

health in southampton 2006



Southampton City Primary Care Trust

Health in Southampton 2006

Report of the Public Health Director



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Health in Southampton 2004 and 2005

In 2004 we reported on the following topics:

- Sexual Health
- Obesity
- Alcohol
- Environmental Tobacco Smoke
- Later Years

In 2005 we reported on the following topics:

- Best Start in Life
- Dental Health
- Health and Housing in Southampton
- Independence and Well-being for Older People
- Poverty, Disadvantage and Exclusion

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

Health in Southampton 2006

Introduction

In 1998 a unique research project began – the Southampton Women’s Study (SWS). Since then 12,500 women living in the Southampton area have been enrolled, and researchers at the University of Southampton will be following them up for many years. The health of these women and their children is the key focus of the research, and findings from the study will help us as we plan new ways of encouraging and enabling people to improve their health.

This year’s Public Health report presents some of the early conclusions from the study, and looks more generally at women’s health. Women live longer than men, but not more healthily. There are significant health inequalities in women’s health across the City, and young women with poor educational attainment are a key group to target, supporting them to make healthy lifestyle choices.

Work to improve health across the City continues to focus on the range of issues that are set out in our *Health and Well-being Strategy*¹. This year we are highlighting two further challenges that we are working on, and that could make a real difference to health in our City.

One in four of us suffer from a mental health problem at some time during our lifetime. Mental health and well-being is therefore important, along with physical health, for quality of life and life expectancy. A lot is being done to promote better mental health, and to support and treat those with mental illness. This report explores a range of issues where more can and must be done to reduce the stigma of mental illness, and limit the devastating impact it can have on individuals and their families.

The health of some of our minority ethnic communities is not as good as that of the rest of the population. A needs assessment has identified some of the reasons for this, and shown that mental well-being, diabetes, heart disease, and access to translating and interpreting services are priority areas for action and improvement.

This year’s report also looks at the environment and global warming which is increasingly important to the public and politicians. The chapter on sustainability and health explores this subject.

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 2006*², which is available on-line and other local public health briefings are available on our website.

Each year a number of recommendations are made in our public health reports. Progress on implementing these is monitored in a separate report that is updated and available on-line, or on request.

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1. *Making the Difference: Choosing Health Caring Communities. Southampton's Health and Well-being Strategy Stage 2: a Framework for Action.* Southampton Partnership 2005. Available at: <http://www.southamptonhealth.nhs.uk/publichealth/plans/hwbs>
2. King D, Wilkinson R. *Local Health Comparisons 2006.* Southampton City PCT 2006. Available at <http://www.southamptonhealth.nhs.uk/publichealth/lhc/lhc2006>

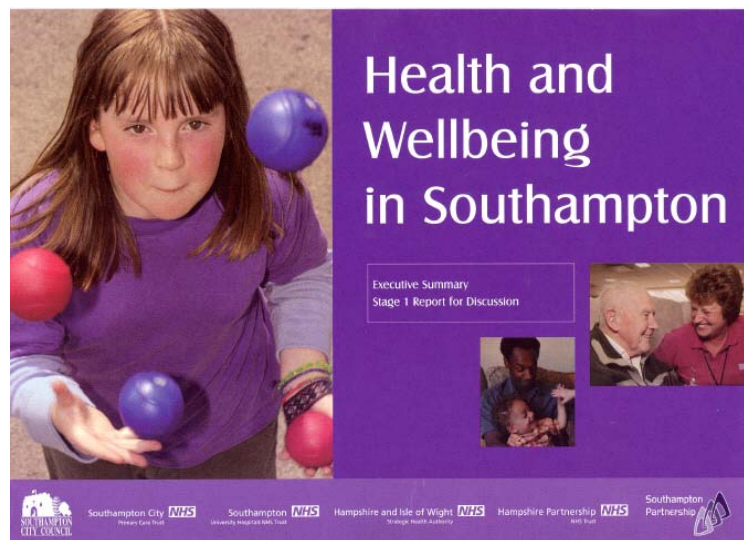
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Key priorities for local action



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
 - Smokefree City

Women's Health

Introduction

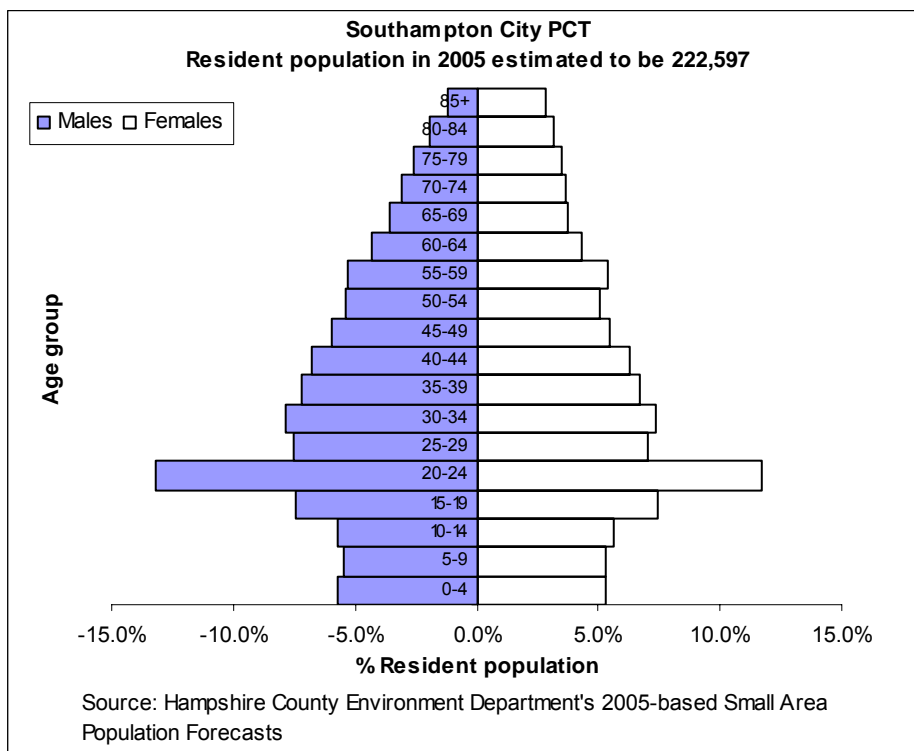
This chapter provides information about the health status of women and girls living in Southampton. We highlight some of the differences in patterns of disease between men and women, and some of the health issues that are particular to women. It looks in more detail at the health of young women, and in particular the lifestyle choices that they make.

Background

Demography

In 2005 there were 110,464 women and girls living in the Southampton City Primary Care Trust (SCPCT) area.

The population pyramid shows the distribution of males and females in the City.



