

# health in southampton 2005





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# **Southampton City Primary Care Trust**

## **Health in Southampton 2005**

Report of the Public Health Director

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## Health in Southampton 2004

The following topics made up the 2004 public health report:

- Locality Health Profiles
- Alcohol
- Environmental Tobacco Smoke
- Later Years health and Well-being
- Sexual Health and HIV
- Obesity

These are available on the Southampton City PCT web site (<http://www.southamptonhealth.nhs.uk/publichealth/phar/2004>) and together with the chapters in this report, give much of the background to the local health priorities listed on page 5.

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# *Health in Southampton 2005*

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## **Introduction**

The health of Southampton people continues to improve, but there are still many who are missing out.

Efforts to improve health across the City are focussing on a range of issues that are now set out in our *Health and Well-being Strategy*<sup>1</sup>. Last year's annual report looked at health issues that are affected by the choices we make – our life styles. This year we are highlighting a further set of challenges that we are working on, and that could make a real difference to health in our City.

Giving all our children the best possible start in life is probably the most important priority if we want to reduce health inequalities<sup>2</sup>. This has been recognised at national and local level, and much has been done to support parents and families across the City. It is encouraging to see the difference that is being made, through initiatives such as Sure Start and family support services – but there is much still to do.

The dental health of children remains a continuing cause for concern - children living in less affluent areas have much higher levels of dental decay than those in the rest of the City. Dental health promotion work in these areas is being stepped up, but the option of water fluoridation needs to be further explored.

We value our independence. People with ill health and long-term conditions need care and support - there are ways of providing this and avoiding inappropriate and unwanted dependency. This will be a key area of work across the City in the years ahead, and we have begun to explore the implications for some of the most frequent causes of ill health.

Housing affects health in many ways. Overcrowding, poor ventilation, damp and lack of adequate heating are recognised to lead to more respiratory and other illnesses. There is considerable pressure on housing in Southampton, and it is important that we ensure 'decent homes' standards are met and provide for the housing needs of our more vulnerable citizens.

Other reports this year look at the health of disadvantaged groups, a priority within the *Health and Well-being Strategy*, and at the impact of communicable disease.

The final section sets out some key health facts and trends for the City. More detailed analyses are available in another key report – *Local Health Comparisons 2005*, which is available on-line.<sup>3</sup>

Dr Andrew Mortimore  
Public Health Director  
December 2005

E-mail: [public.health@scpct.nhs.uk](mailto:public.health@scpct.nhs.uk)  
Web site: [www.southamptonhealth.nhs.uk/publichealth](http://www.southamptonhealth.nhs.uk/publichealth)  
Postal Address: Public Health Team  
Oatlands House  
Winchester Road  
Southampton SO15 5NB

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## Acknowledgments

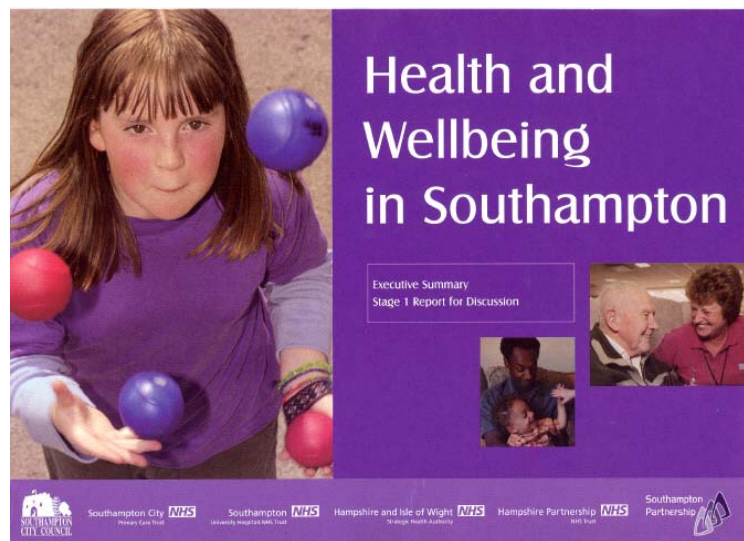
Special thanks are due to Dr Peter Davidson who has edited this year's Annual Report, and to 'guest' authors – Liz Taylor (Best Start in Life) and Dave Shields (Housing and Health).

## Public Health Team:

Sallie Bacon, Alison Coulter, Neil Dacombe, Parvin Damani, Peter Davidson, Jennifer Davies, Sarah Denny, Ayo Eni-olotu, Joanne Fryer, Margaret Hanson, Sylvia Hendy, Susan Hird, Wendy Hislop, Lynn Hoggarth, Nicola Holttum, Leah Homer, Emma Knight, Celia Palmer, Laura Rothery (and the *City Quitters* team), Stella Saunders, Lucy Silk, Thabang Thacker, Glenn Turner, Rebecca Wilkinson.



## Key priorities for local action



Ten key Priority Action Plans are being developed and delivered by the City's Health and Social Well-being Partnership, grouped into three broad programmes:

- Tackling Health and Social Inequality
  - Action in Priority Neighbourhoods
  - Addressing the needs of Black and Minority Ethnic Communities
- Promoting Independence and Choice
  - Meeting Long Term Care Needs
  - Ensuring Better Access to Health and Social Care
- Choosing Health
  - Tackling Obesity
  - Mental Health Promotion
  - Sexual Health and Teenage Pregnancy
  - Dental Health
  - Alcohol Harm Reduction
  - Smoke-free City



## Summary

This report is made up of the following chapters

### **Best start in life**

Local measures are in place to deliver the national policy *Every Child Matters*. Plans and programmes will help children to be healthy, safe, happy and successful, economically comfortable, and make a positive contribution.

The Sure Start approach appears to be having benefits including:

- Fewer babies born too small
- Possibly more babies being breast-fed
- Raising awareness of accidents
- Helping employment

The recommendations in this chapter include action to tackle obesity in children, improve mental health and use existing experience to develop the new health trainers in the wider community.

### **Dental health**

Southampton children have poor dental health compared to Hampshire and England. Dental decay is commoner in more deprived communities, nationally, and locally. Action is taking place to implement the national strategy, *Choosing Better Oral Health*, as one of the work-streams of the health and well-being strategy. Efforts are concentrating on the parts of the city with poorest dental health, identified by high rates of decay at school entry. We are targeting children in the catchments of the five schools with the worst dental health. Water fluoridation has been shown to be effective at reducing dental health inequalities elsewhere, and should be explored further as an option for Southampton.

The recommendations here include the continuation of this work with disadvantaged communities, partnership working to tackle risk factors common to other health problems, and undertaking a feasibility study and consultation on the fluoridisation of drinking water.

### **Health and housing**

Poor housing, especially when cold and damp, is linked to poor health. Southampton has ongoing problems with its housing. The City's housing strategy aims to improve the supply of affordable homes, improve the condition of housing, reduce homelessness and tackle fuel poverty. Links between housing policy and the work with older people is important.

The recommendations on housing and health include multi-agency support for the City's housing strategy, targeting decent homes and fuel poverty in the Local Area Agreement, linking housing action to the Later Years Partnership, and action on housing by the NHS for its employees.

### **Independence and well-being of older people**

People are living longer than previously, but Southampton people are dying earlier on average than England as a whole. Work to tackle ill health and premature death in the elderly includes action on fuel poverty, improved care for people with long-term conditions, falls prevention and improved care for people with hip fractures.

Recommendations to improve independence in older people include action on fuel poverty, disease prevention and health promotion in people at high risk, interventions to prevent fractures and improved treatment of people with fractured hips.

### **Poverty and disadvantage**

People from unskilled or unemployed families have much worse health than professional people. Southampton has an unemployment rate of just below the national average, but incomes are significantly lower. Poorer people are concentrated in parts of the city, the 'priority neighbourhoods'. Action to tackle this disadvantage is through the Health and Well-being Strategy, where improved health will lead to improved opportunities for work, and the Neighbourhood Renewal Strategy which will improve quality of life, educational attainment and neighbourhood management.

The recommendations on poverty include partnership by the PCT to implement the Neighbourhood Renewal Strategy, improving health to improve opportunities for employment, and increasing aspiration and educational attainment in the young.

### **Communicable disease control**

The Health Protection Team continues to monitor and control infectious disease. Two infections have become more common. Mumps has resurfaced in young adults and is being tackled through an immunisation campaign. Measles is very rare due to the success of vaccination. Tuberculosis (TB) is being seen more frequently. The rise in TB is particularly in people born abroad. Plans are being drawn up to tackle all aspects of prevention and treatment. The immunisation programme has been changed to target vulnerable children early in life.

The recommendations here include continuing to immunise older teenagers for mumps, maintaining high coverage of measles vaccination and implementing the TB action plan.

### **Public health indicators**

This section summarises the health statistics on the people of Southampton. Further information can be found in the document *Local Comparisons 2005*. (<http://www.southamptonhealth.nhs.uk/publichealth/lhc2005>)

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# Health in Southampton 2005

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## Best Start in Life

### Introduction

The health and well-being of children is influenced by national and local policies.

#### National policy

In *Every Child Matters: Change for Children*<sup>1</sup> the Government set out its national framework for local change programmes to build services around the needs of children and young people to maximise opportunity and minimise risk. This summarized a series of previous publications<sup>2,3</sup> and the legislation in the Children Act 2004. In the NHS, the relevant guidance included the National Service Framework (NSF) for Children, Young People and Maternity Services<sup>4</sup> and *Choosing Health*, the public health white paper.<sup>5</sup>

*Every Child Matters* emphasises partnership working between agencies working towards enabling children to:

- Be Healthy
- Stay Safe
- Enjoy and Achieve
- Make a Positive Contribution
- Achieve Economic Well-Being

There are performance targets in each of these areas.

#### Local context

The Southampton Children and Young People's Strategic Partnership has refined the following national priorities for local development:

- Raising attainment
- Improving emotional well-being, behaviour and attendance
- Increasing the percentage of 16-18 year olds in education, employment and training
- Improving health and the take up of healthy lifestyles
- Improving sexual health and support for relationships
- Improving support for parents and families
- Developing better local provision for children with complex needs
- Involving children and young people in planning and developing services

*Every Child Matters: Change for Children* is based on successful partnership working. The local groups implementing Sure Start are such local partnerships, based in communities with some of the poorest health.

Sure Start is a Government programme which aims to achieve better outcomes for children, parents and communities by:

- Increasing the availability of childcare for all children
- Improving health and emotional development for young children
- Supporting parents as parents and in their aspirations towards employment

Southampton City Council is accountable for three local Sure Start programmes but they are managed through a multi agency Reference Group that reports to the Early Years and Development Childcare Partnership. The Reference Group has representatives of Southampton City Primary Care Trust (SCPCT) and other statutory, voluntary and private bodies.

The Sure Start local programmes work with children and their families from conception to five years old. This chapter describes the achievements made possible through the Sure Start's community development approach to public health. There are strong multi-agency partnerships, and parents help plan, deliver and evaluate services.

## The Sure Start approach

### Low birth weights

The first local Sure Start programme (for children under four and their families at first) started in Weston in 2000. Two more programmes have been added. Each programme links with maternity services, leading to midwifery teams that provide full care to mothers from conception to up to six weeks after birth. Maternity services are more accessible and link parents to other support services at the earliest stages of their parenthood. This new way of working has led to some real improvements in reducing the number of women who require medical intervention during delivery, increasing the number of home births and in reducing the number of children born with a birth weight of less than 2.5 kg. The data are shown below.

Area	Year			
	2000/01	2002/03	2003/04	2004/05
Weston Sure Start area	13%	8%	6%	6%
Central Sure Start area	N/A	15%	10%	8%
Millbrook Redbridge and Maybush Sure Start area	N/A	11%	10%	6%
The 11 Priority Neighbourhoods (including Sure Start areas)	N/A	N/A	8%	7%
Southampton City	N/A	N/A	7%	6%

### Breastfeeding

The benefits of breastfeeding are well documented. Of particular significance to the current public health agenda is the fact that successful breastfeeding appears to reduce the risk of developing obesity. Compared to children from the same economic background who are bottle fed, breast fed babies are:

- Half as likely to develop childhood diabetes
- Five time less likely to have a urinary infection

- Two time less likely to have an ear infection
  - Five times less likely to be in hospital for gastro-enteritis
  - Half as likely to be in hospital with a chest infection
- (Source: World Health Organisation (WHO) Baby Friendly Initiative)

The partnerships within the Sure Start areas appear to have led to more women breastfeeding their babies.

Percentage of women who initiate breast feeding				
Area	Year			
	2001/02	2002/03	2003/04	2004/05
Weston Sure Start area	25%	19%	57%	53%
Central Sure Start area	48%	56%	70%	70%
Millbrook Redbridge and Maybush Sure Start area	N/A	N/A	57%	50%
Priority Neighbourhoods (including Sure Start areas)	N/A	N/A	68%	64%
Southampton City	N/A	N/A	70%	71%

The initial improvements were particularly impressive but the rates for 2004/05 were not as good as was hoped. The reasons are complex and have not been fully explored. They may relate to a change of emphasis from just improving initiation, to increasing the duration of breastfeeding, in line with WHO guidelines.

A part time midwife has been appointed to draw together a citywide breastfeeding action plan to improve rates across the city especially the priority neighbourhoods. The post is supported by the Local Public Service Agreement for Health Inequalities and the Neighbourhood Renewal Fund and is funded from April 2005 to March 2006. Plans will incorporate recommendations from an independent evaluation of the local Sure Start breastfeeding support programme.

Results from the first two quarters of 2005/06 do suggest an improvement, particularly in areas where support groups and other initiatives are being piloted.

A major part of the plan is to develop a citywide network of breastfeeding support groups from the pilot projects at the Princess Anne Hospital and at Weston. These new peer-led groups will be located within priority neighbourhoods and will offer practical advice and support to parents who are breastfeeding. The groups may change local attitudes and knowledge of breastfeeding and so contribute towards improving the life chances of children within the priority neighbourhoods.

The results from a pilot in Weston are interesting. They show a fall of initiation and breast feeding at 11 days, but a better rate of sustained breast feeding. In fact the rate at six weeks has almost doubled. The results are for the Weston Sure Start area only and involve a small number so it is too early to draw major conclusions. It is hoped that further data over the next two years will show how far groups like the one in Weston are helping mothers to maintain breastfeeding for the first six months of a child's life in line with the WHO recommendations.

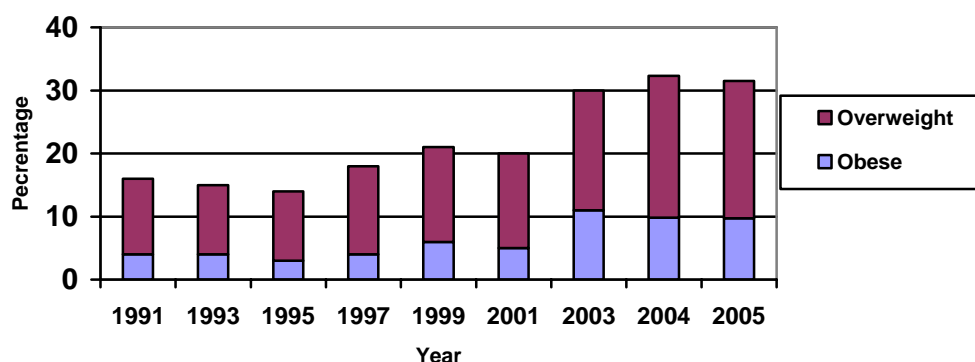
Percentage of women breast feeding for different durations in the Weston Sure Start area

Year	Duration of feeding		
	Initiation	11 days	6 weeks
2003/04	57%	38%	15%
2004/05	53%	30%	29%

### Childhood obesity, healthy eating and play

Nationally there is huge concern about obesity and the increase in associated problems such as diabetes, heart disease and reduced self-esteem. This concern is justified by local data from children. The records for Southampton at school entry (age 4-6 years), as part of the Wessex Growth Study, show that children are becoming heavier. The proportion of overweight children increased from 11% to 15% and obese children from 4% to 5% over the 10 year period 1991-2001.

Percentage of Children Overweight and Obese



The data suggest that in Southampton 721 children at school entry are overweight and 240 obese. In total, approximately 9,000 children and young people under the age of 16 are overweight and 5,500 are obese.

Reducing childhood obesity is now a priority for Southampton, with the challenge of meeting the national target of halting the year on year rise by 2010. It is being included as a major theme in the Children and Young People's Plan and the Health and Well-being Strategy. The Sure Start programmes have developed strategies to promote health eating and physical exercise especially through outdoor play.

Many of the ideas are popular and could be adopted by other agencies and partnerships. Promoting healthy eating includes provision of healthy snacks and drinks at all events and activities. This has also allowed children and their parents to be introduced to new foods including traditional snacks from different cultures. Families have been invited to try out new foods at community picnics. Cooking classes have been provided, and in Weston a monthly luncheon club has been set up to model family meal times around a table.

Promotion of outdoor play is important. Many children live in flats and tower blocks without a garden. Each of the Sure Start programmes has worked with the City Council to improve play areas. Gardens have been designed as part of the Sure Start bases at Pickles Coppice in Millbrook, and in Weston.



Play was also recognised as part of the “Sure Start Mainstreaming Pilot” in SCPCT from 2002 to 2004. As a result of this the Family Point programme has been developed. This is a partnership between play, health and other agencies in providing weekly events in priority neighbourhoods without Sure Start. They are well received and have been used in the City’s plans for children’s centres.

Play helps children’s physical, emotional, social and intellectual health. As well as Sure Start, organisations such as Community Play Link (who support toy libraries and parent and toddler groups), NCH (the children’s charity) and Southampton Voluntary Services (SVS) Family Projects are all involved in giving children and their families the opportunity to play.

### **Accidents and harm**

Accident prevention may not have had the priority it deserves. Many accidents happen in the home and much can be done to improve the safety of children in this environment. Work has been happening in Sure Start areas and also in Thornhill as part of the Thornhill Plus You (NDC) programme. This includes the safety gate scheme, partnership with the Hampshire Fire Brigade, and home safety checks to families with babies. It is too early to monitor any change in accidents in these areas, but the take up of the services has been encouraging. For example 90% of families in the Central Sure Start area now have a home safety visit by a family support worker when their child is four months. Weston Sure Start fitted 195 Safety Gates in 2004/05.

Domestic violence harms the health and well-being of children and young people. In 2004/05 Southampton police were called to 3,373 incidents of domestic disturbance. Children or young people were present at 1,746 of these. Domestic violence was a factor in 43 families with children on the child protection register. Eighty percent of all children referred to the Saucepans team for help with emotional and behavioural issues were living in families with domestic violence.

The Sure Start Mainstreaming Pilot was able to support a series of awareness raising events across the city for agencies in 2003/04. This work, undertaken with the Domestic Violence Forum, has been developed further and training on this issue has now been incorporated into the interagency child protection training programme. The Sure Start local programme in Millbrook, Redbridge and Maybush has worked in partnership with Women’s Aid to develop outreach work to families in the area. It has piloted a support group for women experiencing domestic violence and a therapeutic women’s group to enable women to look at the underlying issues in their lives many of whom have experience violence in the home.

