Sandwell
Metropolitan Borough Council

Public Health

A Life Course

Annual Report 2013 | Sandwell Director of Public Health

Contents

Sandwell Public Health – a life course

First thoughts


Dr John Middleton

I'm calling my final annual public health report 'A life course'. Sir Michael Marmot has generated a lot of interest in the life course approach to public health inequalities through his report, 'Fair Society, Healthy Lives'. In this report I will reflect on some aspects of health inequalities over the life course. I will also use the Sandwell public health experience to show ways in which we can influence health at different stages of life - for better or for worse.

Sir Dugald Baird, the famous Scottish obstetrician and influential thinker on the causes of poor health of infants, believed that outcomes were heavily influenced by the health of the mum-to-be during her 'growing years' – poverty, poor housing and poor diet being major factors for the mother, influencing the health of her offspring.

The 'Barker hypothesis' is another important contribution to the idea of life course influences on health. Barker's 'Foetal Origins Hypothesis' proposes that coronary heart disease, and long-term conditions related to it, stem from responses to under-nutrition during foetal life and infancy. Barker showed that the lower the weight of a baby at birth and during infancy, the higher the risk of coronary heart disease in later life. Recent findings have shown that a woman's body composition and diet at the time of conception and during pregnancy have important effects on the subsequent health of her offspring. The risk of later chronic disease is further increased if a baby has low weight gain after birth so that at two years it is thin or stunted. After the age of two, rapid gain in fatness further increases the risk of later coronary heart disease, hypertension and type 2 diabetes. These findings point to the importance of:

- protecting the nutrition and health of young women before and during pregnancy
- protecting the growth of infants
- avoiding rapid increase in fatness after the age of two years (especially in children who were thin at around two years of age)

As part of the strategy to prevent chronic disease in later life. We can therefore see that 'from womb to tomb' influences at one part of the life course affect outcomes further down the road.

I have written 24 annual public health reports in my 27 years in Sandwell (they were only required from 1990). I have spent most of my professional and, indeed, personal lifetime in Sandwell – so it is for me an education, *a life course*. I will reflect on some of the things I have learned here.

Some significant anniversaries

2014 is a year of some significant anniversaries.

1914 – the start of the First World War.

You don't need a doctor to tell you war is bad for your health. There is very little to be celebrated about the human wastage of this clash of ageing empires. We should celebrate the gains made by the suffragettes in improving the rights of women, including the vote. And there were gains made by working people, albeit slowly. But there is still a long way to go, 100 years later, in securing equality of opportunity on all counts, especially for women. There were, however, a number of public health successes at that time that we might still learn from today – and celebrate and perhaps work to bring back.

National food policy – food rationing

Food rationing in both World Wars was not remembered with any affection by the survivors. But for the only times in our history there was a national food policy. There was some food for all children, instead of all food for some children. More children therefore survived infancy and past the age of five. The major influence on life expectancy is survival of children so life expectancy improved.

The children born in the time of food rationing were better nourished and grew stronger. There was generation-on-generation health improvement with babies born larger and surviving to their first birthday and beyond. Babies born in the years of the Depression from 1929 to 1934 were immunized against austerity to a degree by improved nutrition of their mothers during their grooming years. As Sir Dugald Baird observed:

> *'preventive measures required in the lower income groups are better diet and living conditions in the growing years... the results cannot very easily be seen or appreciated by those engaged because it takes a generation for them to show their full effects. Great progress has been made in Britain along these lines and one of the striking features of the war years was the rapid fall in the stillbirth rate which was much too sudden and too great to be explained by advances in obstetric technique.'*
> **Baird 1952**

Free school meals

The national food policy was enhanced in 1916 when free school meals were brought in, enabling nutritional standards to apply to what children ate.

We see this now as 'too expensive', or 'the nanny state'.

Dig for victory

And food policy made us 'dig for victory'. There was a rebirth of interest in community agriculture, food growing, horticulture and smallholding.

We now need to dig for victory in our war against climate change and our struggle for self-sufficiency. We have to become more self-sufficient in food production, more resilient in our carbon management (so reducing 'food miles' – the distance our food travels 'from plough to plate') and more resilient against outside threats of food shortage and rising prices.

I recommend Sandwell builds on the outstanding pedigree of its community agriculture projects and seeks to grow more food in more venues, involving more people and more communities.

The council cannot be expected to be the sole source of funding for this and current initiatives need to become more self-sustaining.

However, local agencies such as the council, Clinical Commissioning Group (CCG), police and others must recognize the great strength and resource Sandwell has in this area. They should support the potential for such projects as part of neighbourhood management; early help for children and adult social care clients; and recovery and therapeutic horticulture.

Venereal Diseases Act 1917

This directed councils to provide free and confidential treatment and imposed legal penalties for failing to maintain confidentiality. This had been on the cards from a Royal Commission begun in 1913 but became imperative because of the damage being done to the war effort and the economy from sexually transmitted diseases (STDs). Today, therefore, those clinical interests concerned that local authorities have 'never done GU Medicine' should think again. There is no reason why local authorities shouldn't commission STD services and do it well. In Sandwell's case the Cabinet Member is strongly committed to good genito-urinary medicine services. It is vitally important that treatment services are commissioned with strong health advisory services for contact tracing. These are clinical services. However, they are also preventive services interrupting the transmission of infection. In addition, we need to maintain and develop effective public and schools education programmes, including peer education and effective contraceptive and emergency contraceptive services ('morning after pill').

The fact that Sandwell now has a high incidence of HIV is a cause for concern and a call to action. In line with National Institute for Health and Clinical Excellence (NICE) guidance, Sandwell should now instigate routine and widespread opportunistic testing for HIV in clinical settings such as general practice, accident and emergency and other hospital settings. Sandwell people are presenting later with HIV and therefore giving themselves less chance for anti-retroviral drugs to work at their best. In other parts of the country patients present with much lower viral loads and can be treated more effectively.

Licensing and the Defence of the Realm Act 1914

Licensing restrictions came in to limit the hours people could drink. This was to keep munitions workers, among others, sober for the war effort. Restrictions stayed in place almost to the 2003 Licensing Act. Many now feel that Tony Blair's vision of a continental café culture simply hasn't been possible. There are calls for a review of the country's licensing laws. Other restrictions on licensing might include stronger enforcement, extra licence fees for extended hours or a straight return to limited hours.

I recommend that Sandwell should continue to lobby for minimum unit pricing of alcohol. Sandwell should explore the possibility of a local minimum unit price.

I recommend Sandwell s hould expand the use of its LINX system for recording where patients attending with alcohol-related injuries have had their last drink. This data should be used to inform re-licensing decisions.

Sandwell should also look at a late licensing surcharge as other authorities are doing.

A more recent landmark: 1974

Sandwell Metropolitan Borough Council was formed then Public health was removed from West Bromwich and Warley councils and taken into the National Health Service. It was placed under Sandwell Area Health Authority. It was called community medicine and was led by the District Medical Officer, first Hugh Bryant and then Mike Harrison. Here it was to stay for 40 years, nine national statutory re-organisations and more than eight local re-organisations. Now public health has come into Sandwell Council... for how long this time?

1984 is another significant anniversary – the miner's strike

Professor JRA Mitchell, a heart specialist from Nottingham, said at the time, in a *British Medical Journal* editorial:

"Britain is currently witnessing two uncontrolled mass experiments in social isolation and life stress in the shape of our three million unemployed and the conflicts between working and non-working miners, which will produce lasting bitterness for them and their families within previously tightly knit communities. Can we ensure that the medical consequences of the resulting life stress and social isolation will be properly documented?… We must now include life stress and social isolation among our prognostic markers, and try to find out how pain, pleasure, hope, or fear is the cause of an agitation whose influence extends to the heart."

Sadly, Professor Mitchell's appeal for better prospective study was not realised. But a 2009 *BMJ* paper concluded that we were not seeing as much reduction in heart disease in the under-65s in poorer social classes in Scotland.

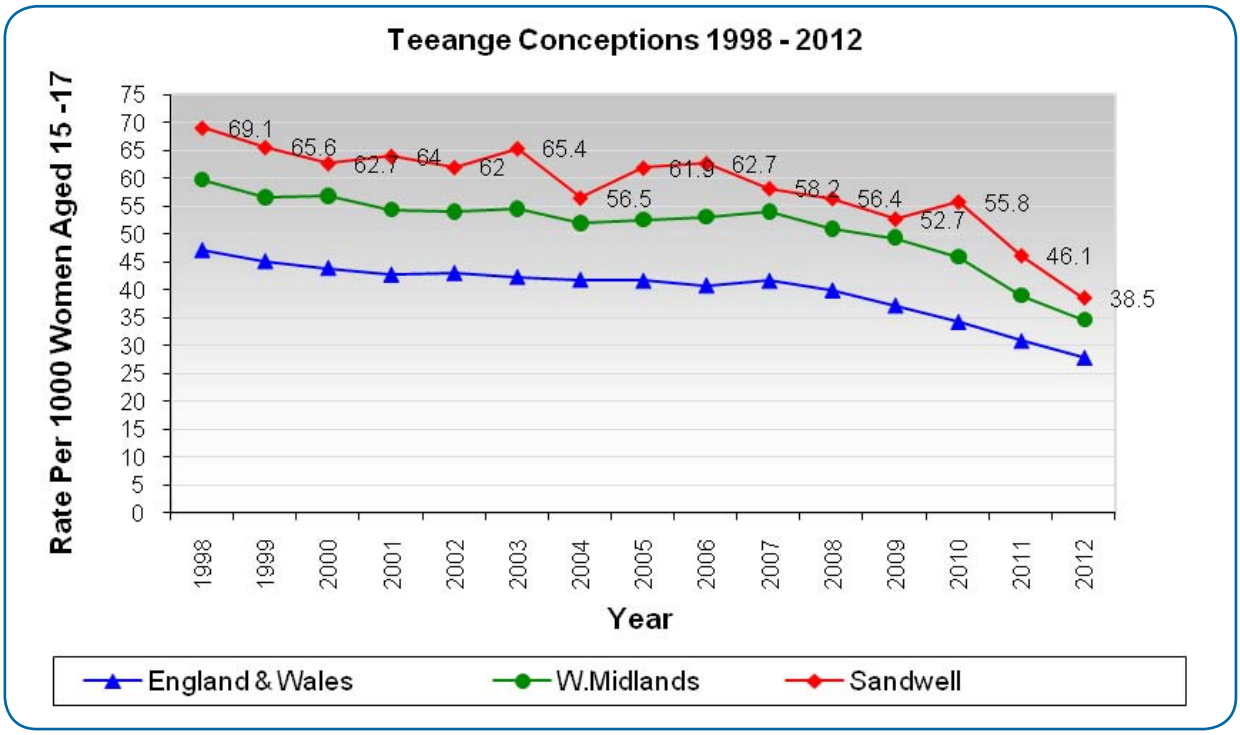
Economic deprivation in one generation will have an impact on people's health for many years, and ultimately result in their untimely deaths. It should be compelling enough evidence to put our potentially lost one million young people back to work now for their own good, for the good of our community safety and for our nation. If we don't, we might simply heap a burden of ill health and early death upon them and society in 30 years' time. Surely this makes it all the more urgent that we get people back to work.

2014: The life course – what then are the main lessons in this annual report?

Teenage pregnancy: a remarkable success

Teenage pregnancy has fallen again in Sandwell – to 38.5 /1000 under-18s. (Figure 1). This is a 44% fall since 1998 and means each year there are about 125 fewer pregnancies to teenage girls. The gap is also closing with the national rate. This is a major achievement. It is testimony to a visionary national policy of the last Government. It is also testimony to a prolonged, patient and concerted local effort. In 1998 the target was to reduce teenage pregnancy by 55% – there was no scientific evidence to back it up. It was a political ambition. Not fully delivered perhaps, but if it had not been there, we would not have achieved so much.

Figure 1, Teenage pregnancies in Sandwell, West Midlands and England & Wales



And it was backed by a compassionate aspiration – that the cycle of having babies at an early age should be broken generation on generation. The Sure Start programme of early support for children and families, the Sure Start Plus support for teenage mothers and the Sure Start maternity grant were all evidence-based measures designed to give newborn babies in deprived areas a better start in life and to help teenage mothers get by with greater social support. Sandwell's early efforts at multi-agency working to support young parents and children started before 1997. The multi-agency centres ('MACs') in Tipton City Challenge became family education and training centres (FETCs, 'Fetishes') and they became Sure Start and Children's Centres.

In 2006 the Cabinet Office Neighbourhood Support Unit was beating us up for failing to reduce teenage pregnancy. Sandwell public health and children's commissioners produced a groundbreaking analysis that suggested educational achievements, particularly for boys, were crucial in determining the risks of teenage pregnancy for local girls. Poorer educational outcomes – more pregnancies. We also plotted the likely timings of conceptions, which suggested May to July in the academic year 11 and after September in year 13 were big risk periods. There was an immense drive for better exam outcomes, encouraged by:

- keeping children at school for a period up to the exams
- academic coaches ('ACES')
- just providing the sheer damn determination that children would do well at school and that deprivation was not a justification for poor educational achievement.

