Write the annual report of the director of public health

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The Acheson report *Public Health in England* defines public health as "the art and science of the prevention of disease, the prolongation of life and the promotion of health through the organised efforts of society."¹ Health circular HC(88)64 requires health authorities to appoint a director of public health and for this director to produce an annual report on the state of the public health in the district or region.²

Before the health service was reorganised in 1974, local authority medical officers of health had a statutory obligation to produce annual health reports. In these the health profile of the local population was discussed, the factors influencing this analysed, and recommendations made for action to prevent and treat disease and promote health. In practice, many of these reports had become indigestible catalogues of mortality and notifiable infections, and after 1974 they stopped being produced to a large extent.

The reintroduction of the annual health report was one of many unimplemented recommendations of the Black report.³ In the 1980s there was a resurgence of interest in health profiles for districts from the local level. These "local Black reports" have shown how adverse social conditions cause ill health and perpetuate inequalities. Such reports have come from community medicine departments in health authorities,⁴⁻¹⁰ from local authorities,¹¹⁻¹³ and from pressure groups, trade unions, and political organisations.¹⁴⁻¹⁵ Some of these have been heavily influenced by the World Health Organisation's European targets for Health For All.¹⁶

The reintroduction of annual health reports will not, in itself, improve public health. The reports must be used as a basis for organised efforts to promote health at district and regional levels. The reports must also become a focus within the health service's planning cycle to enable the available health service resources to be appropriately targeted to meet needs effectively. Explicit in HC(88)64 is the expectation that directors of public health will take part in developing indicators of outcome of health care procedures.

This article draws on our experience in preparing and using our report *The Health of Coventry*.⁴ It also draws on the unpublished proceedings of the December 1988 conference at the London School of Hygiene and Tropical Medicine, *The annual report on the public health: from idea to reality*.

Aims and objectives

The director of public health will need to determine the important issues for the district or region and thence broad aims for each year's report. The broad aims might include those shown in the box.

The director will devise specific objectives from the broad aims. The emphasis of the report will reflect the different local needs.

The aims of the report will determine for whom (besides the health authority) it is written and how it is written. It will also determine the size of the intended distribution, and this will in turn influence whether the eventual report is photocopied or printed. The audience will include lay people and professionals; the written style will therefore need to be uncomplicated,

Possible aims for the annual health report

- To act as the stimulus or focus for multiagency work to promote public health
- To draw attention to social problems affecting health which can be resolved only by action by other local agencies, or by national action
- To draw attention to particular health service deficiencies to influence planning and service commissioning and resource allocation within the health authority
- To "market public health"—to show the work done by the department of public health, indicating its relevance to decisions being taken by the health authority and other agencies, and advertising its expertise as a resource for the local community
- To report local health studies undertaken during the year and recommend action based on these studies
- To report local epidemiological artefacts and advise on further research needed
- To report and restate public health successes such as fluoridation of water supplies or clean air acts
- To act as an archive for reference in the future

and the data used will need to be as precise as possible. The style should be non-sexist and sensitive to local cultural and ethnic minority needs. It may be necessary to include at least a summary and recommendations translated into appropriate languages.

The first annual report may differ from subsequent editions in that the director may wish to adopt a broad brush approach and comment on the full range of locally available health information. Focusing on three or four main themes, however, can be a more effective means of concentrating attention on those areas the director thinks should be the priorities.

In each section of *The Health of Coventry* we included a précis of the evidence on health implications of housing, employment, unemployment, and so on. This widened the lay interest in the report and had the unforeseen effect of increasing the understanding of public health of some senior health service managers.

Content of the report

If annual reports are to be of any value then local "sovereignty" must be protected. Prescribed minimum data sets or directives from the Department of Health or regional director of public health on content will immediately destroy the main function of these reports, which is to assess local needs and make recommendations for local action. The Department of Health has now produced the "common data set," which gives some mortality and morbidity indicators by district and region. These can be used by directors of public health for their annual reports.

