Improving the NHS for everyone in Stoke on Trent

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Foreword

I am pleased to present my first Annual Report to the Board of the Stoke on Trent Primary Care Trust. It has been a tumultuous 12 months. The very poor financial position as well as the re-organisation of the NHS in Stoke on Trent made life very interesting for some and very stressful for others.

However, it is important to note that those very difficult circumstances have also given birth to some new opportunities for us all. These include:

- The new organisation has brought in new people, new ideas and new ways of doing things.
- The single NHS organisation covering Stoke on Trent will make partnership working a little less complicated.
- The financial difficulties were overcome and the new organisation is in financial balance.

The most important event of 2006/07 was that the legislation on smoke free public places was finally agreed by Parliament and will come into force in July 2007. Indeed by the time this report is published it will have been in place for approximately 2 months. This will have a small but important impact on smoking related ill health and will particularly benefit those non smokers who are subject to passive smoking. However, it is important to note that children will continue to be exposed, particularly if parents insist on smoking in their own homes. Therefore, one of the challenges that we need to face is to persuade parents to not smoke in front of their children and only smoke in very private situations and only in the presence of consenting adults!

The added benefit of the legislation is that it may well stimulate smokers to think seriously about quitting smoking. We do have a range of services now available in Stoke on Trent which I hope makes access to services easier than ever before.

In this new environment, it is important to remind everybody about the purpose of Stoke on Trent PCT. In my view this is to secure through the resources available, the greatest possible improvement in the physical and mental health of the people in Stoke on Trent. The PCT does this by commissioning or providing services that:

- Promote health
- Prevent ill health
- Diagnose and treat disease and injury
- And care for those with long term illness and disability

Stoke on Trent PCT and its predecessor organisations have made substantial progress over the last decade in improving health. For example, we have reduced and are continuing to reduce the burden from circulatory diseases and cancer. Access to services has improved considerably and we have implemented major screening programmes. We have also maintained the high vaccination and immunisation rates in Stoke on Trent.
However, there is substantial progress yet to be made. Progress in improving two of the more important measures of population health namely life expectancy and infant mortality has been much more limited. In light of this, we undertook a major review of our work. Reports of that work as well as the action plans that followed are available from Judy Kurth on request. In this report, I have borrowed heavily from the work that took place.

My report this year is aimed primarily at Stoke on Trent PCT and the recommendations are phrased accordingly. The sections cover health status, the major killers, lifestyles, determinants of health and vulnerable communities. There are a number of recommendations which are summarised in Chapter 1. I think there are two common themes inherent in the recommendations. Those themes are of major strategic importance for the Board in delivering its purpose in the way I have defined it previously. These strategic themes are set out below.

1. The first strategic priority is to ensure that primary care is modernised in terms of skills, attitudes and ability to meet the health and health care needs of their registered populations as well as support the wide range initiatives undertaken by partner organisations. Primary care is one of the most important foundation stones of the NHS and the Board needs to act accordingly.

2. The second strategic priority is the commissioning of services required by families with young children. There is emerging evidence to suggest that intensive support during pregnancy and the early years of the child, can improve health and social outcomes for that family over the subsequent decades. The Board in partnership with the City Council and others, needs to consider how midwifery services, health visiting services, school nursing services and Early Years Services are commissioned and delivered so as to meet the needs of this population in a coherent manner and in line with evidence of cost effectiveness.

Finally, I would like to thank all those colleagues who have contributed to this report. Without their help, I would not have been able to complete this report. Having said that, it is important to note that the views expressed in this report are mine and mine alone.

I hope all those who might read this report find it helpful and interesting. Do let me know what you think.

Giri Rajaratnam
Director of Public Health
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SUMMARY OF THE RECOMMENDATIONS

Chapter 2 Life Expectancy
i. I recommend that Stoke on Trent PCT develop a strategy to deliver high quality primary care and community services in Stoke on Trent.
ii. In order to deliver the above, I recommend that the Stoke on Trent PCT in collaboration with primary care and community services consider and if appropriate set up a Primary Care Development Unit to support those sectors in particular to implement the changes needed.

Chapter 3 Infant Mortality
i. Programmes to reduce smoking, obesity, sudden unexplained deaths and teenage pregnancies should continue to be a major priority for the Stoke on Trent PCT for the foreseeable future.
ii. Stoke on Trent PCT in collaboration with partners should consider how the commissioning of and the nature of support provided to mothers from conception to when the infant becomes two, can be changed so as to deliver the sorts of benefits, programs in the United States are delivering to their poorest communities.

Chapter 4 Circulatory Diseases
i. The importance of primary care services in reducing the impact of circulatory disease has to be acknowledged by the PCT.
ii. Additional investment is needed in primary care: a) to make greater use of the practice based information systems to call and recall people at risk of and with, circulatory disease; b) to strengthen the attitudes, knowledge and skills within primary care; c) develop a better skill mix of staff to ensure advances in knowledge and practice can be implemented efficiently and effectively in a timely manner.

Chapter 5 Cancer
i. The PCT should ensure that use of surgery in men with lung cancer is examined as soon as possible by the University Hospital of North Staffordshire. It is important that the analysis includes another hospital in the West Midlands as a comparator.
ii. The PCT should ensure that University Hospital of North Staffordshire contributes to the national audit on lung cancer. This will make future analysis of the care provided to people with lung cancer much easier.
iii. The PCT should commission further studies to understand the reasons for people to present with higher or unknown grades of prostate cancer in Stoke on Trent than elsewhere.

Chapter 6 Respiratory health
i. The PCT should ensure detailed plans that cover diagnosis, management and rehabilitation of chronic obstructive pulmonary disease are constructed and implemented in a phased approach over the next 24 months. Given the work already undertaken by the clinical community in Stoke on Trent, the plans should
be reviewed by the PCT in November 2007 so that any financial requirements are considered as part of the financial plan for 2008/09.

**Chapter 7 Mental Health**

i. Stoke on Trent PCT should increase the capacity (and in particular for cognitive behaviour therapy) within primary and community services for the management of people with mental health problems.

ii. Stoke on Trent PCT should increase capacity to manage and develop the Healthy Minds Network so that all people who may benefit have access.

iii. Stoke on Trent PCT supported by the City Council should develop a strategy on reducing the impact on dementia on the people of Stoke on Trent.

**Chapter 8 Screening**

i. Stoke on Trent PCT needs to review the 2006/07 Diabetic Retinopathy Screening Programme annual report detailing performance against national standards and quality assurance criteria when it is available. The review needs to include the treatment aspects of the screening programme.

ii. Stoke on Trent PCT should through the Professional Executive Team ensure that implementation of the bowel screening programme is successfully accomplished.

**Chapter 9 Smoking**

i. I recommend that the Stoke on Trust PCT as a matter of urgency works with practices to put in place systems to ensure all smokers are identified and are encouraged to attend smoking cessation. It is important that only people who are ready to quit are referred to smoking cessation services.

ii. I recommend that General Practitioners should ensure smoking status is recorded for every person who is 16 and over as a matter of urgency.

iii. Given the importance of smoking to the inequalities in health outcomes experienced by the people of Stoke on Trent, I recommend that the level of smoking status recording is reviewed by the PCT Board every quarter, until it reaches a target of 95%.

iv I recommend that the PCT adds a clause to all service level agreements it has with providers to ensure that smokers are identified, brief interventions provided and if appropriate the individual is referred to a smoking cessation service.

**Chapter 10 Alcohol**

i. I recommend that Stoke on Trent PCT in collaboration with partners should undertake a survey to describe patterns of drinking within Stoke on Trent.

ii. The draft alcohol strategy needs to be approved by all relevant stakeholders and implementation should begin as soon as possible.

iii. Stoke on Trent PCT should take the lead in ensuring all practises are able to identify people who are having problems with alcohol, are able to provide brief interventions and refer when appropriate.
Chapter 11 Teenage Pregnancy
i. I recommend that the Stoke on Trent PCT mainstreams the work on reducing teenage pregnancies in 2008/09.

Chapter 12 Obesity
i. I recommend that the Stoke on Trent PCT review its obesity action plan for agreement at the March 2008 Board meeting. In reviewing the plan, the Board needs to be clear about the following:

• The evidence of effectiveness supporting each intervention and the numbers needed to achieve benefits.
• Where there is no evidence, the evaluation programme and in particular the outcome measures defining success and failure

ii. I recommend that the Stoke on Trent PCT identify and make available the resources needed over a 3 year period, to support the implementation of the obesity action plan.

iii. I recommend that Stoke on Trent PCT works with general practices to enable high risk groups to be identified and referred for obesity management.

Chapter 13 Education
i. The PCT should as a matter of urgency debate the feasibility of commissioning a new model of combined midwifery, health visiting and Early Years services with clear outcomes to be attained.

Chapter 14 Housing
i. The PCT and general practitioners need to recognise the potential inherent in primary care to support action on improving the housing circumstances of people in Stoke on Trent and be willing to respond quickly.

ii. The PCT should work with general practitioners and their teams in developing the proactive use of primary care information systems to identify patients who might benefit from housing support. These include patients with chronic respiratory disease, heart disease and the very elderly.

iii. The PCT should ensure ready access to aggregated health data to support the development of housing policy by the City Council.

Chapter 15 Ethnic Minority Communities
i. I recommend that the Stoke on Trent PCT reviews the level of ethnicity recording in the NHS information systems of relevance to the people of Stoke on Trent and takes all necessary steps to ensure improvement.

Chapter 16 Asylum Seekers and Refugees
i. I recommend that the PCT continues to maintain the additional support provided to asylum and refugee communities in Stoke on Trent.
HEALTH STATUS IN STOKE ON TRENT

Chapter 2:
Life Expectancy

Contributor:
Paul Trinder. Epidemiologist
LIFE EXPECTANCY

1. Introduction

In 2001, the Treasury and the Department of Health established as a priority population target the need to improve the life expectancy of the population. The rationale for choosing life expectancy is that every death in a particular locality is included in the calculation of life expectancy. It is therefore considered to be a good measure of the mortality experience of the population in that locality. The major disadvantage is that it does not take into account ill health that does not lead directly to death.

Figure 1 below shows in a simplified way the relationship between various selected factors and life expectancy. Research suggests that the life expectancy of an individual or a community is the end product of the impact of a range of factors on that individual or community.

Figure 1 Factors influencing life expectancy in Stoke on Trent

The actual relationship is much more complex. However, in the context of determining the type and range of actions we need to take in Stoke on Trent, it provides a reasonable conceptual framework. Although we do not know the relative importance of these factors, scientific and social sciences literature suggest that educational achievement and reductions in levels of poverty are perhaps the most important in determining...
the inequalities in health outcomes. This is not to say that there is little the NHS can do. Indeed, there is considerable evidence to suggest that health services can mitigate some of the effects of deprivation. It is this fact that underpins the recommendations I make in this and subsequent chapters.

2. Targets

The target set by government is to improve life expectancy by 2010 in England to:

- 78.6 for men
- 82.5 for women

In the knowledge that not all communities will be able to reach the target, Government set an additional target. This was to reduce by at least 10%, the gap between the areas with the lowest figures and the population as a whole. The predecessor organisations to Stoke on Trent PCT considered this relative target in detail and came to the view that this wasn’t sufficient. They felt that a reduction of 25% in the gap between Stoke on Trent and England by 2010 was not only desirable but feasible.

However, as table 1 and 2 show, we are a long way from achieving that target and as a consequence, when we reviewed our progress in the autumn of 2006, partners felt that the 25% reduction in the gap by 2010 was not achievable and agreed that a more realistic target should be set. It was agreed that for males we would aim to reduce the gap to 3.1 years and for females to 2 years.

Although this is a good pragmatic approach, I have decided to stick with the original targets. My reasons for this are as follows:

- The 25% reduction in the gap is challenging but remains feasible.
- One of the reasons we were not able to make good progress in the past, was that although targets were agreed, this was not translated into funded action plans.

3. The Challenge in Stoke on Trent

Progress amongst both, males and females, over the past decade or so has been limited (Tables 1 and 2) and the trends between 1997 and 2004 showed a widening of the gap. However, the most recent figures suggest that we may well have turned the corner.

Table 1 Male life expectancy over the period 1991 to 2005

<table>
<thead>
<tr>
<th></th>
<th>91-93</th>
<th>93-95</th>
<th>95-97</th>
<th>97-99</th>
<th>99-01</th>
<th>01-03</th>
<th>02-04</th>
<th>03-05</th>
<th>(1)Target for 2009-11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stoke</td>
<td>71.5</td>
<td>72.1</td>
<td>72.5</td>
<td>72.6</td>
<td>73.1</td>
<td>73.3</td>
<td>73.2</td>
<td>73.7</td>
<td>NK</td>
</tr>
<tr>
<td>England</td>
<td>73.7</td>
<td>74.2</td>
<td>74.6</td>
<td>75.1</td>
<td>75.7</td>
<td>76.2</td>
<td>76.6</td>
<td>76.9</td>
<td>NK</td>
</tr>
<tr>
<td></td>
<td>-2.2</td>
<td>-2.1</td>
<td>-2.1</td>
<td>-2.5</td>
<td>-2.6</td>
<td>-2.9</td>
<td>-3.4</td>
<td>-3.2</td>
<td>-1.7</td>
</tr>
</tbody>
</table>

Source: Compendium of Clinical and Health Indicators/Clinical and Health Outcomes Knowledge Base (www.nchod.nhs.uk) 2007

1 – Baseline taken as 1991-93 and therefore a 25% reduction in the gap leads to a difference of 1.7 to be achieved by 2009-2011.
Table 2 Female life expectancy between 1991 and 2005

<table>
<thead>
<tr>
<th></th>
<th>91-93</th>
<th>93-95</th>
<th>95-97</th>
<th>97-99</th>
<th>99-01</th>
<th>01-03</th>
<th>02-04</th>
<th>03-05</th>
<th>Target for 2009-11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stoke</td>
<td>77.1</td>
<td>77.8</td>
<td>78.6</td>
<td>78.6</td>
<td>78.8</td>
<td>78.9</td>
<td>78.7</td>
<td>79.1</td>
<td>NK</td>
</tr>
<tr>
<td>England</td>
<td>79.1</td>
<td>79.4</td>
<td>79.7</td>
<td>80.0</td>
<td>80.4</td>
<td>80.7</td>
<td>80.9</td>
<td>81.1</td>
<td>NK</td>
</tr>
<tr>
<td>Difference between Stoke to England</td>
<td>-2.0</td>
<td>-1.6</td>
<td>-1.1</td>
<td>-1.4</td>
<td>-1.6</td>
<td>-1.8</td>
<td>-2.2</td>
<td>-2.0</td>
<td>-1.5</td>
</tr>
</tbody>
</table>

Source: Compendium of Clinical and Health Indicators/Clinical and Health Outcomes Knowledge Base (www.nchod.nhs.uk) 2007
1 – Baseline is taken as 1991-93 and therefore a 25% reduction leads to a difference of 1.5

Within Stoke on Trent, there are substantial differences between different parts of the City (Table 3). It is important to note that in order to make sense of the small number of deaths in a ward, five years worth of deaths have been aggregated together in calculating life expectancies for each ward.

Table 3 Life expectancy for wards in Stoke on Trent based on mortality data for the period 1999-2004

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Number of deaths (5yrs)</th>
<th>Life expectancy</th>
<th>Significance(1) compared to England (78.51 years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abbey Green</td>
<td>705</td>
<td>77.3</td>
<td>Significantly lower</td>
</tr>
<tr>
<td>Bentilee &amp; Townsend</td>
<td>716</td>
<td>75.6</td>
<td>Significantly lower</td>
</tr>
<tr>
<td>Berryhill &amp; Hanley East</td>
<td>714</td>
<td>75.7</td>
<td>Significantly lower</td>
</tr>
<tr>
<td>Blurton</td>
<td>671</td>
<td>76.6</td>
<td>Significantly lower</td>
</tr>
<tr>
<td>Burslem North</td>
<td>777</td>
<td>75.5</td>
<td>Significantly lower</td>
</tr>
<tr>
<td>Burslem South</td>
<td>1048</td>
<td>71.1</td>
<td>Significantly lower</td>
</tr>
<tr>
<td>Chell and Packmoor</td>
<td>624</td>
<td>76.2</td>
<td>Significantly lower</td>
</tr>
<tr>
<td>East Valley</td>
<td>721</td>
<td>77.5</td>
<td>Not significantly lower</td>
</tr>
<tr>
<td>Fenton</td>
<td>586</td>
<td>77.3</td>
<td>Not significantly lower</td>
</tr>
<tr>
<td>Hanley West &amp; Shelton</td>
<td>447</td>
<td>73.7</td>
<td>Significantly lower</td>
</tr>
<tr>
<td>Hartshill &amp; Penkhull</td>
<td>744</td>
<td>77.1</td>
<td>Significantly lower</td>
</tr>
<tr>
<td>Longton North</td>
<td>549</td>
<td>76.5</td>
<td>Significantly lower</td>
</tr>
<tr>
<td>Longton South</td>
<td>911</td>
<td>75.4</td>
<td>Significantly lower</td>
</tr>
<tr>
<td>Meir Park &amp; Sandon</td>
<td>494</td>
<td>78.5</td>
<td>Not significantly lower</td>
</tr>
<tr>
<td>Northwood &amp; Birches Head</td>
<td>555</td>
<td>78.2</td>
<td>Not significantly lower</td>
</tr>
<tr>
<td>Norton &amp; Bradeley</td>
<td>676</td>
<td>75.2</td>
<td>Significantly lower</td>
</tr>
<tr>
<td>Stoke &amp; Trent Vale</td>
<td>599</td>
<td>77.1</td>
<td>Significantly lower</td>
</tr>
<tr>
<td>Trentham &amp; Hanford</td>
<td>819</td>
<td>78.2</td>
<td>Not significantly lower</td>
</tr>
<tr>
<td>Tunstall</td>
<td>813</td>
<td>74.6</td>
<td>Significantly lower</td>
</tr>
<tr>
<td>Weston &amp; Meir North</td>
<td>770</td>
<td>76.0</td>
<td>Significantly lower</td>
</tr>
</tbody>
</table>

Source: West Midlands Public Health Observatory and Office of National Statistics
1 – statistical significance to indicate that the difference between the ward and England is not likely to be due to chance (normal variation).
Apart from five wards, life expectancy in all other wards was significantly less than that for England. The word “significance” is important in this instance as it signifies that the difference between figures for the ward and England is more than we would expect by chance alone. The implication of this is that, if we wish to make a real impact on the life expectancy in Stoke on Trent, we do have to focus our work on all fifteen wards rather than one or two.

4. Major Killers

Although the people of Stoke on Trent die of a variety of causes and at different ages, the overall pattern is no different to elsewhere in the country. We simply have more deaths. Table 4 provides an indication of the number of deaths at particular age groups.

Table 4 Number and proportion of deaths in particular age group in Stoke on Trent.

