



# LEARNING FROM THE PAST PLANNING FOR THE FUTURE

Director of Public Health Annual Report 2013



“

An ageing population of course, is something that should be celebrated: it represents the success of increasing life expectancy in the population, and longer lives for individuals.

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**The nature** of public health is largely about achieving long term change and taking action now to prevent poor health outcomes for our population in the future. For example, it has long been recognised that improving health at the very beginning of life – promoting the health of pregnant women and infants – can have a long-term impact on people's health throughout their lives.

The theme of this year's report is a reflection on some of the longer term trends in health over time and the types of action we can take now to promote and protect the health of people in Warwickshire in the future. This action includes addressing the wider determinants of health – influences on health from the environment in which people live – as well as improving people's health through more direct interventions such as reducing rates of smoking.

This report links with my previous series of annual reports which were based around other specific themes:

- 2010** **'Best Health for Older People in Warwickshire'**  
This looked at the challenge in Warwickshire of how, in partnership, we can ensure that our rapidly ageing population live in the best possible health.
- 2011** **'Reaching Higher: Healthy Lives, Healthy People, Healthy Warwickshire'**  
This considered in detail what I considered to be five key public health priorities within Warwickshire: obesity, alcohol, cancer and screening, mental health and wellbeing, and health protection including sexual health.
- 2012** **'1 in 3: The Picture of Ill Health in Warwickshire'**  
This highlighted that every third person in Warwickshire has a chronic health condition, and emphasised the need to take every opportunity to promote healthy living to prevent or postpone the onset of these conditions.

## What is the Director of Public Health Annual Report?

"A vehicle for informing local people about the health of their community, as well as providing necessary information for decision makers in local health services and authorities on health gaps and priorities that need to be addressed."

*Faculty of Public Health*

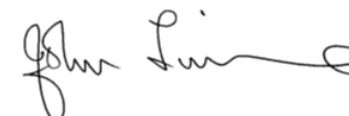
Although all these themes are different, they may be seen as looking at the same set of challenges from different angles. As a consequence, there are some consistent threads and messages which run through the whole series of reports. One of these is the challenge of an increasingly ageing population. This, of course, is something that should be celebrated: it represents the success of increasing life expectancy in the population, and longer lives for individuals. Another consistent thread is that of the challenge of addressing inequalities in health, recognising the differences in life expectancy seen between different areas and population groups within Warwickshire. Other threads relate to specific actions that people can take to improve their health, and ways

in which partner organisations can help to create a healthier environment and make healthy choices easier. All of these threads are therefore picked up again in this report, and reflected in the recommendations.

With the responsibility for public health moving back into local government, this presents us with a real opportunity to tackle these issues through a more collaborative and structured approach. We can build on the key functions of local government to shape the place and environment in which we live.

I hope that this report is of interest to you and serves its purpose of raising awareness of the work we do and the challenges we face.

I am keen to audit the impact of my annual reports and I would be grateful if you could let me know your comments, either by using the online form (see page 51 of this report for the web link), or by email to: [publichealthintelligence@warwickshire.gov.uk](mailto:publichealthintelligence@warwickshire.gov.uk)



**Dr John Linnane**  
Director of Public Health

# introduction

# Chapter 1

## The reorganisation of Public Health and related services

- The Health and Wellbeing Board is well placed, and must continue, to articulate a clear vision for health and social care services in Warwickshire.
- All partners across health and local government should demonstrate their commitment to the Joint Strategic Needs Assessment (JSNA) and the priorities of the Health and Wellbeing Strategy.
- The Health and Wellbeing Board needs to ensure that the new arrangements are used to their full extent to maximise opportunities for health gain.



# Chapter 2

## Looking back: Long term changes in population health

- The continuing inequality in health outcomes is a cause for concern and should be a priority for partners on the Health and Wellbeing Board.
- NHS England and Public Health England must learn from past experience and good practice in Warwickshire to ensure we continue to deliver excellent immunisation rates, especially for the new programmes.



# Chapter 3

## Looking forward: The challenges ahead

- All partners on the Health and Wellbeing Board need to promote the potential to improve health and wellbeing through lifestyle risk factor reduction both for their staff and their customers. This should be achieved through a commitment to, and implementation of, the Making Every Contact Count (MECC) approach.
- The Health and Wellbeing Board and all partners should address the Wanless 'fully engaged' scenario and articulate more ambitious health outcome targets for Warwickshire.

# recommendations

# Chapter 4

## A lifestyle challenge: Smoking

- We need to continue to focus on reducing smoking rates in Warwickshire. All NHS and local government contracts should include a commitment to smoking cessation and tobacco control as standard. A robust smoking cessation policy should be a standard component for all public sector contractors.

- The Health and Wellbeing Board should ensure all partners commit to playing their part in delivering significant reductions in smoking in pregnancy to below national and regional averages.



# Chapter 5

## The Wider Determinants of Health: Everyone's business

- This chapter illustrates the significant impact on our health from 'place' and environment. All local authorities in Warwickshire should ensure good health is a core aspiration for all they do and is reflected in all policies and strategies such as planning, licensing and housing.

- All partners on the Health and Wellbeing Board should commit to the use of Health Impact Assessments for all major developments and policy changes to their services.

# Chapter 6

## Conclusions

- A pledge from Public Health Warwickshire and Dr John Linnane, Director of Public Health, to work with all public sector bodies to ensure improving health and wellbeing is seen as core to all we do.



# 1 Chapter 1

## The reorganisation of Public Health and related services

Local public health services have undergone a major change this year, with the formal transfer of public health responsibilities from the National Health Service (NHS) to local government on 1st April 2013, as a consequence of the Health and Social Care Act 2012.

However, this represents a 'return' of public health responsibilities and functions to local authorities, which have a long history of public health involvement. This extends back to the 19th century, when local authorities appointed 'Medical Officers of Health' to respond to the challenges of the spread of communicable diseases, exacerbated by urbanisation and overcrowding, by actions such as the provision of clean water, sewerage and clearance of slums. It was not until 1974 that a reorganisation transferred most public health functions to the NHS.



Some of the most significant improvements to life expectancy have been achieved through public health interventions, rather than through advances in medicine. In addition to improvements in sanitation and housing, which were crucial to reducing infectious diseases, these include improvements in nutrition and food safety, legislation to improve air quality, other health and safety legislation, and the development of immunisation programmes.

Local government is responsible for commissioning and delivering many services that have an influence over the day-to-day conditions in which people live, and which in turn can affect people's health and wellbeing. The siting of public health within local authorities therefore provides a tremendous opportunity to influence many of the wider social, economic and environmental determinants of health which underlie inequalities in health. These include planning, transport, social care, housing, environmental health, leisure services and education. Although public health is situated within the county council, this also provides an excellent basis for strengthening working relationships with the district and borough councils within the county. There are many possibilities for local authorities to use their new responsibilities and resources for public health to consider health and wellbeing in everything they do, by considering the positive and negative health implications of all policies. In addition, the daily

contact that local authorities have with many of their residents, through provision or commissioning of services, provides many opportunities to 'make every contact count' in promoting health and wellbeing. This makes local authorities well placed to take on their new wider role in health and wellbeing.

The Health and Social Care Act 2012 also brought about other major changes, which came into full effect on 1st April 2013. At a national level, the Act formalised the abolition of Primary Care Trusts and Strategic Health Authorities and created Public Health England, NHS England and Healthwatch England.

**Public Health:**  
**"The science and art of promoting and protecting health and wellbeing, preventing ill-health and prolonging life through the organised efforts of society."**

**Faculty of Public Health.**



## Public Health England

Public Health England (PHE) provides national leadership and expert services to support public health, and will also work with local government and the NHS to respond to emergencies. It has been established as an executive agency of the Department of Health, and has brought together a number of organisations, including the former Health Protection Agency, into a single public health function. Its roles include:

- coordinating a national public health service and delivering some elements of this;
- building an evidence base to support local public health services;
- supporting the public to make healthier choices;
- providing leadership to the public health delivery system;
- supporting the development of the public health workforce.



## NHS England

NHS England has been established as an executive non-departmental public body of the Department of Health, at arm's length to the government. Its overarching role is to improve health outcomes for people in England. Its roles include:

- providing national leadership for improving outcomes and quality of care;
- overseeing the operation of clinical commissioning groups;
- allocating resources to clinical commissioning groups;
- commissioning primary care and a range of specialist services.



## Healthwatch England

Healthwatch England is an independent national body that aims to enable the views of people who use NHS and social care services to influence national policy, advice and guidance. Healthwatch England provide advice to the Secretary of State, NHS Commissioning Board, Monitor and the English local authorities.

# 1972

Snapshot  
from the  
past

Prior to 1974, Public Health was the responsibility of local authorities.

Referring to the impending reorganisation and transfer of public health to the NHS, Dr J. B. Bramwell (Medical Officer of Health for the South Warwickshire area), said in his annual report for the year 1972:

*"... I am quite certain that the work of the Chief Environmental Health Officers and their staffs will be a worthy continuation of the combined work of Public Health Inspectors, Surveyors, Engineers and Medical Officers of Health which has made such notable improvements to the health of the community over the last century. Personally speaking, this semi-divorce of the Medical Officer of Health or Community Health Specialist from the detailed day-to-day health work of Councils can only be looked at with sadness."*



At a local level, in addition to the transfer of public health responsibilities to local authorities, the Health and Social Care Act 2012 also created Clinical Commissioning Groups (CCGs), Health and Wellbeing Boards and local Healthwatch.

The 'return' of public health responsibilities from the NHS to local government presents excellent opportunities for taking action on the wider social, economic and environmental determinants of health, for taking action to reduce inequalities in health, and for considering the health impacts and opportunities of all activities undertaken by the local public services. At the same time, it is important not to lose the benefits of work resulting from the close integration of public health with clinical services in the NHS over the past 39 years, including building prevention into clinical pathways, and a population approach to prioritisation of clinical services.

The new Health and Wellbeing Board in Warwickshire brings together local commissioners across the NHS, public health and social care, in addition to elected representatives and representatives of Healthwatch. This should provide an excellent opportunity, not only to strengthen public engagement and democratic involvement, but also to enhance working relationships between health and social care, and to encourage the development of more integrated commissioning of services.

## Clinical Commissioning Groups (CCGs)

Every GP practice in England is now part of a CCG. CCGs now commission the majority of health services that were previously commissioned by Primary Care Trusts, including urgent and emergency care, most elective hospital care, maternity services and most community and mental health services. Three CCGs cover Warwickshire:

Warwickshire North CCG :  
[www.warwickshirenorthccg.nhs.uk](http://www.warwickshirenorthccg.nhs.uk)

South Warwickshire CCG:  
[www.southwarwickshireccg.nhs.uk](http://www.southwarwickshireccg.nhs.uk)

Coventry and Rugby CCG:  
[www.coventryrugbyccg.nhs.uk](http://www.coventryrugbyccg.nhs.uk)

Further information is available from their websites.

## Health and Wellbeing Boards

Health and Wellbeing Boards are forums where leaders from the health and care system and professionals work together to improve the health and wellbeing of their local population and reduce health inequalities. Every 'upper tier' and unitary authority has its own Health and Wellbeing Board. Board members will collaborate to understand their local community's needs, agree priorities and encourage commissioners to work in a more joined up way which should result in more joined up services from the NHS and local councils in the future.



## Local Healthwatch

A local Healthwatch is an independent organisation which gives citizens and communities a stronger voice to influence and challenge how health and social care services are provided within their locality. Local Healthwatch has a seat on the Health and Wellbeing Boards, ensuring that the views and experiences of patients, carers and other service users are taken into account when local needs assessments and strategies are prepared. For more information on how local Healthwatch operates in Warwickshire, visit [www.healthwatchwarwickshire.co.uk](http://www.healthwatchwarwickshire.co.uk)







# Chapter 1 Recommendations

- **The Health and Wellbeing Board is well placed, and must continue, to articulate a clear vision for health and social care services in Warwickshire.**
- **All partners across health and local government should demonstrate their commitment to the Joint Strategic Needs Assessment (JSNA) and the priorities of the Health and Wellbeing Strategy.**
- **The Health and Wellbeing Board needs to ensure that the new arrangements are used to their full extent to maximise opportunities for health gain.**

# 2 Chapter 2

## Looking back: long term changes in population health

Changes in the health status of the population occur slowly, and public health interventions generally have long-term rather than short-term impacts. It is therefore often difficult to see progress when we look at the small incremental changes that occur from year to year. However, the 'return' of public health to local authorities, after 39 years in the NHS, seems to provide a useful opportunity for reflection on longer-term changes in population health.

To illustrate some long-term trends, this chapter looks at changes in:

- **Population structure**
- **Life expectancy**
- **Causes of death**
- **Infant mortality**
- **Incidence of measles**

In addition to looking at trends at a Warwickshire level (where available) or a national level, some data presented in this chapter has been sourced from archived Medical Officer of Health annual reports from previous administrative areas in

Warwickshire, focussing on selected years in the period of time before the transfer of public health functions to the NHS in 1974.

All local historical analysis included within this report is based on limited available information from archived annual reports which, unfortunately, are not consistent in terms of timeframes or geographies. The local historical comparisons should therefore be regarded as illustrative rather than as direct comparisons.

Appendix 1 contains the 2012 local health profile, which provides a summary of current key health indicators and issues in Warwickshire.

### Population structure

The population pyramid, (Figure 1) illustrates how the population structure of Warwickshire has changed over the last 40 years, with a much higher proportion of the population now being in the older age groups and a lower proportion in younger age groups. This demographic change underpins the increasing demands and cost pressures on health and social care services.



### What is life expectancy at birth?

Life expectancy at birth is an estimate of the average number of years a person born at that time could expect to live if the mortality rates of the given geographical area remain constant throughout their lifetime. However, this does not indicate how long someone could actually be expected to live, both because the death rates of the area are likely to change in the future and because many of those in the area may live elsewhere for at least some part of their lives.

Life expectancy at birth is also not a guide to the remaining expectation of life at any given age. For example, if female life expectancy at birth was 80 years for a particular area, the life expectancy of women aged 65 years in that area would exceed 15 years. This reflects the fact that survival from a particular age depends only on the mortality rates beyond that age, whereas survival from birth is based on mortality rates at every age.



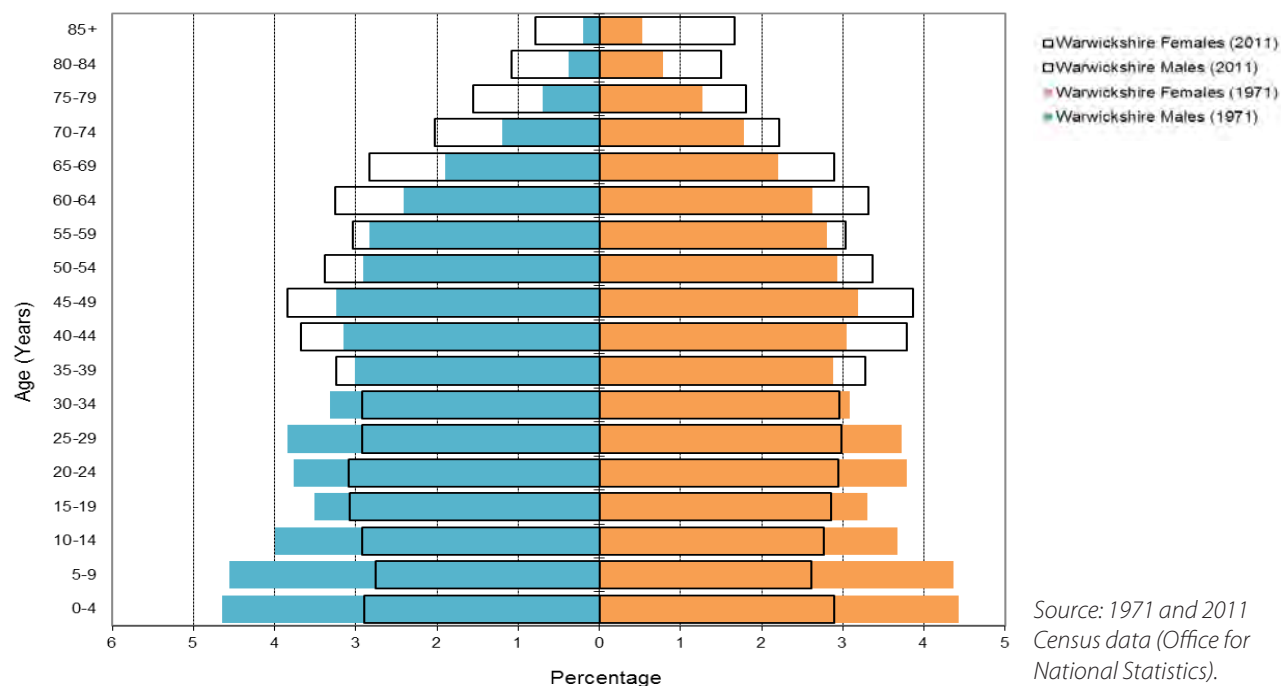
## Life Expectancy

Life expectancy at birth is one of the longest standing measures of health status in England and Wales, the first official life tables being published by Registrar General William Farr in 1839. Since its inception, life expectancy has been used to highlight variations in mortality experience between different geographical regions of the country and this practice has been continued by the Office for National Statistics (ONS) in recent times.

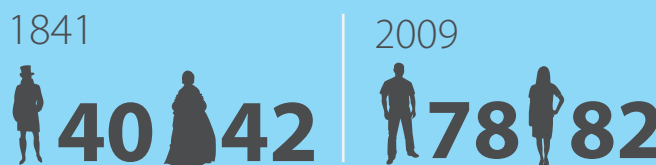
Throughout recent history, life expectancy across England and Wales has dramatically improved, particularly since the introduction of statutory health and hygiene regulations in the latter part of the 19th century. Even in more recent decades, life expectancy has continued to increase.