### **Children with delayed development**

Sure Start local programmes have worked hard to develop a range of activities and resources for all families but have also considered how to better work with children who are showing early signs of developmental delay. This has led to a partnership with the city’s portage service co-ordinated with the health visiting teams. (Portage is a home-visiting educational service for pre-school children with additional support needs and their families.) Children with mild delay in language skills or any other developmental area have the support of a group backed up with home visits. This has worked well for those children who have been identified and has the support of parents, but is only available in Sure Start areas.

## **Reduction in poverty through employment**

Sure Start has helped to improve employment opportunities in several ways:

- Through the provision of childcare places, in partnership with other agencies
- Supporting parents into training and employment with Job Centre Plus
- Jobs such as the Family Support Workers for local people. These posts have provided both employment and a very valuable resource to support families. This model may be similar to the proposed health trainers

## **Other health promotion programmes**

Sure Start is one programme to improve the well-being and health of children. Other health programmes include:

- Saucepans teams, which help children, young people and their families experiencing emotional and behavioural difficulties
- Specialist community health care teams for children with complex health needs (such as respiratory support) looked after at home. These help children, who would otherwise be in hospital

## **Recommendations**

These recommendations reflect the priorities in *Every Child Matters*.

### **Be Healthy**

The PCT and City Council should ensure that there is effective coordination and additional resources to tackle obesity as planned in Southampton's Health & Well-being Strategy

### **Stay Safe**

Agencies should work better together to protect children and young people from domestic violence building on the work of the Children's and Adolescent Mental Health Service (CAMHS) Saucepans team

### **Enjoy and Achieve**

A strategy should be developed for early diagnosis and help for children whose development is delayed, especially in speech and language

### **Making a Positive Contribution**

Each children's service should involve its users in planning, implementation and evaluation of the service

### **Economic well-being**

Experience of introducing family support workers should be used in developing the role of the new health trainers

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## Related Document

The Southampton Children and Young People's Plan 2006 -2009 is available at <http://www.southamptonhealth.nhs.uk/publichealth/plans/cyp>

## **Dental Health**

### **Background**

A healthy mouth is an important part of general health and well-being. Good oral health enables individuals to communicate, enjoy food, socialise and contributes to quality of life and self esteem.

Despite significant improvements in recent decades, many people still suffer unnecessarily from pain and discomfort from dental diseases, which remain an important public health problem in the UK.

Most disease of the mouth is preventable. Many people now have good oral health but more vulnerable, disadvantaged and socially excluded people experience higher levels of oral disease.

### **Adult oral health in the UK**

National surveys of adult dental health are undertaken every ten years. Over the past thirty years there have been considerable improvements in oral health.

More adults are keeping their teeth for longer. In 1968, 37% of adults in England and Wales had no natural teeth. By 1998, this had fallen to 11%.<sup>1</sup> However, dental decay still affects a significant proportion of the population. As people are keeping their teeth for longer, many of these teeth have fillings that require maintenance and repair.

The most recent national survey in 1998 found that 54% of adults aged over 16 had signs of periodontal (gum) disease.<sup>1</sup> Gum disease is more common with increasing age; the most severe disease being found in people over 65. Periodontal disease can result in eventual tooth loss. Gum disease is more prevalent and more severe in smokers.

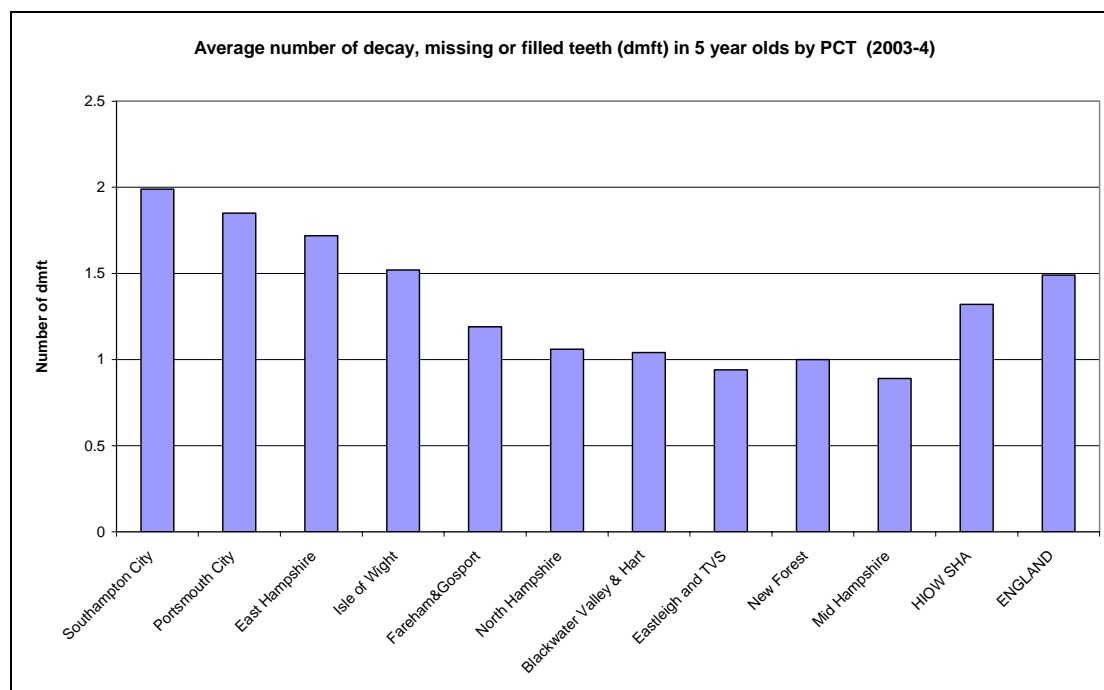
Mouth cancer accounts for 4% of all cancers in the UK. The five year survival rate for oral cancer in England is 50%. Oral cancer is more common in men (male to female ratio 1.6:1) and is usually diagnosed over the age of 40. The incidence is increasing, particularly in women. Smoking and excessive alcohol are the main risk factors for cancer of the mouth.

### **Child oral health in the UK**

Children's dental health has improved dramatically in the last thirty years.<sup>2</sup> National surveys showed that in 1973, 70% of five year olds had experience of dental decay. By 2003, this had fallen to 41%. In 1973, 93% of twelve year olds had experienced tooth decay, reduced to 38% by 2003. In all age groups the proportion of children with decayed, missing or filled teeth has reduced since 1973.

However, despite this overall improvement there remains a gap between the dental health of children in low and high socio-economic groups. The 2003 Child Dental Health Survey found children from the lowest social group to be 50% more likely to have decayed primary (milk) teeth than those from the highest group.<sup>2</sup>

## Oral health in Southampton



The regular national surveys of children's oral health show variation across the country. The most recent survey of children found dental health in Hampshire and the Isle of Wight to be slightly better than the England average.<sup>3,4</sup> However, dental health of Southampton five year olds was markedly worse than the rest Hampshire.

Children with dental disease and the percentage of diseased teeth treated				
	No of children examined	Average no of dmft*	Percent with no caries	Care index <sup>†</sup>
England	159,524	1.47	61%	13%
South	29,453	1.11	67%	16%
HIOW	15,733	1.14	68%	14%
Southampton	2,166	1.51	63%	11%

(Source 2002 dental survey of 5-year-olds)

\*dmft = decayed, missing and filled teeth

<sup>†</sup>Care index = Average percentage of dmft treated by filling.

Although during the past decade there has been some overall improvement in dental health, it remains poor in the most disadvantaged communities. There is evidence that the proportion of children affected by decay has increased in the most deprived areas of the city.

This is shown in the surveys of children in Sure Start schools in the table below. Five year old children who have decay have an average of four decayed, missing or filled teeth each.

Children with dental disease in Southampton Sure Start schools (arrows indicate the trend in 2003-4)

School	Average no of dmft		% caries free	
	2001-2	2003-4	2001-2	2003-4
Weston Shore Infants	2.08	2.35 ↑	53.8	57.7 ↑
Weston Park Infants	1.21	1.43 ↑	69.0	61.4 ↓
Holy Family	1.40	2.67 ↑	58.6	43.3 ↓
Mansel	2.14	2.58 ↑	43.2	42.9 ↓
Mason Moor	2.11	4.09 ↑	54.3	30.1 ↓
Newlands	2.42	2.91 ↑	42.2	37.5 ↓
Redbridge	1.81	1.95 ↑	61.9	45.4 ↓
Maytree	4.34	3.66 ↓	22.0	23.4 ↑
St Mary's	2.93	1.98 ↓	42.5	54.4 ↑
St John's	1.47	2.06 ↑	57.9	43.7 ↓

## Improving oral health; the national strategy

*Choosing Better Oral Health – an Oral Health Plan for England* (2005)<sup>5</sup>, draws on current evidence on the main causes and consequences of poor oral health and measures by which improvements can be made within an integrated PCT-led health promotion programme.

### Causes of poor oral health

The factors leading to poor oral health are also risk factors for a number of other diseases. They include:

- Diet high in sugary foods, including hidden sugars (food not expected to contain sugar)
- Inappropriate infant feeding practices
- Poor oral hygiene
- Dry mouth
- Smoking and other use of tobacco
- Excessive alcohol consumption

This emphasises the importance of including oral health in initiatives to promote health in general. *Choosing Better Oral Health* describes current national initiatives relating to oral health including:

- Brushing for Life schemes, distributing toothbrushes and fluoride toothpaste to parents of young children by health visitors
- Sure Start
- National school fruit scheme
- Five-a-day
- Neighbourhood renewal
- Healthy living centres

## Improving oral health in Southampton – what is happening

### Health improvement

Comprehensive surveys of child dental health in Southampton allow oral health promotion to be targeted towards communities with the poorest oral health. In addition to the national schemes, Southampton's *Health and Well-being Strategy*<sup>6</sup> aims to reduce the dental decay of 5 year olds by 20% by 2008 in the five schools with worst dental health. An oral health promotion team are working toward this with colleagues from health, education and the local authority.

Water fluoridation is effective in reducing dental health inequalities, by improving the health of the worst off.<sup>7</sup> Changes to legislation mean that water companies are obliged to increase the fluoride content of water when requested by the Strategic Health Authority (SHA). In response to worrying levels of dental disease, Southampton City PCT has approved the principle of water fluoridation. Following liaison with the City Council, the PCT has now written to the SHA asking that a cost and feasibility study be undertaken prior to local consultation.

### Access to NHS dentistry

People in Southampton have difficulty in getting NHS dentistry. The *care index* (see previous table) is a measure of dental treatment received in relation to need, and therefore an indicator of access to care. This is lowest in parts of Southampton where the prevalence and intensity of dental disease is at its highest.

The number of people receiving regular dental care in Southampton is not known. The Southampton Dental Helpline offers emergency dental care to unregistered people and offers advice on accessing NHS dentistry. The helpline receives in the region of 1,700 calls a month from people living in Southampton.

## Summary

- Tooth decay is closely related to social deprivation and inequalities in oral health still exist
- Dental health of five year old children is worse in Southampton than in the rest of Hampshire and the Isle of Wight

## Recommendations

Work should proceed with the feasibility study and consultation on the fluoridation of water

Promoting dental health should continue to be part of the integrated approach to health and well-being in the city. Partnership working to improve diet and reduce smoking and alcohol will benefit dental health as well as helping obesity, cancer and heart disease

Dental staff should actively provide smoking cessation services for their patients or refer to the Quitters service

The partnership work to promote the health of infants should continue to be targeted at the areas of greatest dental decay. Sure Start is the main programme to do this

Southampton City PCT should work towards equity of access in dental services as part of its delivery of dental services in the city

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# *Health in Southampton 2005*

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## **Health & Housing in Southampton**

### **Introduction**

There are over 96,000 homes in Southampton, of which 73,000 are owner-occupied or privately rented and around 18,000 owned and managed by the City Council. There are a further 6,000 homes managed by registered social landlords (e.g. housing associations).

### **Background**

In 1999 the Southampton Interagency Healthy City Group (a forerunner of today's Health & Well-being Action Group) aspired "to increase the provision of and access to dry, warm, well-designed, appropriate and secure quality homes within a well-equipped, safe and attractive environment"<sup>1</sup>

### **Housing and health**

Housing is linked to health, although the research does not prove cause and effect. The evidence<sup>2</sup> shows that:

- The highest risks to health in housing are attached to cold, damp and mouldy conditions, and illness increases with severity of dampness
- The strongest links appear to be between illness in children and dampness and mould. These include wheeze and other respiratory problems, aches and pains, nerves, diarrhoea, headaches and fever
- Cold temperature is linked to more deaths in winter
- Environmental tobacco smoke and carbon monoxide, are damaging to health
- Overcrowding and living in high rise flats is associated with psychological symptoms including depression, although people in this situation have other causes for these problems such as economic problems
- Anxiety and depression increase with the number of housing problems
- There is some evidence that housing form and location has an effect on health
- Natural radon in housing causes lung cancer although levels are not raised locally
- Lead water piping causes neurological problems in children

Research shows that associations between housing and health do exist, and supports the argument that good quality housing has a role to play in both physical and mental health.<sup>3</sup> Although it seems important to improve housing to improve health, the research casts doubt on the benefits. It suggests that:

- Housing improvements can improve residents' health, in particular their mental well-being

- Housing improvements can result in rent increases, which in turn can actually make people's health worse
- The original residents may move to another area and not benefit from the housing improvements; and
- Housing improvements can have negative as well as positive effects on health

### **Current issues in Southampton**

There are a number of challenges for housing-related health and well-being:

- Average household size continues to decrease as household composition changes
- Owner occupation is significantly below the national average and owner occupation is not an affordable option for many local households lacking the necessary levels of income
- There are unacceptable levels of homelessness and housing need (as reflected by the numbers on the housing register)
- There are a significant number of properties in need of essential repairs and energy efficiency measures
- There is a strong association between areas of the city with high levels of deprivation and low rates of home ownership
- Home accident rates are particularly marked in more deprived areas

### **Southampton's housing strategy**

The City Council's Housing Strategy<sup>4</sup> covers the period 2003-2007. It identifies a number of areas for improvement:

- To increase the supply of affordable homes, including homes for key workers, in order to go some way towards meeting the current shortfall of 1,400 units p.a.
- To improve the condition of the housing stock to ensure decent standards of accommodation across all tenures – ensuring all social housing properties in the city meet the Government's decent homes standard
- To tackle homelessness
- To contribute to neighbourhood renewal to close the gap between the most deprived neighbourhoods and the rest of the city
- To effectively address the support needs of vulnerable people by developing appropriate housing solutions for these groups
- To improve energy efficiency and tackle fuel poverty

Additional plans have been produced to accompany the housing strategy and these include strategies on homelessness, private sector housing and for key client groups such as older people or people with learning disabilities. To date there is no housing strategy for people with mental health problems. The lack of adequate social housing for people experiencing both mental health problems and misusing substances contributes to longer stays in hospital psychiatric wards.

### A housing strategy for older people<sup>5</sup>

Southampton's Strategy for Older People provides a framework for the future direction of housing solutions for older people. A review has been undertaken to (a) assess the optimum stock of sheltered accommodation (b) to develop retirement housing and (c) to extend the range and number of clients able to access support through dispersed alarms.

The strategy was presented and endorsed at the Later Years Partnership. The council has a vision for 'Extra Care' housing in the city, and also submitted a bid to develop a 'telecare' scheme that involves monitoring the health of frail people who otherwise live independently within the scheme

#### A housing strategy for learning disability<sup>6</sup>

Southampton Learning Disability Partnership Board has developed a housing strategy for people with learning disabilities in order to help people choose where they live with greater levels of independence.

#### **The regional dimension**

Southampton City Council is actively engaged in developing sub-regional networks to ensure that housing needs assessments are undertaken in a consistent manner. Policy is being developed within the context of local housing market extending beyond the city, for example in relation to choice, tackling rough sleeping, key worker accommodation and responding to high rates of teenage pregnancy. The South Hampshire Study published in 2003 identified a range of options for new land-use and transport strategies.

The newly established Partnership for Urban South Hampshire (PUSH) provides an opportunity to link the housing agenda to transport, economic development and spatial planning. There is also an important dimension here for health service planning and addressing the wider determinants of health.

#### Future challenges

More homes will be needed in the south east for future generations. The average size of households has fallen steadily as people live longer, marry later, leave the family home earlier and divorce more than in previous generations. These trends are likely to continue, therefore requiring more properties to house the same population. In Southampton this is likely to be accentuated by inward migration from other parts of the country, the European Union and further afield.

House prices in Hampshire have risen sharply in recent years and increasing numbers of people find it hard to afford a home of their own. Local employers in both the private and public sectors are having difficulties recruiting the staff they need, due to the high cost of housing.

#### House-building targets in South Hampshire

The South East Regional Assembly (SERA) has a house-building target for Hampshire of 6,100 each year from 2006 until 2026. The vast majority of these (4,000 per year or 80,000 new homes in all) are destined for the 'urban South Hampshire' area that includes Southampton.

Hampshire County Council and the Partnership for Urban South Hampshire estimate that 60% of all new housing will be built on brown field development sites in existing urban areas. This will be achieved through measures such as turning former industrial sites to housing use, redevelopment of existing poor quality low density housing and building homes above supermarkets and car parks.

## Homelessness

In 2002 the City Council carried out a review of its services and policies for homeless people. In the period 1999-2002, the City Council accepted over 7,500 households as homeless and in priority need. The rate has been steadily increasing from 375 in 1999 to 779 in 2002.

Families with one or more children make up almost two thirds of the homeless people total. In 1990 the City Council accepted 297 referrals and this had risen to 336 in 2002. Applications from people with mental health problems or other health problems have also increased over this period:

- Two cases were accepted on physical health grounds in 1990; by 2002 this had risen to 22
- No cases were accepted on mental health grounds in 1990; by 2002 this had risen to 69
- Three cases were accepted on grounds of domestic violence in 1990; by 2002 this had risen to 31

In January 2002 the Government extended priority need categories to include 16 and 17 years olds and relevant care leavers up to age 21. These, when added to increasing numbers of people accepted as asylum seekers, has placed additional pressure on the City's homelessness services.

### Supporting People

In 2005 the City Council's Supporting People project was selected by the Office of the Deputy Prime Minister to pilot new ways of working through the Value Improvement initiative. The aim of the Southampton project is to '... undertake an options appraisal of the provision of services for vulnerable homeless people, and to improve the commissioning, procurement and co-ordination of these services.'

