Annual Report of the Director of Public Health 2013-14

A History of Public Health in Sutton

London Borough of Sutton

Introduction by Dr. Ellis Friedman, Director of Public Health, 2013-14

Now that Public Health in Sutton has returned to what is regarded by many as our natural home in Local Government, I embrace this opportunity to work with our partners to improve the health of our population.

Here, I review the Public Health achievements in Sutton over the course of its history. This is set against the context of developments in the rest of the country since around the time of the Industrial Revolution. This was the significant period when the discipline of Public Health emerged and when evidence about the causes of poor health, together with strong political will contributed to major developments.

Firstly, it is worth recapping on what we understand by Public Health.

A definition of Public Health

The definition most often used to describe Public Health (Acheson) is:
'*the science and art of prolonging life, preventing disease and promoting health through the organised efforts of society'* [1]

This tells us that Public Health:

- Is about populations rather than individuals
- Focuses on a collective, joint responsibility for health, protection and prevention
- Recognises that health is influenced not just by disease but by socio-economic and wider determinants of health
- Is about strong partnerships with all those who contribute to the health of the population

Public Health comprises a wide variety of disciplines to deliver three key 'domains'. These are: Health Improvement, Improving Services, and Health Protection.

In this report the past achievements and developments of Public Health both locally and nationally are examined, drawing on comparisons between our work and vision both then and now.

In the first section we briefly describe the history of Public Health in England. Then in the following section we look in more detail at Sutton's own history against the context of national developments.

As I will be Director of Public Health (DPH) of Sutton for just a year, it seemed appropriate to set the context for Public Health as it rejoins the Local Authority, a position many regard as its natural home.

The historic roots of Public Health are worth examining as they potentially offer insights about an effective approach to successfully tackling today's and tomorrow's problems.

[1] Acheson D. Independent Inquiry into Inequalities in Health Report, TSO, 1998.

This is arguably especially pertinent as Public Health can make a persuasive case to have been the most important branch of medicine in improving the health and wellbeing of the population.

How can I make such a seemingly extravagant claim that Public Health has been more important than surgery, medicine and obstetrics to name just a few of the prestigious branches of the profession?

Firstly in terms of lives saved the most important medical intervention has been the Public Health measure of childhood vaccination.

Secondly in respect of environmental changes caused by the Public Health movement, the impact of clean water and food, good sanitation and the reduction of overcrowding has made an extremely large contribution to the prevention of ill health.

These Public Health measures have made enormous contributions to the control of infectious diseases. Their impact has been many times more important than antibiotics.

The success of these Public Health initiatives are now often taken for granted and don't necessarily appear to offer solutions to current and future health challenges.

Sutton faces the challenge of needing to improve its immunisation rates. It is clear that the recorded position is spurious and the major issue is ensuring that the information system reliably records all the immunisations given. A challenge of the new Public Health system is that the Director of Public Health and his team do not control this service and depend on supporting and if necessary challenging the lead agencies of Public Health England (PHE) and NHS England (NHSE).

Another area of great historic Public Health success has been screening. These screening services are also no longer lead by the DPH but by PHE and NHSE. Screening programmes offer opportunities now and in the future for increasing health and wellbeing for the population.

Prevention programmes are generally well used by the public and professionals. Many authoritative reports have demonstrated that preventive programmes especially aimed at pregnancy, mothers and in childhood could make an enormous beneficial impact both on improving life expectancy and reducing morbidity, as well as reducing health inequalities.

In Sutton, along with most of the country, there are large variations in life expectancy at ward level. A significant proportion of this inequality develops during early years and could be prevented.

Unfortunately in the NHS, the demand for emergency and long term care has tended to displace action on the longer term preventive need. So for example, spending on relatively ineffective lung cancer treatments has grown faster than expenditure on well proven cost-effective smoking cessation programmes!

The new health and social care system will have to address the challenge of incentivising the Borough to invest in Public Health prevention whilst other sectors reap the benefit. So in respect of my previous example, how will the NHS, who will benefit from the impact of the smoking cessation programme by having fewer lung cancer patients to treat, recompense

the Local Authority (LA) for increasing its investment in smoking cessation? It is probably naïve in an era of financial stringency for Councils to expect it to commission altruistically!

Collaboration will be key to the future success of the health and social care system.

Public Health is founded on evidence-based practice. There is much which is known which is not applied in practice and it must be expected that as our knowledge increases, further improvement in health and social care will accrue.

I predict that in the next decade there will be much more knowledge gained about the effectiveness and cost-effectiveness of public health interventions in social and educational care settings facilitated by public health being based in the LA.

Collaboration through integrated services placing the patient/client at the centre of our endeavours offers enormous opportunities. The Better Care Fund should assist this development.

I will also predict that the next decade will use Information Technology (IT) much more effectively to allow the public to have easy access to authoritative personalised health information and to facilitate management of their health problems from their own home.

The recognition that health is not just caused by health behaviours and genetics but by social and environmental factors is a key Public Health insight. Sutton has been at the forefront of addressing environmental concerns and in forging alliances between the statutory and voluntary sector.

I wish to thank all my colleagues in Sutton especially the Public Health Team, Councillors and Officers of the Borough and Sutton CCG staff and Board members for making my relatively short period as DPH for Sutton both enjoyable and worthwhile in addressing the key objective of improving the health and wellbeing of the residents of Sutton. In particular I want to record my gratitude to Sylvia Godden and Dr Simon Elliot for their considerable help in writing this historical report.

I hope you enjoy reading this Annual Report

Dr/Prof Ellis Friedman
Director of Public Health
London Borough of Sutton

February 2014

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Contents

A History of Public Health in Sutton

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Section 1: The beginnings of Public Health in England

In England, Public Health has its origins in the 19th century. It was mostly due to two important Public Health Acts that we inherited a legacy of sanitary, environmental and housing reform which established the standards that we expect today. This was followed by the development of a network of preventive medical services in the first part of the 20th century.

It has to be acknowledged that the drivers for our Public Health system did not stem solely from concern for the population! The vast British Empire that stretched from England to India required a constant supply of people to populate its armies, whilst at home the factories, coal mines and heavy industry that characterised the industrial revolution had shifted much of the rural population to the towns. Unsurprisingly, migration on such massive scale led to overcrowding and pollution in these early Victorian cities, in turn leading to ill health and disease. This made it an economic necessity to understand and combat the causes of disease.

The first Public Health Act of 1848 established the post of the Medical Officer of Health, the predecessor of the modern day Director of Public Health. This significant Act focused on the supply of clean water and a proper sewage system, and set out to implement a 'Sanitary Revolution'. Just as the Director of Public Health does today, the primary focus of the Medical Officer of Health was on *prevention* rather than treatment.

Liverpool suffered the nation's worst health problems and was the first city to take a systematic approach to addressing it. The first ever public wash-house opened here and a survey of housing conditions by the nation's first Medical Officer of Health demonstrated that infectious diseases such as TB, measles, smallpox and cholera spread quickly in conditions of overcrowding and squalor.

At this time, before the discovery of bacteria and antibiotics, far less was understood about the causes of disease, but this was to change. During a particularly virulent outbreak of cholera in 1854, physician John Snow traced the deaths of 500 people from the disease to their use of the drinking water pump located in Broad Street, Soho. His theory that water from the pump was contaminated was proved correct after removal of the handle led to a swift end to the epidemic. This and other early studies which were concerned with the distribution and pattern of disease and its causes in defined populations contributed to important new Public Health knowledge and practice.

In 1856, Medical Officer of Health John Simon published the first in a series of annual reports '*On the state of the Public Health'* that continues to this day - the equivalent of the report for Sutton you are reading now!

The second Public Health Act of 1875 extended beyond clean water and sewerage to encompass a whole range of factors that impact on health; factors that these days we refer

to as the ‘wider determinants of health’. These included regulation of roads and new buildings, removal of ‘nuisances’, food inspection, infectious diseases, fever hospitals, hygienic burial, regulation of markets, offensive trades and slaughterhouses and making and enforcing by-laws.

Despite these efforts problems persisted and in the late 19th century the army was still unable to accept half of all potential recruits to the Boer War due to their significant poor health. Malnourishment in children was found to be an important cause of later life health problems. To address this situation, a ‘Committee on Physical Deterioration’ recommended sickness registration, medical inspection of school children and young people, and stillbirth registration. It also recommended setting up a central advisory council with full time Medical Officers of Health across the country, systematic reporting of Public Health problems and good communication with factory inspectors about conditions there. Many of these recommendations were implemented. Personal preventive medical services were developed which included school medical inspection in 1907 and community and school nursing in 1908. Also the state became directly involved in providing hospital services.

With the Public Health system now fully operational, the next major development was the inception of the NHS. The 1942 ‘Beveridge Report’ captured the spirit of the time in its vision for a better post-war society, establishing the foundation for the modern welfare state. It aimed to combat the ‘five giants’ of Want, Ignorance, Disease, Squalor and Idleness through measures such as a national social security scheme, a system of children’s allowances and a comprehensive health service. Subsequently, in 1948 the NHS was created, available to all on the basis of health need, free at the point of use, funded by central taxation. The tripartite NHS encompassed hospital services, family practitioner services and local authority health services - which included Public Health. The ‘Community Physician’ role was created in local authorities, whose work, as it still does today, included undertaking health needs assessment, health service planning, interpreting statistical, demographic and health data, and working with partners to address health inequalities within the population.

