NHS Walsall

Future Proofing Health

A decade of progress in **Public Health - where to now?**

Annual Public Health Report for NHS Walsall ***2010***

Contents

Foreword

This Public Health Annual Report for 2010 is dedicated to the memory of Walsall's first Director of Public Health, Professor Sam Ramaiah.

Much loved and widely respected as he was, Sam was first and foremost a public health physician who genuinely cared for the betterment of the health of the people.

Sam was a dynamic leader, constantly engaging with and influencing key stakeholders across Walsall to bring about change for the public health good. In addition to his presence and communication skills, he believed in the power of information to generate ideas for change and through his numerous reports he tried to win support for action to improve health. In addition to annual reports, there was a constant flow of information through brief and occasional reports and local interpretations of government policies and initiatives.

Sam placed great store by the DPH Annual Report, and used the opportunity to reflect his own independent thinking.

Sam Ramaiah set a high bar indeed for this Report. To rise to that challenge, we decided to take stock of the current state of public health in Walsall, drawing where appropriate on the findings of the last 10 years' Public Health Reports. Based on our findings we also make a small number of strategic recommendations aimed firstly at a) holding on, through the changes currently under way, to the gains made thus far; and b) ensuring that we leverage the opportunities presented by the changes effectively to deliver better health and better, more responsive services. The changes announced in the NHS and Public Health white papers have yet to be worked through, and while the future may not always be as clear as we would like, there are things we can be getting on with now that would make the future a healthier one. This is what we mean by future-proofing public health in Walsall.

We hope you enjoy this report and appreciate the tribute to Sam.

We would greatly value your comments and ideas for the future, especially as we move to a new way of working in Public Health.

Dr Paulette Myers and Dr Sue Laverty
Joint Interim Directors of Public Health

Sam Ramaiah, Walsall's Director of Public Health 1994 - 2010

Professor Sam Ramaiah, Walsall's Director of Public Health and Medical Director of NHS Walsall, made an outstanding contribution to the health and wellbeing of the people of the borough.

Professor Ramaiah, who died suddenly in September, will be sadly missed by his family, friends and colleagues.

These are just a few of the tributes that have been paid to him:

"Sam - A tireless proponent of public health; A great champion of the health of the people of Walsall; An indulgent educator of managers. Sadly missed"

Sir David Nicholson, Chief Executive of the NHS in England

"So many people were enriched by Sam's dedication to public service and have reason to be grateful for his life.

"As well as helping local people to live longer, happier and more fulfilled lives he inspired a generation of public health staff to carry on his work."

Denise McLellan, former Chief Executive of NHS Walsall

"Sam was one of the most outstanding public figures in Walsall's history who made a huge difference to the lives of the people who live here and we will miss him."

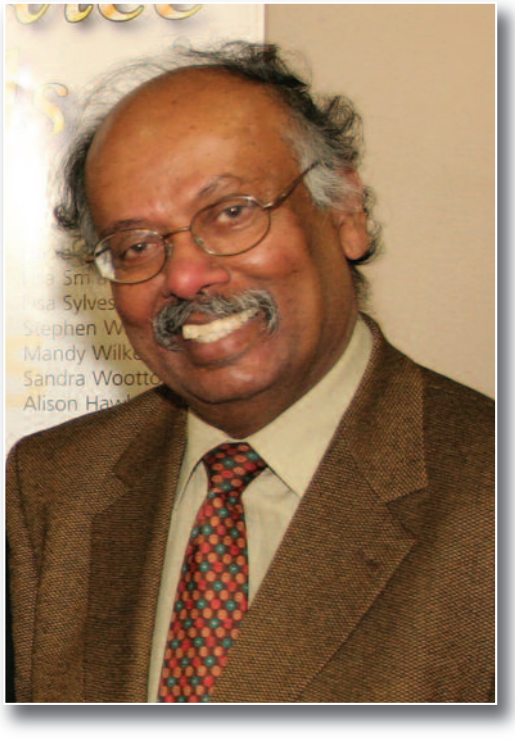
Paul Sheehan, Walsall Council Chief Executive

"Sam was an ardent supporter of action to improve the health of minority and disadvantaged groups in the community."

Dr Jammi Rao, West Midlands Deputy Regional Director of Public Health.

"Sam's passion to raise the standard of health in Walsall, tackle inequality and fight for a better deal for the worst off came through in everything he did."

Dr Mike Browne, Medical Director, The Manor Hospital



Executive Summary

Public Health in Walsall has come a long way since the time when Sam Ramaiah became Director of Public Health of what was then Walsall Health Authority.

There is much that we can be proud of; and we have a few achievements to celebrate. Some indicators of public health like heart disease death rates have steadily improved, all age all cause mortality rates slope downwards; and both male and female life expectancy at birth have continued to climb.

But there are also problems yet to confront, changes to deal with and public health challenges to meet. A cursory glance at the 2010 health profile for Walsall from the Association of Public Health Observatories (APHO) will justify their headline conclusion that 'the health of people in Walsall is generally worse than the England average'.

Looking closer within Walsall, there remain pockets of poor health. Life expectancy for men in the most deprived areas of Walsall is 11 years less than in the least deprived areas.

That one statistic symbolises the one big public health scourge we need to tackle - unfair variations in health outcomes; health inequalities that stubbornly persist.

These public health problems remain to be addressed at a time of change in public health, the health care system and also within the Local Authority; it is essential that cohesive and integrated working between all partners continues. Most health commissioning will soon be done by clinical consortia. Public health functions and responsibilities will transfer to Local Authorities. Changes of this magnitude can be great opportunities for doing things differently and better. Our recommendations are designed to avoid the risks while seizing the opportunities.

In the four main chapters of this annual report we present a convincing case, we hope, for prevention to be the focus of commissioning. We have to do things differently to engage people and communities, make our resources go further and get better outcomes for the same money. We need, in short, to invest in prevention.

That is the one key message we wish to send through this report.

Dr Paulette Myers and Dr Sue Laverty

Thank you to all contributors, across the whole Walsall economy and in particular, the editorial team - Dr Paulette Myers, Dr Jammi Rao, Emma Thomas and Sally Andrews.

		Walsall		Regional			National		
	Data by Theme	Number	%/Rate	Number	%/Rate		Number	%/Rate	
Demographic	1 Geographical Area (sq mi)	40.01	-	5,020	-		50,352	-	
	2 2010 Mid-Year Estimates	256,900	-	5,455,200	-		55,240,500	-	
	3 2033 Projected Population	275,800	-	6,113,500	-		64,063,000	-	
	4 Proportion of Young People (0-19)	67,286	26.19	1,344,309	24.64	▲	13,127,300	23.76	▲
	5 Projected Young People (2033)	72,100	26.14	1,447,300	23.67	▲	14,372,000	22.43	▲
	6 Proportion of Older people (60+)	60,064	23.38	1,270,020	23.28	▲	12,507,400	22.64	▲
	7 Projected Older People (2033)	75,400	27.34	1,768,500	28.93	▼	18,200,000	28.41	▼
	8 Male Life Expectancy	76.3	-	77.5	-	▼	78.1	-	▼
	9 Female Life Expectancy	81.9	-	81.9	-	●	82.3	-	▼
	10 Ethnicity	34,434	13.6	593,012	11.3	▲	4,459,470	9.07	▲
	11 IDACI	12,419	2	-	-		16,241	3	▼
	12 IDAOPI	10,652	2	-	-		16,241	3	▼
Shaping the Environment for Health	13 LTC - Mortality from CHD - Males	50	431.85	963	407.48	▲	8,790	388.98	▲
	14 LTC - Mortality from CHD - Females	28	217.79	381	147.89	▲	3,512	139.97	▲
	15 LTC - Mortality from Stroke - Males	11	93.01	259	108.48	▼	2,416	105.95	▼
	16 LTC - Mortality from Stoke - Females	6	50.21	196	75.81	▼	1,955	77.54	▼
	17 LTC - Mortality from Cancer - Males	107	925.46	2,111	897.24	▲	19,629	870.84	▲
	18 LTC - Mortality from Cancer - Females	79	600.08	1,539	598.05	▲	15,013	606.24	▼
	19 Prevalence of CHD[1]	10,810	4.01	203,026	3.51	▲	1,885,089	3.44	▲
	20 Prevalence of Heart Failure[1]	2,331	0.86	44,888	0.78	▲	393,290	0.72	▲
	21 Prevalence of Stroke[1]	4,740	1.76	101,083	1.75	▲	921,819	1.68	▲
	22 Prevalence of Hypertension[1]	41,750	15.49	830,920	14.35	▲	7,321,472	13.35	▲
	23 Prevalence of Diabetes[1]	16,328	6.06	270,795	5.96	▲	2,388,813	5.4	▲
	24 Prevalence of COPD[1]	5,548	2.06	90,005	1.55	▲	861,341	1.57	▲
	25 Prevalence of Epilepsy[1]	1,819	0.67	37,724	0.85	▼	332,001	0.78	▼
	26 Prevalence of Hyperthroidism[1]	7,307	2.71	175,188	3.03	▼	1,603,670	2.92	▼
	27 Prevalence of Cancer[1]	3,990	1.48	83,861	1.45	▲	775,623	1.41	▲
	28 Prevalence of Palliative Care	494	0.18	-	-		-	-	
	29 Prevalence of Mental Health	1,976	0.73	-	-		-	-	
	30 Prevalence of Asthma[1]	16,971	6.3	355,998	6.15	▲	3,254,562	5.94	▲
	31 Prevalence of Dementia[1]	1,082	0.4	25,622	0.44	▼	249,463	0.45	▼
	32 Prevalence of Depression[1]	23,917	8.87	500,540	11.21	▼	4,648,287	10.91	▼
	33 Prevalence of CKD[1]	10,288	3.82	200,056	4.48	▼	1,817,871	4.27	▼
	34 Prevalence of Atrial Fibrillation[1]	3,921	1.45	82,156	1.42	▲	761,965	1.39	▲
	35 Prevalence of Learning Disability[1]	838	0.31	19,973	0.45	▼	179,064	0.42	▼
	36 Prevalence of Smoking	69,169	25.66	-	-		-	-	
	37 Lifestyle - levels of obesity - Year Reception	-	10.6	-	10.5	▲	-	9.8	▲
	38 Lifestyle - levels of obesity - Year 6	-	21.6	-	20.5	▲	-	18.7	▲
	39 Lifestyle - binge drinking levels	-	14.9	-	18.8	▼	-	20.1	▼

	Data by Theme	Walsall		Regional			National		
		Number	%/Rate	Number	%/Rate		Number	%/Rate	
Shaping the Environment for Health	40 Violent Crime	4,661	18.21	79,717	14.68	▲	821,957	15.0	▲
	41 Burglary in a Dwelling	1,632	14.61	55,532	10.22	▲	522,640	9.54	▲
	42 Total Crime	20,112	78.59	391,209	72.03	▲	4,150,097	75.72	▲
	43 GCSE Attainment (5+A*-C incl. Eng & Maths)	-	49.5	-	-	▼	-	53.5	▼
	44 School Absence	-	7.1	-	-	▲	-	6.9	▲
	45 Road Injuries and Deaths	99	38.1	2,321	42.92	▼	24,765	48.12	▼
	46 Looked After Children	519	85.8	8,010	67.0	▲	64,400	58.0	▲
	47 Children on the Child Protection Register	233	38.5	4,612	38.6	▼	39,100	35.2	▲
	48 Cycle Paths	18	44	-	-		-	-	
	49 Takeaway Food Outlets	208	72.2	-	-		-	-	
Big society, Resiliant Communities	50 Immunisation - DToP/IPV/Hib	-	99	-	97	▲	-	96	▲
	51 Immunisation - MMR	-	94	-	91	▲	-	88	▲
	52 Immunisation - MenC	-	98	-	96	▲	-	94	▲
	53 Jobseekers Allowance Claimants	10,299	6.5	161,708	4.7	▲	1,306,162	3.7	▲
Nudge or Shove?	54 Lifestyle - smoking quit rates	-	52.2	-	46.9	▲	-	48.8	▲
	55 Lifestyle - physical activity rates	75	14.7	664,700	15.2	▼	6,930,200	16.6	▼
	56 Alcohol Related Hospital Admissions	6,282	2121	113,205	1774	▲	1,056,962	1743	▲
	57 Mortality from Chronic Liver Disease - Males	21	16.15	496	17.55	▼	4,116	14.41	▼
	58 Mortality from Chronic Liver Disease - Females	15	9.86	269	8.68	▲	2,334	7.34	▲
	59 Smoking at Delivery	-	19.9	-	-		-	-	
	60 Prevalence of Obesity	31,219	11.58	-	-		-	-	
	61 Infant Mortality	92	8.5	1,313	6.2	▲	9,916	4.7	▲
	62 Perinatal Mortality	-	10.7	-	9.2	▲	-	7.6	▲
	63 Under 18 Conceptions	848	54.4	14,796	46.2	▲	126,081	41.1	▲
	64 Termination of Pregnancies	1,063	27	20,180	20	▲	189,100	17.6	▲
	65 Breastfeeding Initiation Rates	528	61.3	11,933	68.6	▼	121,339	74.3	▼
	66 Low Birth Weight Babies	-	10.6	-	8.5	▲	-	7.5	▲
Shopping for Health	67 Spend - problems of circulation	46.3	10.0	-	-		-	8.2	▲
	68 Spend - mental health disorders	46.1	10.0	-	-		-	12.1	▼
	69 Spend - cancers and tumours	30.9	6.7	-	-		-	6.4	▲
	70 Spend - respiratory problems	24.5	5.3	-	-		-	5	▲
	71 Spend - musculoskeletal system	23.7	5.1	-	-		-	5.3	▼

Key:

▲ Walsall number/rate is lower than comparator

▲ Walsall number/rate is higher than comparator

● Walsall number/rate is no different to comparator

Metadata for Walsall in Numbers Table

Walsall in Numbers Metadata:

1 Geographical Area in Square Miles
2 2010 Mid-Year Estimates, ONS
3 2008 Based 2033 Projected Population, ONS
4 0-19 year olds, 2010 MYE, ONS
5 0-19 year olds, 2008 Based 2033 Population Projections, ONS
6 60+ year olds, 2010 MYE, ONS
7 60+ year olds, 2008 Based 2033 Population Projections, ONS
8 Male Life Expectancy at Birth, 2007-09, NCHOD
9 Female Life Expectancy at Birth, 2007-09, NCHOD
10 2001 Census
11 Income Deprivation Affecting Children Index, DCLG, 2010 - Average Rank and IMD Quintile
12 Income Deprivation Affecting Older People Index, DCLG, 2010 - Average Rank and IMD Quintile
13 Long Term Condition - mortality from CHD, males, number and DSR for 65 to 74 year olds, 2009, NCHOD
14 Long Term Condition - mortality from CHD, females, number and DSR for 65 to 74 year olds, 2009, NCHOD
15 Long Term Condition - mortality from Stroke, males, number and DSR for 65 to 74 year olds, 2009, NCHOD
16 Long Term Condition - mortality from Stroke, females, number and DSR for 65 to 74 year olds, 2009, NCHOD
17 Long Term Condition - mortality from Cancer, males, number and DSR for 65 to 74 year olds, 2009, NCHOD
18 Long Term Condition - mortality from Cancer, females, number and DSR for 65 to 74 year olds, 2009, NCHOD
19 Prevalence of CHD, 2010/11, QMAS
20 Prevalence of Heart Failure, 2010/11, QMAS
21 Prevalence of Stroke, 2010/11, QMAS
22 Prevalence of Hypertension, 2010/11, QMAS
23 Prevalence of Diabetes, 2010/11, QMAS
24 Prevalence of COPD, 2010/11, QMAS
25 Prevalence of Epilepsy, 2010/11, QMAS
26 Prevalence of Hyperthyroidism, 2010/11, QMAS
27 Prevalence of Cancer, 2010/11, QMAS
28 Prevalence of Palliative Care, 2010/11, QMAS
29 Prevalence of Mental Health, 2010/11, QMAS
30 Prevalence of Asthma, 2010/11, QMAS
31 Prevalence of Dementia, 2010/11, QMAS
32 Prevalence of Depression, 2010/11, QMAS
33 Prevalence of CKD, 2010/11, QMAS
34 Prevalence of Atrial Fibrillation, 2010/11, QMAS
35 Prevalence of Learning Disability, 2010/11

Walsall in Numbers Metadata:

36 Prevalence of Smoking, 2010/11, QMAS
37 Levels of Obesity - reception age children, 2009/10, National Child Measurement Programme
38 Levels of Obesity - Year 6 children, 2009/10, National Child Measurement Programme
39 Synthetic estimate of the percentage of the population aged 16 and over who report engaging in binge drinking, 2007/08, LAPE
40 Recorded Violence Against a Person incidents per 1,000 population, 2010/11, Safer Walsall Partnership
41 Burglary Dwelling, per 1,000 households, 2010/11, Safer Walsall Partnership
42 Total Recorded Crime, per 1,000 population, 2010/11, Safer Walsall Partnership
43 GCSE Attainment (including English and maths), 2010, Dept. for Education
44 Percentage of half days missed due to overall absence, 2010, Dept. for Education
45 Occurring Casualties (killed or seriously injured) per 100,000 resident population, 2007-09, APHO
46 Rate of looked after children per 10,000 under 18 population, as at March 2011 (Regional and national comparisons as at March 2010), Walsall Council
47 Rate of children on the child protection register per 10,000 under 18 population, as at March 2011 (Regional and national comparisons as at March 2010), Walsall Council
48 Cycle Paths - length of and number of, 2011, Walsall Council
49 Takeaway food outlets, 2011, Planning Services - Walsall Council
50 Percentage of children under 2 immunised against Diphtheria, 2009/10, Information Centre
51 Percentage of children under 2 immunised against MMR, 2009/10, Information Centre
52 Percentage of children under 2 immunised against MenC, 2009/10, Information Centre
53 Jobseekers Allowance claimants, 2011, NOMIS
54 Smoking quit rates, 2009/10, Information Centre
55 Number and percentage of adults participating in at least 3 sessions of 30 minutes moderate intensity sport, Oct 08 to Oct 09, Active People Survey 3, Sport England
56 Alcohol related hospital admissions per 100,000 population, 2009/10, LAPE
57 Mortality from chronic liver disease, males, number and DSR for all ages, 2008, NCHOD
58 Mortality from chronic liver disease, females, number and DSR for all ages, 2008, NCHOD
59 Percentage of women smoking at time of delivery, 2009/10, Walsall Manor Hospital
60 Prevalence of obesity, 2010/11, QMAS
61 Crude rate of deaths under 1 year old per 1,000 live births, 2007-09, NCHOD
62 Crude rate of deaths under 7 days old per 1,000 live births, 2007-09, NCHOD
63 Rate of under 18 conceptions per 1,000 15 to 17 year olds, 2006-08, ONS
64 Rate of abortions per 1,000 15 to 17 year olds, 2009, ONS
65 Breastfeeding initiation rates, Q1 2011/12, DH
66 Babies born weighing <= 2500 grams, 2009, ONS

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Walsall is well known for its dynamic and diverse population composition which has evolved over the last decade. This collaborative annual report aims to summarise the changes which have taken place in Walsall over the last ten years. This section looks particularly at Walsall's demography.

