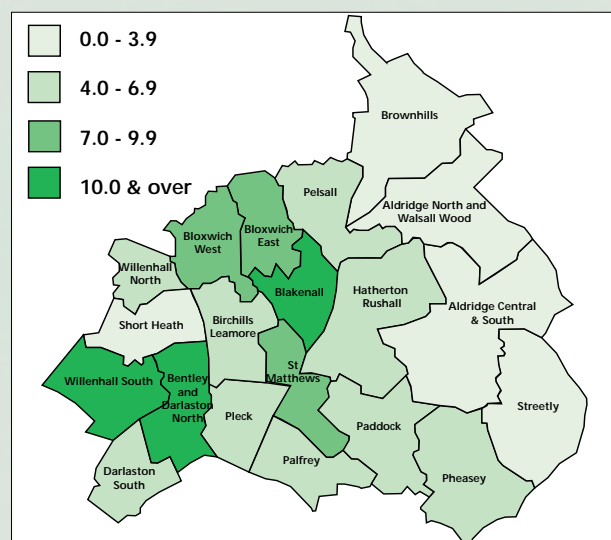
**Figure 2: Infant mortality rates per 1,000 live births, Walsall LECs, 1995/97- 2000/02**



Source: Office for National Statistics

Figure 2 shows that the infant mortality rate for each LEC over the last 8 years fluctuated throughout the period. Generally over the 8-year period, the trend is downward and South and East Walsall had a lower rate than North and West Walsall. In 2000/02 the infant mortality rate in North and West Walsall was 7.5, which was almost double that of South and East Walsall at 3.8.

**Map 1: Infant mortality rate per 1,000 live births, Walsall wards, 1998-2002**



Source: Office for National Statistics

Map 1 shows the variation in the infant mortality rate across Walsall. The highest rates are in the North and West of the borough, with Bentley and Darlaston North having the highest rate of over 13 per 1,000 births, followed by Willenhall South (12) and Blakenall (10). The

rates in these wards are up to 2½ times the national rate. The lowest rates are in Streetly and Aldridge North and Walsall Wood, which had zero infant deaths in this period. However, at a small area level the large variations associated with small numbers may give a distorted picture.

## Tackling the Issues

An action plan to reduce infant mortality has been developed locally for key areas that relate to the underlying causes. The main features are listed below and discussed in more detail, together with their implications for action in primary care, in Chapter 4 of this report.

## Current Activity

- A dedicated smoking cessation support programme for pregnant smokers and their partners has been introduced.
- Additional smoking cessation resources are being provided in Blakenall, which has the highest smoking prevalence rate in Walsall.
- A borough wide tobacco control and education programme is in place.
- The Down's screening programme offered to women at 16 weeks gestation, has moved to the improved triple test, following national guidance.
- Universal neonatal haemoglobinopathy screening and screening for MCADD has been introduced in Walsall during spring 2004.
- Information and support has been provided to improve uptake and duration of breastfeeding.
- Peer support for breastfeeding mothers is being extended across Walsall.
- Information has been provided to improve midwives and other health professionals' knowledge of the screening tests available.
- Expectant women are being offered and recommended HIV screening, with a target to reach a 90% uptake rate.
- A pilot project in Palfrey Sure Start has commenced to adapt the Edinburgh Post Natal Depression Scale to make it more culturally sensitive for ethnic minorities.
- A universal antenatal haemoglobinopathy screening programme is being developed for introduction by end 2004.

## Future Activity

- Anti D prophylaxis to Rh-ve women will be introduced at 28 & 34 weeks gestation in accordance with NICE guidance
- Peri-conceptual care will be improved by increasing the uptake of folic acid
- Ensure women from black and ethnic minority groups access universal services
- More information needs to be given to GPs on breastfeeding



- There is a need for a systematic coordination of all breastfeeding activities district wide
- There is a need to ensure that immunisation coverage is maintained following the GMS2 contract.
- Need to address the issues rising from the child health surveillance and promotion becoming an enhanced service through the GMS2 contract.
- The use of customised growth charts for monitoring fetal growth antenatally needs further consideration.

#### The Role of Primary Care Professionals

- There is a need to promote the use of folic acid peri-conceptually.
- Raise awareness of the importance of early booking in pregnancy and ensure early access to appropriate professionals.
- Promote awareness of the screening programmes available in pregnancy to the general public.
- Promote awareness around the prevention of cot death (SIDS).
- Promote healthy diets in young women.
- To be aware of child protection procedures.
- Support needs to be given to vulnerable parents, such as those involved with substance misuse.
- Greater involvement in promoting breastfeeding.
- There needs to be a more pro-active systematic evidence based approach to smoking cessation support for all pregnant women across Walsall.

# National & Local Targets Contributing to Reducing Infant Mortality

## 4.1 Teenage Conceptions

### National and Local Delivery Plan Target

Reduce the national under 18 conception rate by 15% by 2004 and 50% by 2010, while reducing the gap in rates between the worst fifth of wards and the average by at least a quarter.

### National Indicator

Conception rate per 1,000 women aged 15-17

### Walsall Target

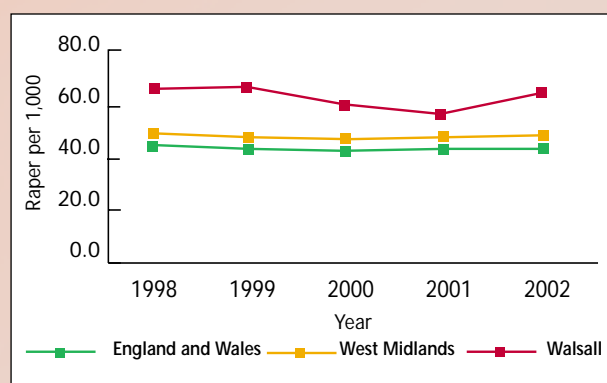
From a 1998 baseline of 68.4 the agreed local targets are a reduction in the under 18 conception rate by 15% to 58.2 by 2004 and by 55% to 30.8 by 2010. This means reducing the number of teenage pregnancies from 326 in 1998 to around 146 by 2010.

### Introduction

Teenage conceptions were identified in the Tackling Health Inequalities consultation document as one of the 3 sub targets and is also a Local Delivery Plan inequalities target. There are a number of reasons for the inclusion of this as a target. A recent report by the West Midlands Public Health Observatory showed the infant mortality rate in children of mothers under 20 is nearly double those in children of mothers aged 25-34 and are higher than any other age group. Furthermore, the rate of teenage pregnancies varies considerably between areas, with the highest rates occurring most frequently in deprived areas. A survey in 1999 of teenage mothers in Walsall identified risk factors for teenage pregnancy. The findings suggest that the majority of girls were from families receiving benefits, that the girls had poor school attendance records and that teenage mothers often came from families with a history of early pregnancies. More information is available in the 2003 Annual Report of the Director of Public Health.

### How Walsall Compares

**Figure 3: Conception rates in under 18's, per 1,000 women aged 15-17 for Walsall, West Midlands and England and Wales, 1998-2002 (provisional estimates)**



NB The calculations are based on 2003 mid year population estimates

Source: Office for National Statistics

Walsall has traditionally had a high teenage conception rate, but between 1998 and 2001 the rate has steadily declined, and the gap between Walsall and national/regional rates has narrowed (Figure 3). However, in 2002 provisional estimates suggest that Walsall's rate returned to the same rate as in 2000.

In 2002 the Walsall rate (63.2) was almost 9% above Walsall's target rate for 2004 (58.2).

### Focus on Walsall

**Table 1: Conception rates in under 18s per 1,000 women aged 15-17 by LEC, 1998-2000**

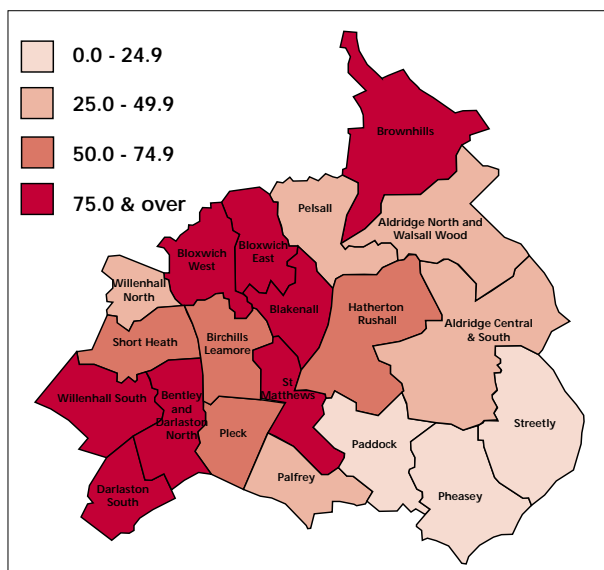
	1998	1999	2000	1998-00
North & West	81.76	85.53	77.24	81.51
South & East	46.03	38.85	40.12	41.67
Walsall	64.91	64.32	60.93	63.39

NB The calculations are based on 2001 Census population data

Source: Office for National Statistics

The rate of teenage conceptions in North and West Walsall is almost double that in the South and East of the borough. Table 1 shows that there has been an overall decrease in the teenage conceptions across Walsall, with the largest decrease occurring in the South and East of the borough.

**Map 2: Conception rates in under 18s per 1,000 women aged 15-17 in Walsall wards 1998-2000**



Source: Office for National Statistics

Map 2 shows that the highest teenage conception rates occur in the North and West of the borough, and in Brownhills and St Matthews. The highest rate is in Blakenall ward (103 per 1,000). The pattern across Walsall shows a high correlation with deprivation.

### Tackling the Issues

#### Current Activity

- The condom scheme operated by some GPs is being extended to youth settings, with youth workers and other professionals distributing condoms to agreed protocols.
- There is a comprehensive training programme provided by the Family Planning Association to all staff working with young people on sexual health issues. Some of this training will be accredited in the future.
- The emergency contraceptive scheme offered by pharmacists, developed by HAZ mainly in the West is being extended to other parts of the borough.
- Areas that are reducing their rates of teenage pregnancy have improved their access to services for young people by providing dedicated services for them, and those that are linked to schools have proved the most successful. Improved access via pharmacies and youth based settings have increased the use of contraception.
- The introduction of the family planning nurse and Genito Urinary Medicine (GUM) adviser in schools has increased uptake of services after their visits to school.

#### Future Activity

- Alternative models for access to services are being developed in non-clinical settings, such as the Electric Palace, Brownhills Community Association and the Skate Park. These will offer information, support, advice and condoms.
- Discussions are taking place to introduce a Brook Satellite clinic into an area where early conceptions are highest (the West and North).

#### The Role of Primary Care Professionals

Primary care professionals have an important role to play in reducing teenage conceptions further.

- Greater progress needs to be made to improve access to young people friendly services in primary care in areas where teenage conceptions are high and access to town centre services is difficult. This needs to include dedicated services for young people within primary care.
- Confidentiality issues need to be addressed, as there is a perception amongst some young people that GP's will tell parents of their visits, or that practice staff have a judgemental attitude towards them. Training has been offered to GP's and practice staff on the 'Confidentiality Toolkit' to raise awareness of confidentiality issues and young people in Primary Care settings.

(see also Section 6.10 Access to Sexual Health Services)



## 4.2 Smoking in Pregnancy

### National and Local Delivery Plan Target

Reduce by one percentage point per year the proportion of women continuing to smoke throughout pregnancy, focussing especially on smokers from disadvantaged groups as a contribution to the national [infant mortality] target.

### National Indicator

Prevalence of smoking among pregnant women

### Walsall Target

This means Walsall must achieve a reduction of 35 pregnant smokers (at the time of delivery) per year until 2006 from 578 in 2002, to 508 in 2004, to 439 in 2006.

### Introduction

Several Department of Health documents have highlighted the importance of smoking cessation in reducing deaths and improving the health of the population. In addition Tackling Health Inequalities and the Local Delivery Plan specifically identify the reduction of smoking in pregnancy as an inequalities target. Smoking during pregnancy is associated with many fetal and neo-natal problems, such as low birthweight, prematurity, miscarriage and Sudden Infant Deaths (SIDs). It also can cause respiratory problems and can aggravate asthma in young children. (HEA Smoking in Pregnancy).

### How Walsall Compares

Nationally a study by Brooker S, Wands S et al 2001 found 20% of women "self report" smoking in pregnancy but the actual figure is likely to be significantly higher; Owen L & McNeill A put the figure at 32%. The data from the Manor Hospital between 1998 and 2001 showed that approximately 10% of mothers smoke in pregnancy. In 2002 the data showed that 16.5% of pregnant women in Walsall reported smoking. However, the increase in smoking prevalence in 2002 shown in Table 2 is likely to be artificial due to an improvement in the recording of smoking status. The Smoking in Pregnancy Coordinator suggests anecdotally that 20% of women actually smoke in pregnancy, with 33% of pregnant teenagers smoking. In Walsall this equates to approximately 640 women smoking during pregnancy, of which 35 would be teenagers. This means that each year, on average, 10 women in each GP practice smoke during pregnancy. Smoking in pregnancy is estimated to be higher in lower social classes and younger mothers, but in the absence of accurate data it is currently not possible to compare Walsall directly to other areas.

### Focus on Walsall

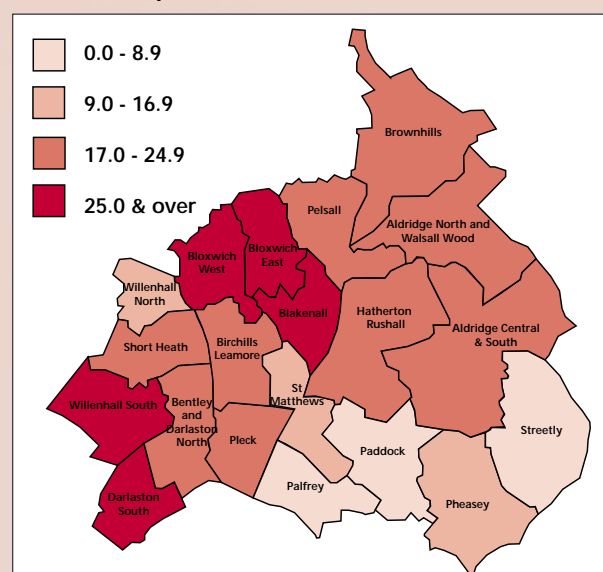
**Table 2: Smoking prevalence in pregnant women, Walsall Hospitals NHS Trust, 1998-2002**

	Prevalence %		
	Walsall	North & West	South & East
1998	10.7	14.9	9.1
1999	9.0	12.3	7.0
2000	9.5	13.6	7.0
2001	8.5	12.5	6.9
2002	16.5	25.0	14.8

Source: Walsall Hospitals NHS Trust

Table 2 shows there is a consistently higher smoking prevalence in North and West locality but the South and East figures may be underestimated due to non inclusion of women resident in this area who give birth in other hospitals (see appendix 1)

**Map 3: Smoking prevalence among pregnant women at first appointment with midwife, Walsall Hospitals NHS Trust, 2002**



Source: Walsall Hospitals NHS Trust

Map 3 shows prevalence is lower in the South and East of the borough in particular in Streetly, Paddock and Palfrey. The lower rates in Streetly and Pheasey may be partly because the data relates only to births at the Manor Hospital. Only around 30% of the births in these wards were at Manor Hospital, with the rest born in hospitals outside the borough. Nevertheless, the figures would still seem to suggest that prevalence is higher in the North and West of Walsall, in particular Blakenall (37%).

## Tackling the Issues

### Current Activity

- A Smoking in Pregnancy Co-ordinator has been appointed to take a strategic and operational lead on the provision of specific services for pregnant smokers and their partners.
- A Smoking Cessation & Tobacco Control Strategy 2003/04 outlines a comprehensive action plan for smoking reduction in Walsall.
  - A home visit service for pregnant women and their partners has been introduced.
  - Several referral routes for pregnant smokers into smoking cessation services have been established and the 'Lead' individuals in Community midwife teams are supported to ensure that referral routes are maintained.
- Theoretical and practical training based on specified HDA standards on smoking cessation treatments, on how to give advice, facts about smoking, risks to the foetus and mother, methods of stopping, (including Nicotine Replacement Therapy (NRT)), and services on offer is available for all relevant health professionals and community based professionals.

### Future Activity

- There is a need to establish links with local playgroups, nurseries, and other community based groups.
- To implement a Patient Group Direction to allow pregnant smokers to access pharmacological support.
- A primary prevention strategy is being developed (see PE and Sport in Schools).

### The Role of Primary Care Professionals

- There needs to be a more proactive and systematic approach to identifying pregnant smokers in order to increase substantially the number of patient referrals from the primary care team to the smoking cessation support services. Referrals to the Smoking in Pregnancy Co-ordinator can be made via the GP, Health Visitor, Midwife or by direct self referral by calling the Walsall Quit Smoking Service Free Helpline number 0800 169 9646.
- The evidence base for delivering smoking cessation support needs to be followed consistently across Walsall.

(see also Section 6.4 Smoking in Manual Groups)

## 4.3 Breastfeeding

### Local Delivery Plan Target

Increase the breastfeeding initiation rate by 2 percentage points a year, focussing especially on women from disadvantaged groups.

### Walsall Target

This means starting from 46% (approximately 1500 women per year) in 2002/03 and increasing to 52% (around 1720) by 2005/06, an increase of 220 women.

### Introduction

Breastfeeding is known to be associated with healthier babies and is one of the Local Delivery Plan's inequalities targets. Research has shown that factors influencing breastfeeding include social deprivation, age of the mother, education and the number of previous babies the mother had given birth to. Breastfeeding rates are also higher in some ethnic minority groups. Breastfeeding and promotion of breastfeeding is reviewed in more detail in the Director of Public Health's 2002 Annual Report.

### How Walsall Compares

The Department of Health has commissioned a series of surveys examining infant feeding patterns in the UK. These show an increase in the number of women breastfeeding at birth from 68% in 1995 to 71% in 2000. In Walsall the comparable figure was 46.5% in the year 2003 at approximately 48 hours.

**Table 3 Prevalence of breastfeeding at ages up to 9 months, 1995 and 2000**

Age of Baby	England & Wales 1995	England & Wales 2000	Walsall 2000
Birth	68	71	42
1 week	58	57	-
<b>2 weeks</b>	<b>54</b>	<b>54</b>	<b>30 (10 days)</b>
6 weeks	44	43	
4 months	28	29	
6 months	22	22	
8 months	16	17	
9 months	14	14	

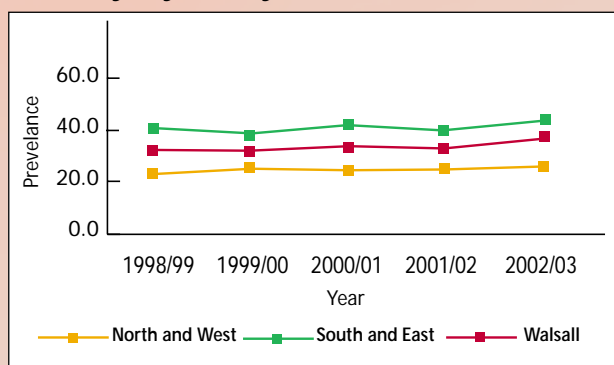
Source: Infant Feeding Survey 2000 and Walsall Manor Hospital

Table 3 shows the decline in the prevalence of breastfeeding as the baby gets older from 71% at birth to just 14% at 9 months. The table also shows that in older babies there has been little or no change in the number of women breastfeeding. At 2 weeks after the birth 54%

of mothers nationally are breastfeeding, compared with only 30% of Walsall mothers breastfeeding their babies at a similar age (10days).