In England and Wales, for males, life expectancy has increased from around 40 years in 1841 to 78 years in 2009. Female life expectancy has increased from 42 to 82 years in the same period. This is shown in Figure 2.

**Figure 1: Population Structure of Warwickshire 1971 and 2011.**



**Figure 2: Life Expectancy.**



“From 1841 to 2009, life expectancy for males increased from 40 years to 78 years and for females increased from 42 years to 82 years.”

## timeline

1839

Under the Poor Law Amendment Act, Medical Officers were appointed to workhouses which provided basic medical care for the poor

1866

The Sanitary Act made local authorities responsible for sewers, water and street cleaning



1875

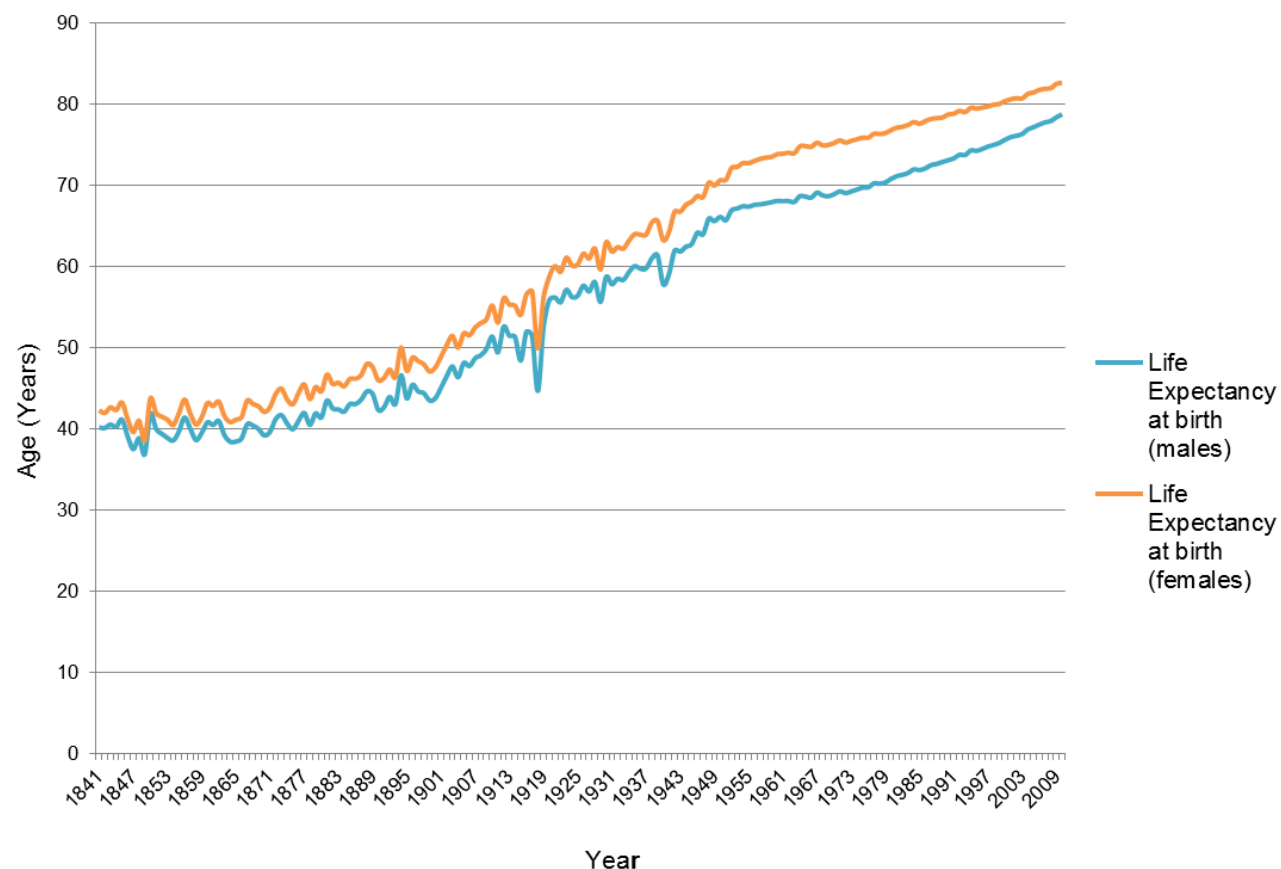
Second Public Health Act brought together a range of Acts covering sewage and drains, water supply, housing and disease



ONS have also published life expectancy data at local authority level. Each district and borough within Warwickshire, for both males and females, has experienced increases in average life expectancy of at least 3 years since 1991-1993. However, Figures 3.1 and 3.2 illustrate persistent gaps in life expectancy between the districts and boroughs in Warwickshire, for both sexes.

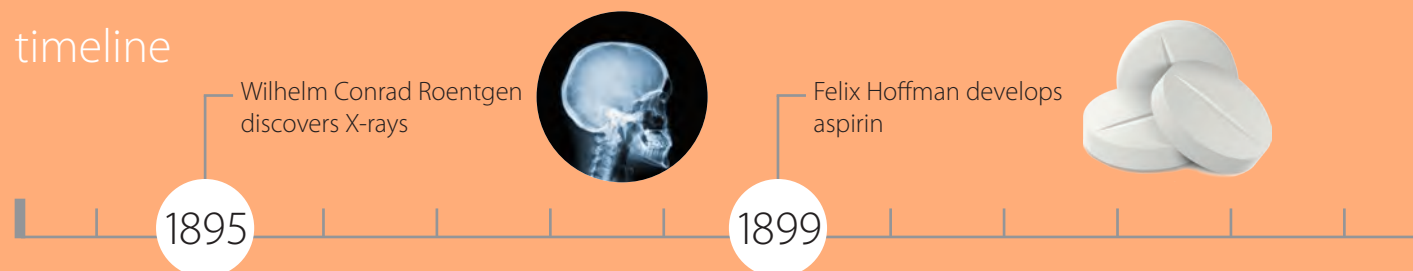


**Figure 2: Average life expectancy at birth in England & Wales, 1841-2009.**

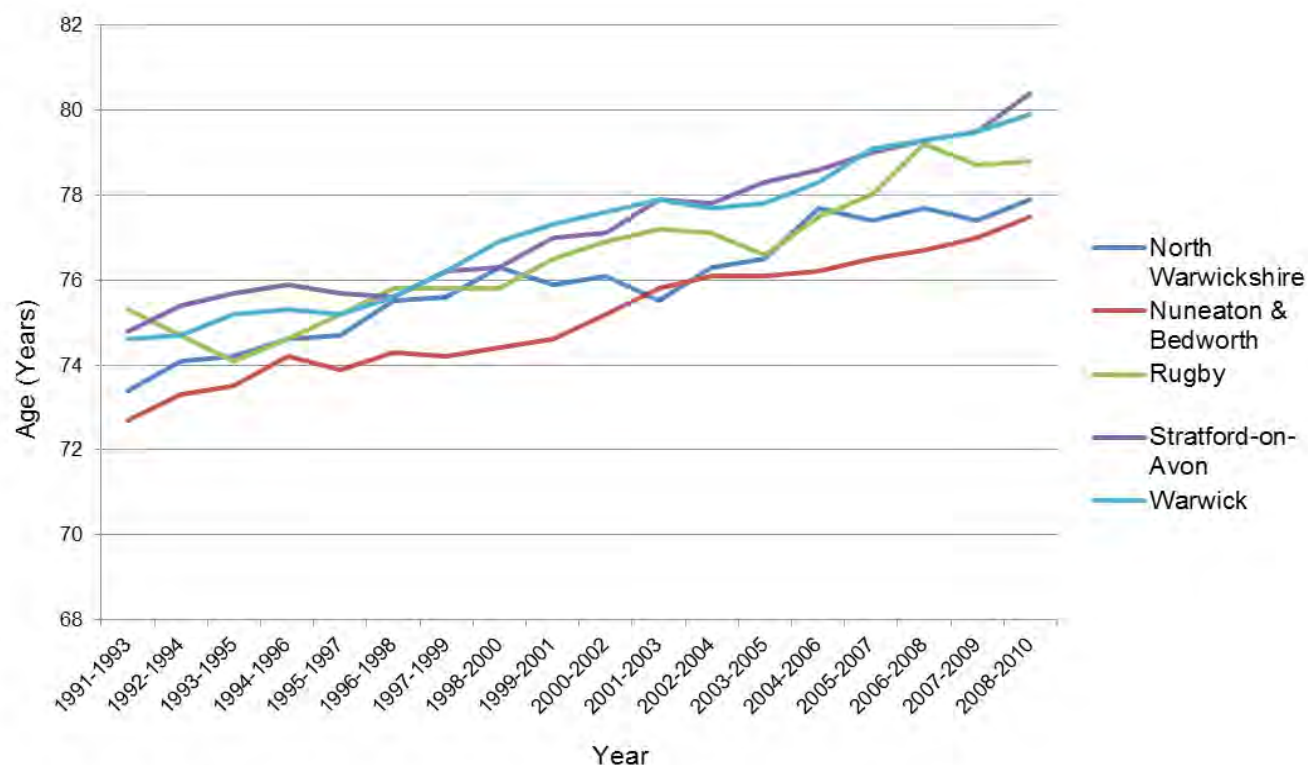


Source: Office for National Statistics.

## timeline



**Figure 3.1: Male life expectancy in Warwickshire local authorities, 1991-1993 to 2008-2010.**



Source: Office for National Statistics.

# 1973

Snapshot from the past

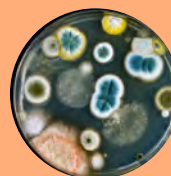
In terms of popular culture, going back forty years brings back some fond memories for some and sheer embarrassment for others. Number one songs for the year included Little Jimmy Osmond's 'Long Haired Lover from Liverpool', 'Welcome Home' from Peters and Lee, the spelling nightmare that was 'Skweeze Me Pleeze Me' from Slade and numerous hits from teen pin-ups Donny Osmond and David Cassidy. Top films of the year included 'The Sting' starring Robert Redford and Paul Newman, 'The Exorcist' and kung fu legend Bruce Lee in 'Enter the Dragon'.



Children's Act bans the sale of tobacco to children under 16

1908

Alexander Fleming discovers penicillin



1928

Fluoridation intervention trial

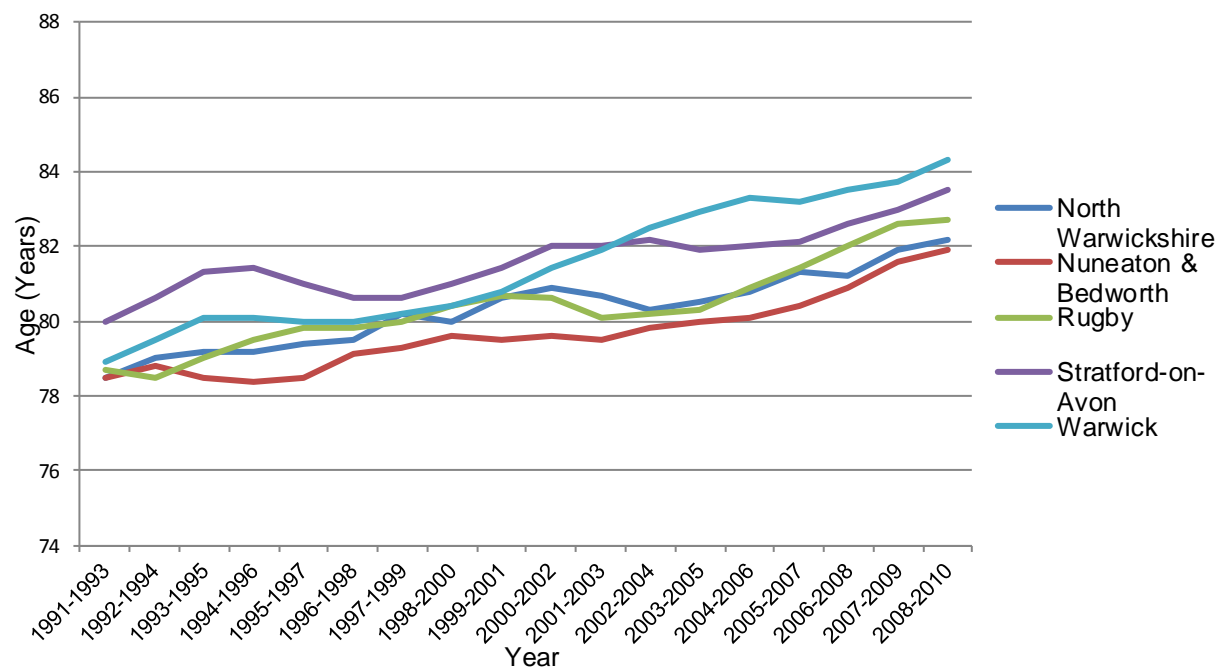


1945

Current life expectancy in Nuneaton and Bedworth, for both men (at 77.5 years) and women (at 81.9 years), is significantly lower than that for Warwickshire as a whole (at 79.1 years for men and 83.0 years for women); while that for men in Stratford-on-Avon (at 80.4 years) and that for women in Warwick district (at 84.3 years) is significantly higher. (The other life expectancy values are not statistically different from the Warwickshire average.)



**Figure 3.2: Female life expectancy in Warwickshire local authorities, 1991-1993 to 2008-2010.**



Source: Office for National Statistics.

timeline

The birth of the NHS



James Watson and Francis Crick work on the structure of the DNA molecule



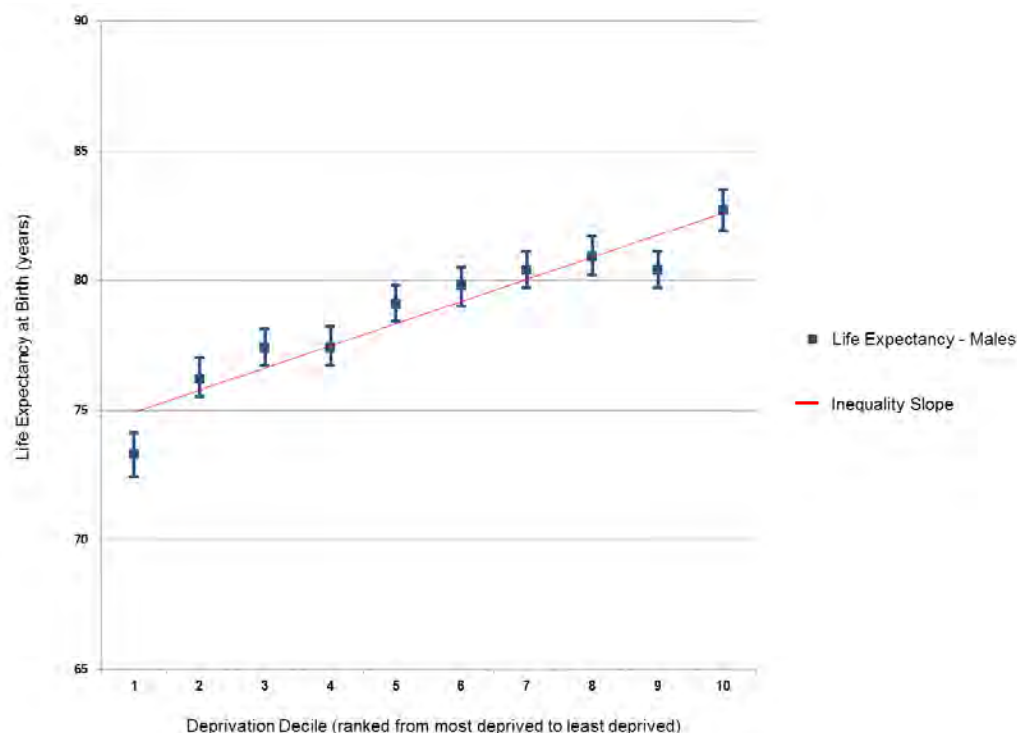
1948

1953



**Figure 4: Life expectancy by deprivation decile, showing the Slope Index of Inequality for males in Warwickshire, 2006-10.**

Slope Index of Inequality = 8.3 years (95% Confidence Interval: 6.0 to 10.6)



Source: Slope Index of Inequality Data for Local Authorities, East Midlands and London Health Observatories.

## The Slope Index of Inequality (SII)

SII is a measure of the difference in life expectancy between the most and least deprived sections of the local population. It is used as part of the assessment of health inequalities in a local area.

The population is divided into ten parts (deciles) by grouping the LSOAs (lower layer super output areas) in the county according to their level of deprivation (using the Index of Multiple Deprivation (IMD 2010)).

Life expectancy is calculated for each of these ten groups and plotted on a graph (Figure 4, shown in blue). A line of best fit (red) is drawn through all of the points, and the difference in life expectancy between the lowest and the highest points on the line is the figure quoted as the Slope Index of Inequality. Like life expectancy, there is a figure for males and a figure for females. This is exemplified in Figure 4 for males in Warwickshire.

In Warwickshire, the latest data suggests a difference of just over 8 years in life expectancy for males and approximately 7.5 years for females between the most and least deprived deciles of the county population. The Warwickshire male life expectancy gap is roughly in line with that for England but, for females, the Warwickshire figure is above the national equivalent (although not statistically significantly so); this means that the gap is larger for Warwickshire than for England.

Smoking and Health is published by Royal College of Physicians: A landmark document which highlighted the link between smoking and lung cancer



British government bans cigarette advertising on television



1962

1965

The Marmot Review into health inequalities, published in 2010, clearly illustrated the differences in health, wellbeing and length of life experienced by people in different social circumstances. It highlighted that people living in the poorest neighbourhoods in England will die on average 7 years earlier than those living in the richest neighbourhoods, with an even greater difference in the length of time people can expect to live in good health (disability-free life expectancy).