<table>
<thead>
<tr>
<th>Age band</th>
<th>Number of deaths</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 to 1</td>
<td>23</td>
<td>0.9</td>
</tr>
<tr>
<td>1 to 4</td>
<td>3</td>
<td>0.1</td>
</tr>
<tr>
<td>5 to 34</td>
<td>28</td>
<td>1.1</td>
</tr>
<tr>
<td>35 to 74</td>
<td>860</td>
<td>34.5</td>
</tr>
<tr>
<td>75+</td>
<td>1576</td>
<td>63.3</td>
</tr>
<tr>
<td>Total</td>
<td>2490</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: Public Health mortality files 2007. Data extracted for 12 months to October 2006

Approximately 98% of the deaths take place amongst the 35+ age group and the major causes of death in this age group are circulatory diseases and cancer (Table 5).

Table 5 Major cause of deaths in Stoke on Trent amongst the over 35s.

<table>
<thead>
<tr>
<th>Cause of death</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Circulatory system</td>
<td>860</td>
<td>35.3</td>
</tr>
<tr>
<td>Cancers</td>
<td>717</td>
<td>29.4</td>
</tr>
<tr>
<td>Respiratory system</td>
<td>378</td>
<td>15.5</td>
</tr>
<tr>
<td>Digestive system</td>
<td>127</td>
<td>5.2</td>
</tr>
<tr>
<td>Mental and behavioural disorders</td>
<td>76</td>
<td>3.1</td>
</tr>
<tr>
<td>Accidents</td>
<td>54</td>
<td>2.2</td>
</tr>
<tr>
<td>Others</td>
<td>224</td>
<td>9.2</td>
</tr>
<tr>
<td>Total</td>
<td>2436</td>
<td>100</td>
</tr>
</tbody>
</table>


The greatest contribution to life expectancy will be made by reducing mortality rates in the youngest age groups as well as by reducing the impact of a number of diseases across the age ranges.
5. Action

What do we need to do?

During 2006/07, Stoke on Trent PCT with support from the Local Strategic Partnership (the group bringing together all types of organisations in Stoke Trent) developed an action plan to make a major impact on life expectancy. That document details the actions we have taken to date and the range of actions we need to take in the coming years.

The intention here is to focus on the critical issues of importance to the NHS in Stoke on Trent because it is those actions that will have the short term impact in relation to 2010. If successfully implemented these actions will also enable us to contribute effectively and efficiently to initiatives which will have impacts on the longer term.

In identifying those critical interventions, we have used the analysis undertaken by the Health Inequalities Unit of the Department of Health and published in July 2006. That analysis identified the following as the most important actions from the NHS perspective:

- Doubling quit smoking rates for two years
- Reducing complications of circulatory disease (e.g., heart disease, strokes) through the use of effective therapies now available.
- Identifying and taking action to ensure people at very high risk of cardiovascular disease do not go on to have the disease.
- Others such as early detection of cancer and effective treatment of both, respiratory illnesses and alcohol related diseases.

The overall impact of these actions should enable the Stoke on Trent NHS to achieve the minimum 10% reduction in the gap with England. However, if in implementing these interventions we are able to change the whole delivery system, we are very likely to meet the target of 25% reduction in the gap in life expectancy between Stoke on Trent and England.

The most important delivery system for implementing the range of actions listed above is primary care. We need to enable general practices to identify eligible people effectively and efficiently and deliver the relevant intervention as close to their home as possible which for most people is inevitably primary care. In my view this will mean a primary care system which goes over and above that predicated by the national contract for general practice services.

A high quality general practice would exhibit the following characteristics:

- 100% recording of all the important clinical variables (smoking status, cholesterol etc)
- Proactively identify smokers, assess them and refer to specialist service if appropriate,
- Ensure all circulatory disease patients had their cholesterol and blood pressure measured and achieving optimum control.
• Will have a strong multidisciplinary team approach to delivering care, offering a range of cost effective brief interventions (smoking, alcohol, exercise etc)
• Link closely to neighbourhood/locality groups so that a holistic approach is taken in terms of tackling the determinants of health.

Who should do it?
Although there are implications for all staff working for Stoke on Trent PCT, in my view the strategic task is for the Board to ensure primary care is fit and capable of taking on the roles expected. This is not just about resources but is also about attitudes, skills and practice.

6. Recommendations
i. I recommend that Stoke on Trent PCT develop a strategy to deliver a high quality primary care and community services in Stoke on Trent.
ii. In order to deliver the above, I recommend that the Stoke on Trent PCT in collaboration with primary care and community services consider and if appropriate set up a Primary Care Development Unit to support those sectors in particular to implement the changes needed.
MAJOR KILLERS

Chapter 3: Infant Mortality

Contributor:
Paul Trinder. Epidemiologist
INFANT MORTALITY

1. Introduction

As the previous chapter on Life Expectancy showed, infant mortality (deaths in the first year of life) is an important contributor to the overall life expectancy that we see in Stoke on Trent as well as being a good indicator of population health. Indeed research shows that the increases in life expectancy experienced in the UK over the last 100 years is due to improvements in death rates at the very youngest age rather than at any other age (Tables 1 and 2 below). The implication of these statistics is that the reduction in infant mortality has been the major driving force in increasing life expectancy.

Table 1 Male life expectancy at stated age, England and Wales

<table>
<thead>
<tr>
<th>Life expectancy at ages:</th>
<th>0</th>
<th>35</th>
<th>55</th>
<th>75</th>
</tr>
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<tbody>
<tr>
<td>1841</td>
<td>41</td>
<td>30</td>
<td>17</td>
<td>6</td>
</tr>
<tr>
<td>1901</td>
<td>45</td>
<td>29</td>
<td>16</td>
<td>6</td>
</tr>
<tr>
<td>1931</td>
<td>58</td>
<td>33</td>
<td>18</td>
<td>6</td>
</tr>
<tr>
<td>1961</td>
<td>68</td>
<td>36</td>
<td>19</td>
<td>7</td>
</tr>
<tr>
<td>1991</td>
<td>73</td>
<td>40</td>
<td>22</td>
<td>9</td>
</tr>
<tr>
<td>2000-2002*</td>
<td>76</td>
<td>42</td>
<td>24</td>
<td>10</td>
</tr>
</tbody>
</table>


Table 2 Female life expectancy at stated age, England and Wales

<table>
<thead>
<tr>
<th>Life expectancy at ages:</th>
<th>0</th>
<th>35</th>
<th>55</th>
<th>75</th>
</tr>
</thead>
<tbody>
<tr>
<td>1841</td>
<td>43</td>
<td>32</td>
<td>18</td>
<td>7</td>
</tr>
<tr>
<td>1901</td>
<td>49</td>
<td>32</td>
<td>18</td>
<td>7</td>
</tr>
<tr>
<td>1931</td>
<td>62</td>
<td>36</td>
<td>20</td>
<td>7</td>
</tr>
<tr>
<td>1961</td>
<td>74</td>
<td>41</td>
<td>23</td>
<td>9</td>
</tr>
<tr>
<td>1991</td>
<td>79</td>
<td>45</td>
<td>26</td>
<td>11</td>
</tr>
<tr>
<td>2000-2002*</td>
<td>81</td>
<td>47</td>
<td>28</td>
<td>12</td>
</tr>
</tbody>
</table>


2. Targets

The national target is to reduce infant mortality by 10% by 2010. The target we have set ourselves is to reduce the infant mortality rate in Stoke on Trent by 10% taking as the baseline the rate for 2003/05.

However, it is important to note that this may not significantly reduce the gap between Stoke on Trent and England.
3. The Challenge in Stoke on Trent

The infant mortality rate for Stoke on Trent has remained above that for England for over a decade (Table 3). The difference between the Stoke on Trent and England appear to have decreased slightly. However, it is not possible yet, to say whether a decreasing trend has been established.

Table 3 Infant mortality rates (per 1000 live births) in Stoke on Trent and England & Wales

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Stoke on Trent</td>
<td>8.7</td>
<td>8.9</td>
<td>9.3</td>
<td>9.3</td>
<td>9.3</td>
<td>8.5</td>
</tr>
<tr>
<td>England &amp; Wales</td>
<td>5.7</td>
<td>5.6</td>
<td>5.4</td>
<td>5.3</td>
<td>5.2</td>
<td>5.1</td>
</tr>
</tbody>
</table>

Source: West Midlands Perinatal Institute

This gap in infant mortality has arisen since the 1970s. As Figure 1 shows the gap between England and Stoke on Trent was closing until the 1980s since when the figures have begun to diverge. Quite clearly, our current approach to maternal and infant services is not having an impact on infant mortality whereas elsewhere, rates are continuing to decrease.

Figure 1 Trend in infant mortality rate from 1973 and 2005


There are approximately 30 (+/- 10%) infant deaths a year in Stoke on Trent and of these approximately 60% die in the first seven days. This group of deaths is termed early neonatal deaths. In Stoke on Trent, since the late 1990s, the early neonatal death rates have increased whereas in England, they have remained fairly constant (Table 4).
The mortality rates between Stoke on Trent and England in terms of the older infants are not that different. The major component of the difference between Stoke on Trent and England appears to be due to the mortality experience during the first seven days of life. Research suggests that this reflects the health of the mother and the pregnancy. The fact that our early neonatal mortality rates are higher than in England does suggest that women (of reproductive age) in Stoke on Trent are not as healthy as elsewhere. Indeed, figures on infants and low birth weights support this hypothesis. As table 5 shows, the proportion of children born in Stoke on Trent weighing less than 2500 grams has increased in comparison to England. Research based on follow up of infants of varying birth weights suggests that infants of low birth weight who survive, go on to have poorer health throughout their lives. This in turn may well lead to the next generation of potentially unhealthy mothers. We do need to think carefully about how we break this vicious cycle.

### Table 4 Early neonatal mortality rates (per 1000 live births) in Stoke on Trent and England & Wales

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Stoke on Trent</td>
<td>4.0</td>
<td>4.5</td>
<td>5.0</td>
<td>5.6</td>
<td>5.4</td>
<td>5.6</td>
</tr>
<tr>
<td>England &amp; Wales</td>
<td>2.9</td>
<td>2.8</td>
<td>2.8</td>
<td>2.7</td>
<td>2.7</td>
<td>2.7</td>
</tr>
</tbody>
</table>

Source: West Midlands Perinatal Institute

### Table 5 Proportion of live and stillbirths weighing less than 2500 grams.

<table>
<thead>
<tr>
<th></th>
<th>1997 (%)</th>
<th>1999 (%)</th>
<th>2001 (%)</th>
<th>2003 (%)</th>
<th>2005 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stoke on Trent</td>
<td>7.3</td>
<td>9.1</td>
<td>9.4</td>
<td>9.3</td>
<td>9.7</td>
</tr>
<tr>
<td>England</td>
<td>7.8</td>
<td>7.9</td>
<td>7.9</td>
<td>8.0</td>
<td>7.9</td>
</tr>
<tr>
<td>Difference</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Compendium of Clinical and Health Indicators 2007

### 4. Action

**What should we do?**

The evidence about the effectiveness of interventions to reduce infant mortality is weak. However, the following have been identified as having the strongest evidence base:

- Smoking in pregnancy
- Obesity
- Sudden unexplained deaths in infancy
- Reducing pregnancies in the under 18s.

These actions are being taken forward in Stoke on Trent. However, by themselves, they will only have a small impact which although important will not lead to a substantial reduction in the gap between Stoke on Trent and England.
In looking at what we need to do, it is important to reflect on Figure 1 which showed that in comparison to England, infant mortality rates in Stoke on Trent have hardly changed since the early 1990s. There is no reason to think that doing more of the same (in the context of health services) will lead to a reduction in infant mortality or early neonatal deaths. I think for us to stand a chance of reducing the gap, we need to be both innovative and be willing to take calculated risks. This means looking critically at health services, both in the UK and internationally.

There are some very promising studies taking place in the United States. These studies using very high quality research methods are beginning to show that intensive and focussed support to mothers from very deprived communities, can lead to improvements in a whole range of health and social outcomes to do with both, the mother and the child. The long term (20 years and more) follow up show that both, the child and the young parent, become much healthier and socially secure adults potentially better able to take full advantage of all the opportunities available to them.

From an American point of view, the high intensity intervention approach appears to be very cost effective. The Rand Corporation was commissioned by American health insurance companies to review the evidence in detail (Early Childhood Interventions: Proven Results, Future Promise, Kardly LA, Kilburn MR and Canon JS – available on the Rand Corporation website). The review came to the following conclusions:

- For each dollar invested in proven early childhood intervention, the net gain was between $1.26 and $17.07.
- The largest returns were associated with the longest follow up (10-20 years).
- Benefits were greatest for programs that target the most disadvantaged families/individuals.
- Common features of the most successful studies were; better trained parents, small child/parent to staff ratio and greater intensity of services.
- Early interventions programs can improve outcomes over what they otherwise would have been. However, they typically do not fully close the gap between disadvantaged children and the more advantaged children.

Given the nature of these conclusions, there are two very important questions that we in Stoke on Trent need to consider carefully:

- Can we by working closely with the mothers of today in the way that the Americans are beginning to do, change the health of the mothers of tomorrow?
- Can we by working intensively with the mothers of today, impact positively on the health of the child as she/he grows older and thereby make a step change to reduce the risk of chronic diseases amongst people of Stoke on Trent?

If the conclusions of such considerations are positive, then we have the potential to transform the health of people in Stoke on Trent within a generation. However, to do so, we may well need to radically change health services for children and families.
Who should do this?

Stoke on Trent PCT has the responsibility to ensure that the services it commissions and provides meet the needs of the communities in Stoke on Trent. In that context the responsibility to take this forward lies with Stoke on Trent PCT. However, there are a number of partner organisations who have a major interest (e.g. Stoke on Trent City Council) and therefore will need to be closely involved.

5. Recommendations

i. Programmes to reduce smoking, obesity, sudden unexplained deaths and teenage pregnancies should continue to be a major priority for the Stoke on Trent PCT for the foreseeable future.

ii. Stoke on Trent PCT in collaboration with partners should consider how the commissioning of and the nature of support provided to mothers from conception to when the infant becomes two, can be changed so as to deliver the sorts of benefits, programs in the United States are delivering to their poorest communities.
MAJOR KILLERS

Chapter 4:
Circulatory Diseases

Contributor:
Paul Trinder. Epidemiologist
CIRCULATORY DISEASES

1. Introduction

Circulatory diseases continue to be the major cause of deaths amongst people of Stoke on Trent. It includes a range of diseases such as heart disease, strokes and high blood pressure. It is important to note that circulatory diseases can also be caused by conditions such as diabetes.

The targets for circulatory disease mortality are as follows:

- An absolute reduction in mortality of 40% in people under the age of 75 by 2010
- Reduction of 40% of the gap between the fifth of areas with the worst health and deprivation indicators and the population as a whole by 2010. We have adopted this as a local target.

2. The Challenge in Stoke on Trent

The progress towards our targets is shown in Figure 1 (using annual figures) and Table 1 (3 year rolling average).

Figure 1 Trends in mortality from circulatory disease amongst those aged less than 75 in Stoke and Trent and England between 1993 and 2005.

Both the absolute difference and the relative difference continue to improve. We are currently on schedule for meeting both the absolute target of 40% and the relative target of 40% reduction in the gap between England and Stoke on Trent (Table 1 and Figure 2).
Table 1 Progress towards target

<table>
<thead>
<tr>
<th></th>
<th>Baseline rate*</th>
<th>Current rate*</th>
<th>Target rate*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stoke on Trent</td>
<td>194.2</td>
<td>124.7</td>
<td>103.8(1)</td>
</tr>
<tr>
<td>England</td>
<td>141.3</td>
<td>90.4</td>
<td>84.8</td>
</tr>
<tr>
<td>Difference between</td>
<td>52.9</td>
<td>34.3</td>
<td>19.4</td>
</tr>
<tr>
<td>Stoke and England</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Compendium of clinical indicators 2005
* deaths per 100,000 people under age of 75
1 – estimated assuming a 40% absolute reduction as well as a 40% reduction in the difference between Stoke on Trent and England.

Figure 2 Trajectory to meet the target in Stoke on Trent

Source: Paul Trinder, Epidemiologist, Public Health Department, Stoke on Trent PCT.

Within Stoke on Trent, there are considerable variations (Table 2). Compared to the analysis described in my report last year, the position of some wards (e.g. the mortality rate in Longton North is no longer significant) have changed. However, given the small numbers it is not possible to comment on the significance of such change.
Table 2 Mortality from circulatory disease (between October 2001 and September 2006) for wards in Stoke on Trent for people aged less than 75.

<table>
<thead>
<tr>
<th>Ward</th>
<th>Number of deaths</th>
<th>Directly age standardised mortality per 100,000 population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abbey Green</td>
<td>91</td>
<td>143.6</td>
</tr>
<tr>
<td>Bentilee and Townsend (1)</td>
<td>123</td>
<td>194.2</td>
</tr>
<tr>
<td>Berryhill and Hanley East</td>
<td>82</td>
<td>141.4</td>
</tr>
<tr>
<td>Blurton</td>
<td>76</td>
<td>123.1</td>
</tr>
<tr>
<td>Burslem North</td>
<td>84</td>
<td>131.3</td>
</tr>
<tr>
<td>Burslem South (1)</td>
<td>106</td>
<td>168.4</td>
</tr>
<tr>
<td>Chell and Packmoor</td>
<td>70</td>
<td>111.7</td>
</tr>
<tr>
<td>East Valley</td>
<td>72</td>
<td>118.2</td>
</tr>
<tr>
<td>Fenton</td>
<td>83</td>
<td>131.2</td>
</tr>
<tr>
<td>Hanley West and Shelton</td>
<td>55</td>
<td>102.4</td>
</tr>
<tr>
<td>Hartshill and Penkhull</td>
<td>67</td>
<td>103.1</td>
</tr>
<tr>
<td>Longton North</td>
<td>87</td>
<td>117.9</td>
</tr>
<tr>
<td>Longton South</td>
<td>97</td>
<td>132.5</td>
</tr>
<tr>
<td>Meir Park and Sandon (1)</td>
<td>61</td>
<td>88.0</td>
</tr>
<tr>
<td>Northwood and Birches Head</td>
<td>75</td>
<td>119.2</td>
</tr>
<tr>
<td>Norton and Bradeley</td>
<td>81</td>
<td>135.4</td>
</tr>
<tr>
<td>Stoke and Trent Vale</td>
<td>65</td>
<td>95.8</td>
</tr>
<tr>
<td>Trentham and Hanford (2)</td>
<td>62</td>
<td>94.9</td>
</tr>
<tr>
<td>Tunstall</td>
<td>94</td>
<td>137.4</td>
</tr>
<tr>
<td>Weston and Meir North</td>
<td>80</td>
<td>121.5</td>
</tr>
<tr>
<td>Stoke on Trent (1)</td>
<td>1611</td>
<td>125.5</td>
</tr>
<tr>
<td>Northern Staffordshire</td>
<td>2809</td>
<td>107.6</td>
</tr>
</tbody>
</table>

1 – Significantly higher than the rate for Northern Staffordshire
2 – Significantly lower than the rate for Northern Staffordshire
Source: Public Health Mortality Files 2007

It is of course important to note that the comparison used in Table 2 is with Northern Staffordshire which includes Stoke on Trent, Newcastle under Lyme and Staffordshire Moorlands. If the comparison was with the rates for England, the majority of wards in Stoke on Trent will have significantly high rates. This point is important, particularly in the context of targeting particular geographical areas. The public health analysis supports the view that, in order to reduce inequalities, we do need to target the majority of wards in Stoke On Trent rather than one or two.
3. Actions

What do we need to do?