A decade ago, the population of Walsall totalled 255,800 people (48.8% males and 51.2% females). During the last decade, Walsall's population has generally declined. 2003 however, saw a steady increase, and in 2009 the total population was 255,900. The age structure of the population has seen noticeable changes with decreases in the number of young people (those aged 0 to 19) of 0.5% and increases of those who are older (60 and over), by 1.7%.

Current population projections highlight that numbers of children and young people in Walsall will increase for children aged 0 to 9 and following an initial decline for 10 to 19 year olds, these will also increase until eventually stabilising.

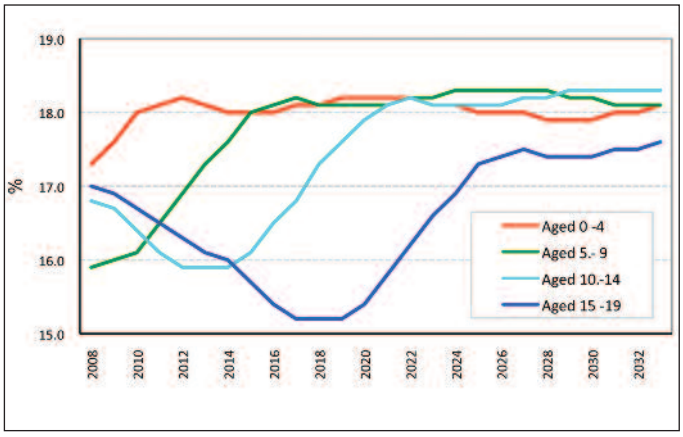


Figure 1 - Projected percentages of children and young people by age group within Walsall (2006-2025)

Source - ONS

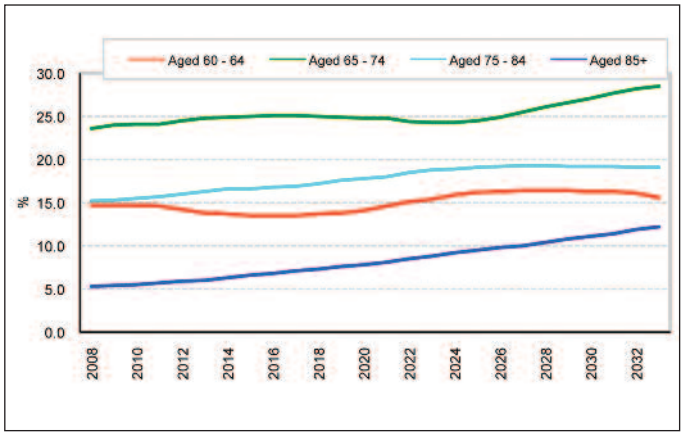


Figure 2 - Projected percentages of older people by age group in Walsall (2006-2025)

Walsall like many areas nationally, shows signs of an ageing population with people living longer. Projections support this with age groups of the over 60's all gradually increasing over time, particularly so for those over the age of 75. Life expectancy in Walsall is also improving. Both male and female life expectancy is increasing, with females living 5.5 years longer than males.

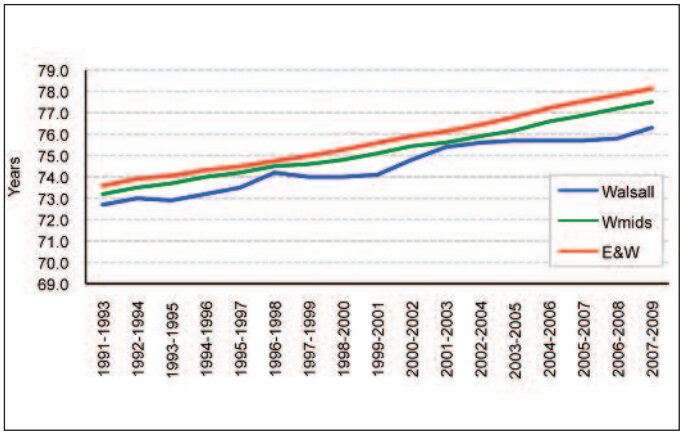


Figure 3 - Male Life Expectancy in Years

Source - NCHOD

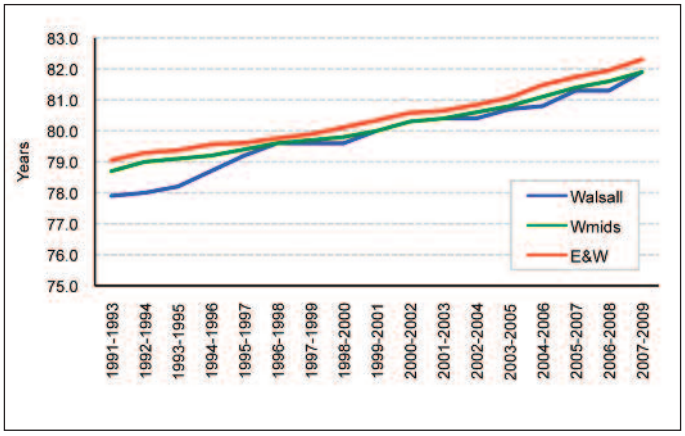
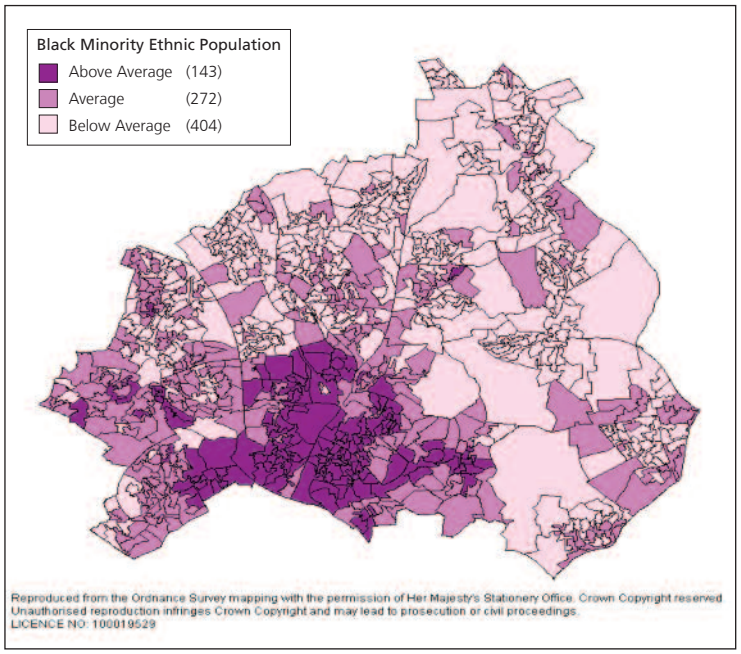


Figure 4 - Female Life Expectancy in Years

The gap in male life expectancy over the last 15 years has increased between Walsall and regional and national figures. Although male life expectancy is still increasing, it has reached a plateau for 3 of the last 4 years. In contrast, the gap for female life expectancy is reducing, with Walsall's figure close to the regional and national years.

The ethnic breakdown of the population in Walsall has varied considerably when compared to other neighbouring areas. 2001 Census figures recorded 13.6% of people from a Black Minority Ethnic (BME) group in Walsall compared to 9.1% nationally and 11.3% regionally. Local estimates however, suggest Walsall's BME population to be around 20%. Typically high concentrations of ethnic communities can be found in central and southern parts of Walsall borough (as illustrated in Map 1 below).



Map 1 - Black Minority Ethnic (BME) breakdown in Walsall by LSOA

Source - 2001 Census

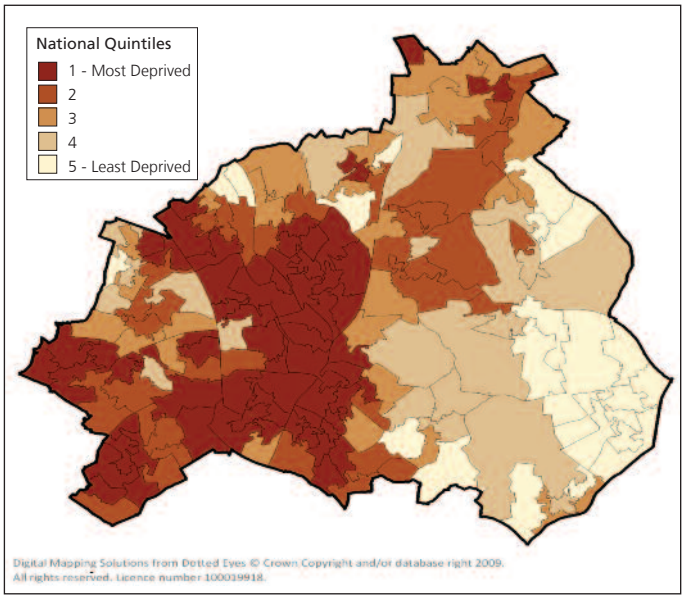
Prior to 2004, deprivation data for Walsall was produced at ward level, of which there are 20 in the borough. Although useful at the time, it was felt that a lot of variation in deprivation was lost in aggregation. For example data relating to Redhouse Estate in Aldridge, a considerably deprived area within an otherwise affluent area, was not visible due to being hidden within the overall ward data.

Post 2004 the unit of area used for measuring deprivation data was smaller consisting of areas with an average of 1,500 people. This allowed for better focus on specific health needs.

The Indices of Multiple Deprivation 2007 (IMD 2007) is a Lower level Super Output Area (LSOA) level measure of deprivation and is made up of seven domain indices - income, employment, health and disability, education skills and training, barriers to housing and services, living environment and crime. There are also two supplementary domains Income Deprivation Affecting Children Index (IDACI) and Income Deprivation Affecting Older People Index (IDAOPI). These two supplementary domains focus on the specific impact of income and how that impacts on their level of deprivation.

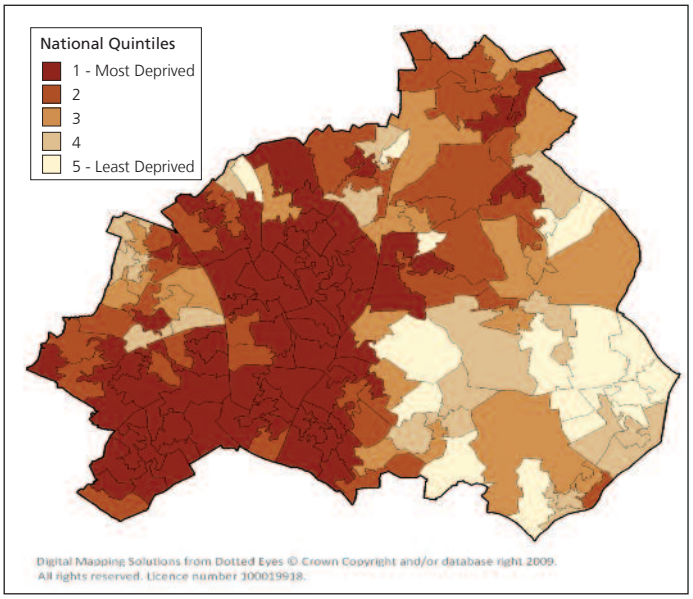
The IDACI focuses only on children aged 0-15 living in income deprived households - defined as either households receiving a range of different benefits with an equivalent income below 60 per cent of the national median before housing costs. The IDACI is the proportion of
children 0-15 living in such households as a proportion of all children 0-15.

The IDAOPI focuses on adults 60 or over living in pension credit (guarantee) households as a proportion of all those 60 or over.



Map 2 - Income Deprivation Affecting Children Index 2010 by LSOA in Walsall

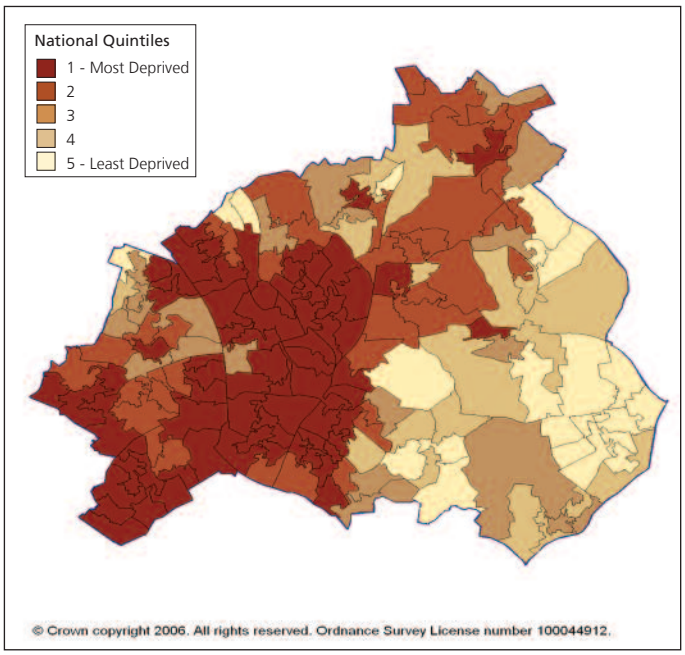
Source - Communities and Local Government



Map 3 - Income Deprivation Affecting Older People Index 2010 by LSOA in Walsall

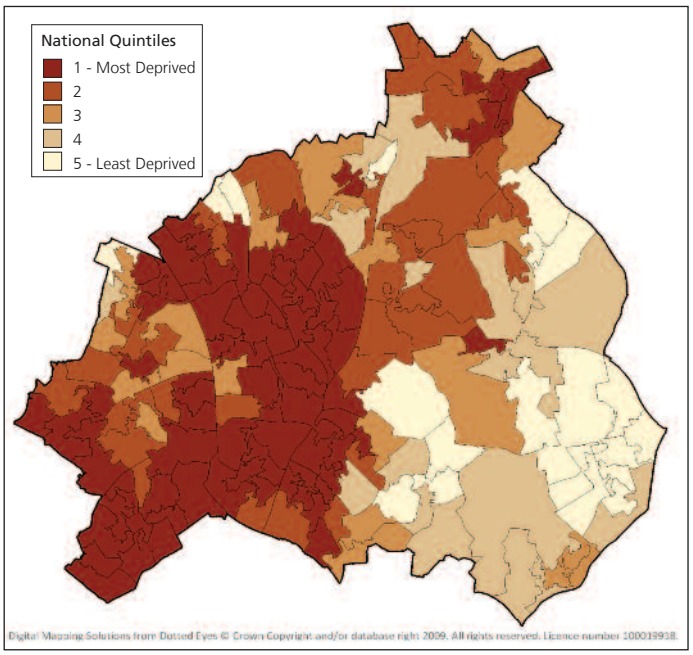
The overall deprivation rank of average score for Walsall in 2010 was 35th most deprived (out of 326 local authorities), this has subsequently worsened since the last deprivation data release (in 2007) where Walsall ranked 45th.

Deprivation levels despite having worsened since the last release of data in 2007, still conform to the familiar pattern when mapped by lower super output area (as illustrated in Maps 4 and 5 below), with just a few select LSOA's showing as more deprived.



Map 4 - Overall Deprivation 2007 by LSOA in Walsall

Source - Communities and Local Government



Map 5 - Overall Deprivation 2010 by LSOA in Walsall

Central and western parts of the borough are typically more deprived than the east, with communities within Blakenall for example, as being in the most 5% deprived nationally.

The country as a whole are still feeling the effects from the recent recession, and this is reflected in the unemployment rates presented here (claimants of Jobseekers Allowance) which are based on the resident population bases produced by the ONS.

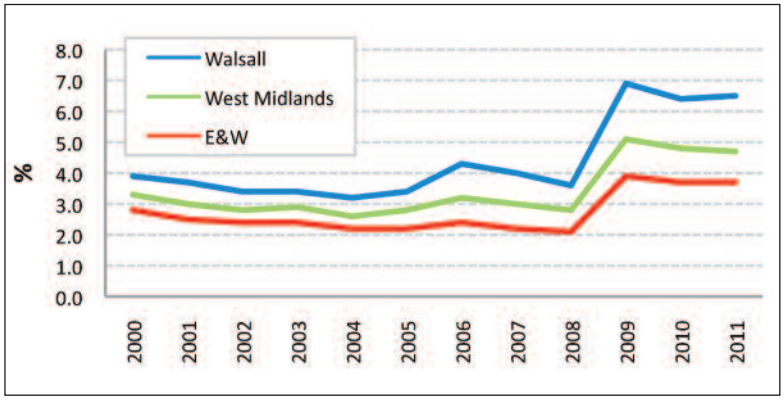
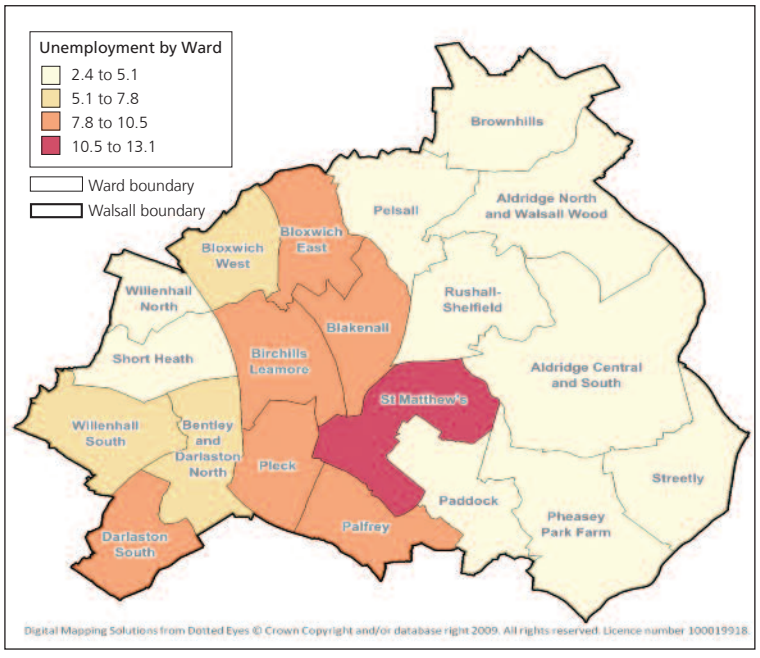


Figure 5 - Jobseekers Allowance Claimants in Walsall, May 2000 to May 2011

Source - NOMIS

Rates from 2000 to 2004 although highest for Walsall compared to regional and national figures were declining slightly. However, from 2004 to 2009, rates peaked and almost doubled, with the gap between Walsall and regionally and nationally widening. In 2010, following the recent economic difficulties, rates did begin to show signs of reducing, however 2011 figures rates show a slight rise for Walsall.



Map 6 - Jobseekers Allowance Claimants by Walsall Wards, May 2011

Source - NOMIS

High levels of unemployment are prominent to central and western areas. The central ward of St Matthew's has the highest rate at 13.1% (double the Walsall average rate of 6.5%) and Streetly has the lowest rate of 2.4%. This map illustrates clearly the common east/west divide in Walsall.