A survey was commissioned in order to assess the profile of people accessing supported hostel accommodation during a snap shot period during June and July 2005. In all 128 people were interviewed. Some interesting findings have emerged:

- Sixty one people (44% of the sample) had an existing connection with Southampton
- Seventy people (51% of the sample) had no existing connection with Southampton, although 20 people (15% of the sample) were connected with either Hampshire, the Isle of Wight or Portsmouth
- Eighty one respondents (59% of the sample) had accessed provision in the past (only 24 of which were hostels outside of the City) with 38 of these having accessed more than one hostel
- Seventy two percent of hostel dwellers are male
- Forty percent of the women accessing hostels were aged under 19
- The vast majority of male hostel dwellers (97%) described themselves as white whereas only 70% of female hostel dwellers did so; 1 in 5 female hostel dwellers are either black, Indian or of mixed race

The Supporting People project team makes three recommendations for Southampton and its neighbouring local authorities:

- To make arrangements to enable more local homeless people to access provision in their home area
- To explore development of a more equitable funding system
- To assume greater responsibility for owning local move-on accommodation or to fund such services if provided in another area

It is important that new arrangements do not lead to people from outside the area presenting as homeless in Southampton being denied services. Similarly it will be important to ensure that other neighbouring authorities do not seek to 'export' their homeless population to the City.

### **Homes fit to live in?**

The Government wants every council home in the country to reach and exceed a decent standard. A decent home is warm, weatherproof and has reasonably modern facilities. Every property must, therefore:

- be reasonably warm with effective heating and/or insulation
- be in a reasonable state of repair e.g. roof, windows, heating and electrics
- have reasonable modern facilities and services e.g. a kitchen and bathroom
- be fit to live in and meet current legal minimum standards

In 2002 the City Council undertook a major consultation exercise called 'Homes for Life' to find out tenants' views about their homes and how best to manage them. More than 7,000 responded and three key priorities emerged:

- More choice within services that are currently delivered to tenants
- Tenants feeling better about living in council estates by providing an enhanced local environment
- An improved and more responsive repairs service

Tenants were also asked about their preferences under a housing stock options appraisal. A near unanimous 97% are in favour of the Council owning and managing the current housing stock.

### Private sector housing fitness standards

Southampton's Private Sector Housing Condition Survey in 2003 found that 29% of the stock (72,700 homes) were either unfit or in substantial disrepair, with the worst conditions in the privately rented sector.

Southampton has over twice the national average of privately rented dwellings (21%) and a high number (7,600) of Houses in Multiple Occupation (HMOs). The survey revealed:

- Eight percent overall, or 5,500 homes, with 21% of private dwellings in a state of substantial disrepair
- Twenty three thousand homes not meeting the new 'decency standard' (33% of the stock)
- Eighty seven percent of homes with significant problems of unfitness, inadequate fire protection and inadequate amenities
- Homes of multiple occupancy (HMOs) are very old with 5,400 (71%) in buildings built before 1919
- A heavy concentration of 4,200 HMOs (55% of the total) in the inner city area

It is calculated that £109 million is required to improve the 23,600 homes that do not meet the Government's decency standards. The cost of removing unfit and substantial repair is estimated at £6.2 million in the owner-occupied sector and £22.6 million in the privately rented sector. The main driver for improving standards appears to be through a system of council loans (replacing the former renovation grants) in order to lever in external grants of various sorts and unlocking the potential equity tied up in many properties.

However the worse conditions and, therefore more costly repairs, are to be found in the homes of more deprived sections of the community. Although the introduction of council loans is designed to unlock equity, many owners are proving reluctant to avail themselves of these.

#### Choice and Council housing allocation

Declining availability of affordable public sector housing, allied to persistently high levels of demand, can restrict the choices potentially available to many applicants. Some groups of people (e.g. low income single persons or childless couples) may find that they are effectively excluded from access to both public sector housing and private ownership, leaving them dependent on the privately rented sector.

Occasionally this may lead to the adoption of desperate measures in order to acquire a better home. Whilst there is no evidence – contrary to public mythology – that young women deliberately become pregnant in order to get a Council house, low levels of aspiration rooted in some people's real experience of material deprivation can play a part in determining when to start a family and its size.

The City Council has recently introduced *Homebid* – an online service that helps local peoples have a greater influence in their application for rented council or housing association properties.

#### Improved neighbourhoods

The Local Neighbourhood Renewal Strategy aims to improve the quality of life for people in the City's 11 priority neighbourhoods through better co-ordination of public services and re-prioritisation expenditure to target greatest need.

However solutions that may work in areas with a high proportion of Council owned properties may not apply to areas with high rates/numbers of private sector rented housing. Integrated approaches to neighbourhood management in these areas need to find imaginative solutions to combining public sector funding streams from a variety of sources. Fresh opportunities may be presented as area-based initiatives give way to a local area agreement in 2007. Actions to tackle fuel poverty, particularly in older person private rented households, could be prioritised.

#### Improved repairs services for tenants

It will be important when improving the repairs services to Council tenants, to consider how these can contribute to important health objectives as well as improved quality of life. There may be scope for linking this area of activity to other key initiatives funded through the Housing Revenue Account (such as the warden and community alarm services) or through other funding streams for much valued services like the handyperson scheme and other services funded by the NHS and Social Care Services. The development of a local handyperson scheme in Thornhill using New Deal for Communities (NDC) funds shows what can be done (see below).

Ensuring that Council homes and their surrounding areas are made safe from accidents or fires should be a higher priority than it currently is. Home accidents have one of the steepest social gradients whereby unskilled families are at significantly greater risk of serious injury or even death from preventable accidents in the home than professional families.

Attempts to develop a joined up approach to accident prevention in the City have suffered from a failure of agencies to work across different age groups, housing tenures or settings such as the home, roads, open spaces and the workplace. There has also been an absence of effective leadership at either a strategic or partnership level. Home accident prevention – whether for children or vulnerable older people – is not a priority in Housing, Children & Young People, Health & Well-being or City Safety Strategies.

Falls prevention is a priority for the Later Years Partnership, but it lacks access to resources of mainstream agencies to make a meaningful contribution to preventing avoidable accidents.

#### Involving housing tenants for health

Housing is a key determinant in health and well-being, ranging from the basics of having a decent home to energy efficient schemes. Involvement in shaping services to the 19,000 council homes has focused on the 30 Tenant Associations and the Tenant's Federation. A newsletter 'Tenants Link' is sent to all council homes every three months which covers a wide range of housing related issues.

Over half of Council households have someone with limiting long term illness or disability, and greater engagement with the tenant involvement network would be useful in:

- getting information across on range of health issues (for example, separate flyers in Tenants Link could be used)
- for specific projects like exercise in sheltered units
- discussing broader health and well-being issues to help shape services in these areas

#### **Affordable Homes for All?**

House prices in Southampton rose by 136% between 1995 and 2003. Earnings have failed to keep pace.

According to the Land Registry the cheapest type of property in Southampton (i.e. a flat or maisonette) in 2003 cost £115,000. The annual income required to buy at this price is £33,000; average earnings are £25,339. The average cost of all property in Southampton in 2003 was over £137,000.

The South East Plan intends that around 35% of all new housing should be affordable and this is being reflected in the City Council's Local Development Framework.

Whilst this is an admirable aim there are some major concerns:

- There is little potential to build new supporting housing in areas like the inner city which already have significant concentrations of social housing and very low rates of home ownership
- Very little affordable housing will be provided in smaller housing developments in more affluent parts of the City
- There are problems providing suitable infrastructure (including access to primary care services, education and shops) to support a number of separate new housing developments within a relatively small area

It is important to ensure that various initiatives of the NHS, City Council and the Partnership are mutually supportive. There is a risk that current policies for land use and house building may inadvertently contribute to widening health inequalities in inner city neighbourhoods. It might be helpful if all parties – including local residents – could work together on a health impact assessment in order to mitigate against this.

### **Strengthening partnerships for better health and housing**

The Southampton Housing Partnership was established to ensure that plans for housing relate to other strategic initiatives (e.g. like those for health or community safety). The Housing Partnership consists of representatives from the housing association sector, the Southampton Tenants Federation, local Registered Social Landlords, home improvement agencies, developers, private landlords and residents' groups. The mailing list has over 200 people.

The partnership has a key role to play in the access to Housing Options Service and already has established projects such as the local Handyperson service and the home improvement agencies.

Examples of areas of joint collaboration already underway include:

- A Social Housing Partnership of five locally Registered Social Landlords with an ambitious goal to provide 250 affordable homes by 2007
- The Council and the PCT working together to deliver public health issues such as the *Breathe Easy* campaign to assist people with asthma who are living in poor housing and a referral system for community
- Improving the standard of student accommodation above the statutory minimum requirement where the Council has entered into a partnership with the University of Southampton and Southampton institute with the use of a voluntary accreditation system

Examples of Housing-related Area Based Initiatives include:

- Targeting all private sector homes on the Shirley estate, to improve energy efficiency levels, thereby reducing fuel poverty
- Promoting the home maintenance service to encourage homeowners to carry out repairs and reduce the cycle of decline in house disrepair. To encourage homeowners to take up grants/loans to improve their homes
- Promoting the city wide handyperson service to encourage independent living for older people
- Piloting a local handy person service in Thornhill that is available to residents regardless of tenure



The NHS is the largest single employer in Southampton and as such it has a responsibility to work with the Housing Partnership and others to identify housing solutions for its existing and future employees.

## Recommendations

There should be greater multi-agency support for the City's housing strategies and related areas such as spatial planning

Ensuring decent homes standards are met and tackling fuel poverty should be key local priorities for partnership action and should be included in the Local Area Agreement

The Later Years Partnership should be enabled to assist the delivery of the Housing Strategy for Older People, in particular ensuring that there are effective plans for tackling fuel poverty in private sector homes occupied by older people

The NHS should work prospectively with the Housing Partnership in order to overcome the barriers to employment caused by the cost of housing, and to ensure health impacts of housing schemes are assessed

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[http://www.southampton.gov.uk/images/complete\\_tcm9-75001.pdf](http://www.southampton.gov.uk/images/complete_tcm9-75001.pdf)

# Health in Southampton 2005

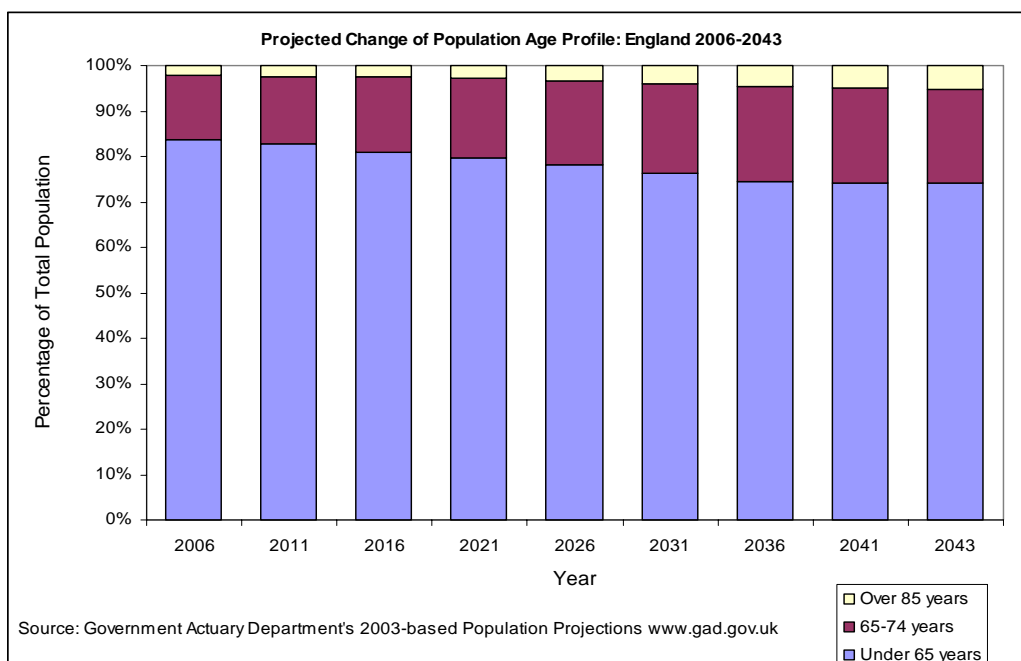
## Independence and Well-being for Older People

### Population ageing

By 2020, 50% of Britain's adult (16+) population will be aged 50 or over. Between 2000 and 2051 the government estimate that the number of people over 65 will grow from 9.3 million to 16.8 million and the number over 85 – who are most likely to need care – will nearly quadruple to 4 million. Over the course of the 20th century, life-expectancy rose by in excess of 2.5 years per decade on average - the only real growth in the population was in the 50+ age groups.

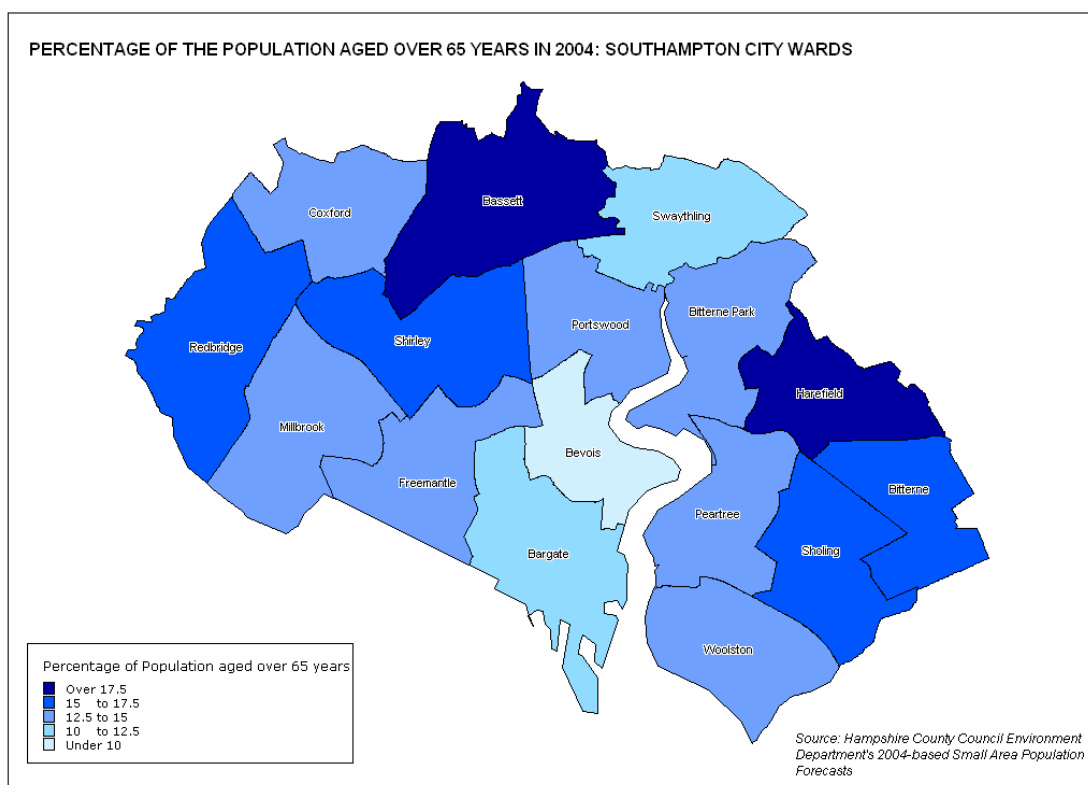
Across Europe large numbers of people are now in retirement and anticipating longer lives. This trend will have a strong impact on welfare and healthcare systems. However, the future is still difficult to predict as some suggest there will be a huge increase in costs of long term care and others that people will be healthier and require less help. There are signs that some of the disabling conditions associated with ageing are reducing. Commitment to the prevention and management of long term conditions has a key role to play in ensuring these gains are maintained.

The changes in the composition of the national population are shown in the graph below and are reflected at a local level. By 2011 the total population of Southampton City is forecast to increase by 3% but the population over 65 will increase by 10% and the numbers over 85 years will rise by over 25%.<sup>1</sup>



## Where older people live in Southampton

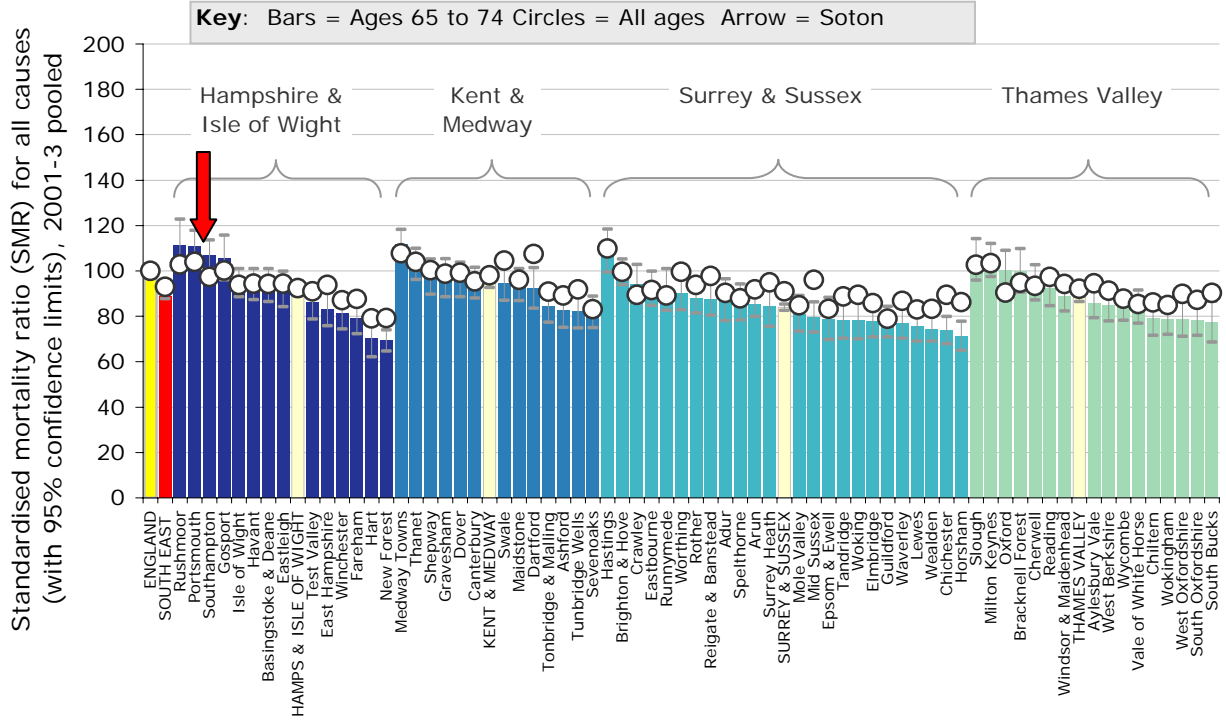
In 2004 there were 31,800 people aged over 65 years living in Southampton. Bassett and Harefield wards have the highest proportion of residents in the older age groups. These wards also have the highest proportions of households that are comprised solely of pensioners; that is, around 29% of all households compared with a City average of 22%<sup>1</sup>.