### Focus on Walsall

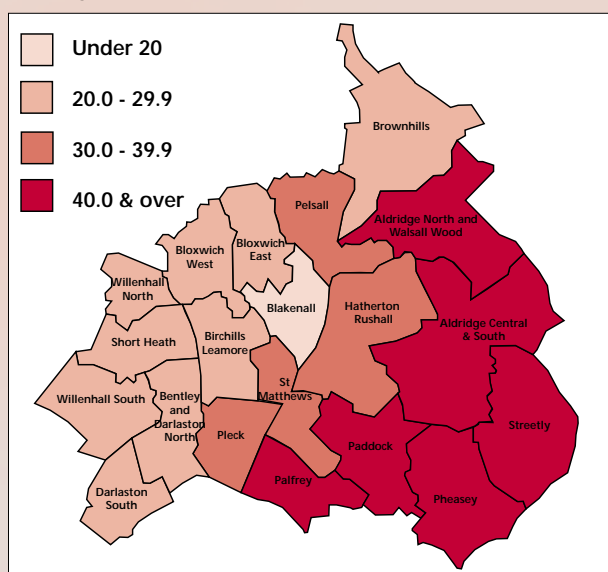
**Figure 4: Percentage of mothers breastfeeding at 10 days by locality, 1998/99 to 2002/03**



Source: Walsall Hospitals NHS Trust

Figure 4 shows that the proportion of women who breastfeed has been consistently much higher in the South and East of the borough than in the North and West (44% in SE versus 27% in NW in 2002/03). These figures may be distorted because the data is provider based. The table also demonstrates an overall slight increase in the number of women breastfeeding over the last 5 years in Walsall. The DoH has introduced a new requirement to improve data collection that will also affect future figures (appendix 1).

**Map 4: Percentage of mothers breastfeeding at 10 days, Walsall wards, 1998/99- 2002/03**



Source: Walsall Hospitals NHS Trust

Map 4 highlights that the areas with a higher proportion of mothers breastfeeding are in the East and South of the borough, in particular

Paddock (54%) and Streetly (46%). The areas with the lowest proportion of women breastfeeding are Blakenall (16%) and Bloxwich East (21%) in the North and West.

### Tackling the Issues

A borough wide breastfeeding policy is being implemented. Initiatives include:

#### Current Activity

- A Breastfeeding Co-ordinator has been recruited to act as the lead for breastfeeding issues within the hospital and the community.
- Training is in place for all health care staff in the hospital and community who come into contact with breastfeeding women in the skills to promote and support breastfeeding.
- The UNICEF UK Baby Friendly Hospital Initiative, '10 Steps to Successful Breastfeeding', is currently being implemented. The Hospital Trust was awarded the Certificate of Commitment in 2000 and is working towards full accreditation in 2004/05.
- Dedicated breastfeeding antenatal classes for women and partners to gain information to help them to initiate and continue breastfeeding are being provided.
- Mother to mother peer support programmes have been established in many areas of Walsall, including areas of social deprivation, with the aim of promoting breastfeeding and improving short and long term health of mothers and babies. Fourteen courses have taken place and 61 supporters have completed the training.
- Breastfeeding support groups have been established at 5 venues across the Borough.
- Supporters regularly participate in antenatal classes, midwife and health visitor training. Some are representatives on the Maternity Service Liaison Committee (MSLC), and some are working with Sure Start areas to develop breastfeeding support.
- South Health Action Zone has developed an arts into health project raising awareness around the benefits of breastfeeding.

#### Future activity

- All GP practices/health centres will be provided with information packs for staff to refer to when giving advice/information to the breastfeeding mother to support her.
- To identify further training needs for all those involved in breastfeeding support.
- There is a need to further develop links with Sure Start, Sure Start Plus and local schools.
- It is planned to create a multi-disciplinary steering group with appropriate time and funding.
- Policies to be introduced and publicised that support a mother's right to breastfeed in all



public places in Walsall.

- Introduce infant feeding education where appropriate into the school curriculum.
- Walsall employers need to be aware of their legal obligations to breastfeeding mothers by allowing them breaks to feed their babies or express and store their breastmilk.
- Introduce infant feeding education where appropriate into the school curriculum.
- Further develop the role and activities of the Breastfeeding Co-ordinator, both in working with the public and voluntary sector.

#### The Role of Primary Care Professionals

- Continue to refuse the promotion of breastmilk substitutes, as well as materials and sponsorship, from manufacturers in all Hospital and tPCT premises.

## 4.4 Access to Antenatal and Child Screening Services

### National Targets

*The NHS Plan:* To introduce linked antenatal and neonatal haemoglobinopathy screening programmes by 2005

*HIV screening:* Target to reach 90% antenatal HIV screening by 2002

### Local Delivery Plan Target

Improve access to services for disadvantaged groups and areas, particularly antenatal and child health screening services

### Introduction

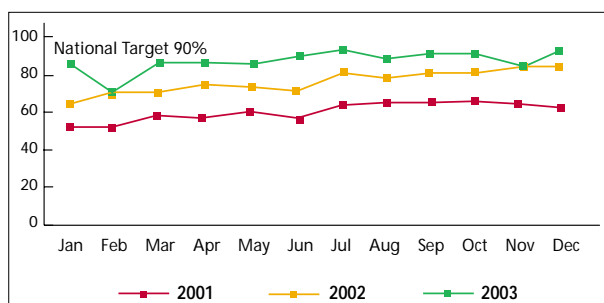
Uptake of antenatal and childhood screening varies considerably between areas. Screening is important because it aims to prevent conditions that impair child development and accentuate inequalities in later life. The National Screening Committee (NSC) has recommended that antenatal screening programmes be improved by 2010. The Antenatal Screening Board in Walsall has put together an action plan to meet these targets. More information on access to screening services is provided in the report by the Board and in the 2002 Director of Public Health's Annual Report.

### Focus on Walsall and Tackling the Issues

An **Antenatal Screening Clinic** has been organised where women can be directly referred for screening advice from the Specialist Midwife.

**Antenatal HIV screening** was introduced in Walsall in December 2000; the uptake rate at that time was 35%. The national target indicated that by December 2002 uptake should reach 90%. Walsall has not yet met the target but uptake has continued to increase and in summer 2003 reached approximately 89% (Figure 5). The future plans for this service are that all midwives will be updated in screening programmes and specialist support will be provided to all HIV positive women throughout the pregnancy.

**Figure 5: HIV antenatal screening uptake Walsall Hospitals NHS Trust, 2000-2003**



Source: Walsall Hospitals NHS Trust

### Down's screening

Guidance for health professionals on more accurate tests for Down's syndrome screening were published by the Department of Health in November 2003. The guidance benefits pregnant women by helping to ensure that they receive a high standard of antenatal screening, are well informed during pregnancy and supported to make an informed choice by health professionals. It is based on advice from UK National Screening Committee (NSC) and the National Institute for Clinical Excellence (NICE) guideline on antenatal care. Walsall meets the current standard by providing a 'triple' test to all women irrespective of age between 15-20 weeks gestation. By April 2007 pregnant women should be offered screening for Down's syndrome with a test that provides an improved detection rate and reduced false positive rate. There are several ways to achieve this and Walsall is awaiting further guidance on the best method to adopt. Women are provided with information throughout. Training is offered to health professionals involved, overseen by the antenatal screening co-ordinator based at the hospital.

**Table 4: Uptake of Down's screening amongst babies delivered at Walsall Hospitals NHS Trust, 2000-2003**

Year	Uptake
2000	61%
2001	66%
2002	76%
2003	68%

Source: Walsall Hospitals NHS Trust

### Sickle cell and thalassaemia

Universal neonatal haemoglobinopathy screening in Walsall was introduced in February 2004. The aim of neonatal sickle cell and thalassaemia screening is to reduce morbidity and mortality. Screening is done using the heel prick test that is currently taken at 6-7 days by midwives. Arrangements are in place to follow up any affected infants and any carriers and their families. Information will be provided throughout in appropriate languages and media. It is also planned to move from targeted to universal antenatal sickle cell and thalassaemia screening of all expectant mothers during 2004. Expectant parents will be given information regarding screening and those identified, as a carrier will be offered specialist support and partner testing.

To provide informed choice **Cystic Fibrosis Screening** will be introduced in Walsall in the next few years.

### General Information and Training

Midwives/ health professionals' knowledge of screening tests available to the NHS and privately needs to be improved, to ensure women are given updated evidence based information on all screening tests for informed choice. Support and training for all those involved in disseminating screening information to expectant parents will be provided. Training packages for both community and hospital based staff will be developed.

### The Role of Primary Care Professionals

- There is a need for primary care staff to provide consistent up to date information and messages.
- Staff need to encourage and facilitate early booking.
- Primary care staff need to understand the screening programmes available and to be able to advise and refer appropriately.

## 4.5 Child Poverty

### National Target

To make substantial progress towards the eradication of child poverty by reducing the number of children living in poverty by 25% by 2004 and by 50% by 2010,

### National Indicator

Proportion of children living in low-income households

### Introduction

The evidence suggests that low income and inequalities in income are associated with poor health. It has also been found that the degree of inequality in a society affects health significantly. In recognition of the importance of this the Government has introduced this target to reduce dramatically the numbers of children living in poverty.

This target will be analysed at a national level as measured in terms of relative low income, low income in an absolute sense, and persistent low income. No baseline period has been identified for the target. The Department for Work and Pensions produced a document in December 2003 outlining how child poverty would be measured in the long term.

More information on income and child health is available in the 2002 Walsall Annual Report by the Director of Public Health, *Growing Up in Walsall*.

### How Walsall Compares

It was estimated that 4 million children in Britain lived in poverty when the current Labour government came into power. The figure is now estimated to be around 3 million.

The number of children in families receiving housing and/or council tax benefit is one indicator of children living in families on low incomes. Table 5 shows that around 2.3 million children in Great Britain live in households receiving these benefits, which is around 20% of all children aged under 16. In Walsall the figure is approximately 26%.

**Table 5: Children under 16 in households receiving Housing Benefit and/or Council Tax Benefit in Great Britain and West Midlands, May 2002 and Walsall September 2001.**

Children in households receiving housing and/or council tax benefits		
	No	%
Great Britain	2,330,000	22%
West Midlands	200,000	18%
Walsall	14,097	26%

Source: Housing Benefit and Council Tax Benefit Management Information System, Annual 1% sample, taken May 2002.

### Focus on Walsall

In Walsall, the 2002 Director of Public Health's report *Growing Up in Walsall* looked at families receiving housing and/or council tax benefit as an indicator of children from families on low incomes. The data showed that around 14,000 children in Walsall lived in families in receipt of council and or housing benefit. In some areas such as Palfrey the proportion of children in low income households was 12 times greater than in other areas such as Streetly. In Palfrey, Blakenall and Pleck around 25% of all households received these benefits.



**Table 6: The DETR's child poverty ward level index from the 'indices of deprivation 2000': Walsall wards' national rankings**

Ward	Child Poverty Index Score	Rank of Child Poverty Index score
<b>North and West</b>		
Blakenall	71.05	124
Darlaston South	59.23	467
Birchills Leamore	58.11	520
Bloxwich East	52.85	786
Bentley and Darlaston North	51.14	900
Bloxwich West	47.74	1151
Willenhall South	46.71	1236
Willenhall North	29.04	3136
Short Heath	28.02	3279
<b>South and East</b>		
St. Matthew's	66.12	221
Palfrey	58.87	490
Pleck	58.32	508
Brownhills	42.74	1590
Hatherton Rushall	34.75	2410
Pelsall	25.92	3621
Aldridge North and Walsall Wood	25.51	3675
Aldridge Central and South	22.40	4218
Paddock	20.72	4525
Pheasey	17.69	5192
Streetly	5.38	8152

Source: Department of the Environment, Transport and the Regions, Indices of Deprivation 2000

The rank is the ward's position out of 8414 wards in England. The rank of the most deprived ward is 1.

Blakenall and St. Matthew's are in the poorest 5% of wards nationally for the Child Poverty Index; and a further five wards are in the poorest 10%. Three of these are in North and West (Darlaston South, Birchills Leamore and Bloxwich East) and two in South and East (Palfrey and Pleck).

This section is taken from the 2002 Director of Public Health's Annual Report. More information is also available in the report. Data will updated when the new indices are made available.

## Tackling the Issues:

### Current Activity

- Walsall tPCT is the lead agency for Sure Start in Alumwell and Pleck. Current initiatives within all Sure Start programmes include Education and Employment Task Groups to identify needs and co-ordinate actions, information, advice and support for individual parents, and training courses in response to parent's needs and requests (e.g. First Aid, basic computing, and NVQ in Child Care).
- Walsall tPCT commits Health Inequalities funding to Steps to Work who manage an Intermediate Labour Market Initiative (ILM). The ILM targets people 18-24 and those over 50 who are long term unemployed and offers them quality work experience for 6 months within the NHS economy, Local Authority services and other partner organisations. NVQ training is offered alongside this and motivational training, job readiness and job seeking support is also given.
- The Job Retention Project, managed by Walsall tPCT, aims to support people who are currently in work and are in danger of losing their jobs through ill health. Referrals are made through GPs, Mental Health Services, Rehabilitation Services and by individuals themselves.
- A number of Family Support initiatives are offered through Sure Start. Many also manage a Neighbourhood Nursery Initiative designed to provide quality Child Care at affordable prices for working parents.
- A 'Welcome to Job Centre Plus event' for all the Sure Start Programmes in Walsall will highlight new opportunities through partnership with Job Centre Plus.

### The Role of Primary Care Professionals

- Primary care staff need to be aware of the initiatives that are designed to support parents who want to return to work or who wish to gain new skills. It is important that they signpost individuals.

# Life Expectancy

## National Headline Target

Starting with Primary Care Trusts by 2010 to reduce by at least 10% the gap between the fifth of areas with the lowest life expectancy at birth and the population as a whole.

## Public Health Interpretation for a local Walsall Target

Starting at 74 years for men and 79.6 years for women in 1998/2000 and increasing life expectancy by at least 10% to 76.9 for men and 81.1 in women by 2010. An increase of 2.9 years and 1.5 years respectively.

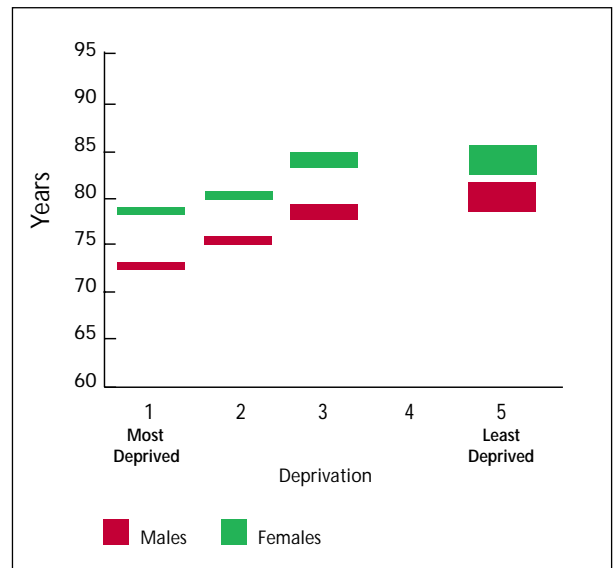
## Introduction

Life expectancy at birth is a way of expressing the all cause mortality for an area. It gives an estimate of how long someone is expected to live based on current mortality rates. Life expectancy varies considerably between the most affluent and most deprived groups and between different regions. The Government therefore introduced a target to increase life expectancy as one of their two 'headline' inequalities targets. In order to increase life expectancy and achieve the national headline target a number of key areas need to be addressed. These include reducing mortality rates from the major killer diseases, improving access to services and changing to a healthier lifestyle. These are discussed in the next section of the report. They include short term and long-term targets and indicators.

Information on the methodology used to calculate life expectancy and local targets can be found in Appendix 1.

Life expectancy varies between the most affluent and the most deprived groups in society. Figure 6 shows this variation between social classes in Walsall. The difference in life expectancy between the most affluent and most deprived groups is around 5 years. The gradient is not quite as steep in women as it is in men.

**Figure 6: Life expectancy at birth by DETR IMD 2000, Walsall, males and females, 1996-2000**



Source: Mortality data from Office for National Statistics, Annual Deaths Extract. Population data derived from census 1991, ONS population estimates for local authorities mid 1998 and Oxford University population estimates for wards mid 1998.

Life expectancy shown with 95% confidence intervals.

## How Walsall Compares

Not only does life expectancy vary by social class but there is also variation by gender. Overall, women can expect to live approximately 5 years longer than men. Life expectancy in women in Walsall was 80 years in 1996-2000, compared to 74.4 in years in Men (Figure 7 and Figure 8).

**Figure 7: Life expectancy at birth (years) males, England and Wales, West Midlands and Walsall, 1991-2001**

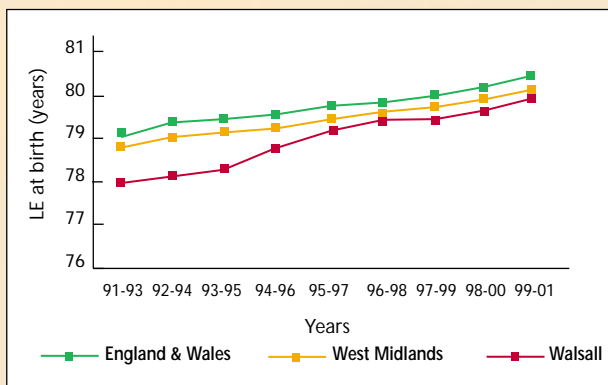


Source: ONS

Figure 7 shows that life expectancy at birth for men in Walsall is lower than the West Midlands and England and Wales. The rate had risen until 95-97, mirroring national trends. However since 1997 the trend has levelled off resulting in a growth in the gap and inequality between Walsall men and the rest of the country. In

1999/01 Walsall men had a life expectancy of 74 years compared with 75½ years in England and Wales.

**Figure 8: Life expectancy at birth (years) females, England and Wales, West Midlands and Walsall, 1991-2001**



Source: ONS

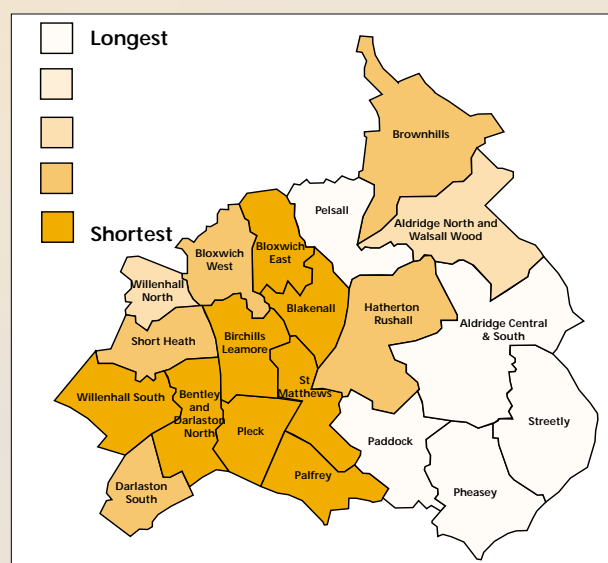
Figure 8 shows that life expectancy at birth for women in Walsall has been rising at a faster rate than the West Midlands and England and Wales, with the result that the life expectancy gap has decreased. In 1999/01 Walsall women had a life expectancy of 79.9 years compared with 80.3 years nationally.

### Focus on Walsall

Life expectancy varies with levels of deprivation and therefore mapping life expectancy across Walsall produces a similar pattern to deprivation levels across the borough.

Life expectancy in Walsall is shorter in the North and West of the Borough with people living longer in the South and East.

**Map 5: Life expectancy at Birth by ward, Walsall, Males, 1996-2000**

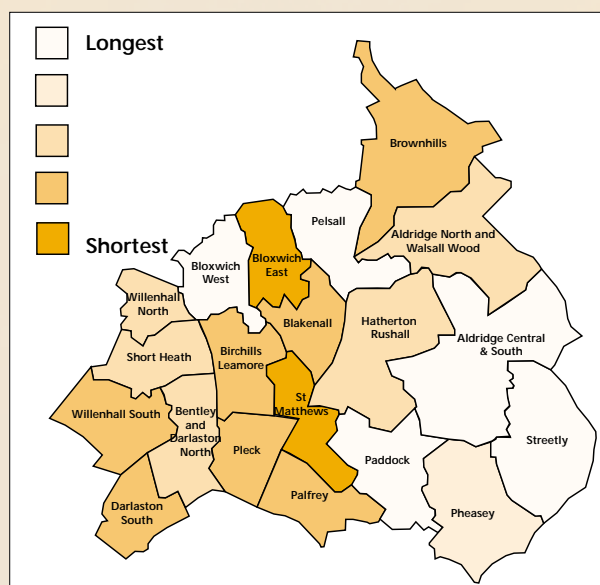


Source: West Midlands Public Health Observatory

Mapping life expectancy in men across Walsall (Map 5) shows the longest life expectancy in men is in Streetly, Pheasey and Paddock (South and East). The lowest life expectancy in men is in Bloxwich East, Blakenall and St Matthew's.