Key Recommendations

- Public health is everyone's business; and everyone's business impacts on public health. Recognising this truism, all public bodies and organisations in Walsall should consider the impact on public health of all their business, commercial, and operational decisions.
- The Local Authority's planning decisions can have a major influence on the environment for health. All partners should explore how health and well-being can continue to be enhanced through initiatives which promote:
    - Cycling, walking and public transport over car use
    - Active transport for school children
    - Safe and enjoyable public spaces
    - Local shops that stock and sell fresh and healthy produce, and exclusion zones for food takeaways near schools
    - Change in the ethos of its leisure centres from an exercise focus to total health, e.g. screening, healthy lifestyles and health checks
- Housing has a real influence on health and well-being. The profile of work already underway in Walsall on the Health Housing agenda should be raised and partners need to accelerate work to tackle non-decent housing and improve the energy efficiency of homes in the private sector.

Introduction

When we talk about health and the environment, most people would understand that it is the physical environment of land, air and water that we are concerned with. The importance of good air quality and safe drinking water goes without saying. We take for granted the improvements that have been gained over the last century in these pre-requisites for health.

But the environment also means the social, cultural, economic and geographical factors that influence our behaviour in relation to health. Specifically in relation to the modern epidemic of obesity, the view has been gaining ground for some time that it is the 'obesogenic environment' that needs to be tackled if the gains made in health in recent decades are not to be lost to obesity-related diseases such as diabetes and heart disease.

It is in this context that we address in this chapter the steps we can take to improve the environment for health.

Evidence from Previous Annual Reports

In an occasional report on long term conditions in 2007, Sam Ramaiah presented data from 2005/6 to illustrate the burden on long term conditions in Walsall compared with national figures.

Long term conditions, also known as chronic diseases, are a collection of diseases or groups of diseases that progressively affect health and for which modern medicine offers no cure. The role of treatment services, including the use of medicines, physical therapies and on occasion surgery, is confined to controlling the progress, alleviation of symptoms, and prevention of further organ damage and complications.

The 2006 report presented data on:

- Coronary Heart Disease (CHD)
- Stroke and TIA
- Diabetes
- Hypertension
- Chronic Obstructive Pulmonary Disease (COPD)
- Asthma

Condition	National Figures	Walsall				
		Whole Population	General Practice Registers*	A&E Attendances	Hospital Admissions	Death
	Estimated Number & Prevalence (%)	Number in Population	Number and Prevalence (%)	Av per year	Av per year	Av per year
All conditions				**75,000**	**64,000**	**2,500**
All chronic conditions	17,400,000 (33%)	88,500 (33%)	73,500 (29%)	2,500	11,000	1,650
CHD	1.5 million men 7.4% men 1 million women 4.5%women	11,600 (7,000 men 4,600 women)	11,000 4%	500 60% are men	2,000 64% are men	500 64% are men
Stroke and TIA	130,000	600	4,000 1.5%	70	450	240 60% women
Hyper-tension	16 million 20%	38,000	35,000 or 13.5%	70	85	20-25
Diabetes	2 million 3.5% and rising	13,000	Over 12,300 4.6%	180	300	40
COPD	Between 3-10%	7,600 to 25,400	3,800 1.4%	Between 150-800	750	140
Asthma	5.2 million (1.1 million children)	22,000 (5,000 children & 16,500 adults	15,000 5.8%	750	340	9
Epilepsy	450,000 0.8%	2,000	1,750 0.7%	70	200	4
Cancer	227,000 (cases/year)	1,250 incidence	In devevelopment	16	7,000 total admissions	650
Renal Disease	10% of people have CKD	20,000 people over 16	5% have stage 3,4,5 CKD	None coded	6	30
Hypo-thyroidism	2% over 60's	1,100 over 60's	5,100 1.9%	1	4	1

Table 1 - Data presented in the 2006 Annual report showing the numbers of known registered cases, hospital admissions, A&E attendances and deaths from selected causes.

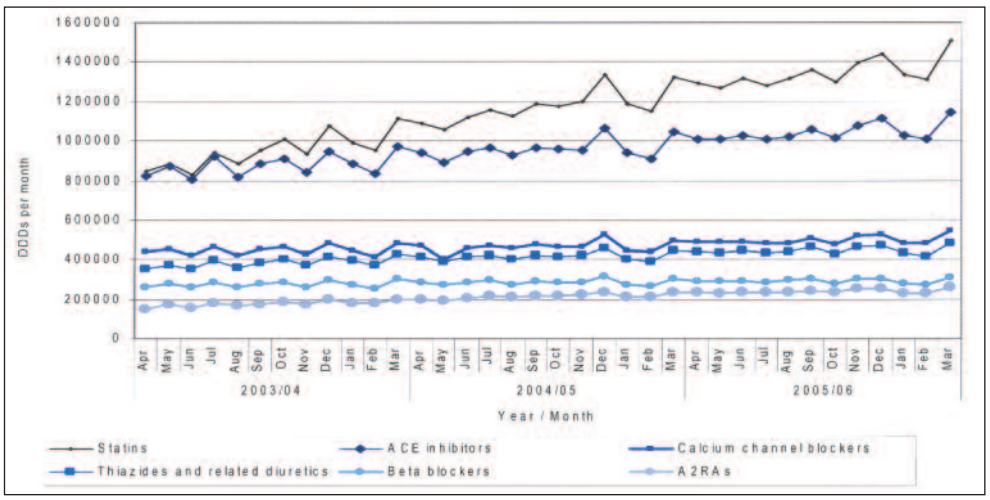


Figure 6 - Chart presented in the 2006 Annual report showing the growth in the use of drugs for heart disease between 2002 and 2006.

Source - 2006 Annual Report

Data at the time showed that the burden of chronic diseases as measured by the level of medicines being prescribed was growing. Even between 2002/3 to 2005/6 there was as much as a 70% rise in the use of some drugs such as statins for raised cholesterol levels.

In the Annual Report of 2007, Sam Ramaiah presented a public health perspective on alcohol and its toll, both on the physical health of the people of Walsall, and the social ill-effects of excessive drinking.

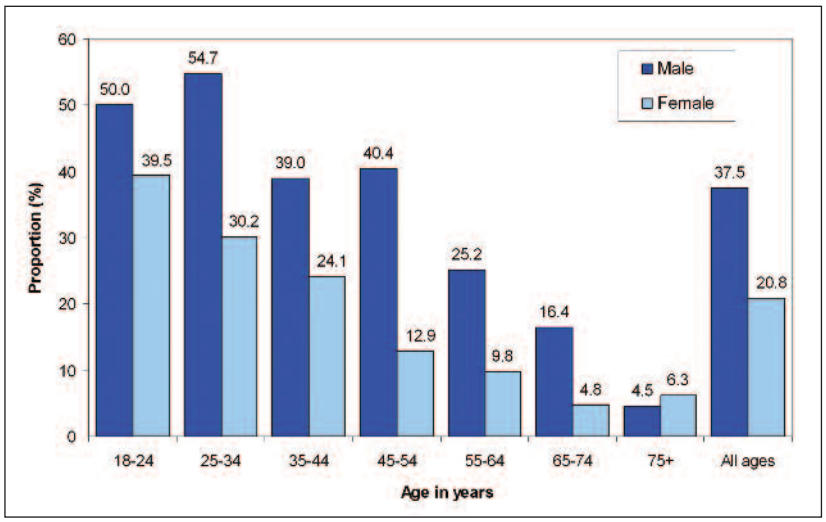


Figure 7 - A chart presented in the 2007 Annual report showing the proportion of Walsall drinkers who reported drinking more than twice the daily safe limit, 2005.

Source - West Midlands Lifestyle Survey, 2005

The situation today

The burden of ill health resulting from long term conditions has increased since the earlier report of 2005.

Data from General Practice

The successful implementation of the Quality and Outcomes Framework in general practice - a mechanism of measuring and rewarding quality care in general practices - has given us good quality local data. Family doctors now keep up to date registers of their patients with defined conditions.

		2006/07	2007/08	2008/09	2009/10	2010/11
Heart Disease	No	10,504	10,555	10,706	10,793	10,810
	%	3.95	3.95	3.99	4.00	4.01
Diabetes	No	12,898	13,835	14,799	15,789	16,328
	%	4.85	5.17	5.51	5.86	6.06
COPD	No	4,072	4,452	4,824	5,150	5,548
	%	1.53	1.66	1.80	1.91	2.06
Cancer	No	2,182	2,680	3,121	3,628	3,990
	%	0.82	1.00	1.16	1.35	1.48
Asthma	No	15,402	15,611	16,112	16,597	16,971
	%	5.79	5.84	6.00	6.16	6.30

Table 2 - Data from general practices in Walsall showing the year on year growth in the number of people known to have the chronic disease listed. *Source - QMAS*

The data in Table 2 shows us that between 2006/7 and 2010/11, there was a:

- 3% rise in the number of people with coronary heart disease
- 26% rise in the number with diabetes
- 36% rise in the number with chronic lung disease (COPD)

It is likely that a part of this rise is apparent rather than real; better recording of data means that more cases are recorded; and increased availability of data in electronic records makes analysis easier. Nevertheless, this cannot be the whole explanation. The rise in the number of people with diabetes certainly mirrors similar rises reported nationally, from studies that take account of the artefact of better data and better case ascertainment.

Diabetes and heart disease are not only linked causally but are in turn linked to a facet of modern life that does lend itself to public health action. That link is obesity.

Obesity

Obesity is the scourge of modern public health. We know it damages our health, we realise the many factors that are responsible for it, we even recognise that a combination of healthy food and increased physical activity is the answer. But collectively we seem unable to stem the rising tide of ever expanding waist lines.

Figure 8 below, present's publicly available data for England that plots this inexorable rise in the burden of obesity.

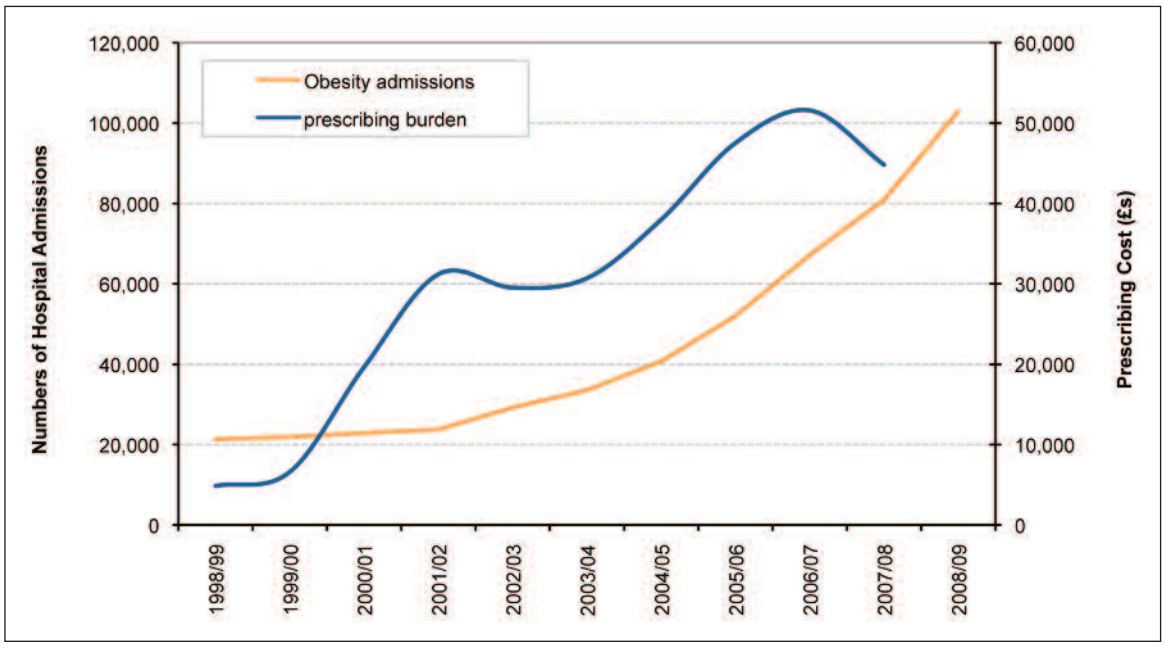
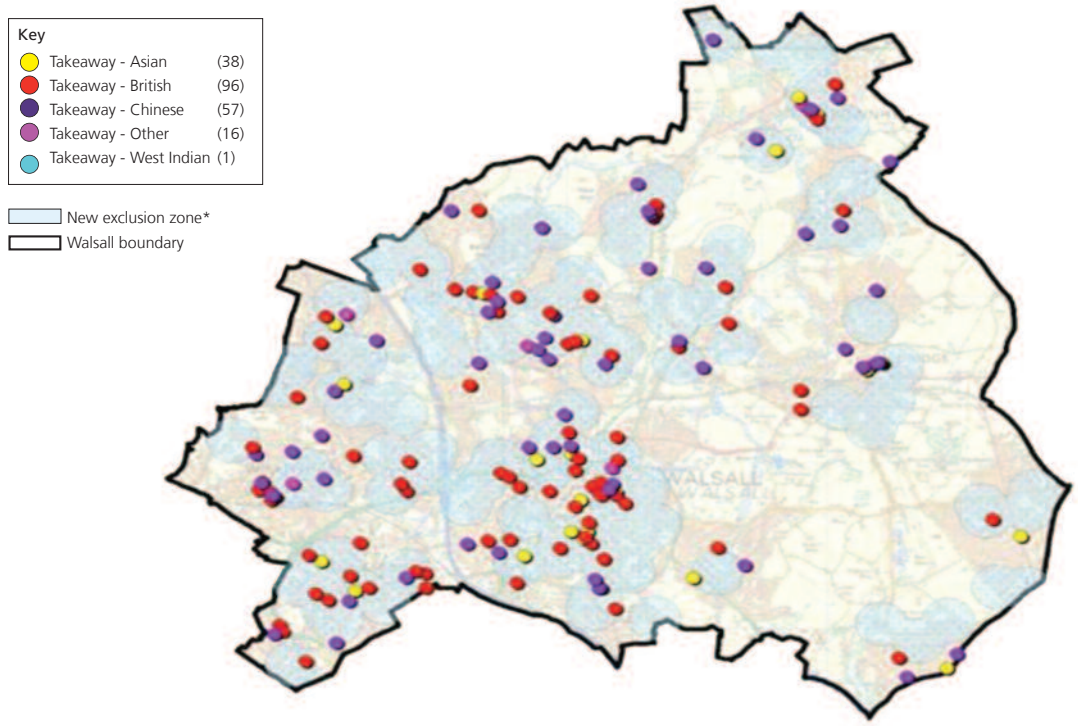


Figure 8 - Obesity hospital admissions and the prescribing costs of obesity treatment. Between 1999 and 2009 the number of hospital admissions with a primary or secondary diagnosis of obesity in England rose by just over 500%. The blue line shows the rise in the costs of prescribing 3 drugs commonly used to control weight, sibutramine, orlistat and rimonabant. The data is for England.

Source - NHS Information Centre website

Takeaways within walking distance of schools are certainly contributing to the obesogenic environment that children in Walsall face every day. An increasing number of Local Authorities are restricting the licensing of hot food takeaways in the vicinity of school gates and Walsall should move to follow suit.



*New exclusion zone where planning permission will not be granted for hot food takeaways (Class A5) if they fall within 400m of a school.
(Includes primary schools, secondary schools, special schools, children centres and nurseries).

Map 7 - Hot food takeaways in Walsall with 400m zones around schools highlighted.

Source - Planning Services, Walsall Council, PHIT

Alcohol

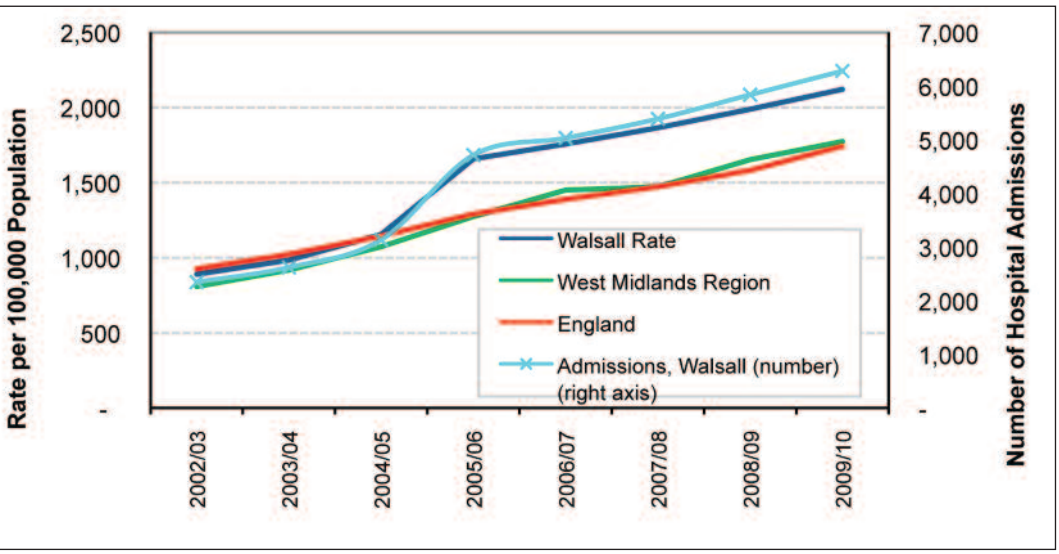


Figure 9 - Alcohol-related hospital admission rates 2003 to 2010. The lines plot the growth in the alcohol related hospital admission rate per 100,000 population for Walsall, West Midlands region and England. Also shown is the actual number of hospital admissions for Walsall residents, to be read against the right hand axis.

Source - LAPE

Excessive alcohol consumption is linked to a range of diseases that end up as a chronic disease - including a few that are not included in the list of conditions that make up the long term conditions (Table 2).

Here again, despite the call to action both nationally from the Department of Health's alcohol strategy and Walsall's own report on alcohol in 2007, the trend is in the wrong direction.

Housing

Housing has a real influence on people's health and well-being. For instance, long term conditions such as COPD and asthma are exacerbated by living in cold and damp conditions. In Walsall, we need to continue the focus on tackling non-decent housing and improve the energy efficiency of homes in the private rental sector. It is essential public health, the Local Authority and the wider housing sector continue to work collaboratively in improving housing standards and thus impact positivley on the well-being of Walsall's citizens.

Prevention rather than cure

There is no doubt that the health services in Walsall have responded to the burden of disease in the population by providing more responsive services. The charts above show that we are spending more on drugs for obesity, and providing more hospital treatment with interventions such as bariatric surgery.

The trouble with an approach to these problems that is confined to curative health services is that despite the name, the service is not truly curative, nor is it particularly sustainable. It is not curative in that while the immediate problem may be ameliorated to some extent, the patient has not been fully returned to the pre-morbid state of health. The underlying societal problem has been left unchecked. Nor is it sustainable in the long term in that the health service will rapidly run out of resources if all we ever do is offer so called curative services.

We need a more intelligent response, one that stems the tide in the medium term while dealing with the immediate needs of those most affected today. This is recognised, for example, through the development by NHS Walsall of healthy weight pathways that have been successful in reducing the amount of bariatric surgery required in Walsall compared with other pct areas that do not have specialist weight management services.