## Deaths and hospital admission

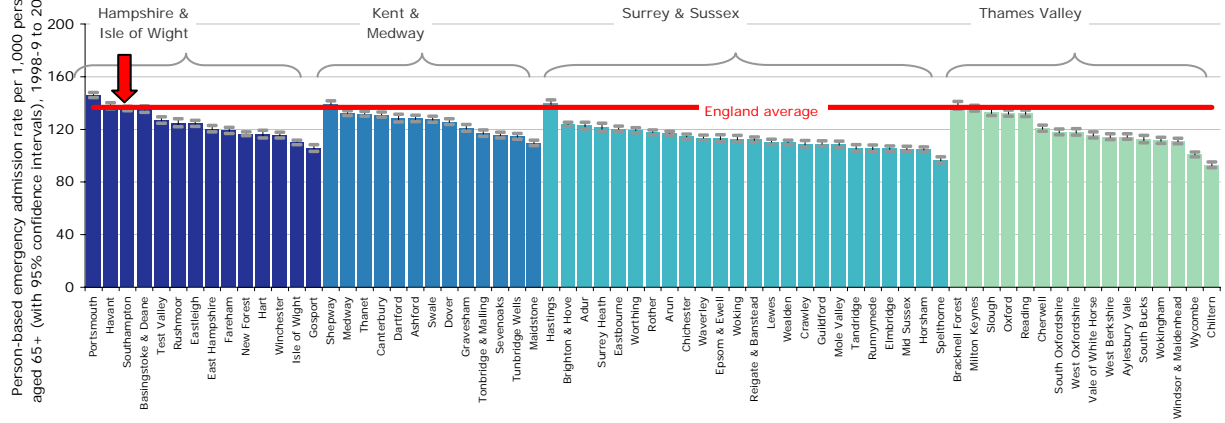
Older people in Southampton die at an earlier age, and more get admitted to hospital, than in the South East as a whole. All-age mortality rates in Southampton are similar to the average for England but significantly higher than average for the South-East. However, among 65-74 year olds Southampton's rate is higher than both England and the South-East.

### All causes standardised mortality ratio for older people aged 65 to 74 and for all persons, South East local authorities, 2001-3 pooled



From report of SE Regional Director of Public Health 2004

### Person-based hospital unscheduled admission rates for older people aged 65+, South East local authorities, 1998-9 to 2002-3



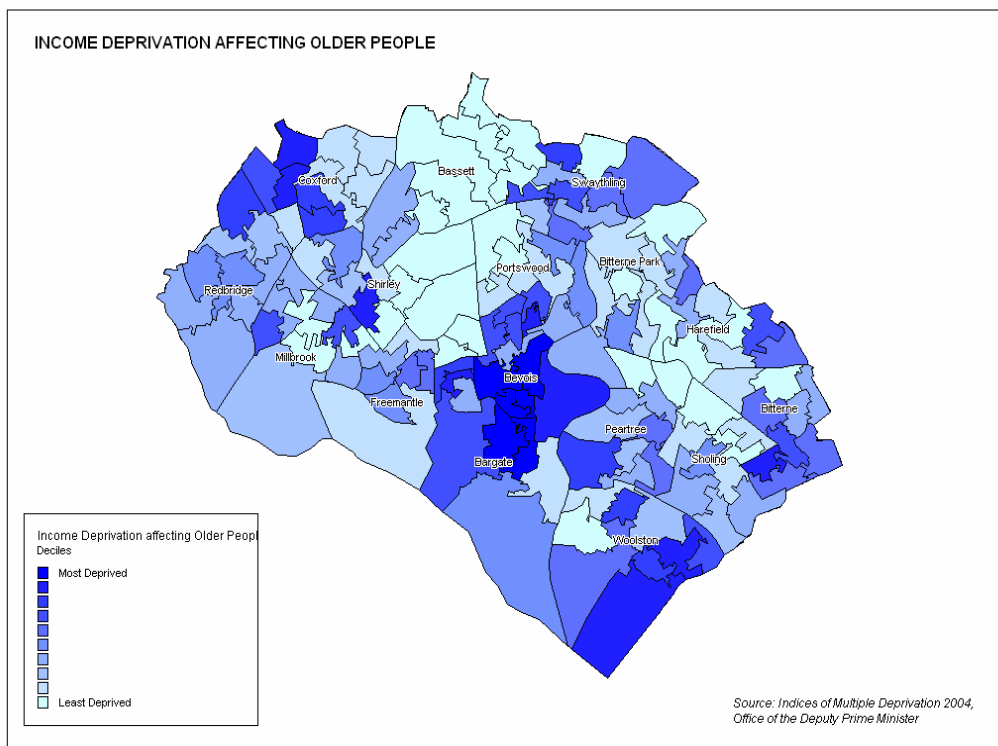
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## Health and well-being issues for our older people

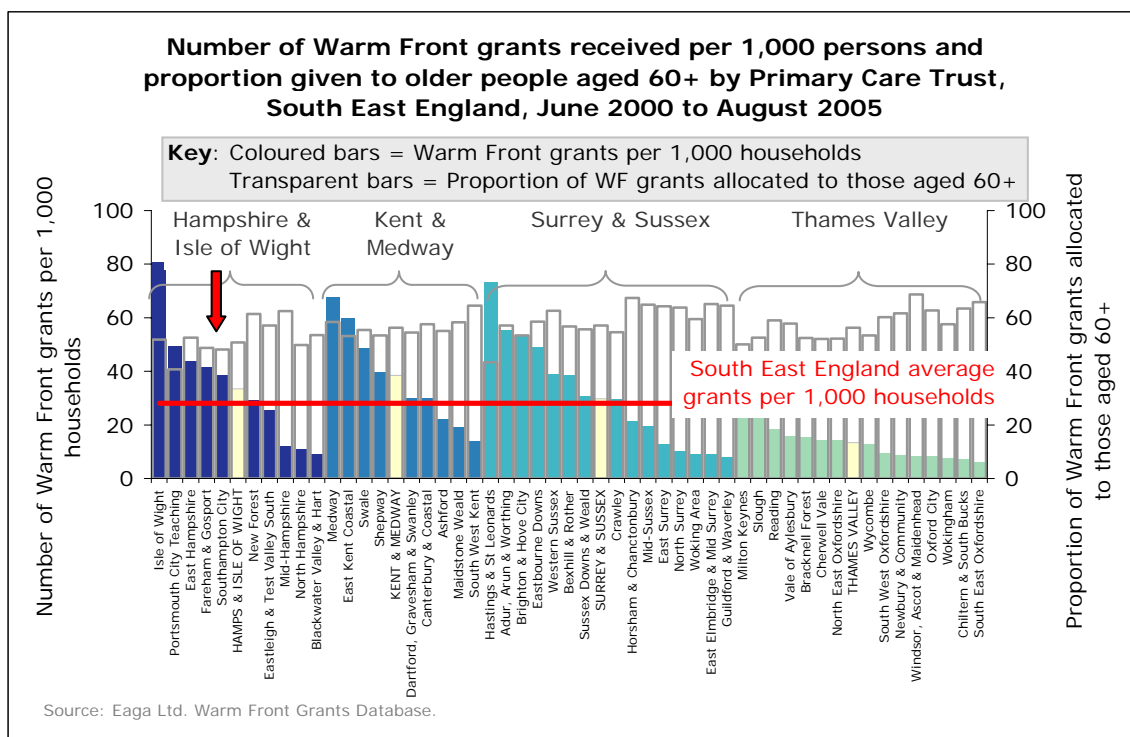
### Fuel poverty

Among the things that affect the well-being of elderly people are access to a car and adequate heating in their homes. Across Southampton 58% of pensioner households had no access to a car in 2001 compared with about 50% nationally. However, in Bargate and Bevois wards nearly three quarters of pensioner only households had no car available to use.

In 2001 there were 2,620 pensioner-only households in Southampton that had no central heating (this is 13% of all households consisting solely of pensioners). Bevois and Peartree wards had the highest proportions of pensioner households without central heating although the highest numbers were in Harefield, Millbrook and Redbridge.



During 2000-2004 Southampton had more households eligible and receiving Warm Front grants than the average for the South East. Approximately 10% of households are eligible (100/1,000). Data for the period 2000-2004 showed that we reached 30 per 1,000 households i.e. roughly a third of those eligible. For the period 2000-2005 we have now reached 38.5 per 1,000 households. Approximately half of these are grants to people over 60 years.



## Aim

- To ensure ALL those who qualify are referred for a Warm Front grant by 2007
- To eradicate fuel poverty in Southampton by 2008

## What has been done this year?

Southampton Warmth for all Partnership (SWAP) which has representatives from health, benefits, Eaga Partnership Ltd (the energy efficiency centre) and the Council is working to ensure people are aware of the fuel poverty grants. This year actions have included mail shots in wards with high levels of fuel poverty, working with the primary care practices to target people who come for influenza vaccination, working with the Later Years Partnership and providing training to a range of front line staff working in health, the council and benefits.

## Recommendations

- All practices to target patients who attend for influenza immunisation
- All our front line staff have the opportunity to attend training in fuel poverty
- Continue to work together in the SWAP partnership. Incorporate membership from voluntary organisations and church groups that are in contact with people who may live in fuel poverty

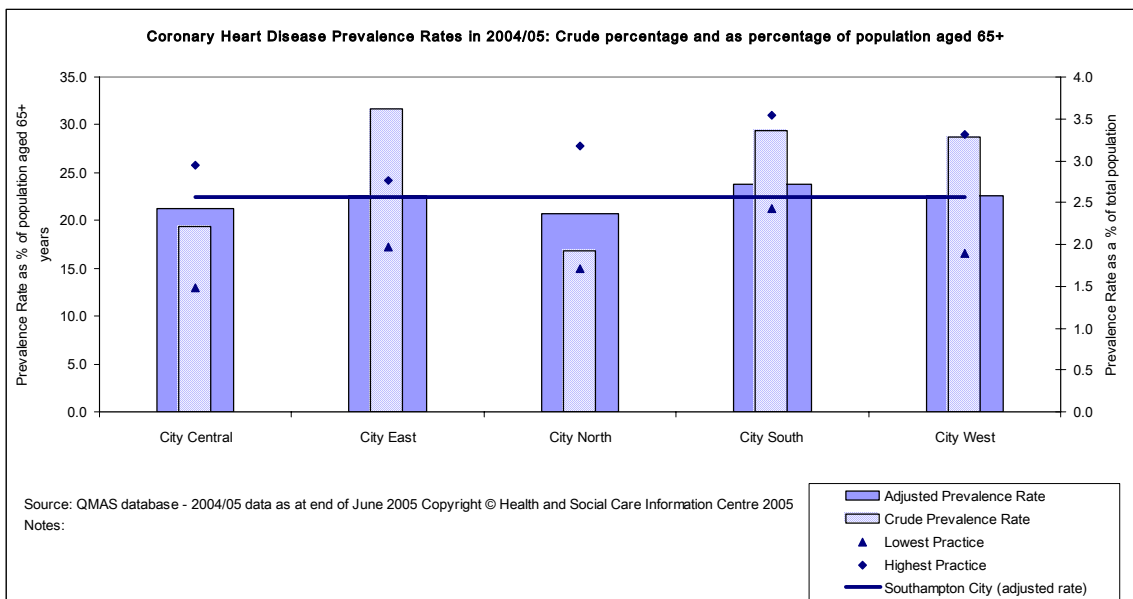
## Long Term Conditions

Data collected by GPs through the Quality and Outcomes Framework (QOF) can be used to monitor prevalence of particular diseases. Crude prevalence rates have been calculated for the five localities in Southampton by simply expressing the number of people recorded as having the disease as a percentage of the total number of people on GP registers in that area.

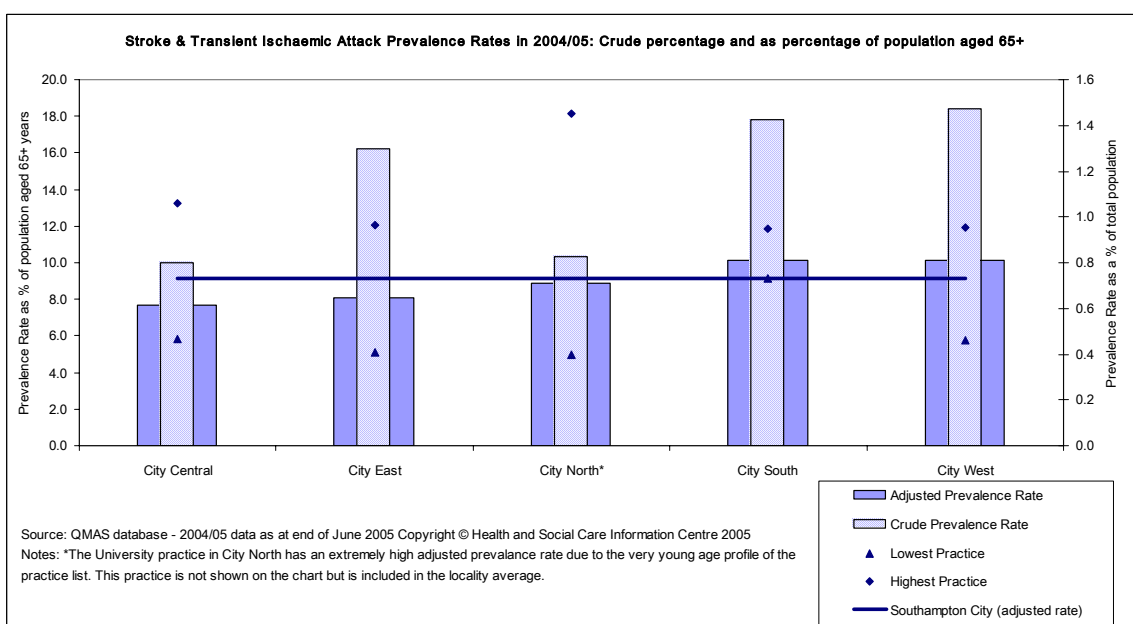
But most diseases are more common in older age so rates will be higher in the localities with an older population. There are insufficient data available through the QOF to fully standardise for age.

But for those diseases most strongly related to old age an adjusted prevalence rate has been calculated; this is the number of people with the disease expressed as a percentage of the registered population aged over 65 years.

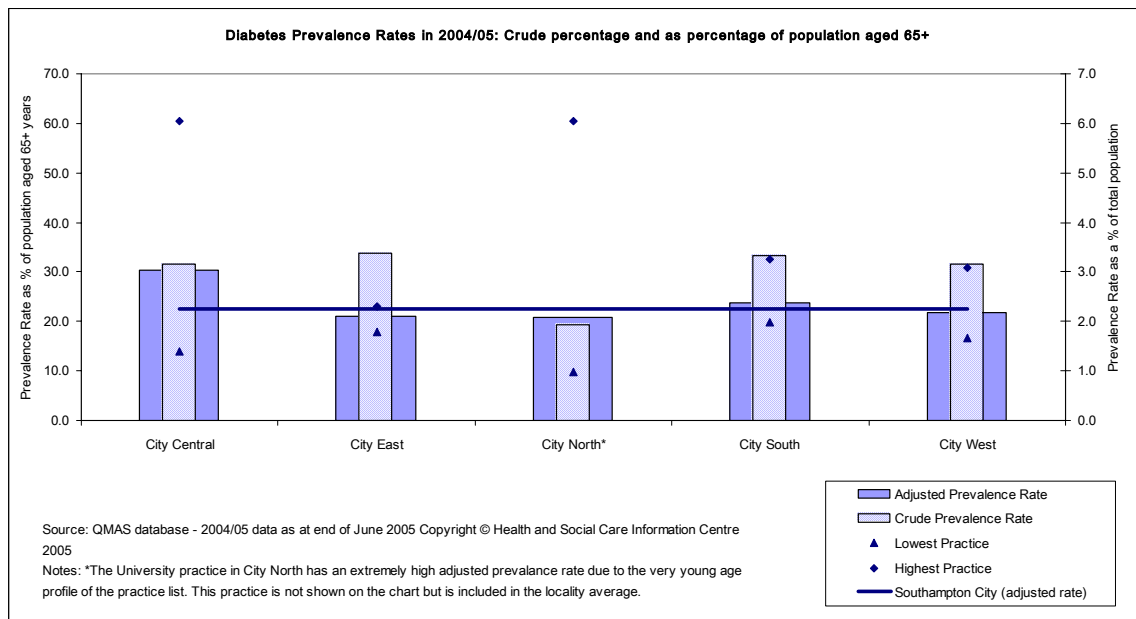
In 2004/05 there were 7,490 people on coronary heart disease (CHD) registers in Southampton (3.0% of the GPs' population). The adjusted prevalence rate for CHD is slightly higher in the South locality than in the rest of Southampton.



There were 3,065 people recorded as having Stroke or Transient Ischaemic Attack (this is a milder, temporary form of stroke) and the adjusted rates were highest in the South and West localities.



The Central locality had the highest adjusted prevalence of diabetes in 2004/05. This may be related to the higher proportion of people of black and minority ethnic backgrounds living in this part of the City.



In Southampton there were 3,570 people recorded as having Chronic Obstructive Airways Disease (COPD – this is mainly chronic bronchitis and emphysema) in 2004/05 which is about the national average (1.4%).

Long term conditions are health problems that require ongoing management over a period of years or decades. It is a broad group of conditions that on the face of it do not seem to have much in common, but they share risk factors. Tobacco use, unhealthy diet, physical inactivity, excessive alcohol use, unsafe sex practices and stress are major causes and risk factors for chronic conditions.

Long term conditions result in many people being admitted to the hospital in an emergency. The most common of these conditions account for about 14% of the emergency bed-days. National targets exist to reduce emergency bed-days and in many areas, including Southampton, additional services are being put in place to assist people with long term conditions in order to provide care in the home where appropriate.

In Southampton we have been increasing the number of people with the expertise to assist people with long term conditions.

### Aim

- To reduce the number of people acquiring long term conditions
- To improve the health and well-being of people who have a long term condition and their carers
- To improve long term conditions by reducing risk factors, regular review, early management of complications, and involvement of patients and their carers

### What has been done this year?

Health promotion initiatives for the general public include programmes to reduce smoking, increase exercise and healthy diets. This year Southampton City PCT has employed five



community matrons to help people with complex multiple long term conditions. The community matrons have advanced nursing skills and can provide care and coordination of services.

In addition the PCT have employed nurse specialists in the areas of diabetes and cardiovascular disease who are now working in the community and with general practices to enhance the services available and improve the quality of care for people with these conditions. Respiratory services have been developed to reduce problems during the transition between hospital and home and patients are able to see nurses who work across this divide. A vascular approach, that is one aimed at helping people with all forms of circulatory disease and diabetes, to prevention would also improve efficiency and ensure more patients are getting the medication and lifestyle information. This is being planned, and would draw together different current ways of working.