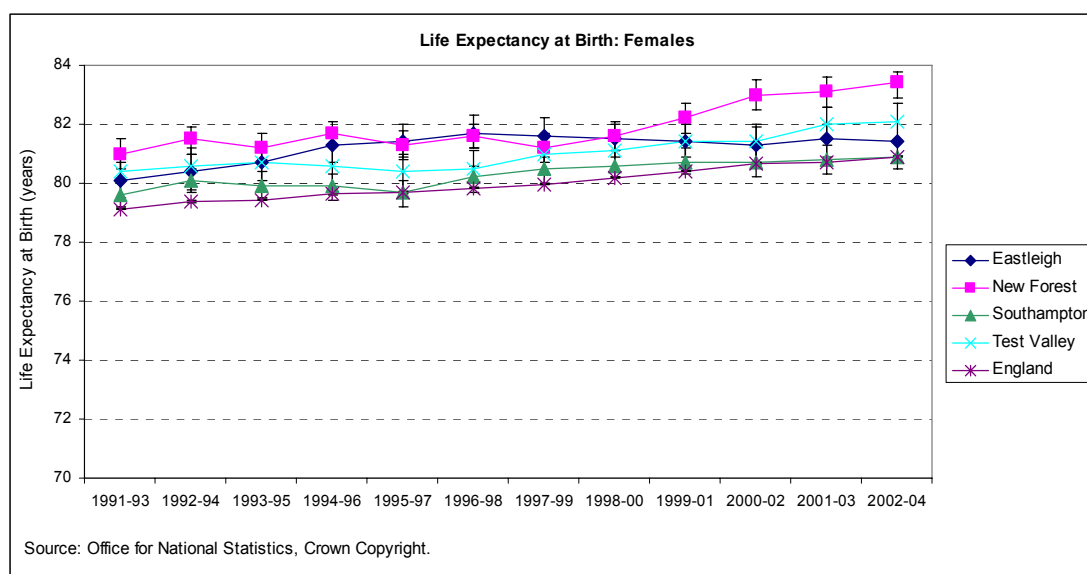
Women and girls make up almost 50% of the population, but the distribution is uneven with more women in the older age bands. From the age of 55 women outnumber men in every age band and there are over twice as many women as men aged over 85.

In common with the national trend Southampton has an ageing population but unlike the national population there are more young adults between the ages of 15 and 24.

Overall the population of SCPCT is forecast to grow by 4.2% between 2005 and 2012, with a smaller percentage increase predicted in females (3.3%) compared to males (5.1%). The rise is sharper and the difference more pronounced when we look at the over 65s, where the number of women is predicted to increase by 9.2% and the number of men by 18.8%.

Life expectancy

Life expectancy at birth is commonly used as an indicator of the health in an area. It is an estimate of the average number of years babies would be expected to live at current population death rates. Over the last ten years life expectancy has increased both nationally and locally, with the greatest improvement in life expectancy for men.



Life expectancy is significantly higher for women than men in all parts of Southampton, and is highest in the North and East localities. Unfortunately some of these extra years will not be lived in good health and women are more likely to spend more years in poor health or with a disability than men. The increase in life expectancy has implications for the PCT when we are planning for the health of the population, as the prevalence of long term conditions increases with age, and an ageing population places high demands on health and social care services.

Ill health

The number of people with a long-term health problem or disability is a useful indicator of the overall health of a population. Chronic diseases such as coronary heart disease, stroke, diabetes, back problems, arthritis and mental illness are the most likely to impair the quality of life.

Arthritis and rheumatism are the most common types of chronic disease in England and they become more common with increasing age. Women are almost twice as likely to suffer from arthritis and rheumatism as men. In 2004/05 in England the prevalence rate in women between the ages of 65 and 74 was 194/1000 compared to 110/1,000 in men.

Osteoporosis is a weakening of the bones that can lead to breaks which are difficult to heal. The wrists, hips and spine are particularly at risk. One in three women are

affected by osteoporosis compared to one in twelve men. Osteoporosis was discussed in detail in the 2005 report.

The 2001 Census asked about long term illnesses and health problems which limited people's daily activities or work. In Southampton over 37,000 residents (17.4%) reported living with a long term illness of whom almost 20,000 were women. This is slightly below the England and Wales rates of 19% for women and 17% for men.

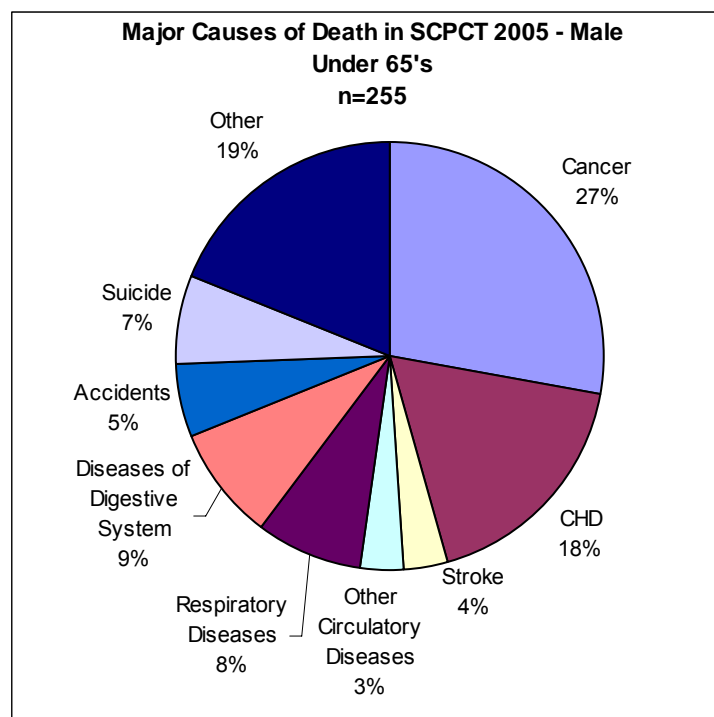
Mortality

Mortality data describe the number and causes of death in a population. Although they help characterise health problems they are rather insensitive and do not reflect the full burden of disease.

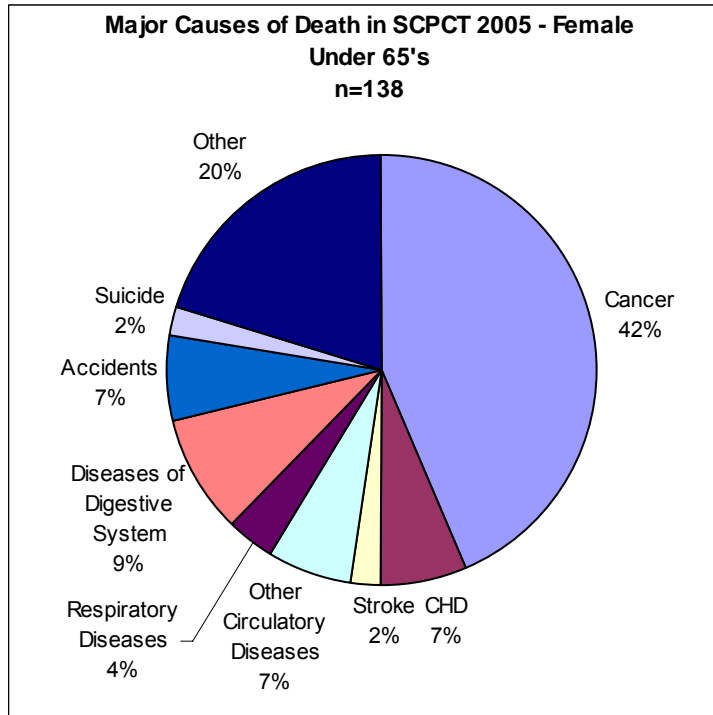
Premature deaths

Out of a total of 1,957 deaths in Southampton in 2005, 393 occurred in people under the age of 65 (premature death). In Southampton premature death rates are significantly lower in women (174 per 100,000) than in men (270 per 100,000). This is true in all localities, but the difference is most striking in the Central locality, which has the highest rates in the City. Here rates in women are 176 per 100,000, less than half those for men (385 per 100,000). However, women in Southampton are more likely to die earlier than women in other parts of south west Hampshire where rates are significantly lower: 119 per 100,000 in the New Forest and 125 per 100,000 in Eastleigh and Test Valley South.