We need to reshape the environment for health in such a way that people choose to live healthily, opt for lifestyles that preserve and promote health and well-being, while encouraging those with milder forms of long term conditions to be their own best physician.

Evidence from research

Can a condition like diabetes be delayed or reversed by means of modifying health behaviours? The evidence is encouraging. Consider the following two stories, one a decade old and the second more recent.

In 2001 the Finnish diabetes prevention[1] trial showed that a programme of moderate physical activity accompanied by a modest drop in body weight could reduce substantially the risk of developing diabetes among middle aged men at high risk of developing diabetes. Had we taken the message of that research and implemented its findings we might have been in a very different place now.

In 2011, a Newcastle group[2] showed convincingly that established diabetes can be reversed to complete normality by dietary treatment alone - but the dietary restriction has to be drastic - a daily intake restricted severely to 600 calories over an 8 week period.

These two studies show that it is feasible to prevent disease by becoming more active and controlling diet. Whether we can roll out the results to a population and achieve the same effect will depend on our collective will to change the environment for health.

This is the kind of intervention that cannot be left to individual decisions made by people acting on their own in consultation with their doctor. It is not a drug that can be prescribed. This is the kind of intervention that calls for societal action at the level of the community, making the kind of change that makes the healthy option the easy option. There is a crucial role here for communities, groups, individuals acting in concert with organisations, and for statutory bodies like the Local Authority, the health service, employers and businesses.

[1] *Tuomilehto J and colleagues. Prevention of Type 2 Diabetes Mellitus by Changes in Lifestyle among Subjects with Impaired Glucose Tolerance. New England Journal of Medicine. 2001; 344:1343-1350, May 3 2001*

[2] *Lim EL, and colleagues. Reversal of Type 2 diabetes: normalisation of beta cell function in association with decreased pancreas and liver triacylglycerol. Diabetologia. Published on-line 5 May 2011. http://www.diabetologia-journal.org/Lim.pdf*

Summary

Long term conditions and chronic diseases are affecting more and more people in Walsall. While clinical services manage and slow progression of major long term conditions, they are not a long term sollution for a more sustainable and enduring response to the ever growing modern epidemic of chronic disease. We need to do more to prevent and recent research shows that this is feasible.

Our recommendations are aimed at structural changes that encourage this shift in thinking towards prevention.

Key Recommendations

- The health of individual people depends upon strong, supportive communities that nurture and sustain mechanisms to cope with adverse circumstances. Health and Local Authorities in Walsall should identify, support and encourage community groups to build up their capacity to identify local needs and provide support to the most vulnerable in society.
- Community groups in turn should pro-actively engage with statutory bodies, demand more responsive and better services and hold public bodies to account.
- The effects of the global economic downturn of 2007-8 and the economic recession of 2008-9 in this country are likely to continue to be felt for some time. All partners need to work together to manage the impact of the recession on health and well-being of families, children and communities. In particular, the impact on the unemployed 16 - 24 year olds and those in financial difficulties as a result of redundancy.
- All agencies need to agree the key priorities and actions for Walsall which will reduce inequalities in health determinants which lead to inequalities in educational attainment and skills.

Introduction

The term Big Society comes from a major policy initiative by the Coalition Government announced in 2010. Big Society is premised on the idea that individual people acting in groups or as communities can do very much more for their own betterment than political or civic leaders think. The Government's policy initiative on Big Society[3] is aimed at 'creating a climate that empowers local people and communities, building a big society that will take power away from politicians and give it to people'.

The idea of a central role for society is not new for Public Health. There has always been a big role for social and community structures in promoting health and creating a sense of belonging, participation, fairness and ultimately, a feeling of well-being. The leadership and facilitation role of the Local Authority is fundamental to this agenda and the work to date between public health and its Local Authority partners has resulted in improved outcomes for residents in Walsall. Vulnerable groups, in particular, are more likely to engage with their peers and this is recognised in the work NHS Walsall and Partners are commissioning through the Citizens Advice Bureau (CAB), using volunteers from migrant communities in Walsall to support other migrants in accessing health services. Individuals can share their views and concerns about health services through MyNHS Walsall, a public membership scheme for residents/Walsall GP patients who have an interest in local health services. Through the MyNHS Walsall Parliament, members have a direct route of communication to local health chiefs. At a neighbourhood level, Local Authority Area Partnership's are supported by all Partners and actively encourage local residents to engage with statutory services and other community members about a variety of health related issues.

Planners and decision makers need also to see health and well-being in the widest sense. Health can all too easily be defined in terms of disease labels and incidence and prevalence rates. Important as these measures of ill-health are, they have some big drawbacks. For a start they focus on the negative, the absence of health. They treat an individual as a single entity without reference to his role and place in the wider community.

Alternatively, health can also be seen as the ability to cope with life's adversities. Individual people vary greatly in how well they can cope; partly as a result of the resources they have available to them. But a strong and supportive community, whether as informal social networks, or formal organisational structures such as workplaces, trade unions, co-operatives, charities, spiritual groups, or voluntary organisations, can all raise everyone's ability to cope through support structures and by offering a participatory role to everyone.

Unequal societies tend to have poorer levels of population health and happiness[4]. The two most important facets of well-being are therefore population mental health, and lack of economic opportunities. This chapter will focus on these two issues.

[3] See http://www.number10.gov.uk/news/big-society/ for the launch announcements. Also http://www.cabinetoffice.gov.uk/big-society for details of how the Government is developing the concept and where the Big Society Fund is spending its money.

[4] Richard Wilkinson and Kate Pickett. The Spirit Level. Why Greater Equality Makes Societies Stronger. 2009, Bloomsbury Press. See also 'Fair Society, Healthy Lives' a review of health inequalities by Sir Michael Marmot. The full review report and other documents are available on http://www.marmotreview.org/

Evidence from Previous Annual Reports

In his 2005 Annual Report Sam Ramaiah took up the theme of minority communities. In 2001, Black and Minority Ethnic (BME) groups made up 13.6% of the population. There was extensive evidence that these groups were particularly affected by disparities in health outcomes and disease prevalence.

In 2000, Sam Ramaiah's Annual Report looked at mental health in Walsall. It was partly in response to the then Government's National Service Framework for mental health, but the report considered more than just clinical health services for mental illness. Looking back now, it was more prescient than even Sam might have thought at the time.

The report focussed on four key areas:

- The determinants of emotional well-being and mental health in Walsall
- The manifestations of poor mental health in the community
- The burden of mental illness in Walsall
- The response of mental health services to local mental health issues

Good data on mental health have always been scant, more so in 2000. But by exploring the known determinants of mental health and their distribution among Walsall's people, the report succeeded in focusing the attention of decision makers and leaders on areas with the greatest need.

In parts of Walsall the adult unemployment rate was as high as 14%. There was a clear east west divide even within Walsall, with electoral wards in the west and north suffering higher rates of worklessness.

Drug and alcohol misuse, both a consequence and in turn a cause of poor mental health and well-being was prevalent in certain parts of Walsall - again particularly affecting areas in the west of the district. Using hospital admissions for self harm as a crude proxy for more precise measures of mental ill-health, the report showed that the young were disproportionately represented in these statistics.

The report also looked at services for people with the most serious forms of mental ill-health, highlighting the need for partnership and closer working among the various agencies, and for a more holistic approach to the case of such people, involving the family, and with an emphasis on rehabilitation with a view to successful return to the community rather than just institutional care.

The situation today

Mental Health

Earlier this year the Government published its plan for better mental health. Called 'No Health without Mental Health' it sets the scene for the next stage in our efforts to improve mental health and well being. The strategy made several important points:

- 1 in 4 people will at some stage in their lives, experience a mental health problem of variable duration. At any one time 1 in 6 adults has a mental health problem. Depression is surprisingly common; half of all adults will experience at least one episode.
- Most long lasting mental illnesses start at a young age. Half of those with lifetime mental health problems first experience symptoms by the age of 14, and 75% do so by their mid 20's.
- Serious and enduring mental illness can have a major detrimental influence on the physical and social functioning of the individual affected; beyond that it also affects other people caught up in the circle of family and friends who may be caught up in dealing with the consequences.
- Severe mental illness can have a detrimental effect on physical health, leading to a reduction of life expectancy of up to 10 years.

The new strategy places a strong emphasis on developing a holistic approach to helping individuals and families to prevent and cope with mental illness rather than have to fall back on drugs to treat the symptoms. This approach calls for:

- Greater involvement of individuals, families and communities, organisations, and community voluntary groups in promoting mental well being.
- Psychological therapies (so called talking therapies) to be available more widely and for more people as a first line response.
- More co-ordinated and responsive services to deal with individuals affected at an early stage of the illness to prevent chronicity and encourage an early return of social functioning.
- People with mental illness caught up in the criminal justice system to be offered help and support to deal with the mental illness that led to the criminal behaviour.
- Help and encourage people with mental health problems to return to employability.
- Concerted action to eliminate the stigma faced by people with mental illness.

The Present Burden of Mental Illness in Walsall

Data from specialist mental health services

Figures from the NHS Information Centre show that in the last 4 years for which we have good data, there has been a steady growth in the number of people seen by the secondary or specialist mental health services.

	Number admitted	Not admitted	total
2006-07	508	7970	9101
2007-08	450	8534	9998
2008-09	532	9397	11238
2009-10	537	10306	11896

Table 3 - Data from NHS Information Centre analysis of Mental health minimum data sets.

Source - NHS Information Centre website

Notes: these figures are counts of individual patients from Walsall PCT who have been in contact with specialist mental health services. The first column is the number of people admitted as an inpatient even if only for a day. The 'not admitted' category counts all those who had some form of community or outpatient contact in the year. The totals may not add up because it includes a small number of patients in each year who were under follow up but may not have been seen. This reflects the long term nature of mental illness.

Information on drugs prescribed for mental health problems

In addition to specialist treatments, a large proportion of people with mental health problems are seen by general practitioners. A good measure of the scale and extent of community mental illness is the amount of medicines prescribed by family doctors.

Benzodiazepine Use

Benzodiazepines and so called Z-drugs are used to treat anxiety and insomnia. They are powerful agents whose use should ideally be confined to short term use in selected cases where other measures have failed. When used for long periods, they lose their early effect and can lead to dependence. Nevertheless their use has grown since they became available.

There is no accurate system that keeps track of the number of people in Walsall who are prescribed these drugs on a regular or intermittent basis. What is counted though is the number of prescriptions that are issued. Currently in Walsall, about 110,000 defined daily doses are prescribed each month. This number has not changed significantly since 2006.

While it is difficult to argue that the use of such drugs is bad, it is equally the case that their use, while a reliable indicator of the prevalence of poor mental health, is neither a desirable nor a complete response. There are other more holistic approaches to dealing with the issues of anxiety, worry, insomnia, phobias and personality disorders. But these approaches call for the involvement of many agencies, community groups, and for the development of social networks and support systems for people caught up in life's crises.

Defined daily doses (DDDs) per 1,000 Prescribing Units (PUs) is a measure of the prevalence of the use of these drugs taking account of the population structure.

Figure 10, taken from a Keele Medicine's Management report shows that Walsall actually has a relatively low use of these drugs compared to other districts in the West Midlands.

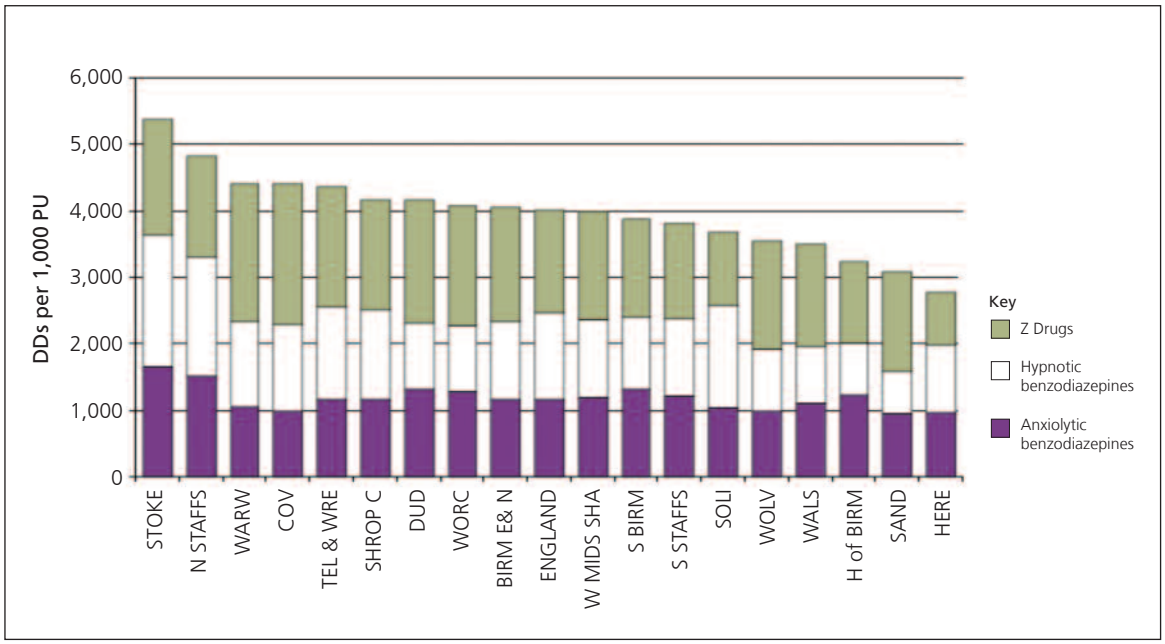


Figure 10 - Chart showing the use of the 3 classes of sedative drugs by PCTs in the West Midlands October 2008 to September 2009. Walsall data is shown in the 4th column from the right. Defined daily dose (DDD) per 1,000 Prescribing Units (PU) is a measure of the amount of prescribing that takes account for the population size and structure and the variation in amounts prescribed.

Source - Quarterly Therapeutics Review, January 2010, Department of Medicines Management, Keele University

Antipsychotic Medication

Walsall currently spends around £160,000 each month on drugs for treating major mental illness. This is half as much again as used to be the case at the end of 2006.

The vast bulk of antipsychotic medication is from the category known as atypical antipsychotic drugs; these are newer drugs and result in fewer side effects. In terms of defined daily doses, the use of this class of drug treatment has grown by a quarter since 2006, while the use of the other two types of drug, the typical antipsychotics and the long acting depot injections has remained broadly the same.

The reason for the 50% rise in expenditure of antipsychotics is therefore a combination of greater awareness of the potential of drug treatment to control symptoms, and the availability of newer, more expensive drugs.

Figure 11 shows that Walsall has the second highest rate spend on Antipsychotic medication of all the PCTs in the West Midlands.

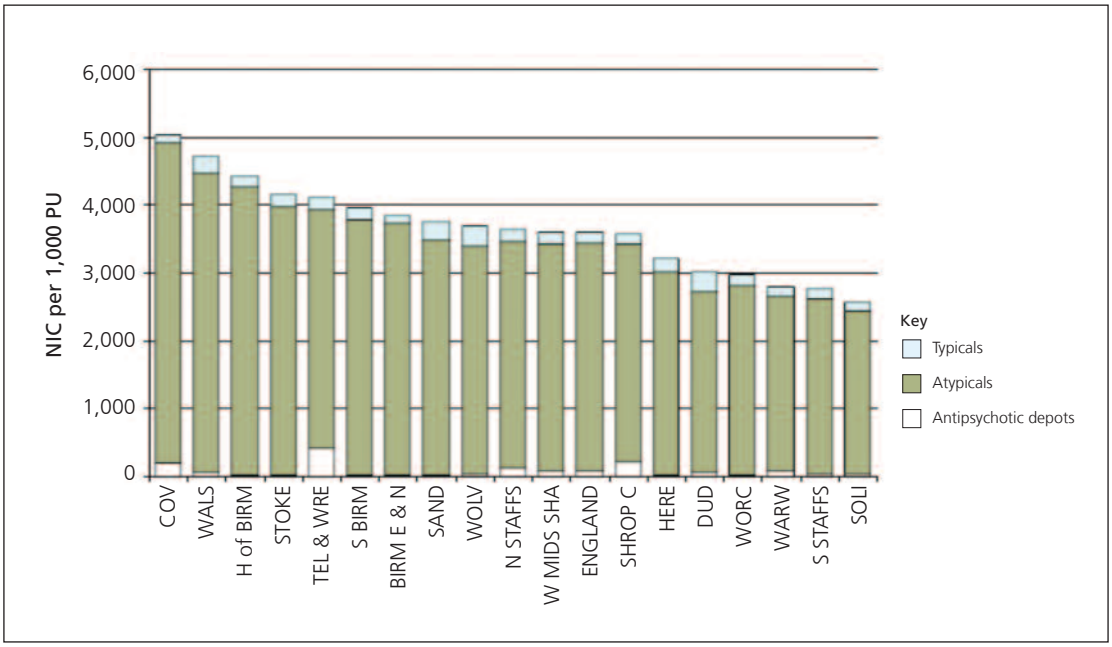


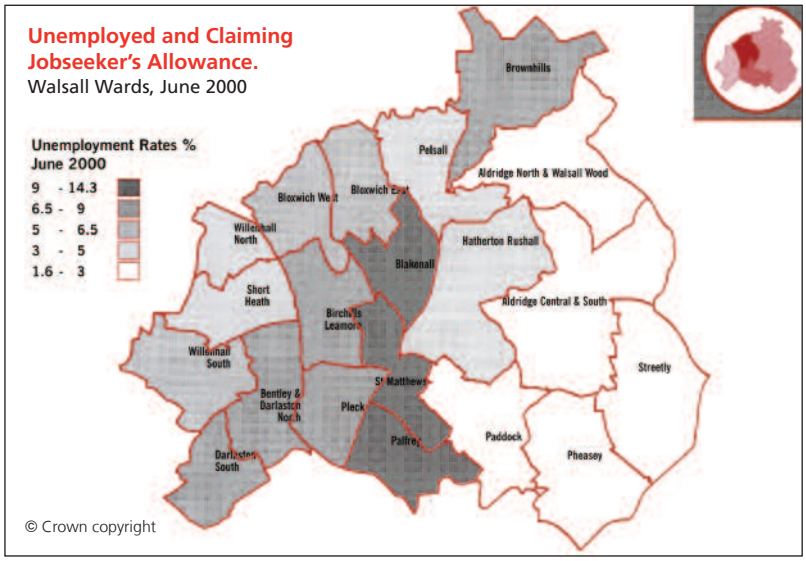
Figure 11 - Expenditure, as measured by Net Ingredient Cost (NIC), on antipsychotic prescription drugs, by Primary Care Trusts in the West Midlands Region, October 2008 to September 2009. NICs per 1,000 PU takes account of the population size and structure so that comparisons between districts are valid.

Source - Quarterly Therapeutics Review, January 2010, Department of Medicines Management, Keele University

Underlying causes of poor mental health

The 2000 Annual Report identified unemployment and underemployment as a major determinant of poor mental health. The link between poverty and ill health was established in the Black Report[5] (1980) which showed that the unemployed suffer worse from mental and physical health than those in work. Unemployment can lead to poverty, ill health and premature death.