### Recommendations

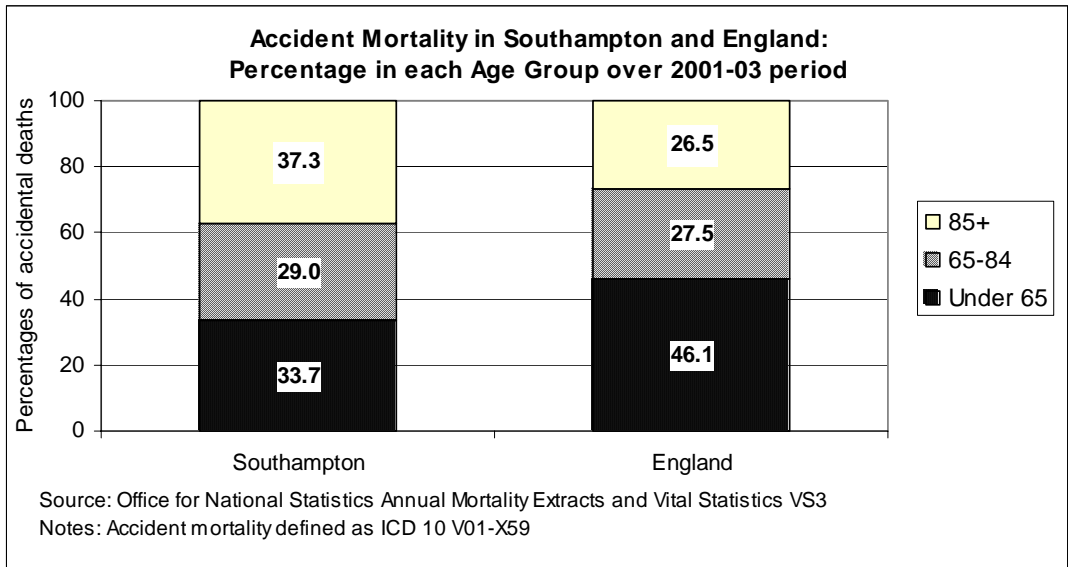
We have much to do in this area. There is huge potential both to improve the quality of people's lives and reduce admissions to hospital by providing more appropriate care. Actions that would improve the care of people with long term conditions and at the same time result in more appropriate use of resources include the following:-

- A co-ordinated prevention strategy should be developed for all vascular disease processes, targeted at those who are at high risk
- Reduce the risk factors for chronic disease through initiatives targeted at those at high risk - focusing on lifestyle factors including reducing smoking, increasing physical activity and encouraging people to have a healthy diet
- Ensure that all people with long term conditions are identified as early as possible to give them the greatest chance of reducing complications and minimising the impact of the condition on their life
- Risk stratification of people with long term conditions with proactive management of care depending on their level of risk and regular review
- Self-management - enabling people to learn as much about their condition as possible so that they can become part of the solution in managing it
- A named key worker supported by an interdisciplinary team who work together to support the patient
- Address the psycho-social needs of people with long term conditions through a combination of methods including cognitive behavioural therapy and management of depression

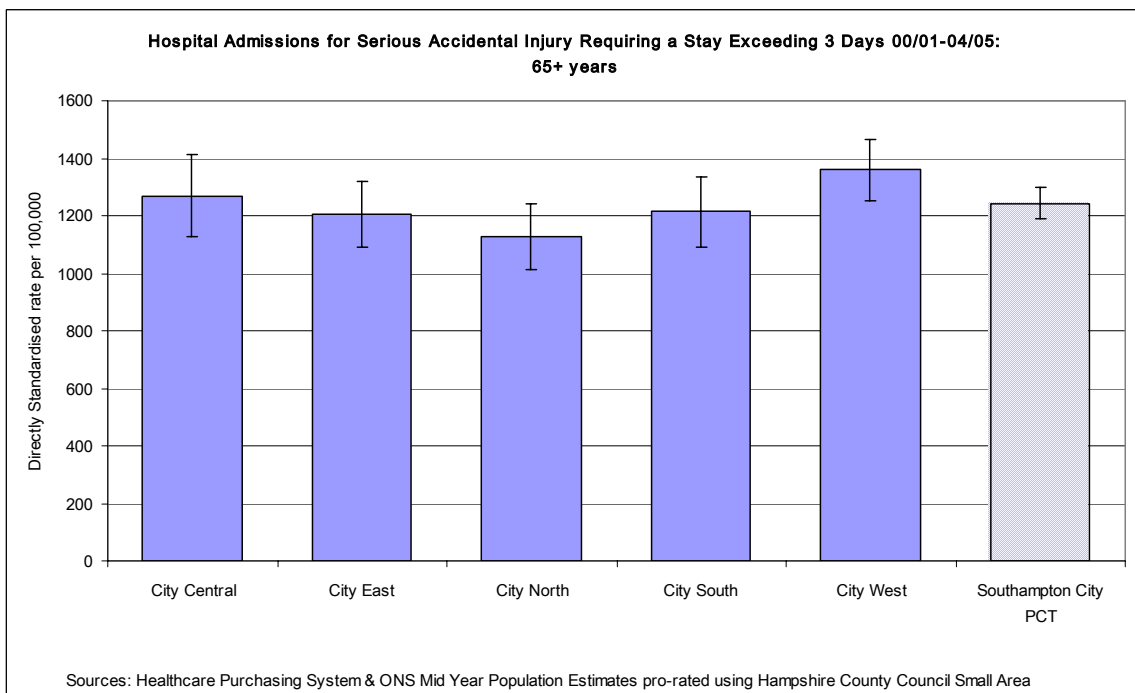
The delivery of services needs to take into account the patient perspective with many patients having more than one condition. Communication between different members of the team caring for the patient and across hospital, community, primary and social service interfaces becomes a crucial factor.

### **Falls and fractures**

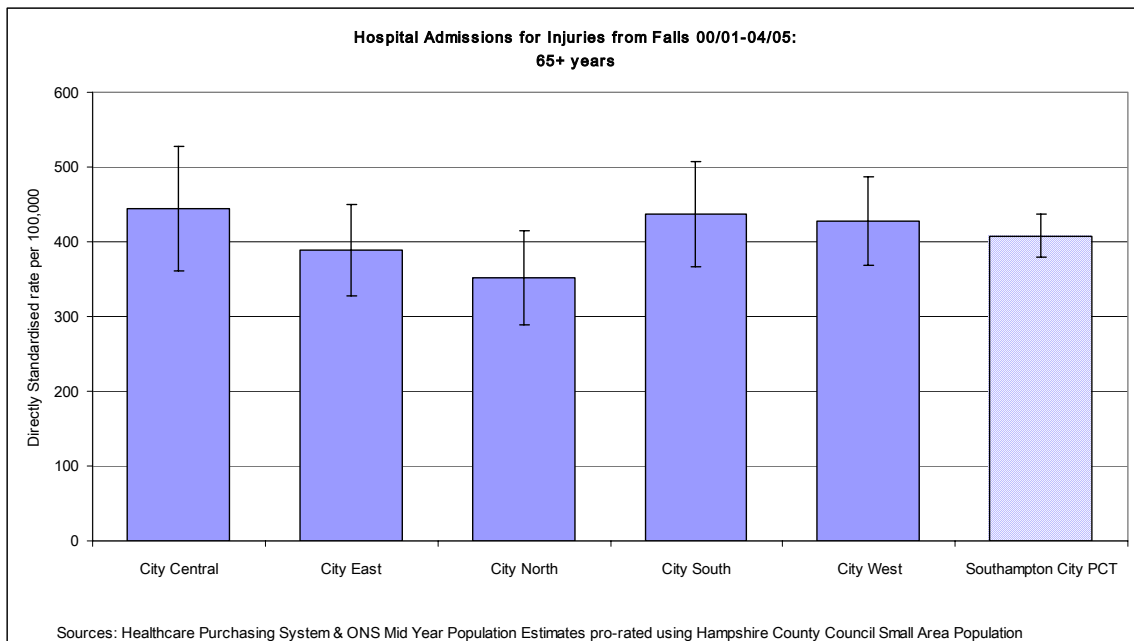
Falls are a common cause of death, disability and hospital admission in old age. Approximately 30 percent of people over 65 years of age and living in the community fall each year. The number is higher in institutions. Although less than one in ten falls result in a fracture, a fifth of all falls require medical attention. Despite a number of strong advocates from the council and PCT, there has been little increase in investment in the prevention or management of falls in Southampton City over the last three years. This could be one reason that older people in Southampton have a higher chance of having an accident than older people living in the rest of England.



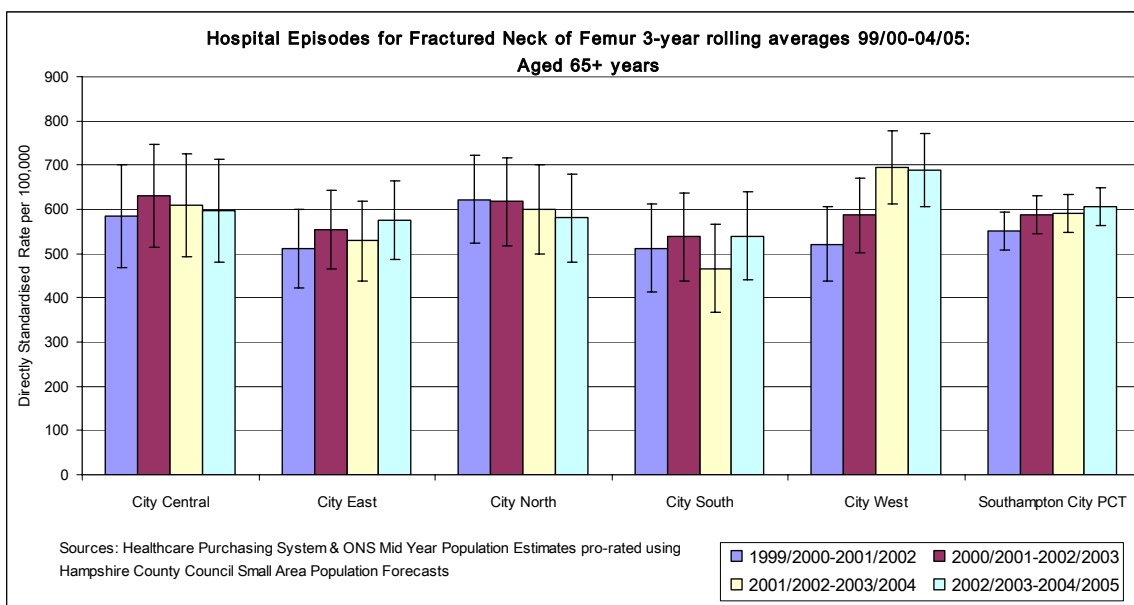
The chart shows age-standardised hospital admission rates for serious accidental injury amongst the over 65s; this is defined as resulting in a stay in hospital of more than three days. Rates are slightly higher in the West locality but the difference from the City average is not statistically significant.



The following chart shows the hospital admission rates for falls amongst the over 65s. There are no statistically significant differences between localities.



Hospital episodes for fractured neck of femur amongst 65+ year olds have increased in the West locality over time but this difference is not statistically significant.



In 2004/5 442 people were recorded as being admitted to SUHT after a fall. Approximately 20% of these had had a fracture. These numbers are known to be under-estimates as a fall is not always recorded. We would expect approximately 720 people to be admitted with a fall according to national figures.

There are a number of effective interventions that will prevent people falling. These are:-

- Multidisciplinary, multi-factorial, health and environment risk factor screening and intervention programmes in the community for older people in general, and those at risk of falling
- A programme of muscle strengthening and balance retraining individually prescribed at home by a trained health professional

- Home hazard assessment and modification that is professionally prescribed for older people with a history of falling
- Withdrawal of psychotropic medication (tranquilisers and antidepressants),
- Cardiac pacemakers for fallers with cardio-inhibitory carotid sinus hyper-sensitivity (a tendency for the heart to slow down with changes of position)
- A 15 week tai chi group exercise intervention

Osteoporosis is a condition that will affect one in three women and one in twelve men at some stage in their lives. It is a skeletal disease characterised by low bone mass with an increase in bone fragility and susceptibility to fracture. It is an important cause of fractures among older people. Osteoporosis is also one of the few areas where early intervention to promote and maintain bone health can make a real impact on the burden of disease. Interest in the disease has grown over the last ten years due to the development of a reliable and reproducible tool for the measurement of bone mineral density in the form of DEXA scanning and also effective treatments. Bisphosphonate drugs are a cost-effective treatment to prevent fractures for people at high risk. In Southampton prescribing of bisphosphonates is steadily increasing but we do not know if it is reaching those who need it most. An increase in the number of DEXA scans available, and dedicated resource to develop and implement agreed guidelines would enhance our ability to maximise the cost-benefits of this type of medication.

- The introduction of guidelines for the management of osteoporosis in primary care (including referral for scanning and prescribing of bisphosphonate drugs)
- Case finding for high risk individuals (those with previous fragility fracture and on steroids for three months or more)
- An increase in the DEXA contract for scanning to reach 1,000 (to cover fragility fractures and steroid related high risk groups) this year. The recommended number for our population is 2,500
- A restriction of primary prescribing of biphosphonates to alendronate and risedronate
- Messages about appropriate prescribing of hormone replacement therapy and Calcium and Vitamin D should result in a reduction in prescribing of these medications

We know that the management of hip fracture for Southampton City residents is not as good as it could be. Too many people who are admitted with hip fracture have to wait longer than 24 hours prior to their operation. In addition the mortality ratios in Southampton have been much higher than in other areas over recent years. Work is being undertaken to understand further why this is and to implement changes to ensure this situation does not continue.

#### Aim

To prevent falls and fractures and reduce the adverse outcomes which occur when someone has fallen.

#### What has been done this year?

Plans for reducing falls and improving outcomes have been developed, costed and supported by clinicians. Despite the importance of this topic, funding has not been allocated.

Identifying and monitoring the delay occurring prior to fracture neck of femur surgery at Southampton University Hospitals Trust. A group with representatives from the PCT and SUHT has been set up to address issues related to fractured neck of femur.

Increased funding has been made available for DEXA scans. These scans assist with the diagnosis of osteoporosis and work is being undertaken to ensure the limited scans will be used appropriately.

### Recommendations

Services for hip fracture should be improved to ensure better outcomes

Funding should be made available to enable implementation of some of the known cost-effective interventions to prevent and manage falls and fractures, and falls prevention should be included in the Local Area Agreement

## **Conclusions**

In this report we have highlighted a number of the issues facing older people in Southampton. There are many others. It is clear that older people in Southampton are not always getting a good deal. They are more likely to die at an earlier age than in other parts of the South East and in England as a whole. Many are living in fuel poverty. Too many are being affected by falls and their consequences. However, some progress has been made both in the areas highlighted here and in others not mentioned here such as housing and older people's mental health. We hope to work with all those interested in promoting the health of older people to make further changes to continually make improvements to their well-being and independence.

## **References**

1. Hampshire County Council Environment Department's 2004-based Small Area Population Forecasts

## **Related document**

Southampton City Later Years Health and Well-being Strategy (2004) is available at <http://www.southamptonhealth.nhs.uk/publichealth/plans/lateryears>

# Health in Southampton 2005

## Poverty, Disadvantage & Exclusion

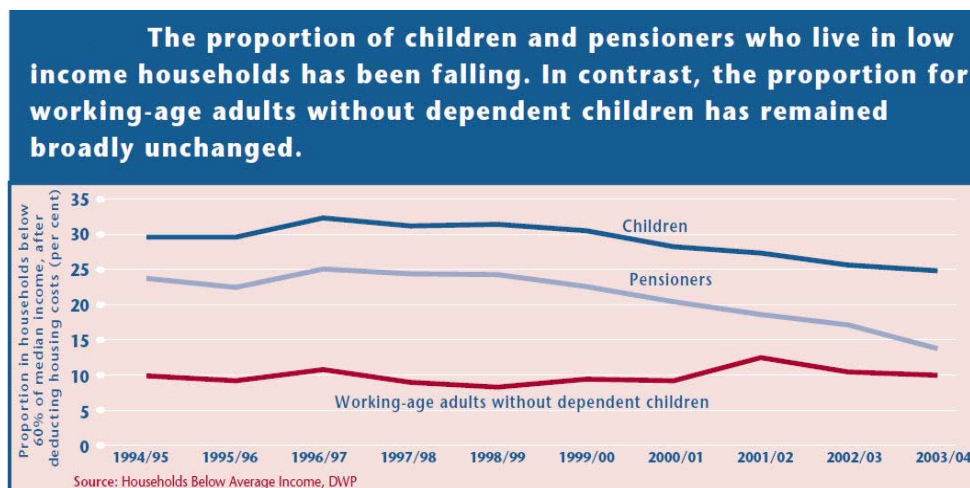
Over the past century, there has been much debate and discussion around poverty and disadvantage.

### Poverty in Britain

The new Policy Institute and the Joseph Rowntree Foundation publishes information on progress with poverty at national level, most recently in December 2005.<sup>1</sup>

The most commonly used threshold of low income is a household income that is 60% or less of the average (median) household income in that year. The latest year for which data is available is 2003/04. In that year, the 60% threshold was worth £180 per week for a two adult household, £100 per week for a single adult, £260 per week for two adults living with two children, and £180 per week for a single adult living with two children. This sum of money is after income tax and national insurance have been deducted from earnings and after council tax, rent, mortgage and water charges have been paid. It is therefore what a household has available to spend on everything else it needs.

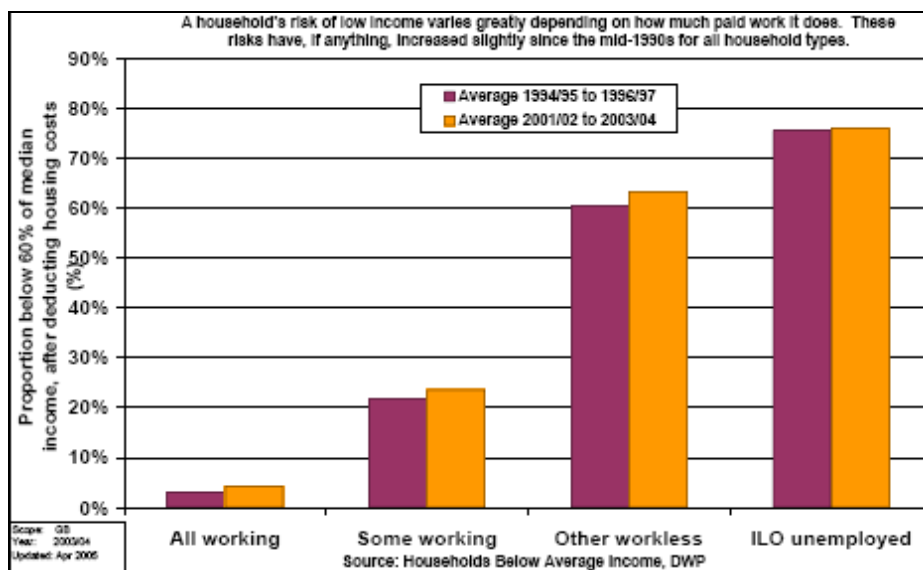
In 2003/04, 12 million people – about one in five – in Britain were living in income poverty. This is nearly 2 million below its peak in the early 1990s, lower than at any time since 1987 but still nearly twice what it was at the end of the 1970s. Since the mid-1990s, the proportion of pensioners in income poverty has fallen from 27 to 22 per cent; that of children from 32 to 29 per cent.



Source: Joseph Rowntree Foundation

Educational qualifications are strongly linked to work and pay. The lower a person's qualifications, the more likely they are to be low paid. For example, more than half of those with no qualifications earn less than £6.50 per hour.