It is difficult to calculate the exact life expectancy of a ward because we are dealing with small numbers. However, the range between life expectancy in men living in wards across Walsall can be estimated to be between 71 and 81 years.

**Map 6: Life expectancy at birth by ward, Walsall, females, 1996-2000**



Source: West Midlands Public Health Observatory

Map 6 shows female life expectancy at birth across Walsall. The longest life expectancy in women is in Paddock, Streetly and Pelsall (South and East). The lowest life expectancy in women is in St Matthew's, Bloxwich East and Blakenall.

The range between life expectancy in women living in wards across Walsall can be estimated to be between 76 and 83 years.

### Tackling the Issues

Life expectancy is being addressed by tackling key influencing factors such as mortality rates from the main killer diseases, access to services and lifestyle issues. Targets and indicators that address these issues and consequently life expectancy are outlined in chapter 6.

# chapter 6

## National and Local Targets Contributing to Increasing Life Expectancy

### Underlying determinants of health and life expectancy

#### 6.1 Housing

##### National Indicator

Proportion of households living in non-decent housing

##### Walsall (Local Authority) Target

By 2006 reduce by 45% social housing not meeting the decent homes standard and bring all social housing into decent condition by 2010

#### Introduction

There is evidence to show a correlation between poor housing and ill health. The strongest reported links appear between dampness and lack of heating. However, other issues such as overcrowding have also been linked to poor health. Nationally the government has set a new standard that all homes should be in 'decent' condition by 2010. Because of the links between health and housing, achieving this target will have positive health benefits.

The local targets for decent housing are taken from the Walsall Metropolitan Borough Housing Strategy (2003), which was agreed in consultation with the council, its citizens and partners. Decent Housing is defined as meeting the current statutory minimum standard for housing, being in a reasonable state of repair, having reasonably modern facilities and services and providing a reasonable degree of thermal comfort. Property however may be classified as non-decent for more than one reason, and being non-decent does not necessarily mean the property is unfit for letting. For example, the definition may include property that may have exceeded the normal life cycle for, say, windows and the windows are in poor repair. Currently data is available from national housing surveys, but no data is available at a local level on privately owned houses. Furthermore, because the term is relatively new, no trend data is available.

#### How Walsall Compares

The English House Condition Survey 2001 showed that 43% of Local Authority (LA) or former LA housing is classified as non-decent compared to 29% of owner occupied. This showed an improvement since the previous survey carried out in 1996 from 55% and 42% respectively.

A report compiled by Walsall Housing Group highlighted that, in council and housing group owned property at 1st April 2002, 21,452 of the 26,000 stock was non-decent or would become non-decent by 2010. This equates to approximately 83% of the council's stock. This is comparable with Birmingham Council, for example, who indicated that eight out of ten of their properties were non-decent.

#### Tackling the Issues

##### Current Activity

- The entire council housing stock was transferred to Housing Associations in March 2003.
- Walsall's Housing Association partners have developed business plans to deliver the decent homes standard by 2010.

##### Future Activity

- Walsall Housing Group has planned investment of £200m over the first five years and WATMOS Housing Co-operative has planned investment of £10m to achieving the decent homes standard by 2008.
- A full private sector strategy will be produced by April 2004.
- A programme of neighbourhood renewal assessment for housing priority renewal areas will be developed and the assessments for Birchills and Alumwell will be completed.
- The private landlords accreditation scheme will be completed and implemented.
- Data from stock condition surveys will be used to develop a new private sector renewal strategy.
- A number of additional initiatives will also be progressed to ensure the decent homes standard is met.

#### The Role of Primary Care Professionals

- To understand and be aware of the current housing strategy.
- Provide feedback/information relating to the health and social care issues around to improving housing in each LEC.
- Identify a key person/group in each LEC to feed into the Health and Social Care Partnership Board – a theme of the Walsall Borough Strategic Partnership.



## 6.2 Homelessness

### National Indicator

Number of homeless families with children living in temporary accommodation

### Introduction

The term 'homeless' usually creates images of people sleeping in cardboard boxes on the streets. However, the vast majority of homeless people are actually families or single people living with relatives and friends, or in temporary accommodation. Research has shown a clear link between homelessness and poor physical health. Overall, homeless people have lower life expectancy and experience higher rates of chest problems, tuberculosis, skin, muscle and joint complaints, digestive problems, and alcohol and drug related problems.

Information is available on the number of households who apply to local authorities for homelessness assistance ('statutory homelessness'), and for the number of people who sleep out in the open ('rough sleepers'). However, there is relatively little data about the number of other people living in temporary or not decent accommodation, or those who experience homelessness but manage to find housing without the help of local authorities.

### How Walsall Compares

In 2000/1 local authorities in England received 252,780 homelessness applications from eligible households:

- Just under half of these (114,350) were found to be unintentionally homeless and in priority need.
- Less than 4% (8,930) were found to be intentionally homeless and in priority need.
- 21% (52,370) were homeless but not in priority need.
- 31% (77,130) were found not to be homeless.

Statutory homelessness statistics have increased in recent years, although they remain below the peak of the early 1990s. The number of eligible applications has increased by nearly 4% between 1997/8 and 2000/1. The number of households found to be unintentionally homeless and in priority need increased by 11% over the same period. This increase has resulted in a rise in the number of households living in temporary accommodation. At the end of September 2001, 77,940 households in England were living in temporary accommodation, including over 12,000 in bed and breakfast hotels. Families account for more than half of these.

Source: ODPM

The number of homeless people is greater in London and the south but across the West Midlands 21,490 households were found to be homeless, an estimated 51,500 individuals. Of those 1,830 homeless households were accommodated in temporary accommodation in July 2002. In 2002/03 in Walsall there were 111 residents registered with the Local Authority as living in temporary homes.

### Tackling the Issues

#### Current Activity

- Priorities for action have been agreed and set out in the Walsall MBC's homelessness review and strategy.

#### Future Activity

- Develop direct access provision, particularly for those over 25 years.
- Increase the effectiveness of prevention measures through improved tenancy relations, housing advice and assistance work.
- Provide improved housing advice services.
- Plans have been agreed to review current provision and related support services.
- Further development of partnerships, re-settlement work, training and employment.

#### The Role of Primary Care Professionals (As for section 6.1 Housing)

## 6.3 Education

### National Indicator

Proportion of those aged 16 with qualifications equivalent to 5 GCSEs at grades A\* to C

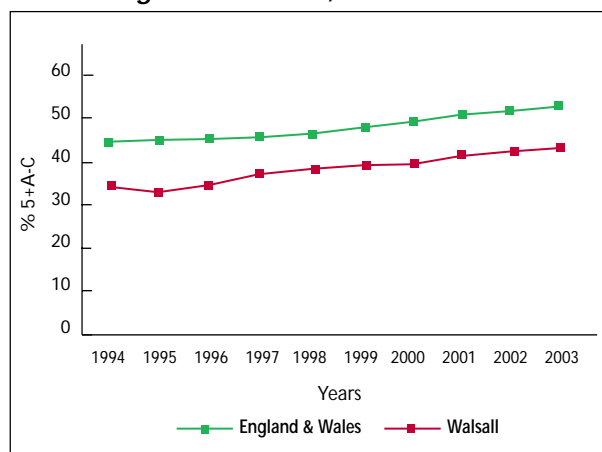
### Introduction

The World Health Organization defines health, as “a state of complete physical, mental and social well-being and not merely the absence of a disease or infirmity”. This demonstrates that people’s health is affected by a wide range of determinants. For example low educational attainment has a detrimental impact on the individual’s health. It is also important to be aware of the level of education in the population in order to target health promotion messages appropriately.

The proportion of pupils receiving 5 or more GCSEs at grade A-C is a national education indicator routinely collected and monitored by the Department for Education and Skills. The annual results are posted on the website ([www.dfes.gov.uk](http://www.dfes.gov.uk)). The information provided for Walsall is based on the overall performance of schools located in Walsall, not the district of residence of the pupils. Therefore, some pupils who attend Walsall schools will not live in Walsall and vice-versa. Data is not available for Walsall resident pupils only.

### How Walsall Compares

**Figure 9: Percentage of pupils achieving 5 or more A-C grades at GCSE, 1994-2003**



Source: DFES

Figure 9 shows that the proportion of children gaining 5 or more A-C grade GCSEs in Walsall is lower than nationally. The national and local rates are increasing, but the rate in Walsall appears to be increasing faster than the national rate. This has led to a narrowing of the gap between England and Walsall. Nevertheless in 2003 only 43% of pupils in

Walsall gained 5 or more A-C grade GCSEs compared to 53% nationally.

### Focus on Walsall

Across Walsall schools there was significant variation in pupils GCSE achievements in 2003. This ranges from 20% of pupils in some schools achieving 5 or more grades A-C compared to 98% in others. The North and West locality contains 7 secondary schools where the range is from 25% to 54% compared to 16 secondary schools in the South and East where the range is between 20% to nearly 98%.

### Tackling the Issues

#### Current Activity

- Work is being undertaken with Walsall Schools on the Healthy Schools Scheme, in order to help raise pupil attainment, to help reduce health inequalities and to promote social inclusion. 64 schools are currently engaged.
- Help and advice is being provided around the following Education and Health Themes:- local priorities, school priorities, PSHE, citizenship, drug education (including tobacco and alcohol), emotional health and well-being (including bullying), healthy eating, physical activity, safety and Sex and Relationship Education.

#### Future Activity

- To recruit schools who have 20% and more pupils receiving free school meals into the healthy schools scheme.

#### The Role of Primary Care Professionals

- To be aware of the wider determinants of health and these programmes.

## LIFESTYLE

### 6.4 Smoking Prevalence in Manual Groups

#### National Target

To reduce smoking rates among manual groups from 32% in 1998 to 26% by 2010

#### Walsall Target

During the period 2003 to 2006, to achieve a cumulative number of 4521 Walsall people quitting smoking (measured at four week follow up). This equates to 1056 quitters in 2003/04, 1651 quitters in 2004/05 and 1814 quitters in 2005/06.

#### National Indicator

Prevalence of smoking among people in manual social groups

#### Introduction

The Government has long recognised the consequences of smoking to peoples' health. The evidence shows a strong association between smoking and diseases such as CHD and lung cancer, and the Department of Health has issued several documents highlighting the importance of smoking cessation. The Tackling Health Inequalities report, The Local Delivery Plan (LDP) and The Commission for Health Improvement (CHI) identify the reduction of smoking as an inequalities target.

Currently smoking rates among manual groups are only measured at a national level due to data problems, in particular the recording of social class. This lack of local data relating to the national target around reducing smoking in manual classes means that in order to meet this target in Walsall we need to target the whole of the population who smoke, focusing in particular, on those areas where prevalence is highest. Information on the prevalence of smoking is taken from lifestyle surveys. In this report we use the data from the West Midlands Lifestyle Surveys of 1995 and 2001. In the future it is planned to collect data on smoking prevalence from practice records which may be more accurate than from sample surveys, although currently this data is not complete. The Smoking Cessation Service provides the data on the number of quitters, although in the past there have been problems with incomplete and inaccurate smoking cessation monitoring forms being returned. However, this issue has recently been addressed.

#### How Walsall Compares

The West Midlands Lifestyle Survey in 2001 estimated that 20% of people smoked in Walsall, the same as in the West Midlands Region. However, smoking prevalence in

Walsall has fallen between 1995 and 2001 from 28% to 22% in men and from 23% to 19% in women. Table 7 shows that Walsall had a marginally lower quit rate than England and Wales in 2002/03.

**Table 7: Smokers accessing services who had quit at 4-weeks follow up, 2002/03**

	England	Walsall
Number of people setting quit date	234,900	1,207
Number of people quit at 4 week follow up	124,100	620
% quit at 4 weeks	53%	51%

Source: Walsall Smoking Cessation Service

#### Focus on Walsall

Early indications for the current year 2003/04 show an encouraging increase in the number of quitters.

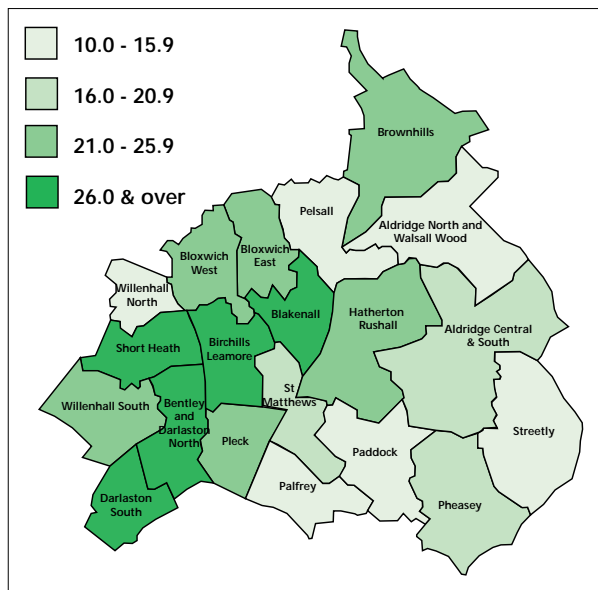
**Table 8: Practices in Walsall who have a written smoking cessation protocol**

	Yes	No	Total
Walsall			
No.	36	15	51
%	71	29	100
North and West			
No.	15	9	24
%	63	37	100
South and East			
No.	21	6	27
%	78	22	100

Source: Baseline Cancer Survey, Walsall tPCT, Public Health Department

Table 8 shows the results of a recent survey of GP practices in Walsall. Overall 71% of practices in Walsall who responded to the survey had a written smoking cessation protocol, indicating a systematic approach to smoking cessation within the practice. The proportion of practices with a protocol was higher in the South and East of the borough.

**Map 7: Prevalence of smoking in Walsall in 2001 (persons, % by ward)**



Source: West Midland Lifestyle Survey

The highest rates of smoking are in the North and West of the borough. 26% of people reported that they smoked in the North and West compared to 16% in South and East.

Map 7 shows that Blakenall (36%) and Birchills (32%) have the highest prevalence, with Streetly (10%) and Paddock (11%) having the lowest.

### Tackling the Issues

#### Current Activity

- A new payment scheme to intermediate advisers was introduced in October 2003. This incentivises practices to return correctly completed monitoring forms to the tPCT.
- Awareness is being increased to GPs via MALT, of the importance of their support to increase referral numbers to Walsall Quit Smoking Service. If GPs advised an extra 50% of smokers at their practice it would lead to 18 more ex smokers a year.
- Work is underway to build improved relations with the primary care advisors.
- Programmes are in place to reach into work workplaces to access hard to reach groups. This includes advising small and medium enterprises (SMEs) on smoking policies and undertaking smoking cessation programmes in SMEs.

#### Future Activity

- There is a plan to expand the number of intermediate advisors.
- It is intended to use MALT to provide more training to encourage brief interventions in primary care.
- Work is planned to raise the profile of the Walsall Quit Smoking Service.

- A primary prevention strategy is being developed (see PE and Sport in Schools).

### The Role of Primary Care Professionals

- There is a need for a more proactive and systematic approach to identifying smokers, in order to increase substantially the number of patient referrals from the primary care team to access smoking cessation support. Referrals can be made via health professionals, medical professionals and self referral cards to Walsall Quit Smoking Services as well as referral into the practice based intermediate advisor. Alternatively referrals can be made by distributing the Walsall Quit Smoking Service card with the free phone number on it. 0800 169 9646.
- The evidence base from National Institute of Clinical Excellence (NICE) and Walsall tPCT protocols for delivering smoking cessation support needs to be followed. These are available on request from the Smoking Cessation Co-ordinator based at Jubilee House.
- Ensure rigorous recoding of smoking status and monitoring on smoking activity. This includes returning complete and accurate smoking cessation monitoring forms.

(see also Section 4.2 Smoking in Pregnancy and Section 6.7 PE and Sport in Schools)



## 6.5 Diet 5-A-Day

### National Indicator

Proportion of people consuming five or more portions of fruit and vegetables per day in the lowest quintile of household income distribution

### Introduction

After smoking, what people eat is the biggest lifestyle contributor to cancer and CHD deaths. A high fat diet, especially where it leads to obesity, is associated with increased risk of several cancers including breast cancer, prostate cancer and colorectal cancer. Poor diet is also an important cause of heart disease and stroke. A high fat diet raises blood cholesterol levels and high salt intake increases blood pressure, both of which increase the risk of heart disease or stroke. Current recommendations are that everyone should eat at least 5 portions of a variety fruit and vegetables each day, to reduce the risks of cancer and coronary heart disease and many other chronic diseases. Yet average fruit and vegetable consumption among the population in England is less than 3 portions a day. Consumption tends to be lower among children and people on low incomes. The main barriers to eating more fruit and vegetables are access, availability, attitudes and awareness.

There is no borough-wide target for increasing 5-a-day consumption but it is one of the Government's national inequalities indicators. Lifestyle surveys are used to monitor this indicator. We cannot however, look at the proportion of people eating five-a-day by income at a local level, because the numbers are very small. Instead local consumption of five-a-day is studied across the whole population. Areas with low consumption rates are then targeted.

### How Walsall Compares

Table 9 shows that fewer people in Walsall than nationally or regionally eat 5-a-day. Over 80% of men and 70% of women in Walsall eat less than the recommended five portions of fruit or vegetables per day.

**Table 9: Adult population eating 5-a-day, 2001**

	% Eating 5-a-day or more	Average portions per day
England & Wales	26	3.6
West Midlands	27	3.4
Walsall	24	3.2

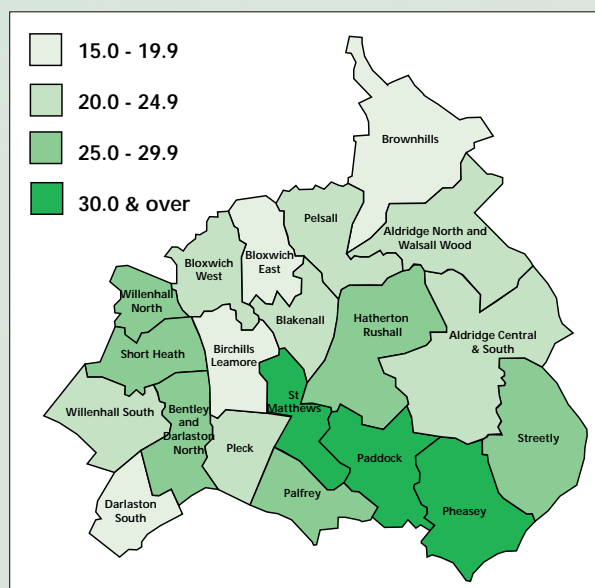
Source: England and Wales (Health Survey for England 2001) West Midlands and Walsall (West Midlands Lifestyle Survey 2001)

### Focus on Walsall

Fewer people eat the recommended 5 portions per day in the North and West (22%) than in the South and East (25%). Moreover, the gender difference in five-a-day consumption is more marked in North and West locality, where only 16% of men eat five-a-day compared to 28% of women.

Map 8 shows five-a-day consumption rates across Walsall. The wards with the lowest consumption are Birchills Leamore (15%) and Darlaston South (17%) and the highest rates are in Paddock (32%) and Pheasey (31%). However, even when the 'best' results are taken into account, it can be seen that the vast majority of residents in every ward are not eating the recommended amount of fruit and vegetables. More information is available in the Lifestyle Survey Reports.