This system continued until, as part of a huge health service reorganisation in 1974, the Public Health function transferred out of local government control and into the NHS.

Now, nearly forty years later, following the implementation of the Health and Social Care Act 2012, April 2013 marked the return of Public Health to Local Government.

Section 2: The beginnings of Public Health in Sutton

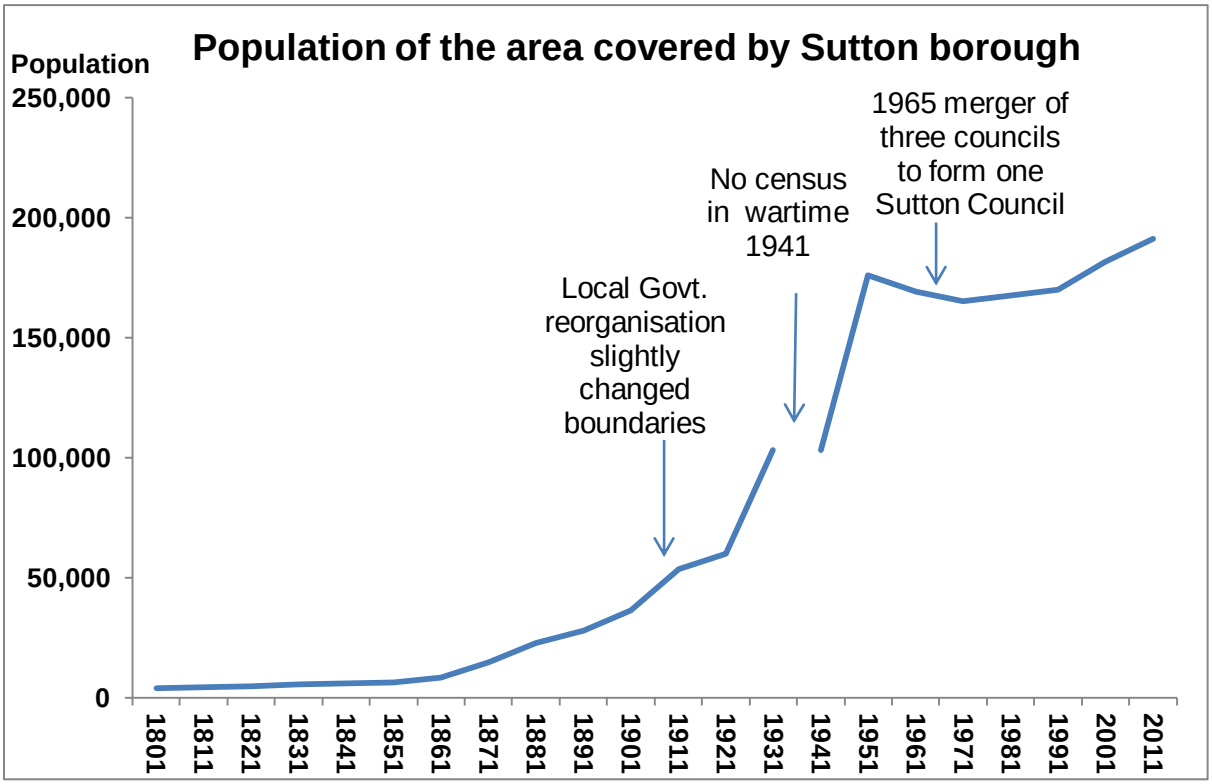
As per Acheson's definition cited in the Introduction, it is recognised that health is influenced not just by disease but by socio-economic and wider determinants of health. So in this section we describe key developments in Sutton, not just in the treatment and prevention of health and disease, but also with regard to the wider determinants, i.e. in housing, sewage and refuse.

The changing population of Sutton

The earliest reliable local population figures date back to the first national census of 1801. Since that time a census has been carried out on the first year of each decade except during wartime in 1941. Since 1801 the population has increased from just under 4,000 to over 190,000 in 2011 – so fifty times more people today!

The 19th century censuses were based on the parishes of Cheam, Sutton, Carshalton, Beddington and Wallington. Carshalton was the most populated area until Sutton assumed this position as recorded in 1861. Local government reorganisation in the late 19th and early 20th centuries altered the geographical boundaries so statistics after this time do not relate to exactly the same areas, but are approximately the same. In 1965 the three separate councils of Sutton and Cheam, Carshalton, and Beddington and Wallington merged to form the London Borough of Sutton.

Population trends in the area covered by Sutton borough[2]

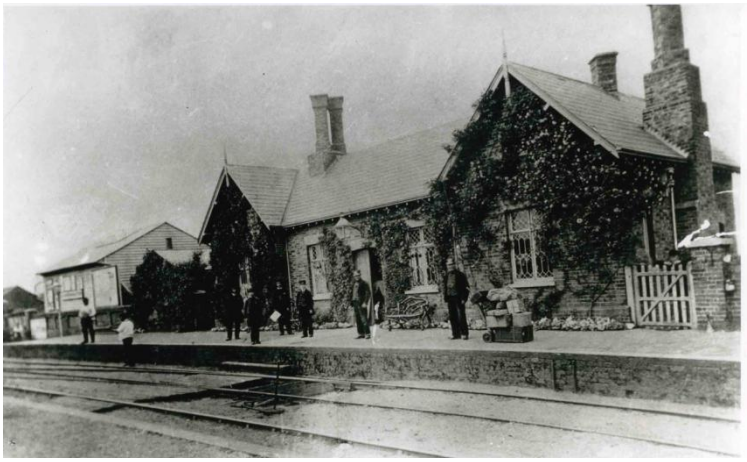


[2] Population Statistics. Source: London Borough of Sutton for statistics through to 1981. ONS mid-year estimates for 1991 to 2011. https://www.sutton.gov.uk/index.aspx?articleid=1496

Key developments in the Public Health of Sutton

The key source for this narrative is Charlesworth L, Eves D, Michell R, Reid C. 100 Years of Public Health in Sutton 1883-1983. Published by the Environmental Health Department, London Borough of Sutton, 1983.

By the early 1860's Sutton had a population of just over 3,000. Carshalton was the busiest local community with its mills and industries, whilst Wallington's development was slower. Cheam and Beddington were still just villages whilst Sutton made a convenient breakfast stop for Brighton-bound coaches. The Croydon and Epsom railway had opened in 1847.



Wallington Railway Station pre 1869

Sutton and its surrounding villages had a reputation as healthy areas and were renowned for the purity of their waters at a time when many Londoners had no course but to drink untreated water straight from the Thames. This was because the original settlement had been on the relatively narrow band of Thanet sand that divides the chalk downs from the clay of the London basin. Here a water supply was readily available which having percolated through some hundreds of feet of chalk was almost free from impurity. Settlement to the north was served by surface wells, while to the south, the higher up the downs that building took place; the deeper the wells had to be. Banstead Village well was 375 feet deep, whilst one near Burgh Health had to drop 500 feet to reach the water table. In 1863 the Sutton Water company was formed.

By the early 1880's, residents of the village of Sutton numbered more than 10,000. This rapid population expansion triggered social and environmental problems as houses were built faster than piped water supplies could be provided to them. In common with many English settlements, Sutton had transformed from a village into a town. This development posed new health risks. Although not as severe as in the industrial cities, the low standard of working class houses, overcrowding and insanitary conditions made infectious disease a constant threat. There was no effective sewerage system. Working hours were long and diet was poor. In 1883 average life expectancy in England and Wales was still just 44 years for men and 47 for women.

Sutton High Street 1890

In 1832 the first cholera outbreak reached London. There was no effective treatment for this disease and half of all cases proved fatal. Nationally, a Poor Law Commission was set up to look into the whole administration of local government as carried out at the time by the Church Vestries. The process was that the Vestries elected churchwardens of the Parish. This Parish Council appointed 'Overseers of the Poor' to collect the Parish rate and distribute relief to those settled within its boundaries who were unable to work. Sutton Vestry had a reputation for being quite mean in its approval of relief to the most needy and paupers were sent to Reigate Workhouse.

Nationally, Edwin Chadwick, the Secretary of the Poor Law Commission led the Poor Law Amendment which grouped individual Parishes into Unions, each managed by a Board of Guardians controlled by the Poor Law Commission in London. As a replacement to the local system of outdoor relief, the Guardians established Union Workhouses whose intent was to create conditions so harsh that only the most desperate pauper would apply. Sutton's Parish came within the Union of Epsom and the Poor Rate of 2/6d in the pound in 1833 was reduced to just 6d, no doubt resulting in abject human misery and poverty!

Had it not been for Chadwick's Inquiry into the Sanitary Conditions of the Labouring classes published in 1842, it is likely that history would have judged him harshly. He instigated this Inquiry after the typhus epidemic in 1837-8 which persuaded him that further economies in poor relief could only be made by addressing the health problems of the most impoverished sections of the community. So although Chadwick's main intent was to spend less on the poor, in pursuing this goal he contributed sound Public Health advice that would prevent death and disease, particularly amongst the most vulnerable population.