Within Warwickshire, there are differences in life expectancy at birth between the districts/boroughs of 2.9 years for males and 2.4 years for females (see Table 1).

At ward level, life expectancy at birth shows considerably more variation than at county or district/borough level. Male life expectancy at birth (2006-2010) ranges from 72.0 years in Abbey Ward (Nuneaton and Bedworth Borough) to 82.7 years in Cubbington, Radford and Stoneleigh Wards (Warwick District), representing a variation of 10.7 years. For females, overall life expectancy is greater and there is still considerable variation in

life expectancy across the county, ranging from 78.4 years in Abbey Ward (Nuneaton and Bedworth Borough) to 87.8 years in Park Hill Ward (Warwick District).

The Marmot Review proposed that national health outcome targets should cover both life expectancy (to capture years of life) and health expectancy (to capture the quality of those years). The Public Health Outcomes Framework (PHOF) sets the vision for the whole public health system, in order to provide positive health outcomes for the population and reduce inequalities in health. It includes two overarching outcomes:

- **increased healthy life expectancy, i.e. taking account of the health quality as well as the length of life; and**
- **reduced differences in life expectancy and healthy life expectancy between communities (through greater improvements in more disadvantaged communities).**

*At the time of writing this report, data was not available for these indicators. However, PHOF indicators are available in appendix 2.*

**Table 1: Life expectancy at birth in Warwickshire district/boroughs, 2008-2010.**

Area	Males	Females
North Warwickshire Borough	77.9	82.2
Nuneaton and Bedworth Borough	77.5	81.9
Rugby Borough	78.8	82.7
Stratford-on-Avon District	80.4	83.5
Warwick District	79.9	84.3
Warwickshire	79.1	83.0
England	78.6	82.6

Source: Office for National Statistics.

## What are 'statistical confidence intervals'?

Estimates based on a random sample of a population are subject to 'sampling error', due to the random variation that occurs when a subset of the population is sampled and used to estimate a percentage or rate for the entire population.

However, even health events that are based on actual counts of an entire population, such as deaths, are subject to random variation. For example, a rate observed in a single year can be considered as a sample or estimate of a true underlying rate.

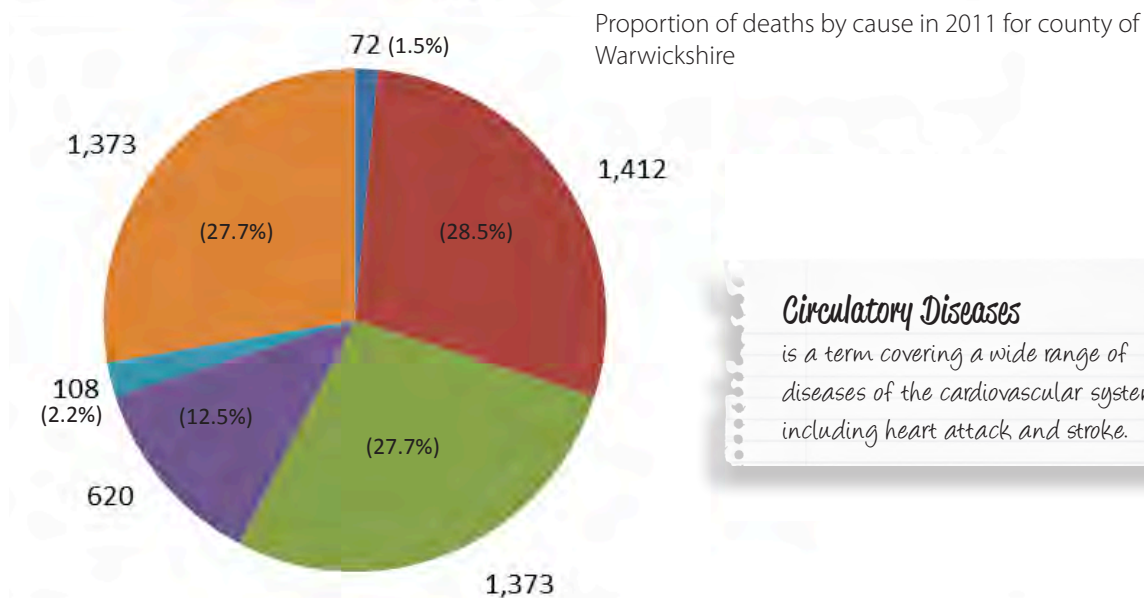
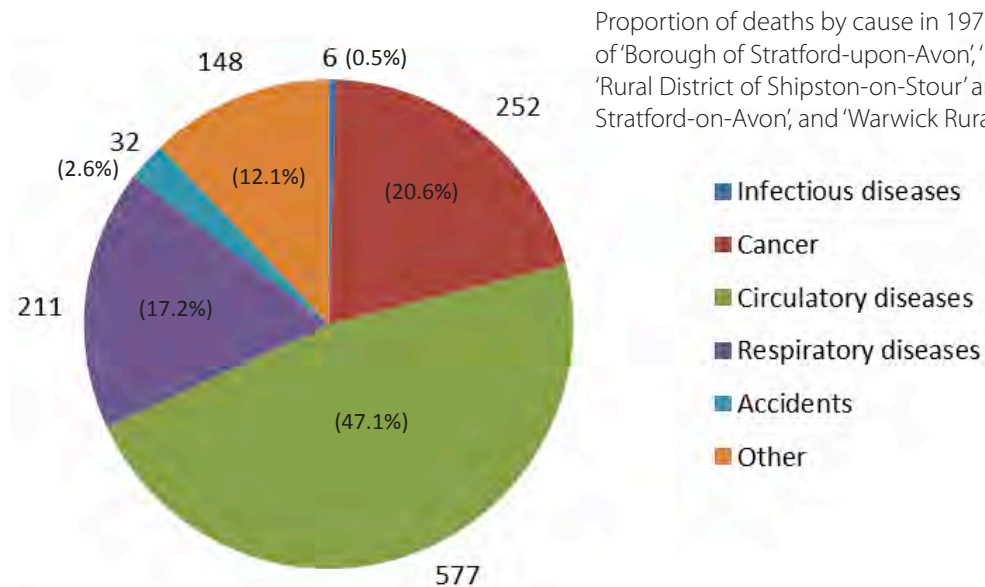
In general, sampling error or random variation is greater when the numerator (the number of events) is small.

A confidence interval gives us an estimated range of values and its width gives us some idea about how uncertain we are about the reliability of the rate that has been calculated.

Using confidence intervals can help to interpret whether differences observed in rates or proportions (between areas, or changes over time) may be due to random variation, or whether they are likely to represent 'real' differences or changes.

“ Within Warwickshire, there are differences in life expectancy at birth between the districts/boroughs of 2.9 years for males and 2.4 years for females.

**Figure 5: Proportion of deaths by cause in Warwickshire 1972 and 2011.**



### *Circulatory Diseases*

is a term covering a wide range of diseases of the cardiovascular system, including heart attack and stroke.

## Causes of death

We had hoped that looking back at annual reports from around forty years ago would enable us to see how death rates for different causes of death had changed in Warwickshire. Unfortunately, the mortality data provided in the old reports that were available does not give age at death, and therefore was not sufficiently detailed for us to calculate and compare rates. However, the reports did include details of the cause of deaths at all ages, and a comparison of proportion of deaths by cause is given in Figure 5. The most striking difference is the change in the proportions of deaths due to circulatory diseases and cancers.

Over the last 40 years, death rates from the main causes of mortality have decreased as medical technology and treatments have improved, along with increased knowledge of key lifestyle risk factors such as smoking. Modelling of the factors contributing to the decrease in coronary heart disease mortality rates in England and Wales between 1981 and 2000 suggested that just under half (42%) of this decrease could be attributed to medical and surgical treatments in individuals. Just over half (58%) of the decrease could be attributed to population risk factor reductions (principally reductions in smoking prevalence) despite adverse trends for physical activity, obesity and diabetes.

**“ The most striking difference is the change in the proportions of deaths due to circulatory diseases and cancers. ”**

Source: 1972 Medical Officer of Health reports for certain combined districts of Warwickshire, Warwickshire County Records Office; VS3 Mortality by Cause, Office For National Statistics Vital Statistics Tables 2011.

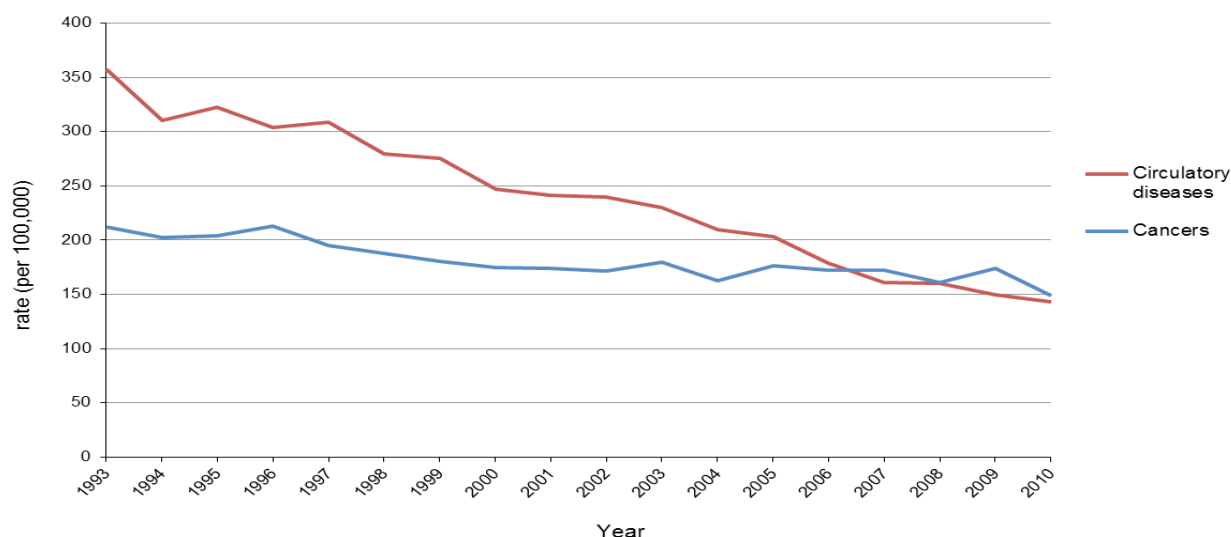


## Mortality Rates

can be adjusted or 'standardised' to take account of differences in the age structure of different populations. When rates are age-standardised, we know that differences in the rates over time or between geographical areas do not simply reflect variations in the age structure of the populations (see Figure 6).

The 'directly age-standardised rate' is the number of deaths per 100,000 that would occur in a standard population (usually using a theoretical population structure called the 'European standard population') if the local age-specific rates of the area applied.

**Figure 6: Age-standardised mortality rates for circulatory diseases and cancers in Warwickshire 1993-2010.**



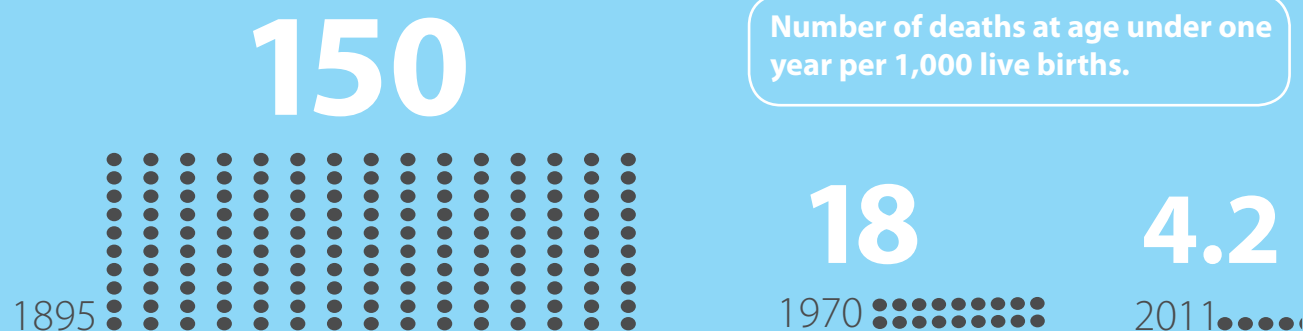
Source: The NHS Information Centre for health and social care.

## Infant Mortality

The infant mortality rate – deaths at age under one year, per 1,000 live births - has long been regarded as a key indicator of the health of a population. At the end of the 19th century, this rate was about 150 in England. (This means that, out of every thousand babies born alive, 150 died during their first year of life.) This rate fell dramatically in the 20th century and by 1970 was around 18 infant deaths per 1,000 live births. Since then, infant mortality rates have continued to fall, as reported by the World Health Organisation in Figure 7, reaching an all-time record low of 4.2 deaths per 1,000 live births in England and Wales in 2011.

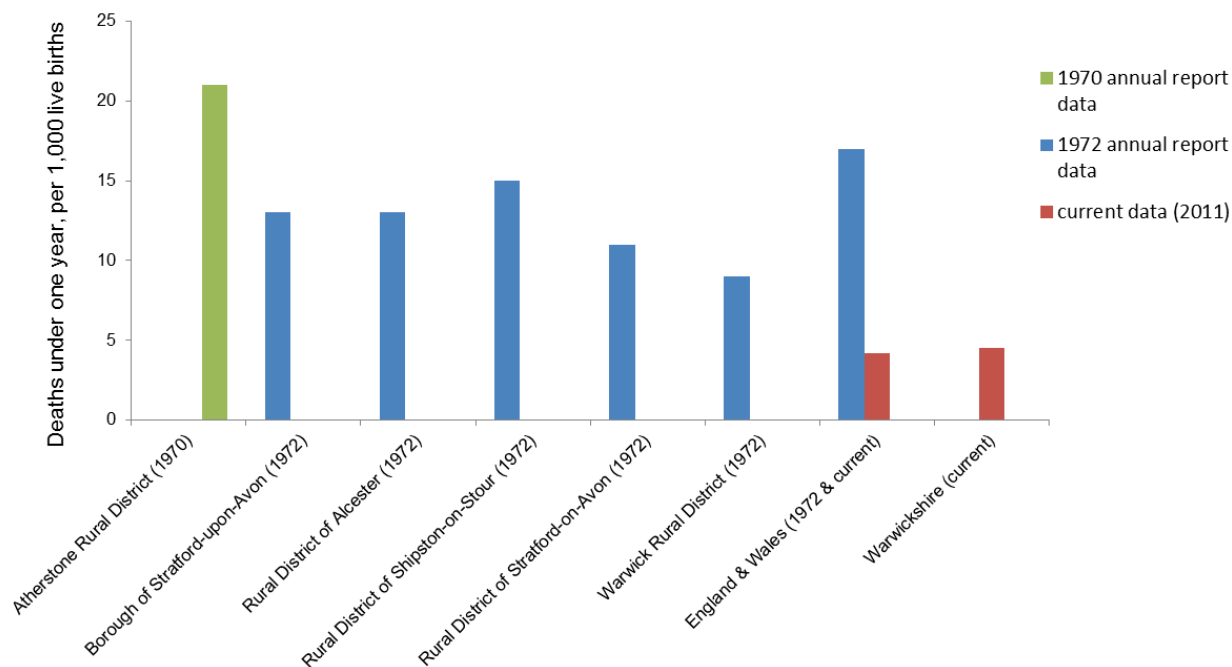
Similar improvements can be seen in local data. Infant mortality rate data from some archived annual reports for parts of Warwickshire in 1970/72 are shown in Figure 8, together with current (2011) national and county rates.

**Figure 7: Infant mortality rate, England, 1895-2011.**



Source: European health for all database (World Health Organisation).

**Figure 8: Infant mortality in specific administrative areas, 1970-1972 and 2011.**



Source: 1972 – Annual reports from archive; 2011 – The NHS Information Centre for health and social care.

“ The infant mortality rate – deaths at age under one year, per 1,000 live births - has long been regarded as a key indicator of the health of a population.

# 1973

Snapshot from the past

Along with VAT coming into effect from 1st April, prices in 1973 were a little different from today.

A pint of beer would have cost you **13p** and a loaf of bread **11p**. In terms of house prices, a typical three-bed semi would set you back **£10,000** whilst the salary of miners was **£36.79** a week and a nurse, **£18** a week. A gallon of petrol was **35p**.



**£36.79**  
p/week

**11p**



timeline

1967

Dr. Christian Barnard performs the first human heart transplant



1971

First health warnings appear on cigarette packets



1974

Public Health leave local authority to become part of the NHS

**NHS**

Infant mortality is associated with a range of biological and social factors, including birthweight, maternal age, mother’s country of birth, marital status, and socio-economic status. Despite the overall continuing decline in infant mortality rates, differences between socio-economic groups persist. The Marmot Review (2010) highlighted a persistent gap in infant mortality between the routine and manual occupation group and the population as a whole, despite a nationwide health inequalities target to reduce this gap. This target is difficult to monitor at a local level, as the number of infant deaths in any given local authority among a particular group is very small and subject to random fluctuations from year to year.

One of the most significant factors in infant mortality is low birthweight, which can be a result of poor growth, prematurity or both. In 2011, the national infant mortality rates for very low birthweight babies (under 1,500 grams) and low birthweight babies (under 2,500 grams) were 172.6 and 36.5 deaths per 1,000 live births respectively, compared with a rate of 1.4 deaths per 1,000 live births among babies of normal birthweight. In Warwickshire in 2011, just under 1.5% of babies born were very low birthweight and 7.3% were low birthweight.

Smoking has been identified as a major risk factor contributing to low birthweight. According to the Department of Health, babies born to women who smoke weigh on average 200g less than babies born to non-smokers. Chapter 4 focuses more on the problems associated with smoking in pregnancy.