[5] *The Black Report, 1980. http://www.sochealth.co.uk/Black/black.htm*



Map 8 - Map presented in the 2000 Annual report showing the East/West divide in the distribution of the proportions of Jobseeker's Allowance claimants. In general, wards in the west of the borough had more claimants.

This remains true today, and with the economic downturn of 2008 and the continuing rebalancing of the economy, this is a factor that is likely to continue to affect sections of the population for some time to come.

As of June 2011, a total of 10,243 Walsall residents were in receipt of Jobseekers allowance (JSA) - the main benefit payable to economically active adults who would like to work but cannot find a job. Our best estimate is that this represents a rate of 5.95 of the estimated adult (aged 16-64 inclusive) population of Walsall.

The trend over the last few years is presented in Figure 12 and is compared with the rate for the Region and for England.

Within Walsall, there is wide variation between the electoral wards, from 1.7% to as much as 27%. Table 4 below shows the number and rate for electoral wards in Walsall with rates above the Walsall average.

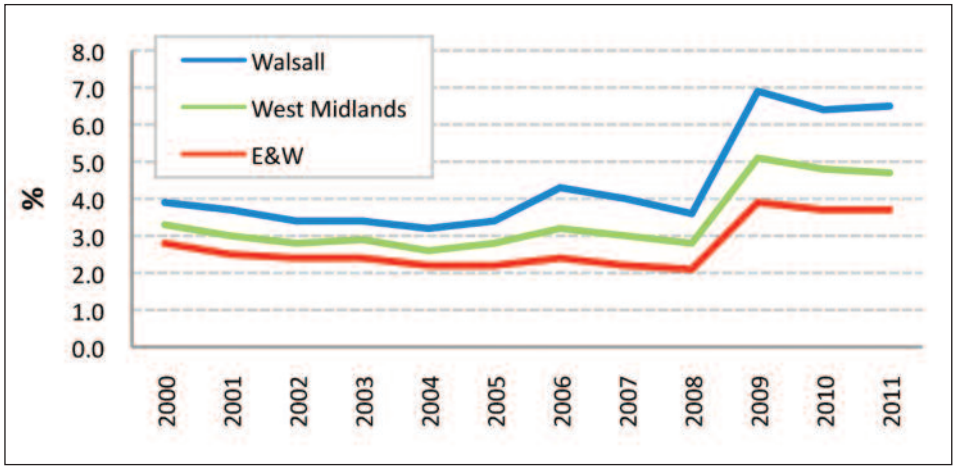


Figure 12 - Trend in the proportion of eligible (16-64) population claiming Jobseekers allowance, 2000 to 2011.

Source - Nomis

Ward	No. JSA claimants	Estimated % of 16-64 population
St. Matthew's	1,120	27.7%
Bloxwich West	635	4.6%
Darlaston South	673	14.4%
Pleck	618	13.3%
Hatherton Rushall	464	11.5%
Blakenall	618	9.0%
Palfrey	778	8.2%
Willenhall South	753	7.5%
Bloxwich East	537	6.9%
Total	10,243	5.9%

Table 4 - Jobseekers Allowance claimant counts by electoral ward as at June 2011. The percentage figures are estimates based on the latest estimated ward populations.

Source - www.data.gov.uk

Are we getting good value for our money?

Data presented elsewhere in this report (see chapter on Shopping for Health) shows that in comparison with other parts of the country, Walsall spends relatively less on mental health services while getting poorer outcomes. The differences between Walsall and other areas in these two measures is by no means large but it does raise the question whether there is not something that we can do to get better health outcomes by focusing more on upstream interventions aimed at helping people cope under difficult circumstances.

Summary

Big Society may be a new Government policy initiative but the role of society and community in preserving and protecting health and well-being has long been recognised in public health circles.

We should therefore take the opportunity presented by the Government's policy on Big Society and work with our Local Authority partners to encourage and facilitate the continued growth of social and community networks and organisations to improve the innate resilience of natural communities.

Key Recommendations

- Nudge is based on the idea that small subtle incentives can shift behaviours in the desired direction. The evidence base for it in achieving major change on a large enough scale in life-style behaviours that impact on health is unconvincing.
- There is a large and convincing evidence base for measures in the fields of alcohol-related harm, smoking, child accident prevention and early years intervention.
- All commissioners responsible for health and well-being should reconsider current programmes and initiatives which support lifestyle change to ensure these are based in the best evidence of what works and expand where necessary to meet the needs of the people of Walsall.
- Health commissioners should also consider targeted intervention to increase peoples' level of physical activity and reduce levels of overweight and obesity.
- Clinical services have a wider obligation to help their patients and their families to stay healthy. They should therefore make 'every contact count' in their programme to enable their patients to quit smoking, drink sensibly, and become more physically active.
- Health Commissioners should also ensure that commissioned change, collect systematically the necessary information to measure the local prevalence of smoking, alcohol consumption, physical activity and adult body weight and to demonstrate improved health and well-being outcomes.

Nudge: the theory and the practice

'Nudge' is the title of a 2008 book by American academics Richard Thaler and Cass Sunstein[6] that attracted the attention of policy makers as a new way of thinking about changing peoples' behaviour. Drawing on research in psychology and economics, the book proposed a social policy approach to shift people towards making better choices in fields such as saving for retirement, travel, or food, using means that did not involve legislation or hectoring by state agencies.

It popularised the terms *'libertarian paternalism'* - a combination of two ideas that are commonly believed to be at odds with each other - and choice architecture - the idea that the same range of choices can be presented in a different way so as to increase the likelihood that certain desired options to be preferentially taken up.

These ideas became popular in the field of Public Health in 2010 when the Coalition Government decided to set up a Behavioural Change Unit in the Cabinet Office to explore the use of these ideas in a range of policy areas including health - to find 'intelligent ways to encourage people to make better choices for themselves.'

The idea is appealing, especially to politicians unwilling to resort to regulation, legislation, or taxation to effect change in population health behaviour for fear of being accused of limiting freedoms. But is nudge enough to achieve health improvement on the scale that we seek? Does it work?

It is not our intention in this report to systematically examine this question. The House of Lords Science and Technology Committee have conducted a year long enquiry into the use of nudge as a public policy tool and its conclusions have been published recently[7]. Rather, we suggest that the scale of health problems that depend for their resolution ultimately on the choices that people make is such that we cannot wait for the 25 years that it takes for behaviour change to take hold at the population level.

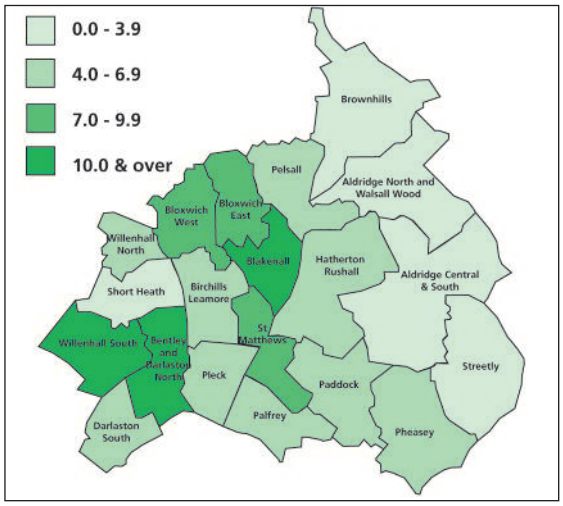
We need to make a choice between nudge (and waiting a long time for it to deliver results)

and, as the title of this chapter might suggest, taking a more proactive approach and tackling more directly some of these urgent problems, if necessary by being more directive of the choices that people make, without intruding on the liberties that we take for granted.

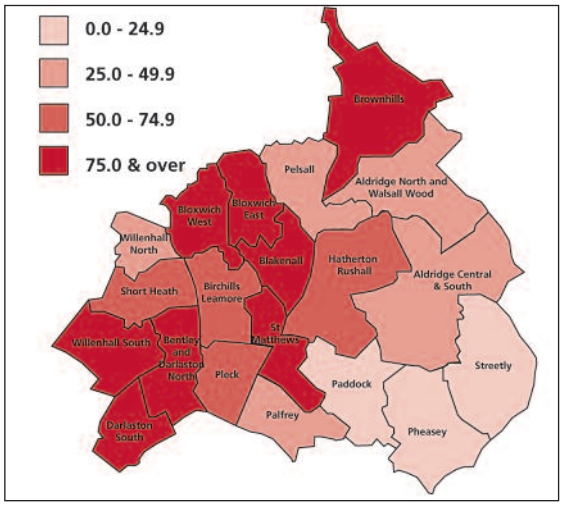
[6] *Richard Thaler, Cass Sunstein. Nudge: Improving decisions about health, wealth and happiness.2008, Yale University Press, Newhaven and London.*
[7]*The House of Lords Science and Technology Committee*
http://www.publications.parliament.uk/pa/ld201012/ldselect/ldsctech/179/179.pdf

Evidence from Previous Annual Reports

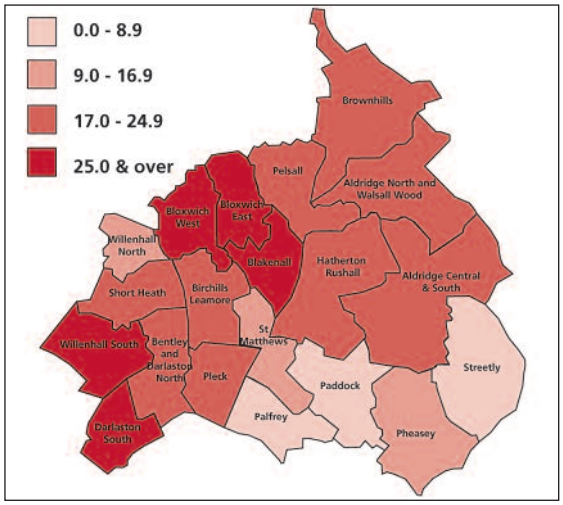
In 2004 Sam Ramaiah's Annual report carried out a health equity audit. It was, of course well known then, as indeed it is now, that there were widespread inequalities in health outcomes, such as death rates, and how long people would expect to live. Within the country there was a clear North/South divide with life expectancy in some poorer areas of the North of the country being 10 years or more less than in the south. But within Walsall too there were differences.



Map 9 - Variations in Infant Mortality rate presented in the 2004 Annual Report

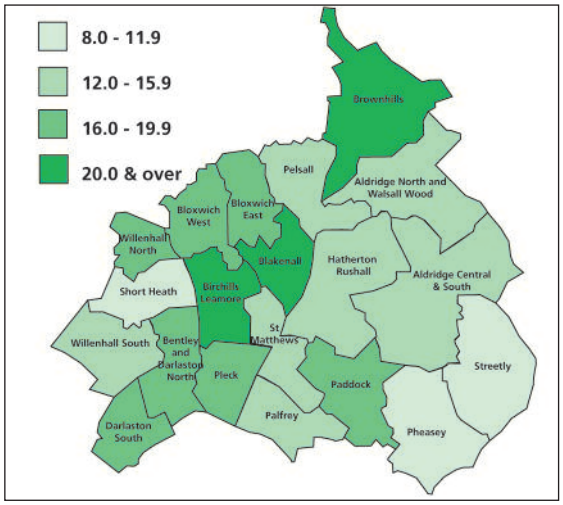


Map 10 - Conception rates in under 18's presented in the 2004 Annual Report



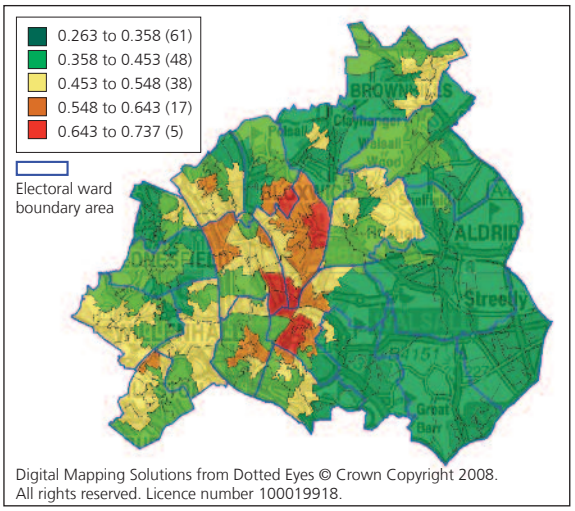
Map 11 - Smoking prevalence among pregnant women at first appointment with midwife, Walsall Hospitals NHS Trust, 2002, as reported in the 2004 Annual Report

Source - 2004 Annual Report



Map 12 - Obesity prevalence as reported in the 2004 Annual Report.

In a more recent report in 2008, Sam Ramaiah drew the attention of Walsall's policy makers to the section of the population that could, in some sense, be regarded as the socially excluded.



Map 13 - Social exclusion map from the 2008 Annual report

Source - 2009 Annual Report

These previous data are still relevant today. The issues identified are as prevalent now as they were then. The political context however has changed in terms of the preventive strategies that we need to adopt. The reality is that 10 years later in some cases, we are in much the same situation, highlighting the urgency with which we need to renew our resolve to act.

In relation to the changed policy context the key question for us is the extent to which nudge will deliver the behaviour changes that we must achieve if we are to reduce the poor health experiences of Walsall's people? Are there other things that we ought to be doing now that will deliver change in the short term? If, as some, including the House of Lords Science and Technology Committee, have argued, nudge has at best a limited effect at the level of individuals and no proven effect on whole populations, then it is relevant to ask whether a reliance on nudge theory might result in better health but only for some individuals while leaving health inequalities to grow.

The situation today

Figures presented elsewhere in this Annual Report suggest that Walsall's public health indicators lag behind the rest of the country. Furthermore the average Walsall figure for many indicators hides health inequalities within Walsall.

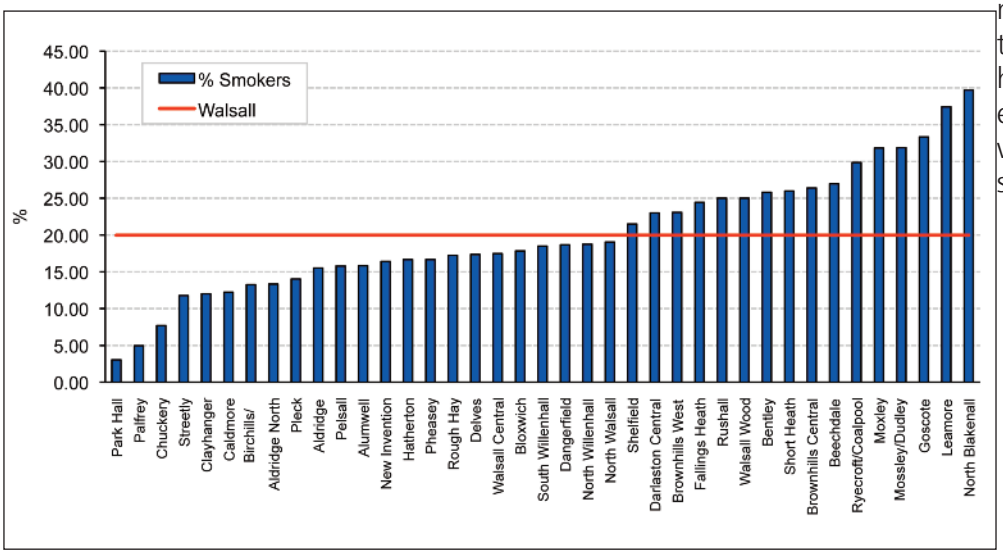


Figure 13 - Percentage of women smoking at delivery, 2009/10 by community area. There is still a wide variation in the proportion of women smoking in pregnancy from 3% to 40% among Walsall's communities. *Source - Walsall Manor Hospital*

Taking just one indicator as an example, the proportion of women who smoke at delivery shows a big variation among different community areas, ranging from very low rates of under 4% to nearly 10 times as great a percentage.

There is a 13% gap between Walsall (61.3%) and the rest of the country (74.3%) in the percentage of mothers initiating breastfeeding. The gap between Walsall and nationally has reduced considerably in 2011 compared to last year with a gap of 21%.

Smoking prevalence and the place of prevention

Smoking remains the single most important preventable risk factor for serious chronic disease and premature mortality. Prevention is clearly the best strategy to deal with smoking related illness.

However, getting smokers to quit seems to have become the mainstay of our efforts to deal with smoking as an avoidable risk factor. We have invested a great deal in a Stop Smoking Service and in pharmaceutical interventions coupled with counselling to wean smokers off their addiction.

The figure below shows the trends in the number of people who have been helped to quit by NHS stop smoking services. The outcome measure, the number of people who remain smoke free at 4 weeks, is at best a weak indicator of success. We know that a lot of people, who claim to have not smoked for 4 weeks after the date they have set for quitting, in fact relapse at some time over the next few months and years. Yet the development of a more meaningful measure of success, for example, 1 year quits, has proved difficult to measure and harder to sustain in practice.

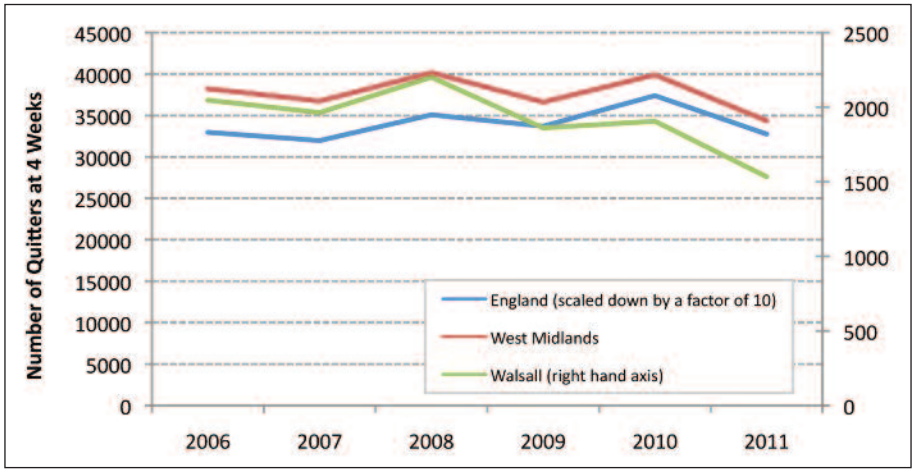


Figure 14 - Achievement of NHS Stop smoking Services as measured by the number of 4-week quits based on self reported success in giving up. The figures for England have been scaled back by a factor of 10 for presentational purposes. Walsall figures relate to the right hand axis. The focus in this chart is on the trends between 2005-6 and 2010-11 in Walsall, the West Midlands region and England.

Source - Information Centre for Health and Social Care, Annual reports on smoking cessation service

Prevention of smoking

These figures, with the limitation of 4-week quits as the outcome measure, show that we are finding it difficult to increase the number of quitters year on year. Indeed the numbers may even be levelling off.

We need therefore to move upstream and prevent rather than 'cure' smoking.