The connection between dirt and disease was not recognised at the time, plus in some parts of society it was unseemly to acknowledge that the dire conditions described in Chadwick's report could actually exist in prosperous Victorian England. TB, typhoid, typhus and cholera were common among those living in the worst housing conditions. Despite that Chadwick and associates believed wrongfully that disease was spread by an evil miasma, fortunately the actions they proposed to address the problem were sound, i.e. that by collecting refuse, building efficient sewers, and providing clean water, ultimately money would be saved. Happily, most of the inhabitants of Sutton did not experience these extreme conditions, but were still covered by the Public Health Act of 1848 which set up a General Board of Health

with powers to set up local boards in areas of high mortality. Despite this, in 1849 cholera returned with vengeance, but once more Sutton escaped.

The second Public Health Act of 1875, as well as consolidating previous legislation, also established every area in the country, whether rural and urban, with some form of Local Authority responsible for sanitary matters under the general supervision of the Local Government Board. In every locality a Medical Officer of Health and a Sanitary Inspector was appointed. The Parishes of Sutton, Cheam and Carshalton came under the control of the Epsom Rural Sanitary Authority, while Beddington and Wallington lay within the Rural District of Croydon. Sutton also had its own Parochial Sanitary Committee concerned with everyday problems, but could make no decisions independently from the larger Epsom Authority. This led to indignation and resentment that Epsom was entitled to make demands that Sutton might consider unnecessary and expensive. In December, 1882 the Parish of Sutton constituted a local government district and in early 1883 members were elected to the Sutton Local Board of Health. The new Sutton Board which met for the first time in April 1883 was now in charge of its own affairs. Its duties were to examine drains, privies, cesspools, nuisances from keeping pigs, and to make provision for proper water supplies to houses and close all polluted wells. It was to put a stop to nuisances from insanitary or overcrowded premises, the keeping of animals, dirty factories, smoking chimneys and piles of refuse. It was also to supervise the proper cleansing of houses where there had been infectious disease and to regulate slaughter houses.

This took place at the time of an agricultural ‘Great Depression’ as cheap American grain and refrigerated meat from Argentina undercut local farm prices. Further, newer industries in America and Germany competed with traditional British markets, and tariff barriers against English goods were raised through Europe. Unemployment peaked in 1886 affecting 10% of the working population.

Sewage: There had been disagreement on the issue of whether a sewage system should be provided, but in 1882 the central Local Government Board received a petition requesting a Public Inquiry as the Royal Sanitary Authority had not provided the district with sewers. Evidence convinced the Board that Sutton must be drained quickly and a system established, but left it open whether this was to be carried out by the Epsom Authority or the local Board. Eventually in 1882 a resolution was passed by the Sutton Parochial Sanitary Committee to drain and sewer Sutton.

However, despite orders against the Sutton Board, delays continued until eventually it approved a plan and work started in 1891. Three years later Sutton Sewage works began operations, 12 years after the Local Board was set up and 37 years after the scheme’s original proposal. The sewage treatment works were located off Willow Walk, Sutton, designed for a population of 16,000, but subsequently extended.

Manager's house, Sutton Sewage Disposal works

Refuse: Although the Sutton Board responded slowly over sewage, it was prompt in the collection of household rubbish. In December, 1883 a regular collection started using the Board's own horse and carts, two men and two boys. Each householder was given a card to display in their window if they wanted the dustmen to call. Refuse consisted mainly of ashes from open fires which were sold to local brick makers for use in manufacture, though there were many complaints about poor quality. In 1896 the allotment ground in Bushey Road was designated as a site for the disposal of household refuse with the volume faithfully recorded in the minutes of the fortnightly Sanitary Committee meetings. When this site was full, others were opened up. It is noted how the days are long gone when refuse could be disposed of locally and now refuse collection is a costly service for Sutton!

Refuse collection in Sutton

Infectious diseases: Despite some inevitable epidemics, notably typhoid in Croydon, Sutton suffered no major outbreaks of disease. This was due to its small population in the most vulnerable period, then, as described, a good supply of pure drinking water, plus the vigilance of its local Board of Health.

In previous centuries the Black Death had decimated the national population between 1348 and 1665. Smallpox was a major killer but the impact of the disease was much reduced by

vaccination following Edward Jenner's discovery in 1798. Vaccination was compulsory from 1853 through to 1948 to help eradicate the disease. During the 19th century a number of breakthroughs in science transformed medicine, anaesthetics, germ theory and knowledge of antiseptics. As noted, the miasma theory was eventually disproved after John Snow demonstrated that cholera outbreaks in 1848 and 1854 were spread by drinking from infected water supplies. Unfortunately, Chadwick's flushing of the sewers to drive out the disease actually contributed to its further spread by flushing bacillus into the Thames! In the 1860s Louis Pasteur advanced his investigations that led towards a theory of germs, which were further developed by Lord Lister and saved countless lives.

When cholera appeared in Southern France in 1884, Sutton prepared to take very practical and sensible precautions as recommended by the Sanitary Committee, recognising water as the chief carrier.

Typhoid was also traced to polluted water but was more difficult to contain. In the overcrowded housing of the working classes, tuberculosis was the most common cause of death, accounting for 9.5% of all deaths in 1883, whilst the bovine form transmitted by infected milk had a huge impact on child mortality. Those who did survive commonly became physically disabled. Although over time there were improvements to housing and diet, vaccination, mass radiography and new drugs made the most impact.

Efforts to combat infectious disease were assisted by the introduction of the Infectious Diseases (Notification) Act 1889 and the Extension Act of 1899. Sutton had already adopted a form of voluntary notification while under the control of Epsom. In 1890 the Infectious Disease (Prevention) Act addressed in more detail than the Public Health Act of 1875 the disinfection of infected premises. Sutton was ahead of these measures and had already adopted them in 1880 as the Committee rightly made the connection between cleansing and the prevention of disease.

In addition to legislation there was an urgent need for a local hospital where infectious patients could be isolated and treated. Sutton had no such hospital and patients were either nursed at home or in extreme cases sent to the London Fever Hospital.

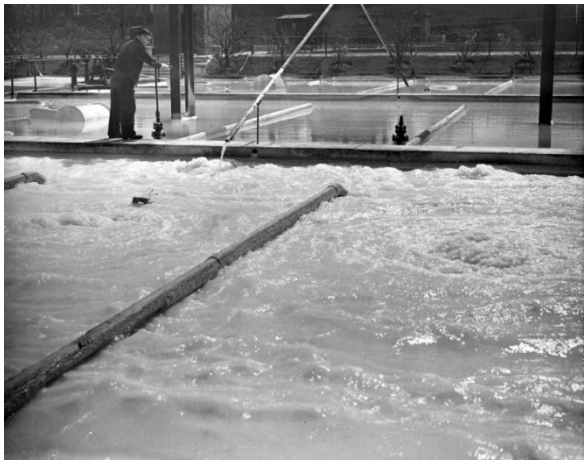
When a strong possibility of an epidemic of scarlet fever was anticipated, two houses in Beulah Road, Sutton were adapted as a temporary hospital. Fortunately, the outbreak was contained and after the six identified cases convalesced, the hospital was dissolved. For a while this policy of creating temporary hospitals seemed to suffice. Another was set up in Bushey Road whilst a cottage in Gander Green Lane was used as a smallpox hospital in 1893.

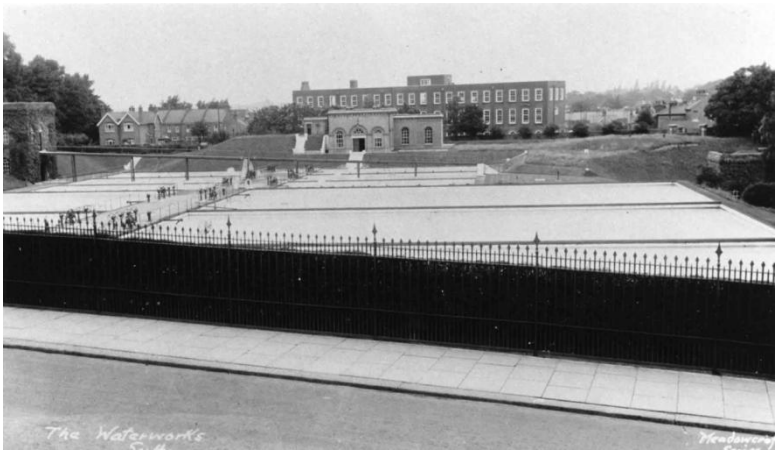
However, these were obviously not the long term solution and in 1897 Cuddington Hospital opened on the edge of Banstead Downs. The reputation of the Downs for health, proximity to London and the affordability of the chalky land attracted interest far beyond Sutton. In 1852 the Poor Law Guardians of 17 Inner London parishes purchased land at Belmont to build huge schools to house over 1,500 of London's pauper children. This was followed by the building of Banstead Asylum. In 1901 a smallpox hospital was built in Cheam (later Cheam hospital) and there were further isolation hospitals at Wandle Valley and Waddon.