We do know what the NHS needs to do to have a major impact. These include:

i. Reducing the risk of circulatory disease: these include factors such as smoking, obesity, stress and illnesses such as high blood pressure and diabetes. Changing these factors can be undertaken quickly and will have a measurable impact in the short term.

ii. Reducing the risk of deterioration of circulatory disease: important factors in this instance include smoking, obesity and long term use of medicines amongst those with circulatory disease. Changes can be implemented quickly and should lead to a measurable impact.

iii. In order to maximise the impact of the work undertaken by the NHS, we also need to improve the determinants of health which includes factors such as a good education, employment prospects, housing and the socio-economic circumstances (e.g. the level of poverty) of a particular area.

Who should do it?

One way or another all these issues are being progressed by Stoke on Trent PCT. However, the approach being taken to date is inefficient and its effectiveness is limited by the capability and capacity of the delivery system.

The delivery system for much of this work is primary care. GP practices are located in the communities they serve and moreover, they hold an electronic register of the patients they look after with particular clinical and demographic data recorded. That electronic population based information system provides considerable opportunities to improve the effectiveness and efficiency of delivery of patient specific care. However, this does require considerable support to make happen and moreover, it requires a change of attitude by both the PCT and General Practitioners to exploit the potential of primary care.

4. Recommendations

i. The importance of primary care services in reducing the impact of circulatory disease has to be acknowledged by the PCT.

ii. Additional investment is needed in primary care: a) to make greater use of the practice based information systems to call and recall people at risk of and with, circulatory disease; b) to strengthen the attitudes, knowledge and skills within primary care; c) develop a better skill mix of staff to ensure advances in knowledge and practice can be implemented efficiently and effectively in a timely manner.
MAJOR KILLERS

Chapter 5: Cancers

Contributors:

Paul Trinder, Epidemiologist
Catherine Thomson, West Midlands Cancer Intelligence Unit
CANCERS

1. Introduction

Cancers are the second most important cause of death among people of all ages in Stoke on Trent. However, amongst the population aged 75 and less, cancer is the most common cause of death.

The target is to reduce mortality rates by 2010;

- An absolute reduction of 20% in people under the age of 75
- A reduction of 6% in the gap between the fifth of areas with worst health and deprivation and the population as a whole. We have translated this to mean a reduction of 6% in the gap between Stoke on Trent and England.

2. The Challenge in Stoke on Trent

The trend in relation to mortality rates experienced by the people of Stoke on Trent is that it is reducing (Figure 1). The trends suggest that we should meet the target of 20% reduction by 2010. It is important to note that the deterioration in mortality rates seen in 2003 and 2004 appears to have been reversed.

Figure 1 Trends in cancer mortality rates amongst people aged less than 75 in Stoke on Trent and England between 1993 and 2005.

Source: Compendium of Clinical and Health Indicators 2007.

The trajectory in terms of meeting both the absolute target and the relative target is more difficult to predict as the local figures do vary considerably (Table 1 and Figure 2).
Table 1 Progress towards targets

<table>
<thead>
<tr>
<th></th>
<th>Baseline rate* 1995-97</th>
<th>Rate* 2003-05</th>
<th>Target rate* 2009-11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stoke on Trent</td>
<td>162.79</td>
<td>149.7</td>
<td>129.2</td>
</tr>
<tr>
<td>England</td>
<td>141.20</td>
<td>119.0</td>
<td>113.0</td>
</tr>
<tr>
<td>Difference between</td>
<td>21.59</td>
<td>30.7</td>
<td>16.2</td>
</tr>
<tr>
<td>Stoke and England</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* deaths from cancer per 100,000 people under the age of 75

1 – estimated assuming an absolute reduction of 20% and a relative reduction of 6% (between Stoke on Trent and England)

However, the trend since 1995 suggests a more positive interpretation of the position (Figure 2). There is greater variation in any given year but over time progress has been maintained and we should be confident of meeting both the absolute as well as the relative reduction targets.

Figure 2 Trajectory to meet the target for cancer (20% absolute and 6% relative reduction)

Source: Paul Trinder, Epidemiologist, Public Health Department, Stoke on Trent PCT

There is geographical variation within Stoke on Trent (Table 2). The variations between wards has changed since last year. Burslem South which had the poorest figures in last years’ report, no longer does so. That position is taken by Abbey Green. This variation is due to the small number effect and will continue to be a feature of ward based analyses.
It is however, important to note that the comparator used in Table 2 is Northern Staffordshire. If England was the comparator, then the majority of wards in Stoke on Trent will have significantly higher mortality rates.

### Table 2 Directly age standardised cancer mortality rates for 2001-2006 in people aged less than 75.

<table>
<thead>
<tr>
<th>Ward</th>
<th>Number of deaths</th>
<th>Mortality rate per 100,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abbey Green (1)</td>
<td>121</td>
<td>194.6</td>
</tr>
<tr>
<td>Bentilee and Townsend</td>
<td>102</td>
<td>164.4</td>
</tr>
<tr>
<td>Berryhill and Hanley East</td>
<td>97</td>
<td>170.9</td>
</tr>
<tr>
<td>Blurton</td>
<td>99</td>
<td>158.5</td>
</tr>
<tr>
<td>Burslem North</td>
<td>95</td>
<td>149.0</td>
</tr>
<tr>
<td>Burslem South</td>
<td>111</td>
<td>174.1</td>
</tr>
<tr>
<td>Chell and Packmoor</td>
<td>72</td>
<td>116.3</td>
</tr>
<tr>
<td>East Valley</td>
<td>100</td>
<td>166.2</td>
</tr>
<tr>
<td>Fenton</td>
<td>83</td>
<td>131.9</td>
</tr>
<tr>
<td>Hanley West and Shelton (2)</td>
<td>44</td>
<td>79.6</td>
</tr>
<tr>
<td>Hartshill and Penkhull</td>
<td>79</td>
<td>129.9</td>
</tr>
<tr>
<td>Longton North</td>
<td>92</td>
<td>129.3</td>
</tr>
<tr>
<td>Longton South</td>
<td>96</td>
<td>135.6</td>
</tr>
<tr>
<td>Meir Park and Sandon</td>
<td>79</td>
<td>114.3</td>
</tr>
<tr>
<td>Northwood and Birches Head</td>
<td>72</td>
<td>111.4</td>
</tr>
<tr>
<td>Norton and Bradley</td>
<td>103</td>
<td>176.3</td>
</tr>
<tr>
<td>Stoke and Trent Vale</td>
<td>80</td>
<td>131.1</td>
</tr>
<tr>
<td>Trentham and Hanford</td>
<td>81</td>
<td>123.5</td>
</tr>
<tr>
<td>Tunstall</td>
<td>85</td>
<td>128.9</td>
</tr>
<tr>
<td>Weston and Meir North</td>
<td>97</td>
<td>152.9</td>
</tr>
<tr>
<td><strong>Stoke on Trent (1)</strong></td>
<td><strong>1788</strong></td>
<td><strong>141.5</strong></td>
</tr>
<tr>
<td><strong>Northern Staffordshire</strong></td>
<td><strong>3309</strong></td>
<td><strong>128.5</strong></td>
</tr>
</tbody>
</table>

1 – Significantly higher than the rate for Northern Staffordshire  
2 – Significantly lower than Northern Staffordshire

Source: Public Health Mortality Files 2007

Table 3 and 4 below provide data for survival, namely the proportion of people with a particular cancer alive, 5 years after diagnosis after allowing for the general population mortality. It is important to note however, that the figures in the tables do not take into account the severity of the cancer at diagnosis. This is very important as most advanced cancers are very difficult to cure.

Table 3 shows that survival from breast, cervix and stomach remains within the levels experienced in the West Midlands. But in terms of all cancers, survival is significantly below the West Midlands figure. The analysis for colo-rectal, lung and prostate cancers for those patients diagnosed between 1996 and 2000, continued to show a significantly lower survival rate for people in Stoke on Trent, a similar finding to analysis reported in my report last year.
Table 3 Five year relative survival rates for the common cancers (diagnosed between 1996 and 2000 and followed up to end of 2005)

<table>
<thead>
<tr>
<th>Cancer</th>
<th>% in Stoke on Trent surviving for 5 years (95% confidence intervals)</th>
<th>% in West Midlands people surviving for 5 years (95% confidence intervals)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast (females)</td>
<td>76.24 (72.34-80.13)</td>
<td>78.67 (77.88 – 79.46)</td>
</tr>
<tr>
<td>Cervix (females)</td>
<td>64.58 (53.09-76.07)</td>
<td>69.49 (66.88-72.10)</td>
</tr>
<tr>
<td>All cancers(1)</td>
<td>39.13 (37.58-40.69)</td>
<td>47.64% (47.28-48.00)</td>
</tr>
</tbody>
</table>

Source: West Midlands Cancer Intelligence Unit April 2007

1 – Survival figures for Stoke on Trent people are significantly lower than in the West Midlands

The West Midlands Cancer Intelligence Unit therefore carried out further detailed analysis to try to explain why people with colo-rectal lung cancer, and prostate cancer had worse survival in Stoke. They were able to use more up to date data. Table 4 shows 5-year survival for these cancers for people diagnosed during 1999-2001, with follow-up to the end of 2006 instead of 1996-2000, followed up to end of 2005.

Table 4 Five year relative survival rates for colo-rectal, lung and prostate cancers (diagnosed between 1999 and 2001 and followed up to end of 2006)

<table>
<thead>
<tr>
<th>Cancer</th>
<th>Percentage of Stoke on Trent people surviving for 5 years (95% confidence intervals)</th>
<th>Percentage of West Midlands people surviving for 5 years (95% confidence intervals)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colo-rectal males</td>
<td>50.77 (42.41-59.14)</td>
<td>51.79 (50.02-53.56)</td>
</tr>
<tr>
<td>Colo-rectal females</td>
<td>47.73 (39.08-56.38)</td>
<td>53.76 (51.74-55.78)</td>
</tr>
<tr>
<td>Lung males(1)</td>
<td>3.45 (1.30-5.61)</td>
<td>7.02 (6.24-7.80)</td>
</tr>
<tr>
<td>Lung females</td>
<td>6.42 (2.47-10.37)</td>
<td>8.43 (7.32-9.54)</td>
</tr>
<tr>
<td>Prostate(1)</td>
<td>65.83 (57.27-74.39)</td>
<td>78.16 (76.63-79.69)</td>
</tr>
</tbody>
</table>

Source: West Midlands Cancer Intelligence Unit June 2007

1 – Survival figures for Stoke on Trent people are significantly lower than in the West Midlands

This showed that whilst survival for colo-rectal cancer for both sexes and lung cancer in women were still lower in Stoke on Trent, they were no longer significantly worse. However, survival from lung cancer in men and prostate cancer remained significantly poorer in this additional more up-to-date analysis.

The West Midlands Cancer Intelligence Unit subsequently tried to look at whether the severity of the cancer could account for the poorer survival. The following conclusions were drawn from that set of analysis:

- The numbers of Stoke on Trent patients included in the analysis were small and as a consequence the survival estimates may be inaccurate.
- The poorer survival from lung cancer could well be due to a greater proportion of men not having surgery in Stoke on Trent compared to the West Midlands. This may be due to men in Stoke on Trent having other illnesses (e.g. heart or respiratory diseases) or it could be due to men presenting at an inoperable stage of the cancer. This particular issue needs to be investigated further.
In terms of prostate cancer, a greater proportion of men in Stoke on Trent were diagnosed with cancers which were of a higher or unknown grade, than elsewhere in the West Midlands. This may well suggest that patients in Stoke on Trent are presenting with very advanced prostate cancer and therefore would expect to have lower survival figures. An alternative hypothesis could be that this is inaccurate reporting of clinical information to the Cancer Intelligence Unit by the hospital. These findings do require further work to explain why this is so in order to take effective action. If the first hypothesis holds true, then we would need to consider carefully how we might raise awareness of prostate cancer in the community.

3. Actions
What do we need to do?

Analysis undertaken in the late 1990s suggested the following as key actions:

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Potential impact on mortality in the context of 20% reduction required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduction in smoking</td>
<td>7.3%</td>
</tr>
<tr>
<td>Improvement in treatment services</td>
<td>4%</td>
</tr>
<tr>
<td>Increase in fruit and vegetable consumption</td>
<td>4%</td>
</tr>
<tr>
<td>Screening services (breast cervix and colo-rectal)</td>
<td>3.5%</td>
</tr>
<tr>
<td>Reduction in alcohol consumption</td>
<td>1%</td>
</tr>
</tbody>
</table>


The table shows that more than half of the reductions can be achieved if life style issues such as smoking and eating and drinking habits could be changed for the better. One way or another, we are intervening on most of the factors listed in the table. However, it would be true to say that treatment, smoking cessation and screening services have had the most effort and resources put into them in recent years and have improved out of all recognition. Unfortunately our work in relation to fruit, vegetable and alcohol consumption is much less well developed.

In my view there are three major areas for development in Stoke on Trent:

i. Screening: The National Screening Committee and the Department of Health have agreed to set up a screening programme for colo-rectal cancer. Once fully implemented, this should lead to further reductions in the differences between Stoke on Trent and the West Midlands, although as we have seen, survival in the latest years was no longer significantly worse in Stoke on Trent. This is covered in some detail in Chapter 7 of this report.

ii. Nutrition and Alcohol: There is a great deal for us to do. The evidence base for alcohol is better developed than for nutrition. These issues are covered in the chapters on alcohol and obesity.

iii. Further analyses are also required to answer the following questions;

- **To understand the reasons for the apparent low use of surgery amongst men with lung cancer in Stoke on Trent.**
- **To identify the reasons for a higher proportion of unknown and higher grade prostate cancers amongst people of Stoke on Trent.**
**Who should do it?**

The PCT has the overall responsibility to ensure a coordinated approach is taken.

### 4. Recommendations

i. The PCT should ensure that use of surgery in men with lung cancer is examined as soon as possible by the University Hospital of North Staffordshire. It is important that the analysis includes another hospital in the West Midlands as a comparator.

ii. The PCT should ensure that University Hospital of North Staffordshire contributes to the national audit on lung cancer. This will make future analysis of the care provided to people with lung cancer much easier.

iii. The PCT should commission further studies to understand the reasons for people presenting with higher or unknown grades of prostate cancer in Stoke on Trent than elsewhere.
MAJOR KILLERS

Chapter 6: Respiratory Diseases

Contributor:

Paul Trinder, Epidemiologist
RESPIRATORY DISEASES

1. Introduction
Although there are no specific national targets for respiratory health, it remains a major challenge for us in Stoke on Trent. This is because:

- Respiratory diseases make a major contribution to the ill health experienced in Stoke on Trent and contribute directly to life expectancy figures.
- There are cost effective methods of preventing respiratory illness (stopping smoking for example).
- There are cost effective methods of delaying deterioration (from stopping smoking to use of medicines and rehabilitation).

2. The Challenge in Stoke on Trent
The respiratory system is subject to a number of diverse conditions which can lead to ill health and death. Table 1 provides information for the commonest group of illnesses experienced by people in Stoke on Trent. The majority of deaths take place amongst the older age groups and often, infections complicate chronic lower respiratory tract diseases (COPD).

Table 1 Particular respiratory illness causing death

<table>
<thead>
<tr>
<th>Cause of death</th>
<th>All ages (number)</th>
<th>Under 75 (number)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infections</td>
<td>151</td>
<td>25</td>
</tr>
<tr>
<td>Chronic lower respiratory tract diseases</td>
<td>154</td>
<td>55</td>
</tr>
<tr>
<td>Others</td>
<td>75</td>
<td>14</td>
</tr>
<tr>
<td>Total</td>
<td>380</td>
<td>94</td>
</tr>
</tbody>
</table>

Source: Public Health Mortality file

The mortality rate for the common causes of chronic obstructive pulmonary disease has decreased in Stoke on Trent but remains above that for England and the West Midlands (Figure 1). There appears to have been a major reduction in mortality rates during the 1990s. However, since the turn of the century, the mortality rate has oscillated around 40 per 100,000 population whereas in England, the trend is one of a steady reduction over time. Such a pattern means that the gap between Stoke on Trent and England continues to widen.

It is important to note that the numbers in Stoke on Trent are small and therefore the year to year variation is high and will remain high.
Figure 1 Mortality from bronchitis, emphysema and other COPD (ICD10 J40 to 44). Directly age standardised per 100,000 population (all ages)

Source: Compendium of Clinical and Health Indicators 2007

The numbers of deaths are too small to enable any conclusions to be drawn about the geographical variations within Stoke on Trent. However, it is possible to use hospital admissions as a proxy measure (Figure 2).

Figure 2 Admissions rates by wards in Stoke on Trent for the period 2002/03 to 2005/06

Blurton, Longton South, Burslem South and Tunstall have significantly higher admission rates and we can therefore assume that people in these wards have the greatest burden from respiratory disease. However, it
is important to note that the comparator is Stoke on Trent. If it was possible to use the average admission rate for England as the comparator the majority of wards in Stoke on Trent will have been seen as having problems.

3. Action

What should we do?

The most important cause of respiratory ill health is smoking. Therefore, helping people to quit smoking will have a major impact and this is covered in detail in the chapter on smoking.

The greatest need for improvement is in the management of chronic obstructive pulmonary disease. People with this group of diseases have very poor quality of life as well as increased mortality. Death can be caused by infection or other complications. In Stoke on Trent, we need to improve the diagnostic pathway, the use of medicines and rehabilitation. The scientific evidence shows that for all age groups, effective implementation of an efficient pathway approach will lead to considerable improvements in mortality, admissions to hospital and the quality of life.

The clinical community in Stoke on Trent which includes colleagues from the hospital sector as well as primary care are clear about what needs to be done and in what order. However, access to necessary funds, clinical change management skills and most importantly the motivation to make it happen are missing.

Who should do it?

Stoke on Trent PCT should take explicit responsibility for ensuring the improvements are made and have the right impact. The PCT has taken the first steps in making this happen by making this a priority.

4. Recommendations

Stoke on Trent PCT should ensure detailed plans that cover diagnosis, management and rehabilitation of chronic obstructive pulmonary disease are constructed and implemented in a phased approach over the next 24 months. Given the work undertaken by the clinical community in Stoke on Trent, the plans should be reviewed by the PCT in November 2007 so that any financial requirements are considered as part of the financial plans for 2008/09 and 2009/10.
MAJOR KILLERS

Chapter 7: Mental Health

Contributor:
Sharon Taaffe, Health Promotion Specialist
MENTAL HEALTH

1. Introduction

The mental health national service framework was published in 1999 and set out standards of care in:

- Mental health promotion
- Access to services
- Effective service models in primary and secondary care
- Carer support
- Suicide prevention

Locally, that framework has been translated into the Stoke on Trent Mental Health Strategy. The strategy aims to reduce the impact of mental distress on people who experience it and their carers, to promote the mental health of the whole population across all ages, and to contribute to a reduction in the suicide rate for England. In addition the Child and Adolescent Mental Health Strategy and the implementation group for the Older People’s National Service Framework, also have goals to promote the mental health of their client groups.