The risk of low income is affected very much by the working status of the household, with the unemployed being much more at risk. About 20% of households in which one or more people only works part time ('some working' in the chart below) are in poverty.



Source: Joseph Rowntree Foundation

## Poverty in Southampton

Indicators of poverty or economic disadvantage tend to place Southampton in line with the country as a whole, but worse than South East England. For instance:

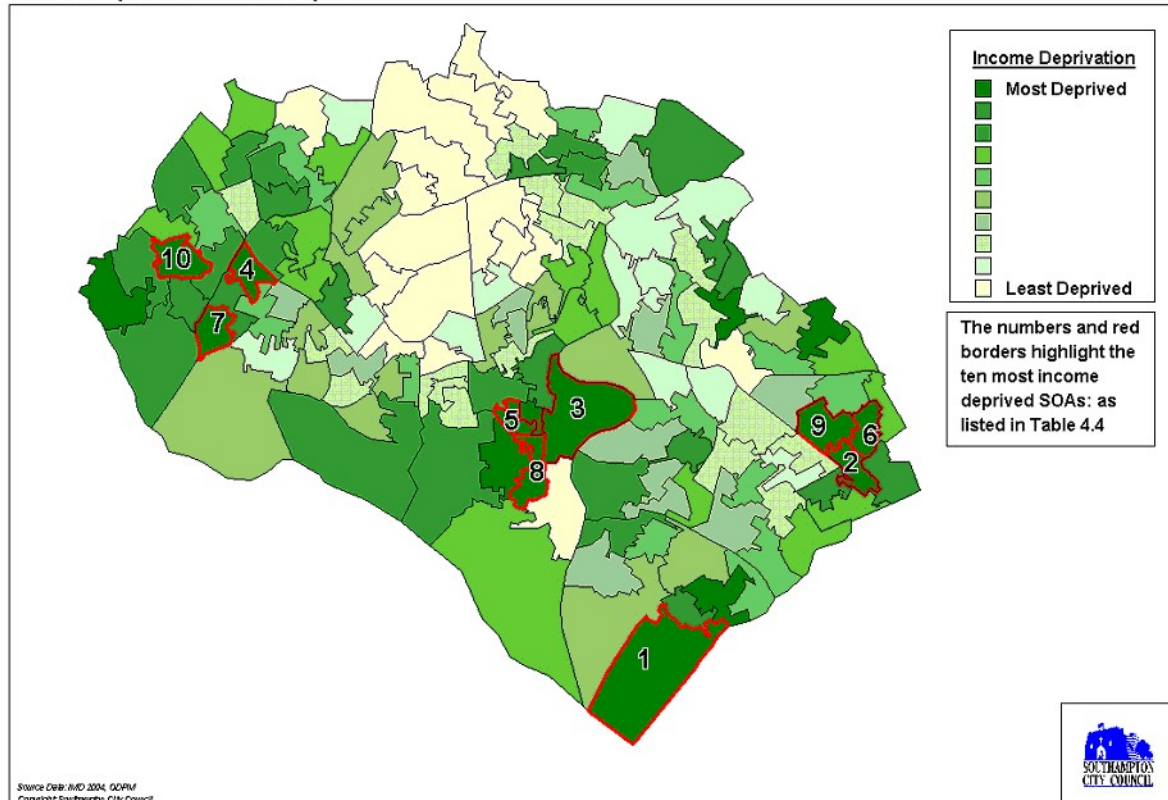
- In December 2005 the unemployment rate (those claiming Job Seekers Allowance) was 1.2% in Southampton, 1.3% in England and 0.8% in the South East
- The percentage of the working age population economically active in 2004/5 was 77.2% in Southampton, 78.4% in England and 82.1% in the South East
- The median wage for workers living in Southampton in 2004 is shown in the table below:

Median wages (2004)		
	Full time,	Part-time
Southampton	£21,588	£6,394
South East	£24,697	£7,195
England	£22,450	£6,791

Source: Southampton City Council

Within Southampton, poorer people tend to be concentrated in certain areas. The Index of Multiple Deprivation for 2004 shows income deprivation by 'super output area', which each have about 1500 people. This is mapped in the following figure.

## Income Deprivation: Southampton



## Effects of poverty on health

We know that being poor leads to poorer health on average. There are many health problems which are less common among the better off in society. The important report by the committee chaired by Sir Donald Acheson in 1998 described some of the health problems where there are important differences by social class.<sup>2</sup>

- Life expectancy
- Death rates for many of the major causes of death, including coronary heart disease, stroke, lung cancer and suicides among men, and respiratory disease and lung cancer among women
- Infant mortality
- Limiting long standing illness
- Obesity and raised blood pressure in women
- Major accidents in men
- Mental health problems, such as milder mental illness in women and drug and alcohol problems in men.

Further and more recent data show that there are also strong links between poverty and:

- Teenage pregnancy
- Suicides in young men
- Poor dental health



# Policy to reduce the underlying inequalities causing health differences

## National priorities

The Department of Health laid out its programme for action to tackle health Inequalities in 2003.<sup>3</sup> This three year strategy built on the evidence provided by the Acheson report and the governments Cross Cutting Review. It included 12 national headline indicators as part of the public service agreement on health inequalities. The priorities for action were:

- Improvement in early years support for children and families
- Improved social housing and reducing fuel poverty
- Improved educational attainment and skills in disadvantaged populations
- Improved access to public services
- Reduced unemployment and income amongst the poorest

The 2005 status report on this strategy reported successful implementation of departmental commitments but worsening inequalities in life expectancy and infant mortality.<sup>4</sup>

## Local action on poverty and social exclusion

The Southampton Partnership has produced its Local Neighbourhood Renewal Strategy.<sup>5</sup> It aims to reduce disadvantage due to where people live, their personal circumstances and the community they belong to.

The Local Neighbourhood Renewal Strategy's actions are to:

- Support and ensure delivery of the action plans for the three established regeneration projects and action plans for the other eight priority neighbourhoods in the City. The local action plans have prioritised issues for each area which will improve quality of life and prosperity
- Improve educational attainment and employability. Southampton stands out in having poor attainment relative to the socio-economic position of its people
- Improve neighbourhood management

It will monitor progress against nationally agreed targets. This strategy will improve the general level of prosperity in the city and the gap between rich and poor.

The Health and Well-being Strategy for the City aims to reduce the effects of poverty and deprivation on health. Improving health will enable people to participate more actively in the local economy, which will further improve health. There are several work streams to do this:

- Reducing the inequalities in the priority neighbourhoods. This will be mainly through support for and implementation of the Action Plans for each priority neighbourhood
- A health needs assessment of people from black and minority ethnic groups. Many people from these groups suffer disadvantage from both discrimination and low income. Work between health and the local authority will identify the priorities to improve their health

- Reducing environmental tobacco smoke. This will both protect non-smokers and also encourage smoker to quit. The different smoking rates account for half the difference in life expectancy between rich and poor
- Improving diet, particularly in children. This work is being taken forward as part of action on obesity and dental decay, both of which are linked to social disadvantage
- Mental health promotion. Action to improve the mental health of vulnerable people and the general health of people with mental illness will help the most disadvantaged in the city

## Recommendations

The PCT should contribute to the delivery of the Local Neighbourhood Renewal Strategy (2006 – 2010) and its constituent local action plans

Raising aspiration and improving educational attainment in the city should be a priority actively supported by all agencies and partners

The Health and Well-being Strategy should be supported by partners to improve the health of disadvantaged people and improve their chances of employment and higher income

## References

1. Palmer G, Carr J, Kenway P. *Monitoring Poverty and social exclusion 2005*. York: Joseph Rowntree Foundation, 2005
2. Acheson D (chair) *Independent Inquiry into Inequalities in Health* London: TSO 1998
3. Department of Health *Tackling health inequalities: A Programme for Action London: TSO 2003*
4. Department of Health *Tackling health inequalities: Status Report on A Programme for Action London: TSO 2003*
5. Southampton Partnership. *Closing the Gap. Local neighbourhood Renewal Strategy (2006 – 2010)* Southampton: SCC 2006

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# *Health in Southampton 2005*

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## **Communicable Disease Control**

### **Introduction**

NHS responsibility for communicable disease control moved in 2003 from the Health Authorities to the Health Protection Agency (HPA),<sup>1</sup> with its local health protection units (HPUs). The health protection service for Southampton City PCT is provided by the Southampton office of the Hampshire and Isle of Wight HPU. Health protection is an important part of the public health service for the people of Southampton.

Controlling communicable disease continues to be important for public health. In the nineteenth and early twentieth century, infectious diseases were the main cause of ill-health and mortality. The post-war years saw a shift in the main causes of illness and death to non-communicable diseases. However, communicable disease continues to be an important cause of ill-health, and new infectious diseases, including HIV, SARS and avian influenza pose new threats to public health.

Pandemic influenza is considered to be a risk to the population in the foreseeable future. National guidance on planning for such an outbreak is in place. In Southampton, detailed operational planning has taken place to protect the population and minimise the impact of a pandemic strain of flu.

This chapter discusses the main communicable diseases affecting the population of Southampton City PCT during 2005. Data are available for those diseases which have to be 'notified' by doctors. The figures given are notifications received, and not necessarily confirmed cases.

### **Food poisoning**

Food poisoning is the most common notifiable disease. It is caused when people consume organisms in food or drink. The symptoms can vary between a mild tummy upset and severe life-threatening disease. The latter is rare, but can occur when frail people are infected, or when the organism (such as E coli O157) has the capacity to produce dangerous toxin. Control is by careful attention to hygiene in preparing food, particularly in commercial premises. Here the quantity of food means that there is a risk to large numbers of people if control breaks down. The City Council's Environmental Health Department leads on the prevention of food and water borne disease.

Locally 372 cases of food poisoning in Southampton residents were reported in 2005, 52 cases more than in 2004. Food poisoning notifications are known to be a considerable underestimate of actual cases, as many resolve without medical help or are not reported even if treated. In the 372 cases the pathogenic agent was identified. Of these, 239 were campylobacter infection and 52 were salmonella.

The incidence of campylobacter infection increased slightly between 2004 and 2005 while the incidence of salmonella fell. Nationally both infections showed small reductions.

Nearly half the cases of salmonella were contracted abroad, and many of the others are linked to imported eggs. The immunisation of poultry in the UK has reduced infections from British eggs in recent years.

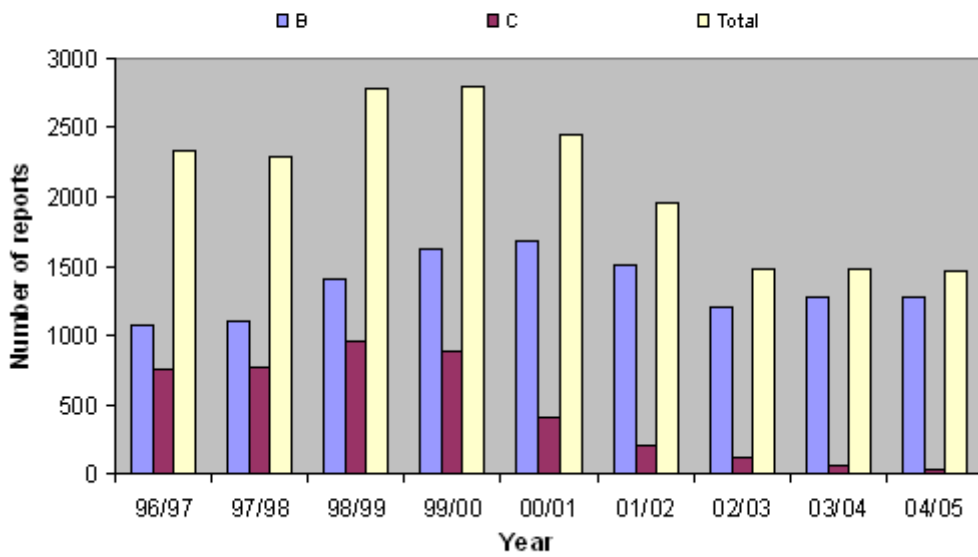
Campylobacter is commonly associated with infected meat, particularly chicken. There is a marked seasonal variation in salmonella and campylobacter, with most cases occurring during the summer months. Cryptosporidium (21 cases), giardia (12 cases), shigella (1 case) and E coli (1 case) are the other notified agents causing food poisoning.

## **Meningococcal disease**

Meningococcal infection causes both meningitis and septicaemia. These are fortunately relatively rare but when they occur, can be fatal. They are commonest in young children, with another rise in older teenagers. Control relies on vigilance by the public and professionals to spot the early signs of disease for urgent treatment, and immunisation for the group C form of the disease. Vaccine is not available for the commoner group B, but is for group A, which occurs in hot climates. This vaccine is offered to certain travellers. Cases of meningitis can be reduced by giving preventative antibiotics.

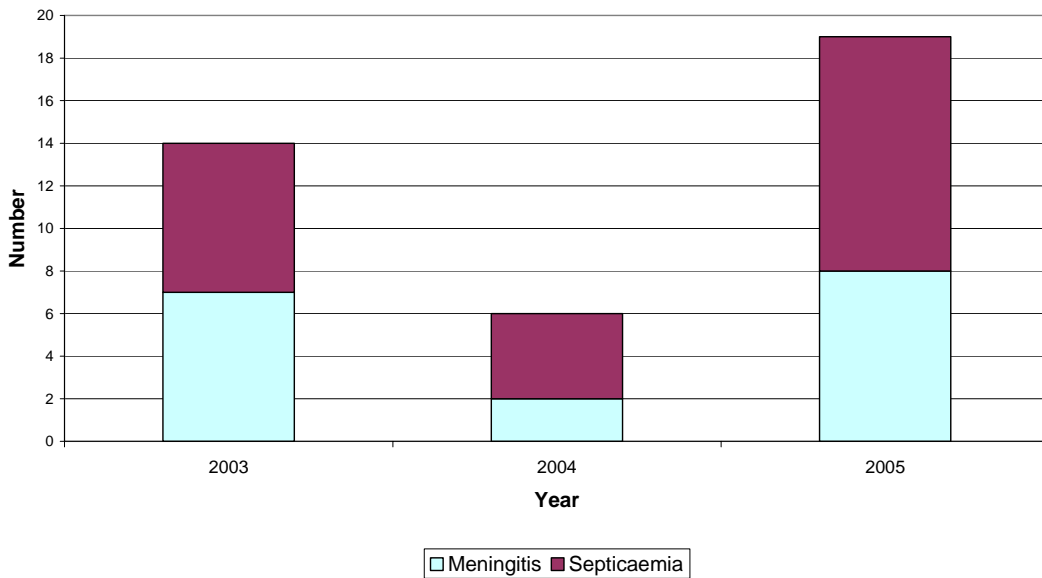
Twenty cases of meningococcal disease were reported in 2005, a rate of 9/100,000, higher than neighbouring PCT areas (3/100,000 in the New Forest and 3.4/100,000 in Eastleigh). This is most likely due to the population differences: Southampton has a higher number of students and young people who are the most susceptible to meningococcal disease. Most of these cases are Meningitis B. Meningitis C incidence has reduced because of the successful immunisation programme. Meningococcal disease tends to follow a 15 year cycle, and this peaked in 2000 and incidence nationally has been decreasing since. Local incidence is in line with this trend, although there is much random variation.

### Meningococcal Disease, laboratory reports by serogroup England & Wales



Meningococcal Disease Reports, England and Wales

### Meningococcal Disease in Southampton



The difference between years in the chart reflects the natural variation due to chance rather than the underlying trend.

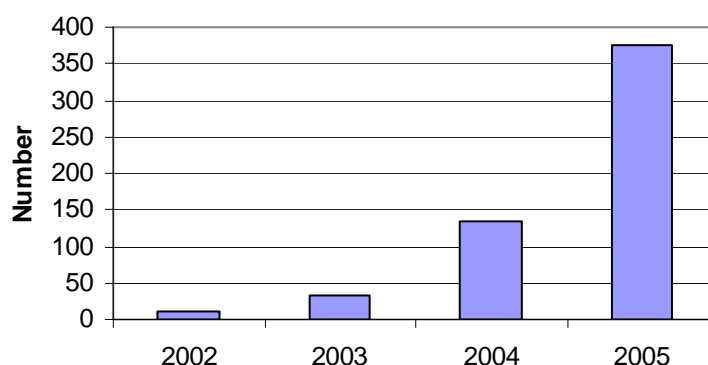
## Childhood infections

### Mumps

Mumps is a viral disease, normally of children. It infects the salivary glands, causing swelling of the face, but can sometimes cause more serious disease. One such is viral meningitis, which usually resolves fully but can result in permanent deafness. An effective vaccine is part of the MMR injection (which protects against measles, mumps and rubella).

The number of cases of mumps has increased this year (375 cases) from very low numbers in 2003. The incidence is expected to remain high, with data from the start of 2006 supporting this. The cause is due to the lack of immunity of the young adult population, particularly those who did not receive the MMR vaccine, or only one dose, as children. The previous lack of circulating mumps in the community has not reinforced their immunity, leaving them now vulnerable. Mumps is categorised as confirmed if laboratory tests on saliva are positive.

**Mumps in Southampton**

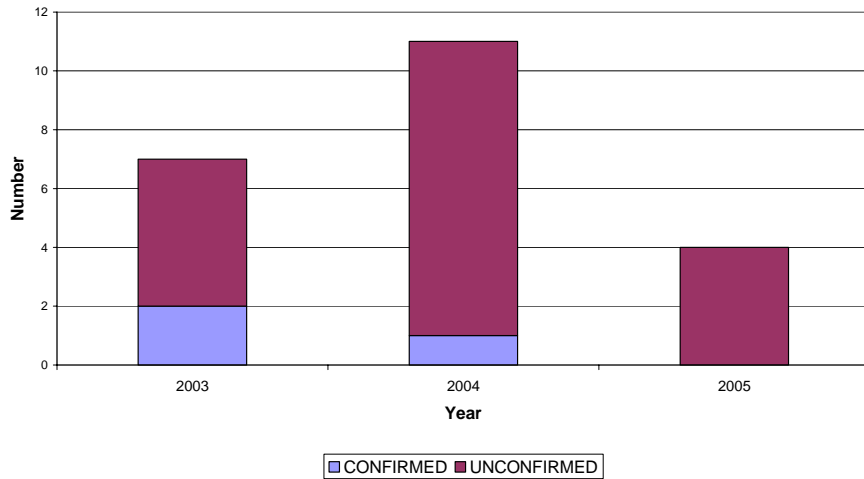


General practices in the PCT have intervened to offer MMR vaccination to those who may not have received sufficient protection as children and are now at university age. This is part of a national initiative. Younger children have adequate protection if they have received their full schedule of immunisations which includes two doses of MMR.

### Measles

Measles is another viral disease in children. It is fortunately rare, but when it occurs can cause dangerous pneumonia and meningitis and encephalitis. The MMR vaccine protects against measles. Measles has reappeared in the population in past years when, like mumps, immunity levels have fallen in older children. This is no longer the case, following previous catch-up immunisation campaigns. Measles continues to be rare in the city. There were no confirmed cases in 2005. The four unconfirmed cases were probably due to other viruses causing a similar rash.