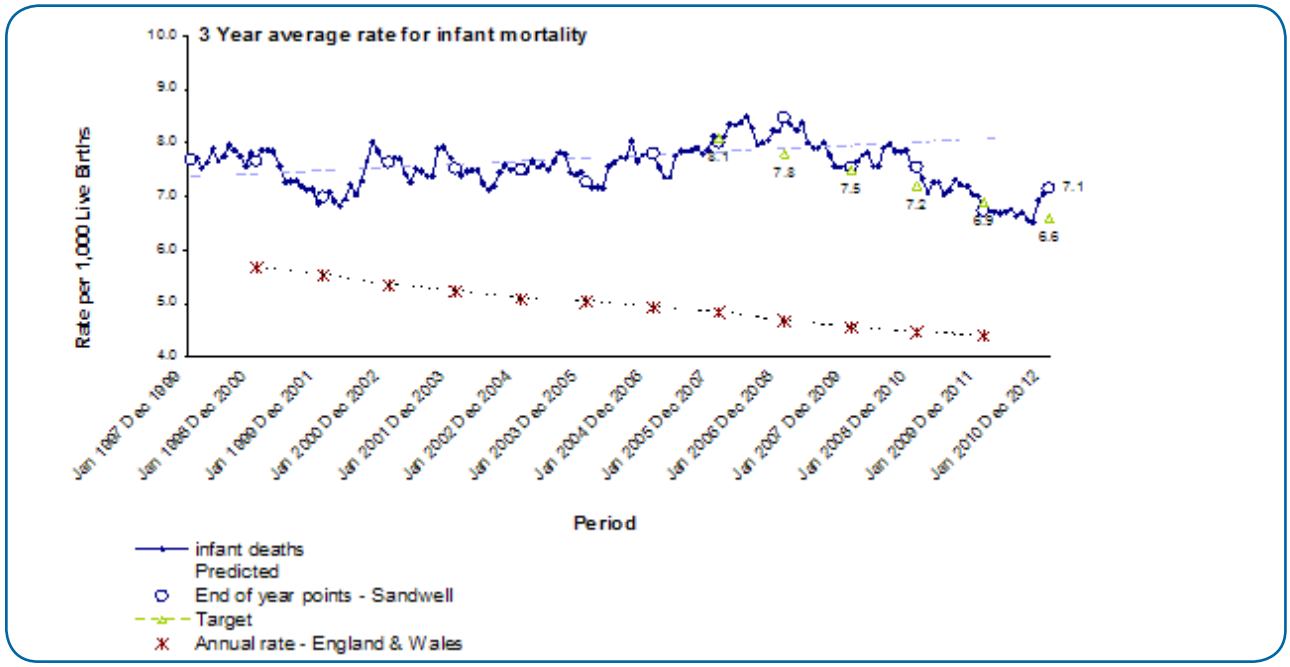
A massive improvement in exam results took off from 2007 and the teenage pregnancy rates began to fall.

In the height of recession we expected the rate to start to increase again. It hasn't. Our children seem to have been insulated to a degree. I believe the cycle of teenage mothers having babies who grow up to become teenage mothers has been interrupted by the visionary caring policies of the late 1990s. This has been combined with rising expectation of successful outcomes and ambition for our young people in education. We have also implemented some excellent services in health settings, Young People Welcome, peer education and sound personal social education (PSE) through teachers and school nurses, and contraceptive and emergency contraception services. Sarah New, Cindy James, Anna Kaur and Janine Brown were instrumental in making teenage pregnancy services effective.

Infant mortality: sadly unimproved, more work to be done

Infant mortality reduced sharply in the mid-90s because the 'Back to Sleep' campaign prevented many cot deaths. There is still a lot which can be done about cot death through safe sleeping. Parents stopping smoking is about the biggest. Not sleeping on sofas is another. Sleeping in a cot and not in the parent's bed is another. All in addition of course, to 'Back to Sleep'. This is still promoted locally now under the 'safer sleeping' campaign, which has seen a decrease in cot deaths.

Figure 2, Infant Mortality (Age<1 year) in Sandwell, 1999 to 2012



There was a suggestion of improvement from 2009-2012, but with a small upturn at the end of the period. Overall, infant mortality has not made sustained improvement in Sandwell in contrast to the fall of about one quarter in the national rate.

This is despite concerted efforts at several points in Sandwell's history:

- the Perinatal Institute's drive on intra-uterine growth retardation and delivering babies prematurely in order to prevent failure to thrive in the womb
- the review of obstetric services in Sandwell and City hospitals after the Royal College of Obstetricians declared Sandwell unsafe in 2007-08
- the resultant service reconfiguration of higher risk maternity care on the City hospital site, with low-risk midwifery-led units at Halcyon and Serenity.

I have great confidence that the reconfiguration can give better outcomes for newborn babies for Sandwell and western Birmingham in time.

I believe that senior midwifery staff are bringing about a sea – change in the culture of birth towards preventive and health promoting models. There has been a considerable fall in the numbers of Caesarian births – from a staggering 33% in 2008 down to a more acceptable 12% currently.

But there is much more to be done. We must:

- double the number of mothers breastfeeding by eight weeks – and that means much higher rates of mothers breastfeeding when they leave hospital or the birthing units
- stop parents smoking during pregnancy and after
- identify and control domestic violence in pregnancy – a major known risk affecting one in four or one in five pregnancies and causing untold damage to mother and baby
- encourage the uptake of the Halcyon and Serenity suites for births that are of low risk – normalising and de-medicalising childbirth as much as possible for generations to come.

We have had over 10 years of the Perinatal Institute's drive to identify failure of growth in the womb and to deliver babies early when they fail to grow.

The strategy has largely failed to deliver any major improvement in infant mortality, certainly for Sandwell babies. There are reasons to believe that early delivery of babies might add to the infant death rate – if babies are brought out alive but do not survive more than a few days or even weeks. In addition, the Growth Restriction Intervention Trial suggested that babies who were developing slowly in the womb should be left there and allowed to grow at their own pace, certainly up to the 34th week.

In the CD of this annual report I have included a presentation from 2009-10 data on infant deaths by a range of different risk factors.

Two-thirds of all Sandwell infant deaths occurred in pregnancies under 34 weeks.

Two thirds of infant deaths occurred in babies under 2.5 kgs at birth.

There were the expected peaks of infant deaths to mothers under 19 and over 35.

Low birth weight makes up around 10% of all births – and is very strongly associated with maternal smoking. High birth weights are likely to be associated with obesity and diabetes.

The deliveries before 34 weeks may have been inevitable and emergencies or they may have been planned in accordance with clinical protocols.

None of the data described above is available now. There is an urgent need to secure linked data for antenatal care and care in the first year. The chaotic destruction of data sources, data collection and data sharing agreements following the 2012 Health and Social Care Act must be reversed as a matter of great urgency.

There is very recent British Medical journal evidence that improving the quality of diets in pregnancy to include more fresh fruit and vegetables may be beneficial in reducing the risk of macrosomia – high birth weight over 4kg. These babies make up 11% of US births but contribute more than a third of obese children at the age of 11. Advice to eat more healthily in pregnancy still makes sense. We have to ask why the experience of poor outcomes for newborn babies is still worse in the West Midlands than elsewhere – we have looked for factors in obstetric care and there are doubtless still improvements to be made. But it is also the case that the West Midlands has the highest level of child poverty in Western Europe. It is also the fattest region in the country. These two factors are related, and are known major influences on the outcomes of pregnancy. We need to revisit these as causes of poor outcomes of pregnancy in the region and we need to do more to address both.

I recommend Sandwell reviews its clinical policies for management of failure of growth in the womb.

I recommend this review be undertaken for the conurbation as well if this can be agreed and organised rapidly.

I recommend that the review should involve externally commissioned experts with a national or international reputation.

We need a new strategy for improving outcomes for pregnant mothers, newborn babies and their families.

Cardiovascular disease: astonishing improvements but more gains to be made

The decline of heart disease as a cause of death is astonishing – as shown for under-65s deaths in Figure 3 and under-75s since 1996 in Table 1 .

Figure 3, Direct standardised mortality for CVD under-65s, 1984-2012

264 deaths down to 62!

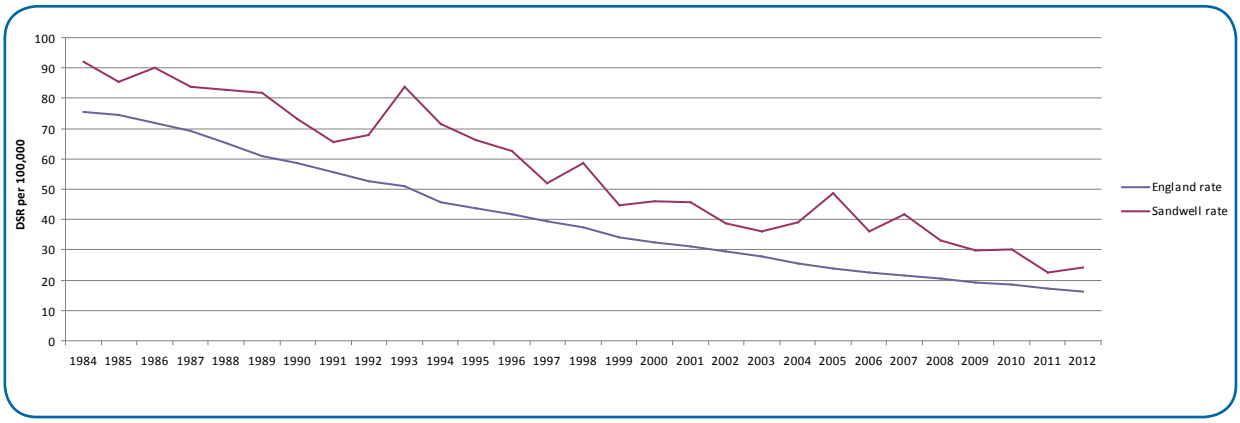


Table 1, Deaths from cardiovascular disease since 1996. Standardised death rates per 100,000.

CVD <75 DSR	1996	2003	2012
Sandwell number	593	381	214
Sandwell rate	187.45	125.13	68.74
England number	71,003	49,792	33,258
England rate	135.91	93.46	56.02

Sandwell mirrors the national trend, but death rates have fallen 5% faster than nationally: we are narrowing the gap. Heart disease is a major killer – and so we are narrowing the gap with national rates for overall life expectancy. Cynic's could say its all part of the long-term trend. Enthusiasts for the Barker hypothesis will say the decline in cardiovascular disease reflects generation-on-generation improvements in maternal nutrition protecting their babies from heart disease when they reach older adulthood. That may be true – but there are points in my lifetime where we can see improvements happening faster than the trend would predict (and when the gap with national rates decreased more) because of the effort people put in to getting new services off the ground. There is an extensive evidence base for coronary prevention and treatment and if this is fully implemented, as was happening with the National Service Framework from 2000, then additional benefits should be expected.

Streptokinase, the clot-busting drug implemented generally in the early 1990s, was used systematically in 1994-95 with our locally agreed policy on immediate treatment of heart attack and rapid referral to hospital. Getting clot-busting drugs (thrombolysis) to people within four hours of chest pain was the standard required and largely met: a major life saving measure. In 2001 we

brought in an ambitious investment plan to use the new catheter lab in Sandwell hospital to provide cardiac catheterisation procedures (percutaneous coronary infusion – PCI) in response to heart attacks. Local access to PCI remains high, commensurate with local need.

From 2005 onwards, we have used a risk stratification approach to identify people on GP lists who are most likely to have a heart attack in the next 10 years. The original trial we did suggested people in the programme were two or three times more likely to get the preventive drug treatments they needed. They were also more likely than controls to get lifestyle interventions they needed, such as taking more exercise or stopping smoking. We rolled out this programme to all practices by 2009 – the result was some 70 fewer heart disease deaths by 2010.

In addition we have seen substantial lifestyle improvements – smoking rates are probably a third less than they were in the 1980s although they are still higher than nationally and still far too high (27% at the best according to the last available GP practice list estimate). We introduced nicotine replacement therapies when Government did not support it. We expanded the service in the 2000s, implementing government policy with limited success. In the last two years of the primary care trust we expanded the smoking quitter service massively, using a payment-by-results reward for local services. The programme performed over target and over 2,200 people quit smoking in each year. For every smoking quitter the local economy gains by about £2,000 as virtually anything people buy is worth more to local businesses than cigarettes. The smoking ban in 2007 has produced major national gains in the continuing fall in heart disease.

Despite 60 years of knowing that smoking causes cancer, more than a quarter of Sandwell's population still smoke. It remains the biggest preventable cause of death for Sandwell people, claiming over 600 lives each year. More action is needed to control tobacco locally and nationally and to get more people to quit.

We should also be aware that the current craze for electronic cigarettes is not a safe and effective way of getting people to stop. It is a craze, which is normalising smoking behaviour just at a time when it was becoming a realistic possibility to see smoking end. It is untaxed and unregulated and it makes it impossible for smoke-free legislation to be policed by bar and pub owners and other public and commercial bodies.

I recommend Sandwell knocks e-cigs on the head – in its own council and partner non-smoking policies, in its enforcement practices and in its national lobbying.

We should celebrate the success stories of the decline in heart disease in Sandwell and in the country as a whole. But we should also recognise that very much more could still be done.