In *The Health of Coventry* we progressed from demography, through major social influences of health, to routine health service data—reflecting our order of importance.⁴ The content is likely to be predominantly from routine sources of data; some of these are suggested in the appendix. One off local studies can be

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included or quoted in the report. As the annual report becomes more established we would expect such local studies to assume a prominent role and further enhance the local relevance of the report. Health service performance indicators are likely to be relevant in the annual report only where they indicate unmet needs and unnecessary suffering in the community.

Computer mapping programmes are becoming more widely available at district and regional level and offer great potential for presenting local health information by electoral ward or enumeration district.¹⁷ Any data that can be postcoded can be presented in these graphics packages. Care is needed in presenting and interpreting data such as standardised mortality ratios by ward as the numbers will often be very small. These data should at least be aggregated over three or five years. The figures should also be accompanied by confidence intervals; alternatively, only the outlying wards can be shown.

One off local studies, reports required by the AIDS Control Act 1987, hospital performance reports, and reports of the public health department's own activities could be included as "special reports" or appendices. There may be special subjects particularly relevant to a district, such as the foundry industry in Sandwell.¹⁷

The report must make recommendations to be adopted and "owned" by the agencies to which it is addressed. The report cannot be solely for reference purposes or for the archive.

Production of the report

The Health of Coventry was written in three months; typesetting, proofreading, and printing took a further three months. A minimum of six months is required to produce an annual report. For the singlehanded director of public health this may sound like an inordinate amount of time, particularly with other calls on his or her time. The preparation of the drafts of the report may be the shortest stage, however; the longest time may be spent when copy is at the printers. Much of the work of assembling data should be delegated to the district or regional information department, and doctors not part of the public health department can be recruited to write sections of the report.

At the outset it is advisable to draw up a schedule for the production of the report (see box). Research tasks and sections to be written should be assigned. It is advisable to write to non-NHS agencies for data required as a first step; while awaiting that information, NHS data can be assembled, processed, interpreted, and formatted for graphs and tables, and the accompanying script can be prepared.

All the text should be put on a wordprocessor for easy editing. A "medical editor," usually the director of public health, is required to supervise the content and ensure a consistent literary style and consistent statements and figures throughout the text. Someone else should proofread. If possible, that person can also act as "administrative editor" to supervise the layout, printing, and distribution.

The choice of presentation style and the printing resources available to the director of public health will determine the time taken before the report is finally produced. *The Health of Coventry* was phototypeset and all the graphs were redrawn by a graphic artist. Desktop publishing software packages are now widely available for around £200 and would obviate the need for, and the cost of, professional typesetting. Desktop publishing needs to be used with a laser printer, however (cost around £2000), and by an experienced operator for high quality results.

If many copies of the report are to be produced the marginal cost of printing becomes smaller and may be less than photocopying. Printing also allows a much

Suggested timetable for production of the annual health report

<i>April:</i>	Planning meeting to agree main priority areas; assign tasks of data collection, processing, and writing; agree special reports or local research for inclusion; agree programme of production Write for information required from non-NHS sources Undertake literature searches on main themes Assess available NHS data and prepare text for first draft
<i>May:</i>	Major period of report writing Collate information and correspondence from outside agencies
<i>June:</i>	Director of public health convenes editorial meeting for review of first draft; formulation of conclusions or recommendations; agreeing "target" organisations and individuals for eventual distribution; starting to formulate plan for launch of steering report in the most constructive manner Advance notices for member seminars; preparations for other seminars (if you wish councillors to attend arrangements are required with the local authority director of finance to ensure councillor's expenses are payable) "Medical editor" assumes control of project, editing content, and providing consistent style If producing in booklet form, prepare final draft to go to graphics artist or for typesetting in the first week in July
<i>July:</i>	Annual AIDS reports required: submit to regional health authority but also include in the annual report OPCS mortality statistics from previous year expected: may be incorporated, but there will be little time for processing and interpretation Arrange summary/conclusions in translation for ethnic minorities (don't use a graphic artist who cannot arrange translations) In parallel, prepare short popular version or leaflet Start to prepare visual aids for presentations (allow eight weeks for poster paper)
<i>August:</i>	Produce final wordprocessed or desktop published draft Send to printers Proofread typeset version—twice Prepare distribution address labels Prepare press release
<i>September:</i>	Final arrangements for member seminars; calling notices Arrangements for public seminars and press conference
<i>October:</i>	Publication Presentation to health authority

more polished and professional finish to be achieved. Annual health reports should be professionally finished and invitingly glossy to read, without being ostentatious.

The central Birmingham health report cost £2650 for 1000 copies in 1987; *The Health of Coventry* cost £5500 in 1985 for 2000 copies. Both have "broken even" through sales to other interested health authori-

ties, some agencies within districts, and to private sources. The opportunities for sales within the health service will decline as these reports become more commonplace. *The Health of Coventry* would probably cost about £10 000 to produce in 1991, but this would still only be an actual cost of £5 per copy—half the cost of photocopying the original draft.

Publication of the report

The annual health report must be presented to the health authority in full public session. The launch should be a media event. A press release should be prepared while the report is at the printers. Distribution lists can also be drawn up at this time (table I). A decision is needed about how many complementary copies are to be distributed and who is to be charged.

The report is intended to be the director of public health's independent professional advice to the health authority, but it would clearly be an empty report if it were presented outside the context of the planning and "purchasing" process and without the support and commitment of general managers and other senior officers of the health authority. Directors will therefore need to determine their most appropriate course of action to secure managers' cooperation when publishing their annual reports.

It is likely that October will become the most appropriate time for publishing the annual report, to coincide with the formulation of the operational plans and contract placement for the following year. This timing might allow for the incorporation of the OPCS mortality statistics for the previous year, which are generally published in July. This would put the report on a very tight time schedule. We believe that the annual report should contain the most recent available data so that it can influence planning decisions in health authorities. Most causes of death are not

TABLE II—Possible uses for the annual health report^{18 19}

Presentations:

Health authority	Formal public presentation and members' seminars
Family health services authority	
Community health council	
Joint consultative committee	
Full council and relevant council committees	
District management board, health authority	
Chief officers' meeting, local authority	
Medical advisory committee meetings	
Nursing professional advisory committee meetings	
Other professional and technical committee meetings	
Staff trade union committee meetings	
Additional seminars offered for all health service staff	
Formal postgraduate medical education presentations	
Schools of nursing and midwifery	
General offer of presentations for schools, political, church, trade union, industrial, commercial, voluntary, community, and ethnic minority organisations (to be circulated with report copies or flyer)	
Press conference(s)	
Formal districtwide or regionwide seminar to publicise findings and explore recommendations ²⁰	
Videos	
Follow up seminars on specific issues ²¹	
Popular, short version of the report—for separate publication or as feature in local authority or health authority free paper	
Service planning, health services, local authority and other agencies:	
Incorporation of major recommendations into operational or strategic plans for health authorities	
Consideration of major recommendations in planning by family health services authorities, local authorities, and other agencies	
Development of outcome measures as part of the information strategy, consumer affairs, strategy, quality of service strategy ²²	
Development of joint activities through the joint consultative committee, a joint health promotion group, or through advice to local authority health committee ^{18 20}	
Advertising services of department as a resource for information for community based health promotion campaigns ¹⁹	

changing sufficiently rapidly to affect planning for a maximum of three years ahead. The health report should be for the year in which it is published and not the year from which the data are drawn.

Major public health reports could be produced to influence the health authority strategic plans (every 10 years) and in the year of the mid-strategy review.

Uses of the report

Ashton has described the use of his report on health in Mersey as the starting point for community based health promotion initiatives.¹⁸ Table II shows some of the uses to which we put *The Health of Coventry*; these have been described elsewhere.¹⁹

The scale of activity generated by the first report is clearly greater than that likely to result from subsequent reports, but public health physicians must capitalise on the interest that is likely to be generated on the publication of their first "new public health" reports, and be prepared to take on the additional work with vigour and enthusiasm. Subsequent reports need to be sufficiently different to sustain the interest of writer and reader and sufficiently consistent for the development of sustained public health initiatives.

Conclusions

The health report has been described as the "community diagnosis"¹⁸; as with the clinical diagnosis, it is not an end in itself, but provides the information on which to base the "community treatment." It is not sufficient to produce glossy reports on the problems faced by our communities; it is necessary to use the information in these reports to campaign on behalf of the public health and to involve people in their own local initiatives to improve health. The development of the annual report on the state of the public health provides the information on which broad based health promotion can be established.

TABLE I—Possible distribution for the annual health report

Health authority members
Senior officers, heads of department, health authority
One copy per ward, department, health centre, and clinic
Medical executive committee members
District medical committee members
Nursing professional advisory committee members
Staff trade union representatives
Medical and nursing education centre libraries
Hospital patient libraries
Reception areas (fixed copies)
Family health services authority
One copy per general practice
Members of local medical committee
Members of local dental, pharmacists, and opticians' committee
Community health council members
Joint consultative committee members
Members of parliament
Representatives of all political parties
All councillors
All local authority chief officers
Additional copies to other key local authority officers, particularly those who have provided information such as planning, economic, and information departments; road safety; environmental health; social services registers
All school headteachers and one copy for school libraries
Social services and housing district or neighbourhood offices
One copy for each general library
Police, fire, and ambulance chiefs
Coroners
Racial equality council members
Voluntary services coordinator (and to all agencies on mailing list if available)
Church organisations
Members of Chambers of Commerce
Other industrial or business organisations
Manpower Services Commission
Enterprise agencies and development corporations
Trades council members
Regional health authority: director of public health, general manager, chairman
Department of Health: chief medical officer, health minister
British Library (the ISBN number is useful)

Appendix

SUBJECT AREAS AND POSSIBLE SOURCES OF INFORMATION FOR AN ANNUAL HEALTH REPORT

1 Demography:

Population: At census; estimates; predictions; crude birth rate; crude mortality; fertility; single parent families; migration; ethnic minorities [from: Office of Population Censuses and Surveys (OPCS) census, local authority planning and information departments, regional health authority statistics department]

2 Major determinants of health:

Housing: Housing "spaces," private, council, other; overcrowding, lacking basic amenities [from census]; housing condition surveys; council waiting lists; homelessness; medical priority for rehousing [from: local authority, homelessness agencies]

Poverty: Benefit claimants [from: Department of Social Security]; housing benefit claimants (indicator of very low income) [from local authority]; percentage unskilled workers [from census, local poverty action groups, and Low Pay Unit surveys]

Employment: Census of employment by standard industrial groupings [from: Department of Employment, local authority economic units or planning and information departments]; employment by socioeconomic groups [from: census]; industrial accidents [from: Health and Safety Executive, hospital episode system]

Unemployment: Local authority economic units [from: Department of Social Security]; water supply, quality and sanitation [from: Water Authority reports, local authority technical services or city engineers]

Education: Provision of nursery education; school population; percentage school leavers entering higher education [from: local authority education department]

Violence and personal security: crime statistics [from county councils or metropolitan police authorities]

3 Hazards:

Fires [from county councils or metropolitan fire and civil defence authorities]

Pollution: Air monitoring and hazardous materials surveys [from local authority environmental health departments]; water quality and pollution incidents [from: local authorities, water authorities]; food hygiene [from local authority environmental health departments]

Environmental control: Pests, public health nuisances [from local authority environmental health departments]

4 Maternal and child health:

Obstetric care; birthweight; congenital abnormalities; perinatal and infant deaths; legal abortions [from district health authority and regional health authority information departments]; notifiable infectious disease [from: OPCS, local authority, district health authority immunisations]; child abuse [from local authority social services departments]; home and road accident statistics [additional data from local authority environmental health departments and police authorities]; dental health [from district health authority local surveys of missing, decayed, and filled teeth in school populations]

5 Physical and mental handicap:

Physical disablement, blindness, and deafness registers [from local authority social services departments; local surveys and proxy measures from national studies]

6 Adult health:

Indicators from primary care [from Royal College of General Practitioners' spotter practices, local practice databases and reports]; contraceptive use [from district health authority]; prescriptions for major groupings of pharmaceuticals [from: Prescriptions Pricing Authority]; notifiable infectious disease; accidents; AIDS; sexually transmitted diseases; local information from lifestyle surveys, coronary heart disease risk factors; smoking related diseases and coronary heart diseases

[information similar to that presented for districts in the Health Education Authority reports "The Big Kill" and "Broken Hearts"]; home, road and work accidents statistics; drugs [from: local drug agencies, local authority social services departments, Home Office statistics, accident department and hospital episode system, Prescriptions Pricing Authority, and family health services authorities]; alcohol [from local agencies and social services; district information system; regional information system; extrapolate national estimates for local proxy measures]

7 Major uses of hospital specialties:

Major causes of hospital admission; major uses of hospital facilities; hospital performance; mental health [standardised hospitalisation rates can be calculated by ward from district health authority, regional health authority; Department of Health and John Yates performance indicator packages; hospital episode system; Hospital Inpatient Enquiry, Mental Health Inquiry district information system; regional information system]

8 Major causes of death

Mortality statistics, numbers [OPCS SD25/V S1 series] rates over time, standardised mortality ratios by ward for major conditions, 3 or 5 year aggregated data (for all ages and for selected ages, for example, 15-64), with confidence intervals [can be supplied by regional statistics departments but requires checking]

9 Special reports and local research

10 Summary of findings and consequent recommendations

11 References or sources

12 Acknowledgements

13 Index

14 Glossary

- 1 Department of Health. *Public health in England*. London: HMSO, 1988. (Acheson report.)
- 2 Department of Health. *Health of the population: responsibilities of health authorities*. London: DHSS, 1988. (HC (88) 64.)
- 3 Townsend P, Davidson N, eds. *Inequalities in health*. Harmondsworth: Penguin, 1982. (Black report.)
- 4 Binysh K, Chishy V, Middleton J, Pollock G. *The health of Coventry*. Coventry: Coventry Health Authority, 1985.
- 5 Bloomsbury Department of Community Medicine. *Health for all*. Bloomsbury: Bloomsbury Health Authority, 1985.
- 6 Ashton J. *Health in Mersey: a review*. Liverpool: University of Liverpool, 1984.
- 7 Central Birmingham Department of Community Medicine. *A picture of health*. Birmingham: Central Birmingham Health Authority, 1987.
- 8 Lewisham and North Southwark Department of Community Medicine. *Dying before our time: health in Lewisham and North Southwark health authority*. London: Lewisham and Southwark Health Authority.
- 9 Boulton G, Roberts RE. *Mid Glamorgan: deprivation and health*. Cardiff: Mid Glamorgan Health Authority, 1985.
- 10 Community Physicians of the Manchester Joint Consultative Committee. *Health inequalities in Manchester*. Manchester: Manchester Joint Consultative Committee, 1982.
- 11 Thunhurst C. *Poverty and health in the city of Sheffield*. Sheffield: Sheffield City Council Environmental Health Department, 1984.
- 12 Fryer P. A healthy city strategy three years on—the case of Oxford city council. *Health Promotion* 1988;3:213-7.
- 13 Nottingham City Council Health Unit. *Health for all in Nottingham*. Nottingham: Nottingham City Council, 1988.
- 14 West of Scotland Politics of Health Group. *Glasgow: health of a city*. Glasgow: West of Scotland Politics of Health Group, 1984.
- 15 Gardner K, Mumby S, eds. *Liverpool's state of health*. Liverpool: Merseyside Communist Party, 1984.
- 16 WHO EURO. *Targets in support of European health for all by the year 2000*. Copenhagen: European Office of the World Health Organisation, 1985.
- 17 Sandwell Department of Public Health. *Life and death in Sandwell*. West Bromwich: Sandwell Health Authority, 1989.
- 18 Ashton J. Health in Mersey—an exercise in community diagnosis. *Health Education J* 1985;44:178-80.
- 19 Binysh K, Chishy V, Middleton J, Pollock G. The health of Coventry—use of a health profile to stimulate community health promotion. *Health Education J* 1989 48:94-6.
- 20 Binysh K, Chishy V, Middleton J, Pollock G. *Coventry health 2000: proceedings of a conference on health for Coventry by the year 2000*. Coventry: Coventry Health Authority, 1986.
- 21 Coventry Safe Driving Team. Coventry: a no drinking driving city by the year 2000? *BMJ* 1987;295:71-2.
- 22 Middleton J. A discussion paper on outcomes for a non-teaching district. *Community Med* 1987;9:343-9.