2. The Challenge in Stoke on Trent

Mental illness causes a major challenge in the context of quality of life. However, it is beginning to become an important cause of death too. In Stoke on Trent, there were approximately 78 deaths due to mental illness (approximately 3.2%) for the 12 months to October 2006. Of these 7 were due to suicides or undetermined injury and of the remainder almost 90% were due to dementia.

There is a national target to reduce suicides and Figure 1 shows the changes in suicide rates for England and Stoke on Trent over time. This shows that the general trend is a reduction in Stoke on Trent and for the most recent years, the rate in Stoke in Trent is actually less than the national figure.

Figure 1 Trends in rates of suicides and undetermined injury

![Figure 1 Trends in rates of suicides and undetermined injury](image)

Source: Compendium of Clinical and Health Indicators 2007
However, it is important to note that the numbers are small even when aggregated for a three year period. The best way of looking at suicides is to consider it as the tip of the mental health iceberg in Stoke on Trent. Tackling this issue effectively and in a sustainable way, does depend on having a successful strategy to improve the wider mental health of the community.

Prevalence data on mental health problems is not routinely collected. In order to assess local need for services it is therefore necessary to extrapolate using data from research. This confirms that mild to moderate mental health problems are common, affecting about one in ten of the population of the City at any one time (Table 1). Psychosis on the other hand is rare, affecting only one in a hundred people at any time.

| Table 1 Numbers of people in Stoke on Trent with particular illness based on national prevalence data |
|-------------------------------------------------|---------------------|-----------------|
| **Stoke PCT - 15+ Population 226,760**         | **Assumed Prevalence** | **2000 people** |
| Depression                                     | 3%                  | 6,805           |
| Mild                                           | 36% (of 3%)         | 2,450           |
| Moderate                                       | 43% (of 3%)         | 2,925           |
| Severe                                         | 21% (of 3%)         | 1,430           |
| **Anxiety**                                    |                      |                 |
| Phobias                                        | 0.7%                | 1,600           |
| Panic                                          | 1.8%                | 4,100           |
| Generalised Anxiety Disorder                   | 2%                  | 4,500           |
| Obsessive/Compulsive Disorder                  | 2%                  | 4,500           |
| Psychoses                                      | 1%                  | 2,250           |
| Personality Disorders                          | 2-3%                | 6,000           |


This pattern of need is reflected in the emphasis placed within the Stoke on Trent Mental Health Strategy. The major focus of the strategy is on increasing the capacity and capability of primary care, voluntary and community sector organisations, communities and individuals, to recognise and manage mental distress. This is not to deny the importance of the need for specialist mental health services but is to be clear that we do need to focus development on meeting the needs of people with mild to moderate mental disease as well as on those with severe mental illness.

3. Actions

What do we need to do?

The Stoke on Trent mental health strategy identifies some of the key actions for implementation locally. These include:

- Implementation of the healthy minds network which will incorporate teams of new mental health workers, primary care mental health workers and black and minority ethnic community
development workers to provide an increased access to a range of non medical responses to common mental health problems.

- Introduction of a stepped care approach to mild to moderate mental health problems in primary care
- Increased access to psychological therapies and in particular cognitive behaviour therapy
- Implementing a model of social prescribing, enabling primary care practitioners to signpost patients to non medical services.

The analysis on the mortality from mental health has also identified unspecified dementia as an important issue in Stoke on Trent. Research is increasingly showing that more people at a younger age are beginning to be affected by dementia and in the future, it is likely to become a major challenge. It is therefore important that we (The PCT and the City Council) take a proactive approach and put in place a programme to prevent dementia (if possible), to diagnose and treat and to support individuals and their carers in the community.

**Who should do this?**

Stoke on Trent PCT working with the City Council has set up a partnership planning and implementation system to take forward the strategy. However, in the context of the key actions above, it is important that progress is reported to the Professional Executive Committee of the PCT.

**4. Recommendations**

i. Stoke on Trent PCT should increase the capacity (and in particular for cognitive behaviour therapy) within primary and community services for the management of people with mental health problems.

ii. Stoke on Trent PCT should increase capacity to manage and develop the Healthy Minds Network so that all people who may benefit have access.

iii. Stoke on Trent PCT supported by the City Council should develop a strategy on reducing the impact on dementia on the people of Stoke on Trent.
MAJOR KILLERS

Chapter 8: Population Screening Programmes

Contributors:

Mary Synnott, Associate Specialist, Screening Co-ordinator
POPULATION SCREENING PROGRAMMES

1. INTRODUCTION

The practice of screening – that is actively seeking to identify a disease or pre-disease in people who are presumed and presume themselves to be healthy has grown rapidly. These programmes are different to the usual system for providing care which is primarily about people coming to the health service asking for help. In contrast, screening programmes request healthy individuals to undergo a particular investigation with the specific intention of preventing or modifying a pathological process. There is therefore, an ethical duty to ensure that screening programmes offer benefits and very little disbenefits to individuals and communities.

To ensure an ethical approach, the UK National Screening Committee was established in 1996 to advise Ministers on the case for implementing new programmes, on screening technologies that are effective and the case for continuing, modifying or withdrawing existing population screening programmes. Locally, we offer screening programmes in line with national policies.

This section deals with screening programmes that have been recently implemented or are likely to be implemented in the near future. Implemented well, they all have the potential to improve life expectancy as well as quality of life.

2. Adult screening programmes

a) BOWEL (colo-rectal) CANCER SCREENING

Introduction

Bowel cancer is second only to lung cancer as a cause of cancer deaths in the UK. It usually occurs in later life at age 60-70 years. The number of deaths from bowel cancer – about 16,000 in 2004 exceeded the number from breast cancer (12,000) and cervical cancer (1,000). Advances in treatment have improved survival rates. However, the most effective way to improve survival is to diagnose bowel cancer while the disease is asymptomatic. This is possible only by screening the general population. The National Screening Committee looked at the evidence in detail and recommended the setting up of a programme. They recommended the use of a particular test (Faecal Occult Blood- FOB) every 2 years for men and women aged 50-69 followed by examination of the colon using an endoscope and subsequent referral for definitive treatment if an abnormality is found.

Implementation began in April 2006 and the only modification to the recommended programme was that people who are 70 and over will be provided with the test kit on request. The University Hospital of North Staffordshire supported by Stoke on Trent and North Staffordshire PCTs has submitted a bid to join the second-wave and become a screening centre during the latter part of 2007.

Epidemiology

In the West Midlands, colo-rectal cancer accounts for 14% of all newly diagnosed cancers in men and 11% in women. It is commoner in more affluent populations. There were 45 deaths per year in North Stoke and a similar number in South Stoke during 2002-04. The trends in mortality rates since 1988 are shown in Fig 1.
The mortality rate at a West Midlands level has declined by about one third. The decline is less marked for Stoke on Trent and is of the order of 12-14%. During 2002-2004, the mortality rate was significantly higher in Stoke on Trent PCT than for West Midlands.

During 2002-2004, the average number of new cases per year in the West Midlands was approximately 3,200 whereas in Stoke on Trent there were 177 cases. There is more fluctuation in the rates at the PCT level because of smaller numbers but the trend is that the rates are higher than in the West Midlands and moreover, the incidence appears to be increasing in contrast to the regional picture Figure 2).
Conclusion

The outcome, as long as all those in the eligible population take part in the screening programme, should be a reduction in mortality from bowel cancer by about 16%. The benefits for Stoke on Trent given the levels of deprivation should be higher. However, the success of the screening programme will be very dependent on the proportion of eligible people taking part.

b) DIABETIC RETINOPATHY (EYE DISEASE) SCREENING

Introduction

Diabetic retinopathy is a complication of diabetes. In 2005 the National Screening Committee reviewed the evidence about screening for sight threatening diabetic retinopathy and recommended that a systematic screening programme be implemented in the UK. The target is 100% coverage of those at risk by the end of 2007.

Diabetic retinopathy affects sight by damaging blood vessels in the retina (lining at the back of the eye) and is the commonest cause of blindness in the working age population. In the early stages there are no symptoms and sight is not affected. The risk of developing retinopathy is greater in people who have had diabetes for a long time, those whose blood sugar is poorly controlled, those with raised blood pressure,
those who are pregnant and those taking insulin. Laser treatment reduces the risk of loss of vision but needs to be given at the appropriate stage and ideally before vision has been affected.

**Progress**
Systematic screening was implemented for all PCTs in Staffordshire on a consortium basis in April 2006. The service is hosted by South Staffordshire PCT. The service is delivered from a network of optometry clinics. There are about 38,000 patients on the collated register of whom 10,576 were resident in Stoke-on-Trent PCT. A central call-recall system is in place. The uptake of screening invitations for 2006/07 in Stoke on Trent was 71.4%. The national minimum standard is that at least 70% of invited patients accept the offer of the initial screen (and 80% for the repeat screen). Patients with positive screening tests are referred to the hospital based specialist teams.

The main challenge for the service is to increase the coverage to 100% by the end of 2007. There is confidence in the system that the target will be met.

**Conclusions**
The screening programme has been in the development phase over the last few years. By the end of 2007, this phase should be complete and the challenge will be to maintain the programme with 100% coverage and ensuring treatment for those detected are provided speedily. Although, reports on the screening programme will be available in late 2007, it is unlikely that this will include the treatment aspects. It is therefore important that a report from University Hospital of North Staffordshire is also requested as part of the annual report.

**3. Screening Programmes during pregnancy**

**Introduction**
Pregnant women are offered screening for infections and fetal abnormalities. Infections screened for include; rubella, hepatitis B, HIV and syphilis. If active infection is detected, steps are taken to protect the health of the woman and to reduce the risk of transmission of infection to the baby. The uptake of the tests is excellent, for example more than 95% of women accept the offer of the HIV screening test which exceeds the national target of 90%.

Fetal abnormalities screened for include, Down's syndrome, central nervous system abnormalities (e.g. spina bifida) and others. These conditions are an important cause of fetal death, impairment and disability. The aim of screening is to offer the couple reproductive choice.

**a) Down's Syndrome Screening**

**Introduction**
Down's syndrome is caused by a genetic abnormality. People with Down's have learning difficulties and a shortened life expectancy. Older mothers have a greater chance of having a baby with Down's e.g. a woman aged 20 has a 1 in 1500 chance whereas a woman aged 40 has a 1 in 100 chance. In the past screening was
based on a woman’s age and women over a certain age usually 35 were offered a diagnostic test. This policy missed many cases of Down’s syndrome and therefore has been changed.

**Screening and diagnosis**

Currently, there are 2 methods of screening – a blood test taken around 16 weeks and widely used; the other method is ultrasound screening (nuchal translucency) scan done at 11 to 13 weeks. This is a special scan and is not currently generally available in the NHS. In 70% of NHS hospitals including University Hospital of North Staffordshire (UHNST), blood screening using the triple test is offered between 12 and 24 weeks of the pregnancy. This test must be preceded by an ultra sound scan to date the pregnancy. The mother’s age, weight and gestation as well as the results of the triple test are used to calculate the risk of the baby having Down’s. If the risk is greater than a 1 in 250 chance, the woman is offered a diagnostic test (amniocentesis) in which a sample of fluid surrounding the baby in the womb is taken. Rapid tests can be performed, but the full genetic analysis takes up to 18 days. Amniocentesis is invasive and the risk of miscarriage is about 1:100. If the diagnostic test is positive, the woman is offered specialist support for her choice of either continuing with the pregnancy or choosing a termination.

**Current issues/developments**

Locally in 2004, 4,015 (73.6%) pregnant women booking at UHNST took up the offer of the ‘triple test’. 176 (4.38%) ‘high risk’ results were reported. 91 of these women took up the offer of a diagnostic amniocentesis test. Down’s syndrome was diagnosed in 7 cases; 5 opted for a termination of pregnancy and 2 continued with the pregnancy and delivered live born babies with Down’s syndrome.

The objective of the NHS Down’s syndrome screening programme is to ensure access to a uniform screening programme which conforms to an agreed level of quality for all pregnant women in England who undergo screening for Down’s. A key aim is to provide information for women so they are able to exercise informed choice. Quality assurance mechanisms have been put in place to improve testing strategies. An education and training pack for midwives has been developed and evaluated. Patient information leaflets were developed and distributed. Equipment to perform nuchal translucency has been assessed with a view to producing a service specification.

It is important to reduce false positive rates as much as possible while keeping a high detection rate. The standard set from April 2007 is for a detection rate of greater than 75% with a false positive rate of less than 3%. However, this performance is not achievable using the current approach. Testing by nuchal translucency is the best way but universal access to this test has major resource and training implications.

A compromise is the triage contingency strategy. This is a 3-step procedure. Women are offered a blood test in the first twelve weeks of pregnancy. The test will show that 80% of these women will be at low risk result and can be reassured. The rest are offered nuchal translucency test. Those who have a normal result will be reassured and those with a positive result will be counselled and have a further blood test. The result of this blood test will determine whether or not the woman needs to consider termination.
This model performs well and is resource efficient. Feasibility and acceptability was demonstrated in a pilot study in the West Midlands. Locally, investment in services would be required to move to such a screening strategy.

b) Sickle Cell and Thalassaemia (Haemoglobinopathies)

Introduction

Haemoglobinopathies are serious inherited disorders of haemoglobin which carries oxygen around the body. Haemoglobinopathies are common in people who have family origins from the malarial parts of the world. In the UK, these disorders are seen among minority ethnic groups from Africa, the Caribbean, the Mediterranean, South East Asia, the Middle East, and the Far East but can be found (less frequently) in all ethnic groups.

The highest prevalence is among Black Caribbean, Black Africans and Black British. In England, it is estimated that there are 12,500 people with sickle cell disorders and 240,000 people who are healthy carriers.

Thalassaemia is a disorder characterised by a reduction in the amount of haemoglobin produced. People with the condition have varying degrees of anaemia and may require regular blood transfusions. Thalassaemia major is the most severe form and is thought to affect more than 700 people and about 214,000 healthy carriers in the UK. The highest carrier prevalence is among Cypriots and other Southern Mediterranean populations, Indian, Pakistani and Chinese populations.

Screening policy

The NHS Sickle Cell and Thalassaemia Programme was set up in 2001 to deliver the NHS Plan commitment of linked programmes for newborn and antenatal haemoglobinopathy screening. The aim of the antenatal programme is to offer effective and appropriate screening for these disorders to all eligible women and couples in a timely manner during pregnancy.

The implementation process depends on whether a particular locality has lots of people (prevalence) at risk of sickle cell disorders. High prevalence is defined as a fetal prevalence of sickle cell disorders of more than 1.5 babies per 10,000 births. Northern Staffordshire including Stoke on Trent is a low prevalence area. The policy in such areas is to offer:

- screening for thalassaemia to all pregnant women
- Family origin questionnaire is used to assess the risk of either the woman or her partner being a carrier for sickle cell and other haemoglobin variants. Women in identified high risk groups are offered laboratory testing.
- Partners of all identified Carrier mothers (irrespective of family origin) are offered screening for sickle cell, other haemoglobin variants and thalassaemia.

Women and couples identified as ‘high risk’ are counselled and offered a pre-natal diagnostic test. National objectives and standards have been set for the programme. The outcome to be achieved is that for women accepting screening, to identify 50% couples/women at ‘high risk’ of an affected pregnancy by the end of the
12th week of pregnancy. This is challenging and relies on women booking early (6-8 weeks) for antenatal care.

**Current issues/developments**

In Stoke on Trent the ‘low prevalence’ area programme will be implemented in autumn 2007. National funding is available to pump prime the programme during the first 2 years. A system will be put in place to ensure that there is a link between antenatal and newborn screening.

### 4. Newborn Screening Programmes

**a) Newborn blood spot screening**

**Introduction**

Newborn blood spot screening identifies babies who may have rare but serious conditions. The following are included in the programme.

i) Screening programme for PKU (Phenylketonuria) was introduced in 1969. About 1 in 10,000 babies has PKU. If untreated, the baby develops irreversible mental disability. Screening means that babies with the condition can be treated early with a special diet which will prevent disability.

ii) Screening for Congenital Hypothyroidism (CHT) started in 1981. About 1 in 4,000 babies born in the UK has CHT. Babies with CHT do not have enough of the hormone thyroxine. Screening means that babies with CHT can be treated early with thyroxine which will prevent mental and physical disability.

iii) Screening for cystic fibrosis (CF) started more recently. About 1 in 2,500 babies born in the UK has CF. This inherited condition can affect the digestion and the lungs. Babies with CF may not thrive and have frequent chest infections. Screening means that babies with CF can be treated early with a high energy diet, enzyme supplements, and physiotherapy. Early treatment helps them live longer, healthier lives.

iv) Screening programme for Medium Chain Acetyl Dehydrogenase Deficiency (MCADD). About 1 in 10,000 babies born in the UK has MCADD. Babies with this inherited condition have serious problems breaking down fats to make energy for the body. This can lead to serious illness, or even death. Screening means that most babies who have MCADD can be recognised early. Special attention can be given to their diet which can help prevent serious illness and allow normal development.

**Performance assessment**

The UK Newborn Screening Programme Centre (UKNSPC), established in 2002 has developed a quality assurance programme and a performance management framework for the blood spot screening programmes. Six key standards have been developed to assure the quality of the process and to ensure that babies who may have one of the conditions for which screening is offered receive timely medical treatment. National generic process guidelines and standards have been set and the performance of the North Staffordshire PCTs in 2005/06 is shown in Table 1.
Table 1: Performance in 2005/06 – Northern Staffordshire PCTs

<table>
<thead>
<tr>
<th>Measure</th>
<th>Core Standard</th>
<th>Northern Staffordshire PCTs (4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Timely sample collection</td>
<td>95% of first samples taken at 5-8 days of age</td>
<td>95.6%</td>
</tr>
<tr>
<td>Timely sample despatch</td>
<td>100% of samples received by laboratory within 4 working days of sample collection</td>
<td>88%</td>
</tr>
<tr>
<td>Completeness of coverage</td>
<td>Screening test result or decline recorded for 100% of resident babies alive at 8 days</td>
<td>100% (North Stoke) 99.9% (South Stoke)</td>
</tr>
<tr>
<td>Enhanced tracking abilities</td>
<td>95% of blood spot cards received include babies’ NHS number</td>
<td>0% *</td>
</tr>
<tr>
<td>Timely identification of babies for whom the laboratory has not received a decline notification or a blood sample</td>
<td>100% of untested babies (including declines) identified by 19 days of age</td>
<td>100%</td>
</tr>
<tr>
<td>Timely processing of positive screening samples</td>
<td>100% positive screening results available and clinical referral initiated for PKU within 4 working days of sample receipt.</td>
<td>1 case of PKU 6 working days to referral</td>
</tr>
<tr>
<td></td>
<td>100% positive screening results available and clinical referral initiated for CHT within 4 working days of sample receipt.</td>
<td>No cases of CHT</td>
</tr>
</tbody>
</table>

* snapshot January – March 2006
Source: Regional Newborn Screening Lab, and North Staffordshire Child Health Information System

Current issues

The West Midlands Newborn Screening Laboratory is working with UHNST to implement the NHS number for babies on labels as the unique identifier for blood spot cards. The NHS number aids the identification and tracking of babies through the screening process. The developmental standard is to use the NHS number in a bar-coded format. This saves data entry time and also minimises errors of incorrect transcription.

b) Newborn Hearing Screening

Introduction

The purpose of the Newborn Hearing Screening Programme (NHSP) is to detect significant congenital permanent hearing loss within 6 months of birth. Early treatment of the hearing impairment (e.g. fitting hearing aids, family-focused information and specialist support, e.g. speech therapy, language therapy education) results in better outcomes in terms of language and cognitive development. One to two babies in every 1,000 are born with a hearing loss in one or both ears.
Screening programme

In Northern Staffordshire, the NHSP was implemented in February 2002 as part of the first wave of the national pilot implementation programme. The programme is based at UHNST. The screening team offers the test to all babies resident in Northern Staffordshire PCTs. Babies are screened in hospital before discharge if possible; otherwise the screener does the test at home. The child health database is used to track ‘missed’ babies and those moving into the area that require a screen. The baby is screened using a particular test (oto acoustic emission screen). If there is no clear response, the test may be repeated and then followed by another test. Following this, approximately 3% of those screened are referred for audiological assessment.