The charts below show the causes of early death in men and women in Southampton.



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Both men and women are most likely to die early from cancer but cancer has a relatively greater impact on women accounting for 42% of early deaths compared to 27% in men.

Cardiovascular disease is the second biggest killer and accounts for 16% of deaths in women under 65 and 25% in men.

Women are slightly more likely than men to die in an accident, while suicide is more than three times more common in men.

Coronary Heart Disease

Coronary Heart Disease (CHD) is the leading cause of death for women in England, accounting for around one in six deaths and killing 125,000 women every year - 48,000 more than die from cancer. Although mortality rates are falling rapidly, morbidity from CHD is rising.

Women have lower rates of CHD than men. The 2003 *General Household Survey* found that 4.5 % of women in England have CHD compared to 7.4% of men, i.e. rates are 1.6 times higher in men.

Overall rates of CHD in Southampton are similar to national rates but we do not have separate rates for men and women. Local data suggests that the South locality has the highest rates of CHD.

Angiography is used to investigate CHD. The ratio of investigations in men compared to women is 1.7, which is what we would expect from the prevalence rates. When we look at the rates of invasive treatment with coronary artery bypass grafts (CABG) and angioplasty the picture is a little different. CABG rates in Southampton are four times higher in men than in women and angioplasty rates are

two and a half times higher. Revascularisation rates are rising, although the proportion of CABGs is falling as angioplasty becomes the treatment of choice for more people with CHD.

These data raise some interesting questions regarding the diagnosis and investigation of CHD in women. We know that CHD is frequently under diagnosed in women as it has been seen as a male disease. Our local data suggest that women are being investigated in appropriate numbers with angiography but that rates of revascularisation in women are lower than we would expect from the prevalence rate for CHD in women, suggesting that there may be inequity of access to treatment.

There are a number of possible explanations: women may have less severe CHD than men; they may be referred less readily for tests and invasive treatment, and; they may be less willing to accept invasive treatment.

Cancer

Cancer affects men and women differently. Breast cancer is by far the most common cancer in women, accounting for one in three of all cancers. The second most common cancer in women is bowel cancer, followed by lung cancer. Together these three account for just over half of all cancers in women. In men prostate cancer has overtaken lung cancer to become the most commonly diagnosed cancer with bowel cancer the third most common.

Lung cancer

Lung cancer is the second most common cause of death from cancer in women. Lung cancer rates in Southampton are the highest in the South East - over 50% higher than the regional average. The highest rates are in the Central, South and West localities. About half as many women as men develop lung cancer.

The causal link between smoking and lung cancer is well established with around 90% of lung cancers in the UK caused by smoking. We know that Southampton has particularly high smoking rates amongst men and women and this is discussed in more detail later in the chapter.

There is a strong link between the incidence of lung cancer and deprivation which is due in part to the fact that smoking rates are higher in areas of high deprivation. Survival rates are very poor for all lung cancer patients but those from lower socio-economic groups have the worst survival rates.

Breast cancer

Breast cancer is the commonest cancer in women and the commonest cause of death from cancer. The incidence of breast cancer in the PCT is 119 per 100,000, below the regional average of 121 per 100,000 which is what we would expect. In contrast to lung cancer, the incidence of breast cancer is highest amongst affluent women and lower amongst socio-economically deprived groups. This is largely due to differences in the most important risk factors for breast cancer:

- Having a late menopause
- Having fewer full term pregnancies
- Having your first baby when you are older

Many of these are hard to influence. However, there is some evidence that women who exercise regularly may have up to a 30% lower risk of developing breast cancer.

Affluent women live longer following a diagnosis of breast cancer, suggesting that disease management is more effective in this group. Why women from deprived groups do less well is not clear but it is likely to be due to a number of factors including: a lower uptake of screening, later presentation, co-morbidity and poorer access and uptake of treatments.

Breast screening

The national breast screening programme is estimated to reduce mortality from breast cancer by 35% in women who participate. Recently the upper age for the programme has been extended to include women aged 65 -70 years.

Uptake in Southampton is just below the national average of 74% but varies between localities, being particularly poor in the City centre at 66%. We know that there is low uptake in socio-economically deprived groups and in some minority ethnic groups and we need to continue to identify and remove the barriers to screening in these groups.

Cervical cancer

The incidence of cervical cancer fell by 42% between 1988 and 1997 and this has been directly attributed to the national screening programme. Rates of cervical cancer in the PCT are the same as national rates, 8.1 per 100,000 women. The actual number of women developing invasive cervical cancer is small.

Cervical Screening

The national cervical cancer screening programme is estimated to have saved 8,000 lives between 1988 and 1997 and incidence rates have fallen by about 40% in that time.

The uptake of cervical screening in the PCT is 78%. This is lower than we would like and below the national target of 80%. The lowest rates are in the City centre and the north of the City. This mirrors the pattern seen in other urban areas in England where uptake rates have been falling. The PCT has implemented a range of initiatives to improve uptake including, out of hours smear clinics with translators available, an incentive scheme for GPs, sharing good practice within primary care and targeted support for practices with particularly low uptake rates. Work will continue to try and increase the number of women who participate in the screening programme and ensure that the service is accessible to all women.

In 2003 NICE recommended that the way smear samples are processed in the laboratory should be changed from the conventional method to the liquid based cytology (LBC) method by 2008. The change has been successfully implemented locally and represents an improvement in the screening service for women, as one of the main advantages of LBC is that far fewer smears will need to be repeated.

Lifestyle and the Southampton Women's Survey

We know that the lifestyle choices a woman makes have an enormous impact on her future health and life expectancy and can influence the health of her unborn children.

Smoking is a major cause of cancer, heart disease and chronic obstructive lung disease and continues to be the main cause of ill health and premature death in women. Smoking in pregnancy can increase the risk of miscarriage, stillbirth and low birth weight. Second-hand smoking is also known to be a cause of Sudden Death Syndrome and childhood respiratory disease.

There is a relationship between low birth weight in babies and increased risk of death from coronary heart disease in later life. Evidence suggests that if a mother has poor nutrition during pregnancy her baby is more likely to develop obesity, diabetes, high blood pressure, coronary heart disease and stroke during their adult life. Low birth weight is more common in less well-off communities and in some ethnic minorities.