Efforts need to be stepped up to prevent people from taking up smoking in the first place. Measures such as reducing the accessibility of cigarettes, taxation coupled with action on smuggling, and public health messages and campaigns that present not smoking as the norm

and smoking as a departure from the default position are capable of achieving dramatic reductions in smoking uptake and prevalence. Our aim should be to reduce smoking rates to the levels seen in places such as California in the USA where the average prevalence rate is under 15% and in some communities much lower.

Excessive reliance on pharmacologically aided smoking cessation interventions, it has been argued in a recent research paper[8] in the British Medical Journal, ignores the fact that the majority of smokers who quit do so without using nicotine replacement therapy or attending any sort of service to help people stop.

[8] *Chapman S. Smoking cessation: big pharma butts in. http://www.bmj.com/content/343/7819/Feature.full.pdf 13 August 2011.*

Alcohol

As pointed out elsewhere in this report, alcohol related health problems are on the rise in Walsall. In the chapter on Shaping the Environment we looked at alcohol admissions and the related burden on health care resources. The data on alcohol related mortality is of no less concern.

An analysis from the North West Public Health Observatory shows that crime related to alcohol has indeed shown a fall in the five years to 2009/10, but the mortality rates especially in females are still rising.

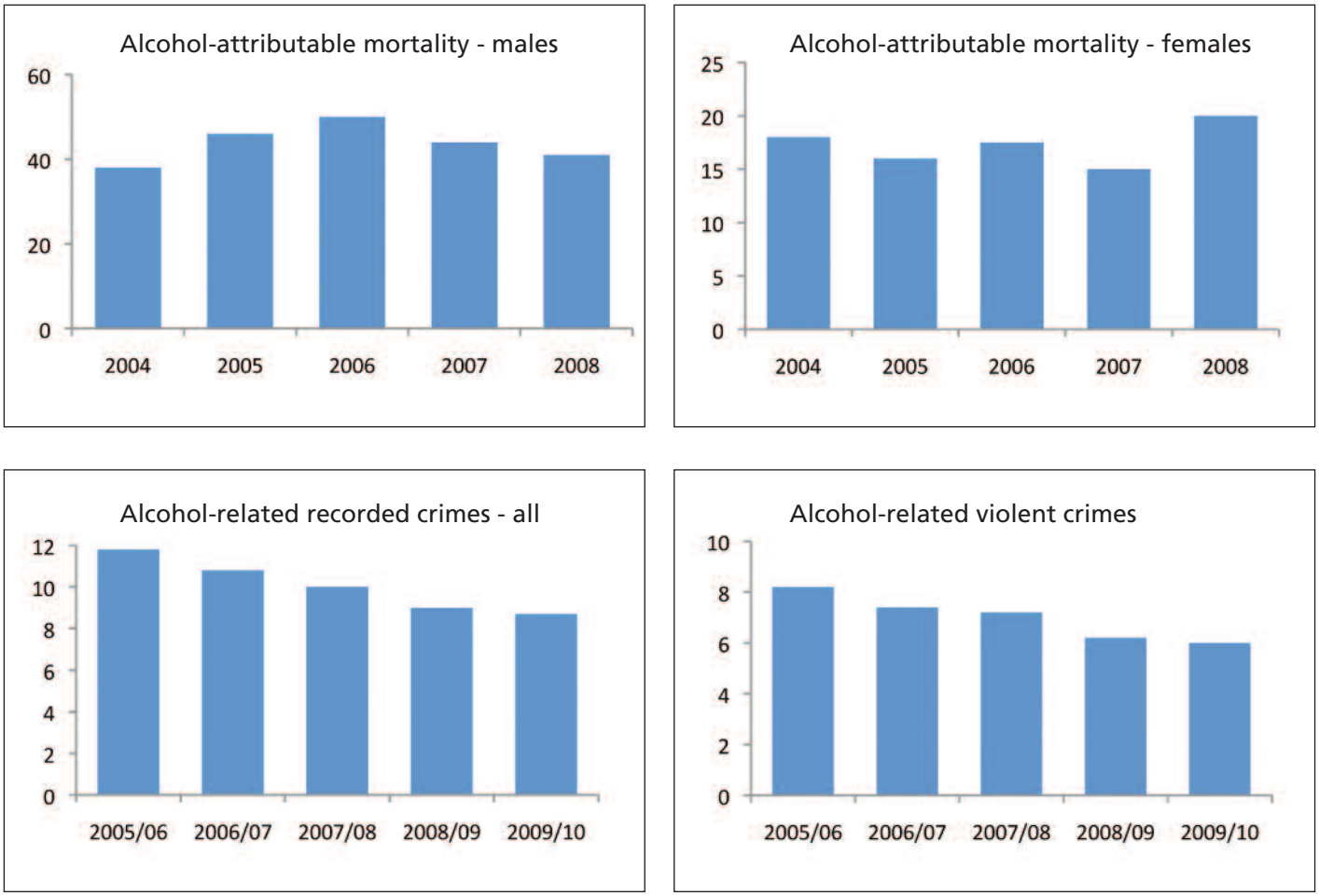


Figure 16 - Alcohol related deaths and crimes per 1,000 population between 2005/6 and 2009/10 in Walsall. Recorded crime is coming down but deaths are increasing.

Source - North West Public Health Observatory.

Obesity in Children

Obesity rates in children remain higher in Walsall than the rest of the country, and in the very youngest children, those in the reception year the trend in Walsall appears to be a slight increase, where as in the rest of the country the prevalence appears to be dropping slightly.

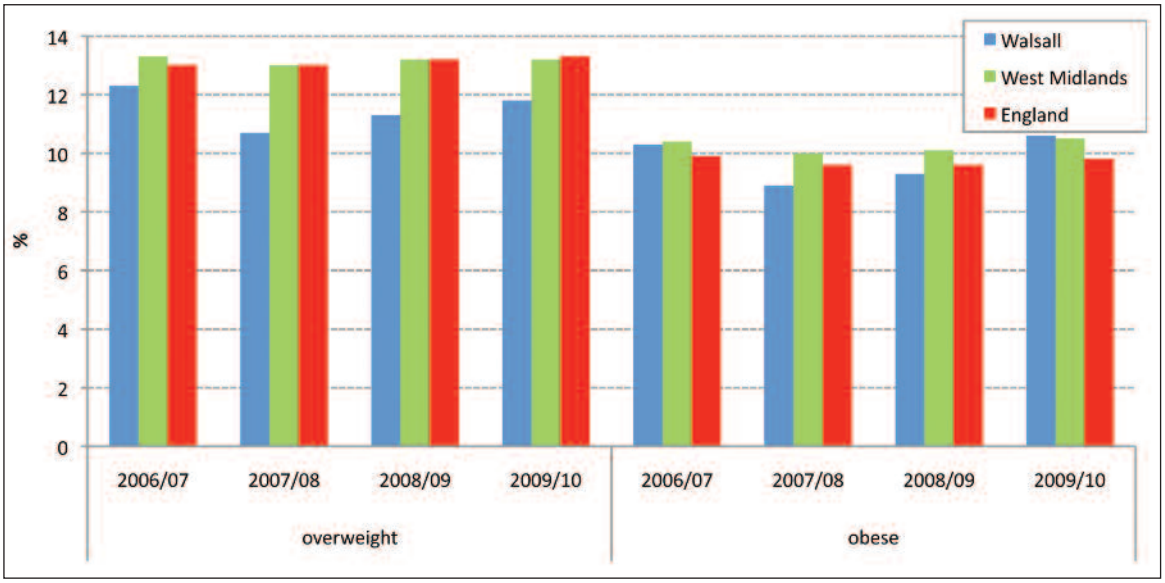


Figure 17 - Obesity prevalence in Reception Year children 2006 to 2010

Source - National Child Measurement Programme, 2006/07 to 2009/10

Obesity and Physical Activity in Adults

In this Annual Report we do not present any fresh locally derived data on the rates of adult obesity and physical activity. There has not been a locally commissioned lifestyle survey since 2005. However there have been national surveys done since then and we have reliable data for England.

The following extract is from the 2011 report of the NHS Information Centre for health and Social Care:

Physical Activity

- In 2009/10, almost a quarter of adult respondents in England reported that they had taken part in sport on 11 to 28 days within a four week period.
- In 2009, 41% of respondents said they made walks of 20 minutes or more at least 3 times a week and an additional 22% said they did so at least once or twice a week.
- However 20% of respondents reported that they took walks of at least 20 minutes "less than once a year or never".
- In 2009/10, 86% of 5-10 year olds had taken part in sports activities outside of school time in the last four weeks and of these, almost 78% participated in the last week. Whereas 97% of 11-15 year olds have taken part in sporting activities in the last four weeks and of these, 88% had participated in the past week.
- In 2009/10, 55% of pupils in years 1-13 of participating schools took part in at least 3 hours of high quality PE and out of hour's school sport in a typical week. Among the three types of schools that were surveyed, 64% of pupils in primary schools, 46% of pupils in secondary schools and 64% of pupils in special schools reported participating in

  at least three hours of high quality PE and out of hour's school sport in a typical week.

Adults

- In 2009, almost a quarter of adults (22% of men and 24% of women aged 16 or over) in England were classified as obese (BMI 30kg/m2 or over).
- A greater proportion of men than women (44% compared with 33%) in England were classified as overweight in 2009 (BMI 25 to less than 30kg/m2).
- Thirty-eight per cent of adults had a raised waist circumference in 2009 compared to 23% in 1993. Women were more likely than men (44% and 32% respectively) to have a raised waist circumference (over 88cm for women and over 102 cm for men).
- Using both BMI and waist circumference to assess risk of health problems, for men: 19% were estimated to be at increased risk; 14% at high risk and 20% at very high risk in 2009.
- Equivalent figures for women were: 14% at increased risk, 18% at high risk and 23% at very high risk.

Children

- In 2009, around three in ten boys and girls aged 2 to 15 were classed as either overweight or obese (31% and 28% respectively), which is very similar to the 2008 findings (31% for boys and 29% for girls).
- In 2009, 16% of boys aged 2 to 15, and 15% of girls were classed as obese, an increase from 11% and 12% respectively in 1995. Whilst there have been marked increases in the prevalence of obesity since 1995, the prevalence of overweight children aged 2 to 15 has remained largely unchanged (values were 15% in boys and 13% in girls in 2009).
- In 2009/10, around one in ten pupils in Reception class (aged 4-5 years) were classified as obese (9.8%). This compares to around a fifth of pupils in Year 6 (aged 10-11 years) (18.7%). Boys were more likely to be obese than girls for both groups. In 2009/10, 13.3% of pupils in Reception class and 14.6% of pupils in Year 6 were reported as being overweight.

The situation in a district like Walsall can be expected at best to closely track the national picture; previous experience though tells us that the prevalence of obesity and physical inactivity is often higher.

Clearly, therefore we have an even greater challenge in Walsall to alter these upstream determinants of health.

Discussion

Health behaviours such as smoking, excessive alcohol consumption, poor diet and physical inactivity are directly linked to poor health outcomes. In Walsall these lifestyle determinants of health are distributed unevenly. Poorer and more deprived wards and neighbourhoods have higher than average levels of unemployment, poorer quality housing, reduced access to safe and inviting public spaces and lower educational attainment. Not surprisingly, these are also the same areas with greater levels of lifestyle related risk factors, greater levels of ill health and reduced life expectancy.

It is in this context that we need to engage local decision makers in the debate on nudge as a policy tool. The key question is not so much 'does nudge work?' - We now have a well researched and qualified answer in the report of the House of Lords Science and Technology Committee[9]. Rather it is whether nudge as a replacement for more direct action including regulation can hope to deliver improvements at the scale and at the pace that we need; and whether it can do it uniformly across all sectors of the population.

Our view, based on the view of may other experts who have considered this question, is that we cannot depend on nudge. We need more and we need it urgently.

[9] *House of Lords Science and Technology Committee Report on Behaviour Change, 2nd report of session 2010-12, 19 July 2011. Available from http://www.publications.parliament.uk/pa/ld201012/ldselect/ldsctech/179/179.pdf*

Every Contact Counts

The health service has an enormous opportunity to work with patients and their families. Large numbers of people are in contact with clinical staff for one reason or another. Each such contact is potentially an opportunity to engage with people in areas such as lifestyle choices to do with alcohol consumption, smoking, physical activity and food.

But it would be easy for such advice to be ignored unless the health service does more to get its own house in order in relation firstly to its own staff and their choices around such questions as smoking and alcohol, where the evidence that committed and visible leadership achieves change over a short time is strong; and secondly in working with existing and planned new Public Health services to increase the number of people who are referred to and followed up for such lifestyle advice.

The role of regulation and enforcement in health and well-being

The Government's preferred way of working is to reduce the regulatory burden on organisations and businesses and instead rely more on harnessing the willing co-operation of the business sector, for example, through the responsibility deals. At the same time Government would rather devolve more of the decision making to local areas and local agencies.

It is here that there is both - a big role and an opportunity for local government - in the field of alcohol consumption, smoking and physical activity. It is the responsibility of local leaders to initiate a debate among community and voluntary organisations, individual citizens, local businesses and other public agencies on the changes needed to the regulatory, planning and infrastructure regimes that would most encourage a positive change in the choices that people make.

On food and nutrition in particular there are many examples of good practice from other parts of the region. These show that local employment and trading schemes and the encouragement and preferential treatment of local food producers and suppliers can encourage a spirit of mutual self help and self reliance that leads to better diets and increased physical activity.

Children's health

With issues such as child accident prevention, early years intervention to raise levels of educational attainment and emotional literacy, bullying in schools, and combating childhood obesity, it is hard to see how interventions based on the theory of nudge can work. It is all the more important therefore to ensure that public statutory health and welfare agencies take a more directive and proactive approach, setting clear objectives for improvement in partnership with children's organisations, including schools and voluntary groups.

Key Recommendations

Prevention

- Commissioners should continue to focus on reducing the burden of preventable disease and disability through shifting to upstream investment
- All clinicians from both primary and secondary care should be supported through education and training to enhance their skills in encouraging lifestyle behaviour change and use every clinical encounter as a potential opportunity for prevention
- Commissioners should also consider new services that offer preventative services and seek a gradual shift over time in the mix of services that they buy, with more resources going toward prevention.

Targeting

- Commissioners should use the latest techniques to identify and target those in the population that are not only most in need but also the most likely to benifit from lifestyle and behaviour change services.
- Commissioners should look beyond the average for Walsall and consider the needs of those in greatest need. This approach would lead to more focused commissioning and a greater return in terms of reducing intra-district inequalities in health outcomes.
- Commissioners should focus more on outcomes than on processes and activities.
- Commissioners should consider the data from the Department of Health's (DoH) programme budgeting tools and ask searching questions based on an understanding of the spend versus outcomes analysis. For those areas where outcomes are getting relatively worse outcomes for higher spends, providers should be challenged whether they are doing enough to prevent illness.
- None of this works without engaging local people in the decicions which affect their lives. Commissioners should seek innovative ways of engaging with community groups to discuss ways of approaching these issues.

Introduction

Ever since the NHS reforms of 1979 separating the roles of purchasers and providers, the trend in health policy has been towards a key role for the state in commissioning services, and a plurality of organisations that provide the services. Thus, while the vast bulk of health and social services is publicly funded, the provision comes from a 'mixed market' of public, private and voluntary or third sector organisations.

Getting commissioning right is therefore of vital importance. Commissioning determines where and on what the available money is spent and therefore the outcomes that are achieved.

This chapter looks at how we can use the levers of commissioning to ensure that improvements in health are secured in the most cost effective and sustainable manner possible.

Evidence from Previous Annual Reports

Sam Ramaiah's Annual Reports in the last decade did not specifically look at where and how the PCT spends its allocated money. Nevertheless, throughout his reports Sam was conscious of the need to shift the focus of the efforts of the health service away from costly and potentially unsustainable treatment services towards prevention.

In 2006, the Annual Public Health Report looked at alcohol and the harm it causes both the individual and society at large and the scope that existed for prevention rather than curative services that at best deal incompletely with the aftermath of excessive drinking.

In 2008, the report on Walsall's socially excluded considered the size and scale of the needs of groups in the community who were regarded as 'hard to reach'. One of the main conclusions of this report was that this group of the population suffered worse health outcomes and the consequences of this were picked up by the curative services.

The 2004 health equity audit made a similar point. A section of the population was materially deprived and disadvantaged and as a consequence suffered worse health outcomes, resulting in necessary but ultimately unproductive and unsustainable health care interventions.

A common, if unstated thread through these reports was the concept of shifting the balance of health resources towards prevention, particularly towards upstream interventions that, by preventing disease and illness would obviate the need for future healthcare expenditure.

The Present Day Context

We now have a large body of data and evidence to consider the question of where we spend NHS resources and what we get in return. This does not automatically mean that understanding the information is easy or that they point unambiguously in the direction of simple conclusions.

There are issues of definitions, how we categorise different expenditure streams, and considerations of historical patterns of service delivery and legacy systems that cannot easily or quickly be changed.

Despite these caveats, there are useful conclusions that can be drawn from examining the available information.

Department of Health Programme Budgeting Benchmarking Tool

Programme budgeting is a technique for assessing investment in health programmes rather than particular services.

Since 2003/4 PCTs have submitted a programme budget return every year and this provides a great deal of information.

In 2009/10 Walsall PCT had a gross revenue expenditure of just over £470 million. The table below shows how much of this was spent on the 5 main programme budget categories (out of the 23 categories that are defined), both in absolute terms and as a percentage of the total. For comparison, we also give the corresponding percentages for the West Midlands region and the country as a whole.

	Proportion of total spend (%)		
	Walsall	Cluster Average	England Average
Problems of circulation	10.0% (46.3m)	7.8%	8.2%
Mental health disorders	10.0% (46.1m)	12.7%	12.1%
Cancers and tumours	6.7% (30.9m)	5.9%	6.4%
Respiratory problems	5.3% (24.5m)	5.2%	5.0%
Musculoskeletal system	5.1% (23.7m)	5.0%	5.3%

Table 5 - Programme budgeting data showing spend in 2009-10 by Walsall health services on the top 5 areas, expressed as percentage of total spend. Figures in brackets show the actual amount spent.

Source - http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_123502.zip

Notes: Walsall is grouped together with 18 other PCTs in what is known as the 'Centres with industry' cluster for purposes of comparisons against PCTs with a similar mix of socio-economic characteristics.

These figures suggest that in comparison with other PCTs we are spending rather more, as a proportion of our total spend, on circulatory diseases and rather less on mental illness. However before we jump to any conclusions on what we should do with this information, we need to be sure that there are not alternate explanations for the data. There may well be differences in the way the figures are added up and assigned to different categories; alternatively, the figures may be the result of historical developments in health services in the district. The fact is that changes in the pattern of health care expenditure can realistically only be made at the margins.

A more interesting question might be to ask whether we are getting as much value out of these investments as we might expect. Answering this question can be quite a challenge. What do we mean by value and how does one measure it? Ideally we would like to get as much as possible in terms of health outcomes. Any analysis of outcomes achieved for a given level of expenditure must also take into account Walsall's position relative to other primary care trusts in the country. This would take into account such factors as the effectiveness with which the services we commission use their resources, how efficient they are while at the same time factoring in the level of unmet need.

