# Annual Report of the Director of Public Health for Walsall, 2013/14

## More people healthier, longer
## Meeting the financial challenge together

Walsall Council

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# Introduction from Dr Isabel Gillis, Director of Public Health

**To:** **The Residents of Walsall**

**The Councillors and Officers of Walsall Council**

**All those in whatever role who have a part to play in improving the health and wellbeing of the people of Walsall**

It is my duty and pleasure to present this annual report. The Health and Social Care Act 2012 placed a duty on Local Authorities to establish Health and Wellbeing Boards which in turn have a duty to prepare and publish a Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy. This has been done. As a result much of the information, analysis and interpretation which has informed annual reports in previous years is already in the public domain.

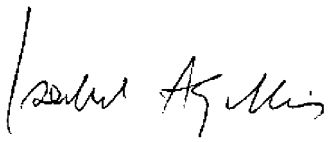
Key themes of this report are:

- Where we came from: A reflection on the history of the Public Health function from the appointment of the first Medical Officer of Health in 1871, through transition to the NHS in 1974 and back to local government on 1 April 2013
- Where we are now: A review of the functioning of the new Public Health system created by the Health and Social Care Act 2012 after its full first year in Local Government including the expenditure of the Public Health grant
- The challenges ahead looking at the intractable health inequalities in Walsall and the challenge affecting the whole public sector including the Council and its partners of 'doing more with less'
- And finally, my suggested priorities for development in 14/15

Much has improved but as this report shows there is much still to be done. Infant mortality, public attitudes to health advice and behaviour change and the impact of the environment on the health of residents are themes in the early reports of the Medical Officers of Health which find their modern day equivalents in this report.

But having picked up the responsibilities of leading Public Health in Walsall through its greatest period of change in 40 years and safely embedding the staff and functions in Walsall Council it is now time for me to handover to others, as my predecessors in the role (by other names) have done before me.

There are many more tools in the Public Health toolbox than there was when I joined the speciality in 1988. Local government is the right setting to align all the skills and resources across the Council to have maximum impact on the public's health. Resources are limited. Resourcefulness? Unlimited! It has been my honour and privilege to serve the people of Walsall as Director of Public Health during this historic change.



**Dr Isabel Gillis**
**Director of Public Health**

# Where we came from

## 1. Public Health in Walsall: A historical perspective

The Health and Social Care Act 2012 created a new Public Health landscape in England.

Arguably the largest change was the transfer of significant Public Health responsibilities from the NHS back to Local Government and the creation of new national bodies including Public Health England and NHS England who also have significant Public Health responsibilities. It is therefore timely to reflect briefly of the origins and history of Public Health in Walsall.

### 1871

Dr James MacLachlan appointed as the first Medical Officer following outbreaks of smallpox in Walsall (1868-69 and again in 1871-72). The Medical Officer for Health's (MoH) first report was damming of the condition of the water supply and other sanitary arrangements, noting that "in some instances there was only one convenience for ten or twelve families". The keeping of pigs in close proximity to dwelling houses was another cause of concern and one of his primary recommendations was the establishment of a slaughterhouse.

### 1893

The high levels of infant mortality were graphically described by Walsall's MoH in his 1893 report as "the slaughter of the innocents". Approximately 15% of all infants born in Walsall between 1880 and 1914 died before their first birthday, a rate that was consistently higher than the national averages. In Darlaston, now part of the unitary Walsall local authority, over 24% of infants died before they were one in 1899 and the death rate for this group throughout the 1890's averaged out at 22% (Woods, 1984: 20).

### 1906

In the preceding year the Walsall MoH had arranged for the distribution of handbills on the nursing of babies, the feeding of infants and the bringing up of children (Annual Report, 1906). This approach was met with some resistance and the 1906 report finds him noting that it was "heartbreaking that the people will not be taught-they throw the handbills into the fire saying that they know best how to bring up a baby" (Walsall MBC, Report to Health Committee).

### 1914

The years up to the outbreak of the First World War were marked by considerable improvements and the MoH's report for 1914 declared that authorities in the Walsall district were providing adequate sewerage, drainage and water supply, "although sometimes property owners failed to take advantage of this". This early recognition of what degree of intervention might be acceptable to improve population was to be a recurrent feature in MoH reports throughout the century up to the demise of the post with the changes wrought by the transition in 1974.

The increasing amount of legislation passed in the Edwardian period, such as the Midwives Act of 1902 and the appointment of health visitors, resulted in the decline of most childhood diseases and the Walsall MoH could acclaim in his report for 1914, "the wonderful work done in the last six years".

### 1919-1945

The ongoing focus on prevention dominated the public health paradigm between the two world wars and was influential in the discussions on health care reform that pre-dated the establishment of a national health service. The 1930s saw the heyday of the Medical Officer of Health (MoH) post with the MoH overseeing a large range of functions within the local authority. These included maternal, child and mental health, district nursing, health visiting, environmental health, welfare, community midwifery, school health and the former Poor Law hospitals. A survey of the MoH reports to the Local Board of Health in Walsall suggests that the post-holder had considerable influence within the local government arena.

### 1948

The establishment of the NHS altered the influence of Public Health in a way that had not fully been anticipated or intended. The reality was that the developing NHS brought a move from a community perspective on health to an increased focus on hospital treatment and raised the prominence of curative medicine (Klein, 1989), with an accompanying reduction in influence for the MoH. The MoH for Walsall, like his counterparts nationally, found that by the 1950s he was largely involved in administrating preventative services having had responsibility for direct clinical services, such as cottage hospitals, removed from his remit.

## 1970

Social work was removed from the work of the MoH and the loss of the area of environmental health in 1972, further weakened their influence (Hunter, Marks and Smith, 2010).

## 1972

The Faculty of Community Medicine was established in 1972 by the Royal Commission on Medical Education (The Todd Commission 1968) "in recognition of the growing need to treat public health practice as a distinct specialty and the unique contribution it makes to health improvement" (FPH, leaflet 2012) with membership criteria that was limited to registered medical practitioners.

## 1974

These changes were the precursors of the reorganisation of 1974 that changed the name of Public Health to Community Medicine and that brought the function out of local government and into the NHS. The MoH position was replaced by the role of Community Physician and historians of this transition, whilst divided as to the effectiveness of the MoH (see Webster, 1992) often viewed the community physician as even less effective due to the wave of administration that rapidly swamped them (Gorsky, 2008).

## 1979

It was originally envisaged that the role of the Community Physician would be centred in epidemiology and directed at making changes in the wider population health (Morris, 1969). Morris had published a seminal paper on combating cardiovascular disease with exercise (1958) and anticipated that the arrival of the community physicians would not only lead to improved population health but also reduce health inequalities. The actual experience however was one of some confusion as to what the community physician's role was meant to cover. While this gave cause for concern, an earlier study had even more worryingly established that community physicians in England estimated that they spent 9% of their time on preventative medicine while 60% was given over to administration (Donaldson and Hall, 1979).

1984 An outbreak of salmonella food poisoning at Stanley Royd Hospital, Wakefield results in the deaths of 19 patients and leads to the establishment of a committee of inquiry, chaired by Sir Donald Acheson, into the future development of Public Health.

## 1988

The Acheson committee finds that Community Medicine had failed to meet expectations, as a result of blurred definitions of roles whilst the need for community physicians (who had replaced the MoHs) to take the long term view of events "often conflicted with short-term pressures on health authority management"

*(Public Health in England: 1988). Acheson also recommended a return to the name Public Health for the speciality, established the role of the Director of Public Health and the duty to produce an independent annual report on the health of the local population, a duty which continues today).*

## 2013

While the changes wrought by the Health and Social Care Act (2012) appeared to some as if it had come out of the blue, the need for change in public health delivery had been heralded for some time. The thinking that prompted this reorganisation was based on the belief that "it would recognise the natural leadership role local authorities ought to be exercising in respect of their wide range of functions, virtually all of which have a health dimension" (Crowley and Hunter, 2005: 267). By placing the public health function back in the local authority, the hope is that this move will allow for the somewhat neglected aspect of public health practice that is integrated with the allied determinants of achieving improved population health, and which have always been located in local government. These developments effectively reversed the changes of 1974, and bring the on-going endeavour to improve the health of the public back to where it all started.

## 2. Public Health in Walsall Council: One year on

The Health and Social Care Act 2012 created a new Public Health system in England. Some Public Health responsibilities transferred to Local Authorities in England, others to a newly created national body, Public Health England and yet others to NHS England.

Alongside the New Public Health system significant changes also took place in the NHS with the creation of NHS England and at a local level Clinical Commissioning Groups. In seeking to protect and improve the health and wellbeing of their local population the Director of Public Health has a responsibility to ensure the new arrangements work as effectively as possible.

### 2.1. Joint working with Public Health England

The following are examples where the Walsall Council has worked closely with Public Health England (PHE):

- A Health Protection Forum led by Walsall Public Health meets quarterly to discuss health protection issues, with good representation from both Public Health England and NHS England.
- Walsall PH has continued to have close working relationships with the health protection team at PHE. While there were a few issues with communication in the immediate aftermath of Public Health transfer to the local authority, these issues have now been largely resolved. There are several examples of joint working in the management of health protection incidents and outbreaks in Walsall. PHE has supported a peer review of infection control services commissioned by Walsall Public Health.
- Walsall PH has worked closely with PHE to describe arrangements for responding to outbreaks and incidents. Local out of hours arrangements for responding to incidents are yet to be finalised. Walsall PH has also worked with colleagues in PHE in developing Health Impact assessment training in Walsall Council.
- The publication of the regional outbreak plan by PHE is currently awaited.

### 2.2. Joint working with NHS England

The following are examples where the Walsall Council has worked closely with NHS England:

- There has been representation by NHS England at the Health Protection Forum.
- There have been some teething problems in the establishment of communication links between NHS England and Walsall Public Health. Walsall Public Health has not yet been successful in establishing local representation at all screening and immunisation committees led by NHS England across the local area. There are outstanding concerns about Walsall PH access to general practice level information on screening and immunisation.
- There has been insufficient engagement by NHS England with local services in the preparation for the flu campaign for 2013/14. However local commissioners and providers in Walsall are playing a more active role in the planning for the 2014/15 flu campaign.
- School based immunisation services are currently being commissioned by NHS England but there is no identified budget to support this – therefore these services are effectively been subsidised through the Healthy Child Programme 5-19 services which are commissioned by Walsall Public Health.
- There have been several examples of good joint working relationships between Walsall Public Health as commissioners of Infection Prevention and control services and the primary care commissioning team at NHS England.

## 2.3. Joint working with Walsall CCG

- The Health and Social Care Act 2012 placed a duty on Local Authorities to establish Health and Wellbeing Board (HWB) which in turn have duties to prepare and publish a Joint Strategic Needs Assessment (JSNA)[1] and Joint Health and Wellbeing Strategy (JHWS)[2], review of commissioning plans of key partners and ensure that these deliver against the priorities identified in the JSNA. This has been done. The HWB has also monitored delivery of 2013/14 priorities for action identified in the JHWS. These have now been refreshed for 2014/15.
- Collaborative working between Public Health intelligence team and the wider Walsall intelligence network through the production of the Joint Strategic Needs Assessment (JSNA), Walsall Strategic Needs Assessment (WSNA)[3] and development of the Walsall intelligence website[4] has been strengthened.
- A Joint Commissioners Forum for Children and Young People bring together senior officers in the CCG Children's Services, Public Health and NHS England to develop better integration of commissioning of services for Children and Young People.
- Establishment of the joint arrangement to support better integration of Health and Social Care to meet growing demand more effectively and to oversee the development and expenditure of the Better Care Fund.

## 2.4. Joint working across wider partnerships

- Launched the Public Health area profiles to support the work of health & wellbeing in the six Area Partnerships.
- Development of asset-based working across the Area Partnerships in Walsall.
- Development of a diabetes awareness campaign targeting certain areas in Walsall south Area Partnership where prevalence is particularly high – to be delivered during May and June (with a focus in Diabetes Awareness week June 9th – 14th) in partnership with Diabetes UK, pharmacists, voluntary sector, social housing providers, Walsall Healthcare Trust and other Walsall Council partners. The campaign is supported by Walsall CCG.

## 2.5. Joint working across the Council

The Health and Social Care Act 2012 places the duty for the health and wellbeing of its population on the Council, not just on Public Health. So it is to the use of all the resources of the Council; the knowledge skill expertise innovation and creativity of its staff as well as the financial resources that need to be aligned to improving health and wellbeing and reducing inequalities.

Even prior to transition, strong joint working between Public Health staff, staff in the NHS, in Walsall Council and other partners thrived. These have been strengthened, developed and extended throughout transition and the first year in the Council. A summary of key achievements is given in section 10.3.

In summary, I am pleased to report that in the first year overall the new system is working well enough and that no adverse impact on the health of the people of Walsall as a result of the new arrangements. It has taken a great deal of commitment on all sides to achieve this. A further transfer of responsibilities will take place in October 2015 when the transfer of commissioning responsibilities for Health Visitor services (initially set up by local authorities) will take place. Of the original community health services set up in local government only the commissioning of midwifery services will remain with the NHS.

1 The current Walsall Joint Strategic Needs Assessment 2013 can be accessed at the following link: - http://cms.walsall.gov.uk/walsall_jsna_refresh_draft_10.pdf

2 The current Walsall Health and Wellbeing Strategy 2013 – 2016 can be accessed at the following link: - http://cms.walsall.gov.uk/final_2014_hws_refresh.pdf

3 The Walsall Strategic Needs Assessment can be accessed at the following link: http://www.walsallintelligence.org.uk/themedpages-walsall/wsna

4 The Walsall Intelligence website can be accessed at the following link: http://www.walsallintelligence.org.uk/themedpages-walsall/PublicHealthIntelligence

# 3. Where does the money go?

Walsall Council is facing a funding gap of £85m over the next 4 years. It has a statutory obligation to produce a balanced budget. It also has a statutory obligation to promote the health and wellbeing of its population. Can it do both? Can it do more with less?

**"How can Walsall Council deploy Public Health resources**

**(PH allocation and knowledge skill and expertise of PH staff)**

**to reduce demand for services by improving outcomes for Walsall residents and save money for Walsall Council (and its partners)?"**

## 3.1. Public Health allocation

In order to discharge Public Health responsibilities that transferred to local authorities on 1 April of 2013/14, local authorities receive a ring-fenced Public Health grant. The financial value and conditions attached to the grant are set out in a Local Authority Circular (LAC(DH)(2013)1). Walsall Council allocation for 2013/2014 was £14,983,000 of which in excess of £13m was spent on commissioned services. The statutory responsibilities also transferred with this allocation are listed in Section 10.1.

The 14/15 ring-fenced Public Health allocation has contributed to the financial challenge faced by Council through use of some of the Public health allocation to create a Public Health transformation where mainstream Council services with a clear link to Public Health outcomes have been funded from the Public Health allocation, and where necessary redesigned and managed through internal service level agreements to ensure anticipated benefits are delivered.

As austerity increases and anticipated uplifts in the Public Health grant are reduced the same approach will require decommissioning of existing evidence-based Public Health interventions which have demonstrable outcomes on health and wellbeing. Reinvestment of Public Health resources needs to be done on the basis of clear evidence of effectiveness and outcomes at least equivalent to those decommissioned.

The Public Health grant for 14/15 is £15.9 million. This included a £834,000 (5.6%) uplift intended to bring Walsall closer to the target allocation based on need. The breakdown of expenditure by Public Health programme is shown below.