There was alarm amongst the local population at yet a new plan for an isolation hospital for children from London's slums, but it proceeded. Then in 1909 its anticipated role changed

completely as the anticipated epidemics receded. The Children's Infirmary was opened by the veteran Dockers leader J.E. Burns "to bring the sick poor children of London out of the workhouses and on to the breezy downs of Surrey". Renamed Queen Mary's Hospital with a capacity of 1,000 beds, it became one of the largest and best known children's hospitals in the world. (See section on Queen Mary's).

A proper water supply was vital for preventing infectious diseases in the 19th century. The Public Health Act empowered Local Authorities to require a proper water supply to houses within their district and to close polluted wells. At that time bacteriological examination of water was not carried out so it could not be scientifically confirmed if water contained bacteria of faecal origin. It was left for the Medical Officer of Health to determine, which was an imprecise affair. The proposal to supply piped water to Sutton was made in 1860 and in 1863 the Sutton and Cheam Water Company was established with its headquarters at Clower's Pit, a quarry beside Carshalton Road. By 1869, 27 miles of mains had been laid. In 1871 the Company became the Sutton and District Water Company with statutory powers to supply Sutton, Cheam, Carshalton, Wallington, Beddington, Morden, Banstead, Woodmansterne, Ewell and Cuddington. Although not everyone had a water supply in their own house, it was accessible to all. By the beginning of the 20th century the Company was delivering 1.3 million gallons of water daily through 142 miles of mains to around 48,000 people.





Sutton waterworks

Housing: In 1865 the village of Sutton consisted mainly of timber framed, weather-boarded cottages with red pantiled roofs standing on a foundation of hard chalk known as 'clunch'. Chalk production was a Sutton industry. There were deep pits on either side of Carshalton Road and in many other places. Damp courses were introduced to dwellings during the 1840s and were a feature of the newer brick houses, though many properties in Sutton Common used basements as a way of dealing with rising damp, or at least keeping it down to a level where only the servants lived!

To meet the demand for locally burnt bricks, a chain of brickyards operated along the line where London clay took over from Thanet sand. It was reported that in a northerly wind, "Sutton was covered with the nauseating stench of burning clay and cinders".

Few houses had bathrooms. Whilst in upper class households maids would carry buckets of hot water upstairs to their rooms, working class families enjoyed bath night in the kitchen where hot water from the 'copper' (of brick construction and used for boiling clothes) was ladled into a tin bath, then they shared the same water to bathe in order with the father first.

The 'new town' district was established around Lind Road in 1847-48, named after the famous Swedish opera singer Jenny Lind. There was another rapid expansion in 1875-80 as new roads were laid in the lower part of town intended to house the working classes, and were cheaply, though not necessarily badly built. The most humble of these cottages were laid in long terraces with front doors that opened directly from the pavement to the front parlour. Slightly larger dwellings had a narrow passage and rear projecting scullery. These were typical of the standard type of house in rural areas until the First World War.

The Public Health Act of 1875 provided some control over new building but the first byelaws in 1877 were aimed at slum properties rather than the type of newly constructed houses in Sutton. The Act allowed courts to prohibit occupation of unfit houses until made habitable. These powers were strengthened by the Housing of the Working Classes Act of 1890 which allowed Urban and Rural District Councils to issue closing and demolition orders. Also, for the first time Local Authorities were to provide new houses for the working classes. There is no evidence that Sutton required slum clearance in this period, despite that demand for new housing could never be met due to the increase in the population. This placed pressure on the small dwellings that were frequently overcrowded, but there was little practical help from the council.

This chronic housing shortage was part of a national problem but had to be endured until the end of the First World War. During the War there was no housing construction plus now the population was expecting better conditions. The government, under the leadership of Mr Lloyd George, promised 'homes for heroes' and building revived in both the private and public sector. Between the wars from the 1920s to 1930s many suburban, semi-detached houses were built in Sutton, many of which are still in use today. These houses were built privately and constructed to a good standard with modern amenities.

During the early 1930s the London Country Council started work on the St Helier Estate which was planned to house people displaced from the clearance of overcrowded slum dwellings in Inner London. These houses had internal toilets and most had bathrooms, though a small number still had baths in the kitchen.

Despite the construction of the large St Helier Estate, overcrowding remained a problem and the Housing Act 1936 required local authorities to survey their areas and report to the Minister. For the first time this Act introduced a standard by which overcrowding could be measured and was punishable by fine. A survey of the Borough of Sutton and Cheam in 1936 found that just less than 1% of houses were overcrowded.

Unfortunately, improvements in housing were yet again delayed by the advent of the Second World War. Again, during this time no new building took place whilst many houses were destroyed or damaged by bombs.

Bomb damage, Bernard Road, 4th July, 1944

The Sanitary Inspector, during and after the War was actively involved in the repair of damaged properties, but the shortage of building material in the 1940s hindered the speed that this could be achieved and a licensing system was introduced for repairs. The War also halted clearance slum clearance programmes. However, in later years the impetus revived. The London Borough of Sutton was formed in 1965 from a merger of the three councils of Sutton and Cheam, Carshalton, and Beddington and Wallington. The demolition of unfit properties was actively pursued and fourteen clearance areas were made between 1967 and 1975. The last was in Clarence Road after a Public Inquiry in 1977.

Sutton Town Hall decorated 1953

By now, although the worst properties were gone, many houses remained in poor repair and without proper amenities. Rehabilitation was the most practical solution and in 1959 the House Purchase and Housing Act introduced grants towards providing the five ‘standard amenities’: a fixed bath or shower in a bathroom, a wash hand basin, a hot water supply, an internal toilet and adequate food storage facilities. The Housing Act 1964 allowed local authorities to make any area an improvement area and the programme was extended by the Housing Act 1969 which introduced ‘general improvement areas’ such as pedestrianisation and tree planting. However, Sutton had no such improvement areas.

One of Sutton borough’s main council estates, the Roundshaw was built on part of the site of the former Croydon Airport. Work on the estate started in 1965, and the first tenants arrived in 1967.

Roundshaw Estate

A close-up on St Helier Estate[3]

The St Helier Estate was constructed between 1928 and 1936 as a 'London overspill' to rehouse people from slum dwellings in inner London areas.

St Helier Estate in 1929

It was built by C.J. Wills and Sons for the London County Council on 825 acres of former farmland, much of which had been used for the local lavender and herb industry, contributing to that industry's final demise.

At the time the area was part of the Urban Districts of Merton and Morden, Carshalton, and Sutton and Cheam. It was the largest London Country Council estate in South London, and second largest overall. It was designed as a 'garden city' on the same lines as Letchworth and Welwyn Garden. The aim was to preserve the existing natural features and to include open spaces and sports and recreation grounds. More than an eighth of the site was retained as open space. Roads were arranged alphabetically.

The aim was to create a community and eighteen schools, seven churches, two pubs, and the 2,000-seater Gaumont cinema were constructed. It had sixty shops by 1938. There were 9,000 houses and flats to accommodate 40,000 people. St. Helier Hospital, opened in 1938, was built near the top of Rose Hill and became (as it still is) an important landmark for miles around.

The estate was named after Lady St. Helier, a former Alderman of the London County Council from 1910 to 1927. Her mission was to improve housing facilities in London, but she died seven years before the estate was completed.

[3] London Borough of Sutton's local history website pages. The St. Helier Estate: Available at: https://www.sutton.gov.uk/index.aspx?articleid=1401

Pollution: Even Sutton, located between the "breezy Downs" and Merton and Carshalton lavender fields was not entirely free from the environmental pollution of the industrial revolution. Gas works and smoking factory chimneys were part of the urban environment and London was covered by a pall of smoke in Winter that formed a suffocating, yellow fog.

Locally, following complaints from Sutton residents in 1884, the Medical Officer of Health was requested to inspect the gas works and report to the Sanitary Committee. Despite attempts to reduce the nuisance, complaints continued, and the Gas Company was eventually forced to suspend the manufacture of sulphate of ammonia.

Similarly, in 1886 complaints around Beulah Road were made against the British Guano Company about chemical manure production from mixing human excrement with locally-burnt lime. As there is no record of further complaints after this time, it seems that operations ceased in the area.

A significant achievement made possible under the 1875 Public Health Act was the elimination of visible smoke pollution from the atmosphere. Rather than industrial sources, the main cause was the domestic chimneys serving inefficient open coal fires. Poor combustion of coal meant that large amounts of smoke were generated from open grates. In the first half of the 20th century the coal fire was the main form of heating in homes. This caused constant low level pollution which built up when air at ground level was still. The London Smog of 1952 highlighted the serious health effects. It lasted from the 5th to the 8th December and during this time there were 40,000 extra deaths due to heart or respiratory disease. This brought chaos to London. The Sutton Advertiser of 11th December, 1952 reports 'smash and grab' raids on High Street shops and all three Sutton cinemas displayed notices that fog was affecting visibility even inside the venue!