Such an analysis is provided nationally by the Spend and Outcome Tool commissioned by the Department of Health from the Association of Public Health Observatories.

Using the same 2009/10 programme budget data they produced the following chart for Walsall (Figure 18).

This chart presents a lot of information, the broad conclusion is:

- Only for maternity and neonatal services are we extreme outliers, i.e. outside the 2 standard deviations box. This means that in these two areas we are spending significantly less proportionately and getting significantly worse outcomes.
- For circulatory diseases we are an outlier though not extremely so. We spend rather more as a proportion of the total and get somewhat worse outcomes.
- We spend rather less on mental illness services and get outcomes that are less good than other PCTs, but the difference is not significant.

This analysis raises questions for health commissioners to consider. They do not by themselves suggest a single and obvious course of action. For example, how is the intelligent commissioner to interpret the first of the above 3 conclusions? We suggest that the answer is not immediately to jump to the conclusion that we should spend more on maternity and newborn services. We should consider carefully what outcomes we are not achieving. Low birth weight and a higher perinatal mortality rate are the obvious outcomes that are worse in Walsall and pushing us into the lower left hand quadrant of the chart. We need therefore to find smart ways of tackling smoking in pregnancy, improving the nutrition of mothers even before conception, reducing teenage pregnancies, improving the social environment for newborn babies, promoting breast feeding and ensuring immunisation uptake. All these are obvious and well known risk factors for low birth weight and infant mortality.

Consider the position for circulatory disease expenditure and outcome. Here we are spending more relative to others and yet getting worse outcomes. This could be because we have poorer health in general and more Walsall people get serious circulatory disease at a younger age and this shows up in the heart disease mortality statistics, despite a good clinical service. The answer may not be to spend more on hospital services for treating serious heart disease but on reducing the risk factors for heart disease such as smoking, particularly among men in deprived areas of Walsall, alcohol consumption, physical inactivity, and better detection and management of diabetes.

We have already made a good start on these measures with the health checks programme, but more can always be done. Are we doing all we can to get smokers to quit? Are we

identifying all those who may be drinking more alcohol that is good for them and offering brief advice?

The opposite situation, and a good example of the powerful effect of upstream prevention, comes from the position of dental services in the chart. Here we spend less relatively and get better outcomes. The reason is not that we have better more efficient dentists but rather that our population enjoys the dental health benefits of fluoridated water supply.

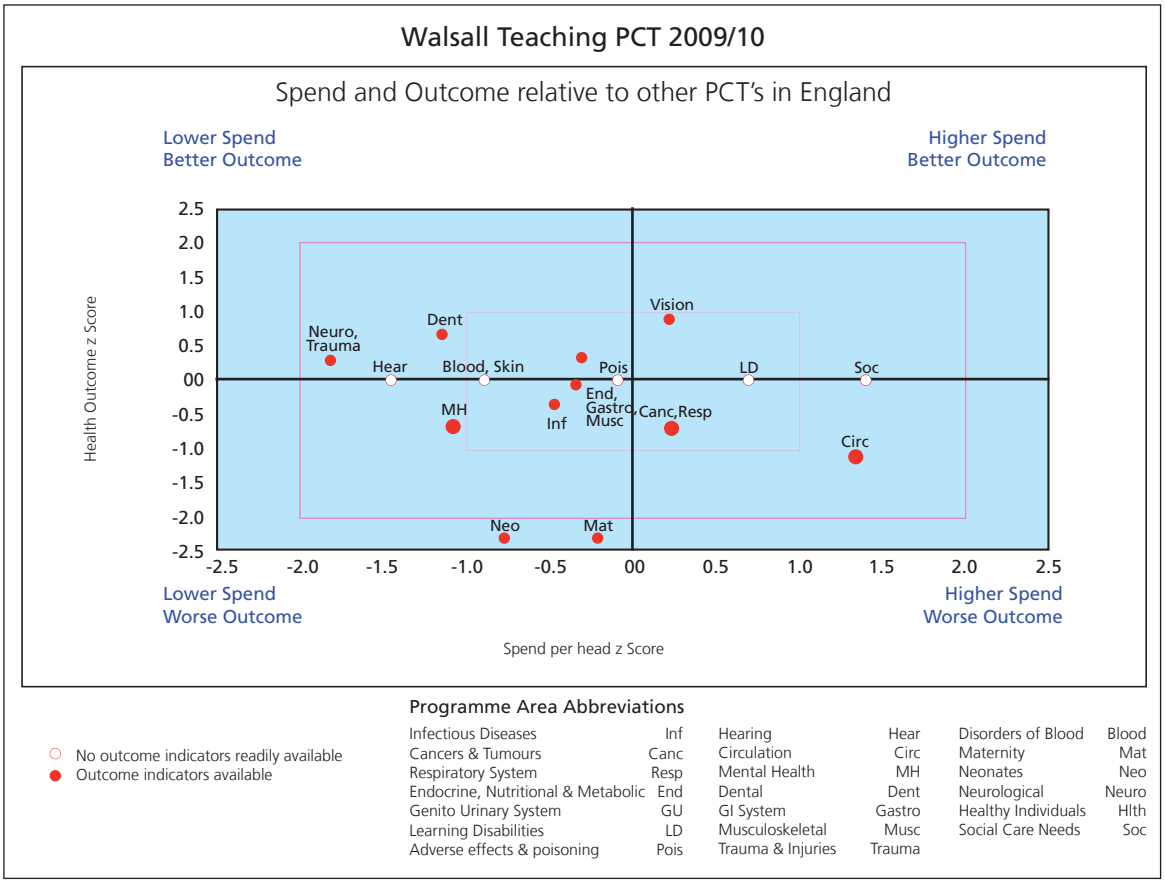


Figure 18 - Spend v outcome data for Walsall (see notes below for further explanation).

Notes on Interpreting the chart:
Z Score: By population, Population: Unified Weighted

Programme Area Abbreviations

Each dot represents a programme budget category. The three largest spending programmes nationally (Mental Health, Circulatory Diseases and Cancer) are represented by larger dots. A z score essentially measures the distance of a value from the mean (average) in units of standard deviations. A positive z score indicates that the value is above the mean, whereas a negative z score indicates that the value is below the mean. A z score below -2 or above +2 may indicate the need to investigate further.

The two programmes lying outside the solid pink +/- 2 z scores box - neonates and maternity, may indicate the need to investigate further. If the programme lies to the left or right of the box, the spend may need reviewing, and if it lies outside the top or bottom of the box, the outcome may need reviewing. Programmes outside the box at the corners may need a review of both spend and outcome.

Programmes lying outside the dotted pink +/- 1 z score box may also warrant further exploration. The outcome measures on the chart have been chosen because they are reasonably representative of the programme as a whole. This means that for some programmes no outcome data is available.

Source - http://yhpho.org.uk/quad/pdfs0910/5M3_PB0910%20Profile.pdf

Programme budgeting has its uses but what is does not do is look at whether we are spending enough on prevention. It focuses exclusively on the services we commission for people with an illness and so is designed to analyse expenditure by different categories of curative services.

The ban on smoking introduced in mid 2007 - an excellent example of a public health measure that set out to prevent illness - resulted in a marked and significant drop in the number of heart attacks.[10,11] There are a host of similar preventive strategies that can improve health by preventing illness without the need for treatment services.

The table below gives some obvious and well known examples:

Preventive strategy/intervention	Health gain/treatment service avoided
Smoking and alcohol advice in pregnancy, youth services to reduce teenage pregnancies	Infant mortality reduction, newborn services for low birth weight
Accident prevention, alcohol and driving, improving road safety	Hospital services for road crash victims
Increasing physical activity through exercise on prescription, better road design; healthy food initiatives	Reduction in diabetes, heart disease, obesity, curative services for heart disease
Opportunistic brief advice for smoking and excessive alcohol consumption	Reduction in cancers, vascular disease, heart disease and respiratory problems; curative services for all these diseases
Health through warmth, opportunistic referral of suitable people by health staff for help	Reductions in winter mortality; Hospital emergency services for elderly patients in winter months
Influenza and pneumococcal immunisation	Pneumonia deaths in elderly people, hospital emergency services in winter months
Community violence prevention through joint action by health, social services and police working with community safety partnerships	Reduction in morbidity due to violence - often mediated by excess alcohol consumption; Emergency admissions for trauma surgery. Sexual assaults and domestic violence admissions
Early detection and support for dementia	Delay of dependency, reduced use of secondary care services.
Better treatment of high blood pressure and raised cholesterol	Reductions in stroke and heart attacks, fewer hospital services.

Table 6 - Examples of upstream interventions that will both improve health and reduce health care spending

[10] 10 Ref: Sims M, Maxwell R, Bauld L, Gilmore A. Short term impact of smoke-free legislation in England: retrospective analysis of hospital admissions for myocardial infarction. BMJ 2010;340:c2161. See http://www.bmj.com/content/340/bmj.c2161.abstract

[11] Bauld L. The impact of emokefreelegislation in England: Evidence review. March 2011. Page 8. For fuller details see http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124959.pdf

None of these interventions are in any sense of the term, 'innovative technologies'. What has been lacking thus far is a focus on commissioning for health outcomes. Instead we have focused on the activity and processes of care - numbers of procedures done, admissions, attendances or bed-days occupied.

Commissioning for Advantage

Too often in the past we have talked about hard to reach groups, and commissioning for disadvantaged groups. Even these groups have natural factors that often work in their favour. They may be disadvantaged or socially excluded in terms of our definitions but that may well be because the service has been built around the mainstream, often along the lines we have become accustomed to.

Commissioning for advantage is a concept that is based on the notion that commissioning is really about putting people first. All communities and groups are naturally endowed with strengths and advantages. Harnessing this potential and building on what people already have is surely a better way to go about commissioning health services.

Combining this concept with the idea of commissioning for outcomes, rather than activity, has to be the way forward if we are fully to exploit the power of commissioning.

Commissioning for Equity

Reducing inequalities in health is an important objective for the NHS and for the wider public health system. Tackling health inequalities must be seen as an essential element of everything that is done by every part of the NHS, including the process of commissioning. The power of commissioning to change the nature and focus of the service must therefore be harnessed to reducing inequalities just as much as to enhancing efficiency, ensuring patient safety and improving quality.

Commissioning for equity must start with a clear understanding of the unequal and unfair distribution of health outcomes and care processes around a Walsall 'average'. This analysis should lead to differential commissioning weighted towards areas and groups at greatest distance from the average outcome.

Prevention as an essential part of cure

It is easy to see prevention and cure as belonging to separate components of the health and social care system. The reality however is that for the majority long term and chronic conditions there is no magic cure, what the health service offers is in reality either alleviation of symptoms, or interventions aimed at preventing complications or further progression of the disease.

Chest physicians who treat asthma are particularly keen on ensuring that their patient lives in an environment free from tobacco smoke. For them, prevention is the treatment. This is equally true for many other areas of the health service too, in the sense that while prevention may not be the treatment for today's symptom or problem, it is often the most intelligent treatment of choice for tomorrow's illness.

If this logic is followed then prevention must be a part of every clinical service that is commissioned.

Leveraging the power of commissioning

Here are some specific examples of what is achievable. Commissioners should ensure that:

- A&E services are proactive in identifying alcohol as an underlying cause for many of their clients, and offer brief advice as well as referral to a counselling service.
- Smokers are identified and offered help and support to quit at every clinical encounter.
- Elective surgery is not carried out on a smoker without the patient being informed about the enhanced risks of anaesthesia and surgery.
- All staff who visit homes are offered training to spot homes that could benefit from additional help and support with heating through schemes such as 'Health through warmth'.

- Every opportunity is taken to ensure uptake of immunisations.
- Every opportunity for prevention in primary care is taken up. In particular, the variations among general practices in Walsall are considered carefully to ensure that every patient has access to a minimum standard of primary care.

Summary

Commissioning presents Clinical Commissioning Groups with a strong lever with which to improve the health of the population.

But in order to do this we need to rethink commissioning and focus on health outcomes and on the innate strengths of patient communities.

A&E	Accident & Emergency
BME	Black and Minority Ethnic
BMI	Body Mass Index
CAB	Citizens Advice Bureau
CHD	Coronary Heart Disease
COPD	Chronic Obstructive Pulmonary Disease
CTC	Child Tax Credit
DDD	Defined Daily Doses
DH	Department of Health
DPH	Director of Public Health Medicine
GUM	Genitourinary Medicine
HAZ	Health Action Zone
IDACI	Income Deprivation Affecting Children Index
IDOPI	Income Deprivation Affecting Older People Index
IMD	Indices of Multiple Deprivation
IM	Infant Mortality
IS	Income Support
JSA	Jobseekers Allowance
JSNA	Joint Strategic Needs Assessment
LBW	Low Birth Weight
LSOA	Lower Super Output Area
MMR	Measles, Mumps, Rubella
MYE	Mid-Year Estimates
NEET	Not in Employment, Education or Training
NOMIS	A web-based database of labour market statistics sourced from the ONS
ONS	Office for National Statistics
PANSI	Projecting Adult Needs and Service Information System
PCG	Primary Care Group
POPPI	Projecting Older People Population Index
PU	Prescribing Units
QOF	Quality and Outcomes Framework
STI	Sexually Transmitted Infection
WHO	World Health Organisation

Area Partnerships	There are 6 in Walsall and their purpose is to resolve the issues of most concern to communities by bringing delivery agencies (such as the police, the Council, NHS Walsall and others) together with local people, to properly understand the problem and take appropriate action.
Breast Screening	A method of detecting female breast cancer at an early stage.
Cardiovascular Disease	A disease relating to the heart and blood vessels.
Cervical Screening	A method of preventing cancer by detecting and treating early abnormalities, which if left untreated, could lead to cancer of a woman's cervix (the neck of the womb).
Conception	The entity formed by the union of the male sperm and the female ovum.
Coronary Heart Disease	Damage to the heart, where not enough blood flows through the vessels because they are blocked with fat or have become thick and hard, thus harming the muscles of the heart.
Deprivation	A state of extreme poverty.
Diabetes	A condition in which the amount of glucose (sugar) in the blood is too high because the body cannot use it properly. Insulin produced by the pancreas helps the glucose to enter the cells, where it is used as fuel in the body. There are 2 main types - Type 1 is known as insulin dependent, where the body is unable to produce any insulin. Type 2 is known as non-insulin dependent diabetes, where the body produces insufficient insulin or when the insulin that is produced does not work sufficiently (insulin resistance).
Immunisation	The creation of immunity usually against a particular disease.
Incidence	The number of new cases of a disease that occur in a defined population within a specified time period, usually a year.
Indices of Multiple Deprivation	The model of multiple deprivation which is based on the idea of distinct dimensions of deprivation which can be measured separately. People may be counted as deprived in one or more of the domains depending on the number of types of deprivation that they experience.
Infant Mortality	Death in the first year following live birth; on or before the 365th day of life (366th in a leap year).
Life expectancy	An estimate of how long a person is expected to live based on current mortality rates for an area.

Low Birthweight	A child born weighing less than 2.5kg.
Mental health cope	The WHO defines mental health as "a state of well-being in which the individual realises his or her abilities, can with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community".
Mortality	The number of deaths caused by a disease that occur in a defined population within a specified time period, usually a year.
MyNHS Walsall Parliament	80 top level members of MyNHS Walsall who meet in full four times a year and in between are actively engaged in a wide range of working groups and other forums that support key priorities. They provide an important channel of communication and are a valuable resource to any local health organisation.
Obesity	A chronic disease characterised by an increase of body fat stores. This is commonly assessed by the Body Mass Index (BMI), which is calculated as measured body weight (kg) / measured height (m2). Adults are classified as obese if their BMI is equal to or greater than 30.
Obesogenic	Causing obesity.
Perinatal	A period of infancy between 24 weeks of gestation and six completed days of life.
Population	The total number of persons inhabiting a country, city or any district or area.
Screening	Screening aims to reduce the risk of disease, premature death or disability. Members of a define 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.
Social exclusion	Deprivation of certain people within a society who are denied benefits enjoyed by the majority. Often connected to education and employment status, or belonging to a marginalised group.
Still births	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'.

Walsall

updated 28 July 2010

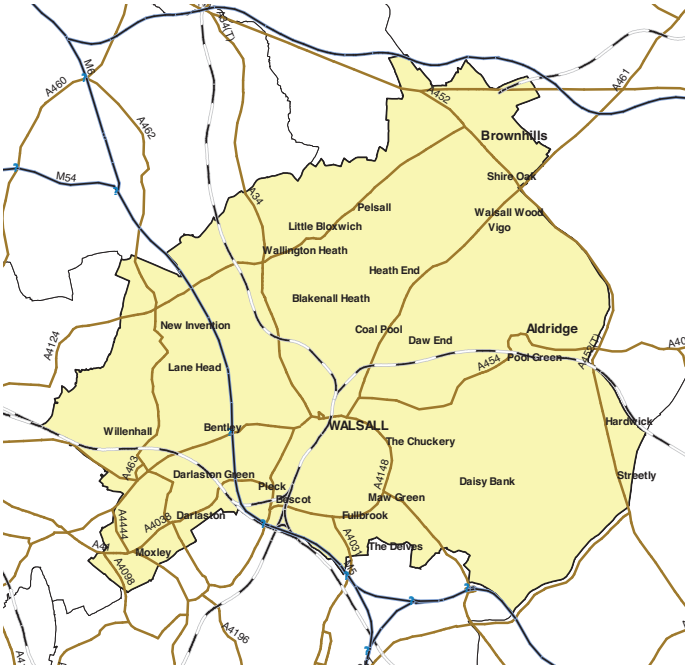
This profile gives a picture of health in this area. It is designed to help local government and health services improve people's health and reduce health inequalities.

Health Profiles are produced every year by the Association of Public Health Observatories.