Babies admitted to the special care/neonatal unit are at higher risk of hearing loss. Such babies are offered both screening tests; about 7% are referred for full audiological assessment at 4 weeks of age. All newly identified babies with hearing loss are fitted with the latest digital hearing aids. These are fitted and managed following protocols and guidelines specified in the Modernising Children's Hearing Aids (MCHAS) programme thus maximising the benefit of newborn hearing screening.

Performance

During the year January to December 2006, 5,353 babies were screened, with 90% being tested in hospital. Babies who missed the screen in hospital and those who moved into the area were tested at home. 95% of qualifying babies were screened within 3 months which meets the national standard for programme coverage. Of the 5,353 babies screened, 210 (3.9%) were referred for audiological assessment. Nine (4%) of those referred were identified with some degree of permanent hearing loss.

The performance during 2006 met the national targets for coverage, referral for assessment and pick up rates. The wider benefits of the programme have included strengthened multidisciplinary working, the development of local guidelines for the surveillance of children at risk of progressive hearing loss and work on developing integrated care pathways for children with hearing aids, multisensory impairment and complex needs.

Developments

National quality standards have been set for the programme to ensure that:

- Families are able to make informed choices about screening uptake
- Screening and diagnostic services are effective and carried out to a high standard
- Results are communicated to parents/guardians effectively
- Families are given comprehensive support post-diagnosis
- Responsibilities for recording and reporting performance are clear

The National Quality Assurance Support Programme began in November 2006. Each NHSP service and its associated Audiology, Medical, Education and Social Care Service will be visited at least once every 18 months and provision will be reviewed against NHSP Quality standards. The visit will be carried out by a team of professionals in Screening, Audiology, Paediatrics and Education.
5. **Recommendations**

i. Stoke on Trent PCT needs to review the 2006/07 Diabetic Retinopathy Screening Programme annual report detailing performance against national standards and quality assurance criteria when it is available. The review needs to include the treatment aspects of the screening programme.

ii. Stoke on Trent PCT should though the Professional Executive Team ensure that implementation of the bowel screening programme is successfully accomplished.
LIFESTYLES IN STOKE ON TRENT

Chapter 9: Tobacco Addiction

Contributors:

Deborah Richardson, Health Promotion Specialist

Claire McIver, Smoking Cessation Facilitator
TOBACCO ADDICTION

1. Introduction

Smoking continues to be the single most important preventable cause of the ill health and mortality experienced by people in Stoke on Trent. Scientific research (Twigg, Moon G and Walker S. The smoking epidemic in England, Health Development Agency 2004) has shown that across the UK approximately 12% of female and 23% of male deaths are attributable to smoking. However, in Stoke on Trent, the same study attributed between 25% and 27% of female deaths and 40% and 42% of male deaths to smoking related ill health. This is not surprising because smoking prevalence in Stoke on Trent is much higher than elsewhere.

This excess mortality due to smoking does explain a considerable part of the difference in health inequalities that the chapters on life expectancy, circulatory disease and cancer have demonstrated. Therefore, reducing smoking prevalence to the national average and beyond is fundamental to reducing the degree of health inequalities experienced by the people of Stoke on Trent.

In this context, the implementation of smoke free legislation is a crucial milestone and will have two important impacts:

- Protect non-smokers from passive smoking
- Encourage smokers to think seriously about quitting.

2. The Challenge in Stoke on Trent

There are two important measures that we need to consider. First, to what extent is the current smoking cessation services having an impact on reducing the numbers of smokers in Stoke on Trent and second, how do we compare with the rest of the country. This latter measure is particularly important as our success needs to be greater than elsewhere if we are to bridge the gaps in health inequalities.

Are we meeting need?

I have used two figures for estimating the need for smoking cessation services in Stoke on Trent.

i. First, estimates from national surveys from the early 2000s, suggest that approximately 32% of those aged 16 and over in Stoke on Trent smoke. National research also suggests that between 60% and 70% of smokers want to quit and in any one year approximately one third of these will make a quit attempt.

ii. Second, local data from the information systems held by general practices contracted with Stoke on Trent PCT. Of the 205,670 people aged 16 and over, 131,048 had their smoking status recorded. 34,050 of these were labelled as current smokers. This suggests a smoking prevalence of 26% which is considerably less than the figure of 32% estimated using national surveys undertaken in 2002. However, it is important to note that 36% of the 16+ population do not have their smoking status recorded and that about a 11% of the people registered with Stoke on Trent PCT GPs do not live within the City. There is also considerable practice variation in recording of smoking status; from less than 40% records having a note of smoking status to more than 90%. It is therefore difficult to be accurate about smoking prevalence in Stoke on Trent.

However, in table 1 below, I have used the national estimate as the maximum and the local estimate as the
minimum. This suggests then in Stoke on Trent, between 30,000 and 40,000 people would like to quit and of these in any one year between 10,000 and 13,000 actually attempt to quit. In my view, the estimated market for smoking cessation services is between 10,000 and 13,000 people in any given year.

Table 1. Estimates of prevalence of smoking and those wishing to give up smoking based on General Household survey

<table>
<thead>
<tr>
<th>Adult (16+) registered Population</th>
<th>*Smokers based on a prevalence of 32% (1)</th>
<th>Smokers based on prevalence of 26% (2)</th>
<th>Number wishing to quit (60%)</th>
<th>Number making an attempt</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stoke on Trent PCT</td>
<td>205670</td>
<td>65,814</td>
<td>53,474</td>
<td>32,085-39,488</td>
</tr>
</tbody>
</table>

(1) – synthetic estimate
(2) - based on general practice information system. Important to note that smoking status is not recorded in 36% of the 16+ population.

Figures from the smoking cessation services suggest that between April 2002 and March 2007, approximately 19,000 attempts were made. However, if national research is correct, the market during this five year period should have been between 50,000 and 65,000; a market penetration of less than 40%.

Our actual achievement is set out in table 2 which shows the numbers giving up smoking during the period 2002 and 2007. Two indicators of success are used; 4 week quitters and 52 week quitters. The first is a good intermediate measure but is a poor measure of long term quitters. This is because considerable numbers of people relapse. In contrast, the 52 week figure is much more robust in measuring the number giving up permanently. Very few who give up for one year relapse, although it does occur.

Table 2. Numbers quitting in Stoke-on-Trent

<table>
<thead>
<tr>
<th>Year</th>
<th>4 week quitters</th>
<th>Number quit at 1 year</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002/03</td>
<td>1395</td>
<td>440</td>
</tr>
<tr>
<td>2003/04</td>
<td>1574</td>
<td>547</td>
</tr>
<tr>
<td>2004/05</td>
<td>2105</td>
<td>588</td>
</tr>
<tr>
<td>2005/06</td>
<td>2007</td>
<td>662</td>
</tr>
<tr>
<td>2006/07</td>
<td>1935</td>
<td>Not available yet#</td>
</tr>
<tr>
<td>2007/08</td>
<td>4000 *</td>
<td>1500 *</td>
</tr>
</tbody>
</table>

* - targets for 2007/08
# - data not available until end of 2007/08

Between the period 2002 and 2006, 2237 people gave up smoking on a permanent basis. This is less than one percent reduction in the prevalence of smoking in Stoke on Trent. Given the importance of smoking in the context of reducing inequalities, we have a long way to go to make any sort of impact. We are currently only scratching the surface of need.
People who wish to quit have several options:

- Quit on their own,
- Quit on their own plus use over the counter nicotine replacement therapy.
- Quit with behavioural support
- Quit with behavioural support and medication.

The last option is four times more effective than the first. Our local estimates and performance figures show that the majority of those making quit attempt do not access help from our services.

**How does our performance compare with the rest of the country?**

This is an important measure because in order to close the health inequalities gap due to smoking, our performance in stopping smoking needs to be better than elsewhere. Table 4 provides a comparison of 4 week quit figures for selected PCTs for the year 2005/06. The 2006/07 benchmarking figures (particularly for England) are not available yet.

**Table 4 PCT stop-smoking performance within Shropshire and Staffordshire in 2005/06**

<table>
<thead>
<tr>
<th></th>
<th>Number successfully quit at 4 week follow-up (self report)</th>
<th>4 week quit rate per 100,000 people aged 16 and over</th>
<th>Estimated prevalence of smokers (synthetic estimates based on national surveys)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telford &amp; Wrekin</td>
<td>1,851</td>
<td>1,466</td>
<td>28%</td>
</tr>
<tr>
<td>Shropshire County</td>
<td>2,137</td>
<td>912</td>
<td>22%</td>
</tr>
<tr>
<td>South Western Staffs</td>
<td>1,111</td>
<td>680</td>
<td>20%</td>
</tr>
<tr>
<td>Burntwood, Lichfield &amp; Tamworth</td>
<td>1,052</td>
<td>862</td>
<td>24%</td>
</tr>
<tr>
<td>North Stoke</td>
<td>1,015</td>
<td>1,032</td>
<td>34%</td>
</tr>
<tr>
<td>South Stoke</td>
<td>992</td>
<td>994</td>
<td>31%</td>
</tr>
<tr>
<td>East Staffordshire</td>
<td>744</td>
<td>810</td>
<td>24%</td>
</tr>
<tr>
<td>Staffordshire Moorlands</td>
<td>708</td>
<td>808</td>
<td>25%</td>
</tr>
<tr>
<td>Cannock Chase</td>
<td>726</td>
<td>709</td>
<td>27%</td>
</tr>
<tr>
<td>Newcastle under Lyme</td>
<td>644</td>
<td>759</td>
<td>26%</td>
</tr>
<tr>
<td>England</td>
<td>298,124</td>
<td>744</td>
<td>25%</td>
</tr>
</tbody>
</table>


Table 4 demonstrates that our performance in the context of 4-week quitters, is better than the national average. Does this mean that we are reducing the difference between Stoke on Trent and England? This is not so easy to answer. The 4 week quit rate does imply that we should be closing the gap. However, the most important measure of permanent quitting, the 52-week figure, is not routinely collected by the Department of Health. As a consequence, we cannot make robust comparisons. Nevertheless, taking into account the prevalence of smoking as set out in the right hand column of Table 4, my assessment is that at best we are maintaining our position and at worst (e.g. in comparison with the Shropshire PCTs), the gap is widening.
3. Action
What do we need to do?

The three strategic priorities are to:

- **Create a social environment that encourages non smoking, discourages smoking and supports quitting**
- **Increase the number of people wishing to quit to access the smoking cessation services**
- **Ensure provision of high quality treatment and behavioural support service for those wishing to quit**

The analysis undertaken by the Health Inequalities Unit of the Department of Health and published in July 2006, suggested that Stoke on Trent will need to double the number of people quitting for two years to have any impact on life expectancy. As a consequence our target for 2007/08 has been doubled to 1500 52 week quitters and we will need to double again in 2008/09 to 3000, 52 week quitters.

It is my view that the systems in Stoke on Trent are not sufficiently robust to deliver this level of performance. Our current approach depends upon clinicians opportunistically identifying and referring smokers to the service. We need to move to a position where we are able to systematically and proactively identify smokers who wish to quit, and ensure they take advantage of the services we offer. It is important to note that the probability of quitting is four to five times greater when people have access to behavioural support as well as medication.

Primary care is the most important sector in identifying and referring smokers. The information system in each practice does have the potential for smokers to be proactively identified and referred. It is therefore important to ensure that General Practice is modernised in this context and supported to enable a good system to be put in place.

It is of course important that we do not forget the contribution that the secondary care sector can make. Again systems need to be set up in both, University Hospital North Staffordshire Trust as well as Combined Health Care Trust that support the identification of smokers willing to quit and referral to the appropriate service.

We need to continue with our work on enabling people to resist tobacco and minimise the impact on people and their families. Our current work includes: support to workplaces, prevention programmes (Signal One Smokebusters) aimed at young people and Smoke free homes project.

Who should do it?

All organisations in Stoke on Trent have a particular responsibility in implementing the smoke free legislation and in supporting individuals to give up smoking. There is however, specific responsibility on Stoke on Trent PCT and the clinicians serving the people of Stoke on Trent to give increased priority to this issue.
4. Recommendations

i. I recommend that the Stoke on Trust PCT as a matter of urgency works with practices to put in place systems to ensure all smokers are identified and are encouraged to attend smoking cessation. This may involve the practice undertaking this activity or an alternative provider.

ii. I recommend that General Practitioners should ensure smoking status is recorded for every person who is 16 and over as a matter or urgency.

iii. Given the importance of smoking to the inequalities in health outcomes experienced by the people of Stoke on Trent, I recommend that the level of smoking status recording is reviewed by the PCT Board every quarter, until it reaches a target of 95%.

iv. I recommend that the PCT adds a clause to all service level agreements it has with providers to ensure that smokers are identified, brief interventions are provided and if appropriate the individual is referred to a smoking cessation service.
LIFESTYLES IN STOKE ON TRENT

Chapter 10:
Alcohol

Contributors:
Zafar Iqbal, Consultant

Paul Trinder, Epidemiologist
ALCOHOL

1. Introduction

Drinking alcohol is widely accepted as a leisure activity but for a large number of individuals it causes serious health and social consequences not only for themselves but also for their family, friends and the community as a whole. Excessive alcohol consumption is associated with higher death rates from injuries, violence, suicide, liver cirrhosis, cardiovascular disease and gastrointestinal cancers. It also affects the health of other people through assault, motor accidents, domestic abuse and child abuse.

The government advises that adult women should not regularly drink more than 2-3 units a day and adult men should not regularly drink more than 3-4 units a day. Women who regularly drink over 6 units a day and men who drink over 8 units a day are at highest risk of alcohol related harm.

Pregnant women or women trying to conceive should avoid drinking alcohol. If they choose to drink, they should not drink more than 1-2 units of alcohol once or twice a week and should not get drunk. Any more and the risk to the unborn child increases.

2. The Challenge in Stoke on Trent

Patterns Of Alcohol Consumption

The UK is in the middle range for alcohol consumption in Europe. However, British alcohol consumption is continuing to rise whilst it is falling in most of the wine producing countries.

We do not have accurate figures for the number of people who exceed the recommended amounts in Stoke on Trent. However, by using figures from the Office of National statistics we are able to estimate the number in Stoke on Trent (Table 1).

<table>
<thead>
<tr>
<th>Level of drinking</th>
<th>“Sensible”</th>
<th>“BRL”(^1)</th>
<th>“Hazardous”</th>
<th>“Dangerous”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>Up to 21 units</td>
<td>&gt;21 units</td>
<td>36 to 50 units</td>
<td>51+ units</td>
</tr>
<tr>
<td>Women</td>
<td>Up to 14 units</td>
<td>&gt;14 units</td>
<td>26 to 35 units</td>
<td>36+ units</td>
</tr>
<tr>
<td>Men</td>
<td>63,277</td>
<td>68%</td>
<td>21,403</td>
<td>23%</td>
</tr>
<tr>
<td>Women</td>
<td>71,651</td>
<td>72%</td>
<td>13,932</td>
<td>14%</td>
</tr>
<tr>
<td>All</td>
<td>134,928</td>
<td>70%</td>
<td>35,335</td>
<td>18%</td>
</tr>
</tbody>
</table>

Source: Office for National Statistics 2006

\(^1\) BRL = Beyond Recommended Levels
Indicators of alcohol related ill health in Stoke on Trent

There are an estimated 340 male deaths and 300 female deaths related to alcohol in Stoke on Trent. The overall alcohol related death rates and liver disease death rates in Stoke on Trent are amongst the worst in England with death for females being the second worst in the country (ranked 353rd out of 354). This is reflected in the almost double the rate of months of life lost when compared with England. The numbers of patients dying due to chronic liver disease is also very high (340th out of 354 for females).

There is an estimated 35,000 people drinking above the recommended drinking with a total of 14,000 of these in the hazardous and dangerous drinking categories.

The pattern of drinking has an important bearing on the harmful effects of alcohol on health. Binge drinking is defined as men consuming at least 8 units and women consuming at least six units in a single day. This is the most dangerous form of consumption. This form of drinking greatly increases the risk of alcohol dependence. It is also likely to be the most significant factor behind the adverse effects associated with alcohol and pregnancy.

Britain has high binge drinking rates when compared with rest of Europe. Binge drinking is increasingly prevalent amongst women. Using national data, the estimated number of binge drinkers in Stoke on Trent is approximately 33,500 (Tables 2 and 3)). The rate of binge drinking in Stoke on Trent is higher than the West Midlands but lower than the England average.