**Public Health Budget Spend by Programme Area: 2014/15**

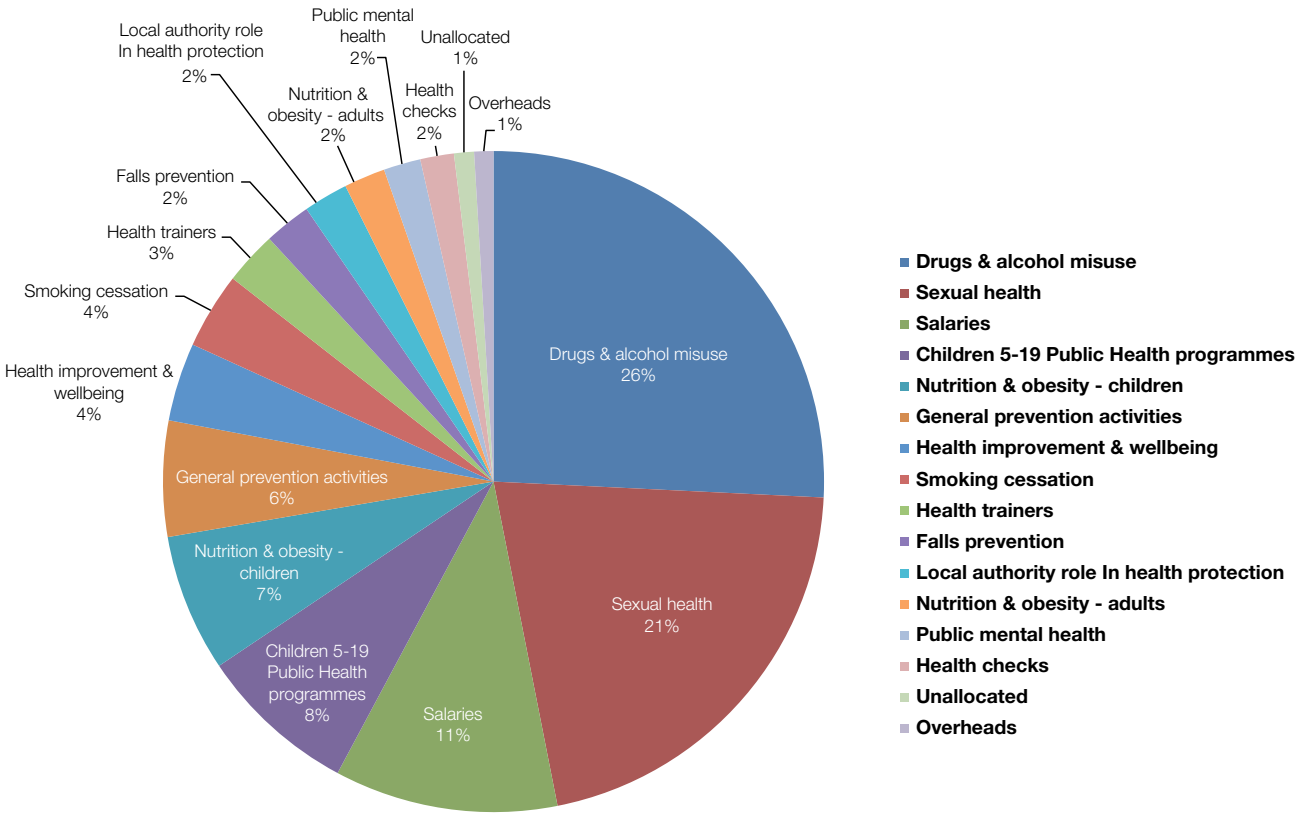



*Figure 1 Public Health Budget Spend by Programme Area: 2014/15*

## 3.2. Management of contracts for Public Health services

Public Health have reported to Health Scrutiny and Performance panel on the management and performance of Public Health contracts on the 11th March 2014.

All Public Health contracts are managed according to a standard commissioning cycle (shown below) with the support of Council corporate departments of Legal, Procurement and Finance, in accordance with Council Contract Rules. All these contracts include service specifications and performance indicators which are regularly reviewed to ensure that providers and Public Health Commissioners can demonstrate that these services deliver against the needs of the people of Walsall as set out in the Joint Strategic Needs Assessment and the Health and Wellbeing Strategy both approved by the Health and Wellbeing Board.

**The Commissioning Cycle used by Public Health Commissioners**

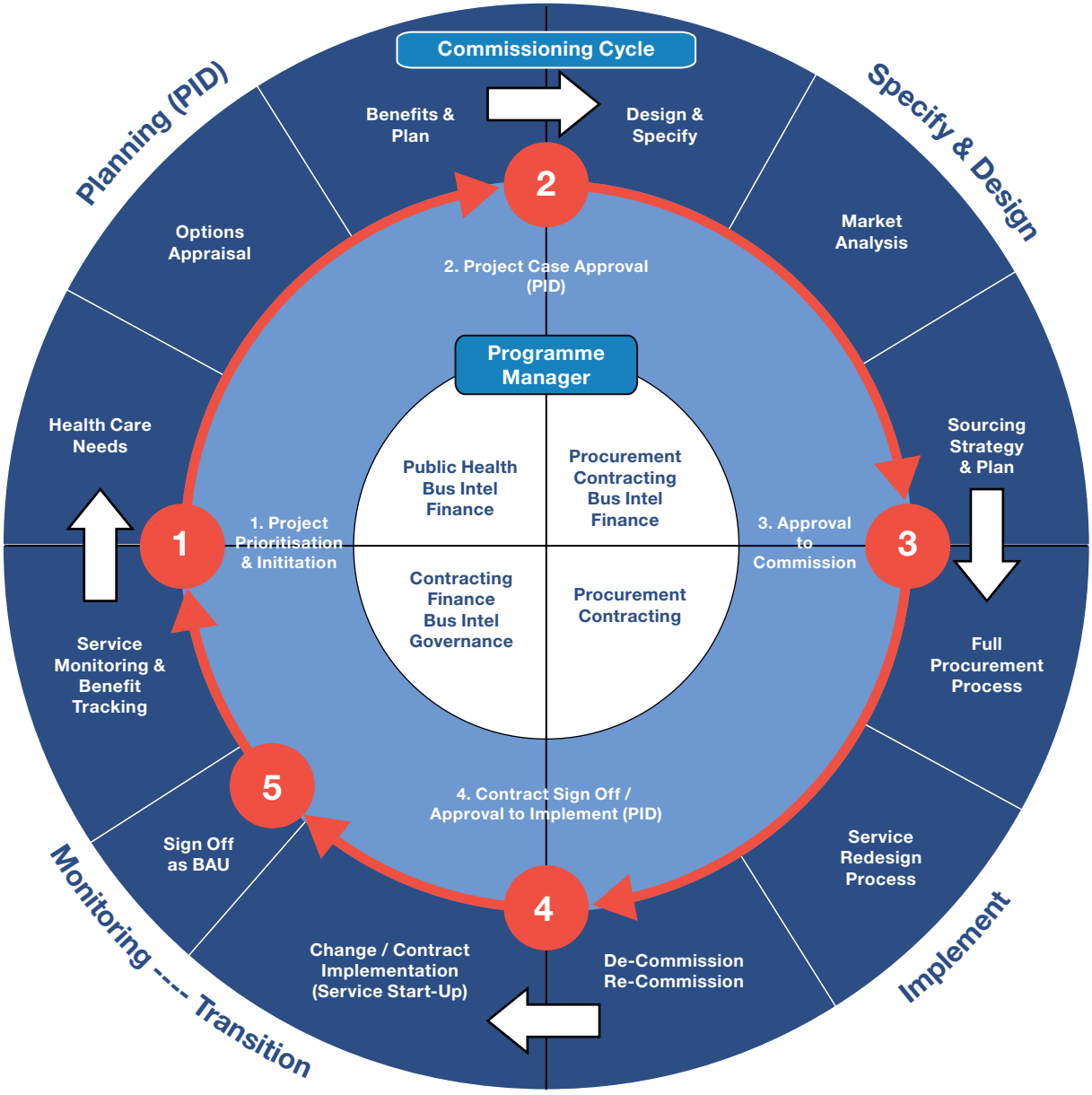



*Figure 2 The Commissioning Cycle used by Public Health Commissioners*

## 3.3. Commissioning for outcomes

The savings that Walsall Council is required to make over the next four years, will inevitably lead to cuts to staff and services. The imperative to use resources more effectively has never been greater. To achieve better value services whilst still improving outcomes requires skilful use of resource, seeking and using evidence wisely whilst always being mindful of targeting population needs.

There is a significant risk that this drive to deliver savings on this scale will contribute to the corporate risk of 'short term gain for long term pain', in other words cutting current investment in prevention to deliver short term savings at the expense of long term increased costs as needs escalates through lack of early intervention. Indeed, there is growing evidence that preventive services have already experienced significant cuts in previous savings rounds. However, robust commissioning based on a robust analysis of need supported by service redesign which makes full use of what research and experience which tell us 'what works' including judicious 'invest to save' initiatives can deliver BOTH improved outcomes and reduced demand/ costs.

Over the years the remit of NICE (The National Institute for Health and Care Excellence) has been widened and valuable Public Health guidance for Local Authorities is now published. These local government briefings are designed to be useful to officers and elected members as well as members of the Health and Wellbeing Boards. Quality standards and guidance for social care in England is also published. It is widely accepted that public health interventions can save money from reducing overall annual costs to society, e.g. from smoking (£13.7bn), alcohol (£20bn), and being obese or overweight (£7bn). Strong arguments have been presented to indicate that through wise investment in preventative activities now, significant savings can be realised in the future. Judicious use of NICE guidance can help identify interventions which can deliver savings to the Council through improvement outcomes and reduced demand for services, in the short term.

### Difficult choices

A reduction in available resources necessitates difficult choices to be made. Prioritisation / re-commissioning of certain services and decommissioning of other services needs to be conducted to rationalise what we are doing in public health and across the Council. This is not a pain free process but can act to refocus our energies and resources on the most pertinent of services and interventions.

### Ambition for Public health over next 5 years

Public health know-how of needs assessment and service specification and design using the best evidence available to meet the needs identified can be shared more widely with Children's services and Social Care and Inclusion both areas of Council services challenged with rising demand and reducing financial resources and thus make a valuable contribution to commissioning for improved outcomes and leading the way in achieving value for money and striving for the very best outcomes over the next 5 years and beyond.

# The challenges ahead

## 4. Tackling Health Inequalities

### 4.1. Giving more children the best start in life

Since transition to Walsall Council in April 2013, Public Health staff have been working in partnership with staff in Children's Services in the Council and in the NHS to explore ways in which more children can be given the best start in life. This is being achieved through better use of evidence of what works, to inform service redesign and the commissioning and decommissioning of services.

**Giving Children the best start in life – Intervention to prevent the Vicious Cycle of Poor Parenting, Poor Educational Attainment, Poor Skills and Worklessness**

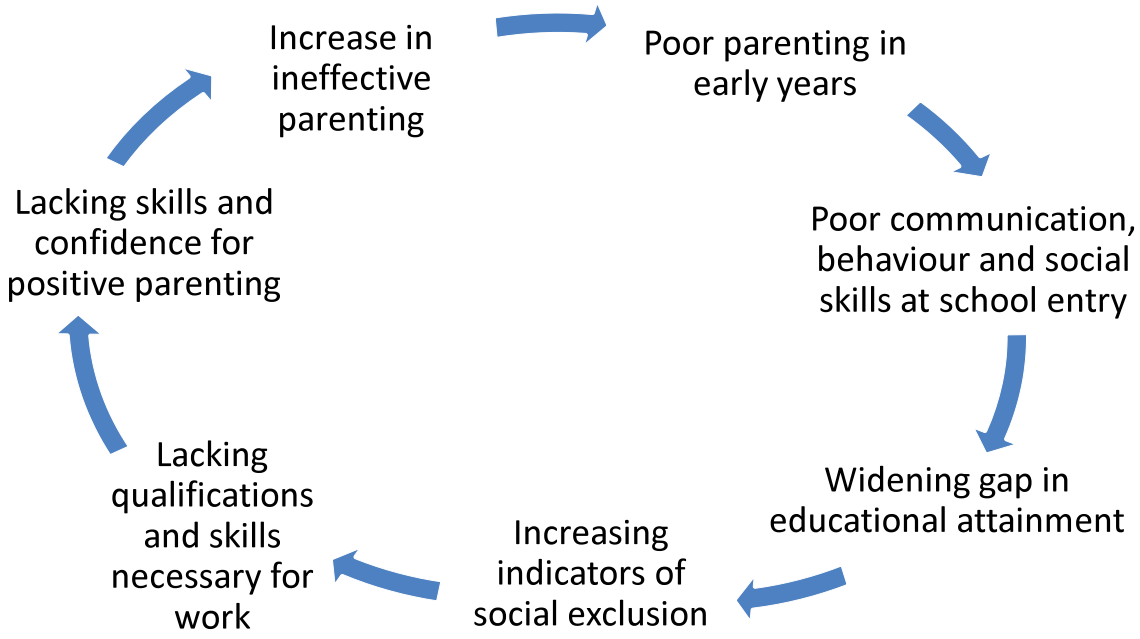



*Figure 3 Giving Children the best start in life – Intervention to prevent the Vicious Cycle of Poor Parenting, Poor Educational Attainment, Poor Skills and Worklessness*

In addition to core work, the following sections highlight the key findings of these key pieces of work, which taken together with what is offered in local authority, healthcare and community settings, can improve outcomes and life chances for children and young people.

### 4.1.1. Infant mortality

Walsall has one of the highest rates of infant mortality in England. For every 1000 babies born in Walsall 7.6 babies die in the first year of life. This figure is not the same for the whole of Walsall which shows the impact of poverty and deprivation on infant mortality with less than 5 per 1000 live births in the least deprived areas compared with rates of 32 per 1000 births in the most deprived areas of Walsall - such as Birchills and Leamore, Blakenall and Palfrey.

Nationally we know that infant mortality is linked to the following which are more likely in areas of deprivation:

- High rates of smoking in pregnancy
- Low birth weight
- Quality of care during pregnancy
- High levels of maternal obesity
- High levels of substance misuse
- Genetic conditions
- High levels teenage pregnancy
- Low levels of breastfeeding
- Unsuitable sleeping environment
- Poor uptake of immunisation and screening

Walsall has set itself the very challenging target that it will reduce infant mortality to 6 per 1000 births by 2019. In order to do this we will work with all partners including current and potential parents and grandparents to tackle the issues above.

We are also working with an expert panel to find out exactly why Walsall babies die and what could be changed in the care and information offered to new parents. Results will be available in January 2015.

In addition, as part of this we have a Bumps and Bloomers roadshow that has gone to the Manor antenatal clinic, the Saddlers Centre and schools to find out where women get their information from, who they take notice of and what they know about keeping themselves and their babies healthy.


*Figure 4 The Bumps and Bloomers clothes show where women pinned on where they get their information from (grandma's bloomers!)*

*Figure 5 Kim and Sam from the Walsall Creative Development Team in the antenatal clinic in their pinnies with their Bumps and Bloomers clothes horse and ironing board*

This has found that women are listening to conflicting advice and take a lot of notice of their own Mum rather than a health professional. Sometimes the messages they take on board are not correct, for example over dressing a baby in bed so they stay warm is still believed to be the thing to do. It has also found that many women also use the Internet for advice, only to find it confusing and often wrong, coming away feeling less confident than they did when they 'googled' in the first place. We will therefore work to highlight reputable internet sites and using this knowledge, help women look after themselves and their babies in pregnancy and after the birth. By working with parents, health professionals and people working in the community, we believe we can achieve our target but know this is going to take concerted work across the whole of Walsall.