**Map 8: Percentage of persons consuming 5 or more portions of fruit and vegetables a day, 2001**



Source: West Midlands Lifestyle Survey

### Tackling the Issues

#### Current Activity

- The government has launched 5-a-day programmes to increase fruit and vegetable consumption. These programmes aim to raise the awareness of, and improve access to fruit and vegetables. The programme also includes a national fruit scheme, which in Walsall has a 100% uptake.
- A 5-a-day Co-ordinator has been appointed in Walsall with NOF funding for 2 years. This programme is focused on the East and West of the borough, targeting deprived areas in particular. The Co-ordinator is delivering training to practice, district and school nurses,

practice staff and health visitors. The training focuses on the main 5-a-day messages from government.

- Pilot workplace initiatives have started to be developed with Health Check Days being delivered at various workplaces. The days raise awareness of the 5-a-day and healthy eating message in relation to disease prevention. Access to fruit and vegetables in the workplace is being targeted through work with caterers.
- A food co-op currently provides door to door or workplace delivery of fruit and vegetables and other household produce to about 50 households and businesses.
- Sow and Grow programmes are being delivered by Groundwork Black Country in the East, West and North of the borough. The Sow and Grow initiative links the curriculum with practical experience of growing, harvesting and eating produce.
- Health events are being held in Primary Care and business workplace settings that include practical demonstrations of portion sizes, preparation tips and availability of fruit and veg.

#### Future Activity

- To develop a co-ordinated and coherent mainstream funded "borough wide" programme of preventative services (including 5-a-day), rather than relying on short-term, externally funded projects that focus on small geographical areas of Walsall.
- Attempt to increase the capacity (staffing) of preventative services within Walsall via (5-a-day, healthy eating, physical activity, weight management and smoking cessation).
- To develop a Primary Prevention Strategy that includes 5-a-day initiatives.
- To develop further the Pilot workplace health checks and provide the necessary "lifestyle" support services to these workplace initiatives.
- Continue the delivery of cook and eat and fruit tasting sessions with community groups and in schools.
- Health Centre promotion events are planned in the East and West of Walsall.

#### The Role of Primary Care Professionals

- To highlight 5-a-day as an important existing preventative service (capacity dependant).

(see also Sections 6.6 and 6.7 Obesity and PE and Sport in Schools)

## 6.6 Prevalence of Obesity

### Local Delivery Plan Target

Reduce the prevalence of obesity

### Walsall Target

To reduce obesity by 25% in men and 33% in women by 2006. This means a reduction of obesity in men from 18% in 2001 to 14% in 2006 and in women from 15% in 2001 to 10% in 2006.

### Introduction

Obesity increases the risk of coronary heart disease, cancer, diabetes, high blood pressure and osteoarthritis. Obesity has been estimated to reduce life expectancy by up to 7 years as a result of the increased risk of these conditions. In his 2002 Annual Report the Chief Medical Officer (CMO), highlighted that the growth in the number of people in the population who are overweight and obese is of increasing concern in most developed countries of the World. So much so that it has been termed a 'global epidemic'. In recognition of high obesity levels in Walsall, a local delivery plan target was introduced aiming to reduce the prevalence of obesity.

Overweight and obesity are most commonly measured through the Body Mass Index (BMI) - calculated by dividing a person's weight in kilograms by their height in metres squared ( $\text{kg/m}^2$ ). An adult is considered to be 'overweight' if their BMI is between 25 and 30, and obese if over 30. Currently this data is collected through lifestyle surveys.

### How Walsall Compares

In his report the CMO estimated that around 21% of adult men and 24% of adult women are now obese. A further 47% of men and 33% of women are overweight. Therefore, nationally two-thirds of all men, and half of all women are now overweight or obese. This is almost 24 million adults in the UK. The 1998 *Health Survey for England* looked at the measurement of obesity by social class. This showed that the prevalence of obesity in both men and women decreases as income increases. Obesity is also higher in manual than in non-manual social classes. In particular, there is a strong social class gradient in the prevalence of obesity in women: the prevalence was only 14 per cent in the highest social class, whereas in the lowest, 28 per cent of women were obese.

A lifestyle survey conducted in the West Midlands in 2001 estimated that 44% of adults in Walsall are of a desirable weight but 31%

are over-weight and 16% obese (18% of men and 15% of women). These estimates are based on self-reported height and weight. The rate was higher than the West Midlands but had fallen since 1995 as shown in table 10. There are some concerns around the accuracy of this data because it does not follow national and regional trends, which are showing an increase in obesity prevalence.

**Table 10: Prevalence of obesity in men and women aged 16-64 years (%), 1995 and 2001**

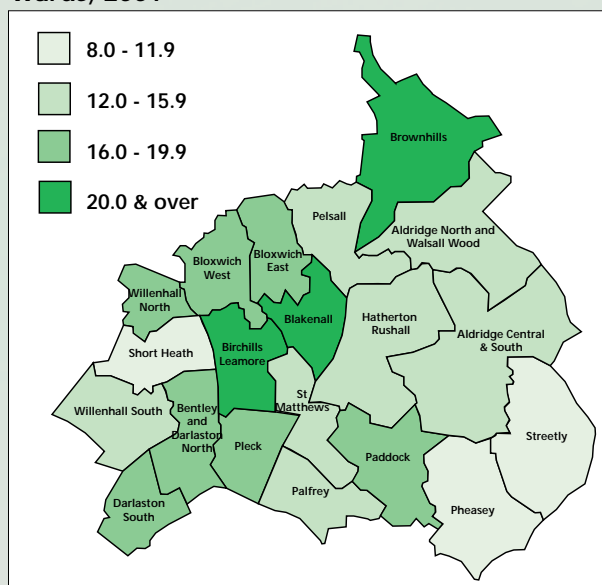
	1995		2001	
	Walsall	West Mids	Walsall	West Mids
Men	21	18	18	13
Women	19	15	15	15

Source: West Midlands Lifestyle Survey

### Focus on Walsall

Map 9 shows the prevalence of obesity by ward in Walsall during 2001. The Survey data indicates that the highest obesity prevalence rates in Walsall (persons) are in Birchills Leamore and Brownhills (each 21%), followed by Blakenall (20%) and Bentley and Darlaston North and Darlaston South (19%). The lowest overall obesity prevalence rates in Walsall are in Short Heath (9%), followed by Streetly (10%) and Pheasey (11%).

**Map 9: Prevalence of obesity, persons, % by wards, 2001**



Source: West Midland Lifestyle Survey

### Tackling the Issues

The National Institute for Clinical Excellence (NICE) is currently preparing evidence based guidelines on the prevention, identification and management of over-weight and obesity.

This is expected to be published during 2006. Initiatives are being introduced in Walsall, which are believed to reflect current best practice. In addition the Health Development Agency evidence base was published late in 2003, which will be used to help shape services.

### Current Activity

- 'Time to Change' is a lifestyle programme based on readiness to change. It aims to; promote healthier eating (reducing the number of people who are overweight and obese), increase physical activity and increase the numbers who quit smoking. All three areas of the programme can be accessed by self or health professional referral. The programme has been piloted and successfully evaluated. Of those attending community run Weight Management Groups, 70% lose weight, 95% increase fruit and veg consumption, 75% increase their consumption of oily fish and 95% reduce their waist measurement and many also increase their physical activity levels. Currently the 'Time to Change' approach is widely used in Walsall, but the diet element is concentrated in 20 GP surgeries.
- People wanting to eat more healthily or reduce their weight are seen individually by Community Dietitians for assessment. These assessment clinics are held in a variety of community venues throughout the borough.
- The initial consultation leads to a variety of recommendations including Weight Management Groups run by Community Dietitians, weight management in the private sector, Cook and Eat groups, supermarket store tours and one to one follow-up.
- Cook and Eat groups, have been shown to increase fruit and veg consumption in 60% of those attending in addition to improving cooking skills and confidence to cook healthy family meals. Cook and Eat was developed initially as a HAZ project.
- Food Access Workers and Physical Activity Specialists in the New Deal area have set up a number of initiatives around their Healthy Hearts Project. One of these is a young persons overweight clinic, which began in January 2004 at the Sneyd School. This is also available to overweight children across the borough.
- The current obesity service is being reviewed to develop single entry pathways.

### Future Activity

- Develop a Primary Prevention Strategy that includes existing and new obesity prevention initiatives.
- Opportunities for physical activity will continue to be developed across Walsall.

- Attempt to increase the capacity (staffing/resources) of services that include obesity prevention initiatives.
- The service needs to be developed to support the African Caribbean and Asian communities.
- Work in the area of healthier eating and young people, needs to be developed.
- There is a need to develop a co-ordinated and coherent mainstream funded 'borough-wide' programme of preventative services (including obesity), rather than relying on short-term, externally funded projects that focus on small areas of Walsall.

#### The Role of Primary Care Professionals

- Primary Care professionals need to be more pro-active in highlighting the benefits of increasing physical activity levels and eating a healthier diet and to be aware of, and refer and recommend, individuals to the borough wide 'Time to Change' lifestyle programme (capacity dependant).

(see also Sections 6.5 and 6.7, 5-A-Day and PE and Sport in Schools)

## 6.7 PE and Sports in Schools

### National Indicator

Percentage of schoolchildren who spend a minimum of two hours each week on high quality PE and school sport within and beyond the curriculum

### Introduction

Compelling evidence has shown that regular physical activity in adolescence plays an important role in the promotion of current health and the prevention of chronic disease in later life. The Government has recognised this and included it as an indicator in its Tackling Health Inequalities report. Supplementing this, the expert recommendation of the former Health Education Authority (supported by the DoH) is that young people should participate in at least 1 hour per day of moderate physical activity (5 hours per week).

Data on school sport and physical education is being collected through the School Sport Partnerships at Willenhall, Shelfield and Streetly. All Schools in the borough have submitted an audit which has assisted in the development of a School Sport and PE Strategy, in addition to forming the basis of Partnership Development Plans within the School Sport Co-ordinator framework. A more comprehensive picture will be available following the Annual National Data Collection process, which will be routinely collected in January and will form part of a national data base. This will then provide a baseline and comparable data will be available in the future.

### Focus on Walsall

Table 11 and Table 12 show some indications of levels of exercise among school pupils in Walsall in comparison with wider data from other schools in other parts of the UK. For boys there appears to be a consistent lower participant rate in Walsall for most activities in the sample, except Basketball and Pool. For girls the levels are generally closer to the wider sample. The tables also show that girls participation in sporting or physical activities is much lower than boys



**Table 11: The physical or sporting activities most often recorded as being taken part in regularly (weekly or more) for primary school pupils – year 5 and 6**

Boys	Walsall	Wider Data
1 Football	61%	67%
2 Running	47%	49%
3 Riding your bike	43%	48%
Girls	Walsall	Wider Data
1 Swimming	45%	45%
2 Running	41%	44%
3 Riding your bike	37%	39%

**Table 12: The physical or sporting activities most often recorded as being taken part in regularly (weekly or more) for secondary school pupils – year 8 and 10**

Boys (Year 8)	Walsall	Wider Data
1 Football	46%	55%
2 Riding a bike	42%	47%
3 Basketball	25%	23%
Boys (Year 10)	Walsall	Wider Data
1 Football	51%	57%
2 Riding a bike	41%	46%
3 Pool	30%	28%
Girls (Year 8)	Walsall	Wider Data
1 Swimming	26%	32%
2 Dancing	23%	29%
3 Riding a bike	21%	33%
Girls (Year 10)	Walsall	Wider Data
1 Dancing	24%	24%
2 Swimming	21%	21%
3 Riding a bike	17%	22%

Source: Young People and their Health Survey 2001

## Tackling the Issues

### Current Activity

- A local authority Sports and Active Recreation Strategy is now in place. This acts as an overview document to drive the strategic development of participation within the borough.
- All Walsall schools are now linked through the PE and School Sport network, which is led by 3 specialist sport colleges in Walsall. These coordinate school sport opportunities through School Sport Coordinators linked to local schools. Supporting this network is a series of sport specific development officers, with a specific remit to develop school and club links.
- Allied to this is the implementation of the New Opportunity Fund 3 (NOF3) funding to

develop facilities for PE, active play and recreation onto school sites across the borough.

- Fun for Life, Walsall's overweight and obesity clinic for young people, operates in partnership with Leeds Metropolitan University to support young people and their parents via a holistic programme of food education and physical activity. Initially the programme will run for one year (to January 2005).
- Lunchtime supervisor training is available to active play and games at school lunch breaks.
- Safe Routes to Schools schemes continue to be rolled out across Walsall to encourage children to walk or cycle to school.

### Future Activity

- Continue the development of physical activity, sport and recreation opportunities across the borough.
- The emerging PE and School Sport Strategy, which has direct links into the Sport and Active Recreation Strategy, will drive further developments towards the targets of schoolchildren participating for 2 hours per week within and beyond the curriculum. There is an identified need through the Sports Colleges and School Sports Partnerships to address lifestyles as well as pure sport. A Partnership Development Manager is a member of the multi-agency Walsall on the Move group, and within this the creation of a Sport and Health subgroup will assist with future developments. Allied to this will be the Strategic Integration of Sport and Leisure operators into one operational area within the MBC (e.g. Leisure Centres, PE and School Sport).
- A primary prevention strategy has been commissioned across the areas of Physical Activity, Obesity, Diet and Smoking Cessation, which will identify appropriate roles and responsibilities of all parties to provide an integrated physical activity and lifestyle programme across Walsall. One key outcome of this will be to identify a lifelong health development framework for Sport and Physical Activity.
- It is planned to involve young children (foundation and pre-school) through the linking of Sports Colleges, secondary, primary and infant schools, the Healthy Schools Programme and Sure Start.

### The Role of Primary Care Professionals

- There is a need for primary care professionals to promote active lifestyles among children and young people, to ensure that they undertake a suitable amount of physical activity in order to develop appropriate body growth, prevent abnormal weight gain, and

prevent social isolation and bullying resulting from low self-esteem. This includes:

- Advising the parents of newborn and pre-school children on active play to ensure normal body growth through activities such as running, jumping, cycling /push along buggy's, as well as developing fine motor skills (finger/arm co-ordination) through puzzles, shapes and games to prevent the individual being classed as a 'clumsy child'.
- Identifying children of school age who may be showing signs of not doing enough physical activity (e.g. abnormal weight gain, poor body development) and advising the individual and parents to try and find an activity that meets their needs. Specialist services are available for primary care professionals to refer people into (e.g. Fun for Life) as well as provision of locally accessible mainstream sport and active recreation services.
- Primary care professionals also need to be proactive in highlighting the benefits to adult patients of taking more exercise and, where appropriate, refer individuals to the borough wide Active Communities Programmes.

## ACCESS TO SERVICES

### 6.8 Access to Coronary Interventions (Revascularisation)

#### Local Delivery Plan Target

To improve equity of access to Coronary Interventions

#### Introduction

Walsall has a higher rate of hospital admissions and mortality from CHD than nationally or regionally, whilst revascularisation rates are lower. Furthermore, work has shown that revascularisation varies by geography, age, gender and ethnicity and that these variations in service provision do not always correlate with need. Therefore, improving equity of access to coronary interventions has been included as a Local Delivery Plan target. Standards 9 and 10 of the CHD NSF also focus on revascularisation.

#### How Walsall Compares

Table 13 shows that Walsall has a higher rate of emergency admissions and deaths for CHD but a lower CABG/PCTA rate than the West Midlands region. The rate of admissions in Walsall is the 6th worst in the region and the rate of deaths in Walsall is the 3rd worst in the region. However, the rate of revascularisation in Walsall is the 7th lowest in the region. This highlights a clear inequality between need (admissions and deaths) and provision (CABG/PCTA) of services in Walsall.

**Table 13: Age/sex standardised rates per 10,000 population of emergency CHD-related admission, mortality and revascularisation, by PCT boundary 1999 / 2000, all ages**

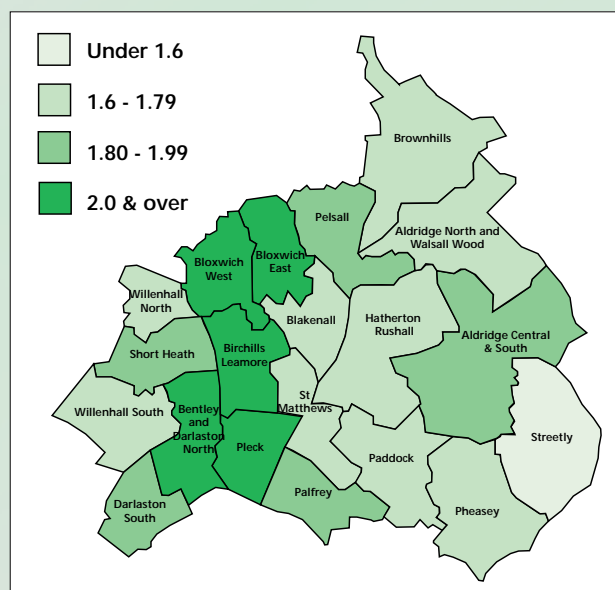
PCT	Admissions	Deaths	CABG / PTCA
Walsall	83.9	26	6.5
West Mids	71.6	21.7	8.7

Source: Key Health Data 2001 HES, ONS

#### Focus on Walsall

Map 10 shows higher AMI admission rates in the north of the borough, in particular in the Bloxwich East (with a rate of over 2.6 per 1,000 population). Birchills Leamore, Pleck and Bloxwich West also have high crude rates of AMI. The area with the lowest rate is Streetly (1.1 per 1,000 population). Willenhall North, Paddock and Aldridge North and Walsall Wood also have low rates. Map 11 shows the combined crude rate of CABGs and PCTAs across Walsall. The map shows that the highest rates of admissions for revascularisation are in Pheasey (1.4 per 1,000 population), Pelsall (1.1) and Bloxwich West (1.0).

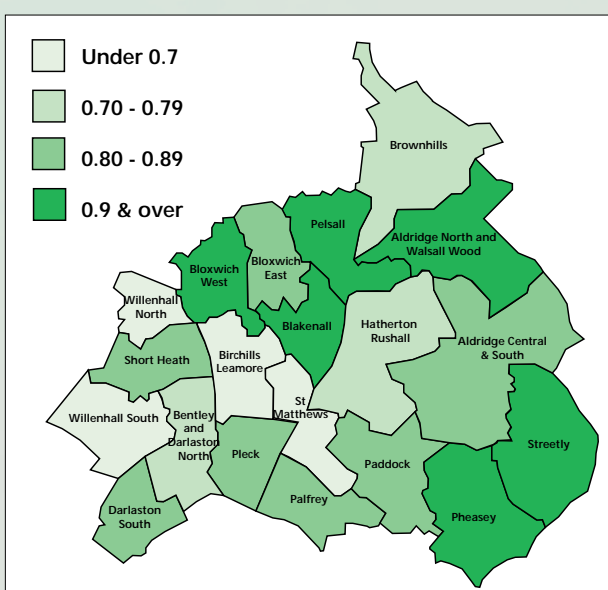
**Map 10: Crude AMI admission rate per 1,000 population aged 16 and over, 1997-2001**



Source: Walsall tPCT, Public Health Department

Maps 10 and 11 show that there is some positive correlation between areas of high AMI rates and high revascularisation e.g. Pelsall and Bloxwich East. Conversely there are areas of low AMI admissions and low revascularisation rates, e.g. St Matthew's and Willenhall North. However, there are also some areas where there is an inverse correlation, such as Pheasey and Streety where AMI admission rates are low and revascularisation rates are relatively high.

**Map 11: Crude CABG and PCTA admission rate per 1,000 population aged 16 and over, 1997-2001**



Source: Walsall tPCT, Public Health Department

Similarly in Birchills Leamore, Bentley and Darlaston North, and Pleck AMI rates are high but rates of revascularisation are low. This suggests that there may be a mismatch between need for services (AMI) and provision of services (revascularisation).

While AMI and angina increase with age (peaking in people aged 80-85, and 75-79 respectively), revascularisation rates appear to decline, rather than increase in older ages, highlighting an inequality in the provision of services. Research also shows variations with ethnic group.

There are several possible explanations for the variation in need and treatment shown in and Map 11. These include clinical features at presentation and access and availability of services.