Stoke on Trent also has very high rates of alcohol related crimes in particular violence (330th out of 354) and sexual offences (335th out of 354). Alcohol contributes to many other problems such as mental illness, teenage pregnancy, domestic violence and child abuse which is not easily quantified.
### Table 2 Impact of alcohol on males in Stoke-on-Trent

<table>
<thead>
<tr>
<th></th>
<th>Stoke-on-Trent</th>
<th></th>
<th>West Midlands</th>
<th></th>
<th>England</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mortality</strong>¹</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic liver</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>disease</td>
<td>73</td>
<td>153</td>
<td>1,210</td>
<td>112</td>
<td>10,013</td>
<td>100</td>
</tr>
<tr>
<td>Alcohol related</td>
<td>268</td>
<td>70</td>
<td>4,948</td>
<td>56</td>
<td>41,541</td>
<td>50</td>
</tr>
<tr>
<td>Months of life lost</td>
<td>15.0</td>
<td>10.9</td>
<td>9.5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hospital admissions</strong>²</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol related</td>
<td>1,019</td>
<td>827</td>
<td>21,948</td>
<td>782</td>
<td>217,938</td>
<td>826</td>
</tr>
<tr>
<td>Alcohol specific</td>
<td>439</td>
<td>372</td>
<td>7,615</td>
<td>285</td>
<td>77,377</td>
<td>306</td>
</tr>
<tr>
<td>&lt;18 alcohol specific</td>
<td>27</td>
<td>78</td>
<td>299</td>
<td>52</td>
<td>3,134</td>
<td>49</td>
</tr>
<tr>
<td><strong>Binge drinking</strong>⁴</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Binge drinking</td>
<td>17.4</td>
<td>15.9</td>
<td>18.2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Crime related</strong>⁵</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All alcohol related</td>
<td>3,711</td>
<td>15.6</td>
<td>53,973</td>
<td>10.1</td>
<td>523,666</td>
<td>10.5</td>
</tr>
<tr>
<td>Violence</td>
<td>2,870</td>
<td>12.1</td>
<td>38,286</td>
<td>7.2</td>
<td>367,075</td>
<td>7.3</td>
</tr>
<tr>
<td>Sexual offences</td>
<td>59</td>
<td>0.25</td>
<td>804</td>
<td>0.15</td>
<td>7,590</td>
<td>0.15</td>
</tr>
</tbody>
</table>

Source: Local Alcohol Profiles for England 2006

1 Mortality: 2002 to 2004
2 Hospital admissions: 2004 to 2005
3 Rate per 100,000 population
4 Binge drinking: 2000 to 2002 for all people
5 Crime related: 2005 to 2006 for all people
6 Rate per 1,000 population
### Table 3 Impact of alcohol on females in Stoke-on-Trent

<table>
<thead>
<tr>
<th>Mortality&lt;sup&gt;1&lt;/sup&gt;</th>
<th>Stoke-on-Trent</th>
<th></th>
<th></th>
<th>West Midlands</th>
<th></th>
<th></th>
<th>England</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>SMR</td>
<td>N</td>
<td>SMR</td>
<td>N</td>
<td>SMR</td>
<td>N</td>
<td>SMR</td>
<td></td>
</tr>
<tr>
<td>Chronic liver disease</td>
<td>50</td>
<td>178</td>
<td>670</td>
<td>107</td>
<td>5,866</td>
<td>100</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol related</td>
<td>251</td>
<td>46</td>
<td>3,883</td>
<td>30</td>
<td>34,361</td>
<td>28</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Months of life lost</td>
<td>9.1</td>
<td>5.5</td>
<td>5.1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Hospital admissions<sup>2</sup> | N    | Rate<sup>3</sup> | N    | Rate | N    | Rate | |
|----------------------------------|-------|------------------|-------|------|-------|------|
| Alcohol related                  | 675   | 467              | 14,573 | 437  | 147,025 | 162  | |
| Alcohol specific                 | 211   | 177              | 3,441  | 127  | 37,173  | 145  | |
| <18 alcohol specific             | 24    | 95               | 390    | 60   | 3,717   | 59   | |

<table>
<thead>
<tr>
<th>Binge drinking&lt;sup&gt;4&lt;/sup&gt;</th>
<th>%</th>
<th>%</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Binge drinking</td>
<td>17.4</td>
<td>15.9</td>
<td>18.2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Crime related&lt;sup&gt;5&lt;/sup&gt;</th>
<th>N</th>
<th>Rate&lt;sup&gt;6&lt;/sup&gt;</th>
<th>N</th>
<th>Rate</th>
<th>N</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>All alcohol related</td>
<td>3,711</td>
<td>15.6</td>
<td>53,973</td>
<td>10.1</td>
<td>523,666</td>
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</tr>
<tr>
<td>Violence</td>
<td>2,870</td>
<td>12.1</td>
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</tr>
<tr>
<td>Sexual offences</td>
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<td>0.25</td>
<td>804</td>
<td>0.15</td>
<td>7,590</td>
<td>0.15</td>
</tr>
</tbody>
</table>

Source: Local Alcohol Profiles for England 2006

1 Mortality: 2002 to 2004
2 Hospital admissions: 2004 to 2005
3 Rate per 100,000 population
4 Binge drinking: 2000 to 2002 for all people
5 Crime related: 2005 to 2006 for all people
6 Rate per 1,000 population
**How important is alcohol relative to other factors causing ill health?**

According to a WHO report in 2002 alcohol is the third leading cause of disease and injury in the developed countries after tobacco and high blood pressure. Alcohol causing a greater disease burden than high cholesterol levels, obesity, diet and asthma when measured by Disease Adjusted Life Years.

**Costs to the NHS**

Alcohol related diseases account for 1 in 8 NHS bed days (around 2 million); up to 35% of all accident and emergency attendances and ambulance costs are alcohol related. The total estimated alcohol related NHS costs for Stoke on Trent (based on 2001 data) were approximately £8m per year, whilst the overall costs including crime, employment and other social costs, were estimated to be £92m per year.

**3. Actions**

**What should we do?**

A draft alcohol strategy has been produced for Stoke on Trent by the Drug and Alcohol Action Team. However, progress has been hampered as a consequence of organisational changes. The document does contain many of the key action we need to take. I would however, wish to emphasise the importance of brief interventions in this context. It is one of the most cost effective actions we can take and there is good evidence to suggest that it can reduce alcohol consumption at 6 months and at one year. Brief interventions refer to structured advice taking no more than a few minutes (sometimes referred to as minimal intervention) and provided within normal consultations time periods (5-15 minutes). The brief intervention includes feedback on alcohol use and harms, identification of high risk situations for drinking and coping strategies. Competence in delivering brief interventions can be achieved through one or two sessions of training.

On average GPs only detect about 10 drinkers per year which implies that the majority of patients with hazardous or harmful drinking are being missed. Most health professionals have yet to incorporate screening interventions for hazardous and harmful drinking into routine practice.

For those people who are dependent upon alcohol, there are cost-effective treatment programmes available and depending upon the circumstances of the patient, treatments can be delivered within the community or as an inpatient.

**Who should do it?**

The key sector is primary care. It is here that we have the greatest scope for identifying people who are having problems with alcohol and referring them appropriately be it within the NHS or to the third sector as appropriate. However, making this a reality does depend on Stoke on Trent PCT supporting the development of primary care.
4. Recommendations

i. Stoke on Trent PCT should in partnership with others undertake a lifestyle survey to describe patterns of drinking within Stoke on Trent.

ii. The draft alcohol strategy needs to be approved by all relevant stakeholders and implementation should begin as soon as possible.

iii. Stoke on Trent PCT should take the lead in ensuring all practices are able to identify people who are having problems with alcohol, are able to provide brief interventions and refer when appropriate.
LIFESTYLES IN STOKE ON TRENT

Chapter 11:
Teenage Pregnancies

Contributor:
Paul Trinder. Epidemiologist
TEENAGE CONCEPTIONS

1. Introduction

Teenage pregnancy causes a great deal of harm for both the teenager and the child. Research shows that the majority of teenage mothers and their children continue to experience quite striking disadvantages throughout their lives. Some facts will illustrate the point:

- At age 30, teenage mothers are 22% more likely to be living in poverty than mothers giving birth aged 24 and over.
- Children of teenage mothers have a 60% increased risk of being born into poverty compared to babies born to mothers in their 20s, have high mortality rates and are more likely to have accidents and behavioural problems.
- Teenage mothers are more likely to partner with men who are poorly qualified and more likely to experience unemployment.

Stoke on Trent continues to have one of the highest teenage pregnancy rates in the country. The targets that guide our work are as follows:

- To reduce by 55% the rate of conceptions among the under 18’s in the City of Stoke on Trent by 2010 and firmly establish a downward trend in conceptions rate for the under 16’s
- To achieve a reduction in the risk of long term social exclusion for teenage parents and their children

2. The Challenge in Stoke on Trent

Information on teenage pregnancies is collected for two particular age groups; under 18s (this includes 15 to 17 year olds) and under 15s (13 to 14 years). The target of 55% reduction applies only to the older age group.

In both age groups, the gap between rates in Stoke on Trent and England has got wider (Figures 1 and 2). However, the pattern of change in Stoke on Trent has been different to that seen in England since 1996-98.

Nationally the under 18 teenage pregnancy rate has fallen from 46.0 per 1,000 females aged 15 to 17 years in 1996 to 1998 to 42.0 per 1,000 in 2002 to 2004, a fall of 9%. In contrast the reduction in Stoke on Trent, the under 18 pregnancy rate has fallen 5% over the same period, from 67.3 to 63.8 (Figure 1).

Amongst the under 15s, there was a dramatic reduction between 1996 and 2002 but since then that reduction has been reversed. Nationally the under 15 teenage pregnancy rate has fallen from 9.0 per 1,000 in 1996 to 1998 to 7.8 per 1,000 in 2002 to 2004, a fall of 13%. During the same period in Stoke on Trent, the under 15 teenage pregnancy rate has fallen just 2%, from 13.8 to 13.6 (Figure 2).
A 55% reduction in the pregnancy rate amongst the 15 to 17 age group, from the baseline year of 1998 would mean reducing the number of teenage pregnancies from 305 in 1998 to 137 in 2010. The pregnancy rate would need to fall in Stoke on Trent from 68.5 to 30.8 by 2010.
3. Actions

What do we need to do?

As a consequence of the lack of progress in improving the teenage pregnancy rates, we undertook two types of reviews during 2006/07. The first was an internal review resulting in the production of detailed action plan. This was followed up by a visit from the National Teenage Pregnancy Support Team which led to a range of further recommendations. The result of these two processes is that we have now identified the critical interventions we need to put in place Stoke on Trent. These are:

- **Sex and Relationship Education Programme for children and young people.** Our current programme has been reviewed in light of a local audit as well as local experience and a new programme will be launched in September 2007.
- **Reducing the number of children not in education, training or employment.** Stoke on Trent has some of the highest figures in the country which is closely associated with the high teenage pregnancy rate. An action plan has been developed to increase the numbers of children staying on in education, training or employment.
- **Reviewing the contraceptive services to ensure access for teenagers is improved.** Part of this work stream is an examination of general practice and the extent to which primary care can be made more teenager-friendly.
- **Maintaining and improving the support provided to teenage parents, so that they can enter education, training or employment as soon as practicable.**

Who needs to do it?

Tackling teenage pregnancy is both, complex and challenging. Stoke on Trent PCT, the City Council and schools have major roles to play. Equally important is the need to involve teenagers in designing intervention programmes so that teenagers do take up the services on offer.

As a consequence of the reviews, the partnership arrangements have been changed with much clearer lines of accountability. There is confidence that we have and are taking all the necessary action. However, the critical systems issue for the future is the ability of the PCT and the City Council to ensure the initiatives we have and are putting in place are funded through mainstream budgets rather than be subject to short term funds.

4. Recommendations

I recommend that the Stoke on Trent PCT mainstream the work on reducing teenage pregnancies in 2008/09.
Chapter 12: Obesity

Contributor:
Siu Ann Pang, Health Promotion Specialist
OBESITY

1. Introduction

Obesity is an important precursor of ill health. It is associated with increased risk of cancers, diabetes, heart disease and high blood pressure. As in most other types of ill health, obesity is also associated with poverty and deprivation. The consequence of these interactions is that people with obesity have a reduced life expectancy of on average 9 years. It is estimated obesity costs the national economy an estimated £3.7 billion a year (National Audit Office, 2001).

Obesity for the majority of people is as a result of an imbalance between energy intake (nutrition) and expenditure (physical activity). There are some illnesses and drugs (steroids) which do predispose to obesity but these are relatively rare.

The national target is “to halt the year on year rise in obesity amongst children under 11 by 2010 in the context of a broader strategy to tackle obesity in the population as a whole”. This is supported by a target to increase by 3-4% per year, the proportion of the population to at doing 30 minutes of moderate levels of physical activity, 5 times a week. There are no targets for nutrition.

2. The Challenge in Stoke on Trent

Table 1 provides ward based information for Stoke on Trent, using data from the 2002 Health Survey of England. Information systems in Stoke on Trent did not until very recently, start collecting data on obesity. However, information on nutrition and physical activity is still not routinely collected and there are no plans to do so currently.

The figures show that more than a fifth of the adult population of Stoke on Trent are obese and in general, the majority of adults and children do not consume the recommended levels of fruit and vegetables.

We do have some data on physical activity as a result of a national survey undertaken by Sport England in 2005 (the Active People Survey 2005). This showed that only 15.8% of the adult population of Stoke on Trent reported being active for 30 minutes or more on at least 3 occasions per week. This is the second lowest percentage score out of all West Midlands Local Authorities and places Stoke on Trent 350th out of 354 Local Authorities nationally.

The Health Profile for England 2003, suggested that approximately 23% of females and 22% of males nationally, were obese. However, as Figures 1a and b show, the proportions recorded as obese in Stoke on Trent is much higher; in 25 out of 57 general practices in Stoke on Trent, more than 30% of their adult practice population were classified as obese.
### Table 1 Obesity and eating habits by wards

<table>
<thead>
<tr>
<th>Ward</th>
<th>% of over 16s classified as obese</th>
<th>% of under 16 eating fruit and vegetables</th>
<th>% of over 16s eating fruit and vegetables</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abbey Green</td>
<td>26</td>
<td>31</td>
<td>14</td>
</tr>
<tr>
<td>Bentilee &amp; Townsend</td>
<td>28</td>
<td>32</td>
<td>12</td>
</tr>
<tr>
<td>Berryhill &amp; Hanley East</td>
<td>26</td>
<td>34</td>
<td>16</td>
</tr>
<tr>
<td>Blurton</td>
<td>27</td>
<td>33</td>
<td>13</td>
</tr>
<tr>
<td>Burslem North</td>
<td>26</td>
<td>31</td>
<td>13</td>
</tr>
<tr>
<td>Burslem South</td>
<td>26</td>
<td>38</td>
<td>14</td>
</tr>
<tr>
<td>Chell &amp; Packmoor</td>
<td>26</td>
<td>35</td>
<td>13</td>
</tr>
<tr>
<td>East Valley</td>
<td>25</td>
<td>29</td>
<td>18</td>
</tr>
<tr>
<td>Fenton</td>
<td>26</td>
<td>32</td>
<td>13</td>
</tr>
<tr>
<td>Hanley West and Shelton</td>
<td>21</td>
<td>50</td>
<td>15</td>
</tr>
<tr>
<td>Hartshill and Penkhull</td>
<td>20</td>
<td>38</td>
<td>18</td>
</tr>
<tr>
<td>Longton North</td>
<td>26</td>
<td>33</td>
<td>15</td>
</tr>
<tr>
<td>Longton South</td>
<td>25</td>
<td>37</td>
<td>18</td>
</tr>
<tr>
<td>Meir Pak &amp; Sandon</td>
<td>24</td>
<td>38</td>
<td>17</td>
</tr>
<tr>
<td>Northw’ &amp; Birches Head</td>
<td>24</td>
<td>35</td>
<td>18</td>
</tr>
<tr>
<td>Norton &amp; Bradley</td>
<td>27</td>
<td>28</td>
<td>16</td>
</tr>
<tr>
<td>Stoke &amp; Trent Vale</td>
<td>24</td>
<td>36</td>
<td>16</td>
</tr>
<tr>
<td>Trentham &amp; Hanford</td>
<td>20</td>
<td>36</td>
<td>21</td>
</tr>
<tr>
<td>Tunstall</td>
<td>26</td>
<td>35</td>
<td>14</td>
</tr>
<tr>
<td>Weston &amp; Meir North</td>
<td>26</td>
<td>32</td>
<td>14</td>
</tr>
</tbody>
</table>

1. The NHS Health & Social Care Information Centre, synthetic estimates (2001 to 2002)
2. Fruit and vegetable consumption focus on children aged 5 to 15 years eating 3 portions of fruit and vegetables and adults aged 16 and over eating 5 portions a day

Note: there are no synthetic data for Stoke on Trent as a whole or for physical activity
**Figure 1a** Proportion of the population aged 16 and over classified as obese by general practice in Stoke on Trent

Source: General practice information systems data extracted between January 2007 and March 2007

**Figure 1b** Proportion of the population aged 16 and over classified as obese by general practice in Stoke on Trent

Source: General practice information systems data extracted between January 2007 and March 2007
There are two notes of caution. First, obesity is defined as a Body Mass Index of greater than 30 and the calculation is based on weight in kilograms divided by the square of the height in meters. As a consequence, very muscular individuals may well be classified wrongly as obese. Second, at a practice level, there are considerable variations in the recording of obesity and this may well explain some of the differences between practices. Despite this, it would be reasonable to assume that obesity levels in Stoke on Trent are likely to be higher than national figures.

3. Action

What do we need to do?

There has been considerable work locally in supporting healthy nutrition, physical activity and obesity management in Stoke on Trent. This has included work on policy development within a number of institutions in Stoke on Trent and various projects (for example, healthy tuck, exercise referral programme for children and adults etc) aimed at individuals, families and communities. Many of these projects are small scale and are funded by a variety of organisations, often on a short term basis. Given the scale of these projects, their impact at a population level is minimal.

The challenge for Stoke on Trent is to ensure that evidence based practices are consistently and systematically applied. Sufficient numbers of people need to take up the relevant intervention to enable a difference to be made. The work on meeting the life expectancy target suggested that we need to ensure at least 10,000 people take part and achieve the relevant benefits. In addition to developing sufficiently large services, the work to change the culture so that healthy eating and physical activity are seen as part of every day life for the residents of Stoke on Trent needs to be developed in parallel.

It is also important to note that the evidence on cost effective interventions to do with physical activity is almost exclusively related to people who are ill (circulatory diseases and diabetes for example). There is little information on the effectiveness of interventions aimed at the general public. It is therefore important that great care is taken in designing and implementing interventions. Where evidence does not exist, it is crucial that good quality evaluations are built in.

Who should do it?

Inevitably focussing on high risk groups does mean that primary care and the information system it holds are crucially important to deliver an effective and efficient delivery system. This will require Stoke on Trent PCT to support and invest in primary care such that people with the particular health risks can be identified proactively and referred appropriately.
4. Recommendations

i  I recommend that Stoke on Trent PCT review its obesity action plan for agreement at the March 2008 Board meeting. In reviewing the plan, the Board needs to be clear about the following:

- **The evidence of effectiveness supporting each intervention and the numbers needing to access services to achieve benefits.**
- **Where there is no evidence, the evaluation programme and in particular the outcome measures defining success and failure**

ii  I recommend that Stoke on Trent PCT identify and make available the resources needed over a 3 year period, to support the implementation of the obesity action plan.

iii. I recommend that Stoke on Trent PCT works with general practices to enable high risk groups to be identified and referred for obesity management.
DETERMINANTS OF HEALTH IN STOKE ON TRENT

Chapter 13: Improving Education

Contributors:

Maureen Wiskin, Head of Health Promotion

Katy Warren, Health Promotion Specialist
IMPROVING EDUCATION

1. Introduction

Health and education are intimately linked and the relationship can be considered in a number of ways:

- **Education for health**: education influences the extent to which individuals and communities are able to achieve good health, remain healthy and respond appropriately to ill health. A good example is that communities which have high aspirations and educational achievements have higher levels of health and lower levels of ill health.
- **Education about health**: the traditional health education model focussing on giving information about sexual health, alcohol etc and includes self help and timely access to appropriate services.
- **Health for education**: healthy pupils are better able to participate in and benefit from learning and achieve academically.