I recommend the CCG notes the strong evidence for the detection and treatment of atrial fibrillation ('irregular heart beat') and implements local detection and treatment in primary care.

There is much more we can do in identifying and treating people with heart failure. The CCG should also fully implement programmes for detection and treatment of heart failure through primary care.

There is much more we can do to promote exercise and much more to prevent smoking and help people stop. The individual risks people take with their health play out over the course of their own lives and determine whether or not they die early from heart disease or lung cancers or respiratory illnesses.

There is another story in the public health life course of Sandwell people, which determines how social and economic policies impact on the health of a whole community. In the mid-2000s the Cabinet Office Neighbourhoods Unit was also berating Sandwell for not improving life expectancy for Sandwell people

There was, at the time, a clear rise in deaths of men under the age of 65 from heart disease. That rise is all the more clearly visible now eight years later as the rates have taken a sharp downward turn.

I said at the time that this upsurge of deaths was probably the legacy of the 1980s recession – young men were thrown on to the dole, in many cases never to return to work, or to live on the margins of precarious, dirty and dangerous drudgery, spending much of their time in the pub, doing little, smoking, drinking, being inactive, but most of all being without purpose, without dignity, without hope. These people in their 20s to 40s in the 1980s were dying before their time in the 2000s. There is, with hindsight, also a peak in the early 1990s – could that relate to 1970s austerity?

Enthusiasts for the Barker hypothesis will recognise that for the first time recently life expectancy has not increased nationally. It cannot be assumed that maternal nutrition is continuing to increase. The babies born in the 2008 recession, to mothers born in the 80's recession, to mothers born in 70's austerity, may indeed have declining nutritional status.

I have at last had some academic support for my observations through the studies of O'Flaherty and Capewell in Liverpool on coronary deaths in Scotland. Researchers from Liverpool and Durham have most recently drawn attention to the 80's recession legacy on early deaths. We should be deeply concerned about

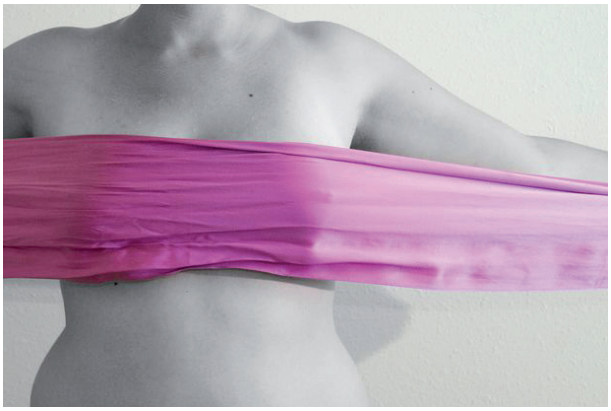
1 million under-25s out of work now, and fear for a rise in early deaths in 20 years' time if the present economic policies are allowed to fail our young people so completely. There has to be a massive effort locally and nationally to get young people into meaningful and rewarding work. We need to massively expand Sandwell Council and other partners' efforts to create and recruit new apprentices.

Cancer – four types

Cancer presents us with a mixed picture – some improvements, some worryingly unchanged figures. Stomach cancer has gone from being a very common cancer in Sandwell when I first came here to being very unusual. Changes in diet, changes in exposure to dangerous chemicals and reductions in smoking may all have paid their part.

Breast cancer

Incidence and survival at one, three and five years are similar to national rates, Breast cancer screening performance is acceptable according to agreed audit standards. Treatment outcomes appear to be consistent with national rates.



Lung cancer

Incidence is much higher than nationally, death rates are much higher but consistent with the high numbers getting the disease. Lung cancer is our biggest single cancer killer.

Survival at one, three and five years is consistent with national rates, so there is nothing to suggest our treatment is worse or better than national. However, this is a cancer with poor survival – so if prevention is better than cure, we must prevent. In this case also, prevention is better than cure because there is no cure. Lung cancer in men from unskilled and semi-skilled social classes has not improved in Sandwell at all, while it has decreased for higher skilled and professional men. Lung cancer in poorer women may have increased slightly. The gap between rich and poor has therefore got wider for men and women dying of lung cancer in Sandwell. There is still much to be done to control tobacco and eliminate smoking in Sandwell.

Prostate Cancer

The incidence of prostate cancer is slightly higher than nationally. Survival at one and three years is similar to the national picture but much worse at five years. Staging and severity of prostate cancer still present problems. There appear to be different kinds of prostate cancer – one may grow slowly and not cause too many problems (and indeed only be diagnosed at post mortem when a man has died from some other cause). The other end of the spectrum is an aggressive tumour, which grows and spreads rapidly through the body, which needs to be treated aggressively and early.

There is still no case for formal prostate cancer screening with the PSA (prostate-specific antigen) test because it doesn't predict people who have cancer well enough – men with a low PSA may have cancer, and men with a high PSA may not have cancer.

There has been recent clarification about the best treatment for the cancer – active surveillance or 'watch and wait' is now an option for men with localised cancer, in which surgical treatment would also be an option. Radiotherapy and

hormonal treatment can now be used in combination for more widely spread cancers.

We do not know if the fall-off of survival in years three to five reflects that Sandwell men have more aggressive tumours kept in check until after year three. There may be clinical factors to be looked at such as poor social circumstances, loss of income or loss of family support. Clinicians and public health specialists need to keep prostate cancer survival and treatment outcomes under close attention.

Bowel cancer

New cases of bowel cancer in Sandwell residents present at similar stages as those seen regionally – 34% versus 37% respectively of all tumours are at the earlier stages (Dukes Classification type A and B).

However, Sandwell patients have significantly worse survival at all points from the start of diagnosis – at one, three and five years. This is equivalent to 14 extra deaths compared to what would be the case if national rates applied.

There is an urgent need for clinicians and public health specialists to review and consider the clinical and social factors which may be involved in these poor outcomes for Sandwell patients with bowel cancer.

The main concern is around the availability of in-depth data to review the pathway from diagnosis to death more accurately. This needs to be available alongside comparator data of local, regional and national outcomes to clearly see if there are differences which may affect patient outcomes and survival.

With this data we can better understand:

- surviving the four cancers – is Sandwell observing lower survival in those with more severe cancer? Or is this the case at all stages?
- does a patient having other conditions (obesity, diabetes, Chronic Obstructive Pulmonary Disease, Coronary Heart Disease and so on) contribute to Sandwell's poorer survival?
- the clinical pathway: clinicians need to critically review their service as to whether the patient is receiving the right care and if there is more that can be done
- do other factors contribute? For example, a patient lacking help at home while they are getting treatment? Does this affect their ability to make appointments? And how about the patient's diet and pressures upon them such as supporting their own families?
- treatment complexity – in Sandwell do we carry out procedures or treatments to increase life which would not be attempted elsewhere?
- people's age: how frail are they when treated?

Other public health concerns

Tuberculosis

I am saddened that there is more tuberculosis (TB) in Sandwell now than there was when I started 27 years ago. It was too high then – around 80 cases per year compared to 120 cases per year now.

Sandwell's health protection and chest clinic heroes continue to battle cases of TB and outbreaks as these arise. There have been two major incident responses to TB in the last two years at Sandwell Academy. Reports on these will be published in due course. We have joined the Birmingham conurbation TB board. We expect this board to:

- look at the number of cases of TB locally
- review evidence for effective treatment and control
- and invest in these across the West Midlands.

Recent guidance confirms the NHS is responsible for funding clinical investigation and treatment in the response to incidents. Sandwell has just commissioned a new latent TB detection service using the IGRA test for high-risk communities and new arrivals.

Sandwell Health Protection Forum needs to make further investment in routine prevention and identification of cases of TB.

It is essential that all partners in Sandwell's local health protection forum take TB very seriously 'to the last case'. A commitment to halving the number of cases we see within 10 years should be a minimum target.

Domestic violence

Sandwell Health and Wellbeing Board and Safer Sandwell Partnership have recently committed to a new strategy on domestic violence. My colleagues Susan Stokes and Carl Griffin have made major contributions to this work as members of the Collaboration for Leadership in Applied Health Research and Care (CLAHRC) and the Safer Sandwell and domestic abuse strategic partnerships. Susan Stokes led a 'getting research into practice' workshop at West Bromwich police station at which police and health and domestic violence agencies reviewed the best evidence for what works to prevent or respond to domestic violence. The conclusions seem obvious and simple but there is a huge amount of inconclusive and contradictory research. In a nutshell the evidence is this:

- arresting someone who is violent against his or her partner is better than not arresting them. This appears to be the case unless the perpetrator is unemployed, in which case it's less clear. For employed men, being arrested for a crime is definitely a wake-up call

- arresting the perpetrator and a service for the victim are better than arresting alone
- arresting perpetrators and providing a service for them and their victim is better still.

It is not clear which interventions work best with perpetrators. For that reason the best possible service evaluation is needed, preferably by a randomised controlled trial. Services which might work include cognitive behavioural therapy and alcohol treatment services. Anger management is popular and seems like a diversion offered by services. But it appears not to be generally effective. A good reason for this might be that men who are violent in the home use violence to assert their authority and control over their partners and families. They are in need of other measures and criminal sanctions cannot be ruled out.

Sandwell Council has just agreed to fund a perpetrator service through the public health ring-fenced budget and Safer Sandwell funds (from the Police and Crime Commissioner).

I recommend that a high-quality research evaluation is designed to be implemented with the successful provider.

I recommend that further work be done combining efforts to reduce domestic violence, protect children in abused families and reduce the element of the problem caused by alcohol abuse.

It cannot be taken as obvious however, that 'early intervention' is always the best approach. It sounds right – but we do not know enough about the natural course of domestic violence. Early action by well-intentioned services might add to the problem and cause a catastrophic outcome. This is why we need a full and safe evaluation.

Housing

Another product of the CLAHRC has been an in-depth study of the health benefits of home improvements done to the Decent Homes (DH) standard. These were implemented in over 25,000 homes in the 2000s. This was under the auspices of Sandwell Homes, the Arms Length Management Organisation (ALMO).

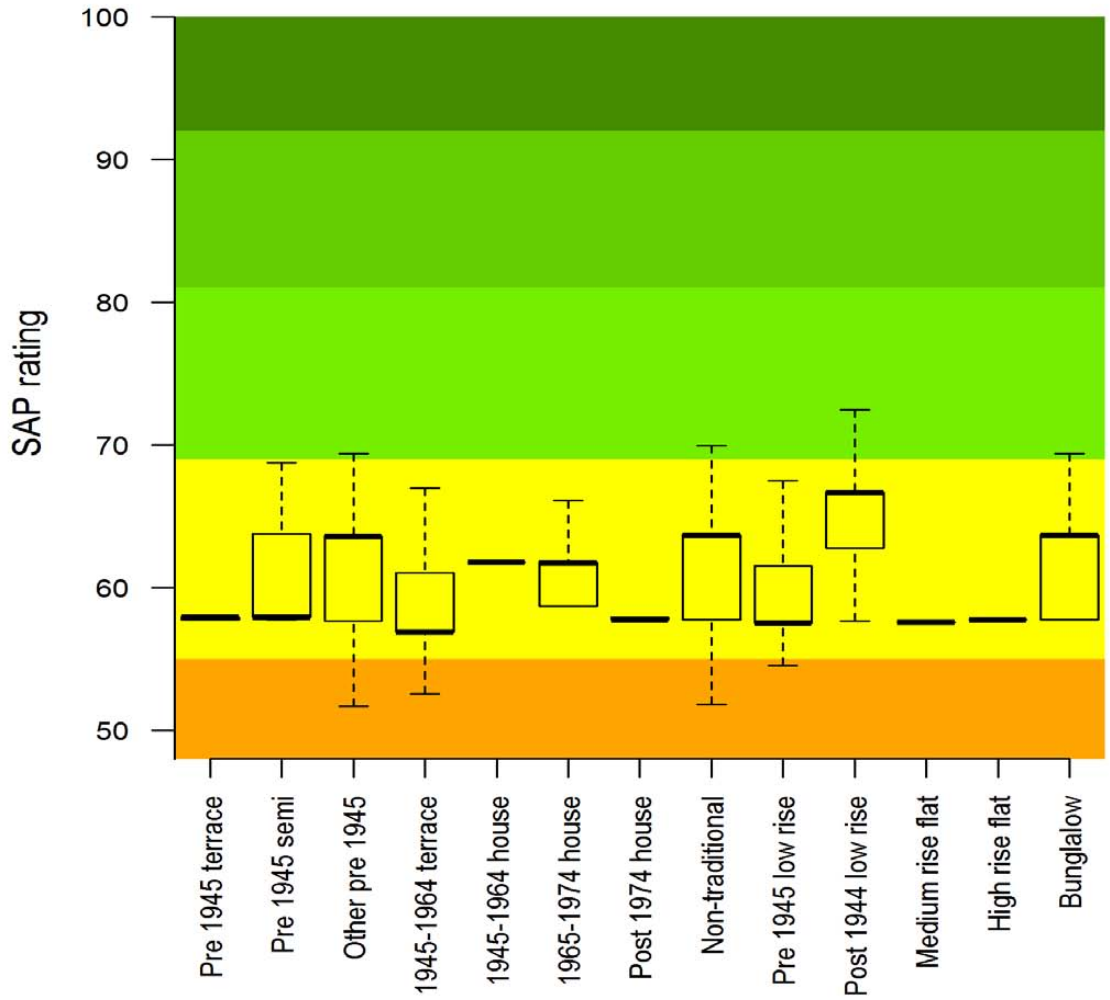
The study involved collating the SAP ratings for energy efficiency of homes (SAP= Standard Assessment Procedure) of the Buildings Research Establishment (BRE). The measure considers insulation, air tightness and housing design with regard to available sunshine.