### Tackling the Issues

#### Current Activity

- The importance of this issue has been agreed and accepted by all the key stakeholders and highlighted by the CHD Local Implementation Team (LIT) as part of their ongoing priorities.
- A comprehensive report is being prepared by Public Health covering a detailed analysis using an accepted research methodology and will be completed in 2004. The overall aim is to ensure appropriate interventions in line with need.
- A research project exploring issues around access to CHD service amongst women of South East Asian origin is in progress.
- The angiography capacity is being developed through completion of a new catheter laboratory at the Manor Hospital
- Progress is being made to improve Walsall resident access rates to angioplasty and CABG procedures undertaken at tertiary centres

#### Future Activity

- It is planned to develop the permanent angiography facility at the Manor Hospital, tackling the backlog of cases awaiting cardiac catheterisation and ensuring future compliance with the three month target for routine access.
- Meeting the local population's need for access to revascularisation procedures, taking into account the national "Choice" initiative (which raises issues for local follow-up and rehabilitation) and the development of the fourth cardiac centre at Wolverhampton.

#### The Role of Primary Care Professionals

- To maintain accurate and up to date CHD registers.

(see also Section 6.14 Circulatory Diseases)

## 6.9 Access to Breast and Cervical Screening

### Local Delivery Plan Target

Improve access to services for disadvantaged groups and areas including breast and cervical screening

### Walsall target

Achieve a minimum of 70% uptake of breast screening at each mobile screening site

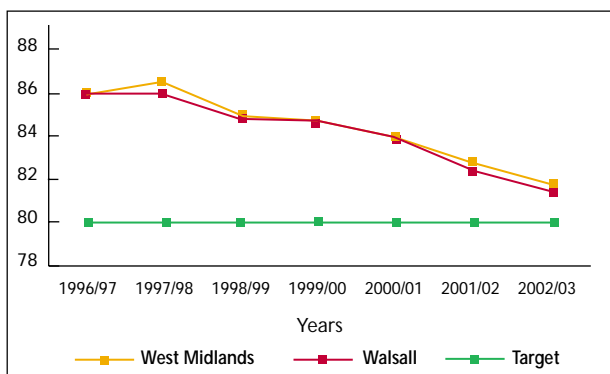
### Introduction

The first target forms part of the Local Delivery Plan inequalities target covering access to services. The second target is one of 5 additional Local Delivery Plan targets. Both highlight the significance of screening for cancer as part of the national and local strategies to reduce cancer morbidity and mortality. There are national screening programmes for both breast and cervical cancer. In Walsall cervical screening is carried out on a 3 year call/recall programme in which women aged 20 - 64 are invited to attend. The patient's GP or Practice Nurse takes most cervical smears. Breast screening also operates on a 3 year call/recall programme. Women aged 50-64, extending to 59-70 years in December 2004, are invited by the consortium, which comprises Walsall and Sandwell, to a mobile breast screening unit in the community or the static site based at the Manor Hospital. Evidence suggests that, since the introduction of screening, mortality from breast and cervical cancer has declined. But there is significant variation in the uptake of screening services. e.g. relating to both deprivation and ethnicity.

### How Walsall Compares:

#### Cervical Screening

**Figure 10: Cervical screening coverage, West Midlands and Walsall, women aged 25-64 years, 1996/97 to 2002/03**



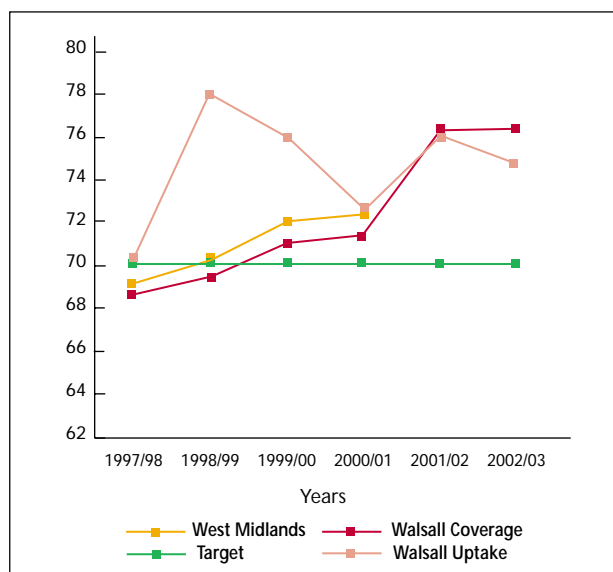
Source: West Midlands Cancer Intelligence Unit

The national minimum coverage target for cervical cancer screening at 5 years is 80%. Walsall currently meets this target. However, as Figure 10 shows, over the last 7 years coverage in Walsall has been falling, mirroring the regional trend.

### How Walsall Compares:

#### Breast Screening

**Figure 11: Breast screening coverage and uptake rates in the West Midlands and Walsall, women aged 50-64 years, 1997/98 to 2002/03**



Source: West Midlands Cancer Intelligence Unit

The national minimum coverage target for breast cancer screening is 70%. Walsall currently meets this target. However, the uptake rate varies peaking every three years. This is because uptake varies depending on the location of the mobile unit. Some areas have higher uptake rates and the sites visit each area on a 3 year rolling programme.

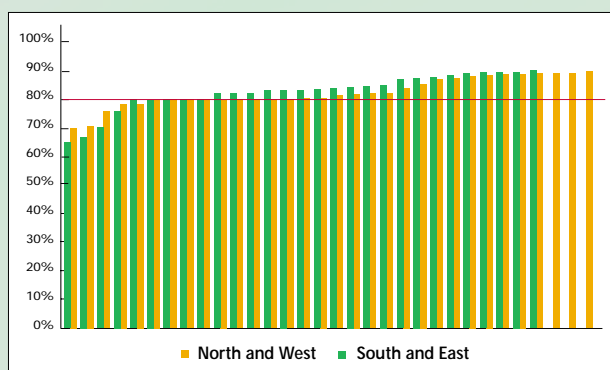
### Focus on Walsall:

#### Cervical Screening

In 2002/03 Walsall achieved an uptake rate of 81.8% overall. However, across the borough there is considerable variation between practices. Figure 12 shows that the widest variation is in the South and East of the borough. Here coverage ranges between 65% and nearly 90%. In the North and West screening coverage varies between 69% and 89%. However, despite this, of the 10 practices with the highest coverage only 1 is in the South and vice versa for those with low coverage.



**Figure 12: Cervical screening uptake women aged 20-64 by Walsall GP Practices, 2002/03**

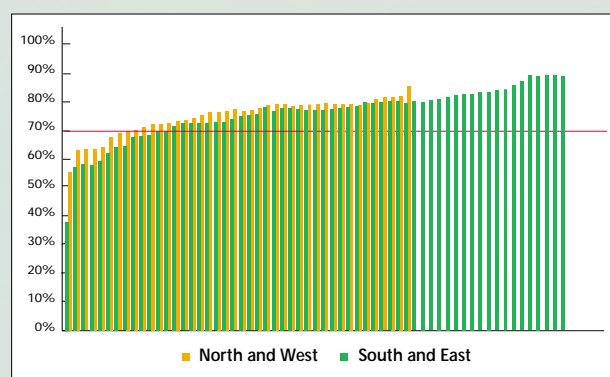


Source: Walsall tPCT

### Focus on Walsall: Breast Screening

The uptake rate by GP practice is calculated by comparing the number of women invited for screening and those who actually attend. The target is an uptake rate of over 70%. However, for the five-year screening period of 1999-2003, 28% of practices in Walsall were below the target (26% in South and East and 29% in North and West). Uptake rates across the borough ranged from 38% to 88%. In the South and East, 79% or 11 of the practices under target were in the South of the borough. In the 10 practices with the highest uptake, 8 were in the East of the borough.

**Figure 13: Breast screening uptake rates by GP Practice in Walsall, 1999-2003**



Source: Walsall and Sandwell Breast Screening Unit

### Focus on Walsall:

#### Mobile Breast Screening Programme

Although Walsall currently meets the national standard, there is significant variation across the different screening sites. The target is to achieve a minimum 70% uptake at each individual site by 2006. However, as this is a 3-year rolling programme this may not be reflected across the borough completely until

2008. In addition, the current expansion of the programme to the 65-70 age group and the introduction of two-view mammography are significant challenges. The sites across Walsall and their uptake rates are shown in Table 14. It can be seen from this that the greatest challenges are to increase uptake rates within the Palfrey, Coalpool, Manor Hospital and Beechdale areas.

**Table 14: Breast screening uptake rate in women aged 50-64 by breast screening area.**

Area	Uptake Rate	Next Screening Date
Brownhills	76%	June-October 2004
Bloxwich	76%	May-September 2006
Coalpool	63%	April-May 2006
Aldridge	80%	October 2004-July 2005
Beechdale	66%	May-September 2006
Willenhall	76%	August 2005-January 2006
Darlaston	69%	January/February 2006-March/April 2006
Manor Hospital	64%	September 2003-May 2004
Walsall Central	74%	September 2003-May 2004
Palfrey	62%	September 2003-May 2004

Source: Walsall and Sandwell Breast Screening Unit

### Tackling the Issues:

#### Cervical Screening Current Activity

- A poster campaign was developed by HAZ to breakdown barriers to accessing breast and cervical screening services.
- Working to meet the targets outlined in the last Quality Assurance Reference Centre visit
- An outreach support worker from the Cancer Information and Support Service is in post to work with women from ethnic minority communities to improve uptake rates.

#### Future Activity

- Introduction of liquid based cytology, which will significantly reduce inadequate smears.

### The Role of Primary Care Professionals

- To have an active register of people who can carry out cytology
- Identify a cytology lead in every practice
- Develop a support system for practices to meet their educational needs and uptake rates.

### Tackling the Issues:

#### Breast Screening Current Activity

- A Baseline survey of all practices detailing their involvement in the breast-screening programme has been carried out.

- Resources are being developed for primary care identifying key responsibilities with regard to breast screening.
- A support worker to work with women from the ethnic minority communities to improve uptake rates for all screening programmes is currently being identified.

#### Future Activity

- Health Promotion workers will be going out to local services to encourage women due to be screened for the first time to attend their appointment.

#### The Role of Primary Care Professionals

- To fully engage with the screening programme by promoting awareness of the benefits of breast screening, ensuring that the Prior Notification List (PNL) is validated, having systems in place to audit non-attenders and to follow up non-attenders opportunistically.

(see also Section 6.13 Cancer)

## 6.10 Access to Sexual Health Services

### Local Delivery Plan Target

To improve access to services for disadvantaged groups and areas, particularly sexual health services.

### Walsall Target:

To increase the percentage of NHS funded abortions undertaken at up to and including 9 weeks gestation from 21% (approximately 160) in 2001/02 to 34% by March 2004 and to over 44% (approximately 330) by 2004/05.

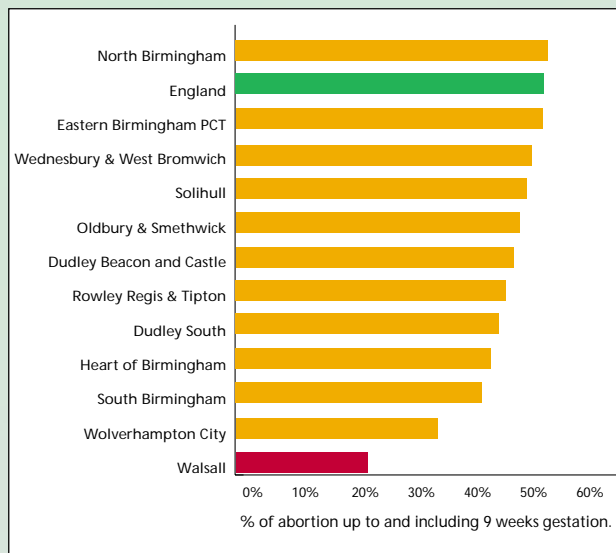
### Introduction

The earlier in pregnancy an abortion is performed the lower the risk of complications. If women can access services before they are 9 weeks pregnant, they can potentially have a choice of an early medical or surgical abortion - medical abortion avoids the need for anaesthesia and surgery. The Sexual Health and HIV Strategy highlighted that there are wide variations in access to NHS abortion services and the methods available, and that women who choose to seek an abortion can wait up to 4 or 5 weeks in some areas of the country.

The data for this target is collected from statutory abortion forms sent to the DoH. These forms carry postcode information and the number of completed weeks gestation. It is these two indicators that provide the means for assessing areas nationwide against targets. Currently, the DoH has taken over this function from the ONS and with a huge backlog. At the present time, only annual data is available and this is used to monitor the local target. Quarterly data will become available during 2004 following agreement of Manor Hospital to collect data each quarter showing the proportion of abortions up to and including 9 weeks gestation performed at the Manor Hospital. Although this will not capture all abortions carried out on Walsall residents, it is estimated that approximately 90% of abortions on Walsall residents are carried out at the Manor Hospital. The data from the DoH or Manor Hospital is only available at a borough level.

## How Walsall Compares

**Figure 14: Percentage of NHS funded abortions undertaken at up to and including 9 completed weeks gestation, 2001/2002**



Source: CHI

Figure 14 shows that the national median for the percentage of NHS funded abortions undertaken at up to and including nine completed weeks of gestation is 52%. Walsall's median is 21%. This is the lowest proportion amongst Birmingham and the Black Country districts and second worst in England. In order to move towards the 44% target, which would give Walsall an average rating, Walsall needs to perform 330 of the estimated 750 terminations per year before the nine-week deadline. As of the end of September 2003, 49 out of 322 (15%) terminations were carried out before nine weeks.

### Tackling the Issues

There are delays in every part of the pathway between women presenting for a pregnancy test and being able to access termination services. Several key actions are being taken to address the situation:

#### Current Activity

- The 'Early is best' campaign was launched over Christmas 2003 to encourage young women, in particular, to access professional help at the earliest opportunity.
- A medical termination of pregnancy service was introduced at the Manor Hospital in April 2003. If more procedures are to be carried out the capacity of the service needs to be increased.
- Emergency contraception is available from some local pharmacies although this has not been widely advertised and the uptake of this

service remains low. These pharmacists offer the service under agreed protocols to under 16's.

- Pre-abortion counselling is offered by the Hatherton Centre and Walsall Pregnancy Help Centre.
- 10% of GP practices offer pregnancy testing on their premises. The Hatherton Centre, Walsall Pregnancy Help and the Walk-in Centre all do on site testing with immediate results and advice. The Manor Hospital also does testing but the results take 3-5 days.
- The Director of Public Health is leading a review of the provision of sexual health services in Walsall.

#### Future Activity

- The availability of medical terminations needs to be advertised more widely, particularly amongst Primary Care staff and the other organisations that undertake pregnancy testing.
- There have been some problems with long delays in accessing the counselling service offered at the Hatherton Centre. This needs to be addressed so that a full pre-abortion counselling service can be offered again.
- A recommendation has been made to appoint a Consultant Community Gynaecologist who will coordinate future activity and the role of primary care professionals, and will carry out the medical termination procedures.

#### The Role of Primary Care Professionals

- Agencies currently undertaking pregnancy testing (GP's, Hatherton Centre GUM, Walk-in Centre, Walsall Pregnancy Help) should be able to refer a woman directly to the Manor Hospital if she chooses a termination. The Hatherton Centre started making direct referrals in July 2003. There is also a strong argument for women to make a self-referral to the Manor Hospital.
- It is important that women requesting terminations are referred promptly from GPs.
- Practice Nurses who wish to be trained to undertake pregnancy testing at GP practices should be allowed to do so. Training can be provided by Brook and protocols developed in the same way as for the condom distribution scheme. Pregnancy testing kits should be made available to practices agreeing to take part.
- Referrals to midwives should be made as soon as pregnancy has been confirmed. Discussions with the Midwife Matron suggests this move would be in line with good practice recommendations for their service.

(see also Section 4.1 Teenage Conceptions)

## 6.11 Influenza Vaccination

### Local Delivery Plan Target

Achieve the target of 70% uptake in influenza immunisation in people aged 65 years and over, targeting populations in the 20% of areas with the lowest life expectancy

### National Indicator

Percentage uptake of flu vaccinations by older people (aged 65+)

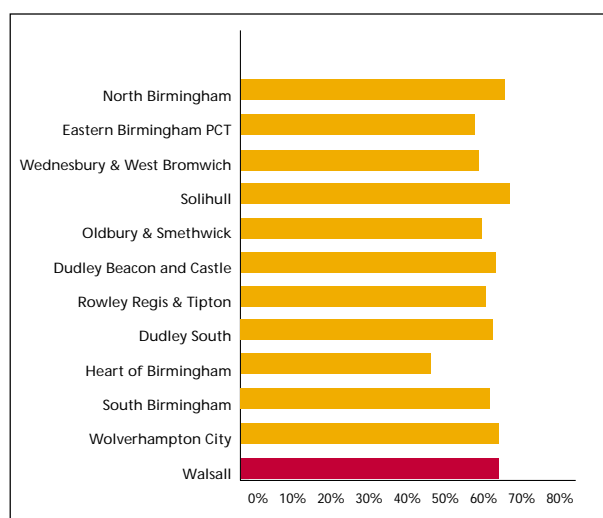
### Introduction

Flu is a highly infectious illness, which spreads very rapidly and may lead to more serious illnesses like bronchitis and pneumonia. Each winter the NHS faces the risk of a flu epidemic posing serious consequences for the NHS and its patients. The flu jab is the best way to protect people from the flu virus, reducing the morbidity and mortality it causes. Free vaccination is given to people aged 65 or over and those in at-risk groups.

### How Walsall Compares

In 2002/03 Walsall fell just short of the LDP Target by reaching a 68% uptake. In relation to the CHI target Walsall was ranked as average. However, as Figure 15 shows, Walsall had the third highest uptake in the BBC StHA region. In 2003/04 the Walsall uptake rate increased to 70.2%.

**Figure 15: Percentage of persons aged 65 and over vaccinated against the flu, Birmingham and Black Country PCTs, 2002/03**



Source: Commission for Health Improvement

### Focus on Walsall

Flu vaccination is an LDP inequalities target and CHI indicator. There is a large variation in the

uptake of the flu vaccination in Walsall, as illustrated in Table 15 and figures 16 and 17.

**Table 15: Flu vaccination uptake in over 65s, by LECs, 2003/04**

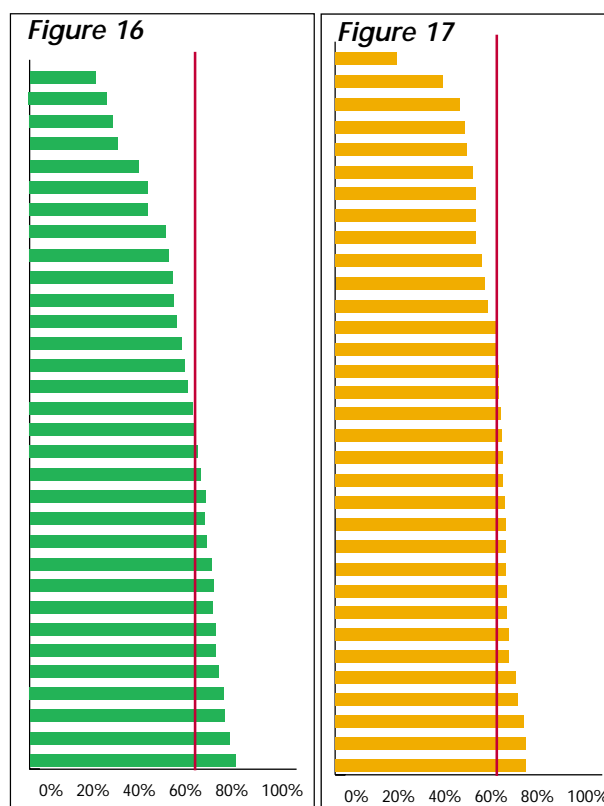
	Over 65s	Claims	% Immunised
North and West	17522	11562	65.99%
South and East	24283	17639	75.64%
Walsall	41581	29201	70.23%

Source: Walsall tPCT

Within each locality there is considerable variation by practice, ranging from 26% in one practice to nearly 89% in others. The largest variation is in the South and East Locality with 16 practices (53%) reaching over the 70% target. In North and West 21 practices (64%) exceeded the target. There are 8 practices in South and East and 6 practices in North and West where the uptake rate is less than 60%.