Visit the Health Profiles website to:

- see profiles for other areas
- use interactive maps
- find more detailed information

www.healthprofiles.info



Population 255,400

Mid-2008 population estimate

Source: National Statistics website: www.statistics.gov.uk

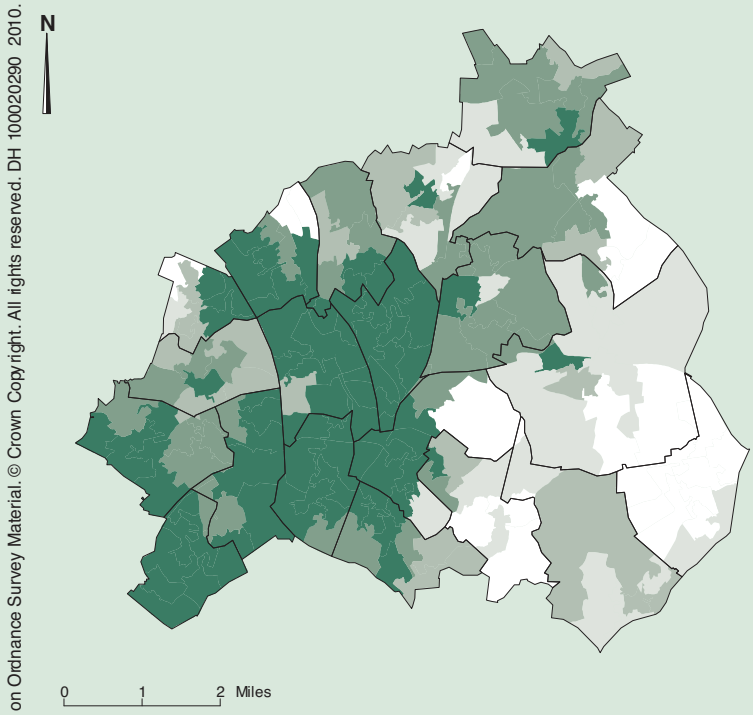
Walsall at a glance

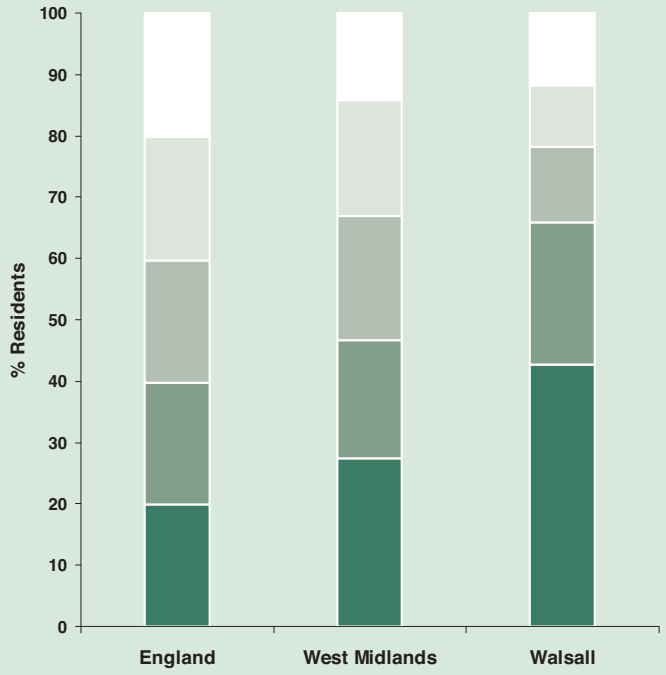
- The health of the people of Walsall continues to be worse than the England average. Over 40 percent of the population lives in the most deprived areas of England.
- The difference in life expectancy between people living in the most and least deprived areas in Walsall is over 8 years for men and almost 6 years for women.
- Death rates for all causes have fallen in Walsall but are higher than the England average, particularly for men. Rates of early deaths from heart disease and stroke and from cancer have improved but are worse than the England average.
- Walsall has a high proportion of children living in poverty. GCSE achievement in children of White and of Mixed ethnicities are lower than the England average. Levels of infant deaths, breast feeding initiation, physical activity in schools, and teenage pregnancy are worse than the England average. Levels of tooth decay in children aged 5 are better than the England average.
- Walsall is better than the England average for road injuries and deaths, and malignant melanoma (a type of skin cancer), and worse than the England average for people diagnosed with diabetes.
- The Local Area Agreement for Walsall has prioritised reducing obesity in children and reducing death rates from all causes.
- Further information can be found in reports of the Director of Public Health for Walsall at www.walsall.nhs.uk.

Deprivation:
a national view

This map shows differences in deprivation levels in this area based on national quintiles (of the Index of Multiple Deprivation 2007 by Lower Super Output Area). The darkest coloured areas are some of the most deprived areas in England.

This chart shows the percentage of the population in England, this region, and this area who live in each of these quintiles.



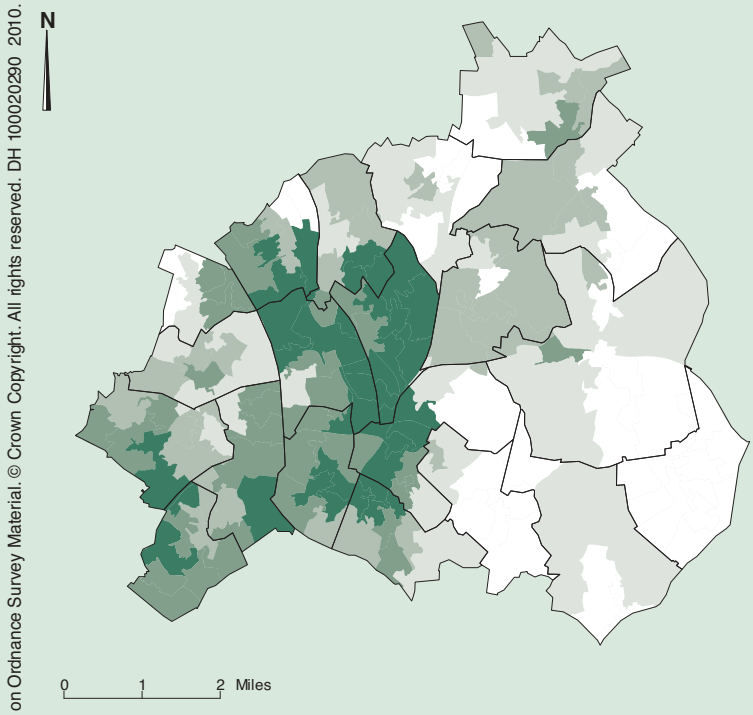


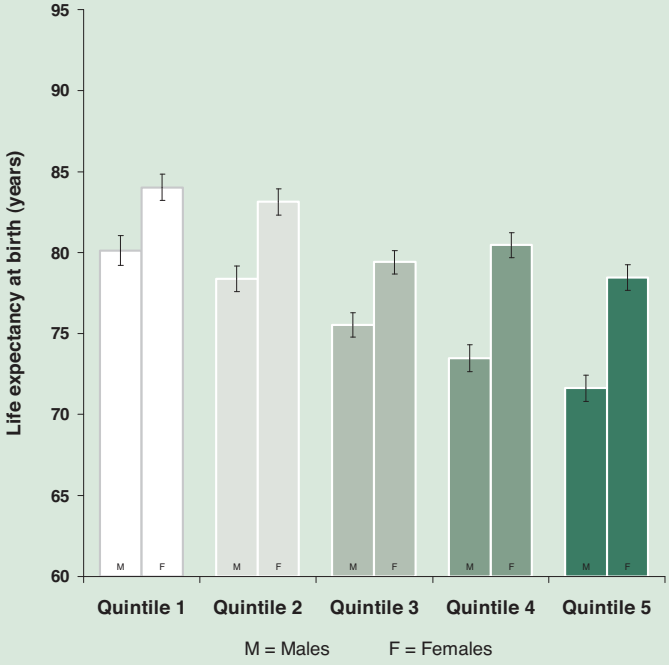
1 - least deprived quintile | 2 | 3 | 4 | 5 - most deprived quintile

Health inequalities:
a local view

This map shows differences in deprivation levels in this area based on local quintiles (of the Index of Multiple Deprivation 2007 by Lower Super Output Area). The darkest coloured areas are the most deprived in this area.

This chart shows the life expectancy at birth for males and females (2004-2008) for each of the quintiles in this area.





95% confidence interval. These indicate the level of uncertainty about each value on the graph. Longer/wider intervals mean more uncertainty.

1 - least deprived quintile | 2 | 3 | 4 | 5 - most deprived quintile

Health inequalities: **changes over time**

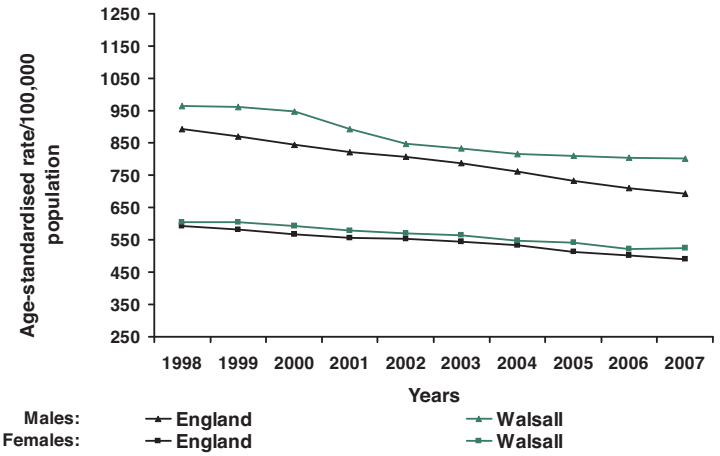
These graphs show how changes in death rates for this area compare with changes for the whole of England. Data points on the graph are mid-points of 3-year averages of yearly rates. For example the dot labelled 2003 represents the 3-year period 2002 to 2004.

Trend 1 compares rates of death, at all ages and from all causes, in this area with those for England.

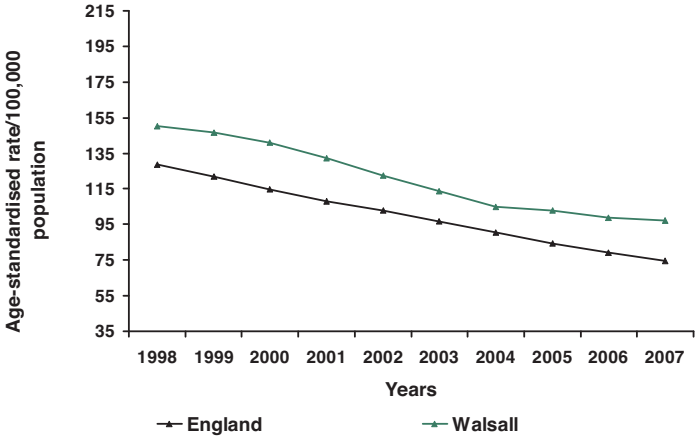
Trend 2 compares rates of early death from heart disease and stroke (in people under 75) in this area with those for England.

Trend 3 compares rates of early death from cancer (in people under 75) in this area with those for England.

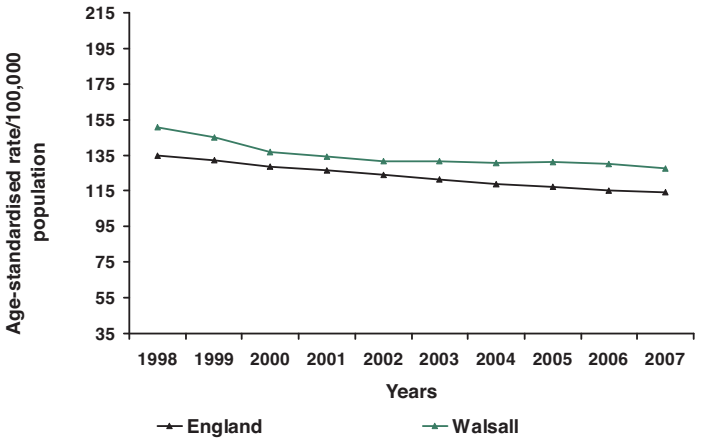
Trend 1:
All age, all cause mortality



Trend 2:
Early death rates from heart disease and stroke

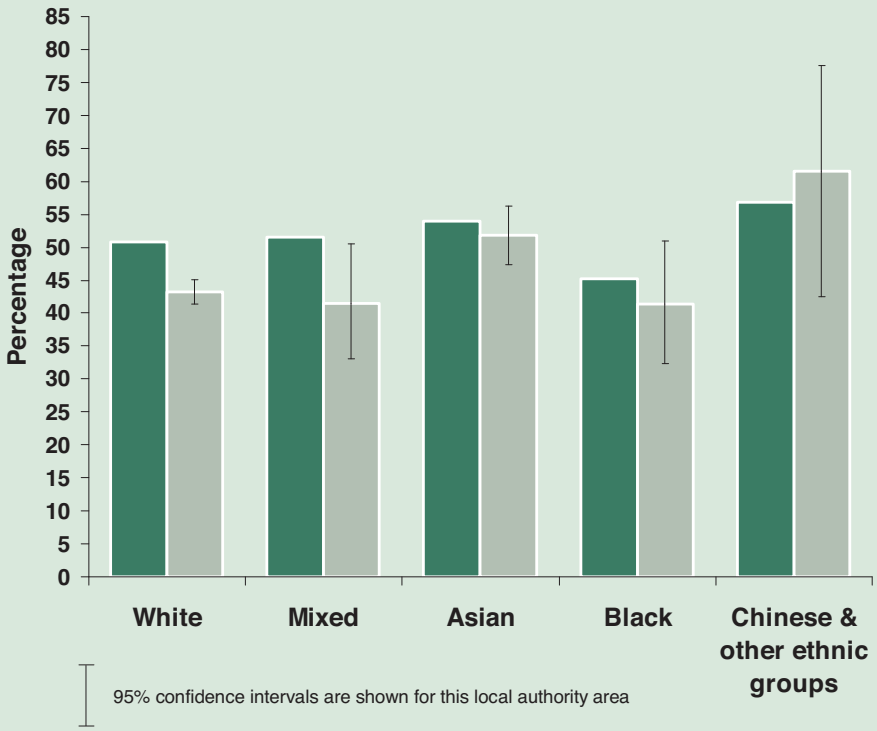


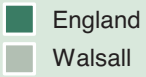
Trend 3:
Early death rates from cancer



Health inequalities: **ethnicity**

This chart shows the percentage of pupils by ethnic group in this area who achieved five GCSEs in 2008/09 (A* to C grades including English and Maths). Comparing results may help find possible inequalities between ethnic groups.





Ethnic Groups	% pupils achieved grades	No. of pupils achieved grades
White	43.2	1,185
Mixed	41.5	49
Asian	51.8	248
Black	41.3	43
Chinese/other	61.5	16

If there are any empty cells in the table this is because data has not been presented where the calculation involved pupil numbers of 0, 1 or 2. Some further groups may not have data presented in order to prevent counts of small numbers being calculated from values for other ethnic groups or areas.

Health summary for Walsall

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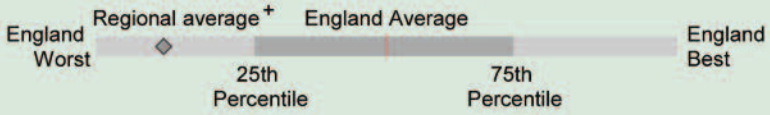
The chart below shows how the health of people in this area compares with the rest of England. This area's result for each indicator is shown as a circle. The average rate for England is shown by the red line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator; however, a green circle may still indicate an important public health problem.

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average
- No significance can be calculated



+ In the South East Region this represents the Strategic Health Authority average

Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1 Deprivation	108795	42.7	19.9	89.2		0.0
	2 Children in poverty	15988	29.7	22.4	66.5		6.0
	3 Statutory homelessness	194	1.88	2.48	9.84		0.00
	4 GCSE achieved (5A*-C inc. Eng & Maths)	1543	44.4	50.9	32.1		76.1
	5 Violent crime	4341	17.1	16.4	36.6		4.8
	6 Carbon emissions	1579	6.2	6.8	14.4		4.1
Children's and young people's health	7 Smoking in pregnancy	626	18.9	14.6	33.5		3.8
	8 Breast feeding initiation	1764	53.5	72.5	39.7		92.7
	9 Physically active children	18015	45.2	49.6	24.6		79.1
	10 Obese children	295	9.3	9.6	14.7		4.7
	11 Tooth decay in children aged 5 years	n/a	0.8	1.1	2.5		0.2
	12 Teenage pregnancy (under 18)	283	54.4	40.9	74.8		14.9
Adults' health and lifestyle	13 Adults who smoke	n/a	25.1	22.2	35.2		10.2
	14 Binge drinking adults	n/a	14.9	20.1	33.2		4.6
	15 Healthy eating adults	n/a	22.3	28.7	18.3		48.1
	16 Physically active adults	n/a	8.2	11.2	5.4		16.6
	17 Obese adults	n/a	28.8	24.2	32.8		13.2
Disease and poor health	18 Incidence of malignant melanoma	26	10.1	12.6	27.3		3.7
	19 Incapacity benefits for mental illness	5005	33.3	27.6	58.5		9.0
	20 Hospital stays for alcohol related harm	5855	2000	1580	2860		784
	21 Drug misuse						
	22 People diagnosed with diabetes	14799	5.79	4.30	6.72		2.69
	23 New cases of tuberculosis	56	22	15	110		0
	24 Hip fracture in over-65s	280	515.3	479.2	643.5		273.6
Life expectancy and causes of death	25 Excess winter deaths	114	14.2	15.6	26.3		2.3
	26 Life expectancy - male	n/a	75.8	77.9	73.6		84.3
	27 Life expectancy - female	n/a	81.3	82.0	78.8		88.9
	28 Infant deaths	28	7.89	4.84	8.67		1.08
	29 Deaths from smoking	474	248.4	206.8	360.3		118.7
	30 Early deaths: heart disease & stroke	277	97.3	74.8	125.0		40.1
	31 Early deaths: cancer	361	127.4	114.0	164.3		70.5
	32 Road injuries and deaths	105	41.1	51.3	167.0		14.6

Indicator Notes

1 % of people in this area living in 20% most deprived areas of England 2007 2 % of children living in families receiving means-tested benefits 2007 3 Crude rate per 1,000 households 2008/09 4 % at Key Stage 4 2008/09 5 Recorded violence against the person crimes crude rate per 1,000 population 2008/09 6 Total end user CO_2 emissions per capita (tonnes CO_2 per resident) 2007 7 % of mothers smoking in pregnancy where status is known 2008/09 8 % of mothers initiating breast feeding where status is known 2008/09 9 % of year 1-13 pupils who spend at least 3 hours per week on high quality PE and school sport 2008/09 10 % of school children in reception year 2008/09 11 Weighted mean number of teeth per 5 yr old child sampled that were actively decayed, missing or filled 2007/08 12 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2006-2008 (provisional) 13 % adults, modelled estimate using Health Survey for England 2006-2008 14 % adults, modelled estimate using Health Survey for England 2007-2008 15 % adults, modelled estimate using Health Survey for England 2006-2008 16 % aged 16+ 2008/09 17 % adults, modelled estimate using Health Survey for England 2006-2008 18 Directly age standardised rate per 100,000 population under 75 2004-2006 19 Crude rate per 1,000 working age population 2008 20 Directly age and sex standardised rate per 100,000 population 2008/09 (rounded) 21 New Problematic Drug User estimates were not available in time for inclusion 22 % of people on GP registers with a recorded diagnosis of diabetes 2008/09 23 Crude rate per 100,000 population 2006-2008 24 Directly age-standardised rate per 100,000 population for emergency admission 2008/09 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.05- 31.07.08 26 At birth, 2006-2008 27 At birth, 2006-2008 28 Rate per 1,000 live births 2006-2008 29 Per 100,000 population age 35+, directly age standardised rate 2006-2008 30 Directly age standardised rate per 100,000 population under 75, 2006-2008 31 Directly age standardised rate per 100,000 population under 75, 2006-2008 32 Rate per 100,000 population 2006-2008

More indicator information is available in The Indicator Guide: www.healthprofiles.info For information on your area contact your regional PHO: www.apho.org.uk

NHS
Walsall