Reduced physical activity in children and adults as well as excessive calorie intake has resulted in increasing obesity in the population. Obesity brings with it an increased risk of diabetes, high blood pressure, stroke and coronary artery disease. Nationally women are less likely to be overweight than men, but the proportion affected is still a major public health problem.

However, we can influence our health by changing our lifestyles. For example giving up smoking is the most effective action anyone can take to protect their own health, their child's and if they are pregnant, their baby's health too. Increasing physical activity and adopting a healthy diet can reduce obesity and prevent the onset of diabetes.

The following section of this chapter presents findings from the Southampton Women's Survey (SWS), which provides insights into the lifestyle choices of young women in Southampton which will help us to promote healthy lifestyles for women.

Southampton Women's Survey

The Southampton Women's Survey was designed to look at maternal influences on a baby's rate of growth and was run by the Medical Research Council Epidemiology Resource Centre at Southampton University. A representative sample of women living in Southampton aged between 20 - 34 were interviewed between 1998 and 2002 and data were collected on health and lifestyle. Students were generally excluded from the survey.

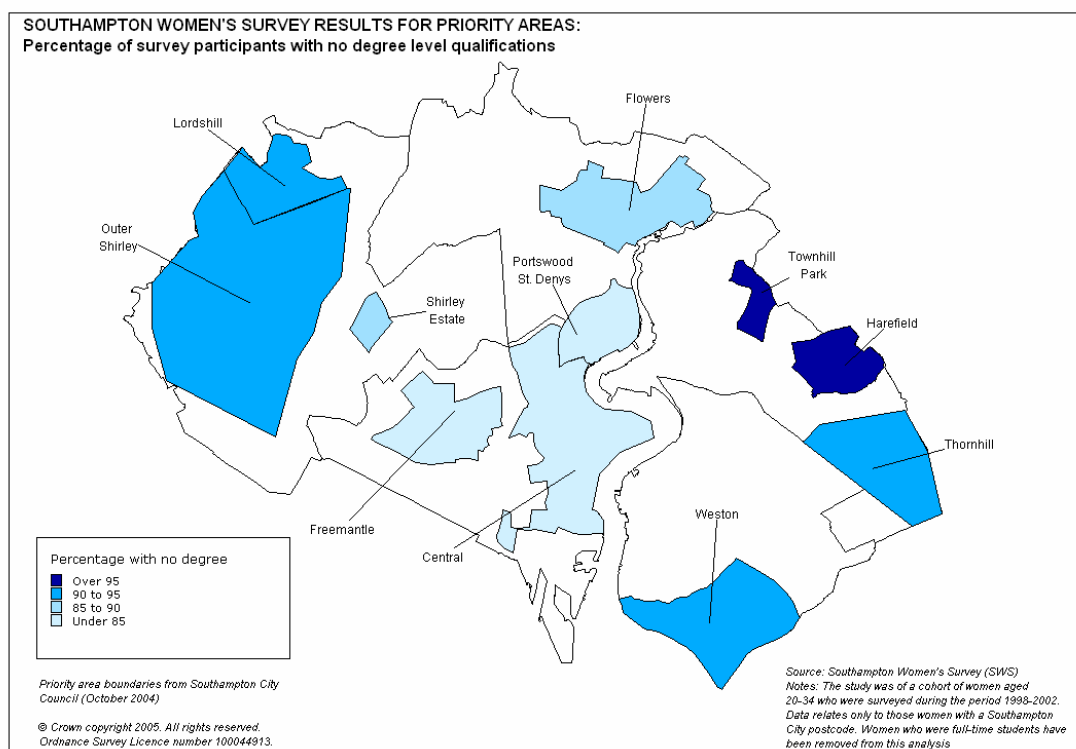
Determinants of Health

Educational attainment

Educational attainment is an important determinant of health. People with poor levels of educational attainment are more likely to have poor adult health. Educational qualifications determine the type of job you are likely to have and consequently your income, where you live and your lifestyle. Education provides a route out of poverty for those from disadvantaged backgrounds. It plays a vital role in providing children with the skills they need in order to realise their full potential, to participate fully in society and to stay safe and healthy.

The SWS found that just over a quarter (27.6%) of women had a higher level qualification defined as a degree, Higher National Diploma, teaching certificate or NVQ level 4. This is consistent with findings in the 2001 census, and is in line with the regional picture and slightly above the level for England as a whole (26%).

Educational attainment varies across Southampton City localities. In the priority areas the proportion of women with a higher level qualification is significantly lower than in the City as a whole. Fewer than 10% of women in Townhill Park, Harefield, Weston, Thornhill, Outer Shirley and Lordshill were educated to degree level, compared to over 50% of women living in Portswood – St Denys.



GCSE level attainment is poor in Southampton and well below national and regional averages: 47% of children in Southampton achieved 5 or more grades A*-C, compared to 57.6% in the South East. Girls generally perform better than boys at GCSE and in 2004/05 in the South East 62% of girls achieved five or more grades A*-C compared to 51% of boys. For Southampton the figures were much lower with only 53% of girls and 41% of boys achieving five or more A*-C grades.

Poverty

The number of people claiming benefits is one useful indicator of poverty. The number of women receiving benefits was highest in the East and West localities and this is in line with other analyses of income support benefits claimants of all ages across the City, although we know that overall deprivation across all ages and both genders is highest in the Central locality.

In the priority areas almost 30% of young women were receiving benefits, more than double the proportion across the rest of the City (11.7%). There is considerable variation between the priority areas, with over 40% of the women in the Shirley Estate and Thornhill receiving benefits compared to just 11.9% in Freemantle.

Housing

The link between poor housing and poor health has been well recognised for many years. Improving the quality of homes and of the built environment will have a significant impact on physical and mental health.

Over 18% of women living in the Flowers priority area found keeping their home warm enough was a big problem; this compares to 11.6% for the priority areas as a whole and 7.7% in the remainder of the City. Women living on the Flowers estate and in Thornhill also reported problems with condensation and damp. Living in a poorly heated, damp and poorly ventilated home increase the risk of respiratory infections and can exacerbate asthma.

Women from the Flowers estate and Thornhill felt that they did not have enough living space. Infectious diseases and stress levels are increased where there is over-crowding.

These poor housing conditions will have an impact on the health of the whole household, including men and children.