Gaumont Cinema Sutton, 1956

As a result the Beaver Committee was established to investigate, and reported in 1956 that air pollution was costing the country £250 million per annum in direct costs (laundry, cleaning) and loss of efficiency. This was apart from the cost of fuel wastage (as smoke is unburnt fuel). A direct correlation between air pollution and respiratory disease was proved. Death rates from bronchitis were significantly higher than elsewhere in Europe and rates from respiratory disease were higher in urban areas where pollution was greatest. Also, the oppressive environment had a psychological effect. The Clean Air Act, 1956 allowed local

authorities for the first time to tackle domestic pollution effectively by introducing smoke control areas where only smokeless authorised fuels could be burned.

Today, pollution control involves sophisticated environmental techniques to contamination. Further, the danger of asbestos has been known for a number of decades.

Food: The food industry of the 19th century served only a very small local population compared to today. In 1884 there were 16 bakehouses and seven slaughterhouses/butchers in the Sutton district, increasing to 20 and nine respectively by 1888. In 1886 there were nine registered purveyors of milk and 15 who were also cow keepers. There were 131 cows in Sutton and 19 grocers. Reports show that bakehouses were well run but there were problems in the butchery and slaughterhouses, cowsheds and dairies. All were required to be regularly limewashed for cleanliness, but in the butchers' yards piles of manure, offal and pools of blood presented a health risk. Milk at this time came directly from the cow without any heat treatment to destroy bacteria. Watered milk, chalky bread and flour, sandy sugar and other forms of adulteration were practiced by fraudulent dealers - activities which could only be detected by regular sampling. In 1886 the Sanitary Committee recommended to the Local Government Board that the Sanitary Inspector should be authorised to sample food and drugs. The main Act was the Sale of Food and Drugs Act 1875. The two main requirements were: that no injurious substance could be added to food, and that any food sold should be of the nature, substance or quality required by the purchaser. Contraventions were punishable by fine and a second offence attracted a maximum six months prison sentence with hard labour.

Today, many of these foundations in food control are still in place, but with the omission of hard labour! Now standards of food hygiene are much higher than in the 19th century, plus refrigeration enables safe foods storage. The elimination of open-fronted foodshops has also contributed.

Further, the growth of the food industry and the variety of manufactured and imported foods has led to much more stringent controls. Environmental Health Officers are required to inspect food and empowered to seize anything declared unfit for human consumption. This requires chemical analysis, e.g. to perceive unfit meat or to identify criminal fraud. Prepacked foods require ingredients to be listed on the packet with a 'sell by' data. Public feedback is vital. Importantly, health education for those involved in cooking or handling food is one of the most effective means of meeting standards. Unfortunately despite all this, the recent horsemeat scandal indicates that the problem of fraudulent food adulteration persists.

The development of Primary Care in England and in Sutton

In the mid 19th century much of the population's medical care was carried out by a doctor, officially named the surgeon-apothecary but usually referred to as the General Practitioner (GP). Three major pieces of legislation fundamentally changed the role: *The Medical Act of 1858* established state registration of qualified doctors, *the 1911 National Health Insurance Act* initiated the stage panel doctor scheme for poorer patients and a mix of public and private finance for their GPs, and the *1946 Act* set out the plan for a comprehensive, publicly funded NHS. Between these dates general practice transformed. Women entered the profession, single handed practices became partnerships and access to phones and cars enlarged the population that could be covered. Doctors learned more about the causes of illness and how the body worked whilst new drugs revolutionised treatment. Competition from homeopaths became marginalised by the end of the 19th century.

Many Victorian GPs worked from home with little room for their surgery and dispensary. Through the important gatekeeping role of the doctor, a patient might gain or be denied access to services, employment or benefits, though the Hippocratic Oath historically taken by doctors was protection against conflicts of interests. In practice, the poor-law doctor tended to take a liberal approach due to an understanding of the connection between poverty and sickness. It was up to the doctor to determine when a person was too infirm to be moved to the workhouse. Sometimes, there were conflicts with the poor law guardians who closely scrutinised the cost of supplements such as mutton, wine and cod liver oil.

The 1911 National Insurance Act established a system of free health care financed by patients in employment, employers and the state. Anyone earning less than £160 a year was eligible to join the panel of an insurance practitioner. Half the working population joined by the end of the interwar period, yet crucially this did not extend to their wives and children.

Later, in the 1920s and 1930s, workers in heavy industry in mining and industrial areas suffered long periods of unemployment. When state benefits expired there was intense pressure on doctors to certify a person as sick and therefore eligible for health insurance benefit.

In 1948 there were 18,000 GPs, almost entirely male and half single-handed, practising mainly from home. GPs had been unwilling to join the NHS until virtually the last minute as the British Medical Association (BMA) clashed with government. After 18 months of ongoing dispute, NHS founder Aneurin Bevan finally managed to win support without compromising his principles, later famously quoting that to broker the deal he had "stuffed their mouths with gold".

Prior to 1948 whilst some GPs made a good living, others were poorly paid and even had to employ debt collectors. The NHS provided security and a better income as payment was by a flat capitation fee. This meant that those in industrial areas with large lists earned more so the Medical Practices Committee regulated the system to some extent. After NHS inception the service was over-stretched for some months as much untreated illness came to light now that there were no bills. This applied particularly to women who had suffered chronic conditions such as a prolapse for years, and older people rushing to get spectacles.

Today, the full range of primary care services includes general practitioners, dentists, pharmacists and opticians. Most of England's 35,000 GPs are independent contractors

although an increasing number have opted to become salaried. Over time lists have grown smaller and consultations are more likely to be concerned with the management of chronic disease and health promotion rather than acute illness. Premises have improved as GPs have moved to purpose-built practice accommodation. Record keeping and prescribing is now electronic rather than done manually.

In 1972 the Royal College of General Practitioners was established to represent GPs. Since 1976 a three-year postgraduate training programme has been required. The Alma Ata declaration on primary health care in 1978 placed an increasing focus on prevention and health promotion.

In 1991 GP fundholding enabled GPs to extend provision of services to take on a commissioning role. The concept was based on giving GPs a budget to purchase health care on behalf of patients. Fundholders allocated money for practice staff, prescription medicines and hospital services, outpatient care and around 110 elective operations covering most surgery. Procedures could be purchased from the private sector as well as the NHS.

Traditionally, practices carry out their duties according to a national contract for General Medical Services. The GP contract of 2004 allowed for the transfer of responsibility for some services to other agencies, importantly including out-of-hours care. Previously, the NHS (Primary Care) Act 1997 allowed for the Personal Medical Services (PMS) contract as an alternative to General Medical Services (GMS) which provided more flexibility in work practices.

The 2004 GP contract increased measures of performance-related pay as measured by the Quality and Outcomes Framework (QOF) to reward practices for providing high quality care. GPs' involvement in commissioning later developed through practice-based commissioning introduced in 2006, and GP commissioning introduced in pilot form in 2010. Competition was encouraged through enabling patient choice of practice and scrapping practice boundaries. There were expanded roles for practice nurses and other staff, and a range of alternative access points introduced. Now patients are registered with a practice, rather than with one doctor. Services have expanded to include many that were previously only provided in hospital and community settings, as well as screening and immunisation, health promotion and disease management programmes.

Recent policy changes have further consolidated general practice's role as a commissioner as well as provider of care. In 2013, implementation of the Health and Social Care Act 2012 fully established Clinical Commissioning Groups (CCGs). All practices must be part of a CCG, organisations that hold most of the local budget for commissioning services, previously held by the Primary Care Trust.

In summary, since 1948 general practice has changed considerably. Whilst in the past sole practitioners visited their patients at any time of day or night, now doctors are usually employed in large practices supported by nurses and other clinicians. Today, General Practice operates in an environment of an ageing population, tighter funding, and better informed patients who are used to accessing the internet for health information.

Primary Care in Sutton

In December 2011, 28 GP practices in the London Borough of Sutton formed the Sutton Clinical Commissioning Group responsible for planning and funding NHS services for the population of Sutton. Its role is to hold the local NHS budget and to spend it appropriately on services to meet the health needs of residents. These include a range of local NHS services including hospital, community and mental health.

Sutton CCG is led by:

Chair: Dr Brendan Hudson

Chief Clinical Officer: Dr Chris Elliott

Chief Operating Officer: Jonathan Bates

Key developments in primary care both nationally and in Sutton have included:

- The development of GP fundholding in Sutton
- PCGs to PCTs
- Practice Based Commissioning
- The development of GP premises in Sutton, e.g. Shotfield at the Jubilee Health Centre

A close-up on Sutton's Hospitals

St Helier Hospital[4]

In 1938 Queen Mary laid the first foundation stone at the site of St Helier Hospital. The first patients were admitted in 1941 and building finished in 1942. The hospital was at the heart of the new community created by the development of St Helier Estate, completed in 1936 and planned to accommodate 40,000 people.

Despite painting the hospital green during the Second World War to conceal it, many German bombs did land in the surrounding areas including an unexploding one on top of the gasometers half a mile away. Unfortunately, less than a month after completion, the hospital was damaged by a bomb and there was further damage throughout the war and it was struck twice in June 1944. However, it remained open and continued to expand after the war.

St Helier Hospital opening of new units, 9 September, 1991

Conservative MP John Major who served as Prime Minister between 1990 and 1997 was born at St. Helier in 1943 to a family in Worcester Park. He is commemorated by a plaque at the main entrance. In 1974 the first kidney transplant took place here. In 1977, the A&E department was opened following £200,000 investment, and in 1987 the Princess of Wales opened the maternity unit.