**Figure 16: Flu vaccination uptake in over 65s, South and East Locality Practices, 2003/04**

**Figure 17: Flu vaccination uptake in over 65s, North and West Locality Practices, 2003/04**



Source: Walsall tPCT

### Tackling the Issues

#### Current Activity

- There has been increased publicity in the 2003/04 campaign.



- More timely feedback is being given to all practices and those with historically low uptake have been contacted to discuss ways to improve uptake.
- This year has also seen greater activity towards immunising the under 65s with appropriate chronic diseases that increase the risks from influenza.

#### Future Activity

- The introduction of the new GP contract means practices can opt out of flu immunisation if they wish. Those practices that take on this on behalf of other practices will need to liaise closely with the practices on whose behalf they are working to ensure accurate registers and call/recall systems are in place.
- Publicity needs to be maintained and more needs to be done to target ethnic populations whose uptake, particularly in the elderly, remains well below average.
- Practices with low uptake will need to be encouraged to plan early for the campaign.

#### The Role of Primary Care Professionals

- All health professionals can promote the use of the vaccine in groups deemed eligible for the vaccination. The best way to ensure high uptake is for a health professional to advise on the need for the vaccine. GPs and practice nurses supported by other practice staff can promote the vaccine throughout the year and the practice should plan the campaign early.
- Community pharmacists could also encourage vaccination among patients receiving prescriptions for medicines that makes them eligible for the vaccination.

## 6.12 Equity in Staffing Levels

### Local Delivery Plan Target

Move towards greater equity in staffing levels across the borough

### National Indicator

Number of primary care professionals per 100,000 population

### Introduction

The variation in primary care staffing levels in Walsall has been recognised. One issue in particular has been filling GP, health visitor and district nursing vacancies in some parts of Walsall. To raise awareness and begin to address the issue, Walsall adopted equity in staffing levels, as one of its 5 extra Local Delivery Plan targets.

Little work has been done in this area so far, although the locality managers have begun to review community-nursing capacity. It is a significant area of work and will require substantial resources for the work to be done in the detail it requires. Initially there is a need for a detailed systematic review of tools and methodologies that will help the tPCT calculate the numbers of staff, such as district nurses and health visitors, that are needed in different areas, each of which have a particular set of needs. For example, an area with high levels of children on the child protection register may require more health visitors. There is no standard number of health visitors or district nurses recommended per head of population precisely for these reasons making this a very complex issue to resolve, and therefore no comparison with other regions is possible.

In this report it is only possible to report the total numbers and rate per 1,000 population of staff working in different areas of primary care across the borough. It is not possible to discuss equity on the basis of these figures alone. Further work is recommended as the single most valuable way to begin addressing equity in staffing in primary care.

### Focus on Walsall

Table 16 shows there are slightly fewer GPs working in the North and West of Walsall per 1,000 population than in the South and East. However, there are slightly more district nurses and health visitors employed in the North and West of the borough.

**Table 16: Number of primary care staff in post in Walsall as at 3rd December 2003**

	North & West		South & East	
	No.*	Rate per 1,000 pop	No.*	Rate per 1,000 pop
GPs	52	0.45	71	0.51
Nurses	33	0.29	31	0.22
District Nurses	42	0.37	46	0.33
District Nurse Trainees	3	-	2	-
Health Visitors	30	0.26	31	0.22
Health Visitor Trainees	2	-	2	-
Nursery Nurses	7	0.06	10	0.07
Others (including specialist nursing services)			64	

\*People in post, not necessarily whole time equivalent.  
Source: Walsall tPCT

### Tackling the Issues

#### Current Activity

- Work is being carried out by the locality managers examining community nursing capacity
- Health Visiting and District Nurse reviews are currently being carried out looking at modernising the services to meet the needs of the community, to ensure there is an appropriate skills mix and equitable service provision. The reviews will look at developing corporate caseloads. This would mean that instead of an individual being responsible for a caseload, there is a collective responsibility.

#### Future Activity

- There is a need for a more detailed piece of research to be commissioned to examine equity in staffing levels.

## MORTALITY

### 6.13 Cancer

#### National and Local Delivery Plan Target

Contribute to a national reduction in cancer death rates of at least 12% in people under 75 by 2005 compared to 1995-1997, targeting the 20% of areas with the highest rates of cancer.

#### National Indicator

Age-standardised death rates per 100,000 population for the major killer diseases (cancer, circulatory diseases), ages under 75 (for the 20% of areas with the highest rates compared to the national average)

#### Walsall Target

Reduce cancer mortality by 17% by 2005 and 25% by 2010 in the under 75s, resulting in saving an additional 71 lives per year by 2005.

#### Introduction

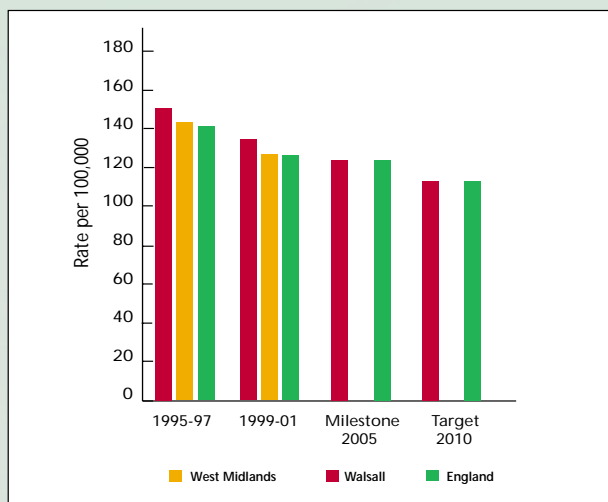
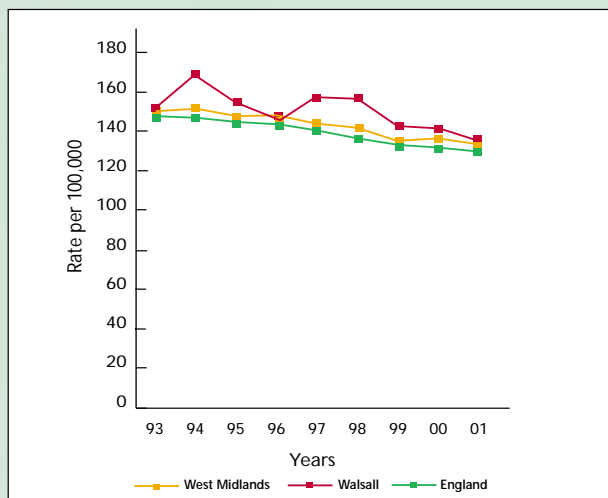
In Walsall about 360 people under 75 years of age die from cancer each year, representing about 35% of all Walsall deaths in this age group. Reducing the number of people dying from cancer will have a significant impact on increasing life expectancy.

The government has long recognised the importance of reducing cancer deaths, including cancer targets in Health of the Nation, Our Healthier Nation and the NHS Cancer Plan. The cancer target above is also incorporated into the Local Delivery Plan inequalities targets, recognising that there is a huge variation in cancer incidence, mortality and survival by gender, age, and deprivation. Because the Walsall mortality rate in the baseline period 1995-97 was above the national rate, Walsall adopted a tougher target, to reduce the inequality through a 25% reduction by 2010.

#### How Walsall Compares

Walsall's progress against its target is monitored annually, together with comparisons with national and regional performance. The most recent data is shown in Figure 18.

**Figure 18: Age standardised mortality rates from all cancers, England, West Midlands and Walsall, persons under 75, 1993-2001**

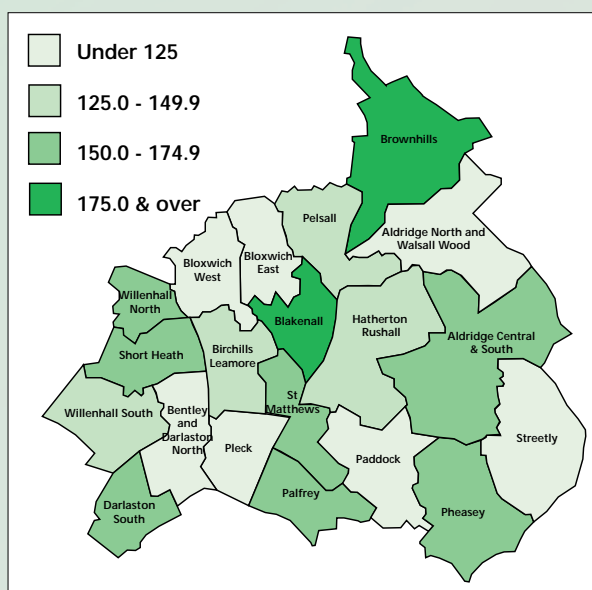


Source: Compendium of Clinical and Health Indicators 2002

For the period 1999/01, which is four years on from the baseline period, Walsall has achieved a 10% reduction in cancer mortality in the under 75s. This represents an additional 35 lives saved per annum, and the trend suggests that Walsall is on track to achieve the targets. In addition, although Walsall's cancer mortality rate remains above the national average, some progress has been made in reducing this inequality, particularly in men.

## Focus on Walsall

**Map 12: Age standardised all cancer mortality rate, Walsall wards, persons aged under 75 years, 1998-2000**



Source: West Midlands Cancer Intelligence Unit  
Data is not available at a ward level for 1999-2001.

Map 12 shows the highest cancer mortality rates among the under 75s in Walsall are in Brownhills, and Blakenall. The mortality rate in Brownhills is significantly higher than the West Midlands rate and Willenhall North also has a high mortality rate. In the South and East area the mortality rates are more uniform.

## Tackling the Issues

### Current Activity

- There is significant overlap with CHD prevention and programmes aimed at smoking reduction, healthy eating and exercise are ongoing
- A recent survey of GP practices in Walsall demonstrated good awareness and significant activity around cancer in primary care. This work needs to be developed further.
- Mechanisms are already in place to ensure rapid access for diagnosis and treatment for cancer patients using the two week referral mechanisms
- There is significant redesign ongoing at the Manor Hospital to ensure cancer patients are diagnosed and treated in a timely fashion.
- Walsall tPCT and Hospitals are fully engaged with both the Birmingham and Black Country Cancer Networks to ensure that National Cancer Plan targets are delivered.

### Future Activity

- The initiatives around prevention need to come together in a comprehensive primary prevention strategy. This would include work to ensure that screening programmes for cancer are effectively and efficiently managed across the tPCT.
- Significant effort is required within the Hospital Trust but with support from the PCT to ensure that the cancer planning and performance framework targets (LDP – T7) are achieved to ensure that there is a maximum of one month from diagnosis to treatment and two months from urgent referral to treatment for all cancer sites. This target is to be achieved by 2005.
- The implications of the Black Country Review with regard to complex surgery and the implementation of the various Improving Outcomes Guidance are high priorities for Walsall to ensure clear pathways and timely access are available for Walsall residents. There is also a need to ensure that services that can be provided locally are available and to the appropriate standard and quality. This refers particularly to the local chemotherapy unit.

### The Role of Primary Care Professional

- Primary care needs to be fully engaged with efforts to increase awareness of cancer symptoms among Walsall residents.
- The new GMS2 Contract will allow practices to improve participation in the various preventative measures such as anti-smoking, as well as improving uptake access for screening.
- GMS2 also requires primary care to develop practice-based registers of cancer patients and to review these on a six monthly basis.

(see also Sections on Lifestyle and 6.9 Access to Breast and Cervical Screening)

## 6.14 Circulatory Diseases

### National Target

Reduce death rates from circulatory disease (principally CHD and Stroke) by at least 25% in people under 75 by 2005 compared to 1995-1997, targeting the 20% of areas with the highest rates of CHD

### National Indicator:

Age-standardised death rates per 100,000 population for all circulatory diseases, persons aged under 75

### Walsall Target:

Reduce circulatory disease mortality in the under 75s by 37% by 2005

### Introduction:

More than 1,000 people of all ages die of circulatory disease in Walsall each year. About 400 people are under 75. Of these about 230 die from CHD and 75 die from stroke. Targets in Our Healthier Nation and the CHD NSF highlight the significance of reducing CHD and stroke mortality to the government agenda to save lives and increase life expectancy. The target has also been incorporated into the Local Delivery Plan under the Inequalities targets. Because the Walsall mortality rate in the baseline period 1995/97 was above the national rate, Walsall has adopted a target to reduce this inequality through a 37% reduction in circulatory disease mortality by 2005 and an overall 50% reduction by 2010. Achievement of this local target will save an additional 183 lives per year by 2005.

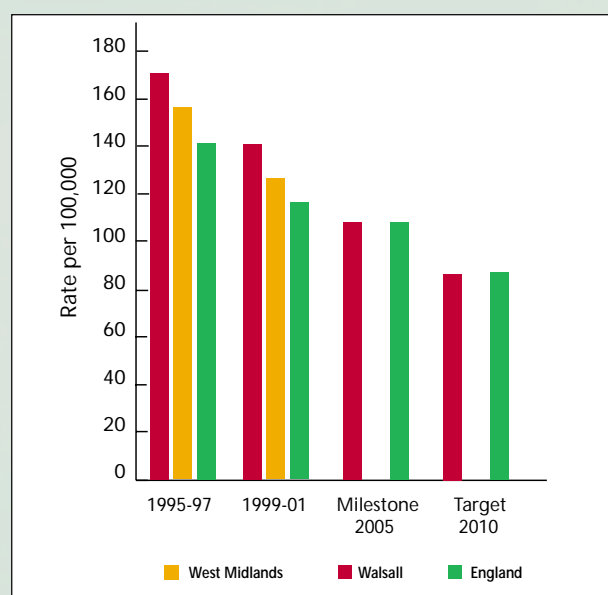
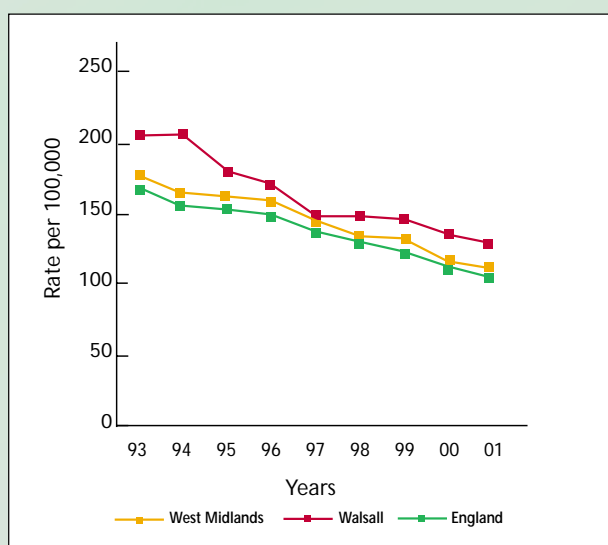
The target focuses on the age-standardised rate in under 75s. While this data is available at a borough level, there is no comparable data by ward. Therefore as a proxy measure the crude rate of deaths at all ages has been calculated (see Map 13).

### How Walsall Compares:

The Walsall death rate from all circulatory disease in people under 75 has reduced by over 16% since 1995-97. However, the Walsall reduction has been lower than achieved regionally and nationally. Consequently the gap has increased: for example, the Walsall death rate is 23% higher than nationally in 1999-01 compared with 20% higher in 1995-97. Nevertheless the local target reduction in the circulatory disease mortality rate should be achieved if the downward trend continues in Walsall.



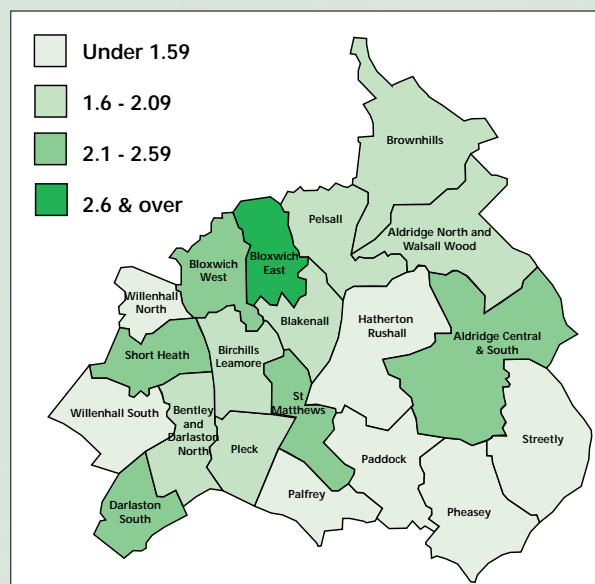
**Figure 19: Age standardised mortality rates from all circulatory diseases, Walsall, persons, aged under 75, 1993-2001**



Source: Compendium of Clinical and Health Indicators 2002

## Focus on Walsall: All Circulatory Diseases (CHD and Stroke)

**Map 13: Mortality from all circulatory diseases, crude rate per 1,000 population aged under 75 years, persons, Walsall wards, 1999-2001**



Source: ONS

Map 13 shows that deaths from circulatory disease are highest in the North and West of the Borough where the death rate is 1.9 compared to 1.6 in the South East. There are also variations in crude death rates between wards with 30% of all Walsall wards having a crude death rate of 2.1 and over. The wards with the highest mortality rates from all circulatory disease are Bloxwich East (2.8), Bloxwich West and Darlaston South (both 2.2). In these wards the rates are almost 3 times greater than the wards with the lowest rates, which are Paddock (1.1), Streetly, Willenhall North and Willenhall South (all 1.3)

## Tackling the Issues

### Coronary Heart Disease (CHD)

Outlined below is a very brief summary of some of the key activities to tackle CHD. More information is available in the CHD Local Implementation Team Annual Report 2002/03.

### Current Activity

- CHD prevention programmes are currently running, comprising a wide range of initiatives aimed at reducing smoking prevalence, promoting healthy eating and encouraging people to take more exercise.
- Accurate and up to date CHD registers have been developed in primary care to improve secondary prevention among patients with established CHD.

- Appropriate and speedy access to diagnostics services for chest pain, angina, heart failure are in place.
- The cardiac rehabilitation service has been expanded to address other CHD patients
- The current care pathways are being improved through a sustained training and development programme to deliver seamless care
- The Black Country CHD collaborative programme is being used to support further service improvement work in Walsall.
- The development of the heart and lung centre in Wolverhampton will ensure improved access to revascularisation services

## Future Activity

- There is a need to maintain 2 week access time to the rapid access chest pain clinic, minimise inappropriate referrals and optimise the implementation of treatment plans.
- Continued development, including evaluation of the integrated heart failure service.
- To build on the pioneering work of the patient and carers forum to give an effective voice to users in the future shaping of services.
- Recommendations of the recent CHI review of CHD NSF implementation need to be taken forward
- A local catheter laboratory is due to open in Autumn 2004

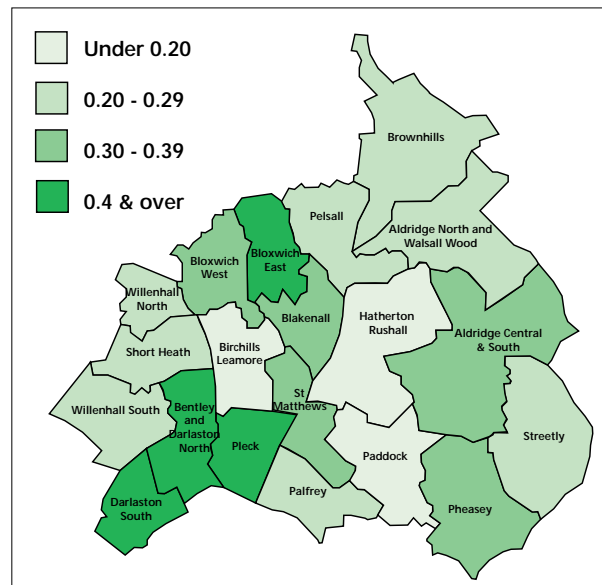
## The Role of Primary Care Professionals

- To ensure referral protocols are followed
- Maintaining accurate and up to date practice based CHD registers
- A more pro-active CHD prevention approach is required in order to identify people who wish to change their lifestyle behaviour.