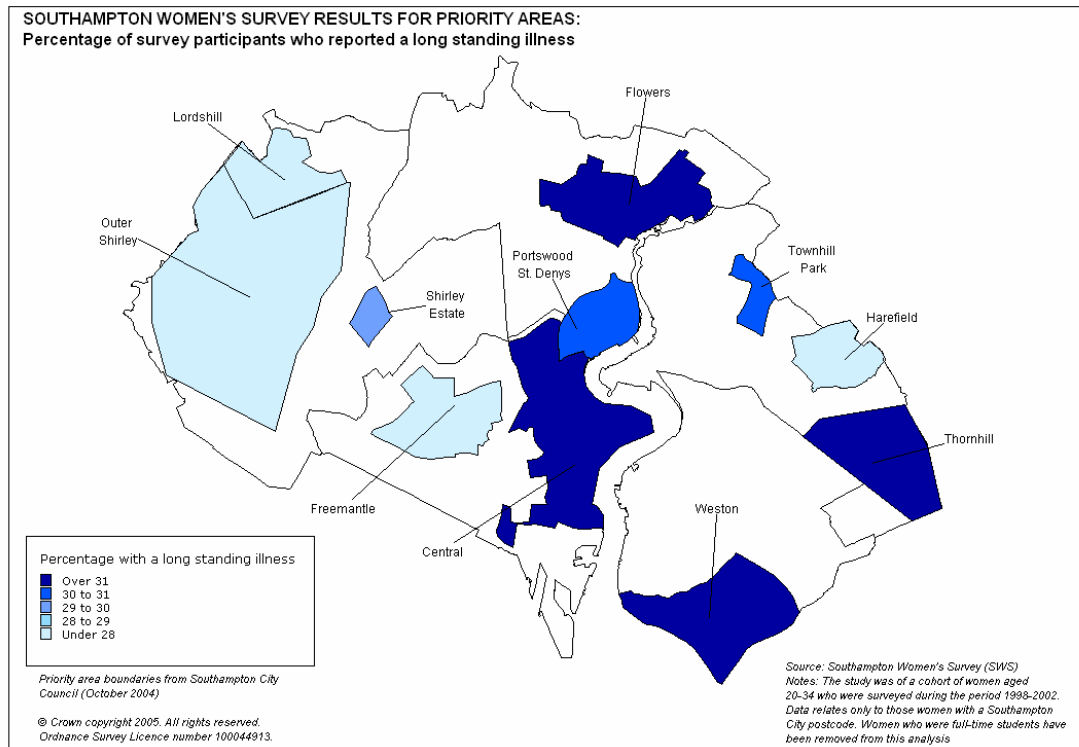
Health outcomes

General health

The SWS examined women's perception of their general health. The Central and East localities recorded the highest proportions of women reporting poorer general health. In the priority areas, 4.5% described their health as bad or very bad compared to 2.6% in the remainder of the City. In the Central and Thornhill priority areas over 8% of women perceived their health to be bad or very bad. This correlates with areas of poverty and poor housing in the City.

Long-standing illness

In the East and South localities almost a third of women had a long-standing illness, with the average 28.9% in the priority areas, compared to 26.8% in the remainder of the City. At first sight this figure is strikingly high, given that the women in the survey were under 34. However, the participants were asked if they had any long-standing illness or disability but not whether this limited their activities in any way. In contrast data from the census shows that 7% of women in this age group had a long-standing illness when asked about long term illness that affected their daily activities.



The finding is important as it tells us that a significant number of young women had a problem with their health that they wanted to report.

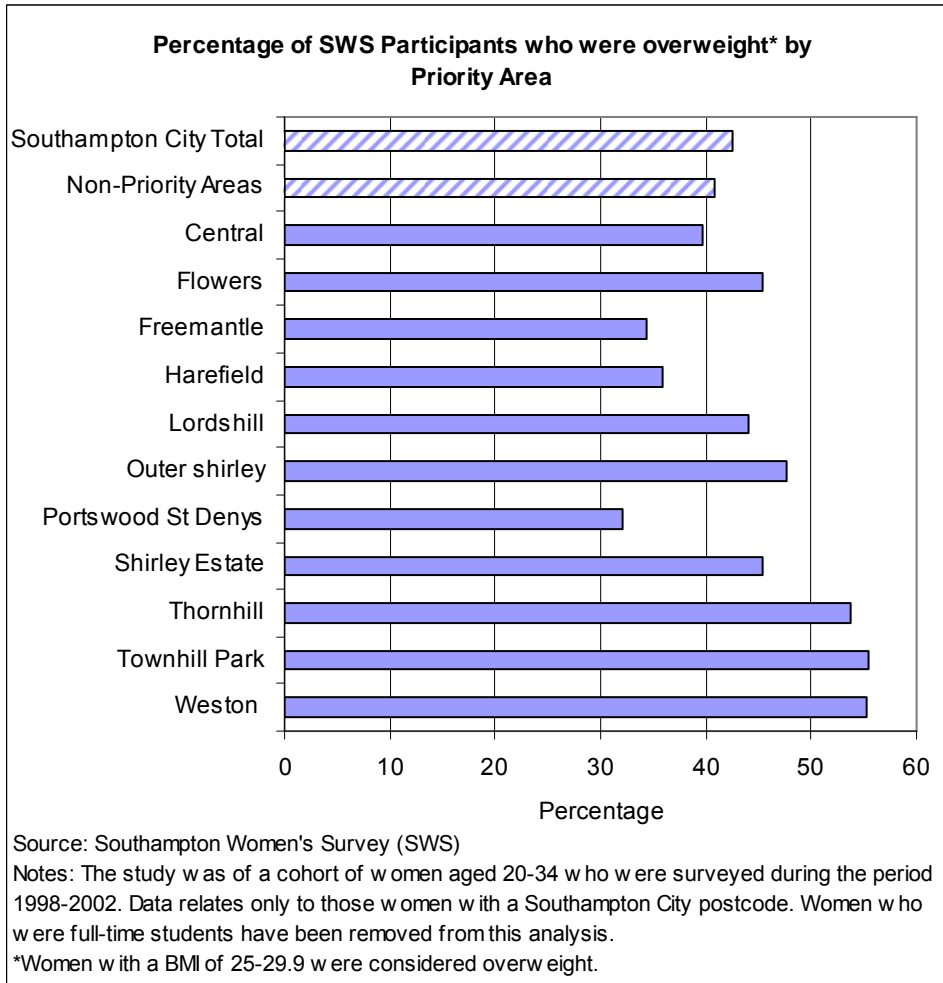
A wide range of conditions were reported including diabetes, asthma, arthritis, backache, premenstrual syndrome and mental health problems including depression, stress and drug and alcohol problems.

Stress and health

Over a fifth of young women felt that stress and pressure in their life had adversely affected their health, with the highest rates in Thornhill where almost 30% of women felt that their health was significantly affected by stress.

Obesity

Body Mass Index (BMI) is calculated from height and weight measurements. Over half the women in the survey were overweight or obese, with the highest proportion in the South locality. Women from priority areas were 1.5 times more likely to be obese: 44.5% were overweight and 19.8% obese, compared to 40.8% and 13.5% respectively for women in the remainder of the City. Rates are highest in Townhill Park and Weston where over 55% of participants were overweight.

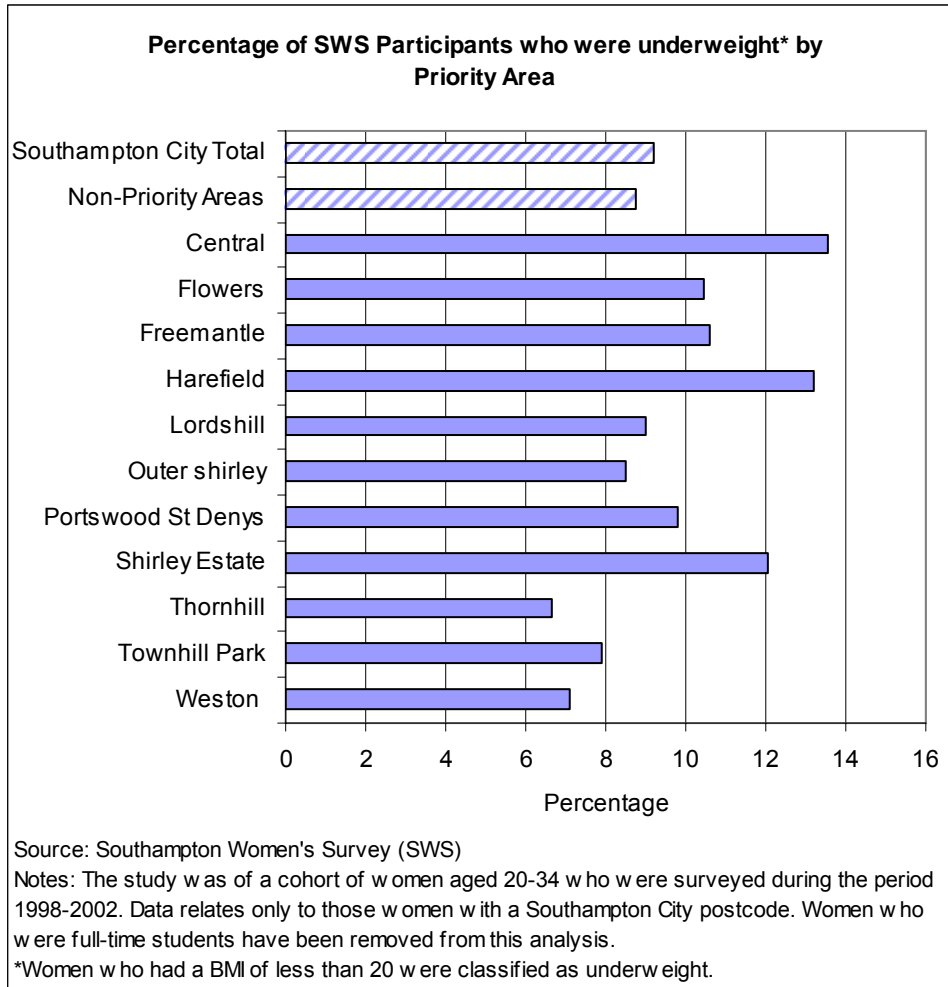


According to the *Health Survey for England 2004* almost a quarter of all adult men and women were obese. Just over a third of women were overweight compared with two fifths of men. Only 29% of men and 37% of women had a healthy weight.

These findings are alarming, particularly as the data was collected between four and eight years ago and with the rising tide of obesity nationally these figures are likely to be even higher. These young women have a real increased risk of developing diabetes, raised blood pressure, stroke and coronary artery disease and of dying early. They also face living with the consequences of these diseases, such as blindness, amputations, kidney failure and heart attacks.

Underweight

A woman with a BMI of less than 20 is classified as underweight. The highest proportion (11.3%) of underweight women was in the Central locality. In the priority areas as a whole 9.7% of the women were classified as underweight compared to 8.7% for the remainder of the City. In Central and Harefield priority areas over 13% of women were classified as underweight, whereas in Thornhill the proportion was only 6.7%.



Obesity is very widespread and rightly receives much publicity; however, there are health implications for those who are underweight. Being underweight can mean a poorly balanced diet that does not provide all the necessary nutrients leading to poor health.

Underweight women may lack body fat, which cushions the internal organs, stores energy and keeps you warm. Other side effects are an increased risk of developing osteoporosis and anaemia, as well as dry skin, hair loss, a weak immune system and exhaustion.

Lifestyle factors

Smoking

Smoking is the single greatest cause of preventable illness and early death in the UK and half of all regular smokers will be killed by their habit. It is one of the key reasons for social class inequalities in death rates.

The SWS provided real data about the number of young women in Southampton who smoke rather than the estimates that we usually use.

The highest rates of smoking were in the East and West localities, where over 35% of women smoked. In the priority areas 36.6% of women were smokers, compared to 27.6% in the remainder of the City. Over 45% of young women living in Thornhill, Harefield and the Shirley Estate were smokers.

Smoking rates in Southampton are significantly worse than the national (24% women; 26% men) and regional (22%) averages.

Exercise

Physical activity is an important means of preventing disease and promoting health (including mental health) and has a range of benefits beyond direct health outcomes, such as promoting community cohesion and addressing the needs of vulnerable groups and communities.

The Chief Medical Officer for England recommends that adults should achieve at least 30 minutes of moderate activity five times a week.

A third of young women in the City reported never doing any strenuous exercise, rising to almost half in the priority areas. In Outer Shirley over half the young women never took strenuous exercise.

Although the survey asked about strenuous, rather than moderate exercise, these rates are disappointingly low, particularly for the priority areas where young women are likely to benefit most from exercise as they have higher rates of stress, overweight and obesity, smoking and we know are more at risk of cardiovascular disease. The *Health Survey for England 2004* found that 83-87% of women aged 16 - 44 participated in some moderate physical activity.

Diet

The women in the survey reported eating an average of just over two portions of fruit and vegetables a day, with women in priority neighbourhoods consuming slightly less than this. This finding is of great concern as it suggests that the majority of young women were eating significantly less fresh fruit and vegetables than the current UK healthy eating guidelines recommendation of at least five portions of fruit and vegetables every day.

This is in line with the *Health Survey for England 2004* which found that 73% of women (86% of men) did not eat five portions of fruit or vegetables a day. The proportion eating the recommended amounts increased with age – only 18% of women age 16 - 24 were eating five portions daily.

The seven factors most strongly related to having a healthy diet were:

- Educational attainment
- Smoking status
- Whether the home was shared with children
- Hours spent watching television
- Dieting to lose weight
- Strenuous exercise in the last three months

Each factor had a significant independent effect on diet. Surprisingly no association was found between a healthy diet and weight¹.

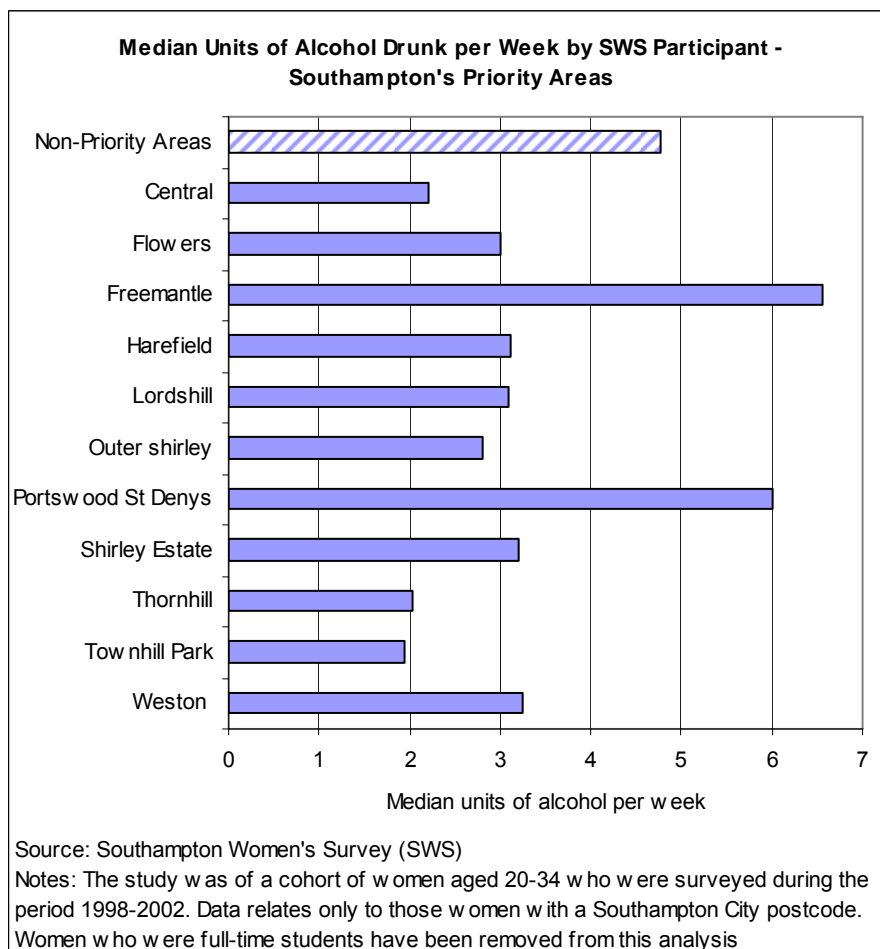
The strongest pointer to having a healthy diet was how well you do at school. The healthiest diets of all were seen in graduates. Over half the women with no educational qualifications had an unhealthy diet compared to only 3% of women who had a degree.

Having children made it less likely that a woman had a healthy diet. The reasons for this are not clear yet, but it is a worrying finding. Some mothers may put the needs of their children above their own where food is limited. It may be that some mothers are not aware what constitutes a healthy diet and so are not able to follow one themselves. This makes it likely that their children are not eating healthily and are not learning healthy eating habits. Some women may find it difficult to buy healthy food due to poor access to shops and the cost of healthy food.

Alcohol

The pattern of alcohol consumption is different to that of other lifestyle factors with generally lower consumption in the priority areas compared to the rest of the City.

In the priority areas young women were drinking about three units of alcohol a week, compared to almost five units across the rest of the City. However, consumption was higher in the Portswood and Freemantle priority areas at over six units a week. This result is found even though full time students, who may be expected to have a higher than average consumption of alcohol, were not part of the study.



This finding is a little surprising but it may represent an association between affluence and alcohol consumption.

The recommended safe level for alcohol consumption in women is 14 units a week. Unfortunately we do not have information on the proportion of women who were drinking over the recommended level.

Conclusions

This survey provides a rich source of information about the lifestyles of young women in Southampton, which was not previously available. It should be remembered that the data was collected between 1998 and 2002 and since then many of the priority areas have seen substantial investment and have been the focus of much health promotion work.

The survey paints a worrying picture of the health of Southampton's young women:

- Over half are overweight or obese and this is a City wide problem
- Many have unhealthy diets
- Most are eating well below the nationally recommended daily amount of fruit and vegetables
- Smoking rates are worse than average and particularly high in some priority areas where over 45% of young women smoke
- One third (half in priority areas) are not doing enough exercise
- Women in the priority areas tend to have the least healthy lifestyles
- Almost 30% report a long-standing illness
- Alcohol consumption is higher in the non-priority areas

Many young women living in socio-economically deprived areas experience poorer health and have very unhealthy lifestyles that will further increase their risk of ill health particularly from diabetes, heart disease and cancer in later life. Their poor diets are also likely to adversely affect the health of their unborn children, putting them at risk of diabetes and cardiovascular disease and perpetuating a cycle of poor health.

Women who do not do well at school are a particularly vulnerable group. They are more likely to have an unhealthy diet and this is not simply explained by living in poverty or in a deprived neighbourhood. It is very important that we understand the barriers that prevent these women from adopting a healthy diet and researchers at the SWS are currently conducting focus groups to explore this issue.

Smoking increases the likelihood of having a poor diet at all educational levels. Even more worrying was the finding that women eat less well when there are children in the home. This has profound implications for the health of these children who will develop their lifetime eating habits during childhood and are likely to adopt the eating patterns of their mothers.

While the survey suggests that women from the priority areas do have a greater need for public health and other interventions and lends support to the targeting of resources to tackle health inequalities, it is apparent that unhealthy lifestyles and their consequences, particularly overweight and obesity, are prevalent in large numbers of young women throughout the City.

It highlights the need for population wide programmes as well as targeted public health interventions with the young women most at risk.

Teenage pregnancy

Background

Teenage pregnancy rates (the number of conceptions in girls aged under 18) in England and Wales have been consistently high for over 30 years. They are the highest in Europe: twice the rate in Germany and six times the rate in Holland.

Giving birth as a teenager is strongly associated with disadvantages in later life. Teenage mothers are twice as likely to live in poverty and be without a partner in their 30s, and three times more likely to be in a home where no one is working.

Babies born to teenage mothers are at increased risk of being born early and having a low birth weight and have a higher chance of dying in the first year of life.

Teenage pregnancy is a complex issue, affected by young people's knowledge about sex and relationships and their access to advice and support. It is influenced by young people's aspirations, educational attainment, parental, cultural and peer influences and levels of emotional well-being.

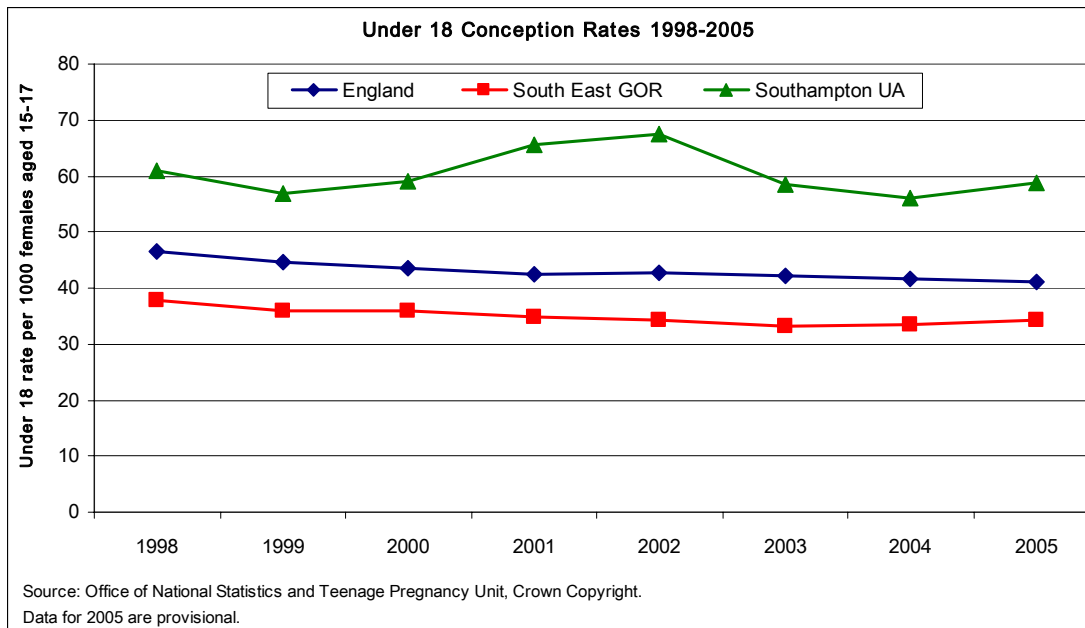
There are more teenage pregnancies in the poorest areas and amongst the most vulnerable young people, including those in care and those who have been excluded from school. There are strong links between leaving school at 16 with no qualifications and early and risky sexual behaviour and teenage pregnancy.

Southampton City has a high rate of teenage pregnancy, when compared to other similar local authorities across the country. The most recent data from 2005 shows that for every 1,000 girls aged 15 -17 living in Southampton 59 become pregnant each year. In 2005 215 girls under the age of 18 in Southampton became pregnant. This is the second highest rate in the South East of England and higher than the national (41.1/1000) and regional (34.2/1000) averages.

Nine of the sixteen wards in Southampton have rates that are amongst the highest 20% in England: Bargate, Bevois, Redbridge, Bitterne, Woolston, Millbrook, Freemantle, Harefield and Swaythling.

In Southampton 64% of under 18 conceptions occur in the priority neighbourhoods, with the highest rates are in Central, Thornhill, Outer Shirley and Weston.

There was a 3.4% reduction in teenage conception rates in Southampton between 1998 and 2005 from 60.9/1000 to 58.81/1000. Although this local trend is encouraging the reduction in rates has been much slower than the fall of 11.8 % nationally and we still have a lot to do.



What is happening?

We have targeted our work in areas with the highest teenage pregnancy rates and have focused on:

- Improving young people's access to sex and relationship education
- Improving access to contraception and sexual health services
- Providing support to teenage parents
- Support for vulnerable young people

Sex and relationships education (SRE)

We have been working with schools to ensure that all young people receive high quality sex and relationships education within Personal Social Health Education in schools and in out of school settings. Good progress has been made but the quality and content of programmes vary. We need to work towards a consistent programme with agreed learning outcomes and to encourage more teachers to achieve PSHE certification.

Work to enable parents to feel more confident and skilled in talking to their children about sex and relationships has proved very challenging. *Time to Talk* training events, which encourage parents to talk openly with their children, were offered to parents in areas with high conception rates but there was no take up. The project has been revised and will be evaluated in 2006/07.

Information about Parentline Plus, a national charity that works to offer free help and support to parents, has been widely distributed in community settings, including SureStart centres.

Contraception and sexual health services

Young people can access information and sexual health advice, including counselling and pregnancy testing, at three drop-in centres and nine clinics across the City. There is a 24 hour a day free emergency contraception helpline that signposts callers

to appropriate services. Access to emergency contraception has been extended through specially trained pharmacists in local pharmacies and is available at the NHS Walk-in Centres.

The sexual health promotion team's condom distribution scheme gave out over 55,000 condoms in 2005/2006 to a wide range of agencies including the Youth Service, No Limits and colleges. The team offers free training in sexual health promotion and condom distribution for people who work with young people. Sexual health promotion events have also been held in secondary schools and colleges.

A fifth of teenage pregnancies are second pregnancies and so it is vital that teenage parents have access to appropriate advice to try and reduce the incidence of unplanned second pregnancies. Professionals from SureStart, New Deal for Communities and maternity services have attended *Preventing Second Unplanned Pregnancy* training events.

Support to teenage parents

Specialist teenage maternity and health visiting services are provided to pregnant young women and young fathers. Uptake of antenatal care is good and midwives tailor care to meet the needs of the individual and encourage young parents to attend parenting courses. All young women are contacted before 12 weeks and 90% are booked by 12 weeks. About 45% of teenage mothers start breastfeeding, but this falls to 15% by six weeks. Between a half and three quarters of teenage mothers are supported to continue in education, training or employment.

Connexions provides information, advice and guidance for young people and supports their personal development. It is important that all teenage parents are put in touch with Connexions and there is still more work to do in this area to ensure that all teenage parents get the support they need.

Vulnerable young people

We have specialist nurses who help meet the needs of vulnerable young people such as those in care, care leavers, young people with learning disabilities, those from black and ethnic minority groups, boys, young men and teenage parents.

A group of vulnerable young people have been involved in piloting the Teenage Pregnancy Prevention Project in Oaklands School and the Girls Talk project works with small groups of girls to increase their sexual health knowledge.

Involving young people

Young people from many areas of the City have attended a series of consultation events which were used to inform media campaigns and prevention and support programmes. There is a City-wide media strategy to involve young people in teenage pregnancy work and to provide information about local services.

The *Mystery Shopper's* project was developed with young people to review access to contraception and sexual health services. Ten young people visited different types of services and looked at how well they were meeting their needs. The findings have been fed back to those services to assist service development.

Smoking in young women

There has been a gradual decline in smoking rates in women over the last ten years but three in ten younger women are still smoking, although, as we have seen earlier in this chapter, this figure is much higher in some parts of Southampton. However, there is a rise in the proportion of teenage girls taking up smoking compared to boys. One fifth of 15 year olds are smokers - 27% of girls compared to 18% of boys. Smoking rates are higher in poorer households and smoking remains one of the major determinants of health inequalities.

City Quitters, the smoking cessation service in Southampton, supports smokers to quit through one to one and group support and by training health professionals, such as midwives, health visitors, practice nurses GPs, and other agencies to provide cessation services. A pharmacy based service was set up in 2005.

More women than men access the Quitters service – 59% of users are women. This does not reflect smoking prevalence in the City but may be due to the fact that more women use primary care services where many people are referred into the service. Very few teenagers access the service, although the pharmacy service and the Quitters group run at a fitness centre appeal to younger women.

Supporting young women to quit smoking is challenging. Recent research conducted in Australia suggests that the social context of smoking – socialising with other smokers, drinking alcohol and going to pubs and clubs - is a major influence on smoking for young women, who also use cigarettes for stress relief².

These issues are very pertinent in Southampton with its many pubs and clubs, high levels of alcohol consumption amongst young people and with over a fifth of young women reporting they are suffering from stress.

The Quitters service promotes itself to women through SureStart and women's groups including those for black and minority ethnic groups and in *Your Life* magazine. *Your Life* is produced by the Dr Foster team in London. Journalists work with local health and communications professionals to put together content tailored to local conditions and issues.

However, women from black and minority ethnic groups are recorded as making very little use of the service. There are likely to be a number of reasons for this:

- Ethnicity recording is incomplete
- Women from black and minority ethnic groups have lower smoking rates
- Women from black and minority ethnic groups generally access services less