Measles in Southampton



## Immunisation

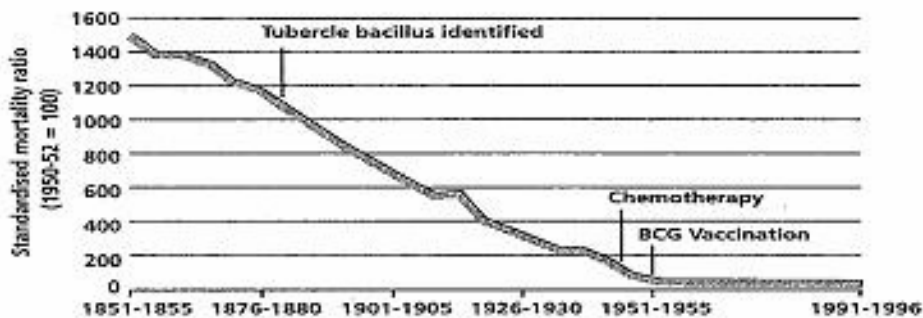
Childhood immunisation is the mainstay of protection against a range of potentially serious or fatal diseases. It is important to maintain high uptakes of immunisation in order to protect individuals and reduce the circulation of viruses in the community. Uptake in Southampton is good. Over 95% of children have had the full course of vaccines by 24 months of age, except for MMR. Although only 90% of children had received this, it was the highest coverage of PCTs in Hampshire, and higher than the national average of 81% (data for July to September 2005).

The rarity of measles in the city is a reflection of the uptake of the vaccine. It is noteworthy that local parents appreciate the benefits this vaccine offers and opt to protect their children in line with the best scientific advice. MMR continues to be a safe and effective vaccine, despite the unfounded assertions to the contrary.

## Tuberculosis

### Background

Tuberculosis (TB) was one of the main causes of ill health and death in the 19<sup>th</sup> century. In 1855 13% of recorded deaths were from TB. The graph below shows the steady decline in the death rate from TB in England and Wales.<sup>1</sup> The number of new cases of TB also decreased with mortality until 1987.



Deaths from TB 1851 - 1996

The decrease in the number of cases of TB was achieved mainly through:

- Better nutrition
- Better housing
- Pasteurisation of milk
- Effective drug treatments
- Early diagnosis
- Public health programmes to detect and treat infection in close contacts
- BCG immunisation

From 1987, however, there has been a 25% increase in the number of new cases of TB in England; there are 1,700 more cases each year than in 1987. The latest year for which national data are available is 2003. There was a very slight drop in numbers that year. In England there were 6608 cases in 2003 (13 per 100,000 population). Most TB occurs among people who live in cities, particularly London where 45% of cases occurred.

Year	Cases reported
1988	4659
1993	5104
1998	5658
1999	5704
2000	6271
2001	6597
2002	6794
2003	6780

Source: HPA

The suggested reasons for the rise of TB are:

- Increased migration of people from areas of the world where TB is more prevalent
- TB in people with HIV infection

Seventy percent of cases of TB are in people born abroad, mainly Asia and Africa. The rate in people born abroad is 23 times higher than in those born in the UK.

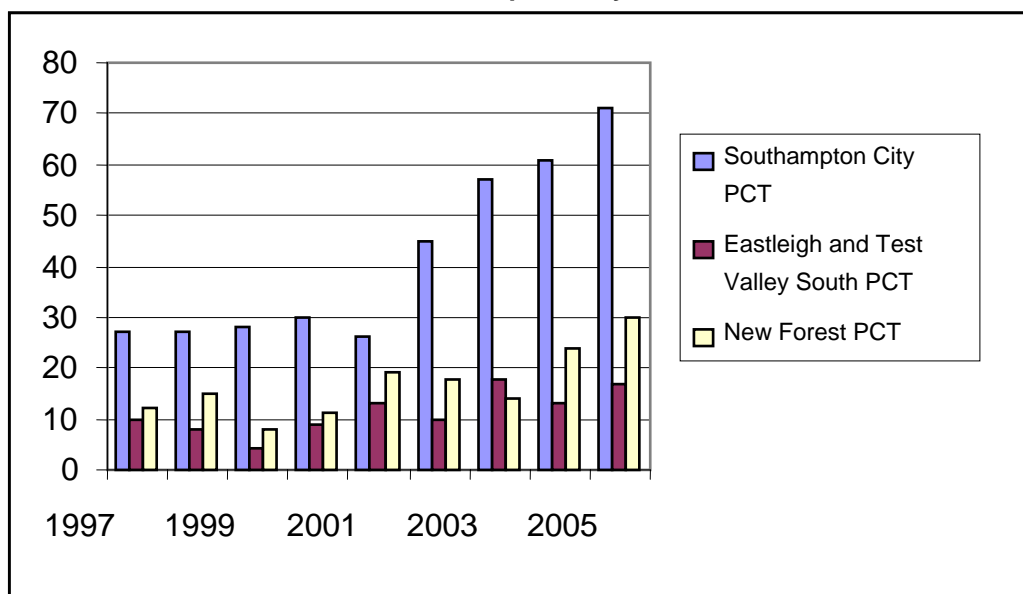
### **TB in Southampton**

In Southampton, there has been a marked increase in notifications and new cases of TB since 2002, shown on the graph below. In 2005 there were 71 notifications for TB, more than double the number in 1997. The graph also shows that there has also been an increase in other parts of South West Hampshire, but not as marked as in Southampton City. Portsmouth has also noted a similar increase to Southampton in the number of new TB cases.

The increase in cases appears to be linked to people, particularly from new communities, from abroad. The disease usually appears to be acquired abroad, either before immigration or by contact with communities abroad. TB can remain dormant, or unrecognised for long periods, making the direct source of infection difficult to identify. Transmission in the population is unusual in Britain.



## Numbers of TB cases notified in South West Hampshire by PCT



Source: Southampton Health Protection Unit

### Chief Medical Officer's action plan

In response to the increasing number of new cases of TB, the Chief Medical Officer (CMO) published an action plan, 'Stopping Tuberculosis in England' in October 2004<sup>2</sup>.

This action plan sets out 10 recommended areas for action, which evidence and experience show will control TB. These are:

- Increased awareness
- Strong commitment and leadership
- High quality surveillance
- Excellence in clinical care
- Well organised and co-ordinated patient services
- First class laboratory services
- Highly effective disease control at population level
- An expert workforce
- Leading edge research
- International partnership

The report highlights learning from the experience in the USA, where TB re-emerged during the 1980s and early 1990s. With a clear plan, a national focus and a build up of infrastructure and resources at a local, state and national level, the rising trend in new TB cases was reversed. Between 1992 and 2002, new TB cases decreased by 45% to the lowest every recorded rate of 5 per 100,000. The CMO suggests that control of TB in England can be achieved with a similar level of commitment. However to date, there have been no announcements of additional resources for TB.

### Local action on TB

Following the publication of the CMO's action plan, a baseline survey of all PCTs and acute trusts has been carried out by the South East Region, to assess the current position of trusts against the targets in the action plan. The results are being used to develop and inform an action plan. A South West Hampshire TB Action Group has been convened.

The CMO has announced a change of policy in immunisation (BCG) against TB. The previous policy of universal immunisation of twelve year old children not already immune has stopped. In order to provide a more effective programme, immunisation early in life will be targeted at those children at greatest risk in the first year of life. In low prevalence areas like Southampton this means that only those children with a parent or grandparent born in a higher incidence (>40/100,000) country will be immunised. This should ensure that there is greater coverage of children who might be at risk, while not immunising those youngsters who are at low risk.

Progress in devising and implementing the TB action plan will be made by working closely with our partners in neighbouring PCTs, the City Council, Southampton University Hospitals Trust, the Strategic Health Authority as well as the Health Protection Unit.

Priorities for TB include:

- Raising awareness of TB in communities at risk and in health professionals
- Ensuring effective delivery of the new immunisation programme
- Commissioning and providing effective and appropriate TB treatment, particularly community services. These must be sensitive to the needs of all communities
- Continue enhanced surveillance of TB, and appropriate control measures including identification of contacts at risk

## Recommendations

Students and those who are still at risk from mumps should continue to be offered immunisation

Work should continue with parents to ensure that uptake of MMR remains high and immunisation coverage improves

The TB action plan should be implemented in collaboration with partners, with appropriate resources identified

## References and notes

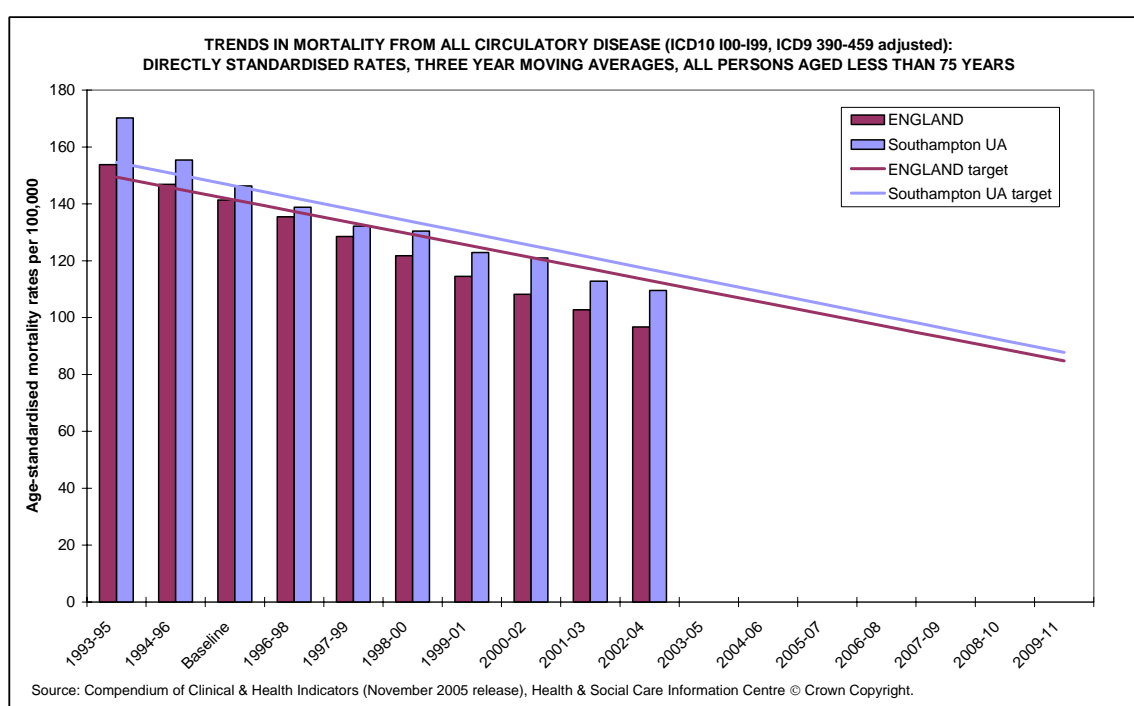
1. The Health Protection Agency (HPA) is a non-departmental public body that protects the health and well-being of the population. The Agency plays a critical role in protecting people from infectious diseases and in preventing harm when hazards involving chemicals, poisons or radiation occur. It also prepares for new and emerging threats, such as a bio-terrorist attack or virulent new strains of disease.  
([www.hpa.org.uk](http://www.hpa.org.uk))
2. Donaldson LJ, Donaldson RJ. *Essential Public Health*. London: Petroc Press. 2000
3. Donaldson L. *Stopping Tuberculosis in England. An Action Plan from the Chief Medical Officer*. London: Department of Health. 2004

# Health in Southampton 2005

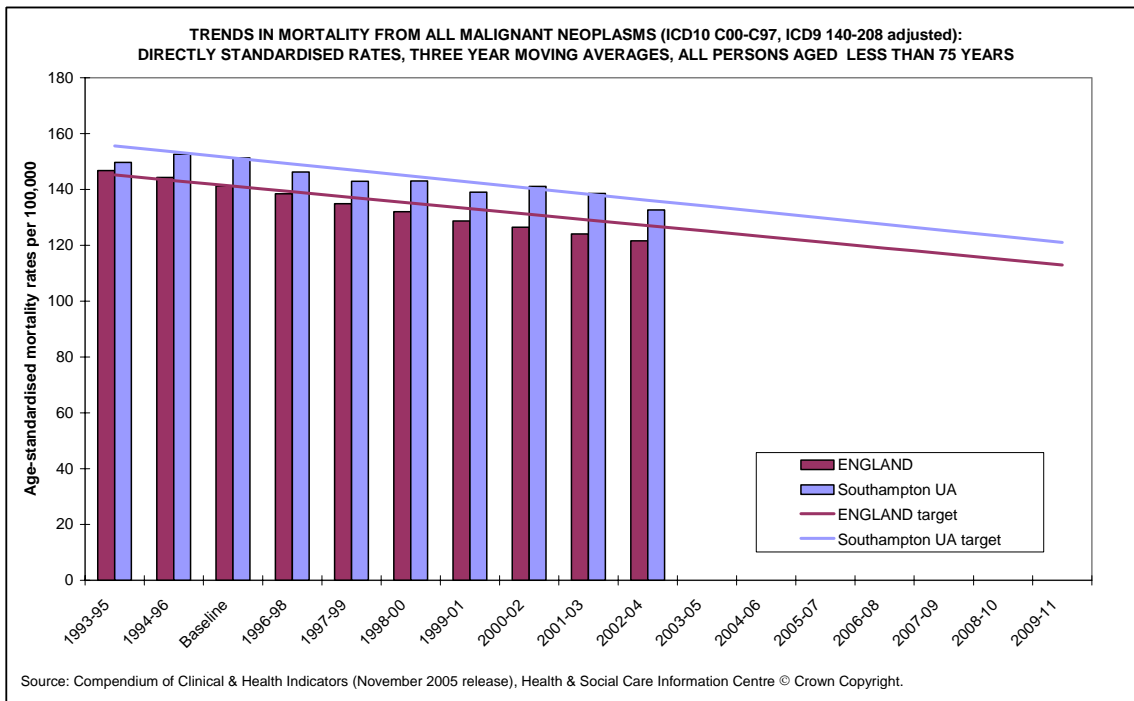
## Key Public Health Indicators For Southampton

The following charts show Southampton's progress towards the four key public health targets in the Government's White Paper *Our Healthier Nation*, the first three of these remain key indicators in the Local Delivery Plan process.

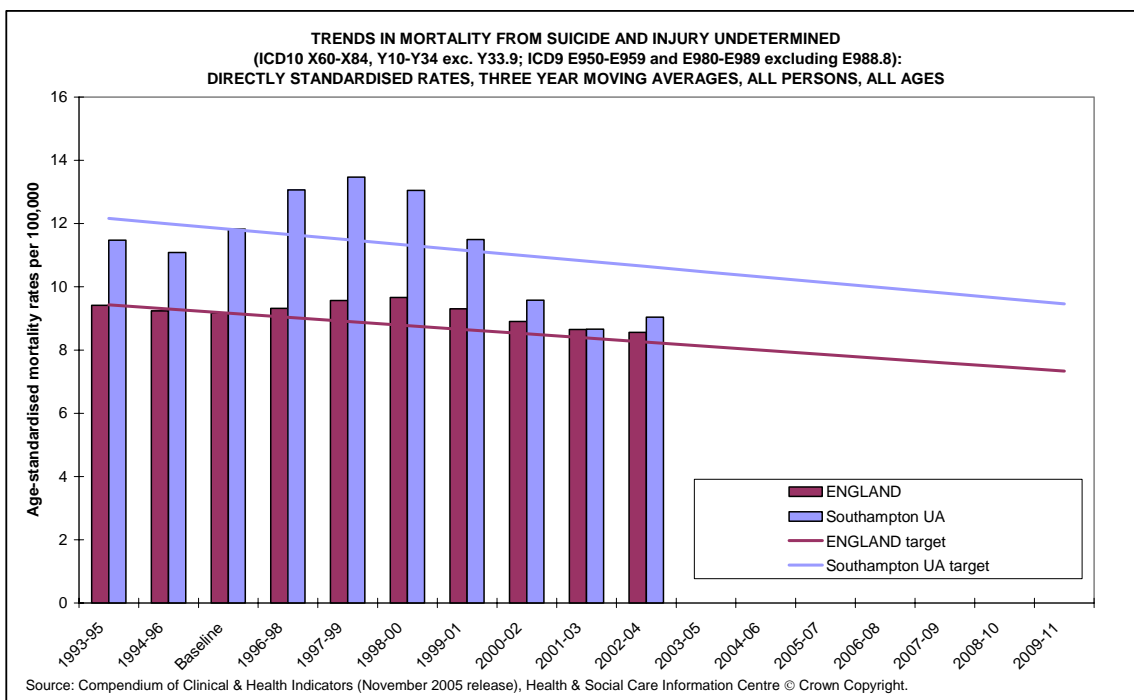
Circulatory diseases are a major cause of illness and death both locally and nationally. In 2004 there were 720 deaths to Southampton residents from circulatory diseases; of these, 370 were from coronary heart disease and 199 were from stroke. The Government set a target for reducing mortality from circulatory diseases amongst the under 75s by 40% by 2010 (from the 1995-97 baseline). The chart below shows that good progress towards this target has been made in Southampton and nationally.



In 2004 26.4% of deaths to Southampton residents were due to cancer. The next chart shows that mortality from cancer amongst the under 75's in Southampton is only just falling in line with the Government's target reduction of 20% by 2010. Lung cancer is a particular issue in Southampton, accounting for higher mortality rates here than in similar authorities such as Exeter, Bournemouth and Brighton (ONS classification 2001-Southampton is in the regional centres grouping).