## Focus on Walsall:

### Stroke

**Map 14: Mortality from stroke, crude rate per 1,000 population, aged under 75 years, persons, Walsall wards, 1999-2001**



Source: ONS

Map 14 shows that deaths from stroke in under 75s are highest in the North and West of the borough. The highest rates are in Bloxwich East (0.8 per 1,000 population), Darlaston South (0.6) and Pleck (0.4). The lowest rates are in Birchills Leamore and Hatherton Rushall (0.1), and Willenhall North and South and Paddock all (0.2).

The recognition of the burden that Stroke illness places upon the individual is well documented in the NSF for Older People, Standard 5. The broad aim of standard 5 is to reduce the incidence of stroke in the population and ensure that those who have a stroke have prompt access to Integrated Stroke Services.

Walsall Integrated Stroke Service already demonstrates many of the features required to achieve the NSF standard 5 milestones by working collaboratively with the CHD and Diabetes LITs. Four key components provide a framework to deliver the stroke agenda, prevention, immediate care, early and continuing rehabilitation and long term support.

## Tackling the Issues

### Current Activity

- The risk factors for stroke are the same as for CHD, and therefore the various CHD initiatives apply equally to stroke prevention.

- A robust electronic Stroke Register collects lifestyle data on all patient's referred to the service and supports identification of incidence and prevalence of stroke in Walsall.
- GP practices have received guidelines and referral pathways for Rapid Access TIA services. A weekly Rapid Access TIA clinic operates in partnership with the local Hospital Trust, providing 6 Carotid Doppler Slots (a diagnostic test) per week dedicated to stroke. This has been further enhanced by training nurses and authorisation for them to request Imaging i.e. CT scans and Carotid Dopplers
- A 25 bedded Stroke Rehabilitation Unit operates at Goscote Hospital and a multi disciplinary Care Pathway supports Early and Continuing Rehabilitation.
- All patients on the Stroke Register are visited at 3,6,12 months and annually thereafter in order to review secondary prevention, support lifestyle changes and monitor maintenance of rehabilitation, with a rapid access back into one of the Day Therapeutic Units where indicated. This system has proved particularly effective, with hospital re-admission rates remaining low.
- Four Maintenance Centres operate across Walsall, in partnership with other agencies, to provide social support following the clinical rehabilitation process, with access to a nominated nurse and physiotherapist for reassessment where appropriate.

#### Future Activity

- A business case for dedicated Immediate Care beds for stroke patients has been submitted to Walsall Hospital NHS Trust to further enhance organised stroke care.
- Engaging Service Users views are an integral part of the service. There are plans to modify the Expert Patient Programme in particular, to engage patients from the ethnic minority population.
- Improve stroke patient access to Clinical Psychology services

#### The Role of Primary Care Professionals

- To develop GPs with a special interest role
- There is a significant role for all Primary Care clinicians in the effective access and use of data collection and retrieval, using IM&T systems.
- Continue to develop awareness of referral and treatment pathways

(see also sections on Lifestyle and 6.8 Access to Coronary Interventions)

## 6.15 Accidents

### Local Delivery Plan Target

Reduce accident rates in deprived populations.

### National Indicator

Road accident casualties in disadvantaged communities

### Introduction

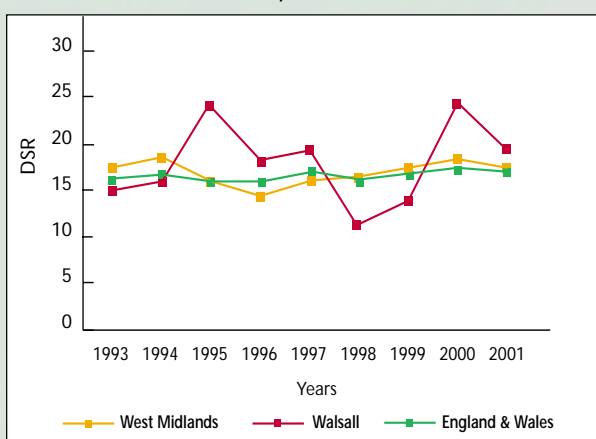
The burden of accidental injury and death is disproportionately heavy in deprived communities. In recognition of this the Local Delivery Plan includes a target to reduce accidents in deprived populations in Walsall.

Deaths from accidents are relatively small in relation to the total incidence of accidents and morbidity from accidental injury. As well as mortality data, this report therefore considers hospital attendances and hospital admissions for accidental injury. At a ward level the numbers are subject to substantial variation and there are no directly standardised rates.

### How Walsall Compares

Nationally, about 11,000 people die each year from accidents. In Walsall there are around 50 deaths each year from of all types of accidents, including about 17 deaths due to Land Transport Accidents.

**Figure 20: Directly standardised mortality rate from all accidents, England and Wales, West Midlands and Walsall, 1993-2001**



Source: Compendium of Clinical Indicators

Figure 20 shows that there are substantial year to year fluctuations in the Walsall mortality rate from accidents. In 2001 the rate in Walsall was 18.6 per 100,000; this was over 10% higher than the regional and national rates (16.7 and 16.4 respectively).

A report from Birmingham University shows

Road Traffic Accident (RTAs) rates in rural areas are higher than those in urban areas such as Walsall.

### Focus on Walsall

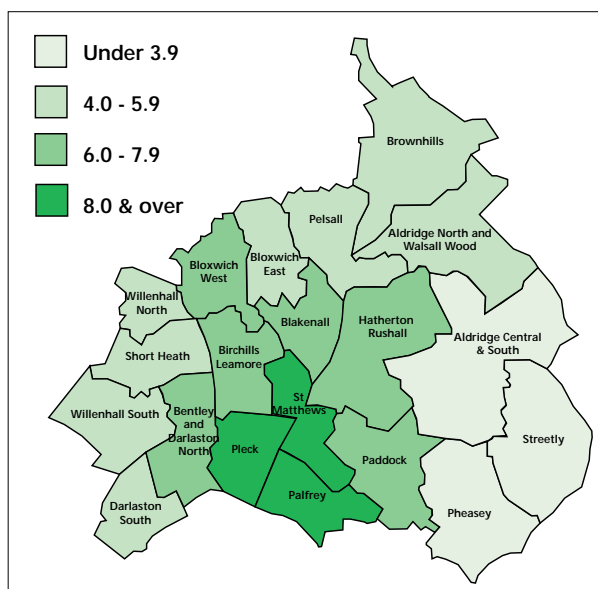
A report prepared by the Walsall Accident Prevention group reviewed attendances and admissions for accidental injury at Manor Hospital during 2001/02 and recent trends. This found that in 2001/02 about 38,000 people attended Walsall Manor Hospital for accidental injury (including non Walsall residents), of which over 15,000 related to accidents at home, over 5,000 for injuries at work, about 2,300 for injuries related to RTAs, and over 2,000 related to accidents at school/college. About 30% of attendances are of children (up to 15yrs), 58% are of people aged 16-64, and 12% are people over 65. Children are the most vulnerable group with an attendance rate 50% higher than for adults aged 16-64. Older people attended less frequently. About 10% of those attending Manor Hospital A & E with an accidental injury have injuries requiring admission for further treatment (around 3,700 admissions annually).

Total attendances for accidental injury fluctuate considerably from year to year and on average are little changed from the mid 1990s. However, attendances related to RTAs have increased by about 20%, with the increase concentrated among drivers passengers, and motorcyclists; in contrast, attendances for injuries to pedestrians and pedal cyclists have fallen.

Police data for RTA casualties on Walsall roads shows a 50% reduction in the number of people killed or seriously injured over the last 10 years, from 194 in 1992 to 97 in 2002.

This reduction is likely to be the result of a combination of factors such as improved safety features on vehicles, improvement to the road infrastructure, speed cameras/enforcement campaigns and faster or more effective treatment of injuries.

**Map 15: Crude rate of admissions to Walsall Manor Hospital A&E department for RTAs by locality, 1998/99-2002/03**



Source: ONS

Map 15 shows the pattern of patients who have been taken to A&E at the Manor Hospital as a result of road traffic accidents. Data is mapped by the patient's postcode. The lower rate in the East of the borough may be due to patients being taken to A&E departments in other hospitals. The highest rate is in the South of Walsall around the Manor Hospital and in Bloxwich West along the M6 corridor.

### Tackling the Issues

#### Current Activity

- A comprehensive falls prevention strategy is being implemented progressively in Walsall to meet the requirements of Standard 6 of the NSF for Older People. Services include falls awareness training, a specialist falls service, medicine reviews, EXTEND exercise programmes, and work around hip protectors. The strategy was developed with the HAZ groups.
- Promotion of the joint fire/police/ local authority 'HomeStamp' scheme to tenants and prospective tenants in the private rented sector. This provides extensive safety checklists and advice, so that tenants can satisfy themselves that the property is of a reasonable standard and what to do if it isn't.
- Free smoke alarms for older people and people on benefits are promoted by the fire service. The fire service also run regular fire safety campaigns, including careless discarding of cigarettes, fire escape plans and fire risk assessment.
- The Health in Business Service offers advice to small and medium sized businesses on



occupational health and safety.

- There is a wide range of ongoing measures aimed at preventing RTAs, including: 20mph speed zones, 'traffic calming', child pedestrian training schemes (Kerbcraft) focusing on schools in deprived areas, 'Safer Routes to School' schemes for secondary schools, cycle training, child car seat campaigns, police/Road Safety Dept enforcement campaigns (speeding, drink driving, automatic number plate recognition, safety cameras, participation in the West Midlands Driver Improvement Scheme for drivers facing prosecution), major refurbishment of street lighting, and TravelWise initiatives to encourage alternatives to use of the car.
- Walsall secondary schools participated in the high impact multi-medium SmartRisk project in February 2004. It targeted 11-14 year olds to help them identify risk and improve their sense of control in relation to injury prevention. About 2500 attended.

#### Future Activity

- Extension of Kerbcraft to schools in St Matthews, Pleck and Palfrey, and extension of Safer Routes to School to include more primary schools.
- Enforcement campaigns targeting drivers using a hand held mobile phone whilst driving.

#### The Role of Primary Care Professionals

- An education officer has recently been appointed to liaise with schools groups and business to raise awareness about the dangers of driving too fast.
- Participate in falls prevention programmes (e.g. in medicines reviews of patients).

**Abortion**

The expulsion or removal of an embryo or foetus from the uterus at a stage of pregnancy when it is incapable of independent survival (i.e. at any time between conception and the 24th week of pregnancy).

**Coronary Artery Bypass Grafting (CABG)**

A major surgical operation in which the blood supply to the heart is restored by replacing blocked arteries with arteries usually taken from the chest wall

**Coronary Heart Disease (CHD)**

Damage to the heart. Not enough blood flows through the vessels because they are blocked with fat or have become thick and hard, this harms the muscles of the heart.

**Commission for Health Improvement**

CHI is the independent, inspection body for the NHS. CHI publishes reports on NHS organisations in England and Wales. They highlight where the NHS is working well and the areas that need improvement.

**Conception**

The entity formed by the union of the male sperm and female ovum

**Confidence Intervals**

A statistical measure which gives a range of values within which we expect the true variable in question to lie with a given level of certainty, e.g. 95%

**Coverage**

The percentage of women aged 50-64 on the index date (e.g. 1st day of March each year) resident in each locality who have been screened in the last 3 years. The target is 70%

**CT Scan (Computerised Tomography)**

A special radiographic technique that uses a computer to assimilate multiple X-ray images into a 2 dimensional cross-sectional image.

**Cystic Fibrosis**

An hereditary disease that usually develops in early childhood. It is characterised by production of abnormally viscous mucus usually resulting in chronic respiratory infections and impaired pancreatic function

**Detection Rate**

Proportion of affected individuals with positive results.

**Down Syndrome**

A chromosome abnormality. Characteristics of these children include learning disability, narrow slanting eyes and short stature.

**Emergency Contraception**

Or the morning after pill. It is normally effective if taken less than 72 hours since unprotected sex.

**False Positive Rate**

This is where people are wrongly reported as having the condition, whereas false negative results are people wrongly reported as not having the condition

**Foetal Toxins**

Substances which have a harmful effect on the foetus

**Folic Acid**

A vitamin B that is important in the synthesis of nuclear acids. Uptake should be doubled during pregnancy to prevent neural tube defects such as spina bifida.

**Gestation**

The period of development in the uterus from conception until birth; pregnancy

**Haemoglobinopathy**

A disorder caused by the presence of abnormal haemoglobins in the blood, e.g. sickle cell disease

**Health Action Zones (HAZ)**

HAZs are multi-agency partnerships between the NHS, local authorities, the voluntary and business sectors and local communities. Their aim is to tackle inequalities in health in the most deprived areas of the country through health and social care modernisation programmes

**Health Development Agency (HDA)**

Is the national authority on what works to improve people's health and to reduce health inequalities. Working to support informed decision making at all levels and the development of effective practice.

**Heel Prick Test**

In the UK virtually all newborns are tested via heel prick blood within the first two weeks of life. By law the blood taken must be screened for phenylketonuria - the Guthrie test and congenital hypothyroidism. In addition some areas also screen for cystic fibrosis - immunoreactive trypsin

**Incidence**

The number of new cases of a disease that occur in a defined population within a specified time period, usually a year.

**Indicators**

An indicator suggests or shows something, for example the national indicator for teenage conceptions are the number of teenage conceptions per 1,000 women aged 15-17 years.

**Infant Mortality**

Death in the first year following live birth; on or before the 365th day of life (366th in a leap year)

**Infant Mortality Rate**

The number of deaths under the age of 1 year following live birth, per 1000 live births per year

**Intermediate Advisors**

Trained advisors working in a primary care and community setting who offer one-to-one behavioral support and pharmacological aids (e.g. Nicotine Replacement Therapy), for smoking cessation

**Local Delivery Plan (LDP)**

A series of targets that aim to lead to improvement in access for the local population.

**Local Executive Committees (LECs)**

There are 2 LECs in Walsall, one covering the north and west and the second covering the south and east of the Borough. They have responsibility for managing primary care services including GP contracts, health visiting, practice and district nurses, dental and optician services.

**Local Implementation Teams (LITs)**

Local teams of professionals and patients who work to implement government national service frameworks (NSFs). For example in Walsall there are cancer, CHD, older people and diabetes implementation teams.

**Life Expectancy at Birth**

This gives an estimate of how long someone is expected to live based on current mortality rates for an area.

**Liquid Based Cytology**

A new standardised way of preparing cervical samples for examination in the laboratory. This modern method will significantly reduce inadequate smears.

**Local Strategic Partnership**

A non-statutory single body that operates at a level that enables strategic decisions to be taken. Includes health and local authorities but also the business, community and voluntary sectors.

**Low Birthweight**

A child born weighing less than 2.5 kg

**National Institute for Clinical Excellence (NICE)**

A national body whose role is to provide patients, health professionals and the public with authoritative, robust and reliable guidance on current "best practice". The guidance will cover both individual health technologies (including medicines and procedures) and the clinical management of specific conditions.

**Neonatal**

Period of infancy between birth and 27 completed days of life.

**Neonatal Mortality Rate**

The number of deaths in the first 27 completed days of life per 1000 live births per year.

### **New Opportunities Fund (NOF)**

This is a Lottery Distributor who award grants to education, health and environment projects throughout the UK. Many grant programmes focus particularly on those in society who are most disadvantaged.

### **Mammography**

The making of infrared ray photographs of the breast. It is used for the early detection of abnormal growths.

### **Mortality**

The number of deaths caused by a disease that occur in a defined population within a specified time period, usually a year.

### **Peri-conceptual Care**

The period around conception

### **Perinatal**

Period of infancy between 24 weeks of gestation and six completed days of life

### **Perinatal Mortality Rate**

Number of stillbirths together with deaths up to six completed days of life per 1000 total births per year age group

### **Percutaneous Transluminal Coronary Angioplasty (PCTA)**

Unblocks coronary arteries by inserting a thin tube (usually) from the groin up the major arteries and then into the coronary artery. A balloon in the top of the tube is inflated to push aside the blockage and restore the blood supply.

### **Rehabilitation**

The treatment of an ill, injured or disabled patient with the aim of restoring normal health and function or to percent the disability from getting worse.

### **Resident Populations**

Population residing in a defined geographical area

### **Revascularisation**

Reestablishment of blood supply to the heart. The two most widely used techniques for restoring blood flow are coronary artery bypass surgery (CABG) and percutaneous transluminal coronary angioplasty (PTCA).

### **Screening**

Screening aims to reduce the risk of disease, premature death or disability. Members of a defined group are asked a question or offered a test in order to identify those at risk of disease so further definitive tests can be offered.

### **Sickle Cell Disease**

A group of inherited disorders of abnormal haemoglobin which is more common in certain ethnic groups. It is characterised by anaemia and acute exacerbations called 'crises'

### **Strategic Health Authority (StHA)**

These Authorities set the strategic framework for PCTs and NHS Trusts and monitors their performance against agreed objectives. The StHA that covers Walsall is the Birmingham and Black Country StHA (BBC StHA)

### **Stillbirth Rate**

Number of stillbirths per 1000 total births per year

### **Stillbirths**

The legal definition in England and Wales is 'a child which has issued forth from its mother after the 24th week of pregnancy and which did not at any time after being completely expelled from its mother breathe or show any signs of life'

### **Sudden Infant Death Syndrome (SIDS)**

May affect infants of any age, but some risk factors have been identified such as premature infants of low birth weight, siblings of infants who have succumbed to sudden infant death syndrome.

### **Sure Start**

This is a Government programme which aims to achieve better outcomes for children, parents and communities by increasing the availability of childcare for all children, improving health, education and emotional development for young children.

### **Target**

A goal or objective that has been set locally or nationally. It is then aimed to meet the target within a specified time scale.

### **Uptake**

The percentage of eligible women who attend for screening. The effectiveness of the breast screening programme is based on a minimum of 70%

### **World Health Organization (WHO)**

WHO's objective is the attainment by all peoples of the highest possible level of health.

### **Infant Mortality**

Director of Public Health's Annual Report: Growing Up in Walsall, 2002  
Jones S, Tackling inequalities: an action plan to reduce infant mortality in Walsall. 2003

### **Teenage Conceptions**

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### **Smoking in Pregnancy**

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### **Child Poverty**

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### **Life Expectancy**

West Midlands Public Health Observatory, Inequalities in Health in the West Midlands: Exploring Headline Targets, 2002

### **Housing**

ODPM, English House Condition Survey, 2001  
Walsall MBC, Housing Strategy: on the brink of something remarkable, November 2003

### **Homelessness**

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[www.homelesspages.org.uk](http://www.homelesspages.org.uk)

### **Smoking Prevalence in Manual Groups**

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Walsall Public Health Occasional Report Volume 1. Walsall Who we are and how we live. A Locality Profile of the 2001 Census and 2001 Adult Lifestyle Survey.

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Department of Health. *Tackling Health Inequalities: A Programme for Action*. London; HMSO 2003  
Walsall tPCT. *Local Delivery Plan, 2003/04*  
West Midlands Public Health Observatory. *Inequalities in Health in the West Midlands: Exploring Headline Targets, 2002*  
*Independent Inquiry into Inequalities in Health Report (Chair: Sir Donald Acheson)* London; HMSO, 1998



### **Prevalence of Obesity**

Chief Medical Officer's Annual Report 2002

National Audit Office. Tackling obesity in England. London: The Stationery Office, 2001.

### **PE and Sport in Schools**

Schools Health Education Unit, Young People and their Health: A Survey of the Health Related Behaviour of 9-15 year olds in Walsall in the academic year 2000-01

### **Access to Coronary Interventions**

Department of Health, CHD NSF Public Health Department, Coronary Revascularisation in Walsall, October 2003

### **Cancer**

Public Health Department. Our Healthier Nation: Targets and Monitoring Data Walsall – Four Years On, 2003

Annual Report 2002/03 of the Walsall Cancer and Palliative Care LIT, November 2003

### **Circulatory Diseases**

Annual Report 2002/03 of the Walsall CHD, NSF LIT: Delivering Better Heart services in Walsall, 2003

### **Accidents**

Falls Prevention Strategy

## **APPENDIX 1**

### **TECHNICAL APPENDIX**

The following is a brief explanation of technical issues concerning the data used in various sections of the report.