[4] St Helier Hospital: Available at: http://www.epsom-sthelier.nhs.uk/about-us/our-hospitals/st-helier-hospital/

Sutton Hospital[5]

Sutton Cottage Hospital was officially opened in 1899, at that time comprising just six beds and operating from two semi-detached cottages in Bushey Road, Sutton. As the population grew, so did the hospital. In 1902 it moved to a new site which consisted of 12 beds in four small wards and an administrative block. It then became known as Sutton Hospital. In 1931 the new hospital was officially opened at its current site.

After the inception of the NHS in 1948 the hospital was incorporated into the St Helier group, although it continued to receive support from the voluntary sector and charities. By 1950 it had gained two further wards and in 1957 a new outpatients department and a pharmacy. In line with raising life expectancy, a geriatric rehabilitation unit was added in 1959 to address the needs of an increasing elderly population.

In 1983 a district day surgery unit was opened, and in January 1991 an orthopaedic surgery opened to patients. Today, it operates as a day hospital and has a modern surgery unit.

[5] History of Sutton Hospital. Available at: http://www.epsom-sthelier.nhs.uk/about-us/our-hospitals/sutton-hospital/

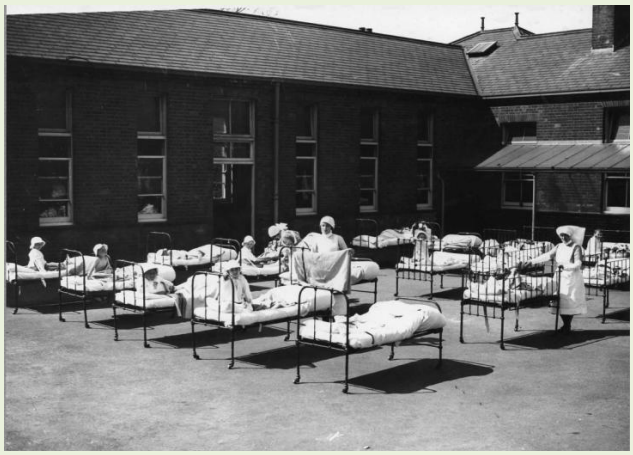
Queen Mary's Hospital[6]

In 1896 the Metropolitan Asylums Board acquired a 136-acre site at Carshalton Beeches, intended to house an 800-bedded hospital for convalescents. It was completed in 1908 and named the Southern Hospital. However, in 1908 the Board was tasked with providing care for sick inner London children in the expectation that Carshalton's clean air and rural setting would help poor and malnourished children to recover. The Board handed the hospital over to the Children's Committee who renamed it the Children's Infirmary. However, the original plan for the 'Southern Hospital' still went ahead when the Gore Farm Hospital at Darenth, previously used for convalescing smallpox patients, expanded its role and inherited the name.

The Children's Infirmary opened in 1909 with 1,000 beds and 300 staff. Children were accommodated in single storey ward blocks arranged in 24 pairs, with two blocks for surgical cases at the south of the site. The Board established its first Nursing Training School here. In 1914 Queen Mary became patron and after visiting in 1915 it was renamed 'Queen Mary's Hospital for Children'.

The hospital was extended during 1928-30 with two new wards, four staff blocks and a block for amenities added. By then 350 children were being treated for rheumatic diseases and 500 children with non-pulmonary tuberculosis (TB).

During World War 2, the hospital was one of the most heavily bombed in London and in 1944 the children were evacuated. After the war it reopened, but damage had reduced beds from 1,284 to 840. It joined the NHS in 1948. The introduction of streptomycin and other antibiotics enabled better treatment for TB and the hospital began to care for children with polio and cerebral palsy.



By 1959 it was caring for children with special needs. When children with learning disabilities were transferred from the run-down Fountain Hospital, it became the UK's first hospital to treat physically and mentally sick children on one site.

By the late 1970s it was the largest children's hospital in Europe. As most were long-stay patients, it had its own school and amenities that even included a zoo and miniature railway. A medical engineering unit opened on the site. However, improved treatments, fewer admissions, and a change in government policy on long stay hospitals, reduced the number of beds considerably.

[6] Lost Hospitals of London. Queen Mary's Hospital. Available at: http://ezitis.myzen.co.uk/queenmarycarshalton.html

Queen Mary's hospital closed in 1993 with services transferred to St Helier Hospital, which now bears the name on that site. The original Carshalton site, Orchard Hill, which housed adults with learning disabilities, finally closed in 2009.

The Royal Marsden NHS Foundation Trust[7]

The Royal Marsden Hospital is a world-leading cancer centre specialising in diagnosis, treatment, care, education and research. The Royal Marsden, in association with its academic partner, the Institute of Cancer Research, has an unrivalled worldwide reputation for its patient care, cancer research and education, forming the largest comprehensive cancer centre in Europe .

It is based on two sites: in Chelsea at the Brompton, with a second site here in the south of the borough in Belmont, not far from Sutton Hospital.

The Marsden was the first hospital in the world dedicated to the study and treatment of cancer. It was founded in 1851 by Dr William Marsden who resolved to classify tumours, research causes and find new treatments after the death of his wife from cancer. The hospital quickly outgrew its original sites and it moved several times during the 1850s until its benefactors raised funds for a dedicated new building and subsequently, the hospital opened to patients at its new site on Fulham Road in 1862.

It was known as The Cancer Hospital (Free) until King Edward VIII added the title 'Royal'. In 1954 it was renamed The Royal Marsden Hospital. After the NHS was founded in 1948 it became a post-graduate teaching hospital and its second hospital in Sutton was opened in 1962 to fulfil the need to treat more patients and train more doctors.

The original buildings at Sutton had first been used as the Banstead Road branch of the South Metropolitan District School for children of workhouse inmates in South London. It later became a sanatorium before the southern half of the site was acquired by the Royal Marsden in 1962.

It was the first NHS hospital awarded the Queen's Award for Technology for its work on drug development in 1991. It achieved the international quality standard for radiotherapy in 1996 and chemotherapy in 2003 and was recognised as one of six centres of excellence in the Government's NHS Plan. It has consistently achieved the Customer Service Excellence standard for its services. In 2006 and 2011, the Royal Marsden and the Institute of Cancer Research were designated the UK's only Biomedical Research Centre for Cancer by the National Institute for Health Research (NIHR). Further, the Marsden was rated as one of England's top performing hospitals in the 2011 Picker patient surveys.

[7] The Royal Marsden. Available at: http://www.royalmarsden.nhs.uk/pages/home.aspx

A comparison between the responsibilities of Public Health in 1973 when it was last part of the Local Authority and today

In 1973 the remit of the Medical Officer for Health in Sutton included:

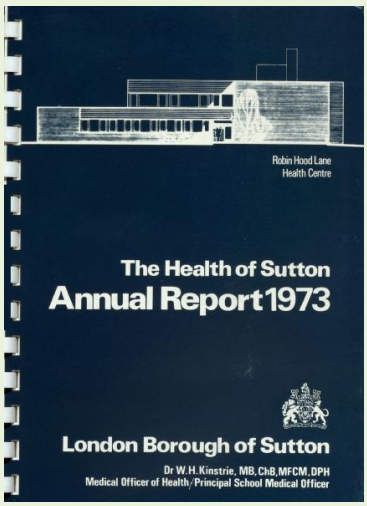
- General Public Health Services, including epidemiological information on vital statistics, mortality, births and disease data
- Personal Health Services – maternal and child care, and child health
- Public Health Nursing and Allied Services, i.e. Home Nursing, Midwifery, Health Visiting, Prevention of Illness, Care and After-Care
- Environmental health – to include services under the Public Health Acts (water , sewerage), services under the Food and Drugs Act, Housing Act and others, e.g. clean air, noise abatement and burial
- School Health Services

Today the Director of Public Health's responsibilities include:[8]

- Leadership, expertise and advice on a wide range of issues, from disease outbreaks and emergency preparedness through to improving local people's health and concerns around access to health services
- Improving the population's health by understanding the factors that determine health, working with appropriate local authority and NHS colleagues such as the Directors of Children's services and Adult Social Services
- Ensuring effective plans are in place to protect the local population from risks to public health
- Working with appropriate partners to promote safer communities
- Working to engage local partners in fostering improved health and wellbeing
- Being an active member of the Health and Wellbeing Board, advising on and contributing to the development of Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies and commissioning services appropriately
- Taking responsibility for the management of the authority's Public Health services, with professional responsibility and accountability for their effectiveness, availability and value for money
- Playing a full part in the authority's action to meet the needs of vulnerable children
- Contributing to and influencing the work of NHS commissioners to ensure a whole system approach across the public sector

[8] Department of Health, Directors of Public Health in Local Government - Roles, responsibilities and context, October 2012. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213007/DsPH-in-local-government-i-roles-and-responsibilities.pdf

How has the health of the population changed over time in Sutton? A comparison between key statistics as reported in the Public Health Annual Report of 1973 and now[9]



In 1973: our population was 168,200 people compared to 191,123 in 2011 as at the last census, so a 14% increase in the number of people living Sutton over this time.