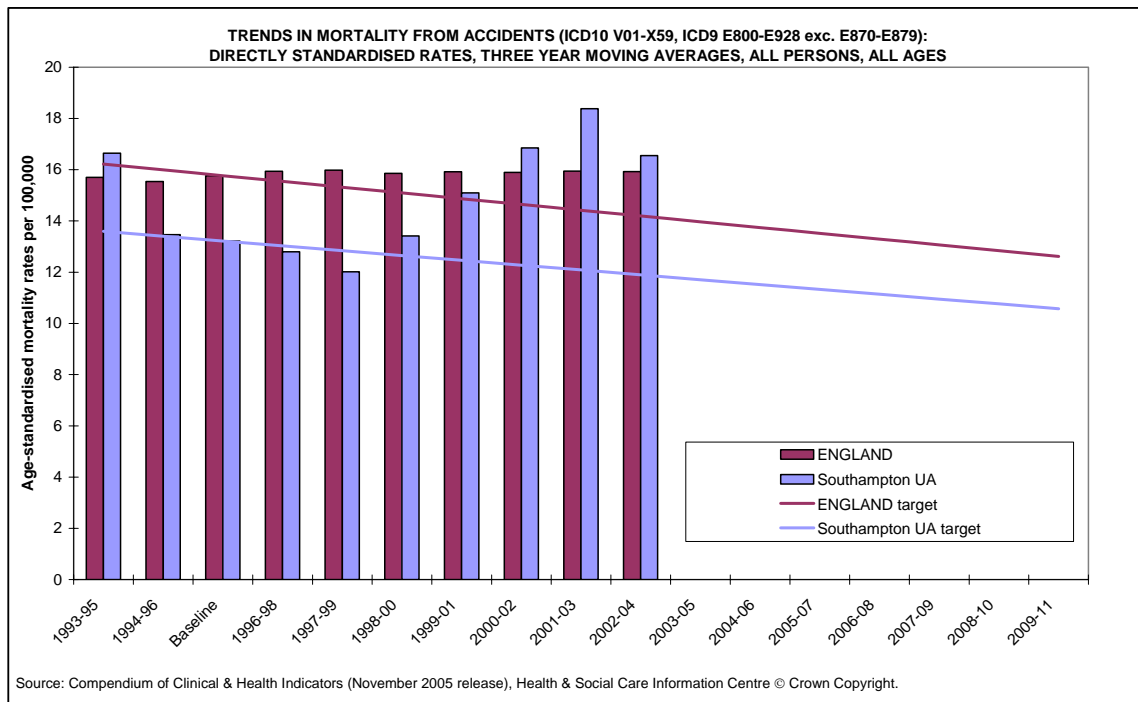
It is more difficult to monitor trends in mortality from suicide and accidents as these account for a much smaller number of deaths and, therefore, the year-on-year variability is much greater.



In 2004 there were 22 deaths from suicide or undetermined injury in Southampton. The chart above shows how mortality rates from this cause have varied over the past few years but overall is in line with the target reduction set in 'Our Healthier Nation'.

In 2004, 43 residents of Southampton died from an accidental cause. The chart below shows the variability in accident mortality rate over the past few years. Rates appear to have risen since 1998 but further analysis of the data shows that the confidence intervals

around these rates are so large that the differences observed are not statistically significant.



Key data from Compendium of Clinical & Health Indicators (November 2005 release), and other government sources are set out in an appendix to this report.

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## *Health in Southampton 2005*

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# **The Major Health Issues for Southampton's Localities**

### **Summary Findings from *Local Health Comparisons 2005*<sup>1</sup>**

#### **Central locality**

- The Central locality is characterised by large numbers of students, a greater ethnic mix and high levels of deprivation. It also contains the areas of the City forecast to see the most residential development and, therefore, the largest population increases
- Residents of Central locality generally have poorer health, higher mortality rates and lower life expectancy than the national or local average. This area has, however, seen significant improvements in mortality rates over the last few years although these may be explained, to some extent, by residential development and associated demographic change in this locality
- Cancer and circulatory diseases are a big issue in the Central locality, as they are in the rest of the City. However, here there is evidence of a lower uptake of breast and cervical cancer screening programmes. There are also indications that patients with circulatory disease are being less well managed here; for instance, the proportion of patients with Coronary Heart Disease (CHD) or stroke who have blood pressure controlled is lower and there are fewer revascularisation procedures to every death from CHD
- The central locality also has a high prevalence of both diabetes and mental illness

#### **East locality**

- The East locality has a slightly older age profile than the City average and high proportions of residents are claiming benefits such as income support
- A big public health issue for Southampton East is infant health as levels of smoking in pregnancy are higher here than elsewhere in the City and breastfeeding rates are lower. In other areas improvement on these indicators has been seen over the past year but in the East locality the situation has actually got worse not better
- Cancer and circulatory disease are the major causes of illness and death in the East locality. There is no statistically significant improvement in mortality from these causes over the past few years

## North locality

- The demography of the North locality is characterised by the very large number of students. The impact of this young and relatively healthy population group can make the calculation of meaningful health indicators difficult. The population of this locality is more ethnically diverse than the City average
- Although the North has generally lower levels of deprivation than other City localities there are pockets within this area of very high need and overall deprivation levels are significantly higher here than in the SW Hampshire localities outside of the City
- Illness and mortality rates may be lower in the North than the City average but compared to the remainder of SW Hampshire this locality scores worse on many health indicators
- Cancer and circulatory disease are the major causes of morbidity and mortality in the North locality

## South locality

- The South of Southampton is characterised by a younger population and some areas experiencing very high levels of deprivation
- This locality has generally poorer health than the local or national average and high rates of emergency hospital episodes
- Data from the maternity units records high levels of smoking in pregnancy and low levels of breastfeeding. Additional information from health visitors shows that breastfeeding rates decline more sharply here in the weeks after the birth than elsewhere in the City
- Cancer, particularly lung cancer, is a major health issue in the South. However, this locality does have the highest rates of people accessing NHS Quitters services and high rates of prescribing of NRT and Bupropion (Zyban)
- This locality has a high prevalence of circulatory diseases and there has been no evidence of a decline in mortality from these causes over the past few years
- Rates of prescribing of anti-depressants are higher than average in this locality

## West locality

- The West of Southampton has a relatively young population and has high levels of deprivation
- The population of this locality are more likely than average to be claiming benefits, to have poor general health and to have high mortality rates
- Emergency admission rates in the West have increased over the past few years and are now the highest in the City
- Infant health is also a major issue in this area with high rates of smoking in pregnancy and low rates of breastfeeding. Additionally, over the past few years childhood obesity has consistently been more of an issue here than elsewhere in the City
- Cancer, especially lung cancer, and circulatory diseases are the main causes of ill health and mortality in this locality
- Respiratory illnesses, such as asthma and COPD, are a bigger issue in the West of the City than elsewhere in SW Hampshire

## Recommendations

The following recommendations are fundamental to improving public health intelligence in Southampton City:

A local survey on health and lifestyles should be undertaken to find data that is not available from other sources. This could provide a baseline from which the impact of public health initiatives and progress towards targets could be measured

In order to assess the health needs and the impact of health care services on all communities the quality and completeness of ethnicity recording in health record systems must be improved

Systems should be developed to that allow the fullest possible use of data from general practice, particularly the data gathered as part of the Quality and Outcomes Framework

## References

1. Binstead T, Wilkinson R. *Local Health Comparisons 2005*. Southampton City PCT 2005. Available at <http://www.southamptonhealth.nhs.uk/publichealth/lhc/lhc2005>



## Appendix - Data Tables

### 1. GENERAL HEALTH

	ENGLAND		SOUTH EAST REGION		SOUTHAMPTON	
	MALES	FEMALES	MALES	FEMALES	MALES	FEMALES
<b>LIFE EXPECTANCY AT BIRTH (YEARS) 2002-2004</b>						
Life expectancy	76.6	80.9	77.7	81.8	76.2	80.9
<b>HEALTHY &amp; UNHEALTHY LIFE EXPECTANCY (2003)</b>						
Unhealthy Life Expectancy	14.3		12.5		15.2	
Healthy Life Expectancy	64.4		67.3		63.0	
<b>LIMITING LONG TERM ILLNESS IN 2001</b>						
Percentage of total residents	17.9%		15.5%		17.4%	
Percentage of working-age residents	13.3%		10.6%		12.9%	
Directly Standardised Rate per 1000 people aged 65+	472.3		414.7		472.4	
<b>GENERAL HEALTH IN 2001</b>						
Percentage of residents with 'good health'	68.8%		71.5%		68.3%	
Percentage of residents with 'fairly good health'	22.2%		21.4%		23.1%	
Percentage of residents with 'not good health'	9.0%		7.1%		8.6%	
<b>PROVISION OF UNPAID CARE IN 2001</b>						
Percentage of people who provide unpaid care	9.9%		9.2%		8.3%	
Percentage of people who provide more than 50 hours per week unpaid care	2.0%		1.6%		1.8%	

Sources:

Office for National Statistics, VS3 Mortality Tables (©Crown Copyright);

Office for National Statistics, 2001 Census (©Crown Copyright);

Office for National Statistics, Mid-2003 Population Estimates (©Crown Copyright).

## 2. FERTILITY

	ENGLAND		SOUTH EAST REGION		SIMILAR AUTHORITIES*		SOUTHAMPTON	
<b>FERTILITY RATE IN 2004</b>								
General Fertility Rate*	58.4		57.4		52.1		50.0	
*Live Births to women aged 11-49 years per 1000 women aged 15-44								
<b>NUMBER AND PERCENTAGE OF LIVE BIRTHS BY MATERNAL AGE IN 2004</b>								
<b>MATERNAL AGE</b>	Number	%	Number	%	Number	%	Number	%
Under 16	1154	0.19%	138	0.15%	143	0.27%	7	0.27%
16-19	40820	6.72%	4984	5.32%	4367	8.27%	243	9.34%
20-24	113779	18.74%	14353	15.33%	10970	20.76%	640	24.59%
25-34	333503	54.93%	53083	56.69%	28112	53.21%	1358	52.17%
35-39	98031	16.15%	17455	18.64%	7716	14.60%	293	11.26%
40+	19897	3.28%	3621	3.87%	1526	2.89%	62	2.38%
Total	607184	100.00%	93634	100.00%	52834	100.00%	2603	100.00%
<b>PERCENT OF BIRTHS UNDER 2500 GRAMS IN 2004</b>								
<2500 grams	7.9%		7.1%		8.2%		8.3%	
*Includes live and still births								
<b>UNDER 18 CONCEPTIONS IN 2003</b>								
Number of conceptions	39553		4932		4027		212	
Conception Rate*	42.1		33.1		50.0		58.5	
Percentage leading to abortion	46.0%		48.2%		n/a		33.0%	
*Under 18 conception rate is the number of conceptions per 1000 females aged 15-17 years.								

Notes:

\*The ONS 2001 Classification of similar authorities placed Southampton in the 'regional centres' comparator group

Sources:

Compendium of Clinical & Health Indicators (November 2005 release), Health & Social Care Information Centre © Crown Copyright. Office for National Statistics, Vital Statistics Tables (©Crown Copyright); Teenage Pregnancy Unit

### 3. INFANT MORTALITY

	ENGLAND	SOUTH EAST REGION	SIMILAR AUTHORITIES*	SOUTHAMPTON
<b>PERINATAL* MORTALITY RATE (PER 1000 TOTAL BIRTHS) IN 2002-2004</b>				
*Includes stillbirths and deaths in the first week of life				
Observed	14786	1906	1287	56
Rate	8.3	6.9	8.3	7.3
<b>MORTALITY RATES IN INFANCY (PER 1000 LIVE BIRTHS) AND NUMBER OF DEATHS IN 2002-2004</b>				
<b>UNDER 1 YEAR</b>				
Observed	9216	1150	832	25
Rate	5.2	4.2	5.4	3.3
<b>UNDER 28 DAYS</b>				
Observed	6291	777	563	21
Rate	3.6	2.8	3.7	2.7
<b>UNDER 7 DAYS</b>				
Observed	4842	584	422	16
Rate	2.7	2.1	2.7	2.1

Notes:

\*The ONS 2001 Classification of similar authorities placed Southampton in the 'regional centres' comparator group

Source:

Compendium of Clinical & Health Indicators (November 2005 release), Health & Social Care Information Centre Crown Copyright.

#### 4. MORTALITY – Number of deaths per year

CAUSE OF DEATH	ICD10 CODES	ENGLAND		SOUTH EAST REGION		SIMILAR AUTHORITIES*		SOUTHAMPTON	
		MALES	FEMALES	MALES	FEMALES	MALES	FEMALES	MALES	FEMALES
<b>AVERAGE ANNUAL NUMBER OF DEATHS FROM SELECTED CAUSES BY AGE AND SEX (average for 2002-2004 period)</b>									
All cancer (all ages)	C00-C97	66318	60920	10494	9778	6401	6056	275	246
Lung Cancer (under 75s)	IC33-C34	8958	5534	1227	741	920	652	53	28
Lung Cancer (all ages)	C33-C34	16064	10761	2273	1493	1706	1269	83	51
Breast cancer (50-69 yr olds)	C50		3578		626		283		11
Breast cancer (all ages)	C50		10528		1798		945		41
Cervical cancer (15-64 yr olds)	C53		427		56		38		#
Cervical cancer (all ages)	C53		904		129		90		5
Coronary heart disease (under 75s)	I20-I25	22024	8204	2968	1065	2094	808	93	34
Coronary heart disease (all ages)	I20-I25	50591	41034	7579	6316	4865	4171	216	169
Stroke (under 65s)	I60-I69	2084	1623	289	231	187	150	7	8
Stroke (all ages)	I60-I69	20205	32773	3176	5506	1913	3222	72	126
Accidents (all ages)	V01-X59	5706	4551	882	761	543	418	23	25
Suicide and self-inflicted injury and injury undetermined (all ages)	X60-X84, Y10-Y34 exc. Y33.9	3305	1169	521	331	233	74	16	#
Suicide and self-inflicted injury (all ages)	X60-X84	2358	727	386	121	349	74	14	#
All Causes (all ages)	A00-Y99	234907	260306	36734	63497	22746	25921	981	1033
All Causes - under 15 years	A00-Y99	2445	1913	323	247	228	165	7	6
All Causes - 15-64 years	A00-Y99	48806	30339	6911	4531	4868	2848	223	126
All Causes - 65-74 years	A00-Y99	51050	35923	7416	5205	4807	3483	206	145

Notes:

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[ ] square brackets indicate that the rate is calculated from a small number of events and, therefore, is subject to greater uncertainty and large confidence intervals

Source:

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## 5. MORTALITY – Rates

	ICD10 CODES	ENGLAND		SOUTH EAST REGION		SIMILAR AUTHORITIES*		SOUTHAMPTON	
		MALES	FEMALES	MALES	FEMALES	MALES	FEMALES	MALES	FEMALES
<b>CRUDE DEATH RATE (PER 100,000 POPULATION) IN 2004</b>									
Rate per 100,000	A00-Y99	933.00	985.20	902.40	988.30	987.80	1066.60	821.90	894.20
<b>AVERAGE DIRECTLY AGE-STANDARDISED DEATH RATES (PER 100,000 POPULATION) AND NUMBER OF DEATHS FROM ALL CAUSES (ICD 001-999) IN THE PERIOD 2002-2004</b>									
Rate per 100,000	A00-Y99	784.90	543.70	716.40	502.20	848.40	571.10	812.10	546.60
Observed number of deaths (3 years)	A00-Y99	704720	780918	110201	126993	68238	77763	2944	3100
<b>DIRECTLY AGE-STANDARDISED DEATH RATES (PER 100,000 POPULATION) FOR SELECTED CAUSES OF DEATH IN THE PERIOD 2002-2004</b>									
<b>(Rates are for all ages unless otherwise specified)</b>									
All cancer	C00-C97	222.0	156.2	207.6	148.2	242.5	167.3	234.0	162.3
Lung Cancer (under 75s)	C33-C34	35.2	20.2	29.4	16.6	43.0	27.7	45.6	28.5
Breast cancer (50-69 yr olds)	C50		63.2		67.1		59.9		56.7
Cervical cancer (15-64 yr olds)	C53		2.6		2.0		2.7		[3.3]
Coronary heart disease (under 75s)	I20-I25	86.8	28.7	71.0	22.6	97.7	32.4	98.9	32.5
Stroke (under 65s)	I60-I69	9.7	7.3	8.1	6.4	10.3	8.2	8.0	10.4
Accidents	V01-X59	21.5	10.4	20.3	9.9	22.3	10.4	20.3	12.6
Suicide and self-inflicted injury and injury undetermined	X60-X84, Y10-Y34 exc. Y33.9	13.0	4.3	12.7	4.2	14.6	5.0	14.2	[3.6]
Suicide and self-inflicted injury	X60-X84	9.3	2.7	9.4	2.6	10.2	3.1	11.9	[1.7]

Notes:

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Source:

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## 6. MORTALITY – Standardised Years of Life Lost

	ICD10 CODES	ENGLAND		SOUTH EAST REGION		SIMILAR AUTHORITIES*		SOUTHAMPTON	
		MALES	FEMALES	MALES	FEMALES	MALES	FEMALES	MALES	FEMALES
<b>STANDARDISED AVERAGE ANNUAL YEARS OF LIFE LOST PER 10,000 RESIDENT POPULATION AGED UNDER 75 BY SELECTED CAUSE OF DEATH IN THE PERIOD 2002-2004</b>									
All cancer	C00-C97	167.0	154.3	154.4	148.6	187.2	162.9	173.9	169.5
Lung cancer	C33-C34	37.3	23.6	31.7	19.9	46.9	32.2	46.9	32.7
Skin cancer	C43	4.1	3.0	4.8	3.3	4.3	3.1	2.7	3.4
Breast cancer	C50		38.3		39.7		35.7		31.1
Cervical cancer	C53		5.0		3.9		5.6		7.0
Coronary heart disease	I20-I25	101.6	27.4	82.6	21.3	117.7	32.0	118.9	28.7
Stroke	I60-I69	24.6	18.8	20.6	16.5	25.9	21.0	23.6	30.8
Accidents	V01-X59	60.8	18.0	58.6	16.6	60.5	18.6	39.5	8.2
Suicide and self- inflicted injury and injury undetermined	X60- X84,Y10- Y34 exc. Y33.9	43.4	13.2	41.6	12.6	48.3	15.8	44.3	9.2
Suicide and self- inflicted injury	X60-X84	30.3	8.0	30.2	7.7	33.4	9.5	38.9	4.4
Infectious and parasitic diseases	A00-B99	8.6	6.1	6.9	4.9	9.3	6.2	8.1	6.9
Stomach cancer	C16	6.3	2.9	5.2	2.2	6.9	3.6	3.5	3.5
Pneumonia	J12-J18	11.0	7.2	9.5	5.8	12.6	7.7	15.9	3.8
Chronic liver disease and cirrhosis	K70, K73- K74	26.6	13.4	21.0	10.5	39.3	17.7	43.3	21.4
All causes	A00-Y99	604.5	362.7	529.2	327.3	695.6	397.1	658.3	395.0

Notes:

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## 6. MORTALITY – Avoidable causes of death

	ICD10 CODES	ENGLAND		SOUTH EAST REGION		SIMILAR AUTHORITIES*		SOUTHAMPTON	
		MALES	FEMALES	MALES	FEMALES	MALES	FEMALES	MALES	FEMALES
<b>INDIRECTLY STANDARDISED MORTALITY RATIOS FOR "AVOIDABLE" AND OTHER POTENTIALLY REDUCIBLE CAUSES OF DEATH IN THE PERIOD 2002-2004</b>									
Cervical cancer (ages 15-64)	C53		100		85		110		[131]
Asthma (ages 5-44)	J45-J46	100	100	87	88	93	94	[133]	[139]
Tuberculosis (ages 5-64)	A15-A19	100	100	81	59	105	90	#	#
Hodgkin's disease (ages 5-64)	C81	100	100	90	96	102	77	#	#
Breast cancer (ages 50-64)	C50		100		107		95		87
Acute myocardial infarction (ages 35-64)	I21-I22	100	100	76	77	121	120	98	[124]
Other ischaemic heart disease (ages 35-64)	I20, I23-I25	100	100	82	75	114	118	137	[83]

### Notes:

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