#### **Infant Mortality**

There are some technical problems mapping the infant mortality target at a local level. The definition of social class and the availability of data relating to it are difficult to obtain at a small area level and, even where it is available, there is substantial year to year fluctuation due to small numbers (17 deaths in 2002 in Walsall). Therefore, at a local level, this report maps the infant mortality rate across all social classes. Furthermore, because of the small numbers the report analyses the data by the 2 LEC areas in Walsall for 3 years and at a ward level only over a 5-year period.

The reduction in infant mortality in Walsall needed to meet the target has been estimated by calculating the percentage infant mortality gap between Walsall and England and Wales in 1998/2000. In this baseline period, the infant mortality rate in Walsall was 7.1 per 1,000 births and in England and Wales was 5.7, a gap of 1.4. The infant mortality rates have been falling nationally and, in Walsall for many years and considering more

recent data (1994/96 onwards), the national infant mortality rates is likely to fall to about 4.5 by 2010. To reduce the infant mortality rates gap by at least 10% between Walsall and the national rate requires Walsall to have an infant mortality rate no more than 1.26 above the projected national rate in 2010. This means reducing the Walsall infant mortality rates from 7.1 to no more than 5.7 by 2010.

#### **Teenage Conceptions**

The 2001 Census population figures were used to calculate the local LEC and ward rates, whereas 2003 population estimates were used for the national data. As a result the nationally calculated figures and local rates differ slightly, although the areas of high rates and low rates remain the same.

#### **Smoking in Pregnancy**

Currently the only data available to assess local smoking rates in pregnancy is from Manor Hospital. The hospital records the mothers "self-reported" smoking status when the initial appointment with the community midwife is made. In the past collection of this data has proved problematic, and was consequently incomplete. However, the implementation of the compulsory Data Set Change Notice (DSC Notice 50/2002) in April 2003 made collection of smoking in pregnancy data mandatory. Although it is expected to take some months before accurate data is achieved, it will improve the quality and quantity of data, giving a more accurate picture of smoking prevalence in pregnancy. However, this data is 'provider based' rather than resident based and will therefore exclude those Walsall mothers who give birth to their babies in neighbouring hospitals (e.g. Good Hope in North Birmingham and New Cross in Wolverhampton).

#### **Breastfeeding**

Currently the target is measured by the percent of mothers recorded as breastfeeding on transfer home from hospital to community and then to the health visitor about 10 days after birth. Information is also collected through the child health system on breastfeeding at 8 weeks and 8 months. However, for the purpose of this target, the initialisation period only is considered. As with smoking in pregnancy, breastfeeding data is 'provider based' (Manor Hospital) and will therefore exclude those Walsall mothers who give birth to their babies in neighbouring hospitals (e.g. Good Hope in North Birmingham and Good Hope in Wolverhampton). From January 2004 the DoH requires all Hospital Trusts nationally to collect data on initiation of breastfeeding within 48 hours of delivery. This will enable Trusts to monitor whether

women from disadvantaged groups, identified from postcodes, are increasingly initiating breastfeeding. Also, if neighbouring Trusts are collecting the same data then this should provide a means of capturing those previously excluded. However it is likely to show a distorted recorded progress by increasing the initiation rate and thus showing greater decline by 2 weeks.

#### **Child Poverty**

At a local level the Department for Local Government and the Regions publishes a supplementary Child Poverty Ward Level Index. The most recent data available relates to year 2000. The Index score is based on the percentage of children in each ward living in families that claim income support, job seekers allowance, family credit, and disability working allowance means tested benefits. A Child Poverty Index Score of, for example, 70 means that 70% of 0-16 year olds in that ward are living in families claiming means tested benefits. These levels do not take account of households entitled to such benefits but not claiming to them. This was a problem particularly with Family Credit; which was replaced in October 1999 by the more generous Working Families Tax Credit. This means that future Indices will not be comparable with 2000, since the threshold of child poverty will have been raised.

#### **Life Expectancy**

The method adopted by the West Midlands Public Health Observatory to calculate life expectancy is the Silcox et al approach. Mapping life expectancy at a small area level can result in large confidence intervals due to large variations as a result of the small numbers. For this reason, following the West Midlands Public Health Observatory recommendations the maps show only a simple scale that takes into account the wide confidence intervals for each ward.

The reduction in life expectancy needed in Walsall needed to meet the target has been calculated using the same methodology that was used to calculate infant mortality. In this baseline period, the life expectancy of men in Walsall was 74 years and 79.6 for women and England and Wales was 75.2 and 80.1 respectively. The life expectancy gap was therefore 1.2 years for men and 0.5 years for women. The life expectancy has been rising nationally and in Walsall for many years and, considering more recent data (1991/93 onwards), the life expectancy rate is likely to rise to around 78 years for men and 81.5 years for women by 2009/11. To reduce the gap in life expectancy by at least 10% between Walsall and the national rate requires Walsall to have



a gap no more than 1.1 for men and 0.45 for women lower than the projected national rate in 2010. This means increasing Walsall life expectancy from 74 to no less than 76.9 years for men and from 79.6 to no less than 81.1 for women by 2010.

#### Access to Coronary Interventions (Revascularisation)

In 2002 the South West Public Health Observatory reviewed equity in the use of CABGs and PTCA's (revascularisation procedures) across their region. No routine data is collected to record CHD morbidity and therefore the need for revascularisation has to be assessed using proxy measures. AMI (heart attack) rates have been shown to correlate with the prevalence of angina and with CHD mortality and therefore offers a reasonable means of estimating need for revascularisation. This methodology has been adopted and modified for the monitoring of this target by gender, age, ethnicity and geography. A full report on Coronary Revascularisation in Walsall will be available in late 2004.

## APPENDIX 2

### LOCAL DELIVERY PLAN TARGETS

#### ACCESS

T1 Reduce to four hours the maximum wait in A&E from arrival to admission, transfer or discharge, by March 2004 for those Trust who have completed the Emergency Services Collaborative and by the end of 2004 for all others. A target will be set relating to a reduction in the proportion of patients waiting over one hour, following consultation with the service over the precise definition

T2 By December 2002 a single phone call to NHS direct will be a one-stop gateway to out- of-hours healthcare, with callers passed on where necessary to the appropriate GP co-operative or deputising service.

T3 Ensure 100% of patients who wish to do so can see a primary health care professional within 1 working day and a GP within 2 working days by December 2004

T4 Achieve a maximum wait of 4 months (17 weeks) for an outpatient appointment and reduce the number of over 13-week outpatient waiters by March 2004, as progress towards achieving a maximum wait of 3 months for an outpatient appointment by December 2005

T5 Achieve a maximum wait of 9 months for all inpatient waiters and reduce the number of 6-month inpatient waiters by 40% by March 2004, as progress towards achieving a maximum 6 month wait for inpatients by December 2005 and a 3 month maximum wait by 2008, ensuring an overall reduction in the total list size and reduction of at least 80% by March 2005 in the number of over 6-month in patient waiters from the March 2004 baseline

T6 Increase the level of choice in each year, offering routine choice of hospital provider at point of booking for all patients by December 2005 with 100% booking of day cases and two thirds of all first outpatient and inpatient elective admissions being pre-booked by March 2004

#### CANCER

T7 Maintain existing cancer waiting time standards and set local waiting time targets for 2003/04 and 2004/05 so that by the end of December 2005 there is a maximum of one month from diagnosis to treatment, and two months from urgent referral to treatment for all cancers.

T8 Reduce the rate of smoking, contributing to the national target of: reducing the rate in manual groups from 32% in 1998 to 26% by 2010; 800,000 smokers from all groups successfully quitting at the 4 week stage by 2006

T9 Extend breast screening to all women aged 65-70 by 2004

T10 Set local targets to achieve compliance with forthcoming national standards on supportive and palliative care (to be derived from NICE supportive and palliative care guidance)

T11 Agree, implement and monitor local plans to improve the outcomes of cancer treatment, as evidenced by increasing compliance with NICE Improving Outcomes guidance and the associated national cancer standards

#### CHD

T12 Improve access to services across the patient pathway and increase patient choice by achieving the two week wait standard for Rapid Access Chest Pain Clinics; setting local targets to make progress towards the NSF goal of a 3 month maximum wait for angiography; and delivering maximum waits of 3 months for revascularisation by March 2005, or sooner if possible

T13 Deliver a ten percentage point increase per year in the proportion of people suffering from a heart attack who receive thrombolysis within 60 minutes of calling for professional help

T14 In primary care, update practice-based registers so that patients with CHD and diabetes continue to receive appropriate advice and treatment in line with NSF standards and by March 2006, ensure practice-based registers and systematic treatment regimes, including appropriate advice on diet, physical activity and smoking, also cover the majority of patients at high risk of CHD, particularly those with hypertension, diabetes and a BMI greater than 30.

T15 Improve the management of patients with heart failure in line with the NICE Clinical Guideline due in 2003, and set local targets for the consequent reduction in patients admitted to hospital with a diagnosis of heart failure

#### MENTAL HEALTH

T16 Reduce the duration of untreated psychosis to a service median of less than 3 months (individual maximum less than 6 months) and provide support for the first three years for all young people who develop a first episode of psychosis by 2004.

T17 Offer 24-hour Crisis resolution to all eligible clients by 2005.

T18 By December 2003, deliver Assertive outreach to the 20,000 adult patients with severe mental illness and complex problems who regularly disengage from services.

T19 Increase breaks available for carers and strengthen carer support and networks to the benefit nationally of approximately 165,000 Carers of people on CPA by 2004.

T20 Improve mental health care in prisons so that all prisoners with severe mental illness have a Care Plan by Apr 2004 (approximately 5000 prisoners nationally) and ensure appropriate use of secure and forensic facilities by 2004, contributing to the national target of moving 400 patients from high secure hospitals by 2004.

T21 Ensure that by April 2004 protocols are in place across all health and social care systems for the care and management of older people with mental health problems

## OLDER PEOPLE

T22 Improve the quality of life and independence of older people so that they can live at home wherever possible, by increasing by March 2006 the number of those supported intensively to live at home to 30% of the total being supported by social services at home or in residential care.

T23 Each year there will be less than 1% growth in the rate of emergency hospital admissions and no growth in re-admissions

T24 By December 2004: all assessment of older people will begin within 48 hours of first contact with social services and will be completed within four weeks, (with 70% within two weeks); following assessment, all social services will be provided within four weeks, (with 70% within two weeks); all community equipment for older people (aids and minor adaptations) will be provided by social services within seven working days.

T25 By 2006, a minimum of 80% of people with diabetes to be offered screening for the early detection (and treatment if needed) of diabetic retinopathy as part of a systematic programme that meets national standards, rising to 100% coverage of those at risk of retinopathy by end 2007.

T26 By April 2004 all general hospitals caring for people with stroke to establish a specialised stroke service, and all health and social care systems to have established an integrated falls service by April 2005

## CHILDREN

T31 Improve the five key dimensions of the patients experience as evidenced by increasingly positive local annual survey results, and other patient focused performance indicators, including those developed for the star ratings system. Agree, implement and jointly monitor local improvement plans as a result of surveys, with Patient Forums, as they come on stream during 2003.

T32 Strengthen accountability to local communities through improved engagement with them, as evidenced by annual Patient Forum reports to the Commission for Patient and Public Involvement in Health, and annual publication of a patient prospectus covering local health services.

T33 Set local targets to contribute to the national target of reducing the value of NHS building backlog maintenance by 25% by 2004.

T34 Introduce bedside TV and telephone systems in every major hospital by December 2003.

T35 Eliminate Nightingale wards for older people by April 2004

T36 Introduce ward housekeepers in hospitals by 2004 and appoint modern matrons to all remaining posts by April 2004.

## HEALTH INEQUALITIES

T37 Deliver a one percentage point reduction per year in the proportion of women continuing to smoke throughout pregnancy, focussing especially on smokers from disadvantaged groups as a contribution to the national target to reduce by at least 10% the gap in mortality between "routine and manual" groups and the population as a whole by 2010, starting with children under one year.

T38 Deliver an increase of 2 percentage points per year in breastfeeding initiation rate, focussing especially on women from disadvantaged groups

T39 Achieve agreed local teenage conception reduction targets while reducing the gap in rates between the worst fifth of wards and the average by at least a quarter in line with national targets

T40 Contribute to a national reduction in death rates from CHD of at least 25% in people under 75 by 2005 compared to 1995-1997, targeting the 20% of areas with the highest rates of CHD

T41 Contribute to a national reduction in cancer death rates of at least 12% in people under 75 by 2005 compared to 1995-1997, targeting the 20% of areas with the highest rates of cancer

T42 Achieve the target of 70% uptake in influenza immunisation in people aged 65 years and over, targeting populations in the 20% of areas with the lowest life expectancy

## DRUG MISUSE

T43 Increase the participation of problem drug users in drug treatment programmes by 55% by 2004 and by 100% by 2008 (against 1998 baseline), and increase year on year the proportion of users successfully sustaining or completing treatment programmes.

T44 Reduce drug-related deaths by 20% by 2004 (against 1999 baseline)

## PHYSICAL CAPACITY

R1 Introduce new providers from the independent sector and overseas to offer patients greater choice over where they obtain diagnosis and treatment

R2 Trusts with major capital schemes are to achieve financial close on the 29 schemes for new hospitals announced in February 2001 by June 2005, or sooner where possible

R3/R4 Improving GP premises and establishing new "One-Stop Primary Care Centres

R5 Establish additional inpatient beds and hospital capacity to meet access and clinical priority targets

R6 Establish new diagnosis and Treatment Centres operational in time to make a contribution to meeting 2005 waiting targets

R7 Plan for at least 40% of the total value of the NHS Estate to be less than 15 years old by 2010

## WORKFORCE

R8 Increase the number of nurses employed by the NHS by 20,000 by 2005 (from a 2000 baseline), and plan to achieve increase of 35,000 by 2008 (from a 2001 baseline)

R9 Increase the number of consultants by 7,500 and the numbers of GPs by 2,000 by 2004 (from a 1999 baseline); increase the number of GPs and Consultants employed by the NHS by 10,000 by 2005 (from a 2000 baseline); plan to achieve increase of 15,000 doctors by 2008 (from a 2001 baseline). This will include: 1,000 cancer consultants by 2005; and increasing total numbers of cardiologists to 685 and cardiothoracic surgeons to 217 by 2004, (enabling single handed cardiologist posts to be eliminated)

R10 Increase the number of therapists and scientists employed by the NHS by 6,500 by 2004 (from a 1999 baseline), and plan to achieve an increase of 30,000 by 2008 (from a 2001 baseline)

R11 Increase the number of health care assistants employed by the NHS by 27,000 by 20005 (from a 2002 baseline)

R12 By 2004 expand the mental health workforce by: 1,000 new graduate mental health workers in primary care; by 300 prison in-reach staff; 500 community mental health "Gateway" workers; 700 more staff to

support carers; 400 staff to support secure step-down

R13 By 2006 expand the mental health workforce by 300 extra prison in-reach staff to ensure prisoners with severe mental illness have an appropriate care plan and care co-ordinator on release; 500 community development workers for black and minority ethnic communities; 200 staff and 6 outreach teams for personality disorder and training of 3,000 STR Workers

R14 Increase workforce capacity and productivity through skill mix and continuing professional development; moving work from doctors to other healthcare professionals and from healthcare professionals to the support workforce, supported by pay modernisation, and service redesign

#### IM&T

R15 Infrastructure – deliver broadband access to NHS net for NHS clinicians and support staff by April 2004. This will be a single national procurement of a new NHS network. StHAs and trusts should be aware of the national procurement and make arrangements for local networks

R16 Booking – implement electronic booking by December 2005. The chosen architecture is decided upon and early adopters (enterprise communities) are developing. Local communities should respond to the national roll out programme

R17 National Prescriptions Service – this will be 50% implemented by December 2005 and 100% by December 2007 with full clinician and patient functionality. Pilots are being conducted in order to define a specification for a national programme. Local communities will need to respond to the national programme

R18 Electronic records – implement key elements of electronic records by December 2005. There will be a national health records infrastructure accessible nationally for out of hours reference and an electronic staff record

- Access to a primary care professional (PCP): Percentage of patients able to be offered a routine appointment to see a primary care professional within one working day
- Drug misuse: treatment: Increase in drug misusers accessing treatment
- Financial management: Achievement of the financial position shown in the 2003/04 Plan, submitted to the Department of Health, without the need of unplanned financial support
- Four-week smoking quitters: Number of smokers who quit at four-week follow-up with the NHS smoking cessation services (performance against plan)
- Improving Working Lives: Continued implementation of the Improving Working Lives standard
- Outpatients waiting longer than the standard: Measurement of the breaches of the 21-week target for first outpatient appointment throughout the year and the measurement of the breaches of the 17-week target for first outpatient appointment as at 31 March 2004
- Patients waiting longer than the standard for elective admission: Measurement of the breaches of the 12-month target for an elective inpatient or day case admission throughout the year and the measurement of the breaches of the 9-month target for an elective inpatient or day case admission as at 31 March 2004
- Total time in A&E: less than 4 hours: Percentage of patients waiting less than four hours in A&E from arrival to admission, transfer or discharge
- Child and adolescent mental health services (CAMHS): (i) audited needs assessment for the population (ii) increase in investment in CAMHS against target expected
- Cervical screening: Percentage of women aged 25-64 screened for cervical abnormalities
- CHD register: Clinical audit data that describe the provision of appropriate lifestyle advice and systematic treatment regimes
- Child protection: Compliance to recommended child protection systems and procedures
- Community equipment: Percentage of items of equipment and adaptations delivered within seven days
- Death rates from cancer, ages under 75 (change in rate): Percentage change in mortality rates from all malignant neoplasms in people aged under 75 per 100,000 population (age and sex standardised)

- Death rates from circulatory diseases, ages under 75 (change in rate): Percentage change in mortality rate from all circulatory diseases in persons aged under 75

per 100,000 population (age and sex standardised)

- Delayed transfers of care: Percentage of patients whose transfer of care from hospital was delayed
- Diabetic retinopathy screening
- Drug misuse: shared care: Percentage of GP practices in a shared care scheme for problematic drug misusers
- Flu vaccinations: Persons vaccinated against flu as a percentage of the number of people aged 65 and over
- GP appraisal: Percentage of GPs appraised during 2003/04
- Health equity audit: Assessment of the effective use of health equity auditing in service planning, commissioning and delivery in order to tackle health inequalities
- Immunisation: MMR
- Percentage of 2-year-old children who have received the MMR vaccine
- Infant health
- NHS dentistry: Access to NHS dentistry
- PCT commissioning of NHS Plan deliverables: mental health (adults)
- PCT patient survey: access and waiting
- PCT patient survey: better information, more choice
- PCT patient survey: building closer relationships
- PCT patient survey: clean, comfortable, friendly place to be
- PCT patient survey: safe, high-quality, coordinated care
- Prescribing rates: selected drugs
- Prescribing: mental health
- Sexual health: access to services for early unintended pregnancy
- Single telephone access through NHS Direct to GP out-of-hours care
- Six-month inpatient waits: Number of patients who had been waiting less than 6 months for inpatient treatment at quarter-end as a percentage of the number of patients on the inpatient waiting list
- Staff opinion survey: health, safety and incidents
- Staff opinion survey: human resource management
- Staff opinion survey: staff attitudes
- Suicide audit: Local system for suicide audit implemented
- Teenage pregnancy: conceptions below age 18 (percentage change in rate between 1998 baseline and 2002)
- Workforce datasets: data quality on ethnic group: Completeness of trust coding for ethnicity in workforce datasets

## APPENDIX 3

### CHI TARGETS

- Access to a GP: Percentage of patients able to be offered a routine appointment to see a GP within two working days