Ratings were available for all properties in 2010. The hard part was modelling what they would have been in 2001. But our researcher Gavin Rudge combined his previous quantity surveying

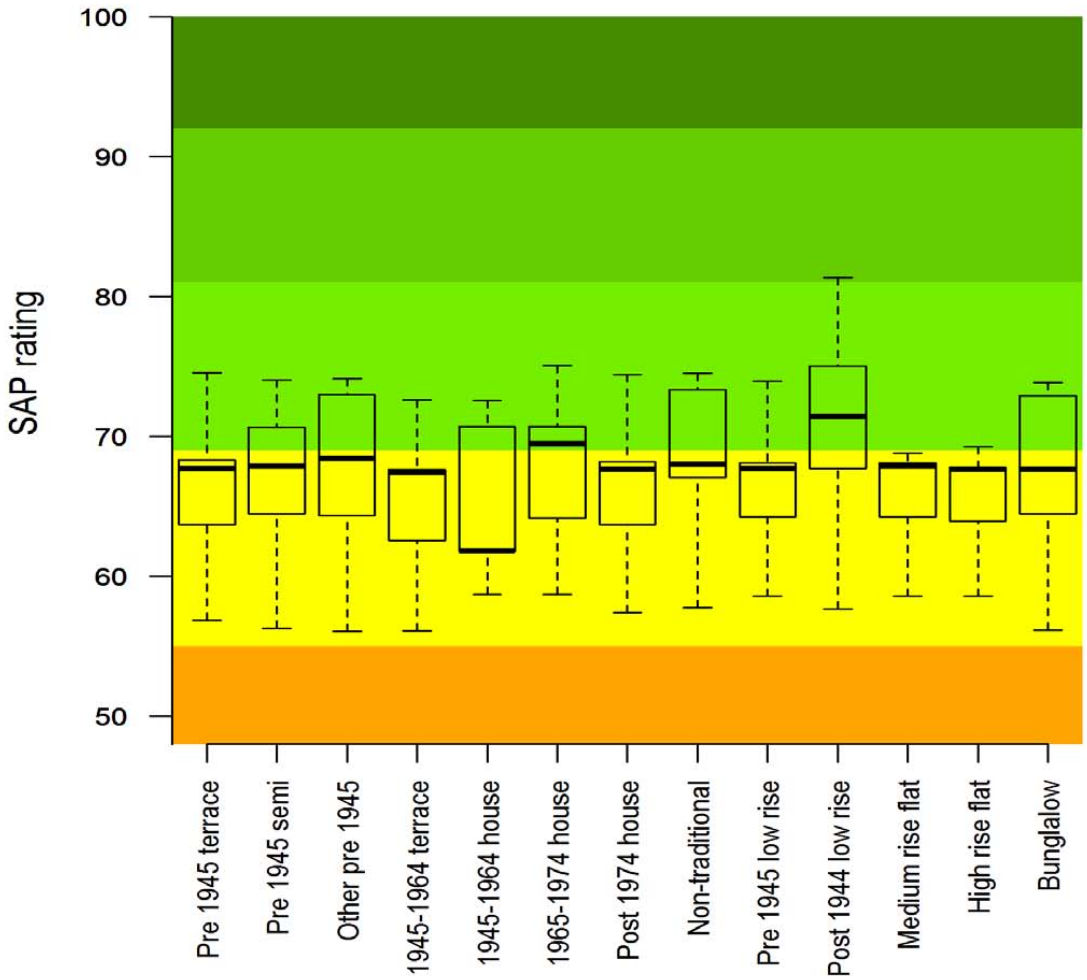
experience with his public health research skills and help from housing intelligence information officer Tony Stockin to create a measure for all the properties. It is the first time such a model has been built on such a large scale. The model was then aligned with health data which is relevant to housing conditions – for example, cold-related excess winter deaths and hospital admissions for heart disease and stroke, bronchitis, pneumonia, falls and fractures.

The early findings are that the DH standard applied to 25,000 properties has been an extraordinary success story – houses that would have made people shiver in 2001 don't now. Houses have been fitted out in some cases more than two levels higher than the SAP rating they were in 2001. And the health benefits also appear to be much bigger than previously reported in research.

Box plot of the Baseline SAP measures for the Sandwell MBC housing stock, 1 April 2001, housing type, n=25,595 dwellings



Box plot of the Baseline SAP measures for the Sandwell MBC housing stock, 31 March 2011, by housing type, n=25,595 dwellings.



Affordable warmth and improved SAP ratings appear to be strongly related to reduced excess winter deaths.

Hospital admissions related to cold stresses also appear to fall by a bigger amount than previously reported. These are extremely important and exciting findings.

We previously modelled reductions in housing admissions based on BRE estimates. This new model uses real current data. If supported by the peer review process we have started (and published in a high weight scientific journal), it will be the strongest evidence yet for affordable warmth, energy efficiency and better health outcomes. Even without the health benefit, the effects on saving energy (and not using French electricity to warm the sky) is vitally important for saving public money, good for the local economy and good for hard-pressed family incomes.

I recommend the council, housing associations and private house builders make major investment in highly energy efficient houses and affordable warmth.

There is much to be done in private sector housing. Novel ways will be needed to fund private sector housing improvement or to buy up properties. The council's finances will suffer in terms of properties left derelict or deteriorating and social care bills for their inhabitants. But the council cannot subsidise private owners who will not improve the properties they own.

Many private sector houses are older than the people growing old in them and are falling into disrepair as fast as their owners. Old people labour under the notion that they are passing on an inheritance to their loved ones when they are as likely to be passing on a liability.

I recommend that the council looks at how greater proportions of the £18m a year Housing Revenue Account (HRA) can be applied each year for 10 years to affordable warmth and energy efficiency to further improve Sandwell homes.

I recommend the council looks at innovative ways to fund more homeowners to improve their properties and stay independent – or ways to transfer older people out of their own homes into acceptable, appropriate independent accommodation.

I recommend the council continues to invest public health ring-fenced budgets in affordable warmth and home safety measures.

The investment should be used to encourage matched funding from other council and CCG sources. The BRE model we have previously applied is still relevant (until such time as the Sandwell research overtakes it).

This suggests that:

Investing £1 million in ring-fenced public health budget in housing:

450 interventions carried out could contribute to preventing 153 deaths, 108 other hospital admissions (assuming the deaths occurred in patients who did also go into hospital) and 189 GP consultations.

Investing £1 million health money prevents 108 hospital admissions @ £220,000 per annum, for non recurrent spend.

However, pool £5 million with housing, social care or CCG:

£5 million pool invested in alleviating winter deaths prevents 765 deaths and 540 hospital admissions.

It enables closure of 10 hospital beds (at an average seven day length of stay) and saves the CCG £1,188,00 for reinvestment in health improvement and supporting social care needs.

It could agree to reinvest the money in housing-related health improvement.

At 2010 National NHS tariff prices

I recommend the council continues to invest in housing and health research.

The data warehouse now set up could be interrogated for housing, health and social care outcomes for many years to come. In addition, there are other consequences of cold homes – children, for example, cannot do their studies properly if they are shivering. Educational outcomes could also be linked to housing and health measures. The data warehouse could also be linked with new local health initiatives and community development. It can be extended to cover new housing developments to look at how health improves or worsens over time.

More knowledge about the housing and health research needs to be shared and transferred to everyday Sandwell intelligence staff, to make the database self-sustaining.

Dementia

We reported our concerns about dementia in last year's annual report. There has been little progress. A proposed primary care case finding and early intervention programme has fallen through and an alternative approach is being explored.
Sandwell is committed to becoming a dementia-friendly community and we are taking steps that will help us achieve this vision. Since the last annual report the dementia strategy has been updated and takes on board the National Institute of Clinical Excellence (NICE) Quality Standards on dementia, the report of the West Midlands Quality Review Services on Sandwell's dementia provision and the Prime Minister's Challenge on Dementia.

Dementia poses a major health and social

care challenge due to the estimated increase in the number of people with dementia nationally and locally over the coming years. In Sandwell it is estimated that over 3,500 people have dementia and this number is predicted to increase by 38% by 2030. This not only presents a financial challenge. It also challenges services to ensure that they meet the needs of people with dementia and identify early those with risk factors that could lead to developing it.

Most of the GP practices in Sandwell are signed up to the Dementia DES (Directly Enhanced Service). This will require GPs to opportunistically offer screening to 'at risk' patients such as:

- those aged 60 and over with cardiovascular disease (CVD), stroke, peripheral vascular disease or diabetes
- patients aged 40 and over with Down's syndrome
- other patients aged 50 and over with learning disabilities
- patients with long term neurological conditions such as Parkinson's Disease.

The Sandwell dementia strategy is underpinned by the commitment to values of dignity and respect and the principles of personalisation and person-centred support to enable individuals to make choices about their care needs and maximising opportunities for independence and improved quality of life.

The strategy in this report's accompanying CD sets out a dementia pathway and a commissioning framework that has been developed jointly with the Sandwell and West Birmingham Clinical Commissioning Group (CCG) and stakeholders. This focuses on:

- a dementia-friendly community (stigma reduction)
- prevention, risk stratification, screening and assessment (pre-diagnosis)
- living well with dementia (post-diagnosis)
- events (reducing events that lead to poorer outcomes and preventing them from happening).

The challenge now is to implement this pathway to improve services for people with dementia and delay its onset in those identified as having the risk factors so that they can remain healthy and live independently as long as they can.

Sandwell Council's priorities for action: the role of public health

Children's safeguarding

An ambitious and revolutionary new model of children's safeguarding began in Sandwell in November 2013. The Multi-Agency Safeguarding Hub (MASH) has been set up with more than a dozen agencies involved working out of the same office in the Council House including police, children's social care, adult social care, housing, women's aid, CCG safeguarding and domestic violence nurses and the early help team. A wider network of supporting resources such as school nurses and drug and alcohol agencies is connected. In addition, the Multi-Agency Enquiry Team (MAET) now involves police and children's social workers investigating cases together.

There is a major commitment to make this work from all agencies. The operational plans and rationale are included in the children's safeguarding folder in the accompanying CD. The public health contribution to children's safeguarding takes many forms:

Creating the joint strategic needs analysis.

Creating specific Sandwell Council-led needs analysis and service evaluation.

Commissioning universal children's services to keep children and their families healthy and out of need for early help and safeguarding services:

- parenting services
- school nursing
- children and families' lifestyle services – food, fitness, weight management, substance misuse and mental health promotion.

Commissioning difficult and dangerous children's safeguarding services:

- children's sexual health services and contraceptive services
- street sex workers, including under-aged sex workers
- sexual exploitation of children
- children's emotional wellbeing services
- drug, alcohol, sexual health/genito-urinary medicine services
- domestic violence services
- making sure safeguarding processes and practice are commissioned and written into operational plans and service pathways.

And delivering health protection

Children's safeguarding issues emerge form a range of infection control problems such as HIV, tuberculosis and blood-borne viruses.

Sandwell children's safeguarding services is not out of the woods yet, but the utter dedication and commitment of staff inspire confidence. The drive shown by the senior management is outstanding, from the Chief Executive onwards.

Integrated Care and the Better Care Fund

Adult social care faces a £20 million budget shortfall in 2016-17. The health service reconfiguration planned under Right Care Right Here involves building a new smaller specialist hospital in Smethwick, the Midland Metropolitan Hospital. This will be in support of redesigned community health and primary care services which will enable more care to be delivered in the community, and to keep people healthy in the first place. Figure 4 (below Tables 2a and 2b) shows how much money could be released from the health care system if local practice was in line with the best in the region – considerable savings appear to be possible:

- if we prevented hospital admissions due to causes of illness amenable to public health intervention – the biggest of these is alcohol related illness. Others are smoking, obesity and diet
- if we had better social care support, including support for carers and for better housing
- by properly immunising people against vaccine-preventable diseases such as pneumococcal pneumonia and influenza.

There are still more conditions which are a problem created by the way we pay hospitals – 'payment by results' which rewards a range of activities which do not improve health at all (for example, 'zero length of stay, no treatment given').