## 4.1.2. The role of Children's Centres

What happens in pregnancy and the early years of a child's life has a profound impact on the rest of his or her life in terms of their physical health, ability to form positive relationships and to gain meaningful work. Research has shown that children born to parents who are responsive and loving will have better prospects than those born to parents who feel unable to cope whether due to stress, health issues or not having been parented well themselves.

There are 18 children's centres across Walsall recently organised into the same 6 clusters as the Area Partnership teams so in the heart of their communities. Their main aim is to improve outcomes for all young children from pre birth up to age 5 and their families but also to identify, reach and help families in greatest need to ensure that:

- Each child's development is supported so they develop as confident and curious learners and the gap in Walsall between the school achievement of the most disadvantaged children and their peers is reduced
- Parents and carers are helped to give their child the best start in life and when needed, are supported into education and training
- Children and family's physical and mental health is promoted.

The earlier the support is offered, the more effective and cost effective it is. Children's Centres are in a key position to identify those families in their areas who need help before this need becomes acute. By using evidence based practice to make sure that the right help is offered at the right time, they are all working towards public health outcomes in ways that have been shown to be effective in communities such as Walsall.

Across Walsall Children's Centres offer:

- Activities and groups ( e.g. parenting groups)
- Childcare
- Health advice (e.g. smoking cessation or preparing for birth)
- Practical parenting advice (e.g. accessing benefits or home safety)
- Training and information (e.g. baby massage or writing and mathematics support)

*Figure 6 Photograph of Darlaston Children's Centre*

It has been set out nationally that:

"In tightened financial times, Local Authorities need to move to better use of children's centres and other services to close the gap between rich and poor children" Policy Exchange Report 2013.

To support better targeting and to ensure that the services complement rather than duplicate other services, uniquely skilled Children's Centre staff in Walsall are now working closely with Health Visitors and midwives and other professionals to ensure school readiness and to offer intensive family support to those families who need additional support.

## 4.1.3. Evidence-based support for parents

Evidence based parenting programmes (EBPP) are important public health interventions. Many are widely recognised, reviewed and supported by the Department for Education and others, including the Chief Medical Officer's report in 2012. The 'Early intervention: next steps' report by Graham Allen (2011) and 'The foundation years: preventing poor children becoming poor adults' report by Frank Field (2010) which both highlight the importance of positive early interventions in the first years of life, including parenting courses and programmes.

Allen strongly advocates positive parenting early in a child's life:

'What parents do is more important than who they are. Especially in a child's earliest years, the right kind of parenting is a bigger influence on their future than wealth, class, education or any other common social factor'.

He goes on to suggest:

'Although poor parenting practices can cause damage to children of all ages, the worst and deepest damage is done to children when their brains are being formed during their earliest months and years. The most serious damage takes place before birth and during the first 18 months of life when formation of the part of the brain governing emotional development has been identified to be taking place'.

Walsall's child poverty strategy states the following objectives:

- Mitigate impact by income maximisation, money advice and tackling debt
- Increase wage levels with the aim of raising household incomes over the 'poverty threshold'
- Reduce the number of adults with no qualifications by promoting educational attainment and skills from the early years onwards
- Decrease the number of local parents classed as unemployed
- Increase the number of jobs for local people
- Narrow the educational attainment gap between disadvantaged pupils and their peers
- Build family and children's resilience and enhance parenting skills
- Increase aspiration of parents, children and young people.

The objectives of Walsall's child poverty strategy above can be linked to the objectives of many parenting programmes offered across Walsall. Programmes include: Understanding Your Child (Solihull approach); Strengthening Families Strengthening Communities; Triple P teen group and teen primary care; Mellow bumps, babies and core and Family Links. A range of providers deliver parenting programmes across Walsall in a variety of settings, including: Walsall Parenting Team, health visitors, Parent Partnership and Anti-Social Behaviour Unit, and volunteers from the community.

Public health is currently investing £150k into parenting programmes in Walsall which presents a real opportunity to ensure parenting needs are being met by programmes offered. This may include ensuring outcomes such as reducing rates of looked after children and children on the child protection plan through implementation of effective, evidence based parenting programmes.

We are looking forward to working more closely with our colleagues in the parenting team and other providers of parenting programmes in the very near future.

## 4.1.4. Looked After Children

Looked after children (LAC) are some of the most vulnerable children in society and Walsall Borough Council wants the best outcomes for these children in the long term. We aim to ensure that the right children enter the looked after system at the right time, for the right time and at the right cost. Reducing the need for children to become looked after will also impact positively on future generations breaking the cycle of deprivation.

In common with many other areas of England, the number of LAC is increasing in Walsall. This increase has been set against a major financial recession. Research based on a large UK cohort study, the Avon Longitudinal Study of Parents and Children (ALSPAC), found that poverty was the most significant risk factor for children placed on local child protection registers prior to their 6th birthday with an adjusted odds ratio of 10. This means that while taking into account other relevant factors, families in poverty are 10 times more likely to have children placed on the child protection register prior to their 6th birthday than families not in poverty.

## What does the evidence tell us?

A literature search has recently been conducted to identify systematic reviews of preventing entry into the looked after system as an overall outcome, with the following as interventions: domestic violence programmes; substance misuse programmes for parents; parental mental health programmes; programmes for children's conduct disorder/ challenging behaviour social care practices This work did not find a systematic review which directly addressed the outcome of prevention of entry to the looked after system, and insufficient evidence on outcomes for children for some interventions such as for parental substance misuse.

Notwithstanding a lack of systematic reviews as outlined above, there is high level evidence from the literature for some interventions which impact on factors associated with entry to the looked after system, such as early education and childcare, classroom based emotional and problem solving programmes for 3-7 year olds and child focused group social and cognitive programmes for 9-14 year olds at high risk of or with conduct disorders. There is also good evidence of cost effectiveness for interventions for the management of conduct disorder, Family Nurse Partnership and some parenting programmes particularly if a wider perspective is taken.

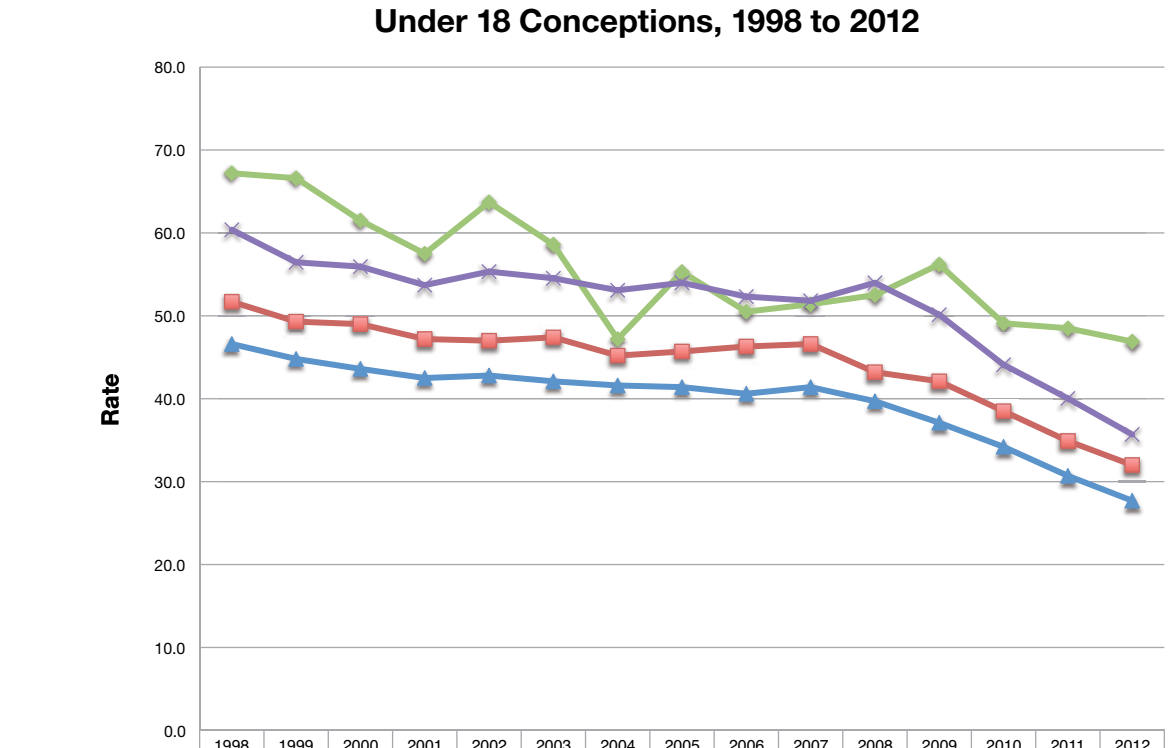
## 4.1.5. Reducing Teenage Pregnancy

It is important to ensure that young people have the knowledge and skills to enjoy good sexual health throughout their life. Helping young people to understand their sexual health means that they can protect themselves against unwanted pregnancies and sexually transmitted infections.

Teenage Pregnancy Reduction in Walsall continues to present a challenge. The rate of teenage pregnancy in Walsall has fallen 30.8% since 1998 from 67.2 per 1,000 to 46.5 per 1,000 in 2012 so we are moving in the right direction; however for many Teenage Pregnancy remains a serious problem social problem.

Most teenage pregnancies are unplanned and around half end in an abortion. While individual young people can be competent parents, all the evidence shows that children born to teenagers are much more likely to experience a range of negative outcomes in later life in terms of the baby's health, the mother's emotional health and well-being and severely limit their education and career prospects resulting in the likelihood of both the parent and child living in long-term poverty. This is evidenced in infant mortality for babies of teenage parents being 60% higher than for older mothers.

The current Teenage Pregnancy trends are shown in the following graph.




| | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Walsall | 67.2 | 66.6 | 61.5 | 57.5 | 63.7 | 58.6 | 47.2 | 55.3 | 50.5 | 51.4 | 52.5 | 56.2 | 49.1 | 48.5 | 46.9 |
| West Midlands | 51.7 | 49.3 | 49.0 | 47.2 | 47.0 | 47.4 | 45.2 | 45.7 | 46.3 | 46.6 | 43.2 | 42.1 | 38.5 | 34.9 | 32.0 |
| England | 46.6 | 44.8 | 43.6 | 42.5 | 42.8 | 42.1 | 41.6 | 41.4 | 40.6 | 41.4 | 39.7 | 37.1 | 34.2 | 30.7 | 27.7 |
| Statistical Neighbours | 60 | 56 | 56 | 54 | 55 | 55 | 53 | 54 | 52 | 52 | 54 | 50 | 44 | 40 | 36 |

*Figure 7 Under-18 conception rate per 1,000 females age 15 to 17 for Walsall by year 1998 to 2012 (Source: Office of National Statistics)*

Going forward there is growing evidence for the following interventions:

- wider measures to reduce poverty and increase aspiration
- intensive structured parenting and family support for vulnerable families
- well resourced youth and career development programmes promoting academic, social skills, self esteem and entry to employment
- sex and relationships education [SRE] in schools and SRE training for professionals working with vulnerable young people
- availability of well publicised, young people–centred contraceptive services

## 4.2. Reducing avoidable early deaths

In Walsall, too many of our residents die too early from diseases and illnesses that are largely avoidable. In 2012, 1,922 Walsall resident died prematurely (that is, under the age of 75). The largest number of deaths are from cancer, heart disease and stroke and respiratory conditions such as pneumonia.

The Global burden of disease study shows that whilst premature mortality rates in the UK have fallen over the last 20 years, our increased years of life are more likely to be spent in poor health.

Many of these premature deaths could be avoided either through:

- prevention of illness through public health interventions
- earlier diagnosis of their conditions by greater awareness of symptoms by health professionals and by the public
- having access to the highest quality treatment and care services.

The national strategy "Living Well for Longer: National Support for Local Action to Reduce Premature Avoidable Mortality" was published in 2013 by the Department of Health. This set out key actions for health and care services to take to reduce premature mortality. As well as tackling the rates for Cancer, Liver, respiratory and cardiovascular diseases, improvements will be expected in deaths under age 75 for adults with serious mental illness, deaths under age 60 for people with learning disabilities and for infant mortality (deaths under 1 year of age).

The following chart shows the Potential Years of Life Lost by Age Group in Walsall. We can see from the chart that the biggest potential years of lost life is in the 60 to 74 year group followed by the 50 to 59 years group. However, the next highest age group is where Infants under 1 years die – 16% of all years of lost life or 6,825 years is accounted for by the under 1's. See the infant mortality section for further discussion on this issue.

**The Potential Years of Lost Life by age Group in Walsall: 2010 to 2012 (Source = Public Health Mortality File)**

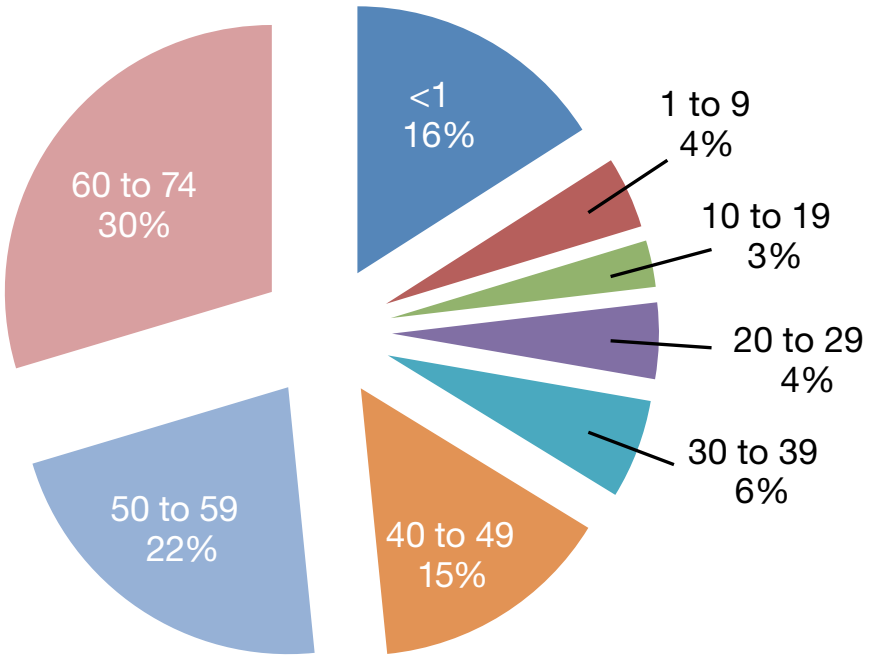



*Figure 8 The Potential Years of Lost Life by Age Group in Walsall: 2010 to 2012 (Source = Public Health Mortality File)*

Early deaths from circulatory disease in Walsall continue to fall (see figures 9 and 10 below), although this continues to lag behind rates in more affluent areas. A similar trend is seen in early deaths from cancer.

The real challenge for Walsall is the persistent inequalities which exist within the Borough.

The other main causes of premature death in Walsall are from Cancer followed by Circulatory Disease (CVD). However, both the graphs below show there has been a fall in premature (<75 Years) CVD and Cancer mortality rate per 100,000 in Walsall over the last 10 years from 2001 to 2011. The premature mortality rates are still higher than the rest of England for both disease areas.