“ One of the most significant factors in infant mortality is low birthweight, which can be a result of poor growth, prematurity or both.

Measles

This extract, (below) from a Medical Officer of Health’s annual report from forty years ago, provide an illustration of the number of notifications measles at that time. (Bear in mind that this illustration relates to a small area within the county of Warwickshire.)



Rural District of Stratford-on Avon - 1973								Infectious Disease Notification		
Classifications	0-1	1-2	3-4	5-9	10-14	15-24	25+	Age unknown	Total	Ad. to hosp
*Measles	-	2	11	16	2	-	-	-	31	-
Acute Meningitis	-	-	-	-	-	-	2	-	2	2
Scarlet Fever	-	-	1	-	1	-	-	-	2	-
Infective Jaundice	-	-	-	-	1	4	4	-	9	1
Food Poisoning	-	-	-	1	1	2	5	-	9	1
*None immunised										

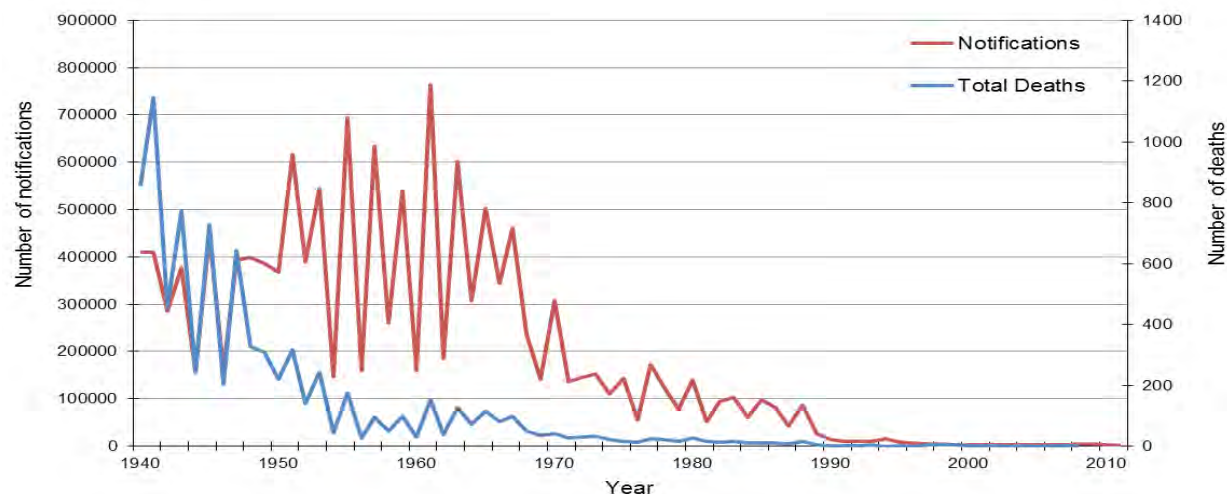
Source: Warwickshire County Record Office

timeline





**Figure 9: Measles notifications and deaths, England & Wales, 1940-2011.**



Source: Public Health England: 1940-2008.

In 1940, there were over 40,000 notifications of measles cases and over 800 deaths from measles in England and Wales. In 1961, there were over 760,000 notifications and 152 deaths from measles. According to the Health Protection Agency, in 2012 there were 2,016 notifications of measles in England and Wales; in 2008 (which is the most recently reported year for mortality from measles), there were 2 deaths from the disease.

**“ Years of low MMR coverage rates have left a significant proportion of the population susceptible to measles, mumps and rubella, and there has been a marked rise in the number of measles and mumps cases in recent years. ”**

Measles immunisation was first introduced in 1968, and the graph in Figure 9 shows that this was followed by a general decline in notifications in subsequent years. The combined measles, mumps and rubella (MMR) vaccine was introduced in 1988.

It is very unfortunate that publication of a paper in a respected medical journal (The Lancet) in 1998, which suggested a link between the MMR vaccine and autism and bowel disorders, led to widespread media attention and a loss of public confidence in the MMR vaccine. It is important to emphasise that:

- The paper has since been withdrawn by The Lancet and discredited.
- The doctor who was responsible for the (now discredited) paper was struck off the medical register by the General Medical Council.
- Numerous subsequent studies have found no link between the MMR vaccine and autism or bowel disease.

This ‘scare’ caused MMR vaccination rates to fall sharply, which in turn led to a rise in cases of measles. The years of low MMR coverage rates have left a significant proportion of the population susceptible to measles, mumps and rubella, and there has been a marked rise in the number of measles and mumps cases in recent years. The number of laboratory-confirmed cases of measles in England and Wales in 2012 was the highest since 1994.

M40 between Warwick and M42 opened



Compulsory basic training for motorcycles introduced



1989

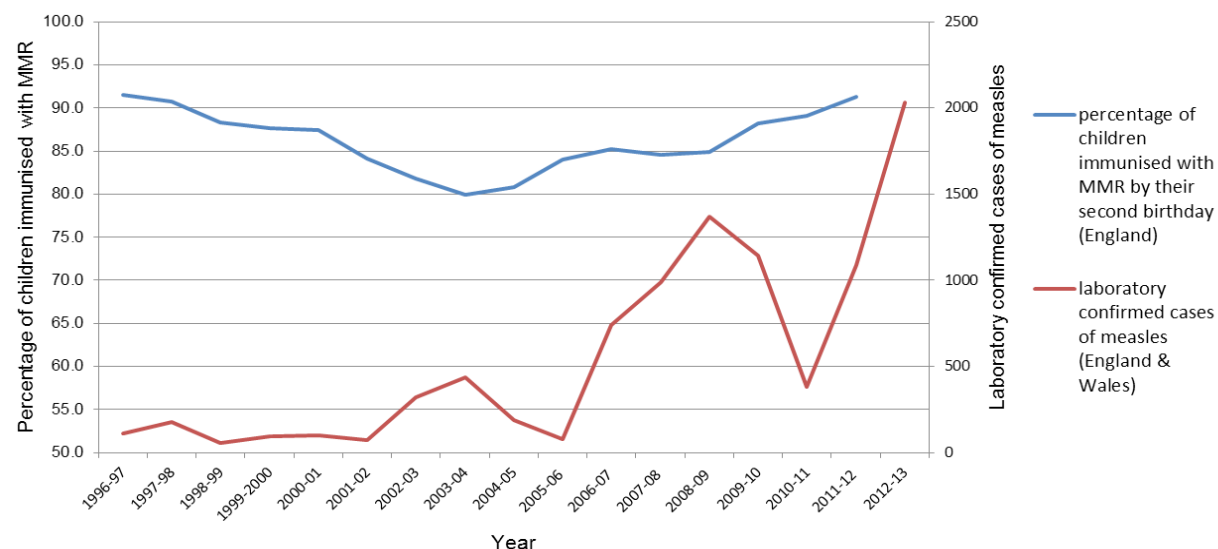
1990

The year 2011-12 was the first time since 1997-98 that over 90% of children nationally had been immunised against MMR by their second birthday (as shown in Figure 10), although this still remains below the World Health Organisation (WHO) target of at least 95 per cent of children immunised.

As shown in Table 2, Warwickshire has been successful in achieving much higher immunisation rates in recent years than those seen nationally or regionally.



**Figure 10: MMR coverage and laboratory-confirmed measles cases in England & Wales, 1996-1997 to 2012-2013.**



Source: Immunisation - The NHS Information Centre for health and social care.  
Laboratory confirmed cases - Public Health England.

**Table 2: Percentage of children immunised with MMR (first dose) by their 2nd birthday**

	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12
<b>Warwickshire</b>	85%	87%	88%	94.4%	95.1%	95.6%
<b>West Midlands</b>	88%	88%	88%	90.5%	91.5%	92.0%
<b>England</b>	85%	85%	85%	88.2%	89.1%	91.2%

## timeline

The Dahlgren and Whitehead model of 'The Main Determinants of Health' is presented

1991

The White Paper, Health of the Nation: identified five key areas (coronary heart disease and stroke, cancers, mental illness, HIV-Aids and sexual health and accidents) and 27 targets were set within these areas to monitor progress

1992

Red traffic light enforcement cameras introduced in Warwickshire

1993

# Chapter 2 Recommendations

- **The continuing inequality in health outcomes is a cause for concern and should be a priority for the Health and Wellbeing Board.**
- **NHS England and Public Health England must learn from past experience and good practice in Warwickshire to ensure we continue to deliver excellent immunisation rates, especially for the new programmes.**





# 3 Chapter 3

## Looking forward: The challenges ahead

The previous chapter illustrated how key health outcomes such as life expectancy and infant mortality have improved significantly over time, although inequalities still persist. Undoubtedly, part of this improvement in health outcomes can be attributed to improvements in living conditions and public health actions, while part can be attributed to 'medical advances'.

Virtually all countries, irrespective of how they organise and fund healthcare, have seen a steady escalation in the costs of providing healthcare to their populations over the last fifty years. In 2010, the UK devoted more than twice the share of its gross domestic product (GDP) to healthcare spending (public plus private) as it did in 1960 (3.9% in 1960 and 9.4% in 2010); for the United States of America, the rise has been more than threefold in the same period.

In terms of public sector expenditure on health, Figure 11 shows the growth in UK spending in real terms over the past 25 years.

**Figure 11: UK public sector expenditure on 'health' in real terms 1988-1989 to 2011-2012. (£billions)**



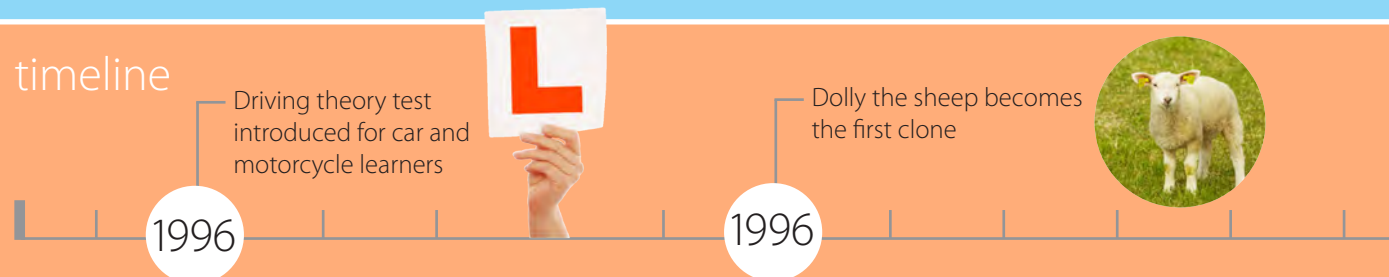
Source: HM Treasury Public Expenditure: Statistical Analyses.

Please note: Graph shows 'real terms' public sector expenditure on health: "Real terms figures are the nominal figures adjusted to 2011-12 price levels using outturn GDP deflators from the Office for National Statistics, and using the 2011-12 GDP deflator forecast by the Office for Budget Responsibility."



**In 2010, the UK devoted more than twice the share of its gross domestic product (GDP) to healthcare spending (public plus private) as it did in 1960 (3.9% in 1960 and 9.4% in 2010).**

timeline



The drivers that have brought about this rise include:

- demographic changes, with an increasingly ageing population (as illustrated in Figure 1, Chapter 2) tending to increase the demand for healthcare;
- advances in medical care, involving new models of delivering care as well as developments of new drugs and other technologies, meaning that more can be done to relieve suffering and prolong life; and
- changing patient and public expectations.

A report by Wanless, commissioned by the government and published in 2002, reviewed the long-term trends affecting the health service in the UK. It illustrated the considerable difference in expected future costs of health care, depending upon both the future productivity of health services and the level of engagement of people with their own health. It described a range of scenarios for the future costs and outcomes of healthcare in the UK, finding that the modelling of a “fully engaged” scenario – “where levels of public engagement in relation to their health are high” – not only promised to deliver the best health outcomes, but also appeared to be the least expensive option. A second review by Wanless, published in 2004, looked at the challenges of achieving the

‘fully engaged’ scenario, particularly in relation to prevention and the wider determinants of health and action that can be taken to improve the health of the whole population and to reduce health inequalities. This recognised that, while individuals are ultimately responsible for their own and their children’s health, there are significant inequalities between socioeconomic groups, and people need to be supported to make healthier lifestyle choices. It also recognised that action is needed not only by individuals, but also by health and care services, national and local government, media, businesses, ‘society at large’, families and the voluntary and community sector.

Of course, knowledge of the relationships between lifestyle factors and health is not new, and nor is the concept of the influence of wider social, economic and environmental determinants on health. These have been acknowledged by successive public health strategies and reports over many years, and this in itself provides evidence that there are no ‘easy fixes’.

There is no doubt that many illnesses and premature deaths could be avoided by adopting healthier lifestyles. For example, it is estimated that up to half of all cancers could be prevented by changes in lifestyle behaviours.

# 1970s

Snapshot from the past

There were a number of changes relating to public health in the 1970s, including:

- The first health warnings appeared on cigarette packets
- Public health leaves the local authority to become part of the NHS, and the title of Medical Officers of Health becomes abolished with public health’s move to the NHS
- Smallpox is eradicated
- The Black Report on health inequalities is published



“ It is estimated that up to half of all cancers could be prevented by changes in lifestyle behaviours.

The results of the Regional Lifestyle Survey (carried out in 1996 by the West Midlands Health Authority) are presented: 3,295 people completed the questionnaire in Warwickshire. Nearly 80% said they felt their health was either ‘very good’ or ‘good’



1997

The White Paper ‘Smoking Kills’ announced the government’s concerted plan of action to stop people smoking



1998

Important lifestyle factors include:

- **smoking**
- **obesity**
- **physical activity**
- **diet**
- **alcohol consumption**
- **sexual behaviour**

These lifestyle factors tend to be common risk factors in many different causes of ill health. For example:

• **Smoking is the single biggest cause of preventable early death and illness.** In addition to its well recognised role as a risk factor for circulatory diseases, respiratory diseases and many forms of cancer, smoking is also implicated as a risk factor in numerous other conditions. It is also a major contributor to health inequalities.

• **A physically active lifestyle can reduce the risk of many chronic conditions** including coronary heart disease, stroke, type 2 diabetes and some cancers, as well as having beneficial effects for mental health.

• **Regularly drinking more than the recommended maximum units of alcohol increases the risk of a range of chronic diseases** including liver disease, diabetes, cardiovascular disease and cancers of the breast and gastrointestinal tract.

• **High risk drinking also increases the risk of psychological ill-health**, in addition to being associated with a range of social problems such as violent crime.

It is also recognised that many people have multiple lifestyle risks to their health, with 'clustering' of risk factors particularly in disadvantaged groups.

However, these individual lifestyle choices are influenced by the 'wider determinants' of health, which include the built environment, transport, social care, housing, environmental health, leisure services and education.



An example would be the way in which physical activity is influenced by these factors:

- The decision to use 'active transport' (such as cycling or walking) for all or part of a journey may depend on site planning and accessibility of housing and amenities, the provision of footpaths and cycleways and the provision of public transport.
- Leisure services, including not only sports grounds, gyms and swimming pools, but also parks and public open spaces, provide people with opportunities for recreational physical activity.
- Community safety influences how safe people may feel in exercising outdoors in their neighbourhoods.

The next two chapters of this report build on the concepts of the influences of lifestyle factors and 'wider determinants' on health. Chapter 4 looks specifically at the issue of smoking, while Chapter 5 provides further examples of the influences of some of the wider determinants.

“ **A physically active lifestyle can reduce the risk of many chronic conditions.** ”

## timeline

2000

'Think' road safety campaign launched



2001

First fixed speed camera introduced in Warwickshire



2001

Smokefree Warwickshire Alliance set up



# Chapter 3 Recommendations



- **All partners on the Health and Wellbeing Board need to promote the potential to improve health and wellbeing through lifestyle risk factor reduction both for their staff and their customers. This should be achieved through a commitment to, and implementation of, the Making Every Contact Count (MECC) approach.**
- **The Health and Wellbeing Board and all partners should address the Wanless ‘fully engaged’ scenario and articulate more ambitious health outcome targets for Warwickshire.**

# 4 Chapter 4

## A lifestyle challenge: Smoking

It will not have escaped the attention of regular readers of Director of Public Health Annual Reports that smoking is mentioned in every previous edition. I make no apology for focusing a whole chapter on smoking in this year's report.

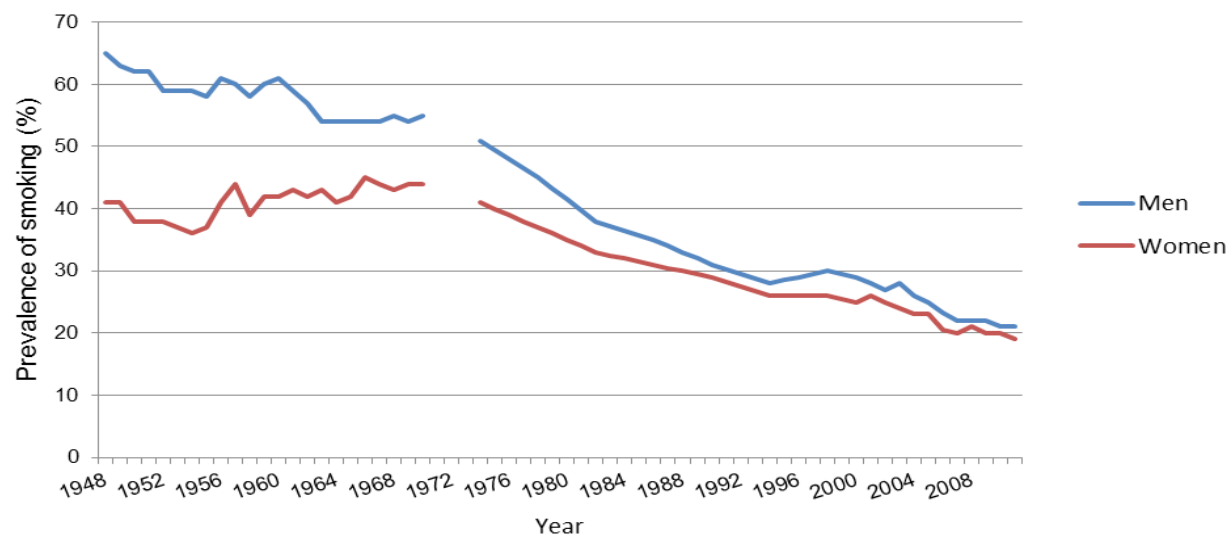
Quite simply:

- **Smoking is the single biggest cause of preventable early death and illness. In addition to its well recognised role as a risk factor for circulatory diseases, respiratory diseases and many forms of cancer, smoking is also implicated as a risk factor in numerous other conditions including dementia, osteoporosis and eye diseases (cataracts and age-related macular degeneration).**

- **For a smoker, the single most important thing they can do to improve their health, is to quit smoking.**



Figure 12: Prevalence of cigarette smoking in UK 1948-2011.