There were 2,076 live births compared to 2,756 in 2011, so a 33% increase in live births.

There were 43 deaths to children aged under one year old. This represented an infant mortality rate of 21 per 1,000 live births, a little higher than the national rate. Now, this has fallen dramatically with just 2.3 infant deaths per 1,000 live births in 2009-11.

There were 2,106 deaths from all causes, a rate of 12.5 deaths per 1,000 people. In 2011 there were 1,371 deaths, a rate of 7.2 deaths per 1,000 people. However, the same diseases still represent the major killers. Heart disease, cancer and cerebrovascular disease were the main causes of death.

Measles was by far the most commonly notified infectious disease (387 cases) compared to a total of 19 cases in 2011 including both suspected and laboratory confirmed cases.

It is interesting to see that at this time the Annual Public Health Report provided a detailed list of all food complaints recorded during the year. In 1973 these included:

- A pint bottle of milk delivered to a school containing a drinking straw
- A one inch rusty bolt found in a wrapped loaf of bread
- A caterpillar found in a can of tomatoes
- A wheatmeal loaf containing an earwig

It was reported that the conversion of Shotfield Clinic into a Health Centre and the building of Roundshaw Health Centre commenced with both centres expected to open in the following year.

In summary, since 1973 both the population and the birth rate has grown whilst the rate of deaths overall has fallen. However, many of the causes of death and illness remain similar.

[9] London Borough of Sutton. The Health of Sutton, Annual Report 1973.

List of Directors of Public Health, and Medical Officers of Health, in Sutton

Organisation	DPH/Medical Officer of Health	Dates
London Borough of Sutton	Dr. Nicola Lang	June 2014 to present
	Dr. Ellis Friedman	April 2013 - May 2014
Sutton and Merton PCT	Dr. Valerie Day (Interim)	2012 - March 2013
	Dr. Jacqueline Lindo (Acting)	2008 - 2012
	Dr. Maggie Harding	2002 - 2008
Merton, Sutton and Wandsworth Health Authority	Dr. Yvonne Doyle	1999 - 2002
	Dr. Salman Rawaf	1998 - 1999
	Dr. Penny Bevan	1996 - 1998
	Dr. Hilary Stirland	1994 - 1996
Merton and Sutton Health Authority	Dr. Salman Rawaf	1988 - 1994
1980s to 1994	Dr Mary Spence	1982 – 1987/88?
London Borough of Sutton	?	1974 - 1982
1965 through to early 1980s	Dr. W. H. Kinstrie	1970 - 1973
	Dr. P. Westcombe	1965 - 1969

Summary

In common with elsewhere in England, in the past Sutton's main Public Health issues have been the supply of clean water, sewage disposal and the threat of infectious diseases. Much of these problems were exacerbated by the pressure to provide good health, housing and environmental standards at the same time that massive increases in the population occurred. In this chapter we have seen how Sutton has benefitted from a supply of clean water, filtered and pumped from deep sources in chalk soil. Housing is generally of a high standard notwithstanding that there have been some problems in modern buildings such as damp. Sutton has benefitted from a range of prestigious acute services located within the borough and from well-developed primary care services that are able to meet the needs of the population. Today, Public Health in Sutton is focused on improving and protecting the population's health. This includes the prevention of morbidity and mortality in the population through avoidable lifestyle risk factors and environmental hazards and through the planning of appropriate services to address the population's needs. The pattern of disease has completely changed since the early 19th century - instead of the threat of epidemics such as TB and cholera, today's epidemics are more likely to be concerned with obesity and physical inactivity. As in the past, the link between poor health and wellbeing and deprivation and poverty remains and we must do all that we can to measure, monitor and address the scale of the problems and anticipate future trends. This will be our remit now that we have assumed our new position as fully part of the London Borough of Sutton - to improve and protect the health and wellbeing of the whole population both now and in the future.

Sources, Key Texts and Acknowledgements

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Wellcome Library resources

The Public Health team at the London Borough of Sutton

If you have any comments on this report, or if you have any information about Sutton's Public Health history that you would like to share, please contact:
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sylvia.godden@sutton.gov.uk

Appendix A: Chronology of key events: Public Health in Sutton and England

Year	National Events that impacted on Public Health	Year	Events in Sutton that impacted on Public Health
1833	First Factory Act - Protected child labour. Prohibited employment of children under 9 and limited hours worked by older children		
1834	Poor Law Amendment Act (New Poor Law) Responsibility for the poor passed from parishes to boards		
1842	Edwin Chadwick's Sanitary Report published		
1842	Mines and Collieries Act - Prohibited women and boys aged under ten years from working underground		
1847	Ten Hours Bill stipulated a 58 hour week for all women and young people 13-18 years old	**1847**	Opening of Croydon and Epsom Railway
1848	Public Health Act - First such Act in the world, shifted responsibility of the poor from local parishes to Poor Law Commission		
1848	The first Medical Officer of Health appointed in Liverpool		
		1852	Poor Law Guardians of 17 inner London parishes purchased land in Belmont to build schools for over 1,500 London children
1853	Smallpox vaccination made compulsory		
1854	Dr. John Snow linked cholera outbreaks to contaminated water		
1858-59	The Great Stink - from the waste polluted Thames	**1863**	Sutton and Cheam Water Company formed
1864 & 1867	Factory Acts – Limited the statutory working day for women and young persons from 6am to 6pm, with one and a half hours for meals. Extended to many other industries.	**1867**	Second rail link via Epsom and Peckham
1870	Foster's Education Act established universal and compulsory education for children aged 5-13 years		
1871	Trade Union Act provided for the registration of trade unions	**1871**	Sutton and Cheam Water Co. became Sutton and District Water Co.
1875	Second Public Health Act - established a national minimum standard of hygiene, created Sanitary Districts and Medical Officers of Health for all areas		

Year	National Events that impacted on Public Health	Year	Events in Sutton that impacted on Public Health
		1881	Banstead Asylum built
		1883	Formal start of local government in Sutton with the formation of Local Boards in Sutton and Carshalton
			Regular refuse collection began
			Sutton opened its first mortuary at the churchyard of St. Nicholas
			Sutton's own Board of Health established
1890	Infectious Disease (Prevention) Act, more detail about disinfection of infected premises		
		1894	Sutton Sewage Works started operations
		1901	Smallpox hospital built (became Cheam Hospital)
1906	The Education Act - supplied food to children in need		
1908	Introduction of the first non-contributory old age pension by Lloyd George		
1908	The Borstal system for child offenders so that no-one under 14 years could be imprisoned		
		1909	The Children's Infirmary opened – later became Queen Mary's Hospital, Carshalton
1911	The first national scheme of health insurance - supported by compulsory contributions from employers and employees to provide domiciliary medical care for very low paid employees (but not their families)		
1929	Local Government Act - Act transferred the Poor Law to large local authorities under the control of the Medical Officer for Health	**1928-36**	Construction of St Helier Estate
		1931	New Sutton Hospital opened
		1941	First patients admitted to St. Helier Hospital
1942	The wartime Beveridge Report on the founding of the welfare state		
1945	The Family Allowances Act provided cash allowances to the second and subsequent child		
1946	The National Insurance Act provided for insurance against accidents, injuries and diseases due to a person's employment		

Year	National Events that impacted on Public Health	Year	Events in Sutton that impacted on Public Health
1946	The National Health Service Act (England and Wales) created a comprehensive health service available to all		
1948	Inception of the National Health Service, 5th July		
1948	National Assistance Act dismantled the Poor Law. Local authorities assumed responsibility for the elderly, handicapped and homeless, and established a national scheme of financial assistance to those in need		
1956	Clean Air Act passed to reduce atmospheric pollution following the London Smog of December 1952		
1959	The Mental Health Act to prevent the long term hospitalisation of patients by extending services in the community		
		1965	London Borough of Sutton formed from merger of Municipal Borough of Sutton and Cheam, Municipal Borough of Beddington and Wallington, and Carshalton Urban District, previously in Surrey
1967	The Abortion Act introduced legal abortion in the UK		
1968	Seebohm Report recommended that Medical Officers of Health transformed into community physicians, and the separation of social work and medicine		
1970	Local Authority Social Services Act produced a unified social service for the elderly, disabled, homeless and mentally disordered		
1971	Education of learning disabled children transferred from health to education departments enabling integration into the normal education system		
1972	Hunters' management arrangements for the reorganised NHS		
1974	NHS reorganisation - Local Health Authorities transferred to NHS	**1974**	The last year Public Health based within the Borough of Sutton
1980	Black Report highlighted persisting social inequalities in mortality/morbidity in Britain		