This chapter focuses on the first of these relationships and that is about achieving high levels of education as a key determinant of health and in particular how the NHS in Stoke on Trent can support educational attainments.

2. Progress in improving education

A child's progress through education can be categorised in various ways. I have chosen to examine progress in terms of pre-school, primary school and secondary school phases. In each phase I have chosen an indicator that best gives us a feel for how well children in Stoke on Trent are doing in comparison to children nationally. The research suggests that the child’s likelihood of success in later life in both education and other walks of life is predicated on successful completion of each of these phases.

**Early years**

One of the critical issues in improving education is to make sure that speech and language development in young children is sufficiently strong, so that when they formally enter the education system they are well able to take advantage of everything that the system has to offer.

A programme aimed at improving language development (Stoke Speaks Out) was developed as part of the SureStart initiatives in Stoke on Trent. In every area where the programme has been implemented, the proportion of children reaching their age related language developmental milestones has increased (Figure 1).

However, research from around the country shows that in affluent parts of England, the majority of children in that locality do not have any delay in speech and language development. In comparison, although the situation in Stoke on Trent is improving, there is still a long way to go to bridge the gap.
Figure 1 Comparison of Speech and language development over time in Stoke on Trent

Note: All areas refer to intervention areas only.

Population aged 5 to 11
Table 1 below shows the proportion of children attaining Level 4 or above in English and Maths at Key Stage 2. In general, the proportion of children attaining level 4 in Maths and English has been relatively static and continues to be below the national average (79% in English and 76% in Maths). However, school tracking data suggests that where schools have been provided with extra support, there has been some increase in attainment in 2007 (2% in English and 7% in Maths).

Table 1 Key Stage 2 results in Stoke on Trent Primary Schools

<table>
<thead>
<tr>
<th>Subject</th>
<th>2004/05</th>
<th>2005/06</th>
<th>Target 2006/07</th>
<th>Target 2007/08</th>
</tr>
</thead>
<tbody>
<tr>
<td>English Level 4+</td>
<td>71%</td>
<td>72%</td>
<td>74%</td>
<td>76%</td>
</tr>
<tr>
<td>Maths Level 4+</td>
<td>67%</td>
<td>67%</td>
<td>74%</td>
<td>76%</td>
</tr>
</tbody>
</table>

Children aged 11 to 16
I have used GCSEs as the key measure of achievement in this age group. Nationally in 2006, 58.5% of pupils achieved 5 or more A*-C grades and 43.5% included English and Maths in that standard. As Table 2 shows the proportion of children achieving the same standards in Stoke on Trent was less. Moreover, the local attainment remains below target. There is also considerable gender difference in attainment with girls in Stoke on Trent better than boys.
Achievement levels have improved over time. Overall compared to the academic year 2003/04, the proportion of children getting 5 or more A*-C grades has increased by 6%.

Population aged 16-19 years

More than 80% of the population in this age group are in education, training or employment. However, in comparison with other parts of the country the proportion that is not, is high in Stoke on Trent. In June 2007, 15% of young people aged 16 to 18 in Stoke on Trent were not in education, employment or training whereas nationally the figure is 8% (as at March 2007). The proportion of young people leaving school at age 16 without anything to go to, has remained static over time in Stoke on Trent (Table 3).

Table 2 GCSE attainment in Stoke on Trent in 2006

<table>
<thead>
<tr>
<th>Subject and level</th>
<th>Key Stage 4 (target)</th>
<th>Achievement overall</th>
<th>Boys</th>
<th>Girls</th>
</tr>
</thead>
<tbody>
<tr>
<td>5+ A*-C GCSE Grades</td>
<td>56%</td>
<td>50%</td>
<td>44%</td>
<td>53%</td>
</tr>
<tr>
<td>5+ A*-C GCSE Grades including Eng &amp; Maths</td>
<td>37%</td>
<td>35%</td>
<td>30%</td>
<td>36%</td>
</tr>
</tbody>
</table>

Table 3 School leaver activity from high schools in Stoke-on-Trent Local Authority (surveyed in the November after leaving school)

<table>
<thead>
<tr>
<th>Not yet settled in full-time education, employment or training (mainly Not in Education Employment of Training)</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>10.1%</td>
<td>12.0%</td>
<td>10.3%</td>
</tr>
</tbody>
</table>

However, a year after leaving school, the proportion not in education, training or employment had increased to 17%. Research locally suggests a number of reasons for young people not settling in education, employment or training:

- 40% of females (aged 16 - 18) in this group are teenage mothers.
- Not having GCSE English or Maths and not meeting selection criteria for jobs, training or education.
- Not having the social skills and ability to perform well at interviews or work alongside adults in training or employment.
- Attitudes and value given to education and training.
Ethnicity and education

Ethnicity is an important issue both in the context of health as well as education. The largest minority ethnic community is that originating in the Indian Subcontinent, although that may well change over time. The table below compares the performance of children of Pakistani origin with those of British origin. At each level, children of Pakistani origin have poorer levels of achievement.

Table 4 Attainment of Pakistani pupils – difference to White British pupils

<table>
<thead>
<tr>
<th>Subject</th>
<th>Key Stage 2 (Age 10/11)</th>
<th>Key Stage 3 (Age 13/14)</th>
<th>Key Stage 4 (Age 16)</th>
</tr>
</thead>
<tbody>
<tr>
<td>English L4+</td>
<td>-6.4%</td>
<td>-6.6%</td>
<td>-7.0%</td>
</tr>
<tr>
<td>Maths L4+</td>
<td>-7.9%</td>
<td>-10.8%</td>
<td></td>
</tr>
<tr>
<td>English L5+</td>
<td></td>
<td>-6.6%</td>
<td></td>
</tr>
<tr>
<td>Maths L5+</td>
<td></td>
<td>-10.8%</td>
<td></td>
</tr>
<tr>
<td>Science L5+</td>
<td></td>
<td>-19.8%</td>
<td></td>
</tr>
<tr>
<td>5+ A*-C GCSE Grades</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5+ A*-C GCSE Grades including Eng &amp; Maths</td>
<td></td>
<td></td>
<td>-4.2%</td>
</tr>
</tbody>
</table>

3. Actions

What should we do?

The tables and figures suggest that attainment at each phase of the education journey in Stoke on Trent is much less than the attainment in the country as a whole. This differential in attainment does reflect very closely the health inequalities between Stoke on Trent and England as a whole.

There is considerable work being undertaken in Stoke on Trent, led by the Director of Children and Young People’s Services to improve levels of achievement at each and every age. The priorities are as follows:

• To raise attainment at all levels with a particular focus on narrowing the gap for boys, looked after children and ethnic minorities.
• To reduce the number of children who are not in education, training or employment

There are a number of areas where the NHS in Stoke on Trent contributes to this effort. The Healthy Schools programme is beginning to involve the majority of schools in Stoke on Trent. This includes a whole range of initiatives to do with smoking, drugs and sex and relationships. However, that alone is not sufficient.

A report presented to Stoke-on-Trent PCT Board in January 2007 set out some of the issues. The report recommended that the PCT’s major contribution to attainment is to ensure a positive start in life for children and made a number of recommendations which are being progressed. However, one of the recommendations was very much more strategic in approach and unfortunately, progress in implementation of that recommendation has been much slower.
The particular recommendation was to do with the need to commission and provide community midwifery and front line universal public health nursing services (health visiting and school nursing) on a locality basis. Part and parcel of the recommendation was the emphasis on working with local partners, and in particular Children’s Centres, to deliver an integrated family support service for families with young children (up to age 4). In my view this is the most important strategic issue for the NHS in Stoke on Trent in the context of children and it overlaps with my recommendation in the chapter on infant mortality.

It is worth re-emphasising that the evidence from the United States using gold standard scientific methods was that intensive support to the mother and the child from conception to age 2 leads to health, education and employment benefits to both the mother and the child. The evidence is powerful and given the poor levels of health, education and employment indicators in Stoke on Trent, I think we need to look very carefully at what we can learn from the American experience of supporting their most deprived communities.

The Community Midwifery service has already been independently reconfigured to provide services on a locality basis and in some parts of the City this has been mirrored by changes to school nursing and health visiting services. However, there is some way to go yet in integrating all relevant services applicable to families with young children.

**Who should do it?**

It is the role of the PCT to ensure the needs of the various communities are met.

**4. Recommendation**

The PCT should as a matter of urgency debate the feasibility of commissioning a new model of combined midwifery, health visiting and Early Years services, delivered on a locality basis with clear outcomes to be attained.
DETERMINANTS OF HEALTH IN STOKE ON TRENT

Chapter 14: Housing and Health

Contributors:

Alun Bragg, Housing Policy Officer, Stoke on Trent City Council
HOUSING AND HEALTH

1. Introduction

Housing affects health in a number of different ways:

- **Poor housing can lead to and exacerbate ill health.** For example poorly designed housing can be a cause of accidents for both young children as well as older people. Poorly insulated housing or where there is fuel poverty, can lead to complications in people with respiratory or heart disease.

- **Housing developments which do not take into account the needs of people in the context of leisure and access to services can also lead to problems.**

In this chapter, I intend to focus on the issue of cold houses and in particular fuel poverty. Evidence from research looking at several cities in temperate zones, suggests that below 16 degrees centigrade, a fall of 1 degree centigrade increases respiratory mortality by approximately 4% and cardiovascular mortality by 4%. This is very much a rough and ready estimate. The West Midlands Public Health Observatory has estimated that in 2004/05 there were approximately 27% more deaths in the winter months in Stoke on Trent compared to the rest of that year. It is important to note that the level of excess mortality does vary on an annual basis depending on the temperature experienced during the winter concerned.

2. The Challenge in Stoke on Trent

The housing stock in Stoke on Trent totals 110,575. The majority is privately owned (Table 1) and this proportion has increased over the last two decades. The major change has been in relation to the proportion renting housing (Table 1). The availability of rented housing from the City Council has reduced quite considerably and the proportion rented from a housing association or private landlords has increased. The consensus is that since the 2001 census, this trend has continued.

<table>
<thead>
<tr>
<th>Owner occupied</th>
<th>Rented from City Council</th>
<th>Rented from housing association</th>
<th>Rented from private landlord</th>
</tr>
</thead>
<tbody>
<tr>
<td>1981</td>
<td>56.4%</td>
<td>34.6%</td>
<td>1.4%</td>
</tr>
<tr>
<td>1991</td>
<td>66.3%</td>
<td>24.6%</td>
<td>2.9%</td>
</tr>
<tr>
<td>2001</td>
<td>65.2%</td>
<td>19.5%</td>
<td>5.0%</td>
</tr>
</tbody>
</table>


As a result of a survey commissioned in 2004 by the City Council, we have detailed data on housing within the private sector housing as well as Housing Associations. The survey sampled 3000 randomly selected dwellings (ensuring representative of all areas and types of housing, ages and tenure). A full external and internal survey of the dwelling was undertaken as well as an interview with the occupying households. The results are summarised below:
i. Approximately 57% (38,933) did not comply with the Decent Homes Standard as set out by the Government. This is considerably above the national figure (43%) which was derived from a national survey undertaken in 2001.

ii. Approximately 12% (10,480) were unfit for "human habitation".

iii. Approximately 41% (37,726) were habitable but did require considerable repair.

iv. Approximately 4% (3,961) did not have reasonable modern amenities and/or thermal comfort. However, overall 11,185 dwellings failed the energy efficiency requirements of the "Decent Homes" standard.

v. A third of the households in "non-decent" dwellings were in receipt of income or disability benefits. This is more than half of all such households in the City.

vi. Geographically, Hanley West, Stoke and Trent Vale, Tunstall, Abbey Green and Burslem North had more than 15% of dwellings classified as unfit for human habitation. In comparison Meir Park, Trentham, Longton North, Weston and Blurton had less than 7% of the housing classified as such.

vii. Approximately 31% (26,169) of all households in the City were fuel poor (spending over 10% of income on fuel).

Since the time of the survey, Government has replaced the Housing Fitness Standard with the Housing, Health and Safety Rating System (HHSRS). The HHSRS, which came into effect in April 2006 is much more detailed in its approach and provides a clear methodology to assess the potential impact on health. The City Council is currently updating the housing stock condition survey to reflect the standards in HHSRS. It is also the intention that a housing condition survey will be undertaken in 2008 to assess progress.

3. Actions

What do we need to do?

There is considerable housing development taking place in Stoke on Trent. The major development is through the Housing Pathfinder Project aimed at impacting on approximately 55,000 of the poorest housing in Stoke on Trent (Table 2).

Table 2 Comparison of dwellings within Housing Pathfinder with rest

<table>
<thead>
<tr>
<th></th>
<th>Housing Pathfinder</th>
<th>Non Pathfinder</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decent Housing</td>
<td>23.3%</td>
<td>56.4%</td>
</tr>
<tr>
<td>Non Decent – Unfit</td>
<td>17.3%</td>
<td>7.4%</td>
</tr>
<tr>
<td>Non Decent – Disrepair</td>
<td>56.7%</td>
<td>30.7%</td>
</tr>
<tr>
<td>Non Decent Amenity/Thermal</td>
<td>2.7%</td>
<td>5.5%</td>
</tr>
<tr>
<td>Fuel Poverty</td>
<td>33.4%</td>
<td>28.8%</td>
</tr>
<tr>
<td>People in receipt of benefits</td>
<td>40.4%</td>
<td>33.4%</td>
</tr>
</tbody>
</table>


As a consequence of the Pathfinder initiative, a substantial proportion of dwellings and households most in need, will have major improvements in their housing circumstances. However, that still leaves a significant proportion of unmet need.

In order to tackle the unmet need in relation to fuel poverty and energy efficiency in Stoke on Trent, the City
Council in partnership with Newcastle under Lyme Borough Council have worked with National Grid and Scottish Power to set up the North Staffordshire Warm Zone. This initiative will target 56,000 private sector homes in the 15 most deprived wards in Stoke on Trent over a two year period. The primary objectives of the Warm Zone are to:

- Improve housing conditions
- Increase household income
- Reduce fuel use and increase thermal comfort
- Reduce carbon dioxide emissions

Clearly, there is substantial overlap between the Warm Zone and the Pathfinder. It is important to note that the Warm Zone is working closely with the Pathfinder and other voluntary groups involved in tackling fuel poverty (in particular “Beat the Cold”).

Who should do it?

Stoke on Trent PCT is supporting both initiatives. The NHS serving the people of Stoke on Trent can play a major role in ensuring that the most needy from the health context are identified and referred to the North Staffordshire Warm Zone initiative. A definition of the most needy might include the following:

- Those with circulatory and respiratory illnesses
- Those with other types of chronic illness
- Families with very young children and households consisting of the very elderly
- Individuals at risk of admission to hospital because of chronic illness.

University Hospital of North Staffordshire NHS Trust, general practitioners and community nursing colleagues have been informed of the initiative and have been invited to refer patients who might benefit. In my view however, the most important sector is primary care. The electronic systems within practices have the potential to systematically identify those most in clinical need quickly and efficiently. These individuals can then be referred to the North Staffordshire Warm Zone initiative who will undertake a full assessment and provide support as needed.

Although some practices and the University Hospital of North Staffordshire NHS Trust have made contact with the North Staffordshire Warm Zone, collaboration has been patchy. It is clear that the NHS in Stoke on Trent does not have the capability to quickly respond to this type of initiative and is therefore unable to take advantage on behalf of their patients.
4. Recommendations

i. The PCT and general practitioners need to recognise the potential inherent in primary care to support action on improving the housing circumstances of people in Stoke on Trent and be willing to respond quickly.

ii. The PCT should work with general practitioners and their teams in developing the proactive use of primary care information systems to identify patients who might benefit from housing support. These include patients with chronic respiratory disease, heart disease and the very elderly.

iii. The PCT should ensure ready access to aggregated health data to support the development of housing policy by the City Council.
VULNERABLE COMMUNITIES IN STOKE ON TRENT

Chapter 15: Ethnicity and Health

Contributor:

Obaghe Edeghere, Specialist Registrar in Public Health
ETHNICITY AND HEALTH

1. Introduction

Minority ethnic communities are at risk of a whole range of social and health deprivation. This is as a result of a combination of factors; differences to do with culture and language coupled with poverty and the challenges in integrating with mainstream communities. This chapter looks at the particular health needs of these communities.

2. Ethnicity

Ethnicity describes a population of people whose members identify with each other, usually on the basis of a presumed common genealogy, ancestry, culture, and/or religion. Minority ethnic communities which account for 8% of the UK population are a heterogeneous group that share a common experience of poor health. These populations now account for 73% for the UK's total population growth, largely as a result of differences in fertility rates and inward migration.

They have worse health than the general population, with some minority ethnic communities faring worse than others, and patterns varying from one health condition to the next. These differences in health status (subjective and objective) are largely driven by inequalities in socio-economic factors. These health inequalities are cumulative, persist over the life-course and can be passed from generation to generation.

NHS and other public organisations are now legally obligated to comply with the Race relations Amendment Act (2000) which requires monitoring of outcomes by ethnic groups and an impact assessment of new policies for race equality. The Quality and Outcome framework (a system to pay general practitioners to improve their quality of care) now provides financial incentives for the recording of ethnicity data by general practitioners in the hope that it will (together with the mandatory requirement in secondary care) lead to good quality data to support planning and evaluation of policies and services.

3. Minority ethnic communities in Stoke on Trent

The 2001 census data show minority ethnic communities in Stoke on Trent account for 5.2% (12525) of the local population. This figure includes 8493 (3.5%) Asians, 2159 (0.9%) Mixed, 1087 (0.5%) Black, and 786 (0.3%) Chinese & other groups. The City Council has produced detailed demographic profiles for the Afro-Caribbean community as well as for the community originating from Pakistan.

There is little local data to show the ethnic variation in health outcomes in Stoke on Trent, but there is no reason to doubt the existence of ethnic health inequalities in our minority ethnic communities. We cannot show variation because, the NHS in Stoke on Trent does not routinely record data on ethnicity of people who come into contact. Current figures show that only approximately 30% of the registered population have their ethnic status recorded. Clearly, this compromises the ability of the NHS in Stoke on Trent to provide ethnicity sensitive services.
We hope this situation will be rectified over the course of the next few years. The Professional Executive Committee of Stoke on Trent PCT has recommended that ethnicity data be recorded systematically and this has been supported by the Local Medical Committee which represents the general practitioners in Stoke on Trent.

4. Health and Health care Issues

The health and health care concerns of minority ethnic communities are in many respects similar to those of the white population. However, the higher rates of poverty and other markers of deprivation as well as higher rates of certain risk factors and diseases have a major influence on the nature of the ill health experienced by minority ethnic communities.

a) Lifestyle & Other Risk Factors

i. Smoking

Smoking prevalence rates vary within and between minority ethnic communities as outlined below.