**Premature mortality (< 75 years) from CVD, rolling 3 year average, 2001-2011**

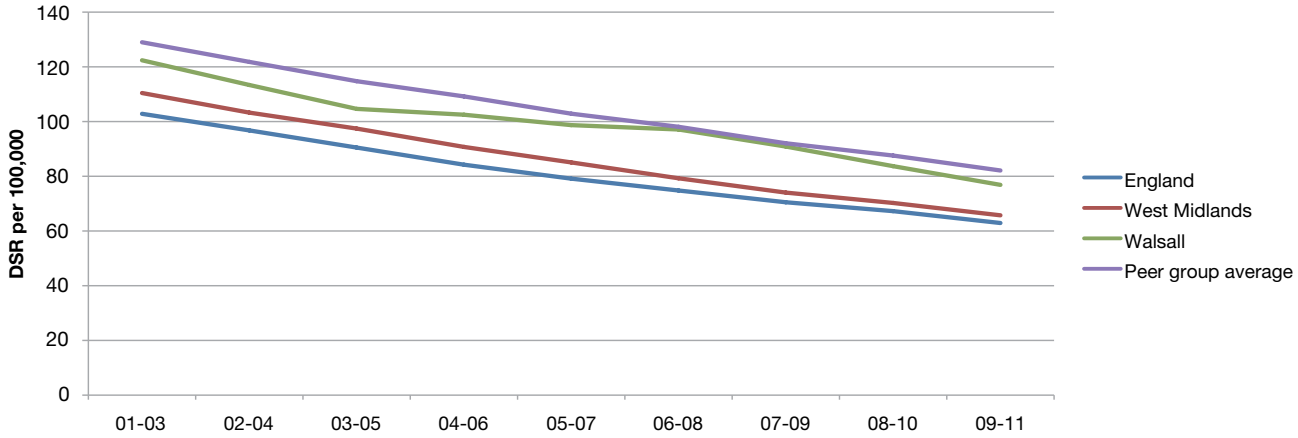



*Figure 9 Premature Mortality (<75 Years) from CVD, Rolling 3 Year Average, 2001 to 2011*

**Premature mortality (<75 years) from all cancers, rolling 3 year average, 1993-2011**

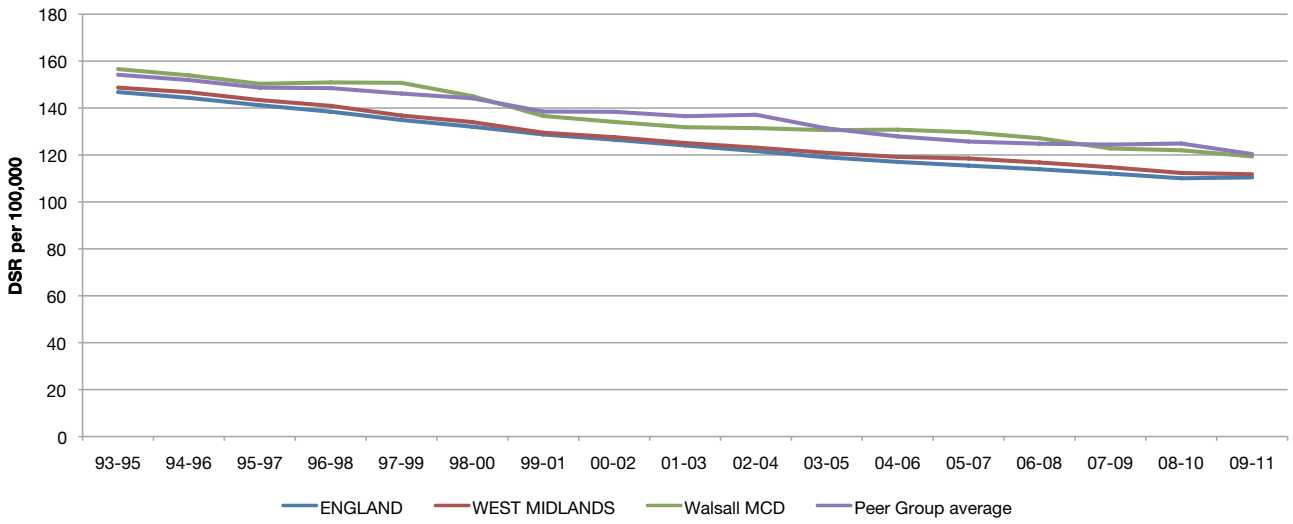



*Figure 10 Premature Mortality (<75 Years) from all Cancers, Rolling 3 Year Average, 1993 to 2011*

Actions to reduce early death will also bring benefits for other illnesses, especially as many people will be living with other long-term conditions at the same time. Our collective actions will also help to reduce avoidable deaths in older age – for example in improving cancer mortality rates amongst older people, where we compare badly to other countries.

Tobacco smoking is still by far the biggest risk to our health, causing almost 150 avoidable deaths every year. High blood pressure, physical inactivity, obesity and excessive alcohol consumption are also important factors so we need to find more dynamic approaches to make an impact on these issues. Physical inactivity in the UK is a contributor to around 17% of premature deaths.

The charts below from the Walsall Health Profile 2014 show that the premature death rates for both men and women are falling. But the gap between the most deprived and affluent areas continue to be wide. This is shown in Figure 11 below.

**Walsall Early Deaths from All Causes: Men and Women 2002 to 2011 (Source = Walsall Health Profile 2014)**

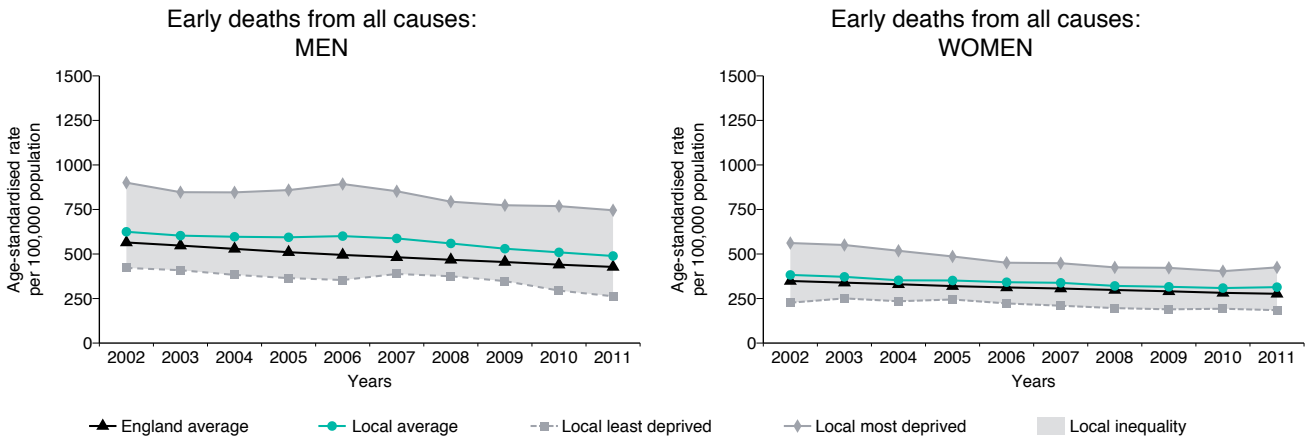



*Figure 11 Walsall Early Deaths from All Causes: Men and Women 2002 to 2011 (Source = Walsall Health Profile 2014)*

In fact we can see from the following charts that the Life Expectancy gap for men is 10.8 years and 8 years for women between the most deprived and affluent communities of Walsall. We also can see that the life expectancy gap has continued to increase over the last 10 years particularly for men (See figure 12 below).

**Walsall Life Expectancy Gap for Men and Women (Source = Walsall Health Profile 2014)**

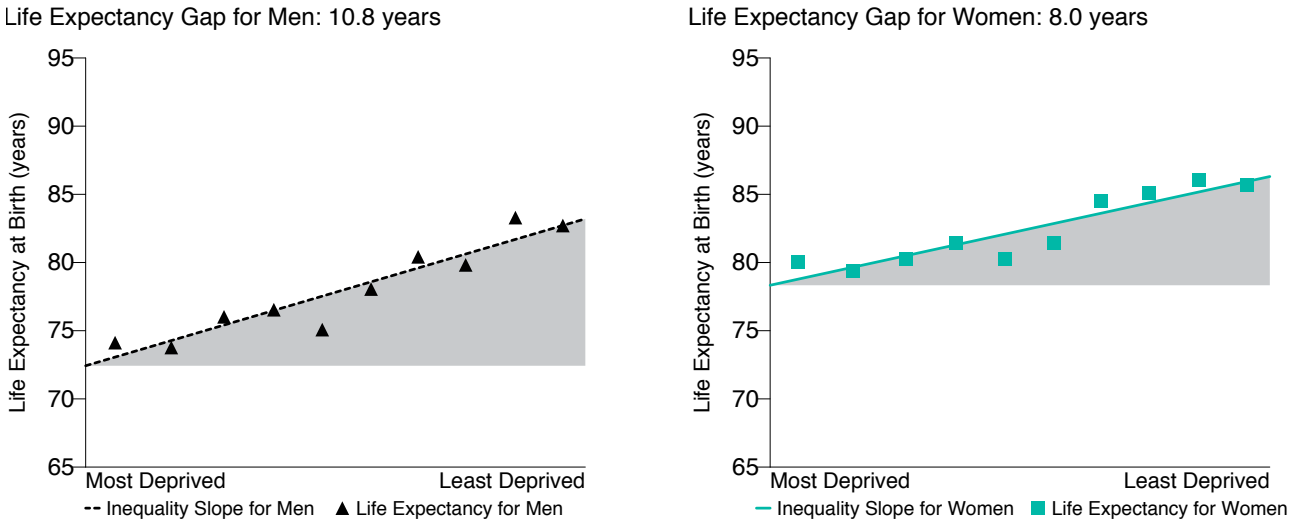



*Figure 12 Walsall Life Expectancy Gap for Men and Women (Source = Walsall Health Profile 2014)*

## Key Actions for Walsall

It is important to influence behaviour from the state, communities, and individuals so that we can all feel supported to take more responsibility for our own and our families' health. Whilst it is for individuals to decide what to eat, whether to go for a run, or whether or not to smoke, the availability of a choice of healthy foods, access to safe areas to run and less promoting of tobacco as attractive are things that local government can do to support healthier choices.

There are key actions that should be accelerated in Walsall to address premature mortality:

- Stop the promotion of tobacco, especially in places accessed by children
- Increase the focus on helping tobacco users to quit, particularly pregnant women
- Improve the detection and management of high blood pressure (BP) – whilst current General Practitioner contracts encourage this, more effort needs to be made locally to both identify and to 'treat to target' for a higher proportion of our population
- General population actions such as reduced salt in all foods and encouraging more physical activity will have a significant impact on all the major causes of ill health e.g. diabetes
- Aggressive joined up actions across Walsall to reduce the prevalence of obesity. Making walking a normal and everyday activity for the whole population has to be a key aim.

The next section discusses in more detail the issues around men health outcomes.

# 4.3. Improving the health and wellbeing of men

## What is the Problem with Men's Health?

Typically, life expectancy is higher in women than men. For women, Walsall is on a par with regional but lower than national figures, although the gap is reducing. In contrast, male life expectancy is considerably lower in Walsall than regional and national figures; however, the gap is starting to narrow again in recent years. This is shown in the following graph.

**The Life Expectancy at Birth of Walsall Men and Women Compared to England and the West Midlands: Trend from 1991/93 to 2009/11 (Source = Office for National Statistics)**

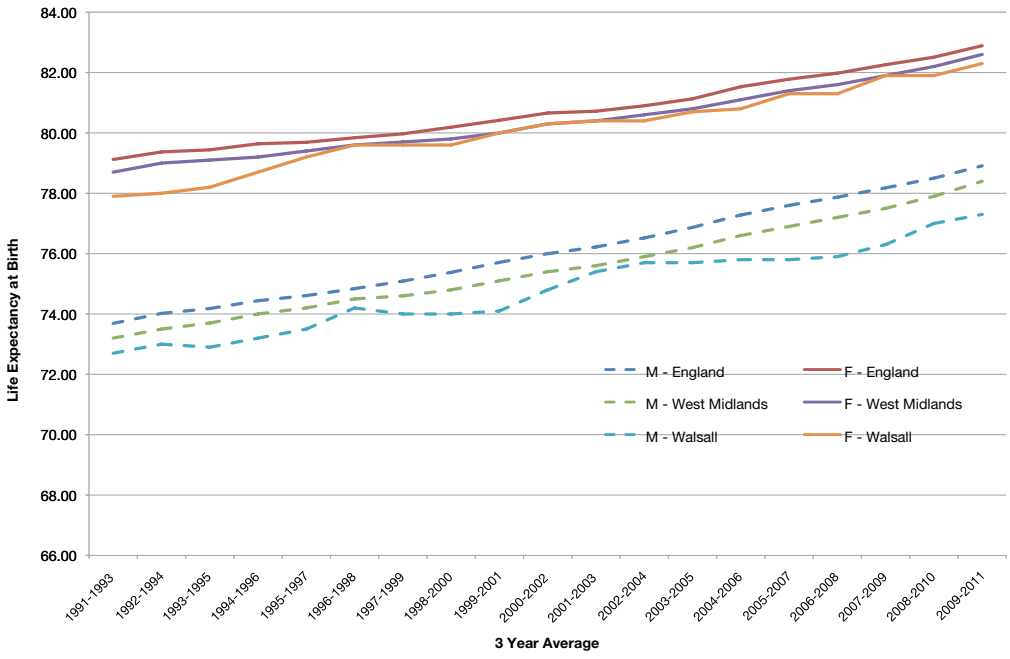



*Figure 13 Life Expectancy at Birth for Females and Males: 1991 to 2011 (Source = Office for National Statistics)*

The Walsall All-age, all-cause mortality is lower amongst females than males. Over the last few years it has gradually declined (with some year-to-year fluctuation) but remains higher in Walsall than regionally and nationally. Following years of steady decline, mortality rates for Walsall men increased in 2005. More recently, the fall in male mortality rates has accelerated and the gap between the local, regional and national rates has narrowed. However, persistent efforts need to be made to prevent and to manage the main contributors to early deaths. The main causes of premature deaths in men are Heart Disease, Cancer and Respiratory disease.

## How are we trying to target Men's health in Walsall?

Walsall Clinical Commissioning Group has identified narrowing the gap in male life expectancy within the five year strategy. The plan describes the following interventions that will be used to improve Male Life Expectancy in Walsall:

- Reduce smoking,  obesity and harmful drinking
- Increase early detection of disease for example through the health checks program
- Influence lifestyle choices through Every Contact Counts
- Encourage participation in screening programs
- Improve care pathways
- Targeted education and service provision through Lifestyle Services.

The Walsall Public Health team also commissions many services that are also targeted at men. For example the following services are available:

- Physical Activity programmes that target men
- A healthy workplace programme that targets men in routine and manual occupations
- Men's Health is a key focus of the Community Health Champions programme. Bridging programmes like ActiveM8 have been successful in engaging men who are physically inactive and encouraging them to take up new activities
- NHS Healthchecks is available to men from 40 to 74 through GP practices. The Healthy Workplace programme, Community Healthchecks programme and Community Health Champions programme all have targets to improve men's uptake  of NHS Healthchecks

## 4.4. Healthy ageing

Ageing is a natural process that happens to everyone. However there can be great disparity between individuals and communities in terms of 'healthy ageing'. Many factors can impact on health and well-being, including lifestyle and deprivation, often not through choice. The term 'healthy ageing' relates to maximising opportunities for good health, so that older people can take an active part in society and enjoy an independent and high quality of life. Therefore the challenge for health and social care is to maximise the opportunity for healthy ageing and minimise the inequality across Walsall.

Ageing does not necessarily need to be a burden, and it does not necessarily decrease a person's ability to contribute to society. For example, older people can make valuable and important contributions to society, and enjoy a high quality of life. But this depends on treating ageing as an opportunity rather than a burden, and taking a so-called 'assets-based approach'. A good example of this approach is described in the 'more voluntary action' section of this report.

Only by concentrating on what people can do, rather than what they cannot, can strategies and political decisions be taken which help create the right conditions to promote healthy behaviours amongst older people and provide the necessary opportunities for regular physical activity, healthy diets, fulfilling social relations, participation in meaningful activities and financial security.

Healthy life expectancy is an estimate of how many years are lived in good health over the lifespan. It is commonly used to try and assess whether ageing populations – including Walsall's – will be vibrant and independent, or suffer from greater chronic ill-health and poor quality of life. Extending a person's life alone is insufficient: if the quality of that life is not healthy, it will have a detrimental impact on service needs such as the planning of health and social services, long term care and pensions.

The most recent data available in relation to healthy life expectancy is shown in the chart below illustrates that Walsall has a slightly lower healthy life expectancy age compared to regional and national comparators.

**The Healthy Life Expectancy Compared to Life Expectancy in Walsall, West Midlands and England: 2009 to 2011**

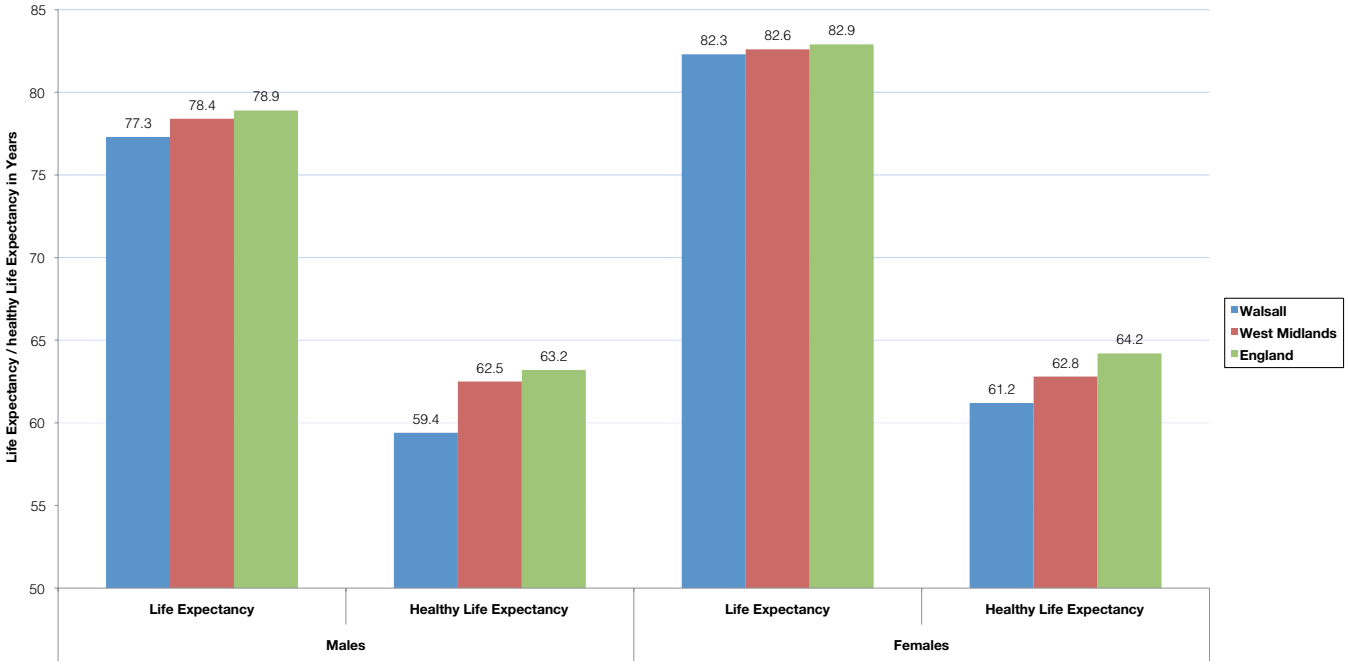



*Figure 14 The Healthy Life Expectancy Compared to Life Expectancy in Walsall, West Midlands and England: 2009 to 2011*

Walsall, like England as a whole, has an ageing population with the proportion of the population aged 65 and older forecast to increase considerably in the next 10 years and beyond. Despite recent success in improving life expectancy, there are still differences in both life expectancy and healthy life expectancy amongst the population.

For too many people in Walsall, old age brings a high risk of social isolation and poverty, with limited access to affordable, high-quality health and social services. Strong leadership and evidenced-based policy and strategy are thus needed to ensure that positive trends can be sustained and the benefits of a longer life can extend to everyone regardless of where they live or the socioeconomic group they belong to.

# 5. Doing more with less

*Choose to be optimistic, it feels better.*
**(Dalai Lama)**

*Have confidence in your ability to make a difference.*
**(Inaugural address Cllr Pete Smith Mayor of Walsall 14/15)**

*We're doomed.*
**(Private James Frazer, BBC sitcom, Dad's Army)**

These quotes illustrate the options which face us in tough times, whether as individuals, communities or organisations. In this section of the report I set out ways in which residents of Walsall can contribute to the challenge of doing more for less, by taking more control of their own situations to make a difference for themselves, their families and communities.

## 5.1. Better access to reliable information, better informed decisions

What Public Health England and Public Health Walsall produce to help individuals, communities and organisations make better informed decisions.

### 5.1.1. More self care: Health Literacy

If individuals are going to take more control of their own health and wellbeing they need the skills and knowledge to find and use reliable trustworthy information. This is what is meant by health literacy. As described earlier young mothers are more likely to take notice of advice from their own mothers than from a health professional. In 1906 Walsall's Medical Officer of Health found the same was true!

The people and groups living in Walsall likely to experience poor health literacy are the very people who are at greater risk of poor health: older people, people with low income or poor educational attainment, people with poor fluency and literacy in English. Public Health, the health and social care system and adult educators have a shared responsibility to improve health literacy in Walsall.

## 5.2. Understanding behaviour change

If only information was enough...! Anyone who has tried to stop smoking, follow a new more active lifestyle or stick to a new healthy eating plan knows that changing ingrained habits requires persistence and encouragement to continue when the going gets tough. The Health Trainer service and Community Health Champions described below provide that support and encouragement to make long term sustainable change.

### 5.2.1. More self care: Community health champions

Walsall Public Health and Walsall Housing Group (Walsall's largest social landlord with 19,000 homes and 50,000 tenants) have a strong track record of working in partnership. Together, they have developed and delivered a successful grass roots engagement model, which aims to bridge the divide between 'failed to reach' groups and mainstream services.

The Health Housing Partnership was established in 2008. Driven by the Partnership's Health Housing Strategy (2012) and its strategic aim to improve health in our most deprived communities where health outcomes are poorest and inequalities starkest, the Community Health Champions (CHC) programme was established.

Four CHCs have been employed from local communities to work in an outreach capacity to engage with local people. Because they live in these communities themselves, they have been able to establish relationships based on trust and empathy and they are often the first point of contact as providers of key health messages.

The CHC programme focuses on three principal areas:

1. Providing brief information and advice through the 'Make Every Contact Count' framework
2. Delivery of 'bridging' programmes e.g. Get Up & Go and ActiveM8, which introduce participants to healthy lifestyle activities over 12 and 8 weeks respectively, address wider determinants and support referral into mainstream health and wellbeing services.
3. Progression pathways into positive activities including capacity building, accredited training, volunteering and employment.

The CHC model is a successful example of employing local people from deprived areas and providing the opportunity to develop skills and knowledge to progress a career in health. Working through the CHCs, we have been able to successfully engage with and support people never previously seen by our mainstream services to access these providers, improve their knowledge and understanding of how to stay healthy and participate in training and volunteering opportunities to improve their employment prospects.

The targeting for this programme is informed by local Public Health profiles and needs assessment and is strategically aligned to priorities identified in the Walsall JSNA and Health and Wellbeing Strategy. Target groups include men (male life expectancy and premature mortality are particular issues in Walsall) and Black Minority Ethnic (BME) groups with a specific emphasis on the Bangladeshi population (this is a population which experiences particularly poor health outcomes in Walsall).

The team work closely with Public Health commissioners and service providers and this is key to the success of the programme.

Delivery partners include:

- Teams from Walsall Healthcare Trust, who are commissioned by Public Health to deliver a range of services including Lifestyle Link, Lifestyle Services, NHS Health checks and Sexual Health Services
- Walsall Council's Sports and Leisure Services
- NHS England Screening services e.g. breast and other cancers
- WHG Income Collection team: 'Money mentors' and Domestic Violence team
- Third Sector organisations e.g. CAB, WVA
- Organisations delivering drug and alcohol support programmes

The team's achievements over the last financial year include:

**1972** Residents receiving brief interventions or attending Healthy Lifestyle Information and Advice Sessions

**597** Residents supported to access mainstream public health services

**142** Residents taking up NHS Health checks

**177** Chlamydia screens completed

**30** Residents supported to take HIV tests

**37** Young people signed up to C card scheme (from January 2014)

**168** Children completed and continue to attend Active Clubs (Healthy weight program)

**500** Residents completed 'Waste not Want not' healthy cooking course

**289** Residents recruited to non accredited training

**79** Residents recruited to accredited training

**28** Residents progressing into volunteering

**5** Residents progressing into employment

**27** Residents supported for debt advice.

## 5.3. Caring for carers

It is important to consider the impact of carers' not only in terms to the individual(s) they care for but also to the wider community and to health and social care services. A large proportion of peoples' care is provided by family, friends or volunteers. It is absolutely crucial to the continuity and sustainability of health and social care services that carers' needs are met as well as those of the people they care for.

A historic piece of legislation has been enacted in 2014; The Care Act 2014. This is the first overhaul of social care statute in England for more than 60 years, and importantly has cross political party support through parliament. Details of the Act are currently being worked through and so we will have to see how this will impact on people in Walsall.

## Dementia

A good example of the crucial role of carers is the care and support of people living with dementia. Carers' of people living with dementia provide a crucial role in helping to support an individual's independence for as long as possible and minimising their utilisation of health and social care services until necessary. However, equally important is that the carer themselves is considered and supported by both health and social services. Providing the appropriate support to carers is vital, especially as more people are living longer and therefore there is likely to be a greater need for carers of people living with dementia.

The National Institute for Health and Care Excellence (NICE) has produced guidance on dementia which includes a section on support for carers[5]. This guidance highlights that health and social care services should ensure the rights of carers to an assessment of needs as set out in the Carers and Disabled Children Act 2000 and Carers (Equal Opportunities) Act 2004. As part of this guidance NICE have developed two quality standards to support carers of people with dementia. These standards describe the emotional, psychological and social needs of carers and respite services for carers.

Examples of tailored interventions that should be considered as part of care plans for carers include; individual or group psycho-education, peer-support groups tailored to the needs of the individual (for example, the stage of dementia of the person being cared for), telephone and internet information and support and training courses about dementia, services and benefits, and dementia-care problem solving. There should be consideration of involving the person with dementia and other family members as well as the primary carer. Services should ensure support (such as transport or short-break services) is provided to enable carer participation in interventions. These services should meet the needs of both the carer (in terms of location, flexibility, and timeliness) and the person with dementia and include, for example, day care, day-and-night sitting, adult placement and short-term and/or overnight residential care. Investment in these support services have been shown to reduce the need for more expensive crisis care as carers feel able to access the support they need when they need it and hence improves their quality of life.

## 5.4. Volunteering

People of all ages are motivated to volunteer their time, to a wide range of causes and activities for an innumerable range of reasons.

Volunteering England's website[6] provides the following definition:

*"Any activity that involves spending time, unpaid, doing something that aims to benefit the environment or someone (individuals or groups) other than, or in addition to, close relatives. Central to this definition is the fact that volunteering must be a choice freely made by each individual. This can include formal activity undertaken through public, private and voluntary organisations as well as informal community participation".*

Therefore volunteering can take many forms, involve varying levels of time commitment and can be focused on an individual to large groups or communities.


5 NICE website – Dementia - http://pathways.nice.org.uk/pathways/dementia?fno=1#content=view-node%3Anodes-support-for-carers

6 Volunteering England website http://www.volunteering.org.uk/iwanttovolunteer/what-is-volunteering

## National participation in voluntary activity

A survey of adults in England during 2012-13[7] reported 44% of adults formally volunteer (giving unpaid help through a group, club or organisation) at least once a year and 29% did so at least once a month. This is a slight improvement on the previous year. Over recent years there appears to be an increasing trend towards more episodic volunteering rather than to regular commitments.

In England females are more likely to volunteer than males (42% and 38% respectively). Adults aged 35 to 49 years are the most likely age group to formally volunteer (47%) and younger volunteers are relatively more likely to volunteer informally than formally. Participation in formal volunteering reduces with socio-economic classification, from 55% in higher/ lower managerial and professions classification to 28% in routine occupations. However participation by full-time students is reported to be 47%.

Volunteering occurs across many different sectors. The most popular sectors for formal volunteers are sport/exercise and hobbies (53%), recreation/ arts/social clubs (42%). Other examples of popular sectors for volunteering include; religion, children's education/schools, youth and children's activities (outside school), health, disability and social welfare, local community or neighbourhood groups, the environment and animals.

Popular activities that people fulfil in formal volunteer roles include; organising or helping to run an event (55%), raising or handling money/taking part in sponsored events (52%), leading the group/ member of committee (37%), providing transport/d riving (26%), giving information/advice/counselling (24%), visiting people (24%), secretarial/clerical or administrative work (23%) and befriending or mentoring people (21%).

## Participation in voluntary activity in Walsall

Numerous organisations in Walsall recruit and train volunteers and often require new recruits. Reflecting the national picture, there is a great opportunity for people to volunteer in different capacities across various sectors. Without the support of volunteers many organisations including sports clubs, youth organisations and community groups would not be sustainable.

Walsall Voluntary Action (WVA) have seen an increase in the number of volunteers registered with them in the first quarter of 2014 (April to June) totalling 224 people, compared to 150 for the previous year. Likewise the number of organisations referred to has increased to 548, compared to 369 for the same time periods. This provides just a small snapshot of volunteering that is currently occurring across Walsall whether it is formal or informal volunteering.

## Case Study

**Lady came in and asked for volunteer work as she had just split from her husband and was going through a lot at home.**

E.g. going to court trying to sort out a house they had together and was feeling a little depressed and needed something to do and was hoping to get a paid job in the future.

The lady came in about 3 to 4 times for different opportunities. The last opportunity I gave was for Volunteer Gallery Assistant at Wolverhampton Arts & Heritage. A week later she came in she said she went for an informal chat and she loved it, and was to start on the Monday. She also said it could turn into part time paid work after a few months and was delighted and couldn't thank me enough. I asked her to come back in and let me know how she was getting on.

## Benefits of voluntary activity

The reasons why people volunteer vary greatly. There are many outside influences that impact on people's ability, willingness and desire to volunteer. The main barrier to volunteering is insufficient time, followed by perceived bureaucracy and risk/ liability issues. However survey results show that the majority of volunteers are happy with the advice and support they receive from the organisation that they volunteer with.

A national survey of people who volunteer state the benefits of volunteering are; a sense of satisfaction from seeing the results (97%), really enjoying the volunteering (96%), a sense of personal achievement (88%), meeting people and making friends (86%) and it gives people the chance to do things they are good at (83%).

7 Community Life Survey 2012-13 http://communitylife.cabinetoffice.gov.uk/assets/q4-2012-13/Community%20Life%20Survey%20Q4%202012-13%20Bulletin.pdf

## Five Ways to Well-being

Evidence suggests there are five steps we can all take to improve our mental wellbeing. These five steps are collectively known as the 'five ways to well-being'. The implementation of 'five ways to well-being' in Walsall is being driven by public health and prioritised in the Health and Well-being Strategy. The fifth and final step is 'give'. This has links to volunteering and suggests the potential benefits are not only to the individual but others that they come in to contact with.

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

# Priorities for development in 14/15

## 6. More people, more active, more often

### Introduction

It is important for us to be active throughout our lives. Physical activity is central to a baby's normal growth and development. This continues through school, and into adulthood and older years.

Being physically active can bring substantial benefits including improvements to mental health, reduced risk of disease such as diabetes and ultimately reduced risk of a premature death.

It can also help to reduce the financial burden on the economy. The estimated direct cost of physical inactivity to the NHS across the UK is £1.06 billion[8]

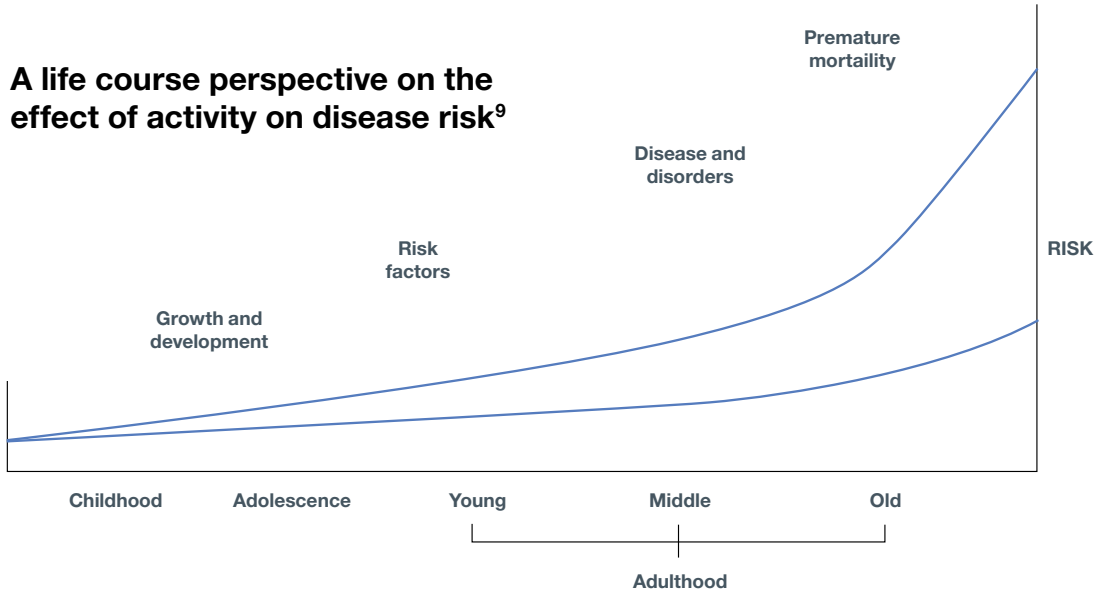



*Figure 15 A Life Course Perspective on the effect of activity on disease risk. The upper line represents risk for individuals with an inactive lifestyle. The lower line represents risk for those with an active lifestyle.*

### How are we doing?

The recommended level of physical activity for different age groups is as follows:

- Children (under 5) – at least 3 hours each day for those capable of walking. Children unable to walk should be encouraged to be active from birth particularly through floor based play and water based activities
- Children (5-18) – at least 1 hour of moderate intensity activity each day
- Adults – at least 150 minutes (2 hours and 30 minutes) of moderate intensity activity every week.

Walsall's population has been extremely inactive, however over recent years the number of individuals taking part in no physical activity has started to decline. Since 2006 the number of adults taking part in no activity (i.e. not achieving 30 minutes of exercise on any day during the week) has actually reduced by nearly 8% (See figure 16 overleaf) – an equivalent of nearly 16,000 adults.

8 Start Active, Stay Active : A report on physical activity for health from the four home countries' Chief Medical Officers: 2011

9 At least five a week Evidence on the impact of physical activity and its relationship to health: Chief Medical Officer: 2004

**Active People Survey Walsall Participation Results (Oct 2006 – Oct 2013)**

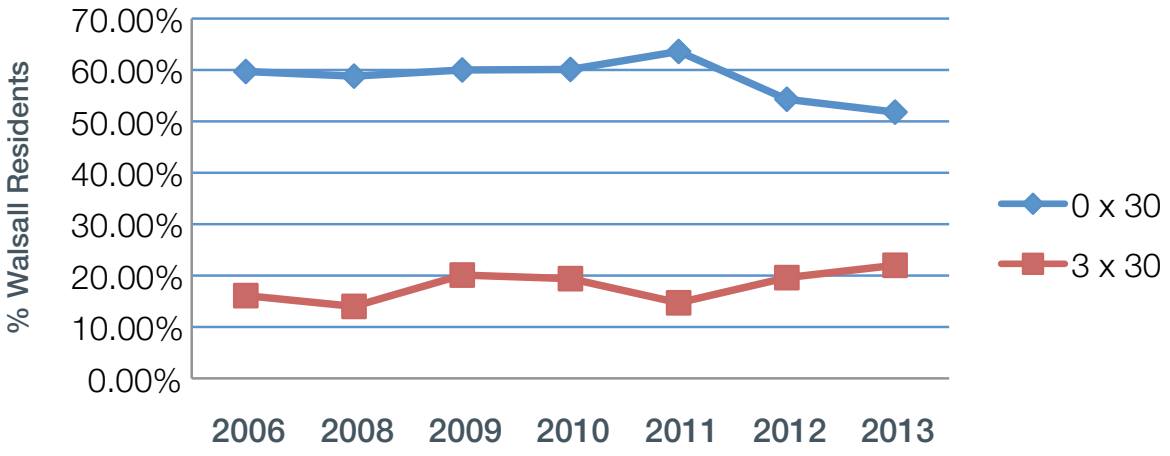



*Figure 16 Active People Survey Walsall Participation Results (October 2006 to October 2013)*

Unfortunately, half of the local population is still inactive and to continue the current positive direction of travel it is fundamental that Walsall continues to build a supportive environment that will promote the uptake of physical activity, especially amongst the least active. A significant contribution to achieving this aim will be through continued alignment of local physical activity development to evidence based best practice. The remainder of this section focuses on the strengths and challenges in meeting some of the key recommendations.

## Evidence base – Strengths and Challenges

### 6.1. Physical Activity Overview[10]

#### Strengths

- Increasing physical activity amongst the least active has been identified as a priority within Walsall and forms a key element of the Health and Wellbeing Strategy
- Tailored physical activity advice to adults and children is available through a range of programmes on the healthy weight pathway. One-to-one support is also available through the Borough's exercise referral scheme
- The Healthy Workplace Programmes develops health and wellbeing of local employees as well as providing support to the least active. Workplace physical activity programmes have demonstrated reduced absenteeism by up to 20%: physically active workers take 27% fewer sick days[11] Making Every Contact Count (MECC) is helping to identify inactive residents and provide consistent messages to encourage healthy lifestyle choices and increase levels of physical activity. With a large number of front line staff being trained, it has potential to reach an even greater number of residents
- Walsall has a wide range of specialised exercise sessions. These include Cardiac Rehabilitation, Hydrotherapy and Adult and Children's Weight Management Programmes.

#### Challenges

- Need to develop a physical activity strategy that recognises a rounded approach to physical activity provision including leisure and recreational activity as well as other approaches in a variety of settings including active travel, recreation within green spaces, schools and workplaces. See overleaf[12].
- Ensuring a sufficient and suitably trained workforce to engage inactive residents.

10 NICE Physical Activity Pathway; 2014

11 NICE Guidance Physical activity : Public Health Briefing 3; 2012

12 NICE Guidance Physical Activity and the Environment; 2008

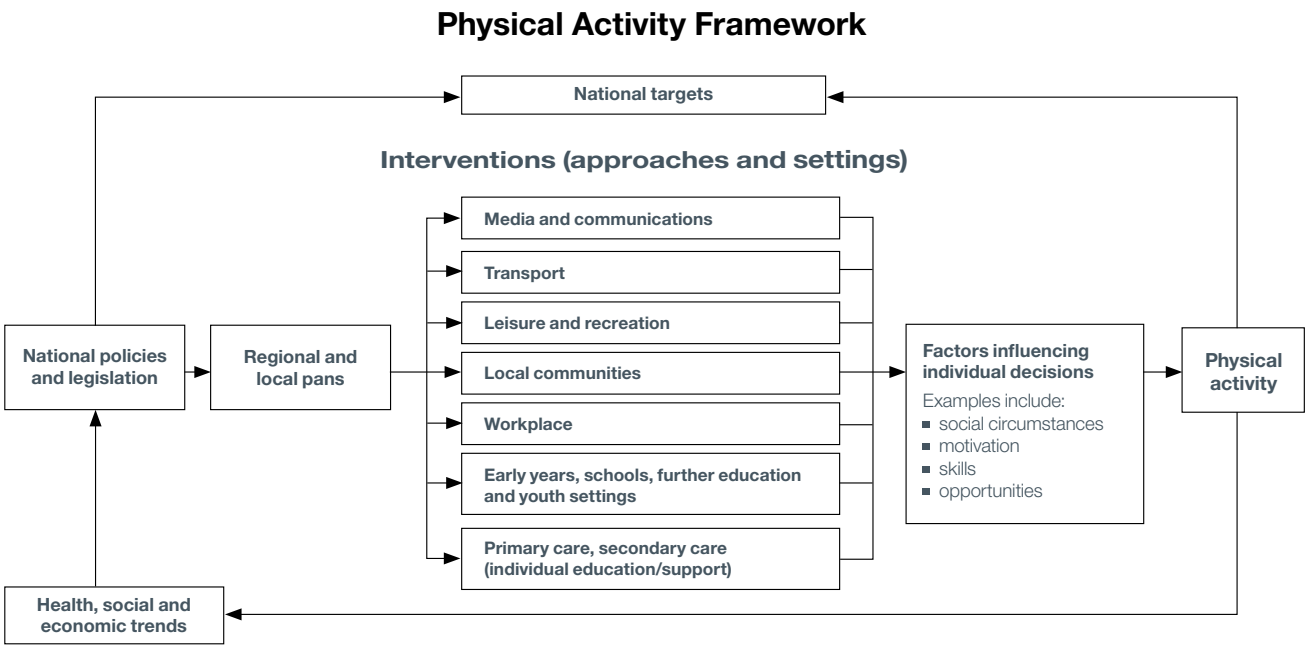



*Figure 17 NICE Guidance Physical Activity and the Environment 2008*

## 6.2. Promoting Physical Activity for Young People and Children (NICE)[13]

### Strengths

- Local strategy including Young People's Plan recognises the need to support young people in being more active
- Overweight and inactive children have access to evidence based treatment and prevention programmes, including group and one-to-one support. A key element is engagement of parents to help them promote a physically active lifestyle whilst children are within their home environment. For example, opting for travel involving walking or cycling
- A culture of active travel is being developed within schools through A-Stars – a road safety and sustainable travel education programme. This also provides schools with tailored sustainable travel plans.

### Challenges

- An insight into local children's attitude towards physical activity is very important in shaping local provision to reflect local need, especially those who are inactive. In recent years, regular Borough wide consultation has been difficult due to resource implications therefore an up to date understanding of inactive local children's attitude to physical activity has been limited
- Ensuring delivery of physical activity sessions is led by staff or volunteers who have relevant sector standards, qualifications and skills to engage the least active.

## 6.3. Physical Activity and the Environment[14]

### Strengths

- One third of Walsall is green, open space. This includes premier parks, countryside as well as play areas and managed tree plantations. These provide an ideal opportunity for independent and structured activity (e.g. led walks) as well as recreational play within the various children's play facilities (e.g. lido / water features).
- Plans are being implemented to assess the health impact of large scale planning proposals – for example, will local services be accessible on foot, by bicycle or by people whose mobility is impaired?
- The level of road traffic collisions resulting in personal injury within Walsall is considered low. Despite this, the ongoing development of education programmes and local safety schemes continue to support the developments in sustainable travel and continued reduction in casualty levels.

13 NICE Guidance; Promoting Physical Activity for Children and Young People; 2009

14 NICE Guidance; Physical Activity and the Environment

## Challenges

- Development of cycle and walking routes, including promotion and signage of existing routes. Walsall has a number of long, continuous routes which serve key destinations, such as Walsall Town Centre. The profile of these routes could be raised so more people are aware of them.

## 6.4. Older people in primary care and residential care[15]

## Strengths

- Walsall has a wide range of tailored physical activity sessions for older people. These include a programme of led health walks and more specialised provision – such as Cardiac Rehabilitation, Hydrotherapy and Falls Prevention. There is evidence that physical activity programmes which emphasise balance training, limb co-ordination and muscle strengthening activity are safe and effective in reducing the risk of falls[16]. Each fall which results in a hip fracture can cost the NHS £12,000[17]
- A discount scheme is available across all leisure centres providing subsidised access to older people for most activities, including swimming and specialised sessions referred to above. There are also free physical activity classes available for individuals who are inactive and overweight
- An exercise referral scheme provides a link between primary care and community based physical activity sessions as well as tailored one-to-one exercise advice and support
- Walsall has nearly 30 volunteer led Walks which take place across the Borough providing a safe and social environment for older people to exercise.

## Challenges

- Delivery of activity sessions accessible to individuals in residential care. Residential care facilities are often unsuitable and therefore may require transport to an external facility which is seldom available.

## Recommendations

- Complete a physical activity needs assessment to inform the Healthy Weight and Physical Activity Strategy due for completion January 2015
- Target resources to adults and children who take part in no physical activity. Moving residents from doing nothing to doing a little will have a substantial health impact
- Implement school based physical activity programme to provide support to children to increase their levels of exercise as well as support to school based staff to increase engagement amongst the least active. The programme will also involve consultation with young people which will help shape future exercise provision
- Increase sustainable physical activity provision through use of suitably trained volunteers. Further development of the Get Active Database will help to promote structured physical activity opportunities that are led by individuals with relevant industry standards and qualifications
- Build on Healthy Workplace Programme through the roll out of Workplace Wellbeing Charter – a set of standards approved through Public Health England
- Roll out physical activity programmes within residential homes led by care staff that are not reliant on having access to certain facilities e.g. led walks.

15 NICE Guidance Occupational therapy and physical activity interventions to promote the mental wellbeing of older people in primary care and residential care; 2008

16 Start Active, Stay Active : A report on physical activity for health from the four home countries' Chief Medical Officers: 2011

17 Fracture prevention services, an economic evaluation: Department of Health; 2009

# 7. Emotional health and wellbeing throughout life

## 7.1. What is emotional health and wellbeing?

"Good mental health and resilience (the ability to bounce back after difficulties and setbacks in life) are fundamental to our physical health, our relationships, our education, our training, our work and to achieving our potential" (No Health without Mental Health: A cross government mental health outcomes strategy for people of all ages. DH 2011)

We can all recognise 'wellbeing' when we see it and feel it but it can be difficult to put into words. Using Maslow's Hierarchy of Need as the starting point, the Joint Strategic Needs Assessment in Walsall has identified the factors which, taken together, lead to positive health and wellbeing for most people:

- A safe and secure place to live: home safety, freedom from violence or fear of it
- Enough money to live on and be able to get to work and participate in community life
- Nurturing relationships: family, friends, community, a sense of belonging
- Purposeful activity and valued achievements: learning, working, volunteering, relaxing
- A healthy mind: emotions, reason, imagination, positive self-esteem, feeling respected by others, emotional resilience, problem solving skills, freedom from fear
- A healthy body; fit, active, enables full life

Wellbeing has two essential elements: feeling good and functioning well. Our sense of wellbeing is constantly being assaulted by the challenges and opportunities that life throws up. There are significant events ranging from the addition of a new family member, to a major change in your daily routine, to getting married or divorced, to the death of a close family member or friend and 'smaller'. The way in which we react to those challenges and opportunities has an effect on the way they make us feel. We often refer to 'resilience' when we describe the factors that can help to buffer us against knocks and, as individuals, we can understand how to build our resilience levels by using the '5 Ways to wellbeing' tool.

The '5 ways to wellbeing' are described as follows:

1. **CONNECT** with people – family, friends, colleagues, neighbours
2. **BE ACTIVE** – walk, cycle, swim, run/jog, dance, play a game that you enjoy
3. **TAKE NOTICE** – reflect on the beauty of the world around you
4. **KEEP LEARNING** – try a new challenge, learn to do something new
5. **GIVE** – volunteer your time, do a favour, look out for someone in need

Evidence shows that building these actions into your daily life can add 7.5 (healthier) years to your life.

## 7.2. Throughout the life course

At every stage of our life there are potential 'stress points', some of which can be planned for and others that cannot. When considering the mental wellbeing of a population it is important that we understand what helps to build resilience in children and adults. When we understand that – as well as having a clear understanding of the issues affecting our communities, we are able to consider relevant services we might commission to mitigate against or contain potential stressors and their effects.

We know, for example, that:

- Children's resilience is enhanced by a secure and reliable family base in which relationships promote self-esteem, self-efficacy and a sense of control
- A parent's resilience is enhanced by family (particularly children's) understanding, satisfying employment, good physical health and professional, community and personal support
- Potential stressors leading to parental mental health problems include a lack of money; breakdowns in valued relationships, bereavement, loss of control at work and long working hours
- For children, stress factors include loss through bereavement, marital breakdown or illness, acting as a carer, being bullied at school, homelessness and poverty.

Services to mitigate against the stressors and build resilience would have to include elements of education, support and advice and provide access to other relevant services if necessary. In Walsall, our health inequalities are driven by the vicious cycle (see figure 3, page 11).

Effective parenting education, the provision of timely support for people and families in crisis as well as strategies to minimise the attainment gap between the least and most deprived children and young people in Walsall by enhancing aspirations and reduce school absence are all recognised priorities within our Health and Wellbeing Strategy.

In later life, resilient old people are more likely to have good quality relationships (confiding; recent contact) among family and friends and to be integrated into their local community. They are able to utilize flexibility and adaptation skills to bounce back from difficulty and do so increasingly due to the consistent nature of change in their lives as they age. They seem to be champions at letting go of previous physical and mental abilities and, in so doing, continually redefine themselves and adapt to what is a "new normal" for them. Other components of resilience among the elderly include:

- A sense of belonging
- Creating meaning through personal memories and life reviews
- Being able to re-value dependence by recognizing what they are still able to offer as a good exchange for depending on others for certain assistance
- Being open to new ideas, values and experiences and reframing loss and change as a means of redefining yourself.

Social relationships, rather than socio-economic circumstances, are at the heart of resilience at older ages. Policies to enhance resilience need to address the conditions of life of all older people, concentrating on the maintenance of enjoyed and valued social relations and activities. Service providers, as well as providing activities, can also create communities involving groups of people with common interests and goals. Facilitators can assist a person to recall their memories and discuss the meaning in events that have occurred throughout their life – perhaps through the use of life reviews. Service providers may want to emphasize the quid pro quo concept of dependence and help seniors to reframe loss and change as a way of redefining themselves by acknowledging the openness they perceive in the individuals they are talking to.

In Walsall we are committed to:

- Working with individuals and communities to promote wellbeing and self-reliance through adoption of 5 ways to wellbeing
- Encouraging local people to connect, keep learning and give through volunteering by promoting the many different ways they can volunteer in Walsall and the benefits involved
- Encouraging local people to be active and take notice by promoting parks, green spaces, the many community and council leisure and sports facilities and other opportunities available to them in Walsall
- Encouraging local businesses and organisations to become healthy workplaces with support delivered through the Healthy Business Awards Scheme and opportunities to focus on work related stress and wellbeing
- Identifying and targeting key groups that evidence tells us will be most likely to benefit from brief interventions and improved access to psychological therapies. These will include for example pregnant women who smoke, people in the workplace with absenteeism problems and diabetic patients where depression is common
- Consult with, and fully involve, both communities and service providers in work to reduce stigma around mental ill-health in Walsall thereby seeking to reduce suicide and promote mental wellbeing
- Commissioning evidence based parenting education
- Enabling individuals to be independent for as long as possible in the setting of their choice
- Providing the support needed to enable individuals to keep as well as possible in their old age and ensure that the message of 'healthy body, healthy mind' is reinforced at every opportunity. Through healthy lifestyles we can reduce the prevalence of dementia over time
- Develop a systematic and multi-agency approach to falls and fracture prevention. This will have a focus on preventing falls through activities that improve stability, mobility, flexibility and coordination over the life course
- Social Care and partners working together to further develop a preventive strategy to help older people and those who are at risk of needing longer term care and support - the focus on that strategy will be in the four areas of universal, preventative, recovery-based and deferred provision.

# 8. Violence as a public health issue

"Preventing violence must be seen as a priority for public health, health care and multi-sectoral working in England. Violence is a major cause of ill health and poor wellbeing as well as a drain on health services and the wider economy. However, it is preventable using measures that save much more money than they cost to implement. Interventions, especially those in early childhood, not only prevent individuals developing a propensity for violence but also improve educational outcomes, employment prospects and long-term health outcomes. Abuse in childhood increases risks of violence in later life, but also risks of cancer, heart disease, sexually transmitted infections, substance use, and a wide range of health conditions that are currently stretching health care resources."

"Moreover, without safe and secure communities, measures to encourage people to exercise, socialise or adopt more sustainable lifestyles (e.g. using public transport) are more likely to fail as people feel trapped in their houses and cars and unable to engage with local communities. Even broader economic inequalities can remain stubbornly entrenched when investment in the poorest communities is inhibited by risks of violence to staff and customers."

"The breadth of individuals and organisations affected by violence and the number that need to be coordinated in order to prevent it mean that public health is uniquely positioned to lead programmes on violence prevention, support the implementation of violence prevention activity by partner agencies and make a major contribution to integrated multi-agency working for violence prevention."

**(Source: Protecting people, promoting health. A public health approach to violence prevention in England November 2012)**

It is not surprising that this national report, published in November 2012 when Public Health staff across England were pre-occupied with arrangements for safe transition from the NHS to Local Authorities, has not received the attention it deserves locally. The extract above, the summary of the report, sets out the pervasive reach and impact of violence across all-ages, communities and organisations.

Locally, the Safer Walsall Partnership plans and co-ordinates action to protect individuals and communities from violence and to promote social cohesion. A review of the current Safer Communities Strategy against the findings and recommendations of this report will highlight much good work locally and also many opportunities for even better and more effective ways of reduce the frequency and impact of violence and it's long-term effects in the lives of the people of Walsall.

The refresh of the Joint Strategic Needs Assessment (JSNA) in 2013/14 addressed concerns expressed by partners in the criminal justice world that the previous JSNA did not give sufficient attention to issues of community safety. This report indicates that there is still more to do.

**Recommendation: that the Safer Walsall Partnership board lead a multi-agency review of current strategy and practice against the findings and recommendations of this report in particular to identify key gaps in early identification and effective interventions to reduce and prevent violence.**

## 8.1. The health and wellbeing of offenders

When we refer to offenders who do we mean? Offenders are not a homogeneous group. They fall into many categories and attract different levels of state intervention on a continuum between arrest to imprisonment on a sliding scale based upon the seriousness or frequency of their offending.

In 2013/14 Walsall police made 11,400 arrests resulting in 5,200 criminal charges. At any one time there are estimated to be 450 Walsall residents in prison and 1,250 individuals under the supervision of the local probation service and 233 offenders supervised by the Walsall's Youth Justice Service. Although not a homogeneous group it is well documented that offenders face specific health challenges that are more acute than those experienced by the general population. There are also fundamental differences between male and female offenders that indicate a different and distinct approach is needed for women. In particular, where women are the primary carers for their children (Corston Report 2012).

Information on prisoner's health is well documented, finding them to have poor physical and mental health, high prevalence of substance misuse, heightened self harm and suicide risk and reduced life expectancy (The Bradley Report 2009). Although there is more limited information relating to the health of offenders in the community, we must assume these health difficulties do not disappear after their release from prison. In fact they may be intensified by the additional economic and social isolation and poor access to primary care leading to the over use of crisis services such as hospital A&E departments. Local Probation Service assessments on 1,658 offenders in 2013 found 31% had high criminogenic risks associated with their emotional well being.

The prevalence of mental health problem for sentenced prisoners is estimated to be 4 times higher than the general population with 20% of male and 37% of female sentenced prisoners having previously attempted suicide (Singleton et al 1997). This is also reflected in the Walsall Youth Justice service where 20% of offenders had self harmed and 12% had been identified as being at risk of suicide. Mental health challenges are often exacerbated in the weeks following release from prison by the use of illicit drugs leading to high incidence of suicide and overdose.

In prisons, the smoking rate is as high as 80% – four times higher than the general population. Smoking is disproportionately represented in the offender population already hardest hit by health inequalities (McManus et al 2009). This is replicated in Walsall's Youth Justice Services offenders where 77% smoke and 67% smoke cannabis.

Home Office Research of offenders on probation (1997) found drug and alcohol misuse is a key driver in offending. An analysis of probation records across 41 Probation areas found that 32% of offenders attributed their violent behaviour to alcohol misuse and 56% of offenders stated they were likely to re-offend, with drugs and alcohol cited as the main influencing factor. Again local Probation assessments reflect a similar finding with 54% citing drugs and 47% alcohol as relating to their offending and of Walsall's offenders in the Youth Justice Service 74% misused substances, 33% identifying alcohol as problematic and related to their offending. Of prisoners who misuse drugs 24% are injecting drug users, increasing the incidence of liver damage, cirrhosis and liver cancer and blood borne viruses, hepatitis B, C and HIV.

A dominant theme across the literature is the screening and assessment of offender's health needs by frontline professionals could be significantly improved as could the coordination and resourcing of specific health service to meet their needs. Joint work between Public Health and the Probation Service is required to better understand the health needs of offenders in Walsall and to ensure access to the services required to improve their health. This is another significant contributor both to improving life expectancy in men and to reducing the inequalities described earlier.

# 9. Antibiotic resistance: The growing challenge.

Antibiotics have always been considered as one of the amazing discoveries of the 20th century. With their use we have been able to survive childhood illnesses that had previously killed many of the population; surgeons have been able to perform remarkable surgery knowing that the patient is unlikely to die of an infection as a result of the surgery; people with poor immunity either as result of disease or through life saving treatments have been protected from infection through the use of antibiotics.

However there has been increasing concern amongst health staff and government, both nationally and internationally that we are beginning to see an increase in the number of infections that are proving difficult to treat with the usual antibiotics we would normally use. This is what is called antibiotic resistance – it means that bacteria have developed defences against the antibiotic that is meant to destroy them. It is estimated that drug-resistant strains of bacteria are responsible for 5,000 deaths a year in the UK and 25,000 deaths a year in Europe. The World Health Organisation, in its report on antibiotic resistance, has promised to take the lead globally to help countries work together to tackle this problem.

The Chief Medical Officer, in her annual report, has made recommendations on how this can be tackled nationally. David Cameron said in a recent press conference that "If we fail to act, we are looking at an almost unthinkable scenario where antibiotics no longer work and we are cast back into the dark ages of medicine where treatable infections and injuries will kill once again".

The UK have produced a 5 year strategy which recommends work in the following areas:

- Good prevention and control of infections in human and animal health
- Quick diagnosis and the correct treatment
- Prescribers of antibiotics will follow national guidance
- Monitoring infections to quickly identify new organisms and new resistance
- Ensure a supply of new and effective antibiotics. In Walsall, healthcare leaders have put control measures in place to manage the antibiotics that are available in the best way. This includes:
- Educating prescribers on the careful use of antibiotics
- Providing guidelines to prescribers on what they should prescribe
- Monitoring what antibiotics are being prescribed across the Borough by the hospital and GPs and reviewing this on a quarterly basis
- Monitoring for new and resistant organisms
- Communicating with colleagues in surrounding areas
- Ensuring an infection prevention and control service is available to all organisations who provide healthcare within Walsall.

What can individuals do to help with this global challenge?

- Go to your GP for routine vaccinations such as the childhood vaccines, annual flu vaccine etc when you are invited
- Keep your home clean, handle and cook food properly and ensure that you wash your hands to reduce the risk of you or your family becoming infected
- Antibiotics don't work against viral infections; If your GP says you don't need antibiotics don't demand them
- If you are given antibiotics make sure you finish the course.

## Case Study

**Frank was always the "go to guy" when anyone in the family needed practical advice.**

He was the main carer for his wife Pat who had Parkinson's Disease and Alzheimer's. He had a brilliant sense of humour. So it's not hard to imagine the impact his death has had on his loved ones.

It was 2005 and the 75-year-old grandfather was looking forward to a family Christmas.

While generally in good health he did suffer from a condition similar to arthritis and his foot was particularly painful. He has had a type of ulcer on his foot and it was being dressed regularly by a nurse at his GP practice.

Frank had to go into hospital for a minor procedure and stayed in hospital over Christmas to rest following this. His family visited regularly and looked forward to him returning home.

But a few days after Christmas they were contacted to say Frank had been rushed into intensive care because he had blood poisoning caused by the MRSA bug. He was transferred to the Intensive Therapy Unit, as his condition worsened, and his family were called to his bedside. Frank passed away on New Year's Day.

Frank's death has affected the whole family. His widow has had to move to another part of the country to be cared for, his children still struggle to accept he's not there to turn to and he has missed seeing his grandchildren grow up. Back in 2005, patients were not screened for MRSA like they are today. This screening and other control measures has led to far fewer patients becoming infected with MRSA in their blood stream in 2014. It's understandable that Frank's family believe that such screening could have meant they had their "go to guy" a few more years.

# 10. Appendices

## 10.1. Statutory responsibilities

### Prescribed functions:

1) Sexual health services – STI testing and treatment
2) Sexual health services – Contraception
3) NHS Health Check programme
4) Local authority role in health protection
5) Public health advice to Walsall Clinical Commissioning Group
6) National Child Measurement Programme

### Non-prescribed functions:

7) Sexual health services – Advice, prevention and promotion
8) Obesity – adults
9) Obesity – children
10) Physical activity – adults
11) Physical activity – children
12) Drug misuse – adults
13) Alcohol misuse – adults
14) Substance misuse (drugs and alcohol) – youth services
15) Stop smoking services and interventions
16) Wider tobacco control
17) Children 5-19 public health programmes
18) Miscellaneous, which includes:
    - Non-mandatory elements of the NHS Health Check programme
    - Nutrition initiatives
    - Health at work
    - Programmes to prevent accidents
    - Public mental health
    - General prevention activities
    - Community safety, violence prevention and social exclusion
    - To provide or commission oral health promotion programmes to improve the health of the local population, and provide and commission oral health surveys
    - Fluoridation
    - Local authority role in surveillance and control of infectious disease
    - Information and Intelligence
    - Any public health spend on environmental hazards protection
    - Local initiatives to reduce excess deaths from seasonal mortality
    - Population level interventions to reduce and prevent birth defects (supporting role)
    - Wider determinants

## 10.2. Health Summary for Walsall 2014

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 black 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

Regional average^ | England Average | England Worst | England Best | 25th Percentile | 75th Percentile | England Range

| Domain | | Indicator | Local No Per Year | Local value | Eng value | Eng worst | Eng best |
|---|---|---|---|---|---|---|---|
| Our communities | 1 | Deprivation | 123,904 | 45.7 | 20.4 | 83.8 | 0.0 |
| | 2 | Children in poverty (under 16s) | 16,145 | 29.2 | 20.6 | 43.6 | 6.4 |
| | 3 | Statutory homelessness | 45 | 0.4 | 2.4 | 33.2 | 0.0 |
| | 4 | GCSE achieved (5A*-C inc. Eng & Maths) | 1,894 | 58.7 | 60.8 | 38.1 | 81.9 |
| | 5 | Violent crime (violence offences) | 2,546 | 9.4 | 10.6 | 27.1 | 3.3 |
| | 6 | Long term unemployment | 3,341 | 20.0 | 9.9 | 32.6 | 1.3 |
| Children's and young people's health | 7 | Smoking status at time of delivery | 552 | 15.7 | 12.7 | 30.8 | 2.3 |
| | 8 | Breastfeeding initiation | 2,233 | 63.3 | 73.9 | 40.8 | 94.7 |
| | 9 | Obese children (Year 6) | 696 | 22.8 | 18.9 | 27.3 | 10.1 |
| | 10 | Alcohol-specific hospital stays (under 18) | 37 | 58.0 | 44.9 | 126.7 | 11.9 |
| | 11 | Under 18 conceptions | 243 | 46.9 | 27.7 | 52.0 | 8.8 |
| Adults' health and lifestyle | 12 | Smoking prevalence | n/a | 23.6 | 19.5 | 30.1 | 8.4 |
| | 13 | Percentage of physically active adults | n/a | 50.5 | 56.0 | 43.8 | 68.5 |
| | 14 | Obese adults | n/a | 30.4 | 23.0 | 35.2 | 11.2 |
| | 15 | Excess weight in adults | 463 | 68.9 | 63.8 | 75.9 | 45.9 |
| Disease and poor health | 16 | Incidence of malignant melanoma | 26 | 9.6 | 14.8 | 31.8 | 3.6 |
| | 17 | Hospital stays for self-harm | 471 | 171.2 | 188.0 | 596.0 | 50.4 |
| | 18 | Hospital stays for alcohol related harm | 1,684 | 664 | 637 | 1,121 | 365 |
| | 19 | Drug misuse | 2,107 | 12.4 | 8.6 | 26.3 | 0.8 |
| | 20 | Recorded diabetes | 17,672 | 8.2 | 6.0 | 8.7 | 3.5 |
| | 21 | Incidence of TB | 19 | 20.4 | 15.1 | 112.3 | 0.0 |
| | 22 | Acute sexually transmitted infections | 3,105 | 1,152 | 804 | 3,210 | 162 |
| | 23 | Hip fractures in people aged 65 and over | 274 | 571 | 568 | 828 | 403 |
| Life expectancy and causes of death | 24 | Excess winter deaths (three year) | 154 | 20.3 | 16.5 | 32.1 | -3.0 |
| | 25 | Life expectancy at birth (Male) | n/a | 77.9 | 79.2 | 74.0 | 82.9 |
| | 26 | Life expectancy at birth (Female) | n/a | 82.3 | 83.0 | 79.5 | 86.6 |
| | 27 | Infant mortality | 27 | 7.2 | 4.1 | 7.5 | 0.7 |
| | 28 | Smoking related deaths | 452 | 318 | 292 | 480 | 172 |
| | 29 | Suicide rate | 15 | 5.8 | 8.5 | | |
| | 30 | Under 75 mortality rate: cardiovascular | 207 | 94.8 | 81.1 | 144.7 | 37.4 |
| | 31 | Under 75 mortality rate: cancer | 359 | 164 | 146 | 213 | 106 |
| | 32 | Killed and seriously injured on roads | 68 | 25.4 | 40.5 | 116.3 | 11.3 |

**Indicator Notes**

1 % people in this area living in 20% most deprived areas in England, 2010 2 % children (under 16) in families receiving means-tested benefits & low income, 2011 3 Crude rate per 1,000 households, 2012/13 4 % key stage 4, 2012/13 5 Recorded violence against the person crimes, crude rate per 1,000 population, 2012/13 6 Crude rate per 1,000 population aged 16-64, 2013 7 % of women who smoke at time of delivery, 2012/13 8 % of all mothers who breastfeed their babies in the first 48hrs after delivery, 2012/13 9 % school children in Year 6 (age 10-11), 2012/13 10 Persons under 18 admitted to hospital due to alcohol-specific conditions, crude rate per 100,000 population, 2010/11 to 2012/13 (pooled) 11 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2012 12 % adults aged 18 and over, 2012 13 % adults achieving at least 150 mins physical activity per week, 2012 14 % adults classified as obese, Active People Survey 2012 15 % adults classified as overweight or obese, Active People Survey 2012 16 Directly age standardised rate per 100,000 population, aged under 75, 2009-2011 17 Directly age sex standardised rate per 100,000 population, 2012/13 18 The number of admissions involving an alcohol-related primary diagnosis or an alcohol-related external cause, directly age standardised rate per 100,000 population, 2012/13 19 Estimated users of opiate and/or crack cocaine aged 15-64, crude rate per 1,000 population, 2010/11 20 % people on GP registers with a recorded diagnosis of diabetes 2012/13 21 Crude rate per 100,000 population, 2010-2012 22 Crude rate per 100,000 population, 2012 (chlamydia screening coverage may influence rate) 23 Directly age and sex standardised rate of emergency admissions, per 100,000 population aged 65 and over, 2012/13 24 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.09-31.07.12 25 At birth, 2010-2012 26 At birth, 2010-2012 27 Rate per 1,000 live births, 2010-2012 28 Directly age standardised rate per 100,000 population aged 35 and over, 2010-2012 29 Directly age standardised mortality rate from suicide and injury of undetermined intent per 100,000 population, 2010-2012 30 Directly age standardised rate per 100,000 population aged under 75, 2010-2012 31 Directly age standardised rate per 100,000 population aged under 75, 2010-2012 32 Rate per 100,000 population, 2010-2012 ^ "Regional" refers to the former government regions.



*Figure 18 Walsall Health Profile 2014 (Source = Public Health England July 2014)*

## 10.3. Summary of achievements of Public Health staff in 2013/14

The following are a selection of achievements of the Public Health team over the last 12 months:

### Policy and strategy

- Public health has a key role in the establishment and ensuring the effective functioning of the Health and Well-being Board
- Provided the lead for the refresh of the Walsall Health and Wellbeing Strategy, ensuring that the HWB is fully aware of progress against the agreed recommendations for action
- Supported the development of the Walsall Plan and specific work around Theme 2: - Health and Wellbeing and input into the development of the first Walsall Strategic Needs Assessment document across the Walsall Intelligence Network
- Participated in the development of the 'Promoting Wellbeing and Preventing Suicide Strategy', including consultation
- Participated in the development of the Mental Health and Emotional Wellbeing strategy for children and young people in Walsall
- Participated in refreshing the Borough's Domestic Violence Strategy (2014-16) with an emphasis on prevention, intervention and justice themes with support from all council directorates and partner agencies represented on the Safer Walsall Partnership.

### Commissioning

- Provided leadership for the Walsall Joint Strategic Needs Assessment (JSNA) refresh supported by all service areas within the council, Walsall CCG and Healthwatch Walsall
- Developed the Eye Health Needs Assessment for Walsall
- Worked with colleagues in the council to establish efficient, effective commissioning and procurement processes for all public health services
- Gained approval by Cabinet of award of contracts for Public Health services and forward plan for procurement
- Successfully procured stop smoking services
- Obtained agreement and implementation of mechanisms to control costs associated with tariff based activity in Genito-Urinary Medicine services in Walsall Healthcare Trust.

### Service redesign

- Redesigning the 5-19 Healthy Child Programme to increase scope of service to include emotional health and sexual health
- Established the Walsall Integrated Sexual Health Project Board with representation from Public Health, Walsall CCG and Walsall Healthcare Trust to support Service Redesign of Sexual Health Services in Walsall.

### Performance and Outcomes

- Set up new internal systems to report and monitor on the performance of Public Health commissioned services
- The community based physical activity programme and specialised exercise programme has engaged over 3,000 participants. 83% are from quintiles 1-3 according to Index of Multiple Deprivation
- The free swimming programme has 9,044 children registered since July 2013
- Physical activity levels have increased making participation rates the highest across Black Country partners (Source = Active People Survey)
- The Healthy Workplace Programme has engaged with 28 companies providing health and wellbeing support to employees who have poor health outcomes and are less likely to engage in health improvement activities
- Attracted record numbers of drug users into treatment services whilst remaining within the national guidance for waiting times
- Consistently delivered the region's best rate of successful completions for alcohol treatment.

### Partnership working

- Agreement and implementation of the Memorandum of Understanding (MOU) with Walsall Clinical Commissioning Group. Projects during 2013/14 include: Urgent Care Review, Stroke Review, Infant Mortality Audit, Infection Control reporting, Suicide Strategy / Needs Assessment and Hospital Mortality review
- Worked in partnership with the Area Partnership (AP) Managers, to lead the assets-based work ongoing in each of the AP areas. Examples include the C2 Connecting Communities work in Darlaston with Walsall CCG, the Community Gardens work in Streetly and the Diabetes work in Walsall South

- Fostered better links between GPs and Councillors through a pilot meeting in the ward of Darlaston
- Established the Health Protection Forum which includes representatives from Public Health England, NHS England, Walsall Clinical Commissioning Group, Public Health and Environmental Health
- Held the '5 Ways to wellbeing' publicity event within the council offices for staff
- Successfully planned and coordinated the inaugural Walsall triathlon with Leisure Services.

## Training and Development

- Public Health Walsall continued to be an accredited training zone for public health specialty trainees and general medical practitioners. A selection of trainee projects are listed below covering the last 18 month period:
- Huw Roderick – HIV audit
- Shweta Malhotra – Maternal and early years healthy weight service
- Eva Liu – Asymptomatic testing for Sexually Transmitted Infection's
- Matthew Fung – Norovirus outbreak analysis
- Pamodha Wasala – Ophthalmology audit
- Matthew Fung - Parenting programmes review – leading to poster at PHE conference 2014
- Matthew Fung - Sunbeds health promotion and compliance
- Matthew Fung - Weight management Local Enhanced Service review
- Public health in collaboration with Public Health England provided health impact assessment (HIA) training for staff in a number of services areas including Legal Services, Planning and Pollution Control.

## Research

- Commissioned research into avoidable causes of infant mortality
- Commissioned research into factors affecting children being taken into care and evidence-based strategies to reduce the number of children being taken into care
- Lead Local Authority for the development of 'Dynamic Dudes', a physical activity pilot. The objective is to provide a long term behaviour change programme to encourage and increase the uptake of physical activity not just in children at school but also to transfer the behaviour change to their parents in the home and other environments
- Evaluation of the role of Children's Centres in improving the health of children in Walsall

## Awards

- The Food Dudes Early Years programme won a Laria award for Intelligence and Research alongside Bangor University
- Achievement of UNICEF Baby Friendly status for the community services in Walsall
- Winners of the Best Poster award at the Faculty of Public Health Conference 2013

## 10.4. Acknowledgments

This report has been produced by the joint efforts of the following people, who either contributed to the writing, design or provided data and information.

**Dr Isabel Gillis**
Director of Public Health

**Dr Paulette Myers**
Consultant in Public Health

**Dr Uma Viswanathan**
Consultant in Public Health

**Dr Barbara Watt**
Consultant in Public Health

**Andrew Harkness**
Locum Consultant in Public Health

**Adrian Roche**
Head of Social Inclusion

**Patrick Duffy**
Programme & Development Commissioning Manager (Alcohol)

**David Neale**
Programme & Development Commissioning Manager (Drugs)

**David Walker**
Senior Programme & Development Commissioning Manager (Sexual Health)

**Susie Gill**
Senior Programme & Development Commissioning Manager (Healthy Weight)

**Cath Boneham**
Health and Wellbeing Programme Manager

**Vikki Tolley**
Oral Health and Childhood Healthy Weight Coordinator

**Joe Holding**
Programme & Development Commissioning Manager (Health at Work)

**Jo-anne Lloyd**
Project Support Officer

**Nina Chauhan-Lall**
Programme Development and Commissioning Manager (NHS Healthchecks)

**Fran Fahy**
Senior Programme & Development Commissioning Manager (Smoking Cessation)

**Mandy Beaumont**
Nurse Consultant – Health Protection

**Adam Biggs**
Health Emergency Planner

**Esther Higdon**
Senior Programme & Development Commissioning Manager (Children and Young People)

**Janice Rowley**
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**Lorraine Bishop**
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Administrative Support to Public Health

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Senior Public Health Intelligence Analyst

**Sarbjit Uppal**
Public Health Intelligence Technical Officer

**David Hughes**
Public Health Intelligence Analyst

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Specialty Registrar in Public Health

**Matthew Fung**
Specialty Registrar in Public Health

**Dr Zahid Iqbal**
GP Registrar

**Dr Pamodha Wasala**
F2 Trainee Doctor

**Dr Neelam Ayub**
F2 Trainee Doctor

**Dr Vanisha Chauhan**
F2 Trainee Doctor

**Dr Jane Fowles**
Specialty Registrar in Public Health

**Dr Hugh Roderick**
F2 Trainee Doctor

**Dr Alex Smith**
F2 Trainee Doctor

**Dr Schweta Malhotra**
GP Registrar

**Dr Eva Liu**
F2 Trainee Doctor

# Walsall Medical Officers of Health and Directors of Public Health – 1871 to 2014

| Medical Officers of Health | Period |
|---|---|
| **Dr James Maclachlan** | 1871-1888 |
| **Dr James Scott Wilson** | 1889-1910 |
| **Dr Harry Shore** | 1910-1923 |
| **Dr James Alexander Macdonald Clark** | 1923-1950 |
| **Dr Thomas Ross** | 1950-1968 |
| **Dr J C Talbot** | 1968-1974 |

## Area Medical Officers of Health

| | |
|---|---|
| **Dr J C Talbot** | 1974-1978 |
| **Dr A R Robertson** | 1978-1982 |

## Area/District Medical Officer/ Director of Public Health

| | |
|---|---|
| **Dr G M Singal** | 1982-1992 |

## Director of Public Health

| | |
|---|---|
| **Professor Sam Ramaiah** | 1992-2010 |

## Interim Directors of Public Health

| | |
|---|---|
| **Dr Sue Laverty and Dr Paulette Myers** | 2010-2011 |
| **Dr Isabel Gillis** | 2011-2013 |

## Director of Public Health

| | |
|---|---|
| **Dr Isabel Gillis** | 2013-2014 |

*Collated by Ruth F Vyse July 2014*

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