Source: 1974-2011 data from ONS; 1948-1970 data from Cancer Research UK. **Please note** that there is a data gap from 1970-1974.

“For a smoker, the single most important thing they can do to improve their health, is to quit smoking.”

### Historical smoking patterns

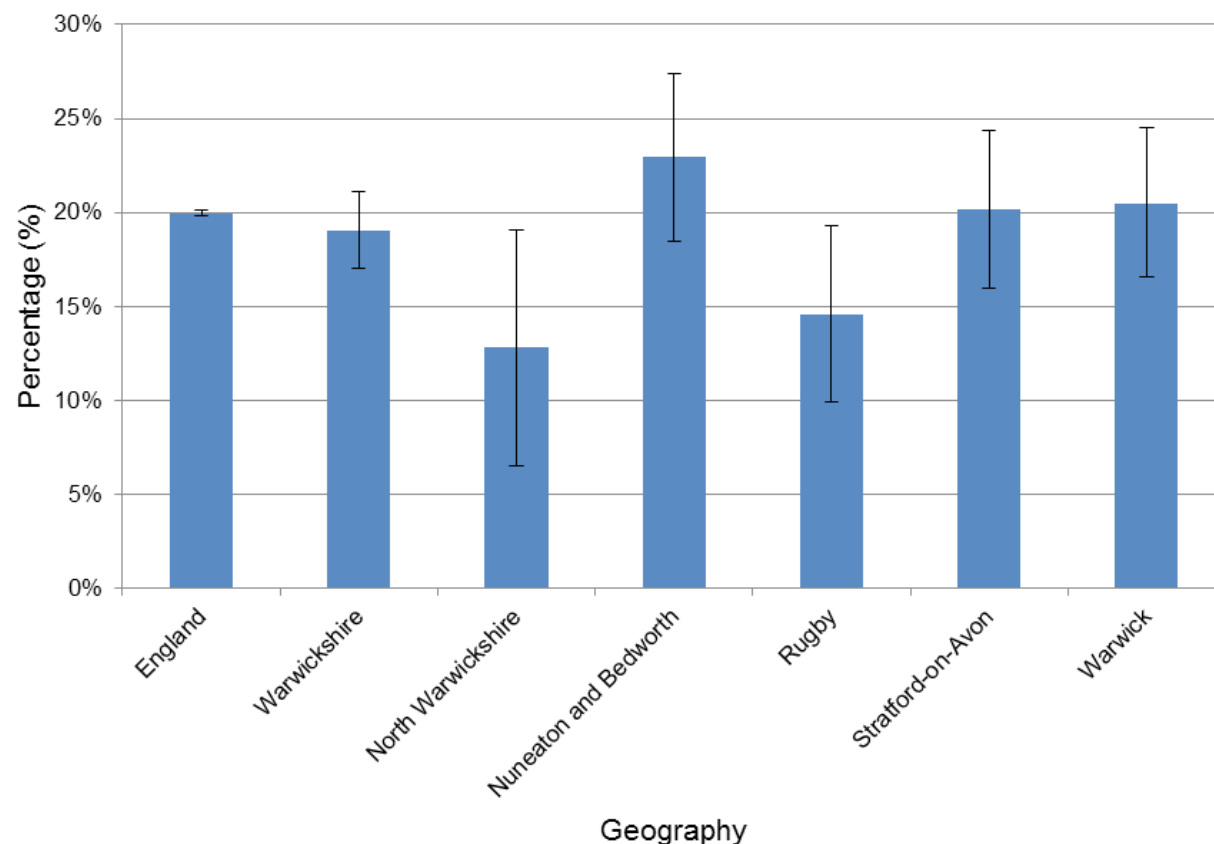
Smoking amongst men reached a peak around the middle of the 20th century, while smoking prevalence amongst women increased until the early 1970s, as shown in Figure 12. As evidence about the harmful effects of tobacco emerged, many individuals were prompted to quit smoking, and various strategies (including the use of legislation) were initiated to try to reduce the harm from tobacco.

### Current smoking patterns

The General Household Survey for 2011 showed a smoking prevalence of 20% of adults (aged 16+) in Great Britain (21% of men and 19% of women).

We do not have detailed information on the extent of current smoking in Warwickshire and its constituent districts. This year, Warwickshire County Council is undertaking a 'Living in Warwickshire' survey in order to gain better knowledge and insight into the lifestyle characteristics of local residents.

**Figure 13: Smoking prevalence among adults in England and Warwickshire 2011-2011.**



Source: Public Health England, Local Tobacco Control Profiles for England.  
Please note: Y error bars show 95% confidence intervals.

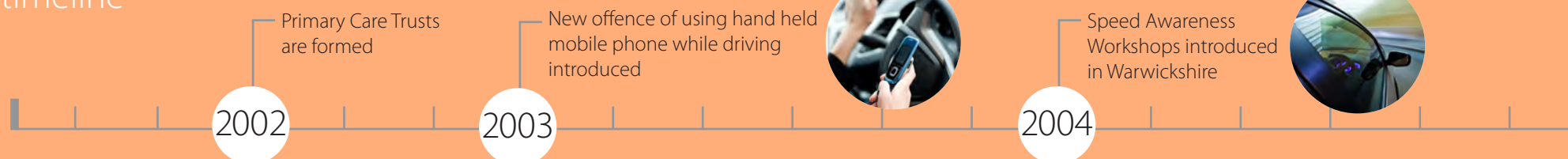
# Tobacco

...was introduced to Britain in the 16th century, and became commonly smoked in pipes by men, followed in later years by snuff-taking and cigar smoking. However, production of cigarettes from the latter part of the 19th century meant that, by 1919, more tobacco was sold as cigarettes than in any other form. Consumption amongst men rose steadily to a peak around the middle of the 20th century. Women began to smoke cigarettes in the 1920s, but not in large numbers until after the Second World War.



**In the last year, more than 1,600 children in Warwickshire have started smoking.**

## timeline





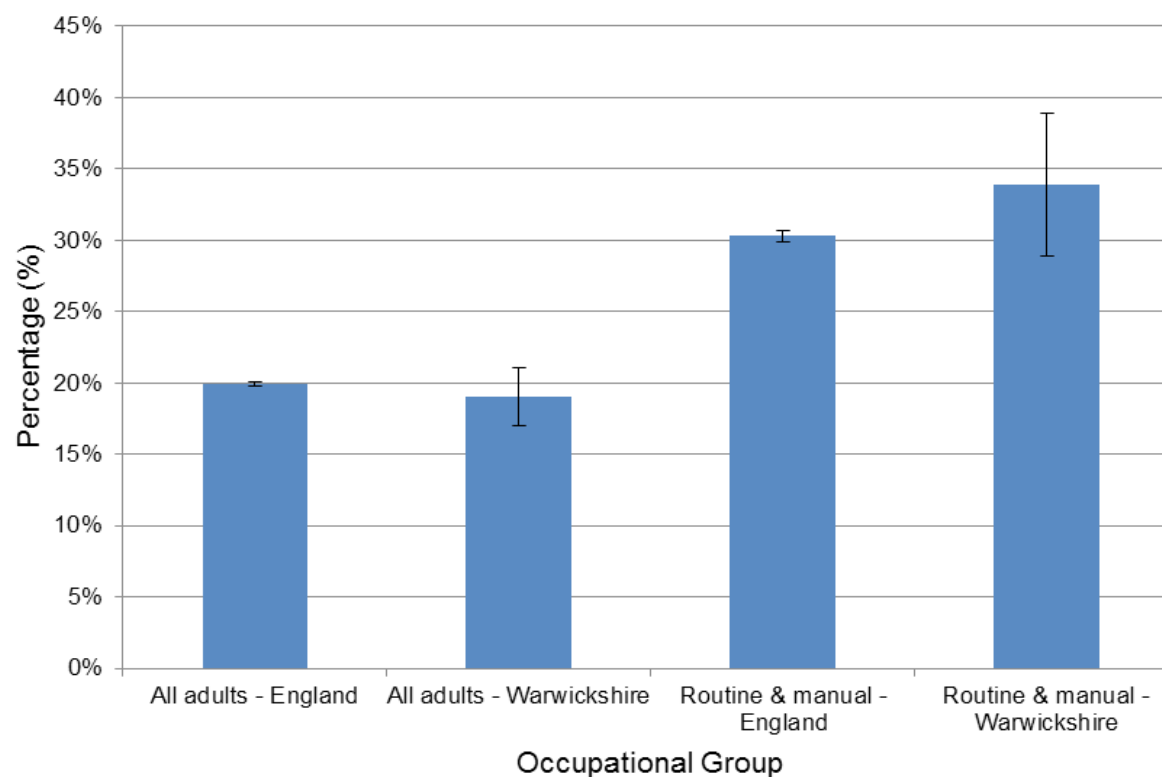
However, 'Local Tobacco Control Profiles' (produced by the London Health Observatory, now part of Public Health England) use data from the Integrated Household Survey (IHS) to estimate local prevalence for adults aged 18 years and over. This estimates the prevalence of smoking in Warwickshire to be 19.1% of adults, compared to 20.0% nationally (England), as shown in Figure 13. It also provides data for the constituent local authority areas, but these estimates are based on small sample sizes in the IHS and the wide statistical confidence intervals should be noted.

It is recognised that the prevalence of smoking varies markedly between socio-economic groups, and differences in smoking are an important factor in inequalities in health. People in deprived circumstances are more likely to take up smoking, to start younger, to smoke more heavily and to be less likely to quit smoking, each of which increases the risk of smoking-related disease.

The 'Local Tobacco Control Profiles' also provide estimates of smoking prevalence for adults in the routine and manual occupational groups, and this illustrates a higher prevalence in these groups nationally and locally, as shown in Figure 14.



**Figure 14: Smoking prevalence among all adults and adults in 'routine and manual' occupations in England and Warwickshire 2011-2012.**



Source: Public Health England. Local Tobacco Control Profiles for England. **Please note:** Y error bars show 95% confidence intervals.

### Smoking and lung cancer

Smoking is known to be a risk factor for many conditions, including circulatory diseases and a number of cancer sites and types. However, this section will look specifically at the association between smoking and lung cancer.

Although lung cancer can occur in non-smokers, it has been established that smoking causes more than four in five cases of lung cancer. Lung cancer

has one of the lowest survival rates of all cancers and is the most common cause of cancer death in the UK. (It causes more deaths in men than prostate cancer and more deaths in women than breast cancer.)

**“Smoking causes more than four in five cases of lung cancer.”**

## Smoking and Lung Cancer: Historical Perspective

During the first half of the 20th century, a striking increase in deaths attributed to lung cancer was noted in the UK. Although some studies previous to this time had suggested a possible association between lung cancer and cigarette smoking, it was the work of Doll and Bradford Hill in the 1950s that was responsible for establishing that most lung cancers are caused by smoking.

Doll and Bradford Hill initially reported a 'case-control study' in the British Medical Journal (BMJ) in 1950, comparing past and current smoking habits of hospitalised patients with lung cancer against a control group of hospitalised patients with gastrointestinal cancer.

*"At the time of the study, smoking was so prevalent amongst men that (even for the control group) a very low proportion of men were defined as 'non-smokers'; a history of heavier smoking was also noted in the lung cancer patients compared to the control patients."*

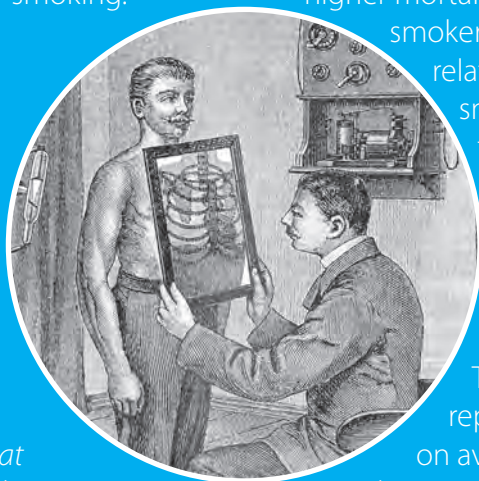
The study concluded that smoking was "an important factor" in the development of carcinoma of the lung.

Following this, Doll and Bradford Hill designed a prospective 'cohort' study to provide further evidence. Questionnaires were sent out to more than 34,000 doctors to collect details of their

smoking habits. The first report of this study was published in the BMJ in 1954 with a follow-up in 1956. The study continued for over 50 years, regularly re-surveying the participants to update smoking habits and causes of death.

Findings from the initial study showed higher mortality in smokers than in non-smokers and a clear dose-response relationship between the amount smoked and the death rate from cancer. The data also indicated a progressive and significant reduction in mortality with the increase in the length of time over which smoking had been given up. The final 50-year-follow-up report, provided evidence that on average, cigarette smokers die about 10 years younger than non-smokers and that cessation at age 50 halved the risk while cessation at 30 avoided almost all of it.

These reports, together with other studies published in the 1950s, provided strong evidence of a causal link between smoking and lung cancer. In 1964, a report of an expert committee for the United States Surgeon General concluded that "cigarette smoking is causally related to lung cancer in men; the magnitude of the effect of cigarette smoking far outweighs all other factors".



# 1962

Snapshot  
from the  
past

When some members of the Warwickshire Public Health team recently looked at some archived Medical Officer of Health reports from certain years that were available from the time prior to 1974 reorganisation, they noted that the harms of smoking had been recognised locally by 1962. A report for that year, for one area of Warwickshire, said: *"In April you agreed to promote the display in the town of posters calling attention to the risks to health arising from smoking of cigarettes. During July it was known that the County Health Committee had booked the Mobile Unit of the Central Council of Health Education for a tour towards the end of the year and that it hoped to include Kenilworth in the itinerary" and "It [the Council] decided to support the campaign to educate the public better in regard to risks to health from cigarette smoking".*

Generally, however, we were surprised by how little reference there was to smoking in the reports (for selected years) that our department members looked at. For example, they found no mention of smoking in the reports that were available for areas of Warwickshire in 1972.



Trends in lung cancer incidence and mortality rates reflect the trends in smoking prevalence in past years. Figure 15 shows trends in age-standardised mortality rates from lung cancer in men and women in Warwickshire and England over the past twenty years.

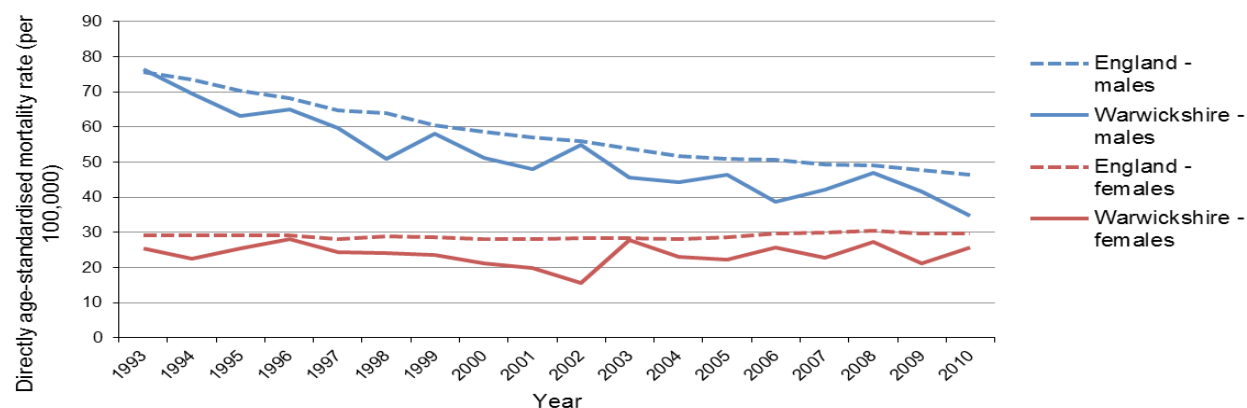
The decline in lung cancer mortality in men reflects the decline in male smoking, starting some decades earlier, while the convergence of mortality rates in men and women reflects the convergence of smoking behaviours in preceding decades (see Figure 12, prevalence of cigarette smoking chart earlier in chapter).

Current lung cancer mortality rates for Warwickshire and its constituent districts and boroughs are shown in Figure 16.

Lung cancer mortality for women in Nuneaton and Bedworth is significantly higher than that for Warwickshire as a whole; while that for women in Stratford-on-Avon is significantly lower. (The other lung cancer mortality rates are not statistically different from the Warwickshire average.)