Table 2a, Hospital admissions for selected causes for Sandwell and Western Birmingham Clinical Commissioning group, 2012-13

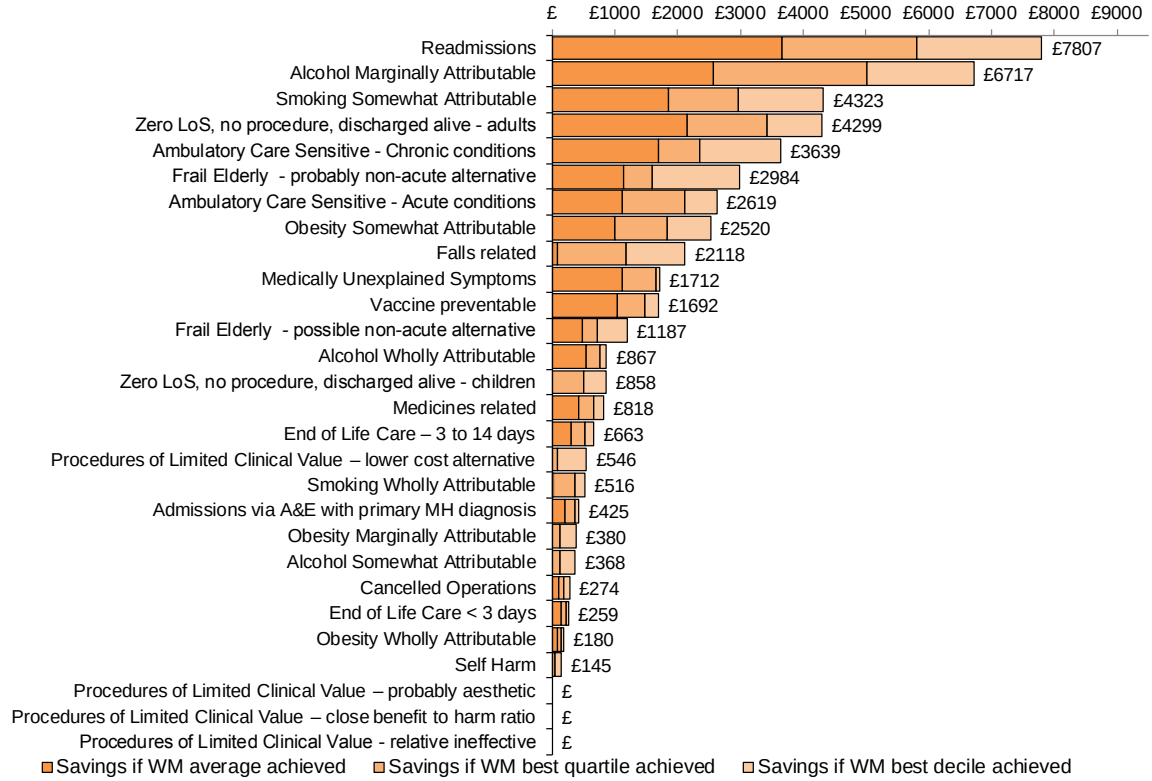
Admission subgroup	Events 2012/13	Spend 2012/13
Ambulatory Care Sensitive – chronic conditions	4,732	7,996,049
Ambulatory Care Sensitive – acute conditions	5,465	8,760,922
Medicines related	810	7,769,949
Self harm	1,028	592,857
Falls related	2,565	7,326,049
Vaccine preventable	1,379	3,546,201
Alcohol wholly attributable	961	1,258,349
Alcohol somewhat attributable	1,554	2,560,359
Alcohol marginally attributable	7,959	19,378,897
Smoking wholly attributable	701	1,508,148
Smoking somewhat attributable	8,402	13,612,605
Obesity wholly attributable	83	255,235
Obesity somewhat attributable	3,346	7,896,152
Obesity marginally attributable	657	1,338,593

Table 2b, Hospital admissions for selected causes for Sandwell and Western Birmingham Clinical Commissioning group, 2012-13

Admission subgroup	Events 2012/13	Spend 2012/13
End of Life Care < 3 days	312	467,289
End of Life Care – 3 to 14 days	370	1,229,308
Medically unexplained symptoms	3,990	3,483,823
Zero LoS, no procedure, discharged alive – children	4,791	3,051,121
Zero LoS, no procedure, discharged alive – adults	11,066	7,360,967
Cancelled operations	1,939	502,287
Procedures of Limited Clinical Value – related ineffective	898	1,059,412
Procedures of Limited Clinical Value – close benefit to harm ratio	1,206	4,338,670
Procedures of Limited Clinical Value – probably aesthetics	651	928,427
Procedures of Limited Clinical Value – lower cost alternative	1,580	3,822,306
Frail elderly – probably non-acute alternative	2,419	6,170,697
Frail elderly – possible non-acute alternative	1,134	2,651,518
Admissions via A&E with primary MH diagnosis	682	611,758
Readmission	8,533	18,521,320

The greater prize is eliminating wastage in health service funds for reinvestment in primary care, social care and keeping people healthy. This may be worth something like £48 million. Figure 4 shows the savings possible for the categories of hospital events in Tables 2a and 2b if Sandwell achieved the West Midlands average admission rate (first bar), the West Midlands top quarter rate (second bar) and the West Midlands top ten per cent (third bar).

Figure 4, Savings from changing local usage of hospital admissions: Sandwell and West Birmingham, 2012-13



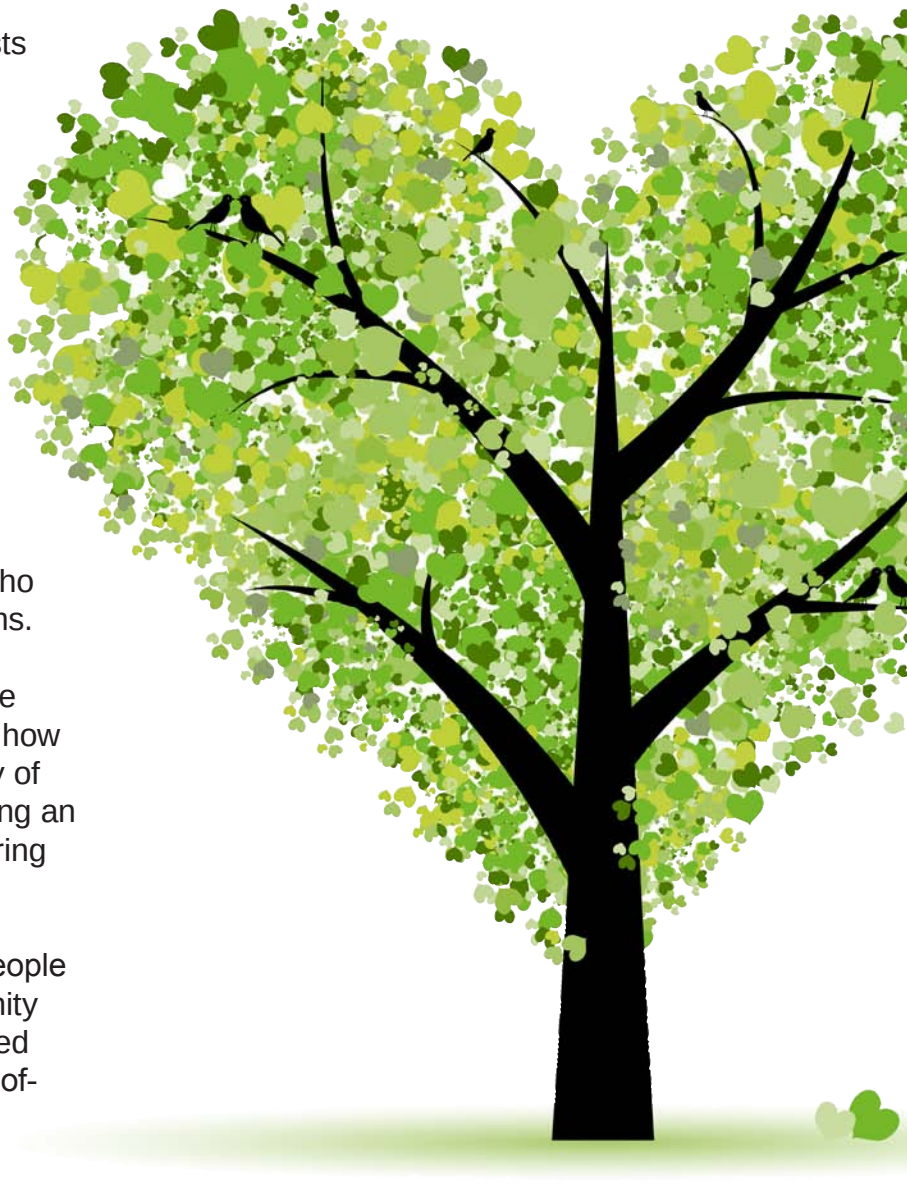
It is imperative that the health services, social services and public health work together to:

- prevent illness
- provide effective services when they are needed
- provide dignity and respect in recovery, and in end of life care.

There are many areas of joint interest between public health, social care and the CCG which are needed to liberate funds locked up in ineffective care. This is also needed so the new hospital can be an asset to the community when it comes on stream and not a facility which is swamped with patients who don't need to be there.

Examples of the kind of preventive services which the Health and Wellbeing Board need to major on to deliver the strategy for 'Right Care Right Here' are:

- services to reduce alcohol-related hospital admissions and prevent alcohol problems arising in the first place
- community safety measures to prevent alcohol-related violence, to stop people starting to smoke and to help people with smoking-related disease and long-term conditions
- housing interventions to reduce hospital admissions and speed up discharge (as described above)
- falls prevention – through gentle exercise programmes for older people, housing repairs on prescription, reviews of medication and eye tests
- faster immediate stroke care in specialised units and better stroke rehabilitation
- better care and rehabilitation for people with chronic obstructive airways disease
- tackling unexplained medical conditions. Some of these arise in victims of domestic violence and patients with psychological or social stresses who present with unexplained symptoms. These need to be addressed in primary care with more appropriate services available. Some is about how hospitals send patients to an array of different specialists, each one giving an unsatisfactory response and referring internally to another consultant
- better end-of-life care, enabling people to die at home or in other community facilities of their choosing. We need to particularly emphasise the end-of-life care needs of people with dementia, cardiac failure, kidney disease and chronic bronchitis
- infection control measures to prevent and catch early healthcare-acquired infections
- preventing norovirus and flu – the major drain on hospital resource
- developing a virtual nursing home care support service to cover pharmaceutical support, infection control, tissue viability, mobilisation and a range of other problems where nursing homes need to be supported.



The life course – final thoughts

Health service planners must plan for action for the short term, say 100 days; for the medium term, say three to 10 years; or the long term, say 100 years. It is quite a fundamental but difficult idea to plan for 100 years. When the new Midland Metropolitan hospital is built, it will need to survive 100 years. Babies born today may be very likely to live to be a hundred, based on current experience.

But waiting for trends to happen is no guarantee that improvement will continue.

The threat of climate change isn't just a threat for just 50 years' time, climate change is happening now – we can see it in the wettest winter on record and the warmest winter on record, following the hottest summer for many years, the coldest April for many years in 2013 and the longest cold winter for many years. Climate change is with us now and it tests our emergency planning capability, our resilience, now. If our supplies of electricity get cut off or the Russians switch off our gas, we will be faced with a need to change more rapidly than waiting for global warming. And right now too many people are dying from cold in winter (although fewer in this current very warm winter).

We owe it to our children and grandchildren to work extremely hard to create jobs in green and environmentally-friendly new manufacturing. We need jobs for a self-sustaining community – growing food, maintaining and retrofitting housing to high energy efficiency, creating low carbon transport and renewable energy supplies. A sustainable self-sufficient Sandwell should be the aim.

I shall be retiring from the end of March 2014 after 27 years in public health in Sandwell. I should like to thank all the people who have helped me professionally and personally over all these years. It has been a great experience and a privilege to serve the people of Sandwell. I know my successor, Jyoti Atri, will receive the same support and encouragement over the years and be given the same welcome I have had. I am sure she will be successful in making further improvement to the health of local people.

Tarra a bit

John Middleton

Director of Public Health for Sandwell

March 2014

Fair Well to Welfare

For John Middleton

Chorus
He's walked the streets of Sandwell
Wearing out his SHOES
He's walked the streets of Sandwell
Wearing out his SHOES
Improving on our borough
And singing out his blues

John questions publically
the politics of health
John questions publically
the politics of health
And who will sign it away
When carving up the nations wealth

He came to us from Coventry
We didn't need to send him there
He came to us from Coventry
We didn't need to send him there
He'd get on to the councils
And give them their fair share

Chorus

Improve the streets of urban life
Make towns safe and clean
Improve the streets of urban life
Make cities safe and clean
Arguments Victorians knew
But advancements cut them lean

Welfare rights and benefits
A fresh look at society
Welfare rights and benefits
A fresh look at society
Build up a firm defence
Of principled notoriety

Chorus

Break – Spoken
Bring it to the publics attention
Of inverse care laws and need
Is it just down to paychecks
and whose importance is decreed?

Chorus

There is so much of Dr Middleton
And of his story to tell
There is so much of Dr Middleton
And of his story to tell
He'll share it over a pint
For now John it's fond fair well

Chorus

And you know that you can swear
It's fare well to welfare

Sandwell Forty Years Ago

In 1974 no Annual Reports of Medical Officers of Health were produced as these posts ceased to exist at midnight on the 31st March of that year, thereby ending a public health tradition which had lasted well over a century. This change came about as part of the reorganisation of local government and the NHS, which had been actively debated since the publication by the Government in 1968 of a consultative document suggesting that the organisation of health services needed to be radically reconsidered. Against this background it is easy to understand how, even in 1972 and 1973, few Medical Officers of Health, actively involved as they were in preparing for the new arrangements, had the time to produce an Annual Report. Therefore that which follows is a selection of material derived from the 1971 Report of the Medical Officer of Health for Warley, and that of 1972 by the Medical Officer of Health for West Bromwich (the two local authorities which together in 1974 would form the new Metropolitan Borough of Sandwell).