- Self-reported cigarette smoking prevalence was 40% among Bangladeshi, 29% in Pakistani, 25% in Black Caribbean, 21% in Black African and Chinese, and 20% in Indian men, compared with 24% among men in the general population. Age adjusted figures show that Bangladeshi men were more and Indian men less, likely to report smoking cigarettes than men in the general population.
- Self-reported smoking prevalence was higher among women in the general population (23%) than most minority ethnic groups, except Irish (26%) and Black Caribbean women (24%).
- Data from the NHS Stop Smoking Service indicate that Asian, Black, and Mixed minority populations have lower rates of setting a smoking quit date for both males and females.

ii. Obesity

The prevalence of obesity among certain minority ethnic communities is higher than the national average with obesity in Asian children shown to be almost four times more common than in white children.

- The 2004 Health Survey for England showed that Black Caribbean and Irish men had the highest prevalence of obesity. Bangladeshi men were almost five times, and Chinese men almost four times, less likely to be obese than men in the general population. For women, risk ratios were higher for Black African, Black Caribbean and Pakistani women and lower for Chinese women than women in the general population.
- The mean Body Mass Index (a measure of obesity) of Bangladeshi, Indian and Pakistani men were lower than in the general population. Mean BMI in Chinese women was markedly lower, in Indian and Irish women was similar to, and in Black Caribbean and Black African women was higher than in women in the general population.

iii. Physical Activity

- The national health surveys show that with the exception of Black Caribbean men, age-adjusted participation in any physical activity of at least moderate intensity was lower in minority ethnic groups than in the general population. Participation in any activity at least once a week reduced among Pakistani men.
between 1999 and 2004, but increased among Bangladeshi men.
• Age-adjusted participation rates in brisk walking for at least 30 minutes were lower in each minority ethnic group than in the general population (32% of men and 27% of women), with the lowest age-adjusted risk ratios among Asian men and women.

b) Ill Health

• Age adjusted figures show that Bangladeshi and Pakistani men and women and Black Caribbean women were more likely to report bad or very bad health than the general population.
• Pakistani women and Bangladeshi men were more likely than those in the general population to report a limiting longstanding illness. The levels of both longstanding illness and limiting longstanding illness were significantly higher for Pakistani women in 2004 than they were in 1999.
• Prevalence of severe lack of social support was much higher among men and women in each minority ethnic group, except Irish men and women. This was particularly marked among Pakistani men (38%) and women (30%), and Bangladeshi men (35%) and women (33%).

ii. Cardiovascular Disease

• Doctor diagnosed cardiovascular disease is 50% more likely in men born in South Asia than men in the general population. The prevalence of cardiovascular disease increased between 1999 and 2004 among Pakistani men, in whom the prevalence doubled (from 4.8% in 1999 to 9.1% in 2004), and among Indian women (from 2.3% in 1999 to 4.2% in 2004).
• There are significant differences in the prevalence of heart disease in the south Asian groups, with Pakistani and Bangladeshi having the highest rates. The cause of higher heart disease amongst South Asians is as much due to socio-economic disadvantage as it is to risk factors such as hypertension, obesity and diabetes.

iii. Diabetes

• Diagnosed diabetes is more prevalent in men than women for most ethnic groups. Age-adjusted figures show that diabetes is almost four times as prevalent in Bangladeshi men, and almost three times as prevalent in Pakistani and Indian men, compared with men in the general population.
• Among women, diagnosed diabetes was more than five times as likely among Pakistani women, at least three times as likely in Bangladeshi and Black Caribbean women, and two-and-a-half times as likely in Indian women compared with women in the general population.
• Prevalence of type 2 diabetes increased with age among all minority ethnic communities, and this age dependent increase is greater among minority ethnic groups than among the general population.

iv. Mental Health

There is limited research on mental health and minority ethnic groups. The few available studies show evidence of disparities and inequalities between minority ethnic communities and the majority white population in the rates of mental ill health, service experience and service outcome.

• Relative to the white population, minority ethnic communities (particularly younger people and those of African Caribbean) appear to be at increased risk of hospital admission, and coercive care within mental health services.
• Research suggests that there are no major variations in registration with GPs and overall consultation rates between minority ethnic groups and the majority population. However, the capacity of GPs to recognise psychiatric disorder in patients from minority ethnic communities appears to be more limited.
than in others. There are indications that consultation rates for mental disorders, in particular, anxiety and depression, may be reduced in some minority groups, such as amongst South Asians.

• Black and South Asian patients are less likely to have mental health problems recognised by their GP or the nature of their presentation wrongly attributed to mental illness. There is also evidence that GPs’ decisions to refer patients with mental health problems to specialist services are influenced by the patient’s ethnicity.

• Treatment rate analysis suggests that Black Caribbean people are between three to five times more likely to suffer from psychotic illnesses. However, this is not supported by population survey data which show a two-fold increase in rates of psychosis in Black Caribbean’s when compared with the white group.

• Patients from all minority ethnic groups are more likely than white majority patients to be misunderstood and misdiagnosed and more likely to be prescribed drugs and ECT rather than talking treatments such as psychotherapy and counselling.

v. Infectious Diseases

• In 2005 in England, Wales and Northern Ireland, 70% (15 562) of heterosexuals living with diagnosed HIV were of black African ethnicity, 18% (4039) of white ethnicity, 3.7% (836) of black Caribbean ethnicity, and 1.4% (321) were of Indian, Pakistani or Bangladeshi ethnicity. Recent work among youth from minority ethnic communities suggest that poor sexual health knowledge is a factor in the rates of sexually transmitted infections, particularly among those who are more sexually active.

• Among the UK born minority ethnic communities, the highest rates of tuberculosis in 2005 occurred in the Black African (41.0 per 100,000) and Indian, Pakistani and Bangladeshi (38.6 per 100,000) ethnic groups. Among the non-UK born minority ethnic communities, those belonging to the Indian, Pakistani and Bangladeshi ethnic groups had a rate of 234.9 per 100,000, while the highest rates occurred in the Black African ethnic group (399.0 per 100,000).

• Case numbers in both of these groups have increased between 2001 and 2005 (by 37% and 92% respectively), while numbers in all other ethnic groups remained relatively stable.

c) Health Services

The body of evidence for disparities in access and utilisation of health services although shown in some studies, has been hampered by the absence (until recently) of routine recording of ethnicity as well as variation in attempts to adjust utilisation rates for key determinants of health. The most accurate and comprehensive source of data on access and quality of health care within minority ethnic communities is the National Patient Survey Series.

• National surveys have shown that South Asians and Black Caribbean’s are more likely to have consulted their general practitioner than the white population.

• Survey findings also show that minority ethnic communities (in particular Bangladeshis) are more likely to be dissatisfied with the outcome of their consultation, more likely to seek a second opinion and more likely to have a lower patient experience than white groups.

• Patient surveys show that Pakistani, Bangladeshi, and Indian patients gave the lowest scores in domains of prompt access to secondary care services, involvement in clinical decisions, and plurality of choice.

• A & E surveys show that Bangladeshis, followed by Pakistanis and then other ethnic minorities are more likely to report dissatisfaction with the service than white groups.

• The use of preventative services such as cancer screening also shows ethnic disparities. Women in some minority ethnic communities have low uptake rates for cervical cancer screening, this is especially true for South Asian groups and in particular Bangladeshi women.
5. Actions

What do we need to do and who should do it?

Minority ethnic communities face a range of health problems. However, the underlying issues are those to do with poverty, differences in culture and the challenges in integration with mainstream communities. The ability of the NHS in Stoke on Trent to provide services that are sensitive to needs of minority ethnic communities is hampered by the lack of ethnicity coding within NHS information systems.

Stoke on Trent PCT has the responsibility to ensure everybody registered with the general practitioners contracted to the PCT have access to health and health care services based on need.

6. Recommendations

i. I recommend that Stoke on Trent PCT reviews the level of ethnicity recording in the NHS information systems of relevance to the people of Stoke on Trent and takes all necessary steps to ensure improvement.

ii. I recommend that all health and health care programmes should be designed in way that is sensitive to religious and cultural issues.
VULNERABLE COMMUNITIES IN STOKE ON TRENT

Chapter 16:
Asylum, Refugee Populations and Health

Contributor:

Obaghe Edeghere, Specialist Registrar in Public Health,

Dave Newall, Policy Officer, West Midlands Strategic Migration Partnership
ASYLUM, REFUGEE POPULATIONS AND HEALTH.

1. Introduction
Refugees and asylum seekers are a vulnerable and marginalised population at risk of considerable health and social inequalities. Asylum seekers are not a homogenous group, but rather present with a range of different needs, experiences and expectations.

2. The Asylum Journey
An application for asylum may be made at the port of entry (port applicant) or after entry to the UK (in-country applicant). In 2006 the Government introduced a "New Asylum Model" (NAM) to deal with asylum applications. Under the NAM applicants have a screening interview as soon as they lodge their asylum claim. They are then allocated to one of a range of segments or tracks through which their claim is processed. The most important difference between segments is between applicants who are "fast-tracked" and those who are given temporary admission into the UK. Fast-tracked applicants, largely determined by nationality are detained in immigration centres while their claim is dealt with in line with tight deadlines.

Applicants who are not detained if they require support and accommodation will be routed to a region and the claimant will then be interviewed about their claim within 7-12 days. An initial decision on their claim will be made and served to the claimant within 15 to 30 days by the "NAM case owner". Those not detained may pending the decision, apply to the Border and immigration agency (formerly NASS) for support only or support and accommodation (the majority do this). Some may choose to live with family/friends and receive no support or accommodation. Asylum seekers who have their application refused and have exhausted all avenues of appeal, will if they are single or childless couples have their support and accommodation terminated 21 days after this decision is made. Families who receive a final refusal currently remain supported by the Border and Immigration Agency until removal.

3. Legal Framework
The legal framework is very complex. The key acts are set out below.

i. The 1951 Geneva Convention and the 1967 protocol form the basis for current international law governing the granting of refugee status. To be granted this status a person must have left his or her own country and be unable to return to it owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion.

ii. The Asylum and Immigration (Appeals) Act 1993 removed the right of asylum seekers to secure social housing tenancies.

iii. The Asylum and Immigration Act, 1996 removed the right to cash benefits for asylum applicants and those appealing a negative decision. Local authorities now had a duty to provide care for the destitute under the National Assistance Act, 1948 and to children and families under the Children Act, 1989. This Act also introduced restrictions on employment.

iv. The Immigration and Asylum Act, 1999 set up the National Asylum Support Service (NASS) and the dispersal of asylum seekers to various parts of the UK. It removed any remaining benefit entitlement from asylum seekers, stopped asylum seekers working and brought in a new voucher system. NASS also
became responsible for the allocation of housing following dispersal. This Act also removed the obligation under the Children Act 1989 for local authorities to ensure that refugee and asylum seeking children had an adequate standard of living.

v. The Asylum and Immigration (Treatment of Claimants, etc.) Act 2004 and the Immigration, Asylum and nationality act 2006 set further legal parameters.

4. Health Problems of Asylum populations

Asylum seekers have health problems that they share with the indigenous population and others that are specific to them. The identifiable threats to health are mostly posed by diseases linked to poverty and deprivation, whether communicable, degenerative or psychological. Therefore most of the health problems of asylum seekers are not specific to refugee status, and are shared with other deprived or excluded groups. Specific health problems originate from the physical or mental torture, or other harsh conditions from which they have escaped.

The few available studies on refugee health suggest that one in six refugees has a physical health problem severe enough to affect their life, and two-thirds have experienced significant anxiety or depression. Further evidence suggests that the health status of new entrants may deteriorate in the first few years after entry to the UK. The sort of health problems, these communities face include:

- Infectious diseases such as tuberculosis, HIV/AIDS, hepatitis, etc
- Sexual health and Family planning
- Maternal health (antenatal and gynaecological services)
- Mental health problems (CTSD/PTSD, depression, etc)
- Haemoglobinopathies
- Vaccine preventable childhood diseases (measles etc)
- Access to Vaccination & Immunisation services
- Dental and eye care
- Access to NHS services (primary, secondary and emergency services) (See Table 1)
- Language and cultural barriers
- Problems with timing and continuity of care
- Health care information and education
Table 1: Summary of Eligibility to NHS Services

<table>
<thead>
<tr>
<th>Asylum Seeker</th>
<th>Primary Care - General Practice</th>
<th>Primary Care - Walk-in Centre</th>
<th>Accident &amp; Emergency Department</th>
<th>Secondary Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligible</td>
<td>Eligible</td>
<td>Eligible</td>
<td>Eligible</td>
<td>Eligible</td>
</tr>
<tr>
<td>Failed Asylum Seeker</td>
<td>Discretionary</td>
<td>Eligible</td>
<td>Eligible</td>
<td>Eligible for treatment started before final refusal. Ineligible for treatment starting after final refusal</td>
</tr>
<tr>
<td>Refugee</td>
<td>Eligible</td>
<td>Eligible</td>
<td>Eligible</td>
<td>Eligible</td>
</tr>
</tbody>
</table>


5. Sources of demographic and health data

Asylum seekers and refugees are a heterogeneous, mobile, and in some respect a 'hidden' population. In the UK there is no centralised information source with adequate demographic information to facilitate the estimation of the numbers and distribution of refugee and asylum seeker populations. There are however a variety of potential information sources that can be accessed and pieced together to provide a composite estimate of the asylum/refugee demographics.

Asylum Seeker and Refugee Project in Stoke on Trent

This service maintains a register of all asylum seekers notified to them by the Home Office and other sources such as the accommodation providers, self referral, and the medical foundation. The register will provide basic vital statistics including information the country of origin. The service also maintains a TB and Mental health screening records which can also be a source of data. However, it is difficult to distinguish between asylum seekers, refugees, failed asylum seekers and illegal immigrants. The register has not been modified on a regular basis to account for attrition arising from relocations or change in immigration status.

The existing register was regularly validated up until August 2006; it however continues to be populated as new notifications are received. To ensure the accuracy and completeness of this dataset, a validation process will need to be undertaken and will involve linking the database with the Exeter system and the data held by the accommodation providers. This will enable us to generate a fairly robust estimate of the number of asylum seekers and refugees in the area. However, it will be unable to provide reliably estimates of the number of failed asylum seekers and certainly no estimates of illegal immigrants.

General Practice Registration

Newly dispersed individuals are usually assigned a GP by the PCTs registration department. The Exeter system may be used to identify individuals whose address is an official sanctioned dispersal accommodation site. However, reliance on address details will depend on completeness and accuracy of records. Records do not specify asylum status or country of origin. Attrition due to relocation cannot be accounted for.
Home Office Asylum Statistics

This is perhaps the most accurate record of Asylum activity locally. Home Office records will provide a measure of the numbers dispersed locally over a period of time and possibly allow adjustments to be made to account for relocations (Table 2). However, it will not provide information on illegal immigrants, failed asylum seekers, children in the care of the LA, and individuals under section 4 support.

Table 2: Number and distribution of Asylum seekers in receipt of NASS support (subsistence ± dispersed accommodation) in the Government Office West Midlands, 2003-2005.

<table>
<thead>
<tr>
<th>Local Authority</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stoke-on-Trent</td>
<td>985</td>
<td>680</td>
<td>590</td>
</tr>
<tr>
<td>Newcastle Under Lyme</td>
<td>35</td>
<td>35</td>
<td>20</td>
</tr>
<tr>
<td>Walsall</td>
<td>580</td>
<td>590</td>
<td>150</td>
</tr>
<tr>
<td>Dudley</td>
<td>700</td>
<td>715</td>
<td>680</td>
</tr>
<tr>
<td>Coventry</td>
<td>1525</td>
<td>1010</td>
<td>865</td>
</tr>
<tr>
<td>Sandwell</td>
<td>1000</td>
<td>885</td>
<td>695</td>
</tr>
<tr>
<td>Wolverhampton</td>
<td>1280</td>
<td>905</td>
<td>755</td>
</tr>
<tr>
<td>Solihull</td>
<td>90</td>
<td>100</td>
<td>85</td>
</tr>
<tr>
<td>Birmingham</td>
<td>3930</td>
<td>2505</td>
<td>1930</td>
</tr>
<tr>
<td>Other</td>
<td>80</td>
<td>75</td>
<td>60</td>
</tr>
<tr>
<td>West Midlands†</td>
<td>10210</td>
<td>7480</td>
<td>5830</td>
</tr>
</tbody>
</table>

† West Midlands total will include disbenefited people and some unlisted dispersal areas

Stoke on Trent City Council (Accommodation team/Destitute support service)

This may be the best way to identify the number of failed asylum seekers in the locality. This data source maybe potentially limited to individuals being supported as a result of health needs that pre-date their unsuccessful application for refugee status. Illegal immigrants and asylum seekers who are destitute will not be provided with accommodation by the Council even though they may have been in contact with the service.

Private accommodation providers

This may be a valuable source of data on the number of asylum seekers in the system. It can provide demographic data including country of origin, asylum status, etc. However, private companies may not share the goals of the PCT (but do have responsibility for the well-being of residents) and may refuse data sharing on grounds of confidentiality. Also does not identify the failed asylum seekers.

Department of works and pensions

Refugees are entitled to receive benefits if their circumstances make them eligible. The benefits agency will routinely record the immigration status of all recipients of benefits. However, it will only identify refugees in receipt of benefits, may lead to double-counting as linkage with other datasets on the basis of identifiable variables will not be possible.
Social services (children’s and adults)
This data source may only identify groups in contact with the service such as children whom the local government provides accommodation for and family in receipt of social support. It is a limited source of information.

Local education Authority
Refugee children’s data and annual school census (PLASC) may provide information on asylum seeking and refugee children in the educational system. But the system will only identify children and only those who are in full time education. Recording is known to be variable.

6. Actions
What should we do and who should do it?
Asylum and refugee communities have considerable financial, social and health challenges. From a health point of view support can be provided as long as the health services can identify individuals and communities. This is being taken on board and plans are being formulated to ensure a coherent approach to the planning and delivery of health services in the West Midlands Region.

Within Stoke on Trent, the PCT funds a specific nurse specialist to support refugees and asylum seekers. The primary role is to ensure that new entrants to Stoke on Trent are supported to access primary care.

7. Recommendation
I recommend that the PCT continues to maintain the additional support provided to asylum and refugee communities in Stoke on Trent.
Glossary

Refugee
A refugee is someone who has gained refugee status under the 1951 UN convention relating to the status of refugees.

Asylum seeker
A person who has crossed an international border in search of safety and applies to be given refugee status under the 1951 UN Convention.

Failed Asylum Seeker
A person who has crossed an international border, applied for refugee status, had their application refused, and have exhausted all legal rights of appeal.

Illegal Immigrant
Someone who has arrived in another country, intentionally not made themselves known to the authorities and has no legal basis for being there.

Stateless Persons
Persons who are not considered nationals by any country under the operation of its laws.

Section (4) Status
This relates to the provision of facilities for persons who were (but no longer) asylum seekers and whose claim for asylum has been rejected.