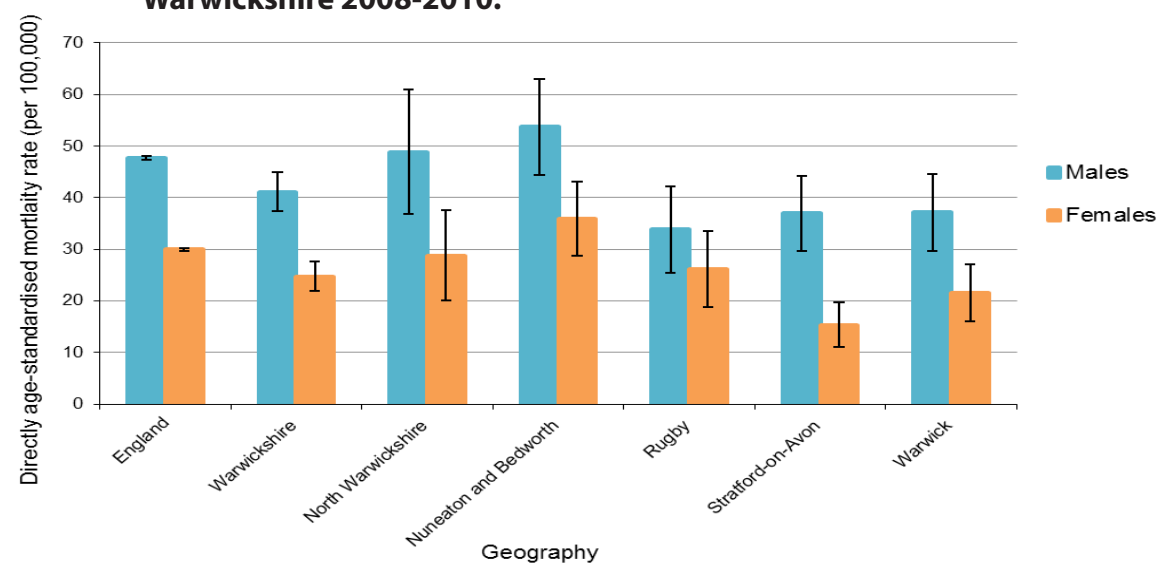
“ **Lung cancer mortality for women in Nuneaton and Bedworth is significantly higher than that for Warwickshire as a whole.** ”

**Figure 15: Mortality from lung cancer for males and females in England and Warwickshire 1993-2010.**



Source: Compendium of Population Health Indicators (The NHS Information Centre for health and social care).

**Figure 16: Age standardised mortality rates for lung cancer for males and females in Warwickshire 2008-2010.**



Source: The NHS Information Centre for health and social care. Note: Y error bars show 95% confidence intervals.



## Smoking in pregnancy

Smoking in pregnancy is known to have a number of adverse effects on the outcomes of pregnancy, including an overall increase in the risk of infant mortality by an estimated 40%. Specific risks include an increased risk of miscarriage, premature birth, stillbirth, placental abnormalities, low birthweight and sudden unexpected death in infancy.

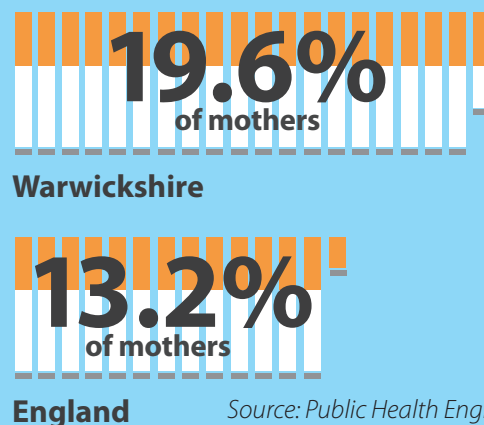
Information about smoking should be routinely collected from pregnant women, and the data gathered is published in the 'Local Tobacco Control Profiles'. However, there are concerns about the validity and accuracy of the data that is collected, attributed both to concerns about the sensitivity of the questions and to problems with record keeping. These factors make it very difficult to obtain the true picture. Nevertheless, as data is published, we need to take account of this. Information from the 'Local Tobacco Control Profiles' about smoking at time of delivery for Warwickshire is shown right in Figure 17.

### **This suggests a considerably higher prevalence of smoking at time of delivery in Warwickshire than nationally.**

Smoking is the single most modifiable risk factor for adverse outcomes in pregnancy. It is therefore a shocking statistic that up to one in five babies born in Warwickshire is born to a mother who smokes. Smoking during pregnancy is strongly associated with age and socioeconomic position, and contributes to inequalities in health.

Women who smoke should be strongly encouraged and supported by all health professionals to give up smoking before planning a pregnancy, or as

**Figure 17: Smoking status at time of delivery.**



Source: Public Health England. Local Tobacco Control Profiles for England

early in the pregnancy as possible. However, there will be some health gains from stopping smoking at any point in the pregnancy. Given that there are also adverse effects for babies and children exposed to secondhand smoke, attention also needs to be given to ensuring that women who have succeeded in giving up smoking during pregnancy are supported not to take it up again after delivery.

### **Tobacco control**

Smoking rates are much higher in some social groups, including those with the lowest incomes. These groups suffer the highest burden of smoking-related illness and death. Smoking is the greatest single cause of inequality in death rates between the lowest and highest income groups in our communities.

**68% of parents who smoke admit to doing so in the car with their children present.**

## Effects of smoking on outcomes of pregnancy

The effects of smoking on outcomes of pregnancy have been recognised for many decades.

A paper in the *British Medical Journal* (BMJ), published in 1959, reported results of a study of the effects of smoking in pregnancy in 2,042 women who delivered in six Birmingham maternity hospitals in the summer of 1958. This found that babies born to mothers who smoked regularly throughout pregnancy weighed on average 170g (6 oz.) less than babies born to mothers who were non-smokers. The paper concluded that "smoking during pregnancy substantially retards foetal growth".

♦ Lowe, C.R. (1959) *Effect of Mothers' Smoking Habits on Birth Weight of their Children*. BMJ, 1959, October 10; 2(5153): 673-676.

Further research over subsequent years has clarified and expanded knowledge of the risks of smoking in pregnancy, but much of what is known was already apparent over forty years ago. A leading article in the BMJ in November 1968 said: "There are many more women smoking now than there were some years ago, and this is reflected in their rising mortality from lung cancer. It seems that the time has come when women should be told frankly that if they smoke they not only put their own lives in jeopardy but, if they continue to do so during pregnancy, also expose their unborn infants to an unnecessary risk".

♦ BMJ (1968) *Smoking during Pregnancy*. BMJ, 1968, November 9; 4(5627): 339-340.



This year, Warwickshire County Council has become the first county council in the country to sign up to a Declaration on Tobacco Control (see appendix 3). Members of the Health and Wellbeing Board have committed their full support to the declaration. So far only Newcastle and Salford councils in England have committed to the declaration, making Warwickshire the third to sign up to the declaration, and the first county council.

Smokefree Warwickshire is working with partners on the following initiatives:

#### • **Helping tobacco users to quit**

Research has shown that two-thirds of smokers want to stop. Smokers are up to four times more likely to quit smoking successfully with support from the Stop Smoking Service.

The county council commissions the Warwickshire Stop Smoking Service which is provided by George Eliot Hospital. The service trains, monitors and supports Stop Smoking Advisors in general practices, pharmacies and other appropriate healthcare and community settings throughout the County. Specialist Advisors to support women to stop smoking in pregnancy are also located throughout the county. (Call 0800 085 2917 or see [www.smokefreewarwickshire.org](http://www.smokefreewarwickshire.org).)

#### • **Participation in CLeaR**

This is an initiative to maintain high standards through using effective evidence-based practice in local action to reduce the use of tobacco.

#### • **Reducing exposure to secondhand tobacco smoke in homes and cars**

80% of secondhand smoke is invisible, odourless and contains harmful cancer-causing poisons. It is estimated that almost 3,000 children in

### **Smokefree Warwickshire**

...is a multi-agency partnership committed to providing smoke free air, helping smokers to stop, and promoting a tobacco free society. It is developing a comprehensive tobacco control plan in line with The Tobacco Control Plan for England published in March 2011. This plan incorporates the key strands of tobacco control which include helping tobacco users to quit, stopping the promotion of tobacco, reducing exposure to secondhand smoke and ensuring effective communications for tobacco control, including promotion of the NHS Stop Smoking Service. The Smokefree Warwickshire Partnership supports the three national ambitions identified in the Tobacco Control Plan:

- reduce adult (aged 18 or over) smoking prevalence in England to 18.5% or less by the end of 2015;
- reduce rates of regular smoking among 15 year olds in England to 12% or less by the end of 2015;
- reduce rates of smoking throughout pregnancy to 11% or less by the end of 2015 (measured at time of giving birth).



Warwickshire visit their doctor each year suffering from the serious effects of breathing in secondhand smoke. In babies and young children, exposure to secondhand smoke increases the risk of sudden infant death syndrome, acute respiratory infection, ear infections, meningitis and asthma. Resources to promote smokefree homes and cars have been produced nationally for professionals and families: <http://smokefree.nhs.uk/resources/news/smokefree-homes-cars-2013/>

From the time the Warwickshire Stop Smoking Service started in October 2000 to the end of March 2013:



**73,033** people have set a quit date

**35,412** were still not smoking at 4 weeks

**14,604** were long-term quitters

And, bearing in mind that half of smokers will die early, it is estimated that over 8,800 premature deaths have been avoided.

#### • **Effective communications for tobacco control**

Issues relating to tobacco are highlighted periodically through press releases and these are often followed up with radio interviews and coverage in the local press. The Smokefree Warwickshire Partnership and the Stop Smoking Service contribute to national campaigns each year, such as No Smoking Day and Stoptober.

#### • **Reducing the number of young people who start to smoke**

Smokefree Warwickshire works with partner organisations to train and support people who work with young people to raise the issue of smoking.

#### • **Illegal and illicit tobacco**

Smokefree Warwickshire works in partnership with Trading Standards and Environmental Health colleagues on initiatives to raise awareness and educate the public about issues such as illegal and illicit tobacco and dangers of shisha.



# Chapter 4 Recommendations



- **We need to continue to focus on reducing smoking rates in Warwickshire. All NHS and local government contracts should include a commitment to smoking cessation and tobacco control as standard. A robust smoking cessation policy should be a requirement for all public sector contractors.**
- **The Health and Wellbeing Board should ensure all partners commit to playing their part in delivering significant reductions in smoking in pregnancy to below national and regional averages.**



# 5 Chapter 5

## The Wider Determinants of Health: Everyone's business

Local government has a key role to play in the promotion of health and wellbeing and preventing disease. Since the 19th century, from its role in caring for the needy and destitute, to the provision of clean water and sanitation, local government has played a leading role in public health.

Today, local authorities have a key contribution to make in ensuring housing, education, environment, planning, transport or regulatory departments promote good health in their population.

Water quality, air quality and road safety developments over the last 40 years are included in this chapter. They demonstrate the achievements that are possible when local authorities, health care and service providers work together to improve the health and wellbeing of the local population.

### Water quality

Safe, clean drinking water is vital to public health and the wellbeing of our society. In fact, the provision of safe drinking water is one of the most important steps that can be taken to improve the health of a community by preventing the spread of water-borne disease.

## The History of Water Quality

The history of water quality spans many years. In the mid-19th century, following the second pandemic of Cholera (an extremely unpleasant disease where victims suffer from violent vomiting and uncontrollable watery diarrhoea), a British doctor named John Snow published his 'waterborne theory'. Snow's theory proposed that Cholera was transmitted by contaminated water and was the starting point for legislation and subsequent joint action by public health and local authorities on improving water quality through sanitation and other mechanisms, which has led to a significant gain in the health of the population.

- ♦ In the late 18th century, governments started to install public water filters (using sand filters and chlorination) and for the first time public water was regulated.

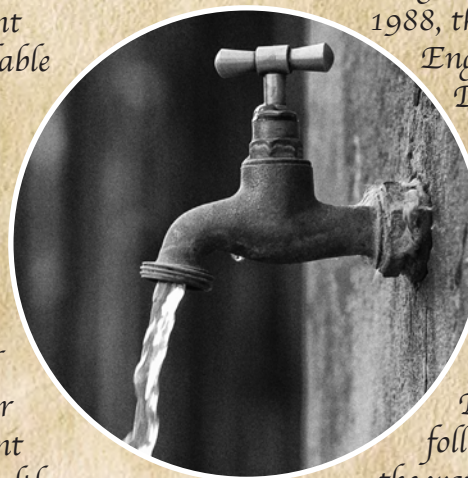
- ♦ In 1963, the Water Resources Act was passed and resources became regulated on a regional basis. The administration of water law remained local until the Water

Act 1973, which created ten regional water authorities whose areas were defined by river basins.

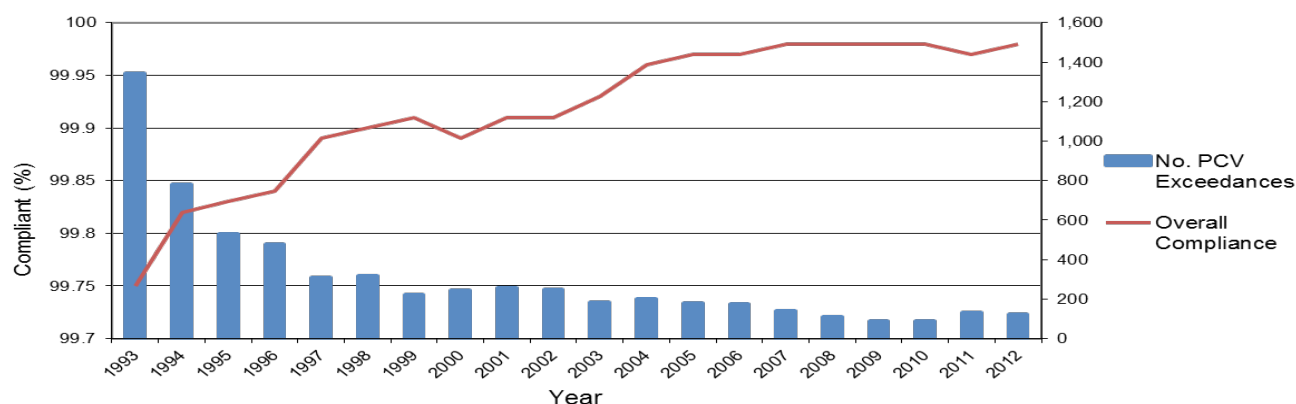
- ♦ Following the passing of the Water Act in 1988, the water and sewage systems in England and Wales were privatised.

Despite early criticism associated with large price increases to customers, privatisation has resulted in increased investment and has brought about compliance with stringent drinking water standards.

- ♦ The Drinking Water Inspectorate (DWI) was created following privatisation to regulate the water industry in England & Wales to ensure that the water supplied is safe and acceptable to consumers and meets the standards set down in law.



**Figure 18: Water Quality Compliance and PCV Exceedances Severn Trent region 1993–2012.**



Source: Severn Trent Water. Note: Total number of Prescribed Concentration or Value (PCV) incidences per year for all parameters.

The majority of Warwickshire's water is supplied by Severn Trent Water.

- Over the last 40 years, water quality in the Severn Trent region has improved significantly, as shown in Figure 18. Compliance with the standards in the EU Drinking Water Directive currently stands at 99.98%.
- Around 95% of the UK population is served by mains water from one of the statutory water companies. However, the other 5% uses water from private supplies. In the West Midlands region, there are a total of 6,567 private water supplies which service approximately 18,192 people.

- It is the responsibility of Environmental Health departments in the local authority to monitor the water quality of private water supplies both microbiologically (bacteria) and chemically (e.g. pesticides). The results for private water supplies in England are of concern with 7.2% of tests failing to meet the standards in 2011.
- Severn Trent Water undertakes approximately 500,000 water quality compliance tests per year to test for substances and organisms (known as parameters). Table 3 shows a selection of Severn Trent's water test monitoring figures over a 3 year

period (2009–2011). This information demonstrates the low failure rate of water quality compliance tests in the Severn Trent region. The DWI receives sampling details from water companies to ensure that water quality is stringently monitored.

- To protect public health and to ensure that drinking quality is of a highest possible standard, water is tested for several different parameters including coliform bacteria, E. coli, aesthetic parameters (colour, odour, taste), nitrates, aluminium, iron, lead, pesticides and turbidity.
- Should water companies detect either microbiological or chemical parameters in the water above the prescribed concentration or value the DWI will be informed. Public Health England will also be informed immediately when anything found could have a potential danger to the health of the population e.g. gastrointestinal conditions or poisoning. Any outbreak would be investigated in conjunction with Public Health England.
- Severn Trent Water also has close liaison with Public Health and Environmental Health officials to assess any likelihood of illness in the community being associated with the water supply. If such an incident occurs, an Incident Management Team will be set up and Severn Trent, with guidance from Public Health England, will issue advice to customers e.g. 'Boil Water' notice, 'Do not drink' notice.

## timeline





## Water Fluoridation

Fluoridation involves the controlled addition of fluoride to public water supplies in a bid to prevent dental decay. The DWI has established a Code of Practice which all water suppliers operating in England and Wales are expected to comply with. The Code sets out the principles underpinning the safe design and operation of fluoridation installations.

At present, around 10% of the UK population receives a water supply that either has been fluoridated to a certain level or has a similar amount of fluoride present naturally. Most parts of Warwickshire are supplied with fluoridated water the first schemes started in Rugby in the late 1960s and in South Warwickshire in the 1970s.

There have been significant improvements in local children's dental health in the years following fluoridation. Figures from the NHS dental epidemiology programme's 2007-2008 survey of 5-year olds show that, out of the 147 primary care trusts that took part in the 2007-2008 survey, Warwickshire has the 7th lowest level of decayed, missing and filled teeth for 5-year old children.

Following the passing of the Health and Social Care Act 2012, responsibility for proposing and conducting consultations on fluoridation schemes and determining their outcome was handed over to local authorities.