Warley 1971

The live birth rate (number of births per 1,000 total population), adjusted by an area comparability factor, was 17.3, which was 1.08 times that of the national rate.

The infant death rate (deaths of children under the age of one year per 1,000 live births) was 17, the lowest ever recorded figure for Warley. It was gratifying also to note that the important related indices of neonatal mortality (death in the first week per 1,000 live births), at 17, and perinatal mortality (stillbirths plus deaths in the first week per 1,000 total births), at 19, were lower than in the previous year and, in fact, lower than the national average. There was, regretfully to report, one maternal death.

The death rate (number of deaths per 1,000 population), adjusted by the area comparability factor, was 14.2, which was 1.22 times that of the national rate –a relatively high rate, in fact. The major

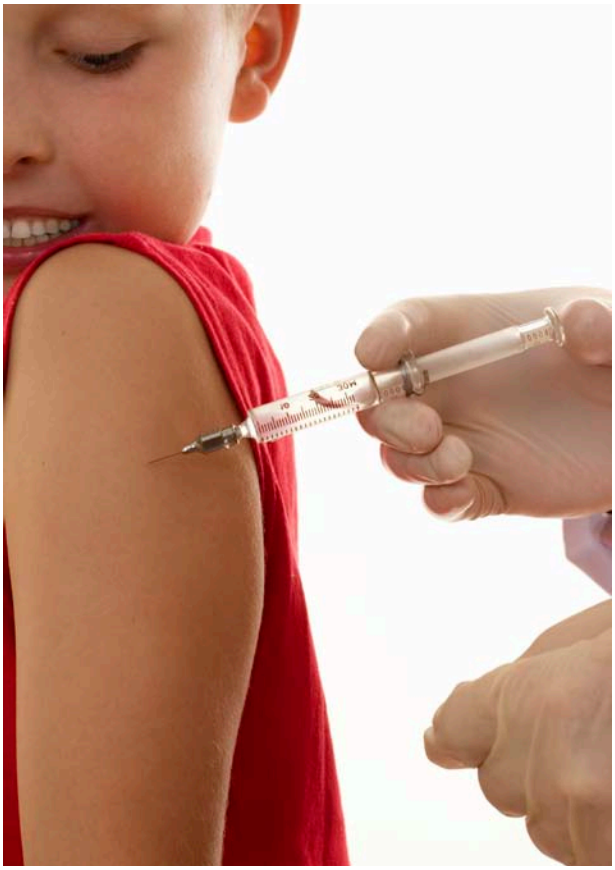
killers remained coronary thrombosis (477), and cancers (423), the most frequent site being the lung, nearly half of these sufferers being of working age. It remained a matter of concern that there was a disappointing lack of progress to be reported with regard to the impact of health education on smoking, a major factor in the causation of many of these diseases. For example, there was a relatively poor attendance at the one-week evening anti-smoking class, compared with the previous year.

Unfortunately much the same could be said with regard to health education in relation to the venereal diseases. The figures for syphilis and gonorrhoea were only slightly above those of the previous year, but the conditions grouped together as 'other conditions' (probably mostly Chlamydia infections) increased by 51%. The widespread availability of highly effective contraceptive pills had clearly brought about a fundamental change in the attitude of young people towards what was previously referred to as extra-marital sexual intercourse. The Council's response was to continue to pay the salaries of hospital-employed contact tracers in the hope that sources of infection might thus be more readily traced and further spread prevented.

Only cervical cytology showed evidence of a satisfactory response, a 26% increase in take-up, and it was felt that the approach of the five-recall period for the earliest examinations might continue to boost the number of examinations to be carried out in future years.

Of the infectious diseases notified, the condition which perhaps caused the greatest concern was that of tuberculosis. A total of 125 new patients was added to the Register, compared with 94 in 1970. It was noted that 60% of these new cases occurred in immigrants, mostly those from the Indian Sub-Continent. As in previous years, there was the closest cooperation with the medical and nursing staff of the Smethwick Chest Clinic. BCG vaccination continued to be offered to 12 and 13-year old schoolchildren; of those eligible, 84% were allowed by their parents to avail themselves of this protection.

During the year there was a major change in the policy of vaccination against smallpox. Local authorities were informed that the Secretary of State had accepted the advice of an expert working party to the effect that routine infant vaccination should be abandoned, although this procedure should continue to be offered by general practitioners to health staff, the Armed Forces and those travellers proposing to visit countries where



smallpox had not yet been eradicated. Many medical officers had serious reservations about this change of policy. [Note. Their reservations were well founded. In March/April 1973 there was a limited outbreak of smallpox in London leading to two deaths. The Committee of Inquiry Report on this incident drew attention to the lack of experience of this disease and its control.]

Other routine childhood immunisation procedures continued to be offered, including those carried out in general practitioners' surgeries. It was interesting to observe that the number of parents seeking the combined 'three-in-one' antigen (Diphtheria/Whooping-cough/ Tetanus) was markedly less than the previous year, although this was more than offset by the much greater number asking for the Diphtheria/Tetanus-only procedure, thereby demonstrating the anxieties felt concerning the Whooping-cough element of the procedure.

In 1971, for the first time, it was possible to offer Rubella vaccination, at this stage to 12 and 13-year old schoolgirls, in an attempt to prevent the Congenital Rubella Syndrome; a total of 1,546 girls took advantage of this protective measure. One had, of course, to be able to rule out the very rare risk that any young teenager might be in the early stages of pregnancy and school nurses had to find discreet and tactful ways of excluding such a possibility. The arrangements for offering Family Planning advice, services and supplies continued, in Warley, to be provided on an agency basis for the local authority by the Family Planning Association.

West Bromwich 1972

The adjusted live birth rate was 15.7 per 1,000 population.

The infant mortality rate was 22 per 1,000 live births compared with 17 for England and Wales.

The stillbirth rate was 14 per 1,000 total (live and still) births compared with 12 for England and Wales.

The perinatal mortality rate (stillbirths and deaths under one week per 1,000 live and stillbirths) was 25 compared with 22 for England and Wales.

These figures were considered to have been influenced by the impression that expectant mothers in West Bromwich did not seek medical and midwifery advice sufficiently early in pregnancy. It was felt that maternity care was not a matter solely for midwives and doctors but also for patient herself who, by booking early and taking the advice offered, had a most important part to play in safeguarding the future wellbeing of her baby.

There were no maternal deaths.

The adjusted death rate was 14.5 per 1,000 population, significantly higher than that for England and Wales, 12.1. Heart disease accounted for 40% of the 1625 deaths, followed by cancer (25%), respiratory disorders (19%), and vascular lesions (14%).

The importance of the promotion of health and the prevention of disease was becoming increasingly recognised and the need for health teaching was likely to expand. The particular contribution of the Health Visitor, with her nursing background and post-registration training, was becoming increasingly recognised.

The West Bromwich Family Planning Association continued to act as agents of the Council in the discharge of their duties under the National Health Service (Family Planning) Act 1967. In addition, however, as an independent organisation, they provided a vasectomy clinic. Forty-six sessions for women requesting ‘smear’ test for cervical cytology were offered at the Council’s clinics. A total of 607 women availed themselves of this facility during 1972.

Of the infectious diseases notified during the year, tuberculosis was the one causing particular concern although 66 new patients were added to the Register compared with 84 during the previous year. The large proportion of these cases from the Indian Sub-Continent continued to be noted and the two specialised TB Health visitors working in this field could each speak at least one of the languages required for adequate communication with these patients. These two members of staff spent a good deal of their time visiting homes and encouraging patients and contacts alike to carry out their instructions and to take advantage of the supervision provided by the Chest Clinic. BCG Vaccination continued to be offered to children attaining the age of 13 years, also to those of 15 years who had not received it previously. It was observed that 80.7% of these took advantage of this facility.

Venereal diseases remained virtually at the same level as the previous year, 238 new cases compared with 234 in 1971. Both syphilis and gonorrhoea cases were fewer in number but ‘other conditions’

rose from 164 to 189. As the Council did not have a Health Education Section, apart from some posters, little could be done in this respect. The continuation of the contact-tracing service, provided by the hospital service, no doubt contributed to a significant extent to the prevention of further spread of these infections.

Although it had been recommended in 1970 that local authorities need no longer routinely offer smallpox vaccination to infants, in 1972 69 children under 14 years of age were vaccinated on request and 31 revaccinated, some in the Council's clinics and others by general practitioners. The fact that there had been an actual case of smallpox in the town in 1962 no doubt kept the issue 'live' in the minds of many people. The general take-up of the other routine childhood immunisation procedures continued to be less than satisfactory but this was not considered surprising with a staff of Health Visitors well below establishment.

These reports recall a world which only those of middle age or older would remember in any detail: a world in which a chief officer of the local authority directed a large community health service – virtually the whole of what we now refer to as Primary Health Care with the exception of the independent contractors such as the general medical practitioners, dentists etc.; a world where it was considered an achievement that domiciliary midwives had just been equipped with personal radio sets linked with the Ambulance Control so that they could summon specialised help at the patient's bedside; a world in which births were recorded as 'legitimate' or 'illegitimate'; a world that still carried the risk of acquiring smallpox from someone recently returned from a country where the disease was still endemic.

Four types of cancer

The concern we have and the way forward

Every year in Sandwell there are over 800 new cases of the four main types of cancer – bowel, breast, lung and prostate.

We have concerns over their diagnosis, the proportion of people who survive and the number of deaths (almost 350 a year).

We have identified specific areas to look at in order to improve things.

Four cancers – some of the main points

- Yearly in Sandwell there are approximately:
  - 180 new cases of bowel cancer
  - 220 new cases of breast cancer
  - 220 new cases of lung cancer (significantly more than in comparable areas around the country)
  - 200 new cases of prostate cancer.
- Yearly in Sandwell there are approximately:
  - 72 deaths from bowel cancer
  - 51 deaths from breast cancer
  - 181 deaths from lung cancer (significantly more than comparable areas)
  - 44 deaths from prostate cancer.
- Breast and prostate cancers have the highest rate of new cases. This is similar to comparable areas for breast cancer. It's slightly higher than comparable areas for prostate cancer.
- New cases of bowel and lung cancers in men are almost double the rates in women in Sandwell and comparable areas.
- We use screening to identify cancer in people without signs of the disease (but only some cancers can be screened for due to accuracy of available tests). Sandwell's bowel screening rates are similar to most comparable areas including the West Midlands and England. Breast screening rates are lower than the West Midlands and England.
- New cases of bowel cancer remain stable. Breast cancer is gradually increasing. Lung cancer is decreasing overall and in men, but increasing in women. Significantly more men and women from deprived backgrounds than from affluent areas get lung cancer. New cases of prostate cancer are increasing.

- About 34% of all bowel cancers are diagnosed when the disease is at an early stage. This is slightly lower than most comparable areas but not significantly.

- About 40% of breast cancers are diagnosed at an early stage. This is higher than comparable areas.

- About 14% of all lung cancers are diagnosed at an early stage. This is similar to most comparable areas.

- The proportions of people who survive a year after diagnosis in Sandwell (for those diagnosed from 2007 to 2011), are:
    - about 95% for breast and prostate cancers (similar to comparable areas)
    - about 66% for bowel cancer (significantly lower than in comparable areas – it could equate to 18 more deaths)
    - about 28% for lung cancers (similar to comparable areas – with slightly more women surviving than men).

- The proportions of people who survive three years after diagnosis in Sandwell (for those diagnosed from 2005 to 2009) are:
    - over 85% for breast and prostate cancers (similar to comparable areas)
    - about 50% for bowel cancer (significantly lower than comparable areas)

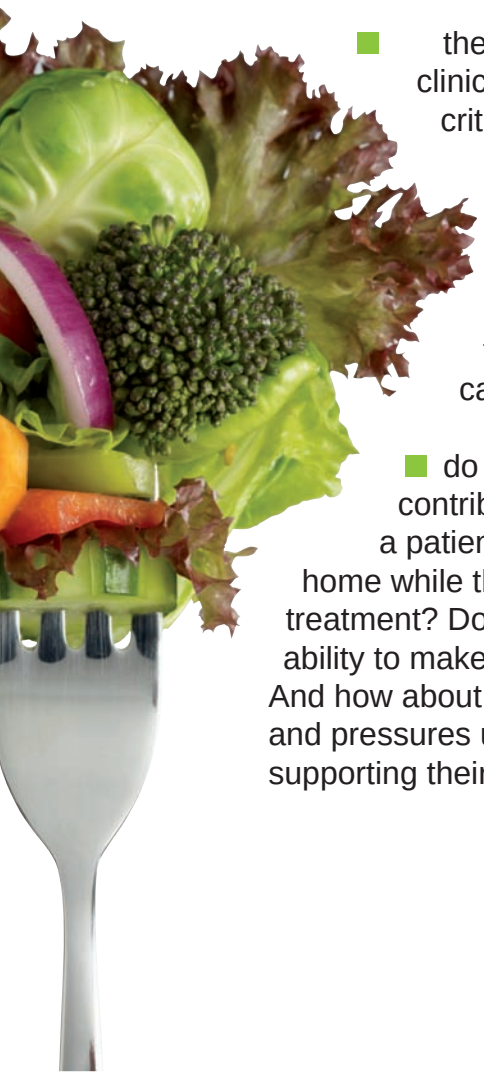
    - just over 12% for lung cancer in men (slightly higher than comparable areas).