Year	National Events that impacted on Public Health	Year	Events in Sutton that impacted on Public Health
1982	NHS restructure, areas abolished	**1982**	Merton and Sutton Health Authority created
1990	NHS and Community Care Act – introduction of internal market		
1991	Implementation of NHS reforms - Internal market - purchaser provider split /GP fundholding		
		1994	Merton, Sutton and Wandsworth Health Authority replaced Merton and Sutton Health Authority
1998	Independent Inquiry into Inequalities in Health Report, chaired by Sir Donald Acheson		
1999	The Health Act - creation of Primary Care Groups (PCGs) to take on much of the previous role of health authorities		
2001	Shifting the Balance of Power - Public Health Practitioners transferred from health authorities to Primary Care Trusts (which superseded PCGs)		
		2002	Public Health function for Sutton delivered through the establishment of Sutton and Merton Primary Care Trust (after closure of Merton, Sutton and Wandsworth Health Authority)
2007	Smoking ban implemented in England, July		
2010	Fair Society, Healthy Lives, Marmot report, February concluded that reducing health inequalities would require action on six policy objectives that covered the entire life course		
2010	Equity and Excellence: Liberating the NHS, White Paper, July – announced, unprecedented NHS reorganisation		
2011	Health and Social Care Bill introduced in House of Commons, January, to encapsulate the themes of the White Paper in law		
2013	1st April full implementation of the Health and Social Care Act, 2012 which had received Royal Assent in March 2012 • Abolition of Strategic Health Authorities, PCTs • Major part of the commissioning budget transferred to CCGs	**2013**	Public Health Department established in London Borough of Sutton, having transferred from Sutton and Merton Primary Care Trust which closed at end of March

Year	National Events that impacted on Public Health	Year	Events in Sutton that impacted on Public Health
	• Local Public Health transferred from NHS to Local Authorities • Establishment of new Local Authority Health and Wellbeing Boards • Establishment of Public Health England • Establishment of NHS England		

Appendix B: The development of Primary Care over the last thirty years - a perspective from one Sutton GP

Out of Hours Care (OOHs)
There have been great changes in Out of Hours (OOHs) Care. Up until around 1997 Southern Relief Services used to offer OOHs care from around 10pm-7am, seven days a week. The rest of the time practitioners would share shifts based on for example a 'one in four' system, from 7am-10pm, and the same at weekends. This offered consistency of care throughout the area. One GP could access the notes of another GP's patients and inform that GP about developments.

Now, as well as Out of Hours, there are Extended Hours – commuter surgeries starting at around 7.20am, plus some surgeries opening on a Saturday morning, and some remaining open up until 8pm.

Immunisations
The approach towards the immunisation of patients in Sutton has changed over the years. Whilst in the past a GP would strive to get immunisations done, if the patient refused, then this was accepted. Now more concerted attempts are made to immunise the population. Previously fewer immunisations were recommended (for example flu was not offered). There was less controversy surrounding immunisations (pre. the Wakefield MMR scare), and so good uptake. Also, the relationship between doctor and patient was different in the past, with patients having become more informed and empowered over time, particularly due to the wealth of clinical information that can be accessed through the internet. There was also less of a focus on records kept about immunisations rather than just making sure they were done.

Quality and Outcomes Framework - QOF
QOF is concerned with payments, incentives and targets for a range of diseases. There are certain criteria to meet, e.g. in the treatment and control of diabetes. This approach is welcome and contributes to a systematic approach to care. QOF targets tend to be around 90%. However, there is a concern about the small percentage missing and that once having hit the target there is no incentive to go further. It is helpful to have an awareness of the risk factors for various population groups, for example recognising that an Asian patient has a higher risk of CHD and diabetes.

Referrals
Nowadays, comparative data on GP referrals to hospital is useful, but there may be questions about interpretation. For example, if a GP is over-referring, does that infer that there is not the skill set to deal with a certain condition in primary care, or is referral to secondary care highly appropriate, begging questions about those practices not doing so? There is a risk that if you try to dissuade or delay GPs from referring, diagnoses may be missed and treatment delayed.

The main cost of referral is that of the hospital visit and subsequent clinics. Referrals do not necessarily have to be to secondary care, but for example could be to a General Practitioner locally with a special interest (e.g. gynaecology).

Quality of GP services, appraisal
The quality of GP services is now rigorously monitored, mainly due to systematic appraisal and better education programmes and Continuing Professional Development (CPD). Whilst this still could not guarantee protecting from 'Shipman' in all circumstances, questions are now raised at an earlier stage. Annual appraisal processes with certified appraisers enable a discussion about how work is done. There is also a requirement for validation every five years and formal training. All of this serves to improve quality and patient safety.

Compared to the past, today nurses undertake a lot of work that would have previously been undertaken by a GP, for example for patients with asthma and COPD. However, it is important that GPs maintain their own complete skill set up so that they can always deputise for others in their practice if required.

Clinical and adult safeguarding
This takes a far higher profile than in the past and has improved significantly with proper processes now in place. There is much closer communication with the Local Authority and some funds are shared. Agencies today have to talk to each other, and consequently awareness and processes are much better.

Learning Disabilities
Likewise, there is a much better awareness of the vulnerability of patients with Learning Disabilities. People and their carers are registered and have a proper care plan, and are made aware of their entitlements.

Older people
Care of older people is now much more systematic, particularly in nursing homes. Also, dementia is better recognised in secondary care for older patients. Carers are identified and treated with understanding. There are support organisations in place, such as Sutton Carers Centre. Services such as respite are available. Older people are entitled to a general assessment and there is more that can be offered than in the past, particularly to support people to stay in their own homes.

Relationships
The relationship with the patient is based on confidence, trust and an understanding that the patient comes first. This is supported by the increase in consultation time over the years from 5 to 10 minutes.

Housing
There is a much greater awareness of the importance of a patient's housing. Priority for housing those who are the most vulnerable is more systematic than it was, and as for older people, the aim is to keep people independent.

Practice versus single handed
There are pros and cons for the changes that have taken place over time, for example in the past when there were more single handed practices the doctor would know the whole family and patients would always see the same person. Now the trend is towards larger practices, and patients may seldom see the same person. In light of this, a good approach is to develop a 'small practice mentality' in a group practice.

Premises
There have been huge improvements in GP practice premises. Today these tend to be custom built, whereas in the past surgeries might be located in a converted shop or a semi-detached house. By today's standards this does not look professional. Patients have come to expect premises that are clean and modern, with spaces appropriate for the purpose of general practice.

Locum, salaried or partner
Traditionally most GPs are independent contractors and are self-employed, and contract their services to the NHS. Now there are a range of arrangements and there has been an increase in the number of salaried GPs who do not profit share. Practices may also have temporary locum GPs filling some of their places. The challenge is to fully involve and engage GPs who may be 'in and out' of the practice. A good feature about the flexibility of arrangements is that over time this has encouraged more women into the profession, who can benefit from part-time arrangements and flexible hours. This is very good for patients who may like to have the choice of being seen by a woman.

Patient participation groups
These used to be few and far between but now there is lay participation on many committees to represent patients' opinions and influence local health policy.

Computers
A big development has been that of keeping records electronically. This makes it possible to get complete information more quickly through the GP record system. A downside might be that the patient may not welcome appointments where the doctor is spending a lot of time typing things into the computer.

Local Authority/Social Care integration
Today there is closer contact with social care in the Local Authority and more representation at the key committees.

Primary/Secondary Care
The relationship has changed between primary and secondary care and in the past there was a perception of 'us' and 'them'. Now there is a culture of much more scrutiny and it is possible to check that all are fulfilling their obligations, with patients at the centre.

Patient's choices
Despite that much is made of 'patient choice', in reality patients are less concerned with choice, but just want to be assured that they will receive the best quality clinical care locally and be seen quickly. There has been a concerted effort to reduced waiting times, whilst patients in the past sometimes waited many months for treatment.

Budgets
Today there is much more of a focus on budgets and cost effective approaches. Whereas in the past GPs might have completed a session on prescribing just once a year, now pharmacists scrutinise how GPs prescribe, and GPs are informed by robust data on the safety and quality of drugs and cost effectiveness of drugs prescribed. NICE (National Institute for Health and Care Excellence) informs prescribing decisions.

Prevention and lifestyle
Today there is a much stronger focus on making improvements to lifestyles to prevent chronic disease. There is support from programmes such as Stop Smoking services, QIPP initiatives, Live Well and NHS Health Checks.

However, GPs need to take a realistic approach according to the knowledge they have of their patients. For example exercise - rather than daunt patients by insisting that they undertake 30 minutes exercise five days a week, let the doctor judge whether to advise for 20 minutes three times a week to start off with, which is still beneficial.

Role models in the school educational system are particularly valuable. Again the approach should be holistic, putting the patient at the centre.

Initiatives and changes in Sutton
Some years ago there was a Sutton initiative aimed at educating people to access care more appropriately than through A&E which was receiving 30% inappropriate attendances. This approach is particularly valuable for migrants to Sutton. Awareness was raised about the Urgent Care Centre and there were efforts to signpost people to the right place, and provide information.

One service that has made a big difference to the care of patients is the IAPT service (Improving Access to Psychological Therapies). This NHS programme is being rolled out across England. It offers interventions approved by NICE for treating people with depression and anxiety disorders. This often avoids the need to be referred to a psychiatrist. IAPT has reduced time off work for people affected and helps them get back.

Also the Drug and Alcohol Team are receptive and provide practical and structured help programmes.

Looking to the future, a focus on intense education and sustained programmes is the key to change, though in reality it needs to be acknowledged that this could take two or three decades, e.g. it took this long to significantly affect the numbers who smoked despite overwhelming evidence of its harmful effects.