**Table 3: Water test monitoring (water testing carried out at water treatment works, reservoirs and consumer taps), Severn Trent Water Region, 2009-2011.**

Parameter	Number of Tests carried out	Number of Tests failed	Failure rate
Coliform Bacteria	130,648	60	0.050%
E Coli	189,941	7	0.004%
Lead	4,588	6	0.130%
Nitrate	22,280	0	0.000%
Iron	17,465	37	0.210%
Colour	13,262	2	0.015%
Turbidity	15,504	1	0.006%

As can be seen, the water quality in Warwickshire is of a high standard and the population should be reassured that maintaining this level of quality is high priority for all of the agencies involved. However, it could be argued that the challenge for the future is not about water quality but more about water conservation.

“...the water quality in Warwickshire is of a high standard.”



### timeline

New motorcycle crash helmet safety rating scheme announced

2007

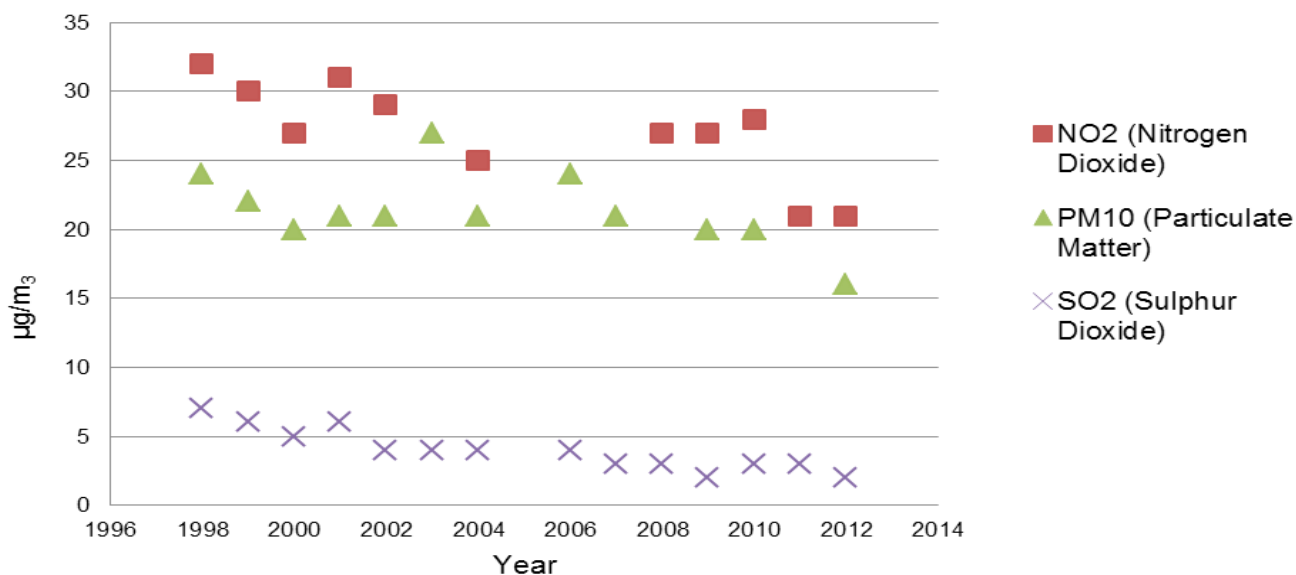


Regulations prohibiting the display of tobacco in small stores come into force.

2012



**Figure 19: National surveillance of air pollutants in Warwickshire, 1998-2012.**



Source: Automatic Urban and Rural Network (AURN) Leamington Spa (Department for Environment Food and Rural Affairs)

## Air quality

It is known that poor air quality leads to poor health and as a large number of people are exposed to air pollution everyday it has the potential to be a large scale problem. Air can be contaminated by emissions from industry, motor vehicles and household fuels.

Long term exposure to air pollution can:

- reduce lung function and has been linked to asthma and chronic bronchitis;
- be linked to cancer and heart and circulatory diseases;
- be particularly harmful to the most vulnerable members of society such as children, the elderly and those with existing lung and cardiovascular conditions;
- reduce life expectancy by an average of 7-8 months and result in thousands of hospital admissions per year costing the NHS up to £20 billion each year.

There is little that individuals can do to avoid air pollutants so action and control is needed by a range of public authorities. Many partners such as transport, planning, housing and industry work together to ensure that health is included in the development and implementation of long term policies that affect air quality in Warwickshire.

The government collects air pollution data from a measuring station in Leamington Spa, which can be used to compare Warwickshire to the West Midlands region and the rest of the UK. Additional data is collected by district and borough environmental health departments and helps to inform local action to tackle air pollution and helps to inform local action to tackle air pollution. Over the last 15 years levels of air pollutants in Warwickshire have been decreasing, as shown in Figure 19.

“Over the last 15 years levels of air pollutants in Warwickshire have been decreasing.”

The number of people killed or seriously injured in Warwickshire road traffic accidents falls below 300 for the first time

Public Health moves back to the local authority



2012

2013

## Industry and domestic sources of air pollution

Progress on reducing industry and domestic based air pollution in the last 40 years includes:

- Multiple regulations throughout the 1970s and 1980s were passed which gradually reduced the permitted level of emissions of key pollutants.
- The introduction and continuation of the National Survey, a monitoring network regularly measuring air pollutants.
- The introduction of Smoke Control Areas (SCA). Within Warwickshire there are still several areas in the County where households can only use smokeless fuels and are not allowed to burn coal or wood.
- The technological advances in the availability of clean fuels and the increased popularity of gas as a fuel.
- Changes in the industrial and economic structure of the UK.
- Work with industry and partners, providing expert advice and data on the impacts to health.

Since 1979, there has been an overall reduction of more than 89% in sulphur dioxide emissions due to the changes in industry and domestic settings. As a result pollution from industry and households is no longer the major concern in Warwickshire.

## Air pollution from motor vehicles

The air quality in the UK from various road traffic pollutants has changed dramatically over the last few decades. Over the last 40 years there have been great reductions in lead, carbon monoxide and sulphur dioxide:

- Lead has been completely removed from petrol sold in the UK and was banned in the EU in 2000. In

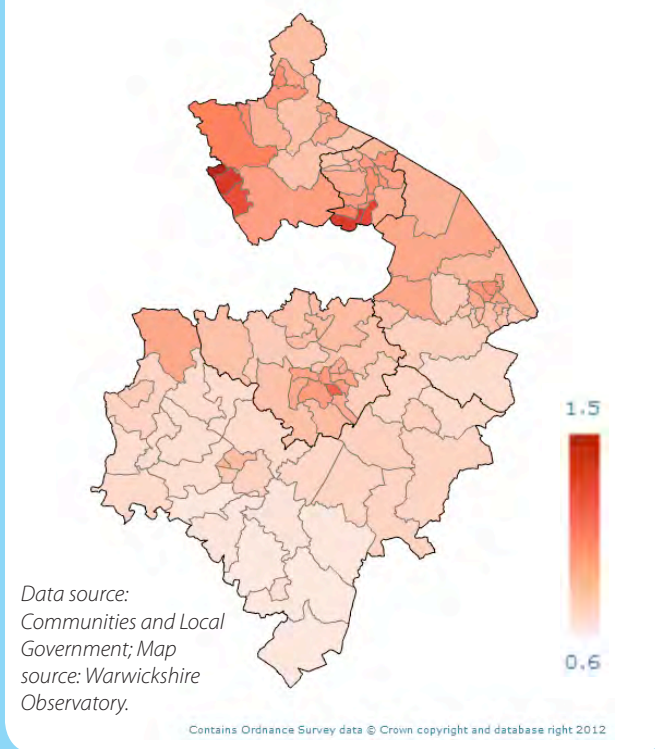
the 1970s almost all the petrol contained lead and was responsible for 90% of human lead exposure. Even low levels of lead are toxic and cause impairment to mental and physical development as well as higher risk of cardiovascular disease and premature death.

- Catalytic converters were introduced and fitted as standard on cars. These reduce harmful emissions by 50-90%.
- Conducting local air quality reviews to assess the current situation, designating high pollution areas as Air Quality Management Areas and predicting future air quality.
- Encouraging the use of sustainable transport, increasing the number of journeys taken by cycling or foot instead of car.
- In Warwickshire, new rail stations Stratford Parkway, Warwick Parkway and Coleshill Parkway have opened to reduce congestion and others are being explored, for example in Kenilworth.
- Warwick and Leamington are part of the national cycling programme Sky Ride to encourage more residents to cycle rather than drive, and measured miles for walking have been introduced across the county.

Despite the great reduction over the last 40 years, air pollution remains a problem and there is now an increased recognition of the health significance of NO<sub>2</sub> and particulate matter, which affects the lungs and causes decreased lung function. Road transport is now the major focus for improving air quality as it is the main contributor of pollutants in Warwickshire.

In some areas of Warwickshire, due to congestion, idling traffic and the increasing number of cars and other vehicles on the road, concentrations of air

**Figure 20: Overall air quality score for benzene, nitrogen dioxide, sulphur dioxide and particulates in Warwickshire, 2010.**

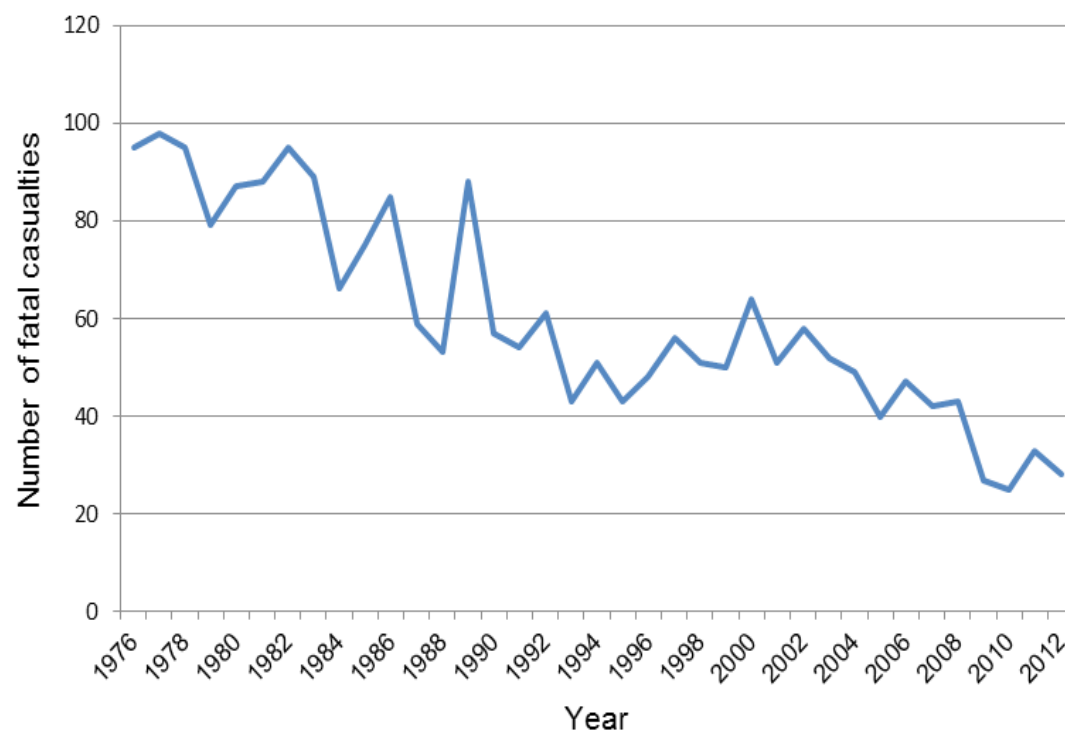


Please note: an index value of 1 is equivalent to the national standard for each pollutant. The values are then summed so an overall score of 4 would represent all four pollutants being present at the national standard level.

pollution exceed health guidelines. Figure 20 shows the overall air quality across Warwickshire; air quality is worst in:

- Nuneaton town centre
- Rugby town centre
- Warwick town centre
- Leamington town centre
- Studley
- North Warwickshire close to the M42/M6

**Figure 21: Fatal casualties in Warwickshire 1976-2012.**



Source: Transport and Highways, Communities, Warwickshire County Council.

### Road safety

Improving road safety (reducing the number of people killed and injured) on Warwickshire's roads is a key element to protecting the community and making Warwickshire a safer place to live.

Traffic volume is probably the greatest single influence on the level of road casualties.

Warwickshire's position at the centre of England and the motorway network means it has a high traffic volume and consequently higher than

average numbers of casualties when measured against population. However, when measured against traffic volume (a more accurate reflection) Warwickshire tends to perform better than average. We also know that pedestrians are at higher risk in urban areas, whereas drivers are at higher risk in rural areas. Figures are also affected by motorway collisions which are not usually directly related to the communities nearby.

Figure 21 shows the decline in fatal road casualties between 1976 and 2012.

Locally in Warwickshire, the county council, police and other organisations work together to reduce road casualties through the Warwickshire Road Safety Partnership; the future of road safety will continue to focus on:

- **Enforcement**
- **Education**
- **Engineering**

The Partnership has set the target of reducing the number of people either killed or seriously injured on Warwickshire roads to 277 by 2015. This figure is based on a national target for 2020, which the Partnership is aiming to achieve five years early.







## Chapter 5 Recommendations

- **This chapter illustrates the significant impact on our health from 'place' and environment. All local authorities in Warwickshire should ensure good health is a core aspiration for all they do and is reflected in all policies and strategies such as planning, licensing and housing.**
- **All partners on the Health and Wellbeing Board should commit to the use of Health Impact Assessments for all major developments and policy changes for their services.**

# 6 Chapter 6

## Conclusions

This report has been written in the year that public health 'returned' to local government after 39 years in the NHS, and it has marked this milestone by looking back at some of the achievements of the past decades, as well as exploring the challenges for improving health in the future.

It has provided some examples of longer-term trends in health status in terms of changes in the population structure (towards an older population), increases in life expectancy, changes in causes of death, improvements in infant mortality and reductions in preventable infectious diseases using measles and vaccination as an example. However, it has shown that inequalities in health still remain, as illustrated through notable differences in life expectancy between districts and boroughs within Warwickshire. It has also been demonstrated that there can be no complacency in keeping up preventive action such as childhood immunisation.

Having looked back at these trends, it has also looked at the future challenges of increasing demands on the health services, particularly those arising from the successes of increasing life expectancy. It has discussed the need for maximising the commitment of individuals, communities and organisations, to work with people to engage in healthier lifestyles and to



support them to do so through action on the wider determinants of health.

As an example of a health behaviour, I included a chapter on smoking. Smoking is the single biggest cause of preventable early death and illness. For a smoker, the single most important thing they can do to improve their health is to quit smoking permanently. For a pregnant woman who smokes, the single most important thing she can do, to give her baby the best chance of health, is to quit smoking permanently. For health professionals, one of the most important things they can do to improve their patients' health is to encourage and support them to quit smoking. We must take every opportunity – for example, through contracts for health services, and through the 'Making Every Contact Count' (MECC) initiative – to ensure that this encouragement and support is given.

As examples of 'wider determinants of health', the report has looked at the topics of **water quality**, **air quality** and **road safety**. Every day, we expect to be able to get up, run the tap and have a safe

“Inequalities in health still remain, as illustrated through notable differences in life expectancy between districts and boroughs within Warwickshire.”

water supply; to go outside and breathe air that will not harm us; and to go about our daily routines via the roads with as much safety as possible. These are **all things that we take for granted**, but they are all examples of the business of wider public health – much of which takes place largely 'unseen'.

The transformation of public health services this year provides a renewed opportunity to address these difficult issues, as Warwickshire County Council, the Health & Wellbeing Board, and partner organisations – including the district and borough councils, the new NHS organisations and Public Health England – all take on their new responsibilities for improving the health and wellbeing of the population.

### Coming Soon...

Next year, my annual report will focus on the theme of 'health protection': the area of public health concerned with policies and practice to improve the prevention and control of infectious diseases and other environmental threats to the health of the population.