- The proportions of people who survive five years after diagnosis in Sandwell (for those diagnosed from 2003 to 2007), are:
    - just over 80% for breast cancer (similar to comparable areas)
    - about 80% for prostate cancer (significantly lower than comparable areas – 10 more men would survive if Sandwell equalled regional rates)
    - about 44% for bowel cancer (significantly lower than comparable areas – potentially 14 more deaths)
    - about eight per cent for lung cancer (similar to comparable areas – slightly more women than men survive).

The way forward – how to improve things

We need to look at:

- surviving the four cancers – is Sandwell observing lower survival in those with more severe cancer? Or is this the case at all stages?
- more in-depth data to review the pathway from diagnosis to death more accurately
- does a patient having other conditions (obesity, diabetes, Chronic Obstructive Pulmonary Disease, Coronary Heart Disease and so on) contribute to Sandwell's poorer survival?



- the clinical pathway; clinicians need to critically review their service as to whether the patient is receiving the right care and if there is more that can be done
- do other factors contribute? For example, a patient lacking help at home while they are getting treatment? Does this cut their ability to make appointments? And how about the patient's diet and pressures upon them such as supporting their own families?

- treatment complexity – in Sandwell do we carry out procedures or treatments to increase life which would not be attempted elsewhere?
- people's age: how frail are they when treated?

Cardiovascular disease

Where we are now and what we can do to prevent it

The background

Cardiovascular disease (CVD) is a general term for disease of the heart or blood vessels.

It includes conditions such as:

- coronary heart disease (CHD)
- stroke
- irregular heartbeat (atrial fibrillation)
- high cholesterol that people inherit from their parents (familial hypercholesterolaemia)
- heart failure.

There are over 200 risks which can lead to people developing CVD. The most important ones we can change for the better are:

- smoking
- diet
- exercise
- obesity.

Sandwell last drafted a strategy to prevent CVD in 2008. Our new five-year strategy replaces that and builds on the progress we have already made to cut deaths and ill health from the disease. It combines measures to prevent heart disease and stroke both before someone gets them (primary prevention) and after they do so (secondary prevention).

Despite the progress we have made, the age a person can expect to live to on average (their life expectancy) is still lower in Sandwell than in the rest of the country. The gap has closed by five per cent since 1996, but there is still more that can be done. We need to renew our efforts to close this gap.

CVD in Sandwell – some of the main points:

- cutting CVD also cuts chronic kidney disease and dementia (because these conditions share some risks)
- preventing CVD will help achieve the four priorities in Sandwell's July 2013 Health and Wellbeing Strategy (early years and adolescent health, long-term conditions and integration of care, the frail elderly and dementia, and alcohol)
- life expectancy at birth in Sandwell is 76.3 years for men (14th lowest out of 150 English councils) and 81.4 for women (33rd lowest)
- Sandwell is 13th worst for premature death from heart disease and stroke. The main cause of death is CHD and stroke (30% of all deaths – about 3,200 a year)
- CVD deaths among under-75s in Sandwell are well above the national rate (but they have come down by over 60% since 1995 and there has been a 5% reduction of the gap with national rates
- figures on admissions to hospital with a stroke (and subsequent death rates) suggest Sandwell people may not recognise stroke symptoms (or they, friends and family may not seek immediate help for them)

- estimates suggest smoking costs over £75 million a year in Sandwell (litter clearance, sick days, health costs, lost output and so on)
- there are estimated to be over 50,000 smokers in Sandwell – and our death rate from smoking-related conditions is 294 per 100,000 people (compared with 234.4 in England – 25% higher)
- 596 people die every year in Sandwell from smoking
- anti-smoking measures in Sandwell include clamping down on smuggled tobacco, enforcing 'age of sale' laws, publicity campaigns and a 'joined up' approach which shows people where they can get help to stop smoking
- estimates suggest obesity costs about £38 million in healthcare in Sandwell – and £154 million more in other costs
- Sandwell already has a number of programmes to combat obesity among both children and adults – and we're working on more
- a 2011 survey highlighted that 41.4% of Sandwell people said they took no physical activity (29.5% nationally)
- figures suggest a smaller increase in the percentage of people taking part in sport in Sandwell than elsewhere in the West Midlands and in England (despite investment in leisure and open space facilities)
- Sandwell has an overall plan to boost physical activity and a range of projects to increase the exercise people take (including a '5 x 30 Time to Get Active' campaign)
- diet recommendations to people who want to cut the risk of CVD include eating '5 a day' portions of fruit and vegetables, less fat and salt and one to two portions of oily fish a week
- fewer than one in five adults in Sandwell are thought to be getting their '5 a day'
- Sandwell also has more 'high fat, high salt' fast-food takeaways than elsewhere
- there is a range of health services in Sandwell to help people change their diets for the better including a 'Cookwell' course, weight management initiatives, projects aimed at children and special nutrition programmes
- the council is also working to boost the availability of healthy food
- estimates suggest alcohol misuse costs Sandwell £63 million a year (£23 million in healthcare and prevention)
- the Health and Wellbeing Board is tackling such misuse by increasing and revising treatment services, with multi-agency efforts to tackle alcohol-related violence and with prevention and education services to inform the public about the harmful effects of alcohol. A joint strategic needs analysis for alcohol was updated in 2013. The board has also taken part in national lobbying on national legislation to bring in minimum unit pricing of alcohol
- a CVD risk project (involving all GP practices in Sandwell) identifies people at high risk who are not yet getting treatments that would help them

- this has helped literally thousands of people – and over 10 years is estimated to prevent 260 heart attacks/strokes and save 78 lives
- there is also another programme to identify 'medium risk' people, involving a session with a health trainer to assess them and refer them to services that could help.

Main ways to cut and prevent CVD in Sandwell

For the council:

- carry on cutting smoking and people's access to tobacco
- get people to do more physical activity and cut obesity
- set up health checks for everybody at low risk of developing CVD
- develop our CVD nurse team's work to educate and train people
- investigate differences in how we identify, manage and treat a range of conditions (and highlight what we do well)
- carry out Make Every Contact Count (MECC)

For health services:

- develop better ways to identify people at medium to high risk (those with Type 2 diabetes, for example)
- continue screening those at medium to high risk – and get more people to go to them
- improve people's access to getting their condition diagnosed
- improve the way people with long-term conditions are looked after – and cut variations in the results that different GP practices achieve
- put into practice better routes to treatment for people with irregular heart beat and those recovering from heart disease
- set up a route to treatment for undiagnosed heart failure.

Domestic abuse in Sandwell

The background

Domestic abuse is a serious issue in Sandwell. It has a devastating impact upon victims, their families and the wider community.

Plans to tackle it aim to:

- break the cycle of abuse
- lead a concerted effort to prevent and cut cases.

The situation in Sandwell – some of the main points

- dealing with cases of abuse costs services in Sandwell over £29 million (with mental health costs estimated at an extra £176 million – and human and emotional costs estimated at £52.3 million)
- many abusers have problems with alcohol, drugs or other substances – and mental health issues
- much abuse (65%) happens where children are in the home
- on average 355 cases a month are reported to police (Sandwell has more incidents reported than any other area in the West Midlands)
- numbers appear to be going down over the past three years (but the data may not give a true picture of the extent of abuse and there has also been a change in the way incidents are recorded)
- 37% of "violence with injury" offences in Sandwell are classified as domestic abuse (over four in five committed in the home by the partner or ex-partner of the victim)
- figures show most abuse happening in Sandwell's three 'priority areas' (Soho and Victoria, Princes End and West Bromwich)
- research shows most cases are assaults or verbal abuse – and the risk of a second assault is greatest in the next six months.

How Sandwell mirrors the national picture

- most abuse is by someone known to the victim (usually a partner or family member)
- there's a continued rise in the number of victims losing their home because of domestic abuse
- deprivation and unemployment (Sandwell is the 12th most deprived authority in the country and joblessness is at 7.4% in comparison to 3.8% nationally) pose greater risks of abuse.

What we are doing to tackle abuse

Our research shows we need to:

- concentrate on households where children are present when abuse happens (for their safety and to influence their future attitudes and behaviour)
- target Sandwell's areas where the reports are highest

- continue monitoring where abuse happens across the borough
- take the characteristics of both victims and abusers into account when we do something to tackle abuse
- take account of risks which lead to abuse (alcohol and drugs misuse, mental health issues)
- get repeat offenders into programmes to tackle their behaviour
- recognise that people who experience domestic abuse are at twice the risk of having poor health than those who don’t.

People who inject drugs

People who inject drugs risk illness and death from many infections.

In November 2013, Public Health England and the Department of Health published a report - “Shooting Up: Infections among people who inject drugs in the UK 2012”.

This highlights various findings on infections among people who inject psychoactive drugs (chemical substances which affect how the brain works) and those who inject drugs to enhance their image and performance.

Infections among people who inject psychoactive drugs (heroin, amphetamines and so on):

- injectors remain the group most affected by hepatitis C in the UK. In England around half have been infected with hepatitis C. Only 1.4% have HIV and most know they have it

- HIV infection remains rare compared with many other countries. This probably reflects the number of needle and syringe programmes in England and the availability of treatments for drugs use

- the proportion of injectors ever infected with hepatitis B has fallen from 31% in 2002 to 18% in 2012. Less than 1% of injectors currently have it. This public health success reflects a marked increase in the proportion of injectors vaccinated against hepatitis B (from 45% in 2002 to 75% in 2012). There has also been a decline in the sharing of needles and syringes from 33% in 2002 to 14% in 2012

- bacterial infections remain a problem. Thirty per cent of injectors say they have had a symptom in the previous year. Severe illnesses such as botulism and tetanus, though rare, continue to crop up

- the most commonly injected psychoactive drug in England, on its own or with crack-cocaine, is heroin. However, there is evidence of an increase in the injection of amphetamines and amphetamine-type drugs such as mephedrone. There is evidence, too, that injecting them is more likely to lead to infection. For example, those who say they inject amphetamines and so on as their main drug are more likely to report they share injecting equipment than those who say they use other main drugs.

Sandwell compares very favourably with national averages for cutting the harm caused by hepatitis B and hepatitis C.

Here, 70.8% of new clients (43.9% nationally) accepted hepatitis B vaccinations, 21.8% (18.8% nationally) started a course of vaccination and 17.6% (15.5% nationally) completed one.

However, 69% of people in treatment who inject / have injected received a hepatitis C virus test; slightly lower than the national average of 73%.

Figures show, too, that hepatitis B vaccinations in Sandwell were 18% higher from July to September 2013 than in the same period the year before.

Infections among people who inject image and performance enhancing drugs (such as anabolic steroids and melanotan).

The number of people who inject such

drugs and use needle and syringe programmes has grown substantially in many areas of England. In some areas they are now the largest group of users of such programmes.

The injection of these drugs is not new. A study in the 1990s indicated that injection risks were much lower than those for psychoactive drug injection. It found infections were rare (no HIV was found and 2.7% had ever been infected with hepatitis B).

A recent survey of those injecting image and performance enhancing drugs found that overall 1.5% had HIV, 9% had ever been infected with hepatitis B and 5% had antibodies to hepatitis C.

These findings indicate that the level of HIV infection among this group is now similar to that among people who inject psychoactive drugs. The proportion ever infected with hepatitis B is lower than among people who inject psychoactive drugs, although the survey suggests the level of this infection has increased.

What are we doing to reduce harm from injecting drugs?

Sandwell Public Health will make sure we carry out the main recommendations from the national 'Shooting Up' report. In line with national guidance, we will commission services which make sure that injectors can easily get:

- information and advice on safer ways to inject, avoiding infections, preventing virus transmission and safely disposing of used equipment

- vaccinations (hepatitis B, tetanus and, where indicated, hepatitis A)
- testing for HIV, hepatitis C and B – and care for those infected
- health checks and treatment for infections
- help to cut or stop injecting – or support safer injecting where it continues.

These services will reflect the range of drugs being injected and the needs of particular groups of injectors, such as men who have sex with men.

In line with national guidance, we will make available easily accessible needle and syringe programmes for all injectors. These will prevent sharing of injecting equipment and support hygienic injecting. They will also help people into treatment.

Our services will identify injectors not getting treatment and encourage drug users to cut and stop injecting. We will help them recover.

For more information:
http://www.sdap.co.uk/phe-report-published-shooting-up-infections-among-people-who-inject-drugs-in-the-uk-2012/

Recommendations

Begin to collect Sandwell data on:

- **HIV and hepatitis B and C in drug injectors**
- **use of amphetamine/amphetamine-like drugs (for example, mephedrone) in Sandwell**
- **people who inject image and performance enhancing drugs and use needle and syringe programmes**
- **identify injectors not getting treatment and encourage them to do so.**

The National Ultra Sound – Seeing through it all

We all grew up under the banner
of a free health free for all
And now that right is under threat
we all need to heed the call

The ultra-sound concept
that is the envy of the world
Is being sold off brick by brick
as harsh words are being hurled

Our ancestors built this dream
for all generations to come
And my how we were weaned
on this birthright care provision

That crossed all social class lines
All cultures and ethnicity
Bringing up a healthy nation
that was born of fair-handed
democracy

From factory furnace grit and
smoke
the office and the shop
From builders that could touch the
sky
and down to the pit head prop

A human right to well-being
was foremost in our psyche
Donating as we worked for health
made the concept more likely

And now we'll all be tagged and
labelled
by complaint and made a minority
For suffering in a non-mainstream way
cannot possibly drive corporate
prosperity

Get on line and in line to save the vital
signs
and cut out all dangerous cells
Get passionate about this trade off
and ring all remaining alarm bells

Because the heartless profiteers
are circling around the sick
Our NHS is now on the critical list
to save it we need to act quick

Get behind the service
that is all that's good in health
And let's not give in to the jealous ones
who are wielding share holders wealth

HIV in Sandwell

Where we are now and how to improve things

The background

The number of people diagnosed with HIV (human immunovirus) in Sandwell is falling yearly.

But we continue to be an area with a high rate of the infection.

It mostly spreads from people who have not been identified with HIV – so we need to do all we can to cut the number of those undiagnosed.

Early diagnosis helps stop the infection spreading – and improves the health of those affected.

Individuals can change their sexual behaviour to cut the risk of getting HIV.

Some of the main points

- Sandwell has a high rate of HIV (2.03 cases per 1,000 people aged from 15 to 59 in 2012).
- In the same year there were eight children aged up to 14 getting treatment for HIV – and 19 people over 60.
- The number of people in Sandwell getting treatment for HIV rose from 90 in 2003 to 376 in 2012.
- The number of people diagnosed with HIV fell from 50 in 2010 to 30 in 2011 and 22 in 2012.
- Figures show that HIV affects people from all ethnic groups in Sandwell. There were nine new cases, for example, among white people in 2012 – and nine among Black Africans.

Cutting the risk of getting HIV

- Have a HIV test if you think you may have had sex that puts you at risk. Get tested regularly if you are one of those most at risk – men who have sex with other men and Black African men and women.

- Men who have sex with other men should be screened for HIV and other sexually transmitted infections at least once a year – and every three months if they are having unprotected sex with new or casual partners.
- Black African men and women should have a HIV test (and regular screening for HIV and sexually transmitted infections) if having unprotected sex with new or casual partners.
- Always use a condom. Use it correctly – and until all your partners have had a sexual health screen.
- Cut the number of your sexual partners and avoid overlapping sexual relationships.
- Remember: unprotected sex with partners of the same HIV status is unsafe. For the HIV positive, there is a high risk of getting other sexually transmitted infections and hepatitis. The HIV negative run the same risks – and also a high risk of spreading HIV.

What we can do to improve things

Do more to prevent HIV and make people more aware of it by:

- increasing HIV testing
- targeting ‘at risk’ groups with advice on safer sex
- considering ‘point of care’ testing for high risk groups.

Dementia

Our plans

The government published a five-year national plan – 'Living Well With Dementia' – in 2009. It aims to improve care for people with dementia and their carers.

Dementia is the biggest health concern for people over 55. Its economic costs are higher than cancer, heart disease or stroke.

We have refreshed Sandwell's Dementia Strategy. It will continue to concentrate on providing services (tailored to the individual and their carer) ranging from prevention and early intervention through to timely diagnosis and living well to the end of life.

We will particularly target people:

- who develop dementia at a younger age
- from ethnic minority communities
- with learning disabilities, HIV or a history of substance misuse.

Public health will play an important role in contributing to this work.

People who have other mental illnesses ('functional' mental disorders) will have a full range of care and specialist services based on need and not age.

Carers' needs, too, for support, education and breaks will be properly assessed.

Achievements

Publications

Middleton J. *http://betterhealthforall.org/2012/12/10/dr-john-middletons-healthcheck-on-the-public-health-transition/*

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Middleton J. *http://betterhealthforall.org/2013/02/14/how-to-feelgood-about-end-of-life-care/.* February 14 2013.

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Middleton J, ed. A public health council. The 23rd annual report for the metropolitan borough of Sandwell (for the year 2012). Oldbury: Sandwell MBC, July 2013.

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Stokes S, Middleton J, Bramley G, Veigas H. Evidence review study of public health interventions in policing: an example of translating evidence into practice for implementation of effective interventions for crime reduction. Lancet 2013; Public health science: 92.

Southon P, Sandwell Joint Health and Wellbeing Strategy 2013-2015. Sandwell Health and Wellbeing Board. *http://www.sandwell.gov.uk/healthandwellbeingboard*

Southon P (named contributor). Planning Healthier Places: report from the reuniting health with planning project. Town and Country Planning Association. 2013

Conferences

Dr John Middleton

The future of public health. All Party parliamentary Group on health, West Midlands Event. (Chair Lord Hunt) Heartlands Hospital 1 February 2013.

LGA annual public health conference; local government house: presenting for FPH 26 February 2013.

Reducing health inequalities. Westminster conferences. Faculty of Public Health speaker. 30 April 2013.

Reducing health inequalities at the local level: what can public health directors in local authorities do? Liverpool University Masters in public Health course on health inequalities. 2 May 2013.

Stokes S, Middleton J. Better evidence for better community safety. Sandwell Health's Other Economic Summit. 13 June 2013.

Ashton J, Middleton J. The Faculty of Public Health: implications for leadership post Francis. The Francis inquiry workshop. Public Health England Annual conference, Warwick University. 5 September 2013

Middleton J. Health and wellbeing strategies, public health and the economy. Public Health England West Midlands Centre, West Midlands Improvement and Efficiency and Learning for Public Health WM. Regeneration, economy and health conference. 4 November 2013.

Middleton J, Social work in austerity, poverty and health. British Association of Social Workers, West midlands branch. Blakenhall Health living centre, Wolverhampton. 4 March 2014.

Middleton J, Recession, Austerity, inequality, welfare reform and health. GovToday Public health national conference, The Brewery Conference centre, London. 12 March 2014.

Conferences

Paul Southon

Food sector innovation project. Poster presentation at the WHO UK Healthy City Network Annual General Meeting, Preston. 12 February 2014

Fuel Poverty: the public health business case. Oral presentation at the Sustainable Housing Action Partnership conference, Birmingham. 17 February 2014

West Midlands Healthy Urban Development Group: from local to national. Oral presentation at the Midlands and East planning and health conference. Leicester. 27 November 2013

Healthy Urban Development: Local to National. Poster presentation. PHE Transforming the Public Health System Together conference. Birmingham. 6 September 2013

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Responsibility for the opinions expressed in this report rest with the Editor, Dr John Middleton, Director of Public Health.

Any errors or points of clarification that need to be further addressed should be forwarded to Jyoti Atri at jyoti_atri@sandwell.gov.uk.

Detailed reports that make up Sandwell's Public Health Annual Report for 2013 are contained on the accompanying CD.

CD Content

Cancer
- Bowel Cancer Pathway Analysis
- Breast Cancer Pathway Analysis
- Lung Cancer Pathway Analysis
- Prostrate Cancer Pathway Analysis
- Top four Cancer Pathway Analysis
- Cancer rates in Tividale

Cardiovascular disease
- Cardiovascular disease BMJ awards submission

Child Health Profiles
- Sandwell Child Health Profile 2014
- Dudley Child Health Profile 2014
- Walsall Child Health Profile 2014
- Wolverhampton Child Health Profile 2014

Commissioning
- Commissioning for value information pack

Dementia
- Sandwell Dementia Needs Assessment
- Sandwell Dementia Strategy 2013-16

Dental Public Health
- Sandwell children's dental health

Environmental Public Health
- Access to healthy food in Sandwell
- Air Quality monitoring in Sandwell
- Case for biomonitoring programme
- Composition and dietary quality of hot food takeaways in Sandwell
- Phase II Sandwell Environmental Public Health tracking System

Health Profiles
- Sandwell Health Profile 2013
- Dudley Health Profile 2013
- Walsall Health Profile 2013
- Wolverhampton Health Profile 2013

Hearing impairment
- Creating a hearing loss register

Housing and health
- Housing and health presentation

Infant mortality
- Sandwell infant mortality how do we compare presentation

Joint Strategic Needs Assessment (JSNA)
- Alcohol JSNA
- BME JSNA
- Environment and health JSNA
- Frail older people JSNA
- Learning disabilities JSNA
- Long terms conditions JSNA
- Obesity JSNA
- Pan Birmingham Cancer Needs Assessment

Learning disabilities
- Sandwell learning disability profile 2013

Life expectancy
- Life expectancy segment report Sandwell
- Life expectancy segment report Dudley
- Life expectancy segment report Walsall
- Life expectancy segment report Wolverhampton
- Female life expectancy train map
- Male life expectancy train map

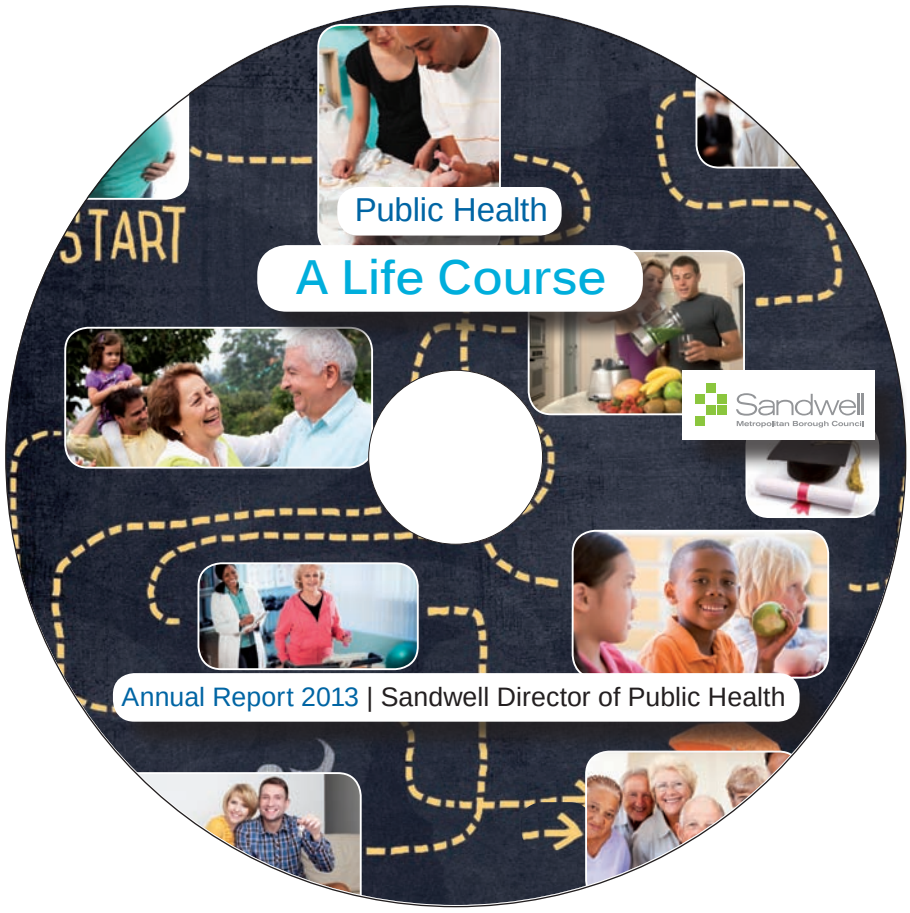
Marmot indicators
- Sandwell Marmot Indicators
- Dudley Marmot Indicators
- Walsall Marmot Indicators
- Wolverhampton Marmot Indicators

Maternity
- Maternity modelling

Mental Health
- Sandwell Mental Health Profile 2013

Obesity
- Obesity prevalence in children 2012-13
- Sandwell obesity strategy map
- Excess weight in adults

Pharmaceutical needs assessment
- Sandwell pharmaceutical needs assessment



QIPP

- Identifying potential QIPP opportunities

Respiratory disease

- Respiratory disease service review – Sandwell Birmingham and Solihull
- Respiratory disease service review – Sandwell Birmingham and Solihull (Full report)

Right Care Right Here

- Right Care Right Here Hospitalisation utilisation presentation

SHOES 2013

- SHOES programme 2013
- SHOES flyer 2013
- SHOES keynote speakers 2013

Presentations

- Ecological Public Health
- The patient paradox
- The challenge to restore universality
- Welfare reform
- Evidence based crime prevention
- Asset based approaches
- Sandwell – A healthy town
- Regulating public health
- Environmental tracking
- Environmental tracking 2
- Tracking and food
- Transport and health
- Improving air quality

Stroke

- Stroke and modifiable risk factors

Suicide and self harm

- Sandwell self harm hospital admissions

Tobacco Control

- Sandwell Tobacco Control Profile
- Dudley Tobacco Control Profile
- Walsall Tobacco Control Profile
- Wolverhampton Tobacco Control Profile
- Smoke free homes – pilot evaluation in schools

Tuberculosis

- Public Health England – reporting a TB patient
- West Midlands quarterly TB report

Visual impairment

- RNIB sight loss factsheet
- Registered and partially sighted people March 2011

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