Walsall Council

Public Health Walsall 2015 Men's Health: A Review of Current Intelligence and Research

This needs assessment is part of the Walsall Joint Strategic Needs Assessment process

Contents

Acknowledgements

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Executive Summary

The Joint Strategic Needs Assessment (JSNA) for Walsall 2013 identifies demographic, lifestyle characteristics, and health determinants in Walsall's population. However it makes no specific reference to tackle the gap in male life expectancy.

This Men's Health Review is aimed at enabling Public Health Walsall and its partner organisations to:

1. To improve local knowledge of male health in relation to the perceived, current and predicted needs of the resident population of Walsall

2. To use this local knowledge to influence current health and social care services and tailor bespoke packages to engage with and raise awareness of men's health needs.

Its recommendations will endeavour to:

1. Identify priorities for improving premature mortality for men

2. Reduce the life expectancy gap between men and women

3. To improve overall health of local male population

Recent data demonstrates that 70% of premature deaths within the male population of Walsall are due to circulatory disease, cancer, respiratory disease and external causes. This report will hone in specifically on these causes in order to focus interventions. Each of these diseases is largely preventable with early lifestyle adjustments.

Men's Health Forum (2015) published a report to highlight The Gender Data Deficit in Local Health. After examining 147 Joint Strategic Needs Assessments (JSNA) the report found only 18% adequately recorded information by gender. Walsall Metropolitan Borough Council ranked 100 on the JSNA gendered league table. This has highlighted a gap in the way in which data is presented, not just for Walsall but, across the board.

Key Recommendations:

- All partners should ensure gender-disaggregated data is used in all JSNAs. This will allow all partners to fully address male-specific health inequalities.

- Strong health focus on prevention and early intervention

- All partners to prioritise reducing levels of smoking in our male population. This is a prominent theme throughout this review.

- Maximise opportunities to influence male lifestyle choices through the Every Contact Counts initiative (For example: Walking Football groups)

- Encourage participation in NHS Health Checks and national screening programmes

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- All partners should maximise opportunities to promote more active lifestyles for men of all ages and provide access to affordable active leisure provision

- Commit to regularly reviewing Walsall Male life expectancy and updating this review to tackle the top three causes of premature male mortality.

Introduction

"One in five men within the UK dies before the age of 65. The majority of these deaths are preventable" (Men's Health Manifesto, 2014) Men's Health Forum is a charity that works in partnership with NHS England, Public Health England, the Department for Health and other agencies to champion men's health. The Men's Health Manifesto highlights the issues that impact upon men's health and advises where services can be improved.

This men's health review has been compiled to identify the factors affecting Walsall male life expectancy. It seeks to identify the local patterns of health and disease affecting this group. Historically there has always been a marked difference in the life expectancy of men and women. Although life expectancy is rising for men residing in Walsall, there is still a gap between national and regional figures. This report will pull data from various existing reports highlighting men's health concerns in line with Public Health England's key themes of: Starting Well, Living Well and Ageing Well. The areas identified in this piece of work will contribute to future projects working towards narrowing the gap within Walsall male life expectancy compared to national and local figures .

Background

The information in this section will provide some background information on the male population that reside in Walsall.

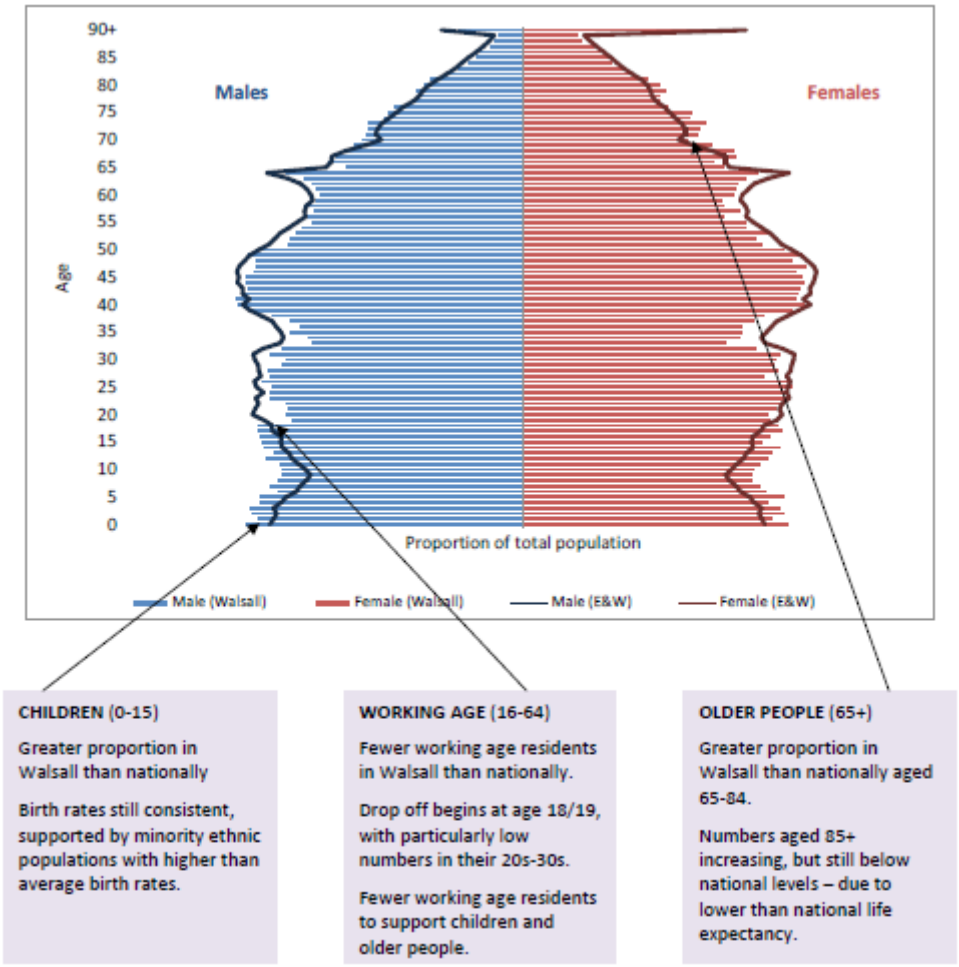
Demographics

Population

[1]Walsall's overall population is predicted to increase over the next 10 years by 4.5% from 269,500 in 2011 to 281,700 in 2021. 138,800 men live in Walsall making up 49% of the total population. Of these, 21,327 (7.8%) are aged 65 years and above, this is predicted to increase to 24,078 in 2021. The 2011 census data states that of the male population in Walsall, 14,472 are living alone, 4,209 of those living alone are 65 or older and 10,263 are described as residing in a one person household: other.

[1] *Text taken from Walsall Joint Strategic Needs Assessment (JSNA) 2013*

[2]Figure 1: 2011 Population structure pyramid of men and women, Walsall, England & Wales



Minority Ethnic Population

[3] Walsall also has a culturally-mixed population. People of Indian, Pakistani and Bangladeshi background form the largest minority ethnic groups in Walsall. The estimated male population within Walsall's ethnic minority group is 28,690 (Nomis, 2011 census data) this is 21.5% of the total Walsall male population. Walsall's current older (65+) ethnic minority population is estimated to be 1,461 (Nomis, 2011 census data).

[2] *Data taken from Walsall Strategic Needs Assesment (WSNA) Key Findings - May 2014*

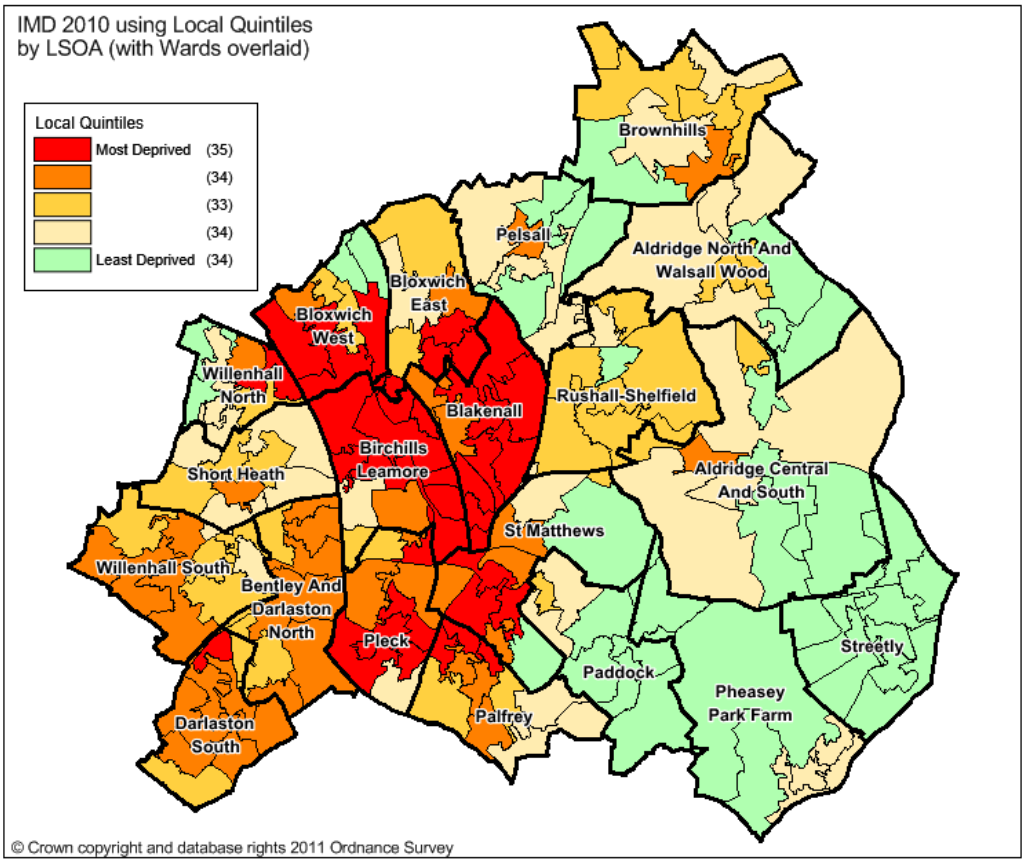
[3] *Text taken from Walsall JSNA 2013*

Deprivation

[4]In 2010, Walsall was ranked as the 30th most deprived of the 326 Local Authorities in England. This position has worsened since the last data release in 2007, where Walsall ranked 45th out of 354. The borough fares particularly badly in terms of education, income and employment deprivation. Central and western parts of the borough are typically more deprived than the east. However, while some parts of the borough such as Blakenall are among the most deprived in the borough, others rank within the very least deprived (see Figure 2 below).

The figure below also details that 114,800 (44.6%) of Walsall's total population (2010 mid-year estimates) live within the most deprived quintiles compared to 30,400 (11.8%) living in the least. Looking specifically by age, 28,100 (52.3%) of 0 to 15 year olds live within the most deprived quintiles in Walsall and 16,100 (35.5%) of over 65's. This compares to 5,000 (9.2%) of 0 to 15 year olds living within the least deprived quintiles in Walsall and 7,000 (15.6%) of over 65's.

Figure 2: Walsall LSOA deprivation using Local Quintiles (Source: Department for communities and Local Government)



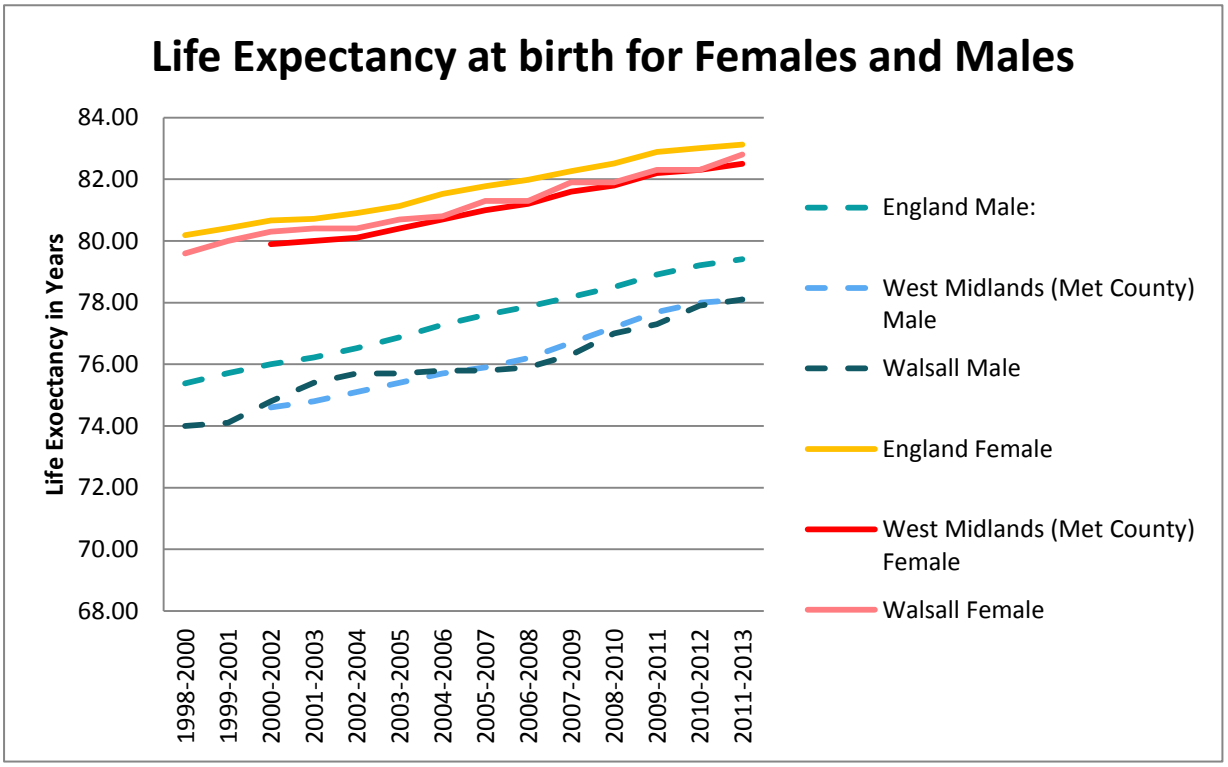
[4] *Text and data taken from Walsall JSNA 2013*

Male Life Expectancy

[5]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 1998 to 2013 (Source = Office for National Statistics)

Figure 3 Life Expectancy at Birth for Females and Males: 1998 to 2013 (Source = Office for National Statistics)



Life Expectancy Gap

[6]We can see from figure 4 that the Life Expectancy gap for men is 10.1 years 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.

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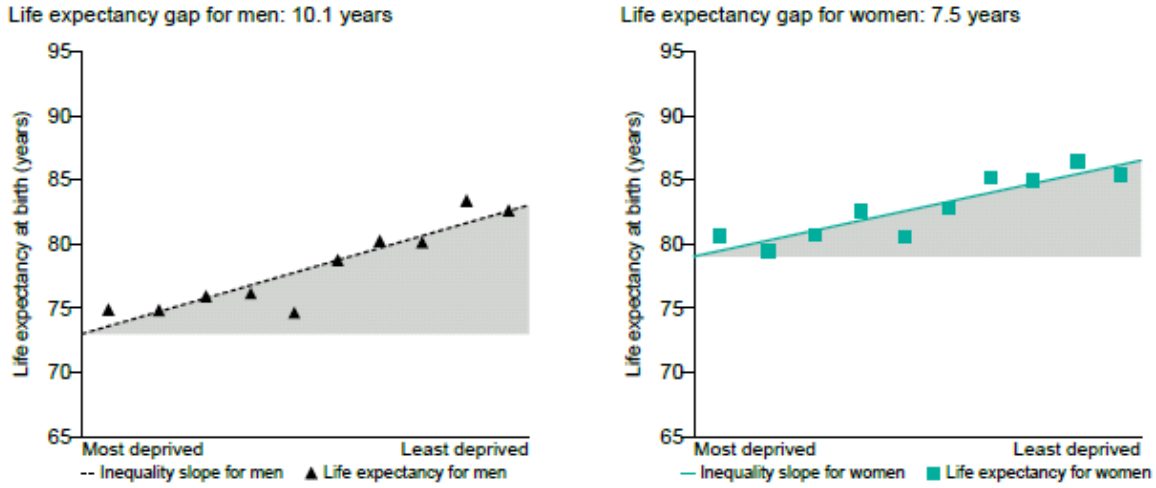
[5] *Text and data taken from Annual Report of the Director of Public Health for Walsall, 2013/14*

[6] *Text and data taken from Annual Report of the Director of Public Health for Walsall, 2013/14*

Figure 4: Walsall Life Expectancy Gap for Men and Women (Source = Walsall Health Profile 2015)



Healthy Life Expectancy

[7]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 shown in Figure 5 illustrates that Walsall has a slightly lower healthy life expectancy age for men and women compared to regional and national comparators.

Figure 5 Life expectancy (LE) and healthy life expectancy (HLE) comparison, 2009-2011 (Source: ONS)

	Males		**Females**		**Person**	
	LE	**HLE**	**LE**	**HLE**	**LE**	**HLE**
Walsall	77.3	59.4	82.3	61.2	79.8	60.3
West Midlands	78.4	62.5	82.6	62.8	80.5	62.65
England	78.9	63.2	82.9	64.2	80.9	63.7

[7] *Text and data taken from Walsall JSNA 2013*

Summary and Recommendations

Deprivation and poverty in childhood lie at the heart of inequalities throughout life. The Government's 'New Approach to Child Poverty 2011' recognised that 'poverty can be such a destructive force because of its long-term grip on families and communities, holding them back generation after generation'. The ultimate outcomes of inequalities in wellbeing are life expectancy and healthy life expectancy. Although improving in Walsall, both lag behind regional and national levels, and much needs to be done to narrow the gap between healthy life expectancy and life expectancy.
Key priorities are:

- Proportionate action with greater intensity in areas of greater socio-economic need
- Reducing the impact of child poverty (see CYP Plan Priority 8)
- Break inter-generational cycles of poverty and deprivation
- Partnership action from the early years onwards to ensure the growth of strong, resilient, healthy adults
- Maximise aspiration, educational attainment and employability across the borough
- Strong health focus on prevention and early intervention
- Robust pathways of care for all key contributors to mortality

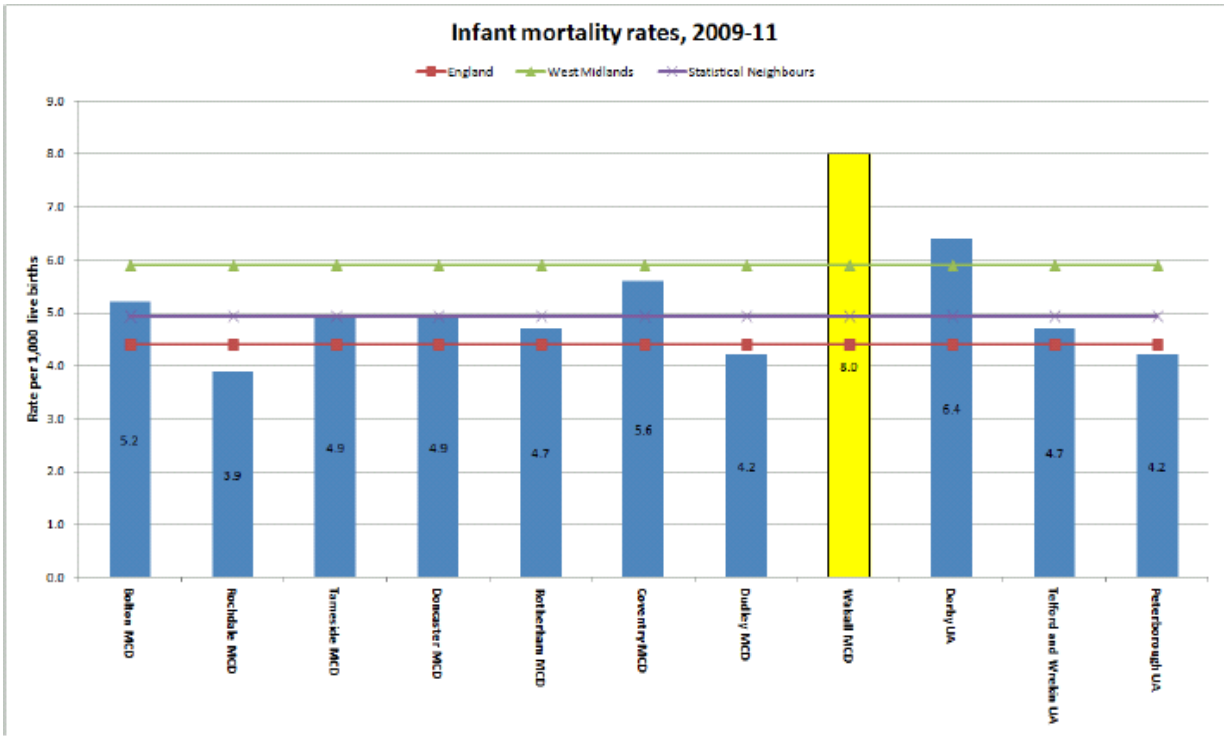
Premature Male Mortality

Infant Mortality

[8]Infant mortality is a sensitive indicator of the overall health of a population, providing a measure of the wellbeing of infants, children and pregnant women. Although infant mortality in England is at an all-time low and falling, significant inequalities persist. Walsall's infant mortality rate is consistently higher than regional and national rates, reflecting its high level of deprivation. [9]Of the 108 total deaths between 2010/11 to 2013/14, the majority were male (59.3%). 38.0% were female and the remainder were unknown, blank or ambiguous genitalia.

An audit into infant and perinatal deaths in Walsall completed in 2008 identified four key contributing factors to infant and perinatal deaths in Walsall, namely smoking in pregnancy, consanguinity, maternal obesity and deprivation, which are in turn linked to prematurity and congenital abnormalities.

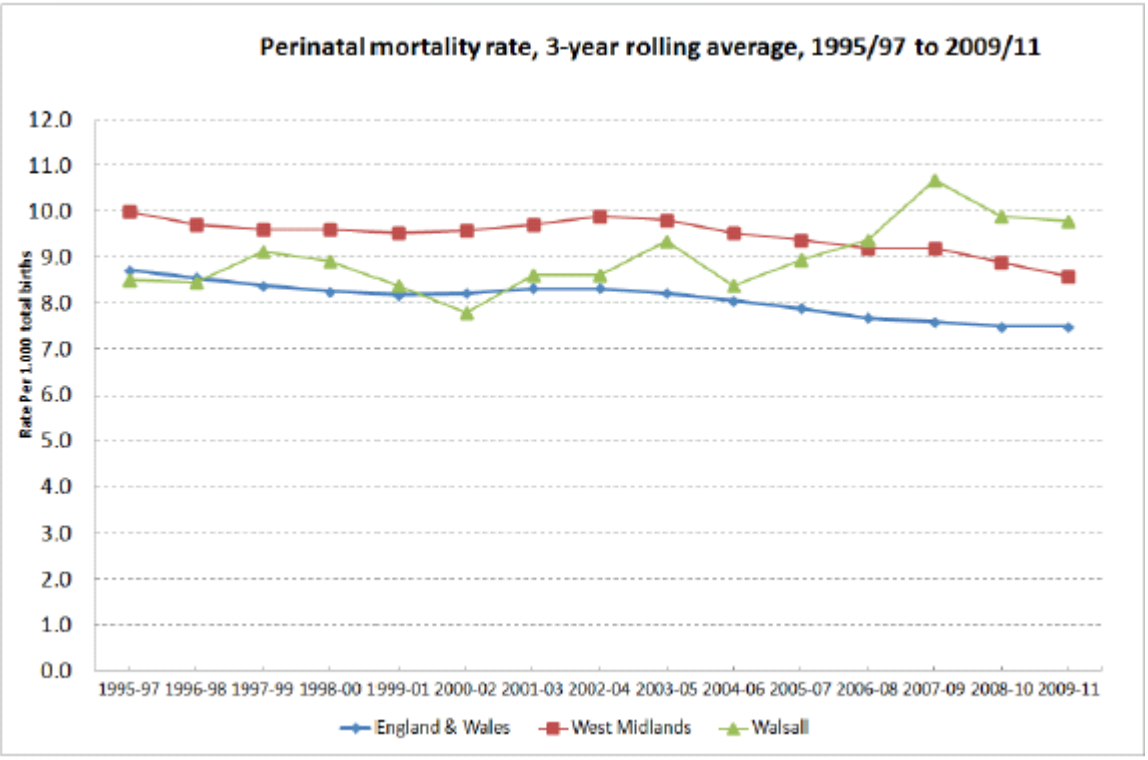
Figure 6: Infant Mortality rates per 1000 live births per year by local authority 2009-2011 (Source: HSCIC)



[8] *Text and data taken from Walsall JSNA 2013*

[9] *Data from Office for National Statistics*

Figure 7: Perinatal Mortality rates 1995-2011 (Source: ONS)



Public Health key messages and evidence suggests that with the following robust practices reduce infant mortality rates:

- Identification and clinical management of high risk pregnancies

- Modifying behaviour per-pregnancy and during pregnancy (for example action on obesity, smoking and alcohol consumption)
- Enabling early access to maternity services

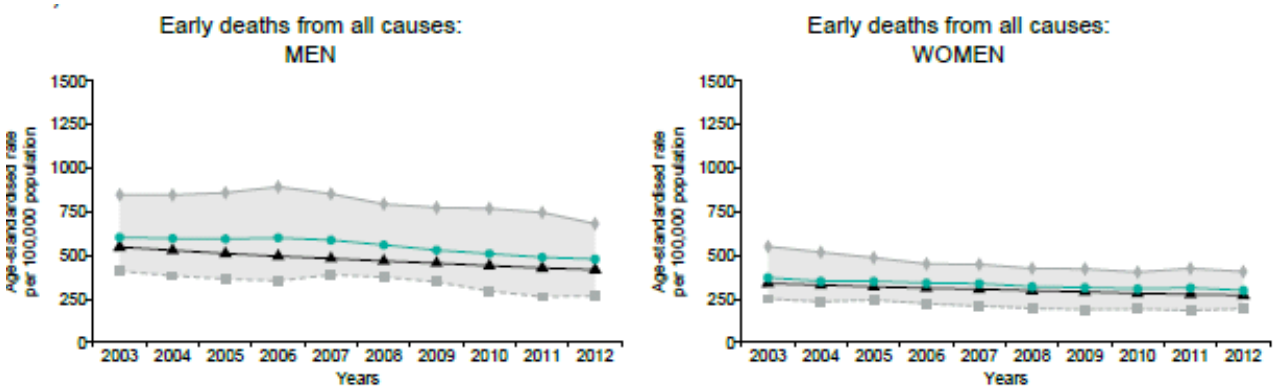
- Ensuring a caring and safe environment in the first year of life (and beyond)) through supporting parents, promoting attachment and development, advising on home safety and safe sleeping.

- Health promotion to benefit the whole family for example stopping smoking and healthy eating.

Premature Mortality

[10]Too many Walsall residents die prematurely 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, stroke and respiratory conditions such as pneumonia.

Figure 8: Walsall Early Deaths from All Causes: Men and Women 2002 to 2012 (Source = Walsall Health Profile 2015)

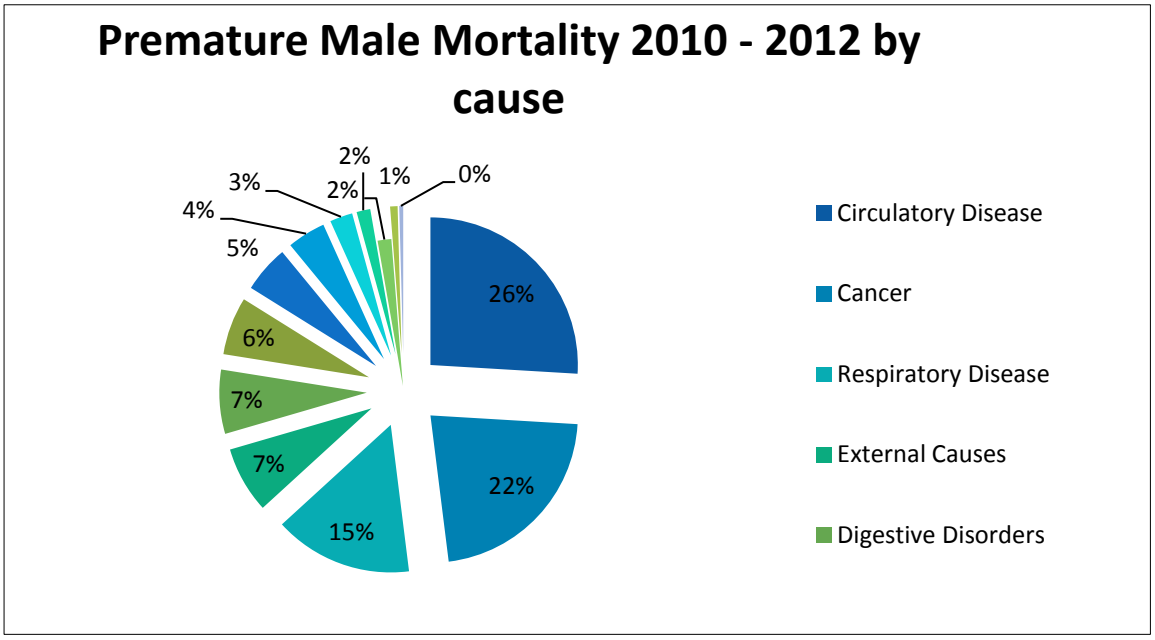


The Men's health manifesto highlights heart disease and cancer as the causes most likely to result in premature male mortality. The major lifestyle risks contributing to these deaths are: obesity, smoking, substance misuse and sedentary lifestyles.

The data below demonstrates the causes of Walsall male mortality from 2010 to 2012. This data will inform the focus of this review, concentrating on the four biggest causes of male mortality in Walsall.

[10] *Text and data taken from Annual Report of the Director of Public Health for Walsall, 2013/14*

Figure 9: Premature Male Mortality (deaths under 75 years of age) by cause in Walsall: 2010 to 2012 (Source = Public Health Mortality File)



Summary and Recommendations

For Infant Mortality:

- Improving antenatal care through encouraging early booking for antenatal care, continuity of carer through pregnancy and improved detection of intrauterine growth restriction (IUGR)

- Reducing levels of maternal obesity and smoking in pregnancy through projects such as Maternal and Early Years, Smoke-Free Homes, improving smoking cessation in pregnancy and working with ethnic communities to reduce the use of ethnic tobacco products

- Maintaining an effective antenatal and newborn screening programme

- Reducing sudden unexpected death in infancy (SUDI) and improving breastfeeding initiation and continuation rates

- Target vulnerable groups through specialised programmes such as the Enhanced Community Genetics service and the Family Nurse Partnership

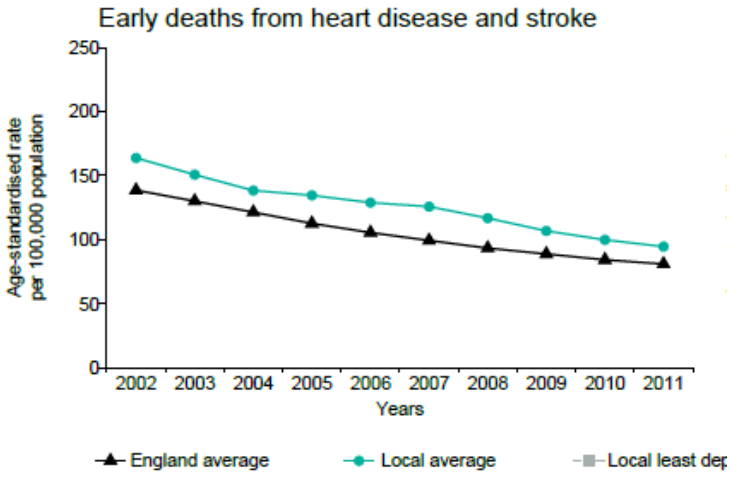
For Premature Mortality:

- Robust response to the main causes of death in the borough (Circulatory disease, cancer, respiratory disease and external causes) with a focus on prevention and early detection.
- Maximise opportunities to influence lifestyle choices through the Every Contact Counts initiative (encouraging smokers to quit to reduce number of smoking related cancer incidences and respiratory disease)
- Encourage participation in NHS Health Checks and national screening programmes with a particular push on cancer screening
- Robust pathways of care across all health providers
- AAA Screening
- Blood pressure and diabetes management

Circulatory Disease

Circulatory disease is currently the biggest killer of men in Walsall, it equates to 26% (2010-2012) of all male mortality. Circulatory Disease is ailments that affect the heart blood vessels or blood (for example: heart disease, arrhythmia, deep vein thrombosis, stroke and coronary artery disease). This piece of work has focused specifically on the main concerns within this group.

Figure 10: Early Deaths from heart disease and stroke (Source: Walsall Health Profile 2014)

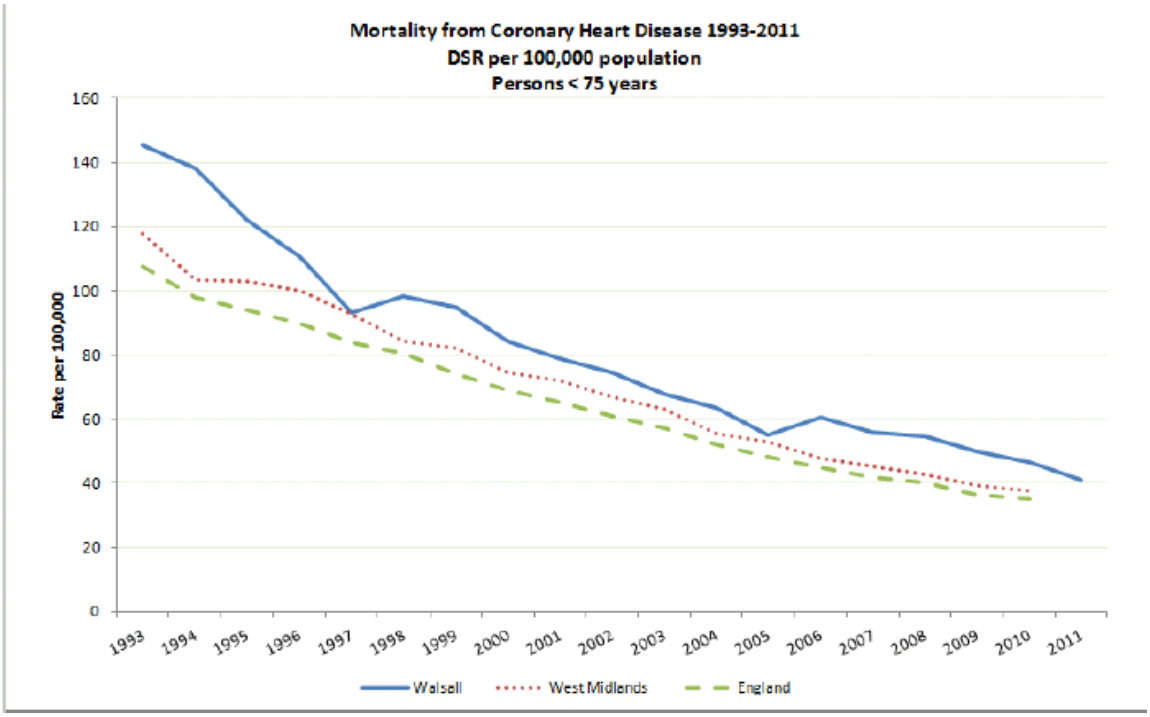


Heart Disease

Coronary Heart Disease (CHD) is a common circulatory disease but is a condition for which there is very strong evidence based interventions for prevention and for treatment. Whilst deaths from CHD have reduced in the past 10 years, the rates in Walsall remain higher than nationally. This means we still have too many people dying before reaching 75 years of age. Organisations and the population as a whole should redouble efforts to implement the key actions which we know will reduce CHD.

In the Figure 11 below, Walsall still shows a downwards trend in mortality up to 2011, but at time of writing, comparable data isn't available for the West Midlands and England. Walsall 2011 rates are provisional. The number of coronary heart disease deaths per 100,000 (DSR) is recorded and compared to the West Midlands and England.

Figure 11: Under 75 Coronary Heart Disease Mortality DSR 1993-2011 (Source: NHS Information Centre and Public Health Mortality File for 2011 Walsall) (Rates for Walsall 2011 are provisional)



Summary and Recommendations

To reduce the prevalence of CHD and its impact on families the following actions should be taken:

- All partners to prioritise reducing levels of smoking in our population. This includes controlling tobacco, preventing children from starting smoking, supporting people to stop smoking. Major areas for opportunity are in the workplace

- Commissioners of health services need to promote the aggressive identification and management of heart disease, e.g. through the national health service health checks programme – a primary prevention initiative which identifies those at highest risk of developing heart disease and puts actions in place to reduce those risks

- Health professionals and patients should work consistently to manage coronary heart disease in line with best available evidence. A wider range of health professionals can contribute to this ,e.g. community pharmacists supporting patient self-care, medicine-use reviews and NHS health checks

- All partners should maximise opportunities to promote more active lifestyles for all ages and provide access to affordable active leisure provision

Stroke

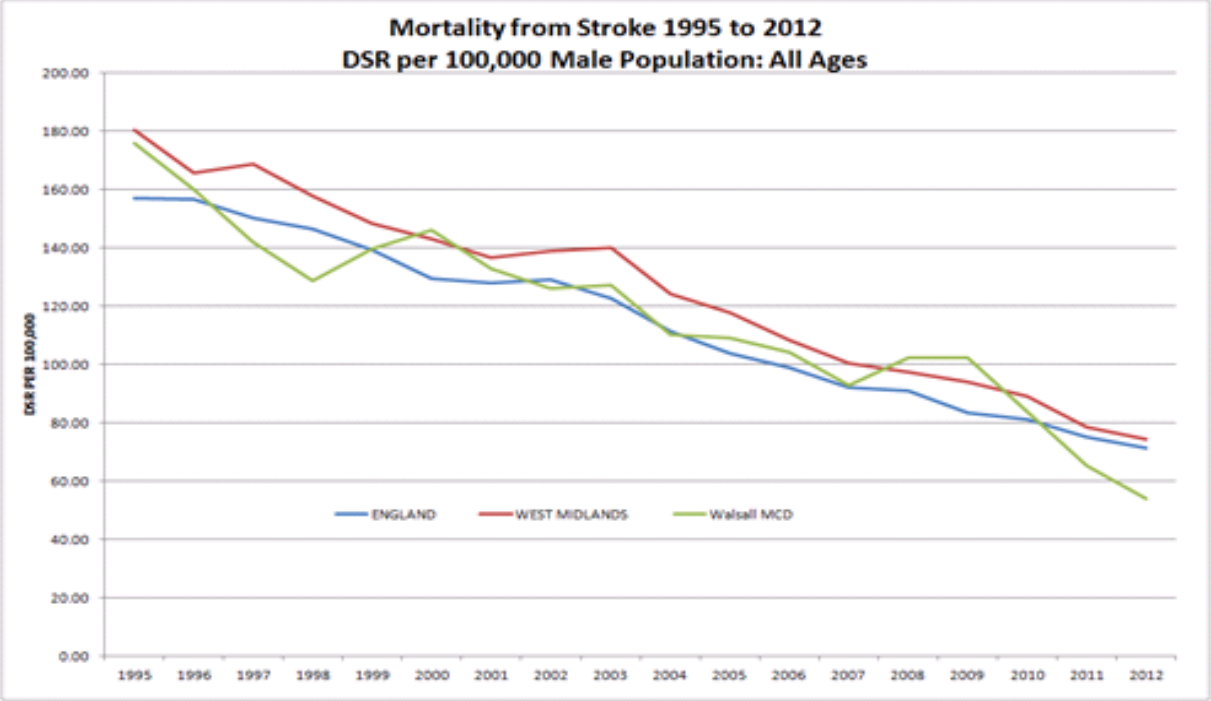
Stroke is a preventable and treatable disease. Over the past two decades a growing body of evidence has overturned the traditional perception that stroke is simply a consequence of aging that inevitably results in death or severe disability.

Stroke is the largest cause of disability in the UK, and the third commonest cause of death (after heart disease and cancer). Most cases occur in people aged over 65 but, a stroke can occur at any age, even in babies. Each year in Walsall, around 480 people have a stroke. 25% of these people die from the effects of their stroke. Of those who survive, one third have moderate to severe disability.

[11]In England, stroke is estimated to cost the economy around £7 billion per year. This comprises direct costs to the NHS of £2.8 billion, costs of informal care of £2.4 billion and costs because of lost productivity and disability of £1.8 billion. Until recently, stroke was not perceived as a high priority within the NHS. However, a National Stroke Strategy was developed by the Department of Health in 2007. This outlines an ambition for the diagnosis, treatment and management of stroke, including all aspects of care from emergency response to life after stroke.

When comparing stroke mortality of males against females, there is a marked difference. Looking at the male trends of Walsall, there was a spike in 2008 of 57.82, but levels have reduced since then. Between 2009 and 2010, the level of reduction closely matches that of the West Midlands and England. The rates from 2010 show that Walsall's mortality rate (of 45.26 per 100,000) is slightly better than the West Midlands rate (45.93 per 100,000), but higher than the England value of 41.91 per 100,000.

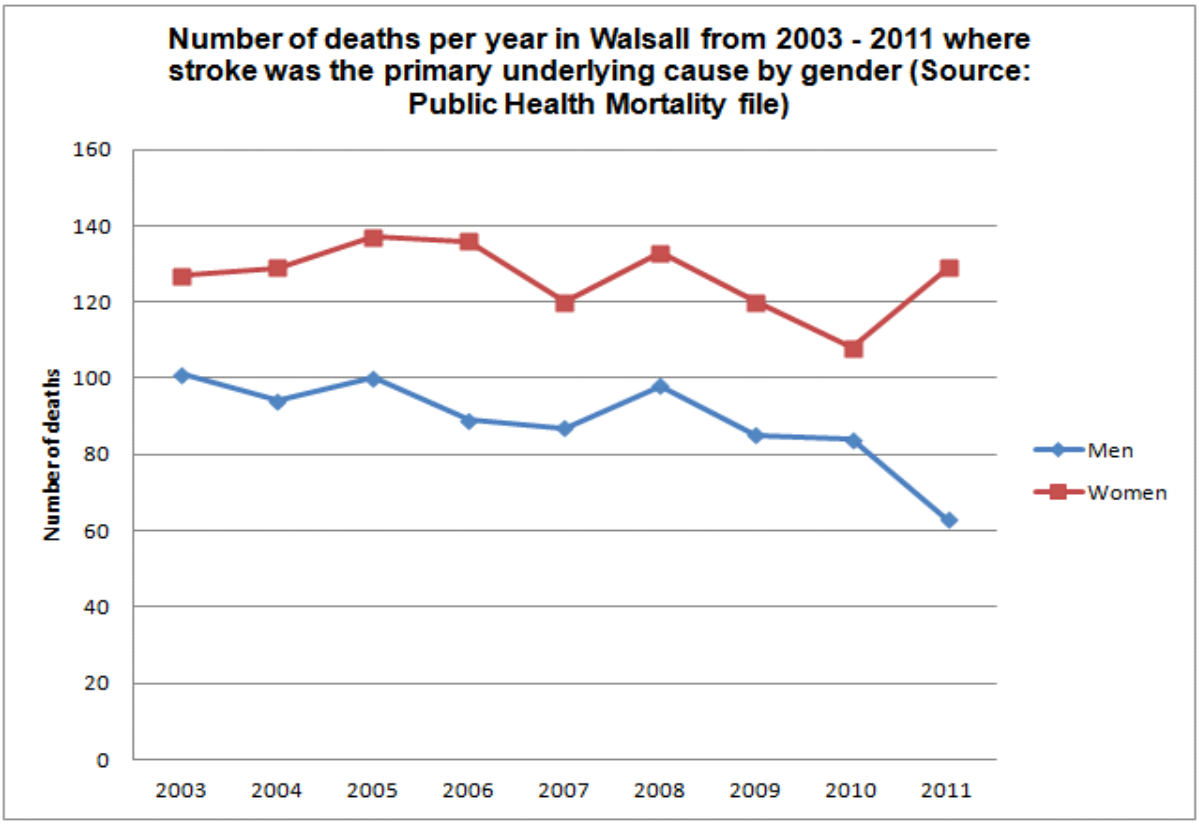
Figure 12: Mortality from Stroke, Males only (Source: NHS Information Centre; Mortality from stroke DSR between 1995 and 2012)



[11] *Text taken from NICE guidance (2008)*

West Midlands and England figures aren't yet available for 2011, but Walsall (provisionally) shows a substantial 24.9% drop in male stroke mortality between 2010 and 2011. As with the female statistics for 2011, there is a wide confidence interval, which could affect the trends in these charts.

Figure 13: Walsall Mortality from stroke by gender (Source: Public Health Mortality file between 2003 -2011)



Summary and Recommendations

[12]Evidence is accumulating for more effective primary and secondary prevention strategies, better recognition of people at highest risk, and interventions that are effective soon after the onset of symptoms. Understanding of the care processes that contribute to a better outcome has improved, and there is now good evidence to support interventions and care processes in stroke rehabilitation.

[12] *Taken from NICE Stroke Guidance (2008)*

The main preventative actions for stroke are good control of high blood pressure and correction of heart rate abnormalities (atrial fibrillation). People who have suffered 'mini strokes', also known as transient ischaemic attack (TIA), are at high risk of developing more severe strokes and effective actions to reduce this risk are of most benefit. Access to fast and effective acute treatment and high quality rehabilitation can significantly reduce both death and disability. Specific details for this are described in the Accelerating Stroke Improvement report. The following must also happen:

- A clear and robust service for younger stroke sufferers needs to be commissioned and delivered within Walsall. This will increase the proportion of stroke sufferers returning to work within 6 (and 12) months

- Clinicians dealing with acute care need to be mindful of the rehabilitation and secondary care needs of people with stroke to ensure a smooth transition across the different phases of care. In addition, it should be borne in mind that some recommendations in the guideline may not be appropriate for patients who are dying or who have severe co-morbidities.

- All partners need to design and implement appropriate bed-based rehabilitation services within Walsall. This will maximise the regaining of functions for all stroke patients

Cancer

[13]Cancer is the leading cause of death in under-75s in Walsall. Cancer is responsible for 22% (2010-2012) of premature male deaths in Walsall. Prostate, bowl and lung cancer have the highest incidence rate among Walsall men, respectively. The mortality rate indicates that it is lung, bowl then prostate cancer responsible for premature mortality.

[13] *Data and text taken from Walsall JSNA 2013*

Figure 14: Early Deaths from Cancer (Source: Walsall Health Profile 2014)

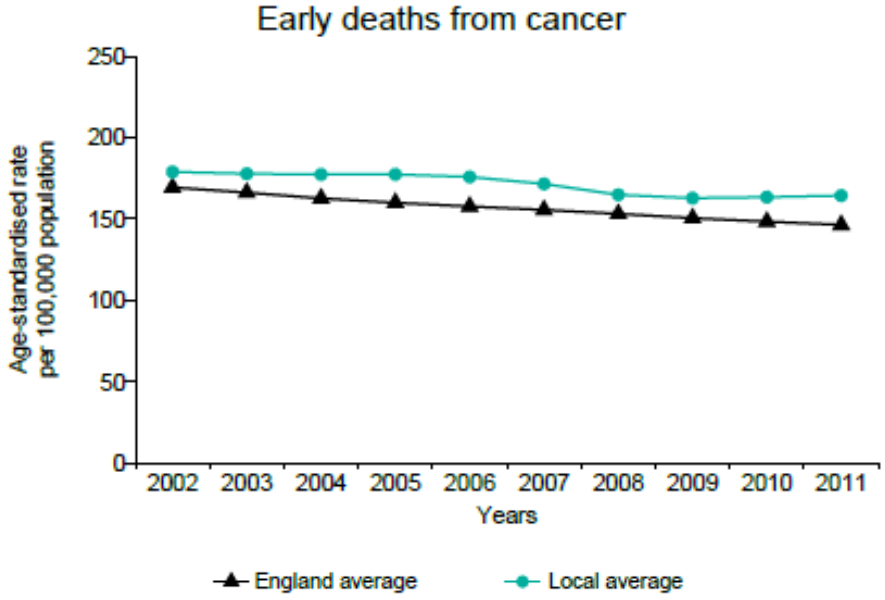


Figure15: Cancer incidence and Mortality 2009 – 2011 by gender (Source: Cancer profile 2013 Walsall Metropolitan District)

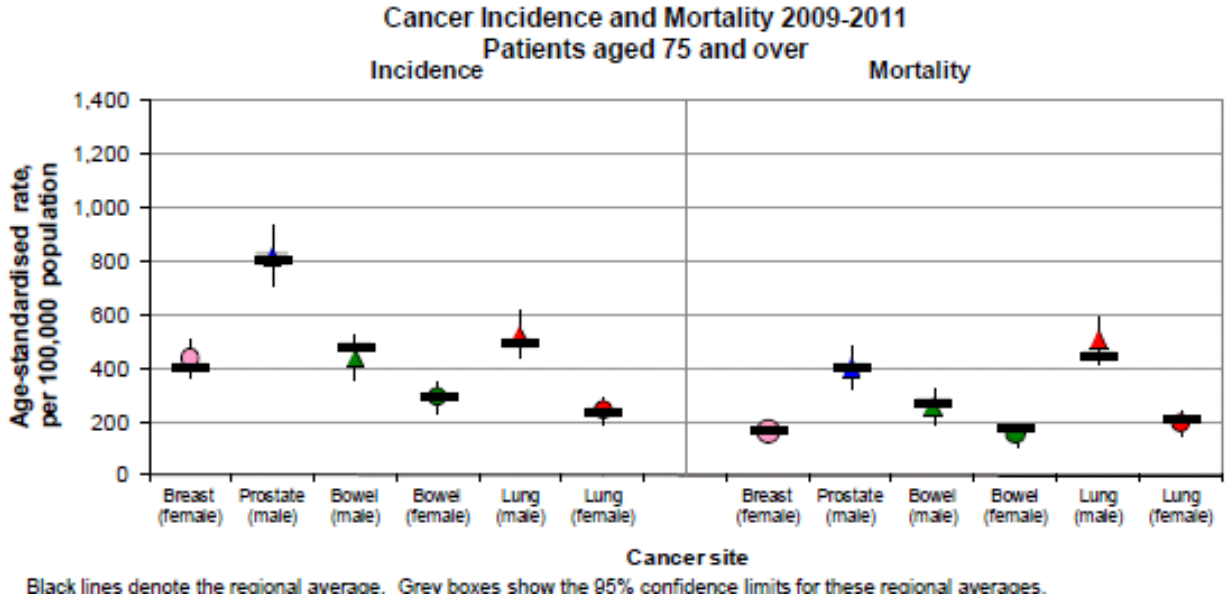
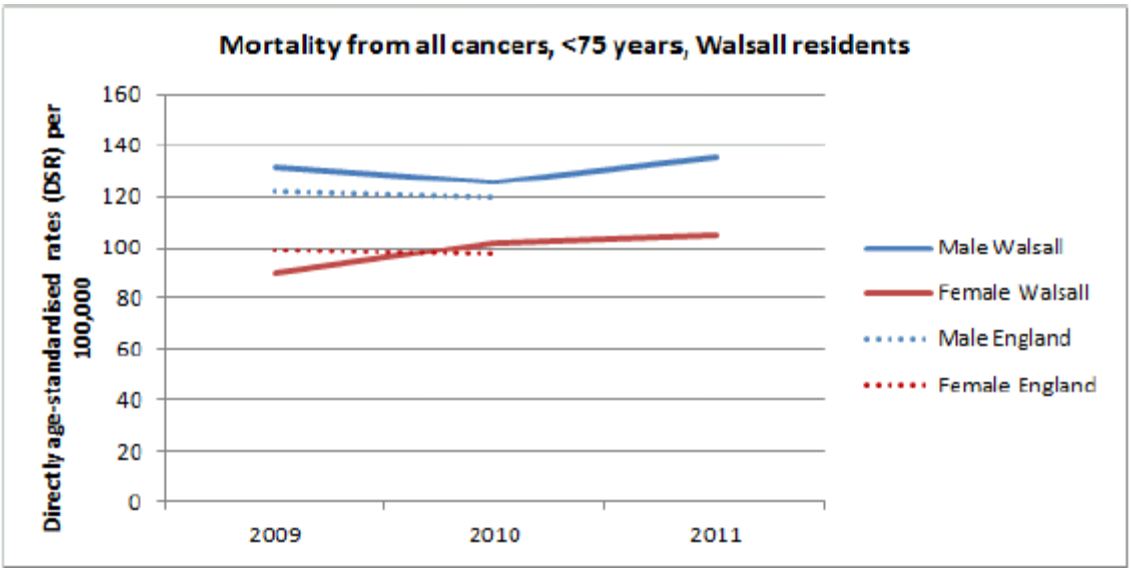


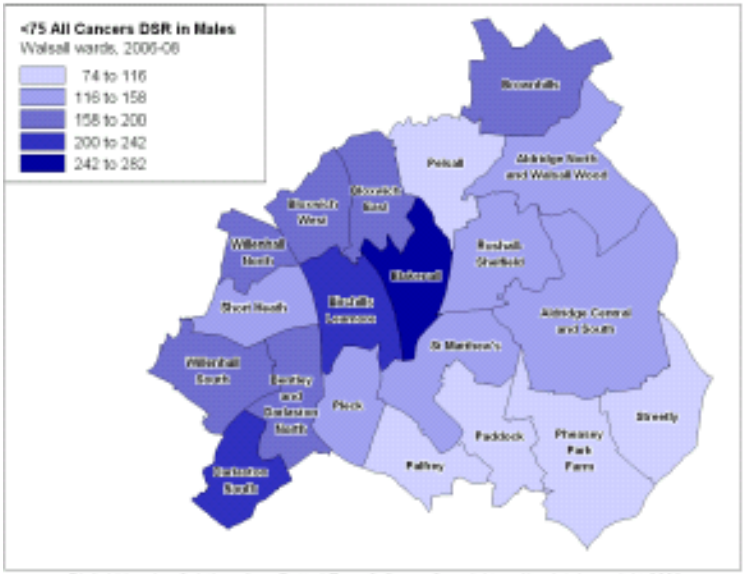
Figure 16 shows that mortality from cancer has increased for both genders between 2009 and 2011. Cancer mortality for males has increased by 3.2%, while females have increased by 16.6%. In 2010, both genders mortality rate was greater than that for England. The rates for 2011 are currently provisional.

Figure 16: Mortality from all cancers (Source: Public Health Mortality File [ONS])



Mortality rate from cancer, ages under 75, per 100,000 population varies across the borough. Male rates in Blakenall, Darlaston South and Birchills Leamore more than double the rates in Paddock and Streetly. The commonest types of fatal cancers in Walsall are lung, colorectal, oesophageal, breast, prostate and stomach.

Figure 17: Under 75's all cancer DSR by community – Males (Source: Public Health Mortality File)



[14]National public health screening programmes are in place to support and improve the early detection and treatment of breast, bowel and cervical cancer. These are having a significant impact on cancer survival, but not everyone eligible attends.

Bowel screening

For the 6 months up to February 2013, 51.0% of 60-74 year olds took up bowel screening. This is an decrease on the previous year's uptake of 52.8% (at Feb 2012). The target as shown in the Health Protection Dashboard is 60% uptake.

The 2.5 year coverage rate for 60-74 year olds has increased from 52.9% in Feb 2012 to 54.6% in November 2013. The target as shown in the Health Protection Dashboard is 60% coverage.

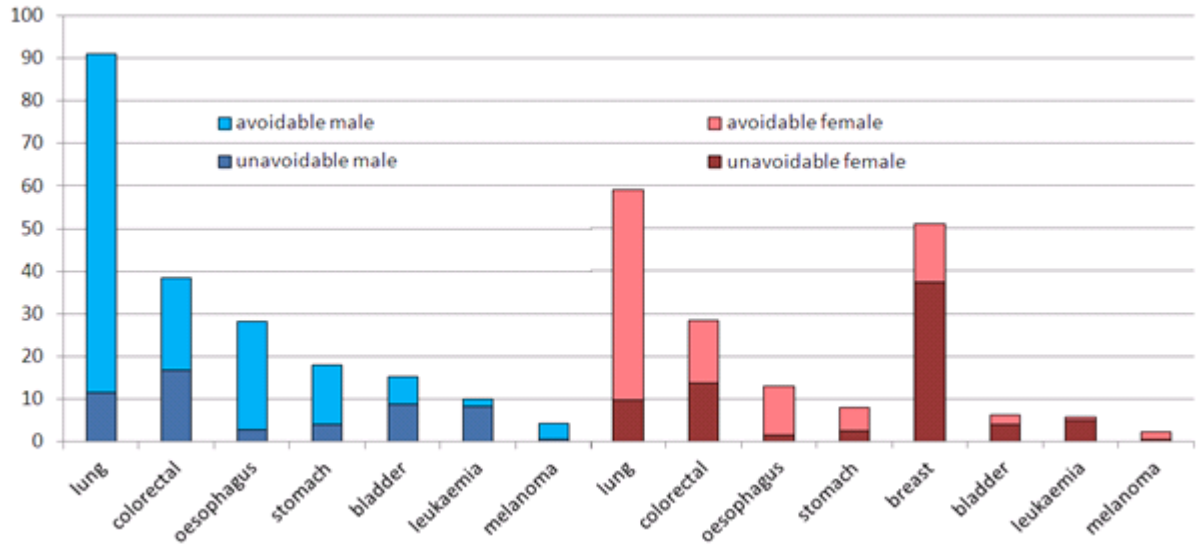
Cervical screening

The Walsall coverage rate has dropped slightly from 74.94% in 2010 to 73.1% in December 2013. This is for those aged between 25 and 64 years, over a 3.5/5.5 year coverage. The target as shown in the Health Protection Dashboard is for 80% coverage.

Breast screening

In Walsall, the uptake in breast screening (for 50 to 70 year olds) has reduced from 73.8% in Feb 2012 to 77.8% in December 2013. This is still above the 70% target seen in the Health Protection Dashboard.

Figure 18: Walsall potential avoidable and unavoidable cancers by gender - impact of eliminating common risk factors



[14] *Data taken from Walsall JSNA 2014*

Summary and Recommendations

- Nearly 90% of the 150 cases of lung cancer that occur each year in Walsall are due to smoking, so if everyone stopped smoking in Walsall there would be 128 fewer cases each year.

- A further 90 cancers of oesophagus, stomach and bowel could be prevented by healthier diets and reduction in obesity. Potentially 45% of the 670 cancers diagnosed in Walsall each year could be avoided by modifying simple lifestyle risk factors.

- Bowel screening uptake in Walsall, of 60-74 years old, was 53% with a target of 60% (November 2014)

- Recommendations to target areas of lower than average uptake will increase the numbers of people with cancer diagnosed sooner, and hence treated when their cancer is at an earlier and more easily treated stage.

- Effectiveness of treatment depends on speed of diagnosis, quality of and compliance with treatment and mitigation of social isolation. There is increasing evidence that people with poor social networks, isolation and depression have poorer survival rates than those without.

- We should therefore ensure, where possible, that patients are offered the necessary social support to maximise their chances of survival.

Respiratory Disease

Respiratory disease is responsible for 15% of premature male deaths in Walsall. Chronic Obstructive Pulmonary Disease (COPD) is the leading cause of death within this group followed by influenza which tends to affect the older population. Other ailments that come under respiratory disease include: asthma, pneumonia, emphysema, bronchitis, cystic fibrosis and many more. To keep this review focused only COPD will be looked at as it the most prominent cause of premature death, locally, in this category.

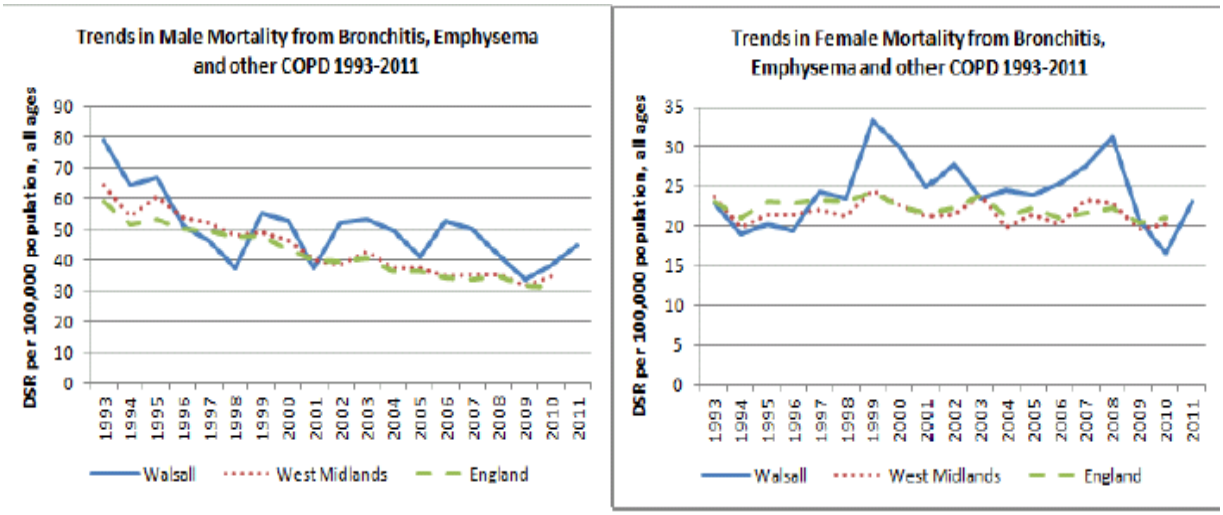
[15]Chronic Obstructive Pulmonary Disease

Chronic Obstructive Pulmonary Disease (COPD) is a common group of respiratory disorders which includes chronic bronchitis and emphysema. About three million people in the UK have COPD and it is estimated that another half-a-million have the condition but have not been diagnosed. The main cause of COPD is tobacco smoking, but other relevant causes include exposure within the mining and pottery industries. According to "Modelled estimate of prevalence of COPD in England", there are 10,140 people suffering from the condition in Walsall. This is made up of 5,975 males and 4,165 females.

In 2011, it was estimated that around 3.9% of Walsall's registered population had COPD. This is considerably higher than the England rate of 2.9%. COPD mainly affects people over the age of 40 and becomes more common with increasing age. The average age of diagnosis is around 67 years and it is more common in men than women. COPD accounts for more time off work than any other illness; exacerbation of COPD is one of the most common reasons for admission to hospital (1-in-8 admissions are due to COPD).

Traditionally, male mortality from COPD is higher than females – 38.23 (male) compared to 16.5 (female) [2010 rate per 100,000]. Rates in Walsall are generally higher than regionally and nationally. The male COPD mortality rates have been climbing steadily in recent years, showing an increase of 34% between 2009 and 2011 (provisional).

Figure 19: Trends in mortality from bronchitis, emphysema and other COPD, 1993-2011 (Source: NHS Information Centre)



[15] *Data and text taken from Walsall JSNA 2013*

Summary and Recommendations

The main action to prevent this high morbidity and mortality is to prevent people from smoking and to support those who do smoke to stop. This stops the damage to the lungs which leads to COPD. In addition to this, robust approaches to managing the condition, monitoring and aggressive treatment of flare-ups will prevent or shorten hospital stays and reduce days lost from work.

External Causes

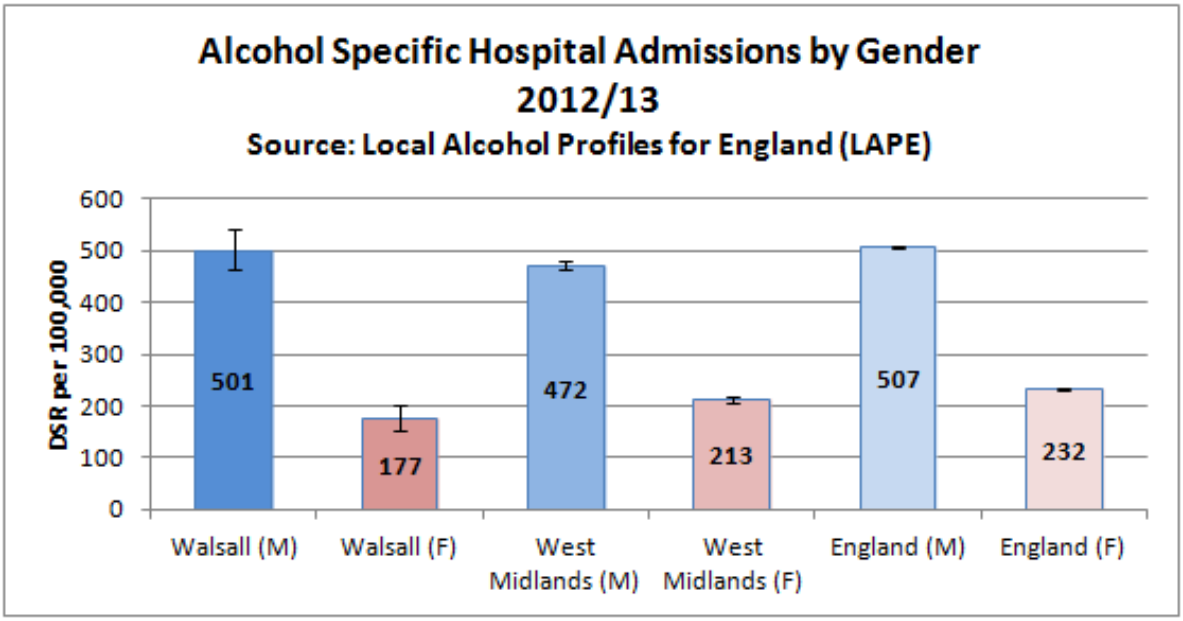
External Causes are responsible for 7% of premature male deaths in Walsall. This is the fourth biggest cause of premature male mortality. External causes include deaths caused by: road accidents, injury, poisoning, homicide, terrorism and many other causes. To keep this assessment focused only alcohol related hospital admissions and mental health and suicide will be looked at as the most prominent causes of death in this category.

[16]Alcohol Related Hospital Admissions & Mortality

Nationally, regionally and locally, there are significantly more males than females being admitted to hospital with alcohol specific conditions. Alcohol-specific outcomes include those conditions where alcohol is causally implicated in all cases of the condition; for example, alcohol-induced behavioural disorders and alcohol-related liver cirrhosis. The alcohol-attributable fraction is 1.0 because all cases (100%) are caused by alcohol. Walsall is not hugely at variance on this measure with either the regional or national figures.

[16] *Taken from the Public Health Walsall 2014 Substance Misuse Needs Assessment*

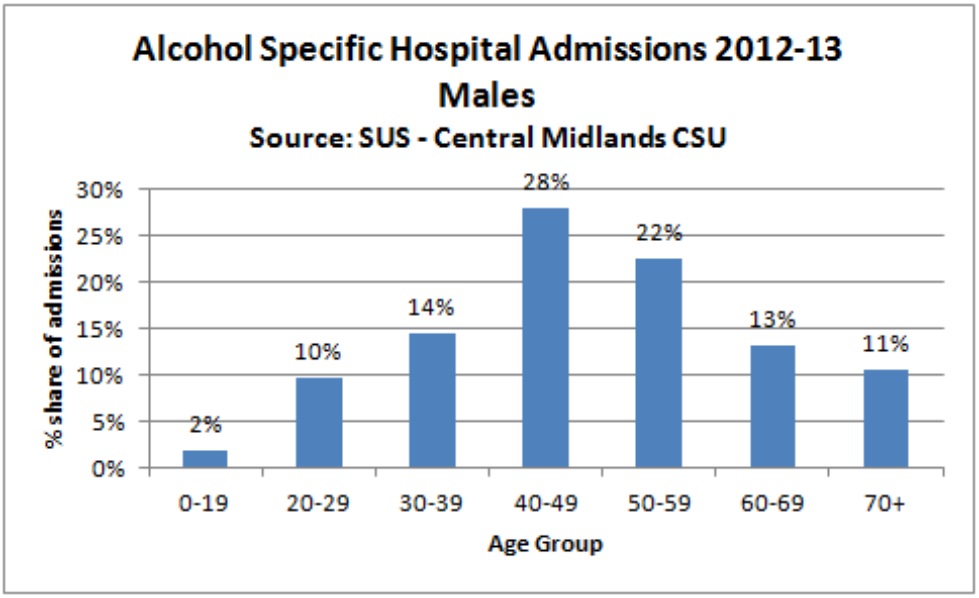
Figure 20: Alcohol Specific Hospital Admissions by gender



Male admissions with alcohol specific conditions have increased across all reported geographies since 2008/9 (Table 67, Substance Misuse Needs Assessment). Walsall had the lowest increase over the period to 2012/13 at 6%, while the West Midlands have increased by 12% and England by 15%.

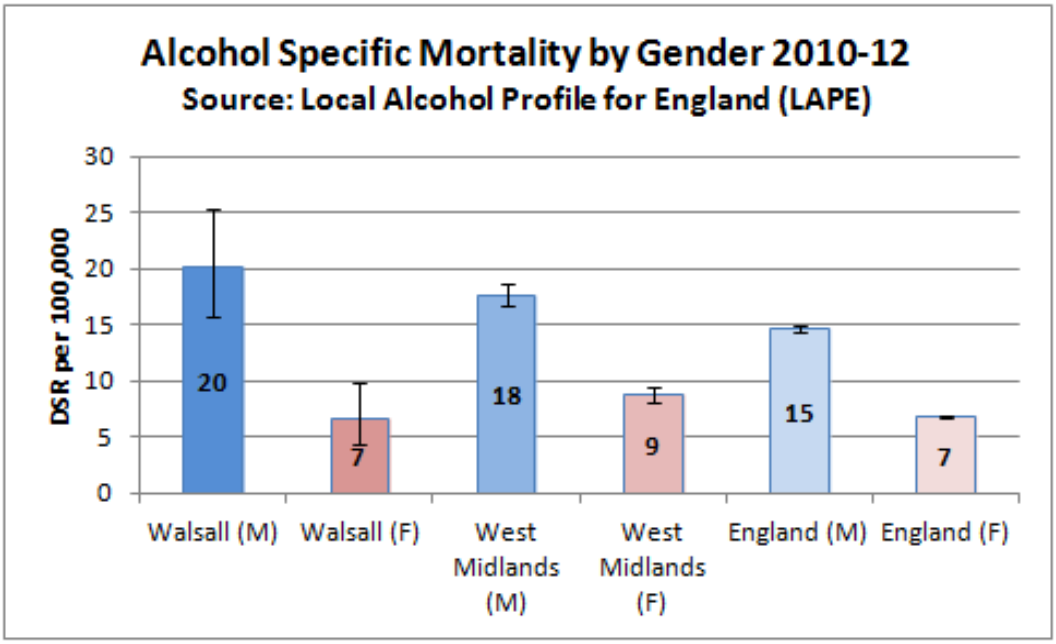
The 40-49 age- group, has the highest level of alcohol specific admissions for males (291 or 28%), while the 14% in the 30-39 group is significantly lower than the 22% for females of the same age group. The 'peak' years for male alcohol specific admissions are the two decades between 40 and 60. This fits with a fairly common feature of alcohol structured treatment, where hazardous drinking levels have evolved into harmful and/or dependent levels of alcohol use over a period of twenty, thirty or forty years. There would be substantial benefits to the individual, to the wider health economy and to society as a whole, if this pattern could be identified at an earlier stage and effective remedial action took place.

Figure 21: Alcohol Specific Hospital Admissions: Males by Age Group



There is also a gender difference in the alcohol mortality rates observed over the 6 year period between 2006-2012 where for females in Walsall there has been a 26% reduction against a national 3% reduction in the same period meaning Walsall's rate is now equal to the national rate and below the regional rate, whereas the rate for males has risen by 10% and is higher than the regional and national rates.

Figure 22: Alcohol specific mortality rate by gender



Mental Health and Suicide

[17]The mental health of children and young people in Walsall

The Walsall Joint Strategic Needs Assessment in December 2013 identified the emotional health and wellbeing of children and young people as being a priority for the Health and Wellbeing Board. The Walsall Children's Safeguarding Board and Walsall Children and Young People's Board have also identified this as a priority.

There are a large number of risk factors that increase the vulnerability of children and adolescents experiencing mental health problems. These include deprivation, poor educational and employment opportunities, enduring poor physical health, peer and family relationships, witnessing domestic violence, and having a parent who misuses substances or suffers from mental ill-health. Children who have been physically and sexually abused are at particular risk. Asylum seeker and refugee children have consistently been shown to have higher levels of mental health problems, including post-traumatic stress, anxiety and depression. Current data informs us that:

- The Number of Walsall patients aged 0-18 years old admitted with a primary diagnosis of a mental health disorder has increased from 31 in 2009/10 to 39 in 2012/13.

- There has been a slight increase in total admissions for Walsall PCT patients under 18 years for intentional self-harm and poisoning (ICD codes X60-84) from 87 in 2009-10 to 99 in 2012-13.

- The number of patients aged 0-18years from Walsall admitted to acute hospitals with a primary, secondary or tertiary diagnosis of intentional self-harm increased from 113 in 2009/10 to 143 in 2012/13.

- For Walsall PCT patients aged 0-17 years old admitted to acute hospitals between 2009/10 and 2012/13 the majority of self-harm is by poisoning.

[17] *Taken from Walsall JSNA 2013*

[18]The Mental Health of Adults in Walsall

1 in 4 adults in Britain experience at least one diagnosable mental health problem in any one year, and 1 in 6 experiences this at any given time (The ONS, Psychiatric Morbidity report, 2001). Department of Health's National Mental Health Strategy 'No Health without Mental Health' published in 2011 outlines the overarching goal to mainstream mental health, and establishes parity of esteem between mental and physical health problems. Work around adults with mental health conditions has been identified as a gap by the Walsall Health and Wellbeing strategy. [19]Data from the Mental Health Foundation tells us:

- Women are more likely to have been treated for a mental health problem than men (29% compared with 17%).
- More than half of contacts with the Samaritans are made by men – 53% compared with 43% by women. 4% were unidentifiable.
- Depression is more common in women than men. 1 in 4 women will require treatment for depression at some time, compared with 1 in 10 men.
- Doctors are more likely to treat depression in women than in men, even when they present with identical symptoms.
- Women are twice as likely to experience anxiety as men. Of people with phobias or OCD, about 60% are female.
- Men are more likely than women to have an alcohol or drug problem.
- The prevalence of schizophrenia is about the same in men and women, but the average age of onset is 18 in men and 25 in women.
- All personality disorder categories are more prevalent in men, apart from the schizotypal category.
- Men are five times more likely than women to be diagnosed with anti-social personality disorder.
- About 75% of people to die by suicide are men. This proportion has been about the same for more than a decade.

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[18] *Taken from Walsall JSNA 2013*

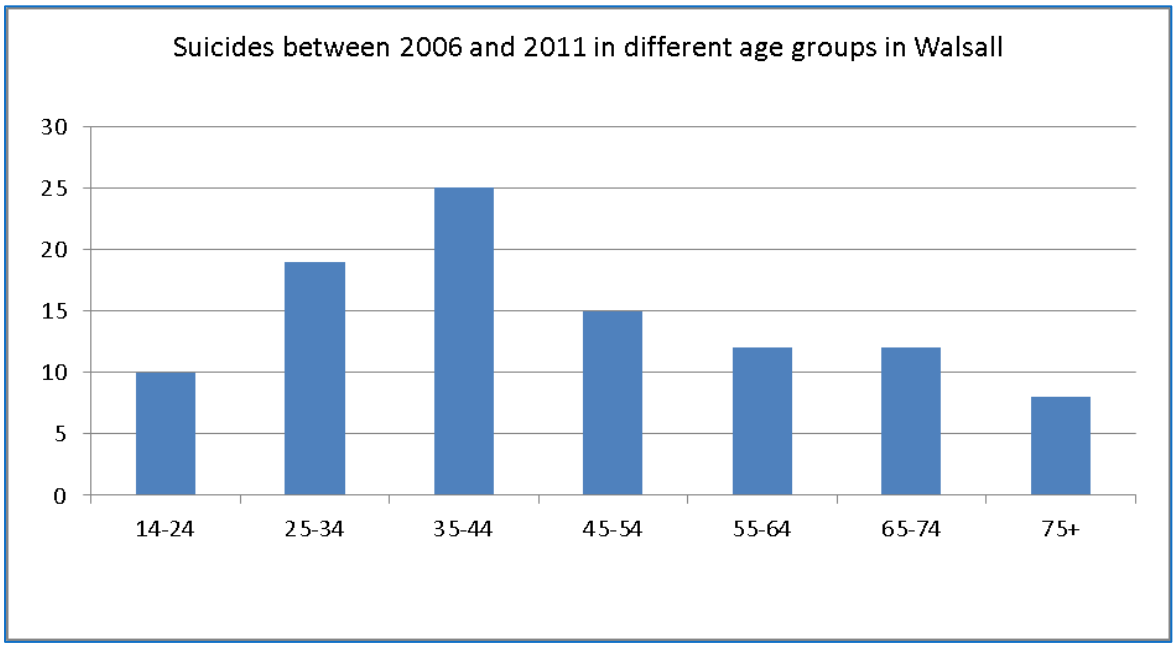
[19] *Data taken from Mental Health Foundation(2007) The Fundamental Facts*

Suicide

[20]Around 22 people each year commit suicide in Walsall, though suicide rates are lower than the England average. However 75% of people who commit suicide have not had any contact with mental health services, making it potentially difficult to identify people at risk of suicide.

The suicide age in Walsall, between 2006 and 2011, varied from 14 to 75+, with average age at 45 and median age 43. The highest suicide rates in Walsall were among those aged 35 - 44 for males and 65 - 74 females, whereas the young people cohort (14-24 years) had lowest number of suicides (see Figure 23).

Figure23: Number of Suicides and injury undetermined by age, 2006-11.



Suicide is a complex issue and one which requires further research to understand better the specific risk factors associated with it. Looking at suicides in the UK between 1997 and 2003, one study has made the following observations (Windfuhr, K., 2008)[i]:

- Three times as many young men as young women aged between 15 and 19 committed suicide
- Only 14% of young people who committed suicide were in contact with mental health services in the year prior to their death, compared with 26% in adults.
- Looking at the difference between sexes, 20% of young women were in contact with mental health services compared to only 12% of young men.

[20] *Data taken from Walsall JSNA 2013*

Summary and Recommendations

Data for Walsall's Suicide Prevention Strategy was refreshed in 2013. Some of the male specific key findings are:

- Deaths from suicide and undetermined injury in Walsall have averaged 15 males and 3 females per year in the five years 2006-10. There is, however, a wide fluctuation from year to year.
- Almost 4 times as many men commit suicide in Walsall than women, which is in line with the national pattern.

- In recent years the rate of suicides in Walsall men has remained static whereas in England and Wales it has been falling, so the gap between Walsall and the rest of the country is shrinking.

Current health service interventions that improve mental health and wellbeing include:

- Suicide prevention training with front-line personnel who come into contact with people at risk of mental health problems. These front-line personnel include officers in the employment and housing sectors. These actions should be continued and embedded for all staff.

- Mental health first aid training for healthcare workers.

- Other local priorities should include brief interventions in primary care and Improving Access to Psychological Therapies.

Lifestyle Risks

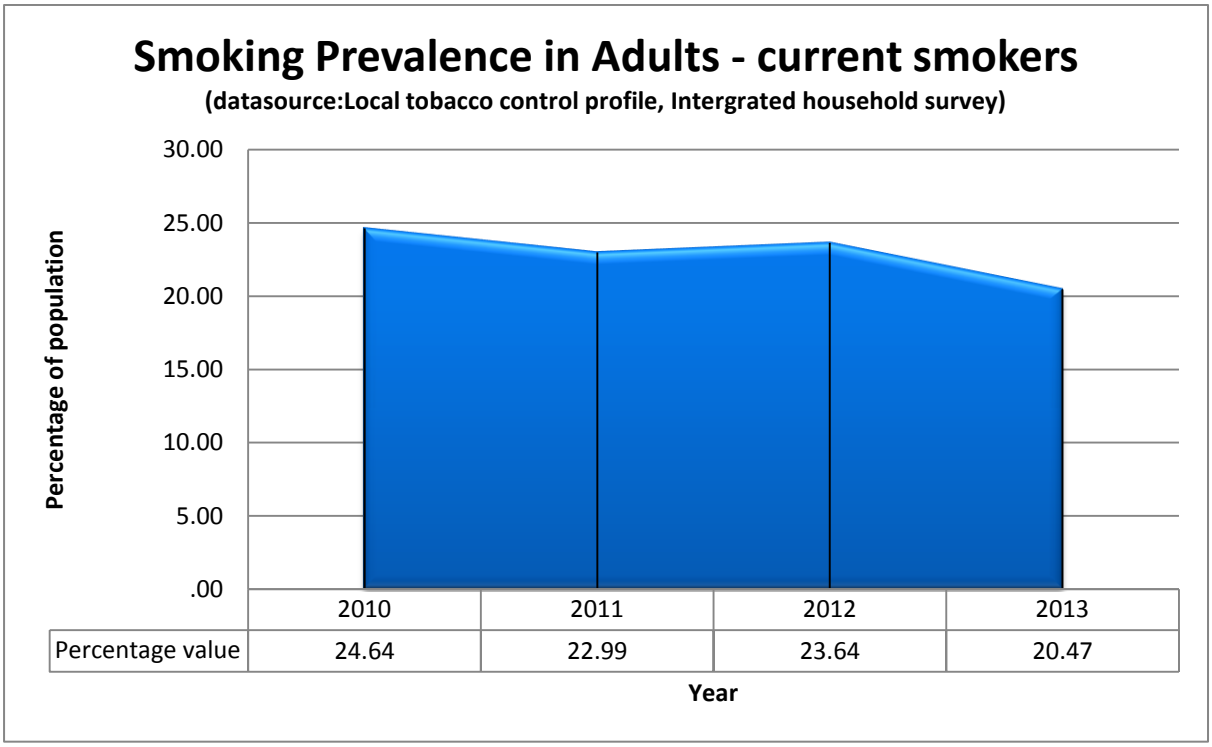
As mentioned multiple times above, the causes of premature male mortality are largely preventable with lifestyle adjustments. The four biggest causes in premature mortality are all as a result of long-term poor lifestyle habits. Working strategically by planning early interventions the future generations of the Walsall male population can look forward to a better life course and life expectancy. This section highlights those life style changes that need to be made to increase healthy life expectancy and reduce premature mortality.

Smoking

Smoking is still the single greatest cause of illness and premature death in England, killing one in two smokers prematurely. For each cigarette smoked, a smoker's life span is shortened by about five minutes. Those who die as a result of a smoking related illness will have lost, on average, 10-15 years of life.

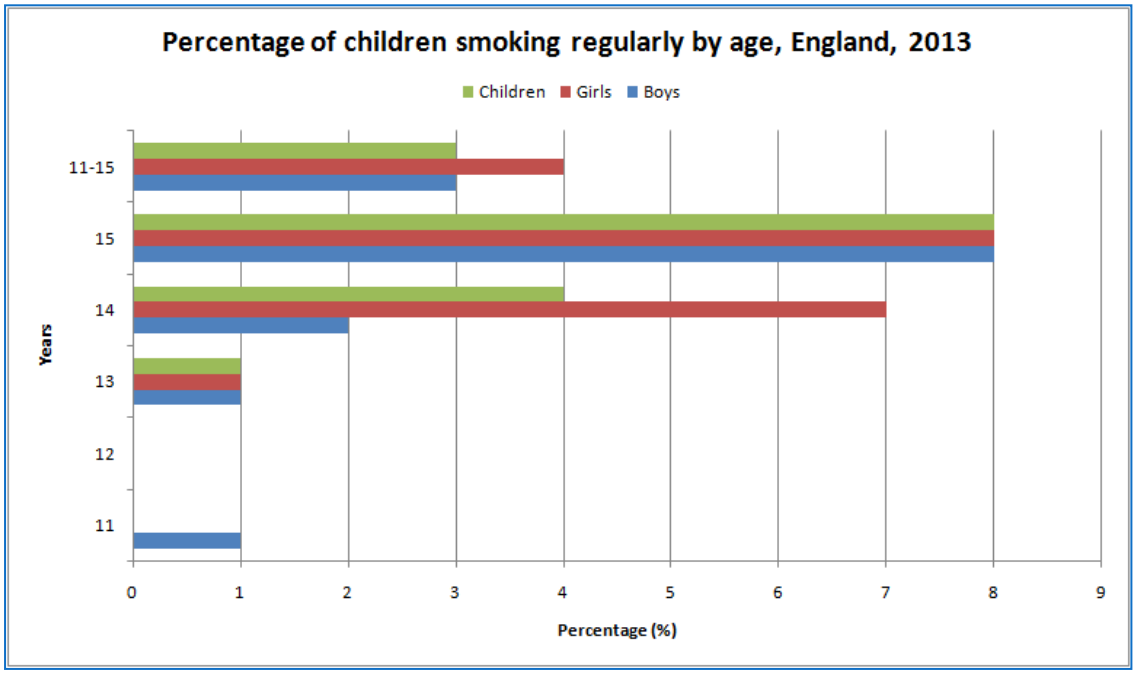
Figures taken from the latest Local Tobacco Control Profile (2015) for Walsall suggest 20.5% of the adult (18+) population are current smokers. The value nationally is 18.4%. The profile also highlights data provided from QOF reports which suggest smoking prevalence in Walsall adults for the 2013/14 year is 22.1%. The prevalence for England is 19.1%. This data is currently not broken down by gender so male specific population figures are unavailable.

Figure 24: Smoking Prevalence in Walsall Adults from 2010 – 2013 (Data source: Public Health England Local Tobacco Profiles)



It is also estimated that every year more than 200,000 children in the UK start smoking (Childhood smokers, Cancer Research UK, 2013). Regular smoking is defined as at least one cigarette a week. By the age of 15, approximately 8% of children in England report being regular smokers.

Figure25: Percentage of children smoking regularly by age and gender, England 2013.



***Source**: Health and social care information centre (HSCIC); Smoking, Drinking and Drug Use among Young People in England in 2013.*

According to Walsall's health profile for 2012, there were 242 smoking related deaths in Walsall per 100,000 population of 35 years and over (for the period 2008-10). This has reduced from 256 during the period 2007-09 but is still significantly higher than the England average of 211 deaths per 100,000 (2008-10). Smoking is the single biggest modifiable risk factor for cancer and heart disease and a major aetiological factor for Lung cancer (84% of all deaths), cardiovascular disease (17% of all heart disease deaths) and respiratory diseases, such as chronic obstructive pulmonary disease (COPD) (84% of deaths from COPD).

An emerging trend is the use of electronic cigarettes (e-cigs). These are a method for nicotine delivery (generally described as Electronic Nicotine Delivery Systems (ENDS), they are currently regulated under consumer law only. The Medicines and Healthcare Regulatory Authority have recently announced plans to regulate these products as a medicine but this will not come into force until 2016.

Summary and Recommendations

In March 2011 the Government launched its Healthy Lives, Healthy People: a Tobacco Control Plan for England. The plan outlines the key elements for work to address tobacco use from Government level down to local communities, which are stopping the promotion of tobacco, making tobacco less affordable, effective regulation of tobacco products, helping tobacco users to quit, reducing exposure to second hand smoke and effective communications for tobacco control. The plan also outlines 3 national ambitions:

- To reduce adult (aged 18 or over) smoking prevalence in England to 18.5% or less by the end of 2015, meaning around 210,000 fewer smokers a year

- To reduce rates of regular smoking among 15 year olds in England to 12% or less by the end of 2015

- To reduce rates of smoking throughout pregnancy to 11% or less by the end of 2015 (measured at time of giving birth)

These ambitions have now been translated into measures in the Public Health Outcomes Framework and will form the basis of our strategic plan.

Our overall aim is to have fewer people smoking. Research shows that at any one time 63% of smokers want to stop which would give us around 35,000 potential users of stop smoking services in Walsall against the 4000 people who used the services in 2010/11, therefore, there is a high level of unmet need

- To review and refresh the Tobacco Control Plan for Walsall to establish a multi agency coordinated approach to implementing ambitions in the National Strategy locally emphasising prevention

- To establish a baseline for number of under 15's who smoke and to review current activity to ensure that work with young people in all settings includes action on smoking, to address issues associated with this target group

- To address with all groups in the community the issues around use of Shisha, chewing tobacco and electronic cigarettes

- To continue to tackle the supply of counterfeit tobacco products in the shadow economy

- To continue to implement the Smoke Free legislation through statutory visits to local business.

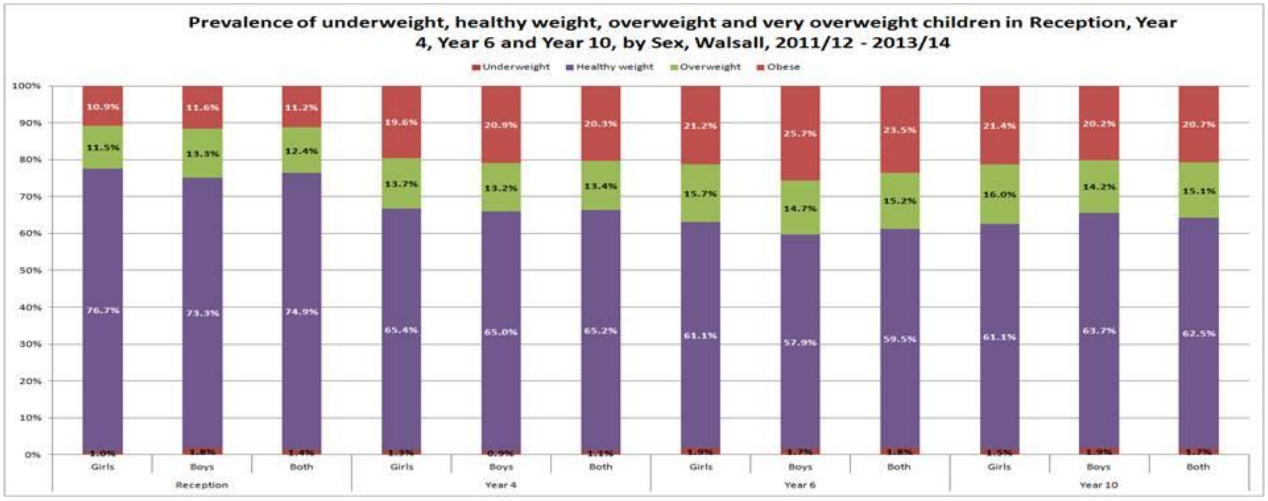
- To continue raising awareness of and gather data on the impact of parents smoking has on children (for example: more hospital respiratory admissions)

Healthy Weight

Childhood Obesity

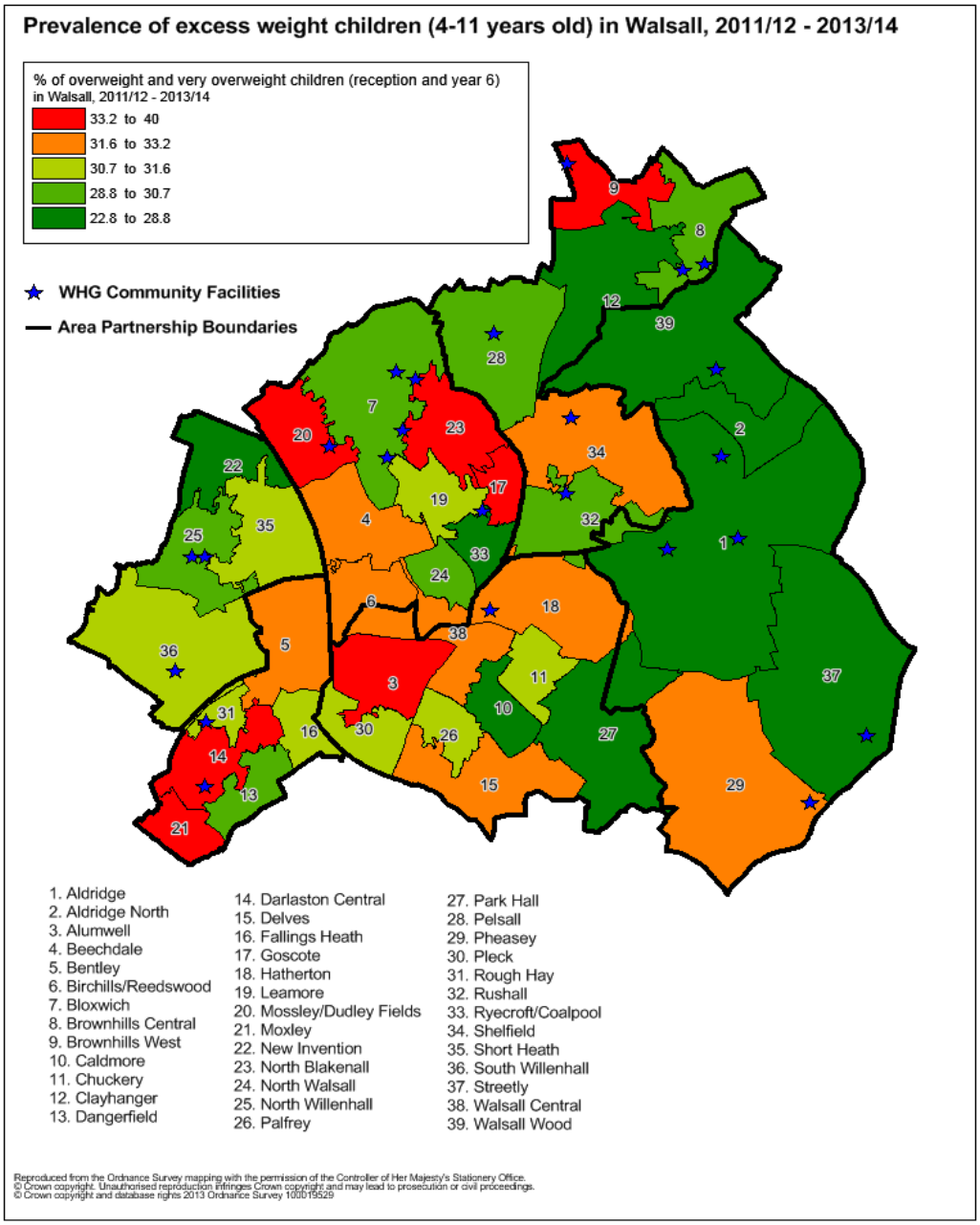
[21]Childhood obesity is a particular concern and it is widely accepted that there is a link between childhood obesity and risk of disease and death in later life. The strongest predictor of childhood obesity is parental obesity (a mixture of nature and nurture) and children who are very overweight (clinically obese) are more likely to grow up to be obese adults, therefore a vicious circle is created. In later years issues for overweight children are social and psychological, including stigma, bullying, low self-esteem and depression. In the first instance the National Child Measurement Programme (NCMP) measures Reception (age 4-5 years).

Figure 26: Prevalence of underweight, healthy weight, overweight and obese by gender in Walsall for 2010/11-2012/13.



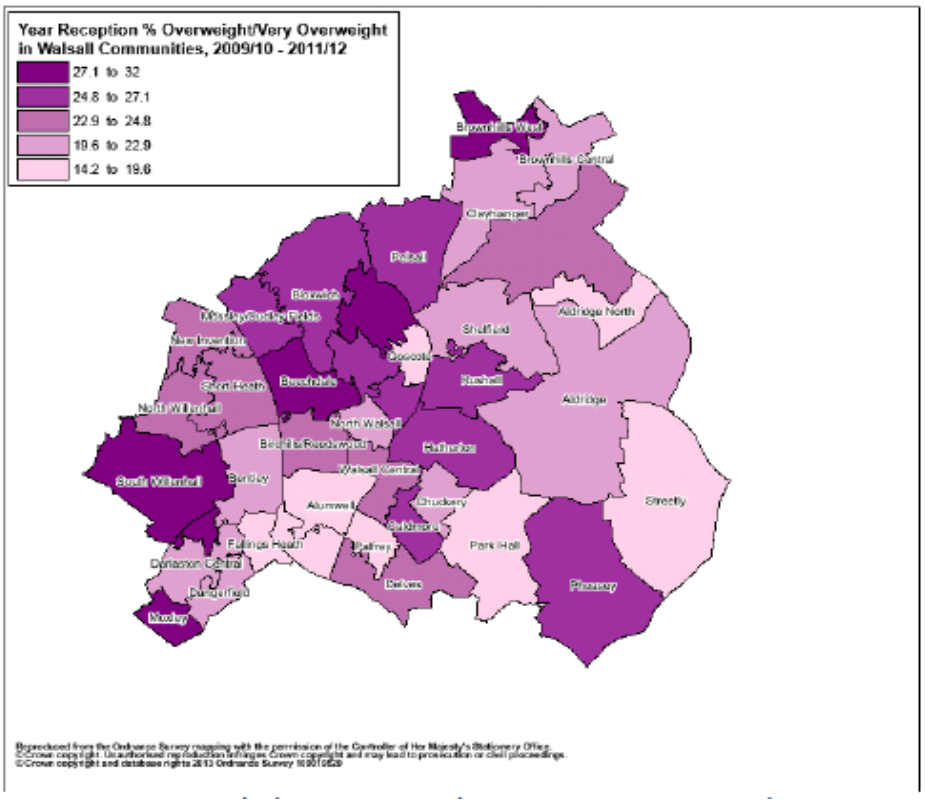
[21] *Text and data taken from Walsall JSNA 2013*

Figure 27: Prevalence of excess weight children (4-11 year olds) in Walsall, 2011/12 – 2013/14



Obesity is associated with social and economic deprivation; there is a particularly strong gradient nationally in children, with increased deprivation being associated with increased obesity. This is reflected in local childhood obesity data, as seen in Figure 27 below, which shows that obesity rates are higher in the most deprived wards in the west of the borough.

Figure 28: Walsall communities overweight/ very overweight at age 4-5, 2009-2012 (Source: National Child Measurement Programme)



[22]The key findings from the Healthy Weight and Physical Activity Needs Assessment (2015) state:

- The prevalence of obesity is higher in boys than in girls in all age groups except in Year 10.

- The prevalence of obesity between reception and year 6 more than doubles, this is similar for boys and girls, with the largest increase in boys (11.6% to 25.7%).

- In reception and year 10, slightly more boys were underweight than girls, whereas in year 4 and year 6 the opposite is true.

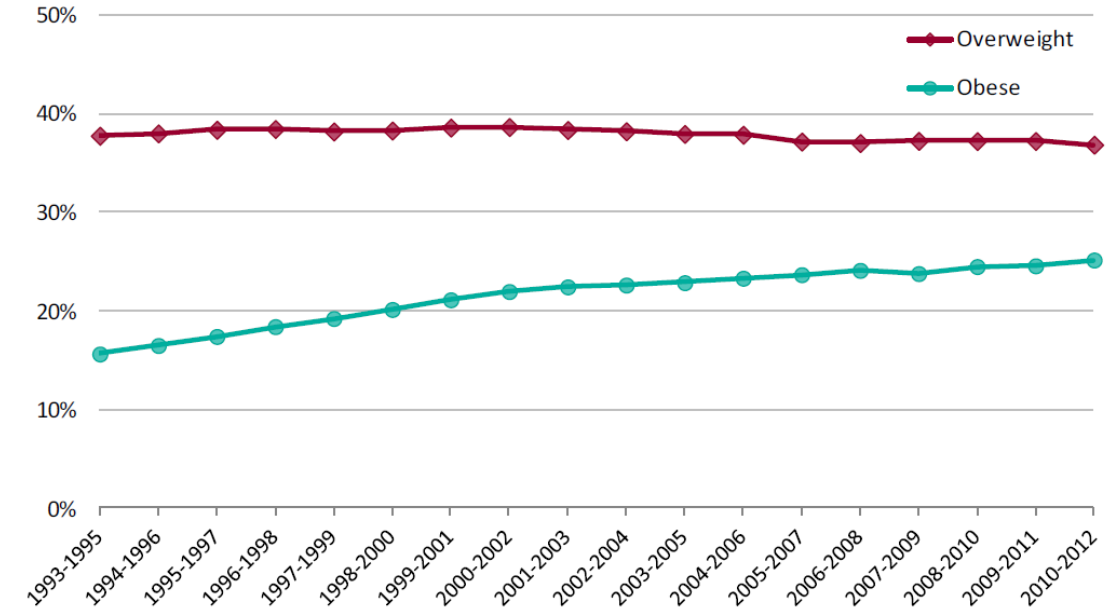
[22] *Data and text taken from Healthy Weight and Physical Activity Needs Assessment 2015*

Obesity in Adult Males

The Health Survey for England estimated in 2012, 62% of adults were overweight or obese. Local figures are more difficult to determine.

Figure 23 demonstrates the national prevalence of overweight and obesity among adults (aged 16 and over), 3-year moving averages, 1993 to 2012. It shows the prevalence of adult obesity continues to rise and has increased from 15% in 1993 to 25% in 2012. The prevalence of overweight has remained broadly stable during this time at 37-39%.

Figure 29: National prevalence of overweight and obesity among adults (aged 16 and over), 3-year moving averages, 1993 to 2012



Source: Health Survey for England

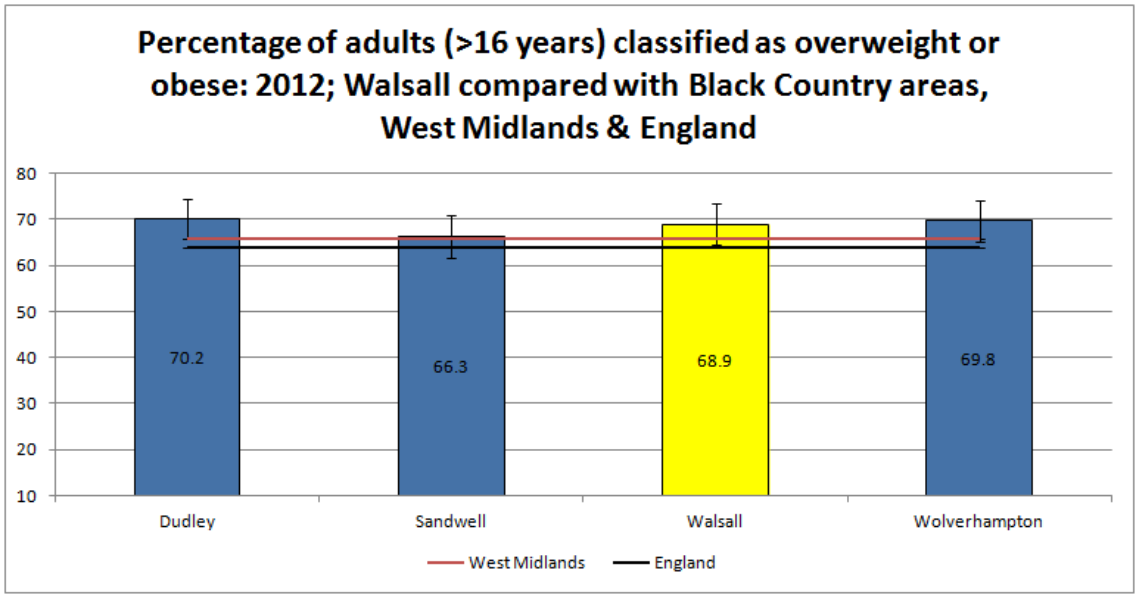
Figure 29 provides a national breakdown of weight status in recent years, based on Health Survey for England (HSE) data. It shows that in 2012 around 62% of adults were overweight or obese (BMI ≥25kg/m2); this equates to 57% of women and 67% of men. Men and women have a similar prevalence of obesity (25%), but men are more likely to be overweight (32% for women and 42% for men). The adult prevalence of severe obesity (obesity III: BMI ≥40kg/m2) is 2.4%, and the prevalence of underweight is 1.8%.

Figure 30: National weight status among adults (aged 16 and over)

		Underweight	Healthy weight	Overweight	Obese
2010 (%)	Men	1.3	30.9	41.6	26.2
	Women	1.9	40.4	31.7	26.1
	Adults	1.6	35.6	36.7	26.1
2011 (%)	Men	1.4	33.6	41.4	23.6
	Women	2.2	39.4	32.5	25.9
	Adults	1.8	36.5	36.9	24.8
2012 (%)	Men	1.3	32.1	42.2	24.4
	Women	2.3	40.6	32.1	25.1
	Adults	1.8	36.4	37.1	24.7

[23]The Health Survey data for England offers national statistics on adult obesity so local figures are more difficult to determine. To analyse data at a more local level we have analysed data from the Active People's Survey this data estimated in 2012 that adult overweight and obesity prevalence was slightly higher than HSE at 63.8%.

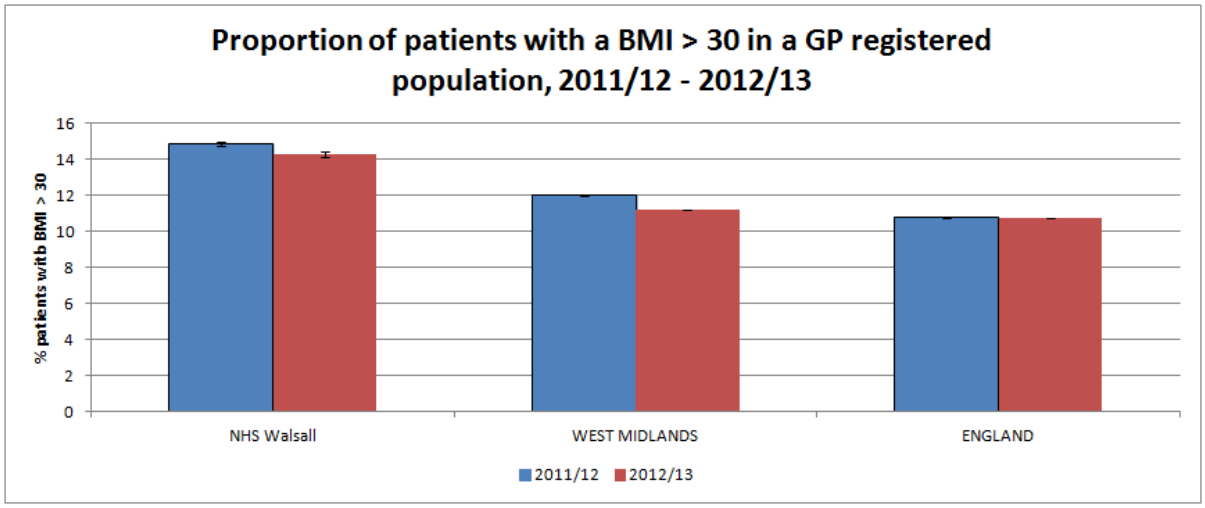
Figure 31: Prevalence of overweight and obese Adults in Walsall, Black Country areas, West Midlands and England, 2012



[23] *Text and data taken from Healthy Weight and Physical Activity Needs Assessment 2015*

In Walsall, the prevalence of overweight and obese adults are higher than the regional average (65.7%) and statistically significant higher than the national average (63.8%); however amongst the Black Country cluster Walsall has a lower prevalence than all except Sandwell.

Figure 32: Proportion of patients with a BMI > 30 on GP practice obesity register, 2011/12 – 2012/13



Datasource: Quality and Outcomes Framework, QMAS database

In Walsall 96% of the population are registered with a GP. In 2012/13, the proportion of GP registered patients with BMI > 30 in Walsall (14.3%) was significantly higher than the regional (11.2%) and national average (10.7%) however there seems to have been a significant decrease between 2011/12 and 2012/13 in Walsall which was also reflected in regional and national averages. The above data measure only patient's registered with a GP with a chronic illness and therefore is not reliable data in relation to the whole population and Walsall's obesity prevalence as highlighted above is likely to be much higher.

Summary and Recommendations

- Utilise the 'Your place, your wellbeing: Walsall household and lifestyle survey 2012' to establish robust baseline information to enable targeted and effective commissioning and delivery of weight management and physical activity interventions (Please see Appendix One)

- Improve identification, delivery of brief interventions and referrals from GPs and other frontline staff from a range of organisations and agencies through implementation of the 'Every Contact Counts' initiative

- Create and maintain an environment that promotes physical activity through planning mechanisms and policy development

- Implement robust pathways with key partners to identify and refer patients who will benefit most from specialist weight management services

- Work through planning mechanisms to limit the number of fast food outlets in Walsall, particularly in the vicinity of schools

[24]*Diabetes*

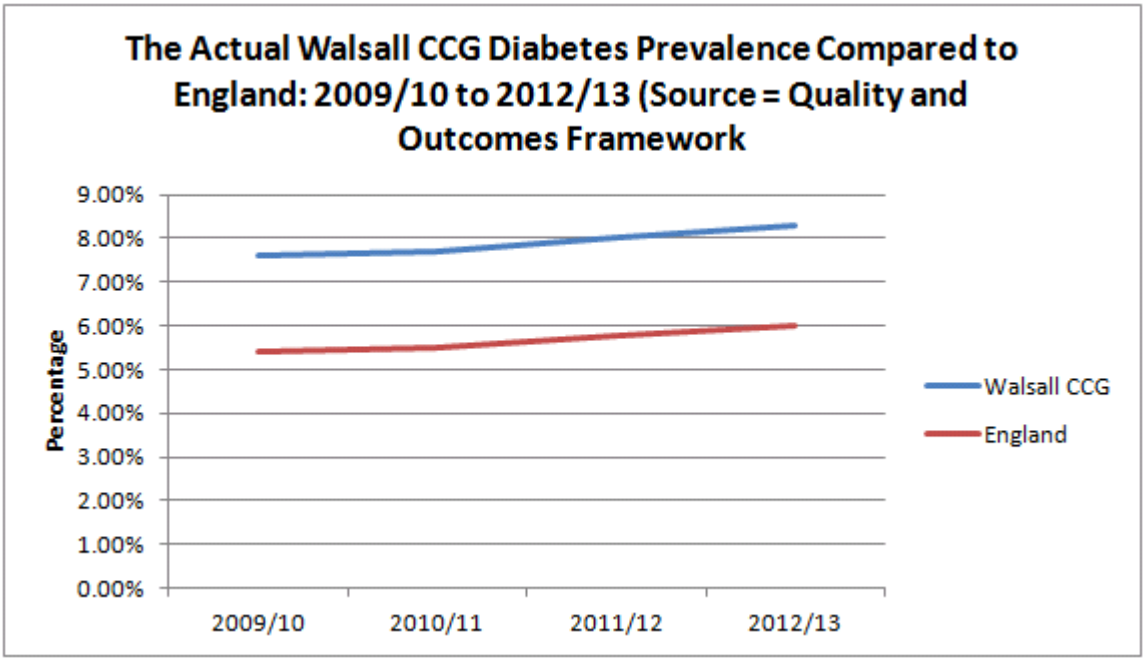
In Walsall, Diabetes continues to be a leading commissioning priority as Walsall has the 3rd highest Diabetes prevalence in England. Diabetes increases the risk of heart attack and stroke. In the 2012 – 2013 National Diabetes Audit (NDA), there are 16,913 patients registered as Diabetic patients in Walsall. Type 1 Diabetes patients total 1,094 and Type 2 Diabetes patients 15,499. This amounts to 6.62% of the total Walsall population of which Type 1 account for 0.43% and Type 2 6.05%, compared to an England total prevalence of 4.87%, 0.40% for Type 1 Diabetes and 4.38% for Type 2 Diabetes. Walsall population prevalence is higher than England.

This is partly due to population demographics with a relatively high proportion of patients from a South Asian background but also due to diet lifestyle, high levels of deprivation, high levels of obesity in Walsall and an increase in the elderly population. These are specific challenges for Walsall CCG.

Figure 33 below shows that Walsall CCG practices consistently have a higher adult Diabetes prevalence compared to England. During the four year period the Walsall Diabetes prevalence has increased from 7.6% in 2009/10 to 8.30% in 2012/13 – during the same period England's Diabetes prevalence has only increased from 5.4% to 6%.

[24] *Text and data taken from Walsall Diabetes Strategy 2014*

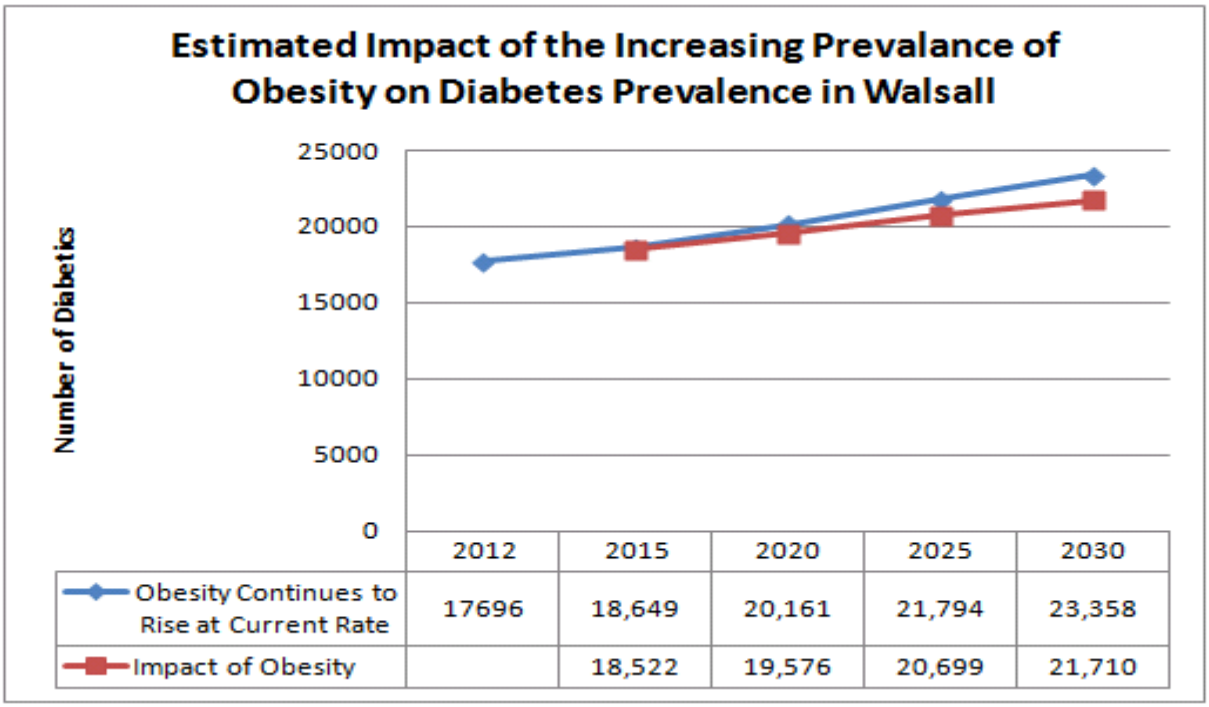
Figure 33 Walsall CCG Diabetes Prevalence compared to England



Adult Obesity Affect on Diabetes Prevalence

Across England about a third of the projected rise in Diabetes prevalence is attributed to the increasing prevalence of Obesity. If Obesity levels in Walsall could be maintained at 2010 levels there would be 585 fewer Diabetics by 2020. This is shown in figure 34 below. By 2030 a static prevalence of obesity would mean an estimated 1648 fewer people with Diabetes.

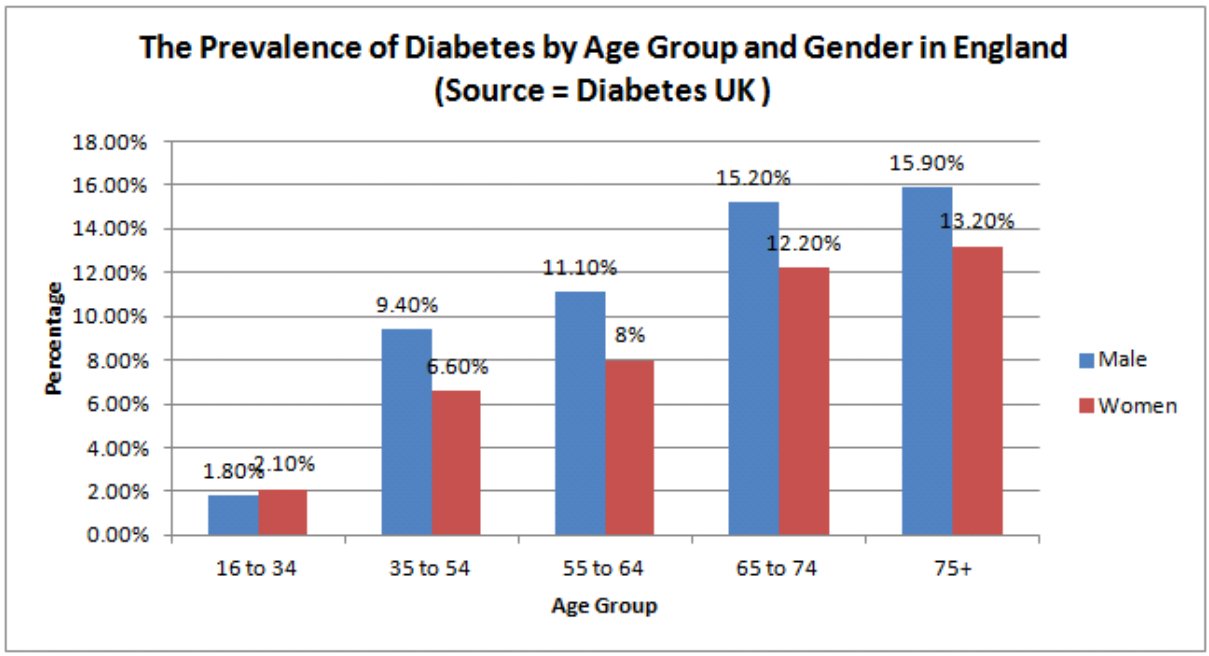
Figure 34: Estimated impact of increasing prevalence of obesity on diabetes in Walsall



	2012	2015	2020	2025	2030
Obesity Continues to Rise at Current Rate	17696	18,649	20,161	21,794	23,358
Impact of Obesity		18,522	19,576	20,699	21,710

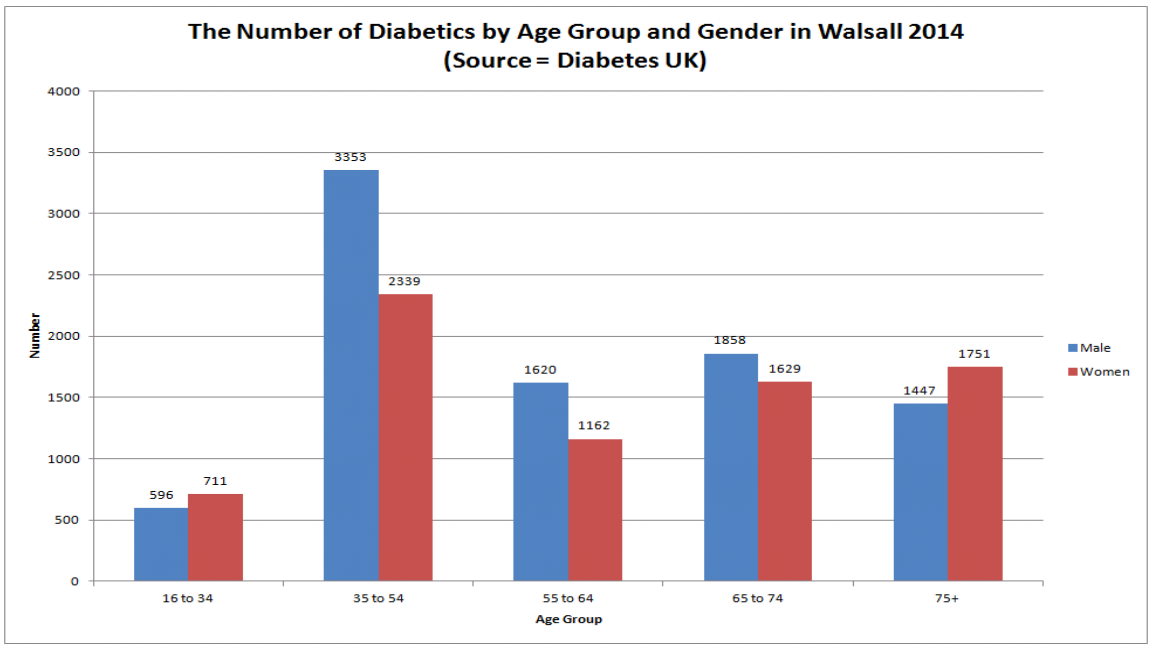
Diabetes Prevalence by Gender and Age Group

Figure 35 Diabetes prevalence for England by Age Group and Gender



We can see that the Diabetes prevalence for men is higher than the female prevalence in each age group over 35 years of age. If these prevalence figures were applied to the Walsall adult population then the numbers of Diabetics in each gender and age group would be the same as in Figure 36 below. For example the most diabetics would be in Walsall men aged between 35 to 54 years.

Figure 36: The Number of Diabetics by Age Group and Gender in Walsall 2014



Summary and Recommendations

In summary, Walsall's performance in Diabetes care is variable - broadly comparable to national average in some areas, but below average in others. We want to do better - and with motivated healthcare professionals and patients, we know we can.

We have identified the following areas for Improvement and action:

- All GP practices should use computer systems to target those at risk of diabetes and implement prevention interventions.

- There is evidence that lifestyle interventions can make a significant difference in the prevention of Diabetes in some patients and delay the onset of Diabetes in others. This should include a specific target of Walsall men aged 35-54.

- The NDA shows only small proportions of newly diagnosed patients are being referred to education programmes. All practices should pro-actively encourage and make referrals as this will lead to better patient self-management.

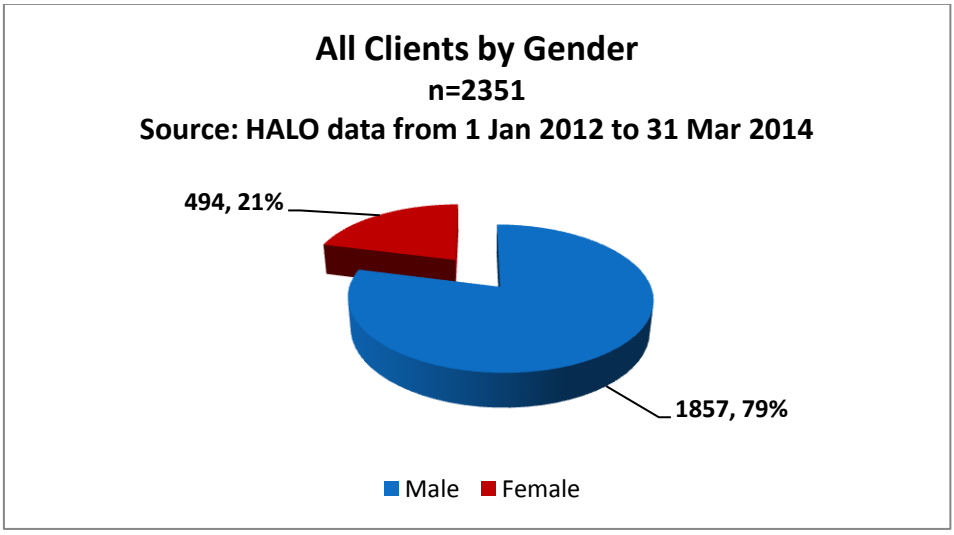
- The NDA also highlighted areas for improvement within the eight key care processes. These include better screening for: feet, retinal, micro albuminuria and recording the patients smoking status.

Substance Misuse

Drugs

[25]The typical adult drug service user in Walsall is male (79%); white British (77%) with the next highest represented groups being Indian (4%), Pakistani (4%) and white/black Caribbean mixed heritage (3%); 52 % are parents with a third with dependent children living with them; the largest cohort fall within the 25 – 34 age range (47%) followed by 35 – 44 range (27%). There has been an increase in the last 12 months of 18 – 24 year olds in treatment from 17% to 21%; the primary drug used is heroin (54%) followed by cocaine (16%) and cannabis (13%); 11% of service users are injecting and 22% have previously injected; 18% are in regular employment and 63% unemployed; 66% have no accommodation issues with 11% having housing issues of which 2 service users each month present with urgent housing needs. Three out of four individuals (79% n=1857) receiving interventions in adult treatment services were male which is also reflected within the latest twelve month period.

Figure 37: All adult drug service users by gender



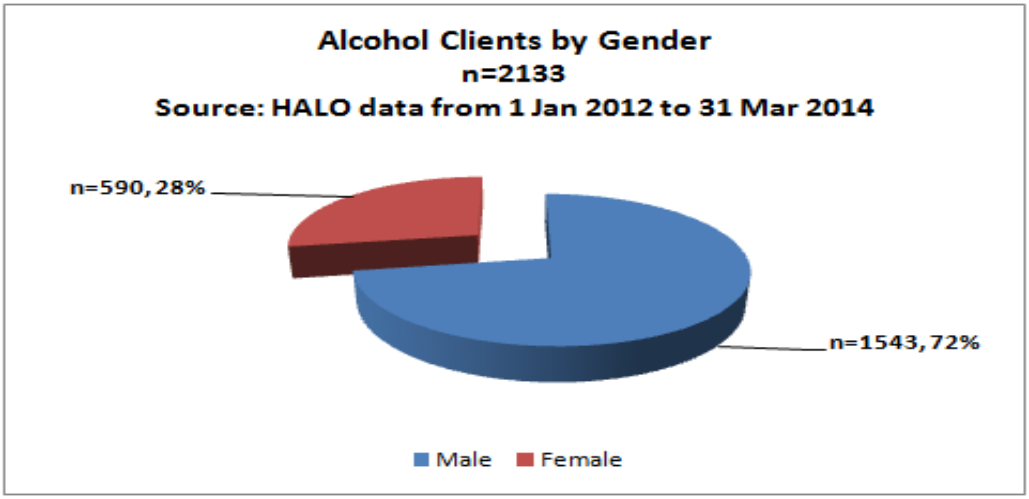
[25] *Taken from the Public Health Walsall 2014 Substance Misuse Needs Assessment*

Alcohol

[26]The typical adult alcohol service user in Walsall is male (72%); 72% falling within the 25-54 age categories; white British (85%) and Indian (5%) being the second highest group. The highest volumes of referrals come from Health Services (37%) and self referrals (35%), followed by criminal justice services (11%). In addition to primary alcohol use secondary drug use includes cannabis (45%) and cocaine (25%).

In 2013/14, of the 937 alcohol clients in treatment, 670 (72%) were male with 267 (28%) females. The figures are exactly reflected in the data for the longer period 01/12 to 03/14.

Figure 38: Alcohol clients in treatment by gender



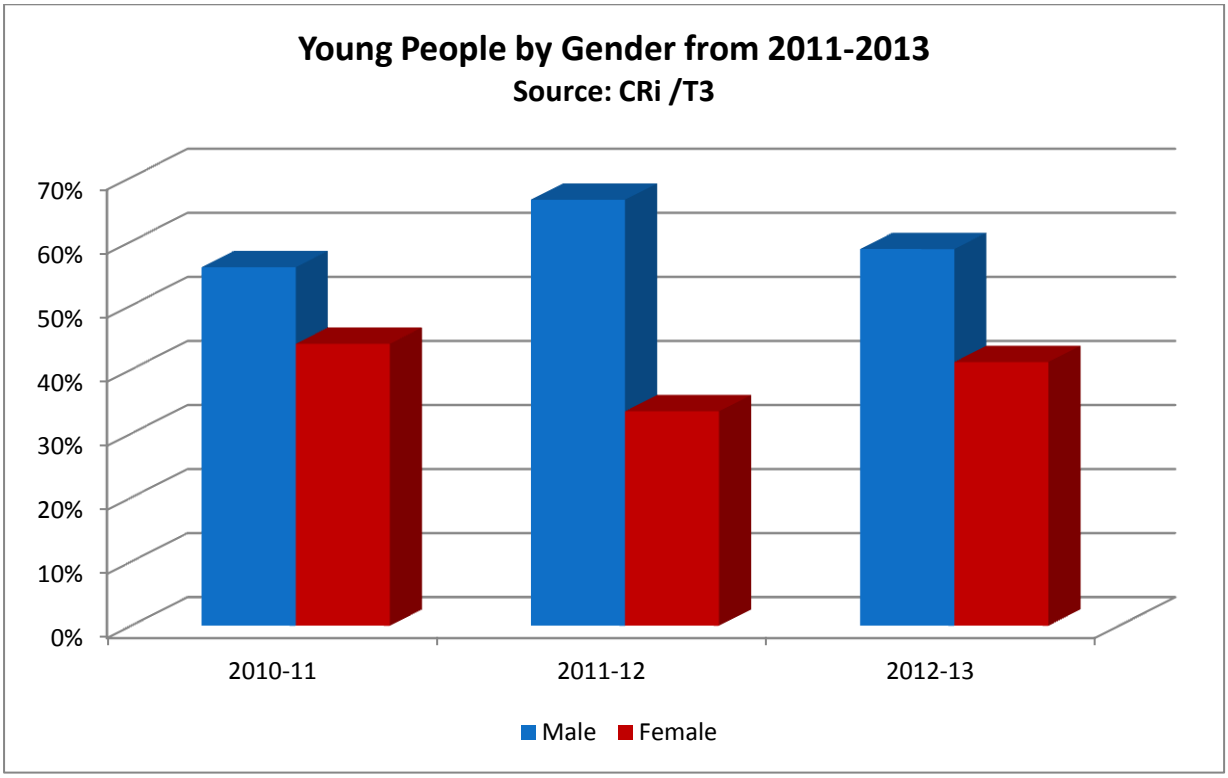
[27]Young Adults and Young People Substance Misuse

In the under 25 cohort (aged 19 – 25 years), in comparison to the total adult cohort, there are slightly higher rate of male (80%) to female (20%); referrals are low for 18 year olds, who may still be seen in the young people's service, with an upward trajectory of referrals from 19 years peaking at 23 years; fewer are unemployed (52%); fewer are parents (25%); there is higher rates of primary cannabis use(29%) and alcohol use(26%) followed by cocaine (22%), lower rates of heroin (13%) with lower rate of injecting (3%) and never injected(68%). In comparison to the full adult cohort there is no significant difference in; ethnicity and accommodation needs. The highest referral source is criminal justice agencies (53%) in comparison to 36% in the full adult cohort. During the three year period 61% (n=380) of those in structured treatment have been males. In the latest twelve month period the balance has shifted downwards slightly to 59%.

[26] *Taken from the Public Health Walsall 2014 Substance Misuse Needs Assessment*

[27] *Taken from the Public Health Walsall 2014 Substance Misuse Needs Assessment*

Figure 39: Young people engaged in substance misuse treatment service



Summary and Recommendations

- Ensure young people have the knowledge and confidence to resist pressure and recognise risks of controlled drugs, New Psychoactive Substances (NPS) and alcohol through health promotion work in schools

- Develop and implement the use of the young people's Drug Use Screening Tool across all young people's services

- Further Integrate Health Promotion services and the Making Every Contact Count (MECC) programme to train partner agency staff to identify and deliver appropriate Brief Advice interventions to maximise opportunities to influence behavioural change

- Mainstream and develop further the Alcohol Liaison Service working between the hospital, primary care and specialist community alcohol services

- Increase the available opportunity for detoxification, in the community and in-patient residential settings, to support individual's recovery

- Maintain Walsall's good performance of people swiftly entering the treatment system and successfully exiting substance misuse treatment services

- Establish more robust support networks services to those who have exited treatment to sustain their recovery

- Maintain the strong support that substance misuse treatment services offer to the criminal justice system

Male Health Perception & Feedback

[28]The Men's Health Forum (2014) carried out some research on Male understanding of Health and Access to Services. They focused on health literacy, access to services and attitudes to health. Below is a summary of their findings:

- Men have lower levels of health literacy than women. With men twice as likely to have inadequate health literacy.
- Men are less likely than women to use a general practice or visit a pharmacy - in persons aged 20-40 women attended a general practice twice as often.
- Men are less likely than women to acknowledge illness or to seek help when sick.
- Health is often socially constructed as a feminine concern

Here is an extract from the findings on male attitudes to health:

> Many men appear to legitimise health service usage, only when a perceived threshold of ill health has been exceeded. There is also a tendency amongst men to play down symptoms or to view potentially serious symptoms as simply signs of growing old.
>
> Fear surrounding the potential loss of masculinity may result in a façade of control and stoicism, instead of honesty about reporting symptoms and accepting interventions, or openness about feelings and insecurities associated with particular illnesses (Reference: A. White).
>
> A King's Fund study that looked at four behaviours – smoking, drinking, diet and exercise – found that men were more likely to participate in a combination of risky behaviours. There was a social gradient with unskilled men most likely to have three or four risky behaviours. (Reference: Kings Fund).

The walsall Lifestyle Survey 2012 provides a snapshot of male self reported quality of health and self reported quality of health by age (Figure 40 and 41). However to truly understand the health perception of the male population in Walsal, taking into consideration the above findings, further research is required.

[28] *Text taken from Men's Health Forum 2014*

Walsall Lifestyle Survey 2012

Figure 40 Self Reported Quality of Health by Gender: Walsall Lifestyle Survey 2012

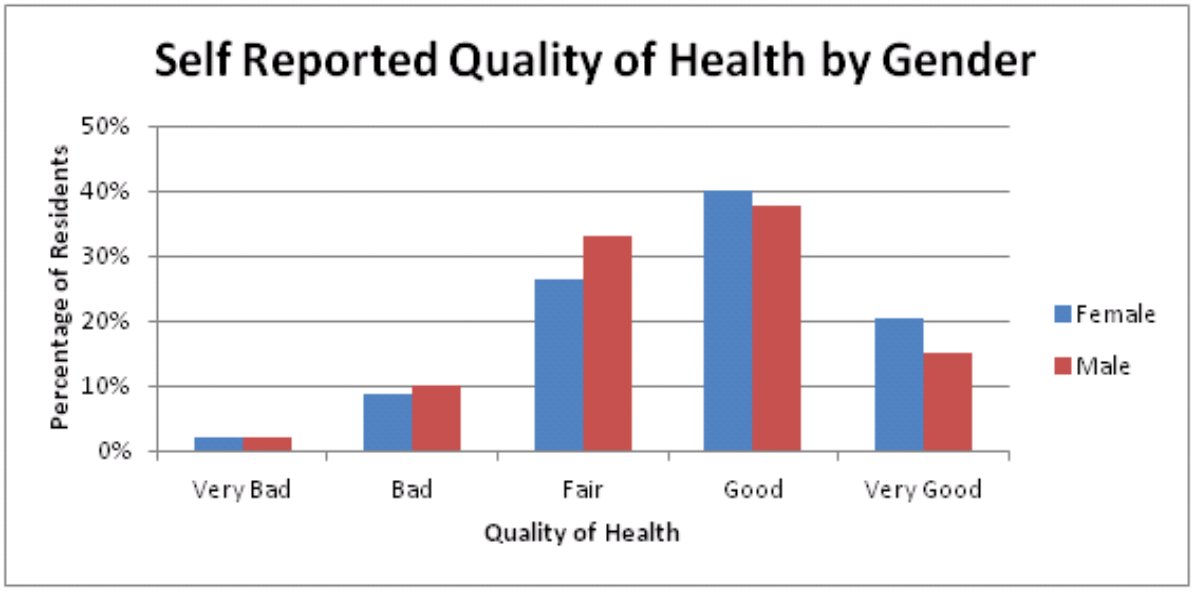
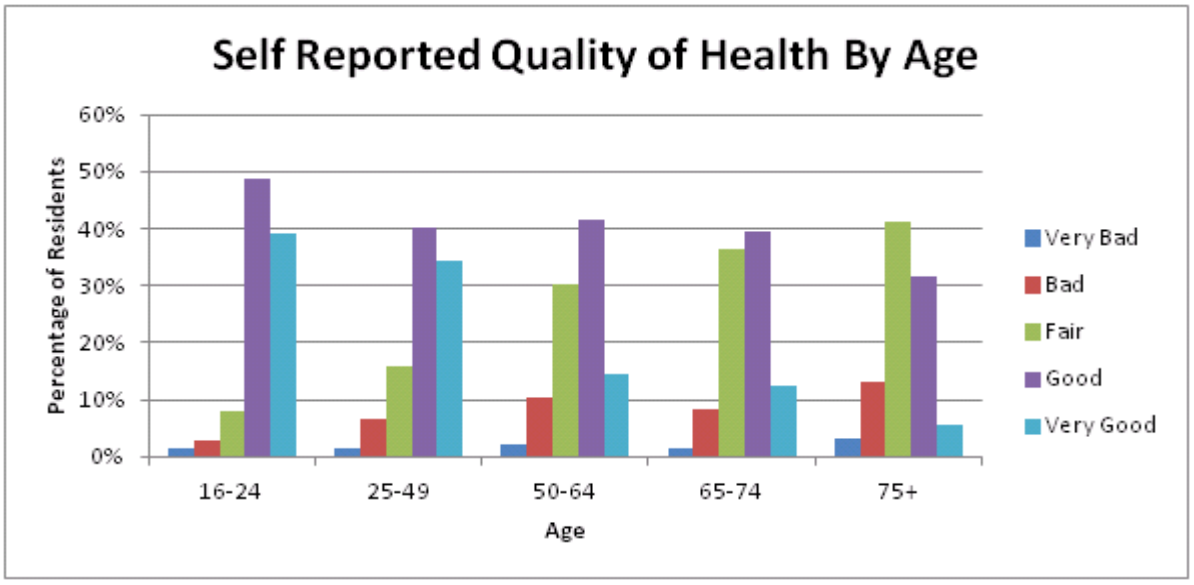


Figure 41 Self Reported Quality of Health by Age: Walsall Lifestyle survey 2012



Appendices

Appendix One- Case Study

Case Study - Walking football

An excerpt from a case study by BSc Public Health Student Chipo Nduna

Walsal's Walking Football Team was introduced in 2014 by Martin Berry one of the Health Champions in Walsall, working together with the Health and Wellbeing team to extend health in maturing men to keep them healthier for longer. Walking football helps to improve the Cardio vascular and Respiratory system as well as increase muscle mass and core body strength. It also assists with weight loss - this was emphasised by all men in the team.

One of the team members said "I heard about walking football when I was in Hospital suffering from a long term illness. Due to my condition I was advised to lose weight but I found it too difficult to follow the advice which I was given. In the end my situation got worse and I found myself in hospital. That is when I was told about the walking football. I contacted Martin (the coordinator of the programme) and he told me where they meet.

To tell you the truth the moment I stepped out there after spending forty five years without kicking a ball, my memory went back to when I was seventeen. Emotionally I started to feel like a seventeen year old again. This motivated me a lot because I was given a chance to do what I enjoyed.

The first time I attended the Walking football I could barely walk. Now I am happy that I can kick the ball and I am able to move fast. My breathing has improved as well. The four months I been here I have lost a lot of weight and I am able to control my long term condition. This is an important thing I have done to join the Walking football. I am losing weight doing the things I love and I am not stressed like before. If it was not for this Walking football, I probably was not going to be here right now."

Another member said "most of the people think that we are just a group of old men playing football but as for me I have benefited a lot. I have lost weight and am controlling my diet. After every session, we are provided with healthy information. , I do not feel depressed anymore. I have also managed to build a good relationship with my grandkids because I can go out and play with them when they visit me. Whoever, would have believed that at my age I could wear a Walsall football jersey, representing Walsall, this makes me proud."

Appendix Two - References

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