2014



## Chapter 6 Recommendations

- **A pledge from Public Health Warwickshire and Dr John Linnane, Director of Public Health, to work with all public sector bodies to ensure improving health and wellbeing is seen as core to all we do.**
-



# Appendix 1 - Health Profiles 2012

## The health of Warwickshire at a glance

- **The health of people in Warwickshire is generally better than the England average.**
- **Deprivation is lower than average, however about 14,400 children live in poverty.**
- **Life expectancy for both men and women is higher than the England average. Life expectancy is 8.3 years lower for men and 7.6 years lower for women in the most deprived areas of Warwickshire than in the least deprived areas.**
- **Over the last 10 years, all-cause mortality rates have fallen.**
- **The early death rate from heart disease and stroke has fallen and is better than the England average.**
- **About 16.2% of Year 6 children are classified as obese, lower than the average for England.**
- **Levels of breast feeding initiation and smoking in pregnancy are worse than the England average.**
- **The level of GCSE attainment is better than the England average.**
- **The estimated level of adult obesity is worse than the England average.**
- **The rate of road injuries and deaths is worse than the England average.**
- **Rates of sexually transmitted infections, smoking related deaths and hospital stays for alcohol related harm are better than the England average.**

*Source: Local Health Profiles, Department of Health*

## Appendix 1 cont'd

Domain	Indicator	North Warks	Nuneaton & Bedworth	Rugby	Stratford-on-Avon	Warwick	Warks	England	Trend	Variation across districts	Data
Communities	Deprivation	4.9	18.4	3.3	0	1	5.6	19.8	→	0.0-18.4	% living in deprivation
	Proportion of children in poverty	15.3	20.9	14.6	10.7	12.6	15	21.9	↑	10.7-20.9	%
	Statutory homelessness	0.8	1.7	2.1	1.4	1.8	1.6	2	↑	0.8-2.1	Rate per 1,000 hholds
	GCSE achieved (5A*-C)	49.1	51.9	63.6	70	64	60.5	58.4	↑	49.1-70	%
	Violent crime	7.9	14.5	11.3	7	8.8	10	14.8	↓	7-14.5	Rate per 1,000
	Long term unemployment	3	5.1	3.9	1.7	2.6	3.3	5.7	n/a	1.7-5.1	Rate per 1,000
Children's and young people	Smoking in pregnancy	16.7	16.7	16.7	16.7	16.7	16.7	13.7	↑	16.7	%
	Breast feeding initiation	71.6	71.6	71.6	71.6	71.6	71.6	74.5	↓	71.6	%
	Obese children (yr 6)	19.5	17.8	13.9	15.8	14.9	16.2	19	↑	13.9-19.5	%
	Alcohol-specific hospital stays (u18)	76.1	82.1	48.6	44.1	70	63.9	61.8	n/a	44.1-82.1	Rate per 100,000
	Teenage pregnancy (u18)	47	48.8	30.8	23.7	32.6	36	38.1	→	23.7-48.8	Rate per 1,000
Adult's health and lifestyle	Adults smoking	22.3	22.4	19.7	18.9	15.5	19.3	20.7		15.5-22.4	%
	Increasing & higher risk drinking	23.8	22.1	23.3	24	23.9	23.3	22.3	n/a	22.1-24	%
	Healthy eating adults	24.5	22.6	28.8	32.6	30.6	28.2	28.7	→	22.6-32.6	%
	Physically active adults	9.5	11.5	12	13.3	9.9	10.6	11.2	↓	9.5-13.3	%
	Obese adults	29.6	29.8	25.8	23.5	21.4	25.5	24.2	→	21.4-29.8	%
Disease and poor health	Malignant melanoma	6.7	12	10.5	17	15.7	13.1	13.6	→	6.7-17	Rate per 100,000
	Hospital stays: self-harm	197	255.6	257.2	149.4	120.1	189.3	212	n/a	120.1-257.2	Rate per 100,000
	Hospital stays: alcohol related harm	1534	1935	1867	1519	1627	1,693	1,895	↑	1519-1935	Rate per 100,000
	Drug misuse	4.3	6.3	6.4	3.2	8.4	6	8.9	n/a	3.2-8.4	Rate per 1,000
	Diabetes diagnoses	5.6	6.3	5.3	4.7	4.6	5.2	5.5	↑	4.6-6.3	%
	New cases of TB	6.5	10.7	18.2	3.4	10.1	9.7	15.3	→	3.4-18.2	Rate per 100,000
	Acute STIs	550	862	743	445	675	664	775	n/a	445-862	Rate per 100,000
	Hip fracture in over-65s	413	470	555	452	446	465	452	→	413-555	Rate per 100,000

## Appendix 1 cont'd

Dom ain	Indicator	North Warks	Nuneaton & Bedworth	Rugby	Stratford -on-Avon	Warwick	Warks	England	Trend	Variation across districts	Data
Life expectancy and causes of death	Excess winter deaths	24.5	14.2	15.1	18.6	19.8	17.9	18.7	→	14.2-24.5	Ratio
	Life expectancy – M	77.9	77.5	78.8	80.4	79.9	79.1	78.6	↑	77.5-80.4	Yrs at birth
	Life expectancy – F	82.2	81.9	83.7	83.5	84.3	83	82.6	↑	81.9-84.3	Yrs at birth
	Infant deaths	5.1	5.4	6.4	5.8	2.8	5	4.6	↑	2.8-6.4	Rate per 1,000
	Smoking related deaths	210	226	177	146	156	178	211	→	146-226	Rate per 100,000
	Early deaths: heart disease & stroke	66.6	75.5	60.8	41.9	50.4	57.5	67.3	↓	41.9-75.5	Rate per 100,000
	Early deaths: cancer	104.7	111.5	105.8	95.6	95.2	101.6	110.1	→	95.2-111.5	Rate per 100,000
	Road injuries & deaths	89.4	39.9	65.7	74.6	46.8	59.6	44.3	↓	39.9-89.4	Rate per 100,000
Health Protection	Chlamydia	144.7	225.8	167.7	111.1	124.1	156.2	183.0	n/a	111.1-225.8	Rate per 100,000
	Gonorrhoea	22.5	28.6	39.7	7.5	20.2	23.2	48.1	↓	7.5-39.7	Rate per 100,000
	Syphilis	n/a	n/a	n/a	n/a	n/a	2.2	5.6	↓	n/a	Rate per 100,000
	Herpes	49.8	77.9	71.4	48.1	50.5	60.4	603	↓	48.1-77.9	Rate per 100,000
	Warts	77.2	139.1	158.7	128.5	132.8	131.8	139.1	↓	77.2-158.7	Rate per 100,000
	Flu Vaccinations (over 65s)	71.6	69.9	71.6	75.5	78.2	74.1	n/a	n/a	69.9-78.2	%



# Appendix 2 - Public Health Outcomes Framework

						England average		Worst		Best	
						25th	Percentile	75th			
Indicator		Local Number	Local Value	Eng Avg	Eng Worst	England Range				Eng Best	
Wider Determinants of Health	1 Children in poverty (%)	14050	14.6	21.1	45.9					7.4	
	2 Pupil absence (%)	1083964	5.6	5.8	7.1					4.8	
	3 First time entrants to the youth justice system (rate per 100,000)	294	575.6	748.8	2134.0					296.0	
	4 16-18 year olds not in education employment or training (%)	830	4.5	6.1	11.8					1.6	
	5 Adults with a learning disability who live in stable and appropriate accommodation (%)	645	54.5	70.0	93.8					93.8	
	6 Adults in contact with secondary mental health services who live in stable and appropriate accommodation (%)	1770	65.8	66.8	92.8					92.8	
	7 Killed and seriously injured casualties on England's roads (rate per 100,000)	922	57.3	42.2	82.4					18.1	
	8 Violent crime (including sexual violence) - hospital admissions for violence (rate per 100,000)	688	47.4	67.7	213.5					9.9	
	9 Violent crime (including sexual violence) - violence offences (rate per 1,000)	5150	9.6	13.6	32.7					4.9	
	10 Re-offending levels - percentage of offenders who re-offend	994	20.2	26.8	36.3					17.3	
	11 Re-offending levels - average number of re-offences per offender	2670	0.5	0.8	1.3					0.4	
	12 The percentage of the population affected by noise - Number of complaints about noise	3129	5.8	7.8	66.7					1.3	
	13 Statutory homelessness - homelessness acceptances (rate per 1,000)	430	1.9	2.3	9.7					0.2	
	14 Statutory homelessness - households in temporary accommodation (rate per 1,000)	50	0.2	2.3	32.4					0.0	
	15 Utilisation of outdoor space for exercise/health reasons (%)	n/a	10.8	14.0	29.1					2.2	
Health Improvement	16 Low birth weight of term babies (%)	143	2.4	2.8	7.8					1.8	
	17 Breastfeeding - Breastfeeding initiation (%)	4263	72.5	74.0	41.8					94.3	
	18 Breastfeeding - Breastfeeding prevalence at 6-8 weeks after birth (%)	2694	45.1	47.2	19.7					82.8	
	19 Smoking status at time of delivery (%)	1155	19.6	13.2	29.7					2.9	
	20 Under 18 conceptions (rate per 1,000)	299	30.9	30.7	58.1					9.4	
	21 Excess weight in 4-5 and 10-11 year olds - 4-5 year olds (%)	1161	19.8	22.6	30.0					16.1	
	22 Excess weight in 4-5 and 10-11 year olds - 10-11 year olds (%)	1638	31.6	33.9	42.8					26.6	
	23 Emotional well-being of looked after children	n/a	14.1	13.8	9.5					20.1	
	24 Smoking prevalence - adults (over 18s) (%)	n/a	19.1	20.0	29.3					13.2	
	25 Successful completion of drug treatment - opiate users (%)	131	12.4	8.6	4.3					19.9	
	26 Successful completion of drug treatment - non-opiate users (%)	36	42.4	39.5	19.7					69.0	
	27 Recorded diabetes (%)	24572	5.4	5.8	8.0					3.6	
	28 Cancer screening coverage - breast cancer (%)	48469	78.9	76.9	59.4					85.1	
	29 Cancer screening coverage - cervical cancer (%)	105768	76.5	75.3	60.3					81.4	
	30 Access to non-cancer screening programmes - diabetic retinopathy (%)	17909	86.4	80.9	66.7					95.0	
	31 Take up of NHS Health Check Programme by those eligible - health check offered (%)	7434	4.5	14.0	0.0					91.1	
	32 Take up of NHS Health Check programme by those eligible - health check take up (%)	6219	83.7	51.2	8.6					100.0	
	33 Self-reported well-being - people with a low satisfaction score (%)	n/a	26.6	24.3	30.5					14.6	
	34 Self-reported well-being - people with a low worthwhile score (%)	n/a	25.0	20.1	25.4					12.8	
	35 Self-reported well-being - people with a low happiness score (%)	n/a	32.2	29.0	36.6					19.2	
	36 Self-reported well-being - people with a high anxiety score (%)	n/a	39.5	40.1	48.3					34.4	
	37 Injuries due to falls in people aged 65 and over (Persons) (rate per 100,000)	1993	1532.1	1664.8	2985.0					1070.0	
	38 Injuries due to falls in people aged 65 and over (males/females) (rate per 100,000)	563	1161.0	1301.6	2535.0					704.0	
	39 Injuries due to falls in people aged 65 and over (males/females) (rate per 100,000)	1430	1903.3	2027.9	3713.0					1298.0	
	40 Injuries due to falls in people aged 65 and over - aged 65-79 (rate per 100,000)	633	831.8	940.5	1726.0					545.0	
	41 Injuries due to falls in people aged 65 and over - aged 80+ (rate per 100,000)	1360	4683.7	4923.9	8965.0					2892.0	



# Appendix 2 cont'd

						England average		Worst		Best	
						25th Percentile 75th					
Indicator		Local Number	Local Value	Eng Avg	Eng Worst	England Range				Eng Best	
Health Protection	42 Fraction of mortality attributable to particulate air pollution (%)	n/a	5.5	5.6	8.3					3.6	
	43 Chlamydia diagnoses (15-24 year olds) (%)	927	1472.5	2124.6	5995.0					783.0	
	44 Population vaccination coverage - Hepatitis B (1 year old) (%)	10	100.0	-	-					-	
	45 Population vaccination coverage - Hepatitis B (2 years old) (%)	5	83.3	-	-					-	
	46 Population vaccination coverage - Dtap / IPV / Hib (1 year old) (%)	5791	97.6	94.7	84.9					98.8	
	47 Population vaccination coverage - Dtap / IPV / Hib (2 years old) (%)	5466	98.2	96.1	85.7					98.8	
	48 Population vaccination coverage - MenC (%)	5757	97.0	93.9	81.4					98.6	
	49 Population vaccination coverage - PCV (%)	5763	97.1	94.2	83.8					98.6	
	50 Population vaccination coverage - Hib / MenC booster (2 years old) (%)	5292	95.1	92.3	75.7					97.3	
	51 Population vaccination coverage - Hib / Men C booster (5 years) (%)	5152	94.8	88.6	0.0					97.6	
	52 Population vaccination coverage - PCV booster (%)	5351	96.1	91.5	74.7					97.0	
	53 Population vaccination coverage - MMR for one dose (2 years old) (%)	5323	95.6	91.2	78.7					97.2	
	54 Population vaccination coverage - MMR for one dose (5 years old) (%)	5221	96.1	92.9	79.8					98.0	
	55 Population vaccination coverage - MMR for two doses (5 years old) (%)	5092	93.7	86.0	69.7					95.3	
	56 Population vaccination coverage - HPV (%)	2717	89.3	86.8	62.3					97.2	
	57 Population vaccination coverage - PPV (%)	73700	68.2	68.3	52.8					76.6	
	58 Population vaccination coverage - Flu (aged 65+) (%)	76995	74.6	74.0	64.8					81.5	
	59 Population vaccination coverage - Flu (at risk individuals) (%)	27062	53.6	51.6	43.4					66.3	
	60 People presenting with HIV at a late stage of infection (%)	25	50.0	50.0	75.0					0.0	
	61 Treatment completion for TB (%)	n/a	89.6	84.3	0.0					0.0	
	62 Treatment completion for TB - TB incidence (rate per 100,000)	47	8.8	15.4	1.1					137.0	
	63 Public sector organisations with a board approved sustainable development management plan (%)	5	71.4	84.1	100.0					20.0	
Healthcare & Premature Mortality	64 Mortality rate from causes considered preventable (provisional) (rate per 100,000)	2694	129.8	146.1	264.2					100.7	
	65 Under 75 mortality rate from all cardiovascular diseases (provisional) (rate per 100,000)	1069	53.6	62.0	116.0					40.3	
	66 Under 75 mortality rate from cardiovascular diseases considered preventable (provisional) (rate per 100,000)	722	35.9	40.6	75.1					23.0	
	67 Under 75 mortality rate from cancer (provisional) (rate per 100,000)	1960	99.3	106.7	152.0					82.5	
	68 Under 75 mortality rate from cancer considered preventable (provisional) (rate per 100,000)	1047	53.2	61.9	98.1					45.2	
	69 Under 75 mortality rate from liver disease (provisional) (rate per 100,000)	252	13.9	14.4	39.3					8.7	
	70 Under 75 mortality rate from liver disease considered preventable (provisional) (rate per 100,000)	224	12.4	12.7	37.0					7.5	
	71 Under 75 mortality rate from respiratory disease (provisional) (rate per 100,000)	369	17.9	23.4	62.0					13.7	
	72 Under 75 mortality rate from respiratory disease considered preventable (provisional) (rate per 100,000)	175	8.4	11.6	28.6					5.3	
	73 Mortality from communicable diseases (provisional) (rate per 100,000)	932	27.2	29.9	54.9					22.0	
	74 Suicide rate (provisional) (rate per 100,000)	140	7.8	7.9	13.9					4.3	
	75 Emergency readmissions within 30 days of discharge from hospital (%)	5573	10.8	11.8	13.8					8.1	
	76 Emergency readmissions within 30 days of discharge from hospital (%)	2648	11.3	12.1	14.8					8.6	
	77 Emergency readmissions within 30 days of discharge from hospital (%)	2925	10.3	11.4	13.2					7.2	
	78 Preventable sight loss - age related macular degeneration (AMD) (rate per 100,000)	77	78.6	109.4	224.4					10.0	
	79 Preventable sight loss - glaucoma (rate per 100,000)	24	8.4	11.8	36.9					0.0	
	80 Preventable sight loss - diabetic eye disease (rate per 100,000)	10	2.2	3.6	12.9					0.0	
	81 Preventable sight loss - sight loss certifications (rate per 100,000)	170	31.7	43.1	85.7					2.9	
	82 Hip fractures in people aged 65 and over (rate per 100,000)	611	442.3	457.2	599.5					337.9	
	83 Hip fractures in people aged 65 and over - aged 65-79 (rate per 100,000)	145	185.4	222.2	346.7					135.7	
	84 Hip fractures in people aged 65 and over - aged 80+ (rate per 100,000)	466	1598.4	1514.6	2021.0					993.0	

# Appendix 3 - Tobacco Declaration

## Warwickshire Declaration on Tobacco Control

### We acknowledge that:

- Smoking is the single greatest cause of premature death and disease in our communities;
- Reducing smoking in our communities significantly increases household incomes and benefits the local economy;
- Reducing smoking amongst the most disadvantaged in our communities is the single most important means of reducing health inequalities;
- Smoking is an addiction largely taken up by children and young people, two thirds of smokers start before the age of 18;
- Smoking is an epidemic created and sustained by the tobacco industry, which promotes uptake of smoking to replace the 80,000 people its products kill in England every year; and
- The illicit trade in tobacco funds the activities of organised criminal gangs and gives children access to cheap tobacco.

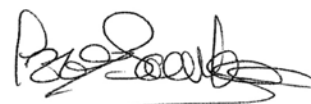
### As local leaders in public health we welcome the:

- Opportunity for local government to lead local action to tackle smoking and secure the health, welfare, social, economic and environmental benefits that come from reducing smoking prevalence;
- Commitment by the government to live up to its obligations as a party to the World Health Organization's framework convention on Tobacco control (FCTC) and in particular to protect the development of public health policy from the vested interests of the tobacco industry; and
- Endorsement of this declaration by Department of Health, Public Health England and professional bodies.

### We commit our Council from this date 1st August 2013 to:

- Act at a local level to reduce smoking prevalence and health inequalities and to raise the profile of the harm caused by smoking to our communities;
- Develop plans with our partners and local communities to address the causes and impacts of tobacco use;
- Participate in local and regional networks for support;
- Support the government in taking action at national level to help local authorities reduce smoking prevalence and health inequalities in our communities;
- Protect our tobacco control work from the commercial and vested interests of the tobacco industry by not accepting any partnerships, payments, gifts and services, monetary or in kind or research funding offered by the tobacco industry to officials or employees;
- Monitor the progress of our plans against our commitments and publish the results; and
- Publicly declare our commitment to reducing smoking in our communities by joining the Smokefree Action Coalition, the alliance of organisations working to reducing the harm caused by tobacco.

*Signatories*



**Leader of the Council**



**Chief Executive**



**Director of Public Health**





## Feedback

This year, I am keen to gain your views on my annual report. Your comments and feedback will help me to make decisions about improvements for future reports. If you would like to fill out our short survey, please visit this link:

[www.surveymonkey.com/s/publichealthwarwickshire](https://www.surveymonkey.com/s/publichealthwarwickshire)

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## LEARNING FROM THE PAST PLANNING FOR THE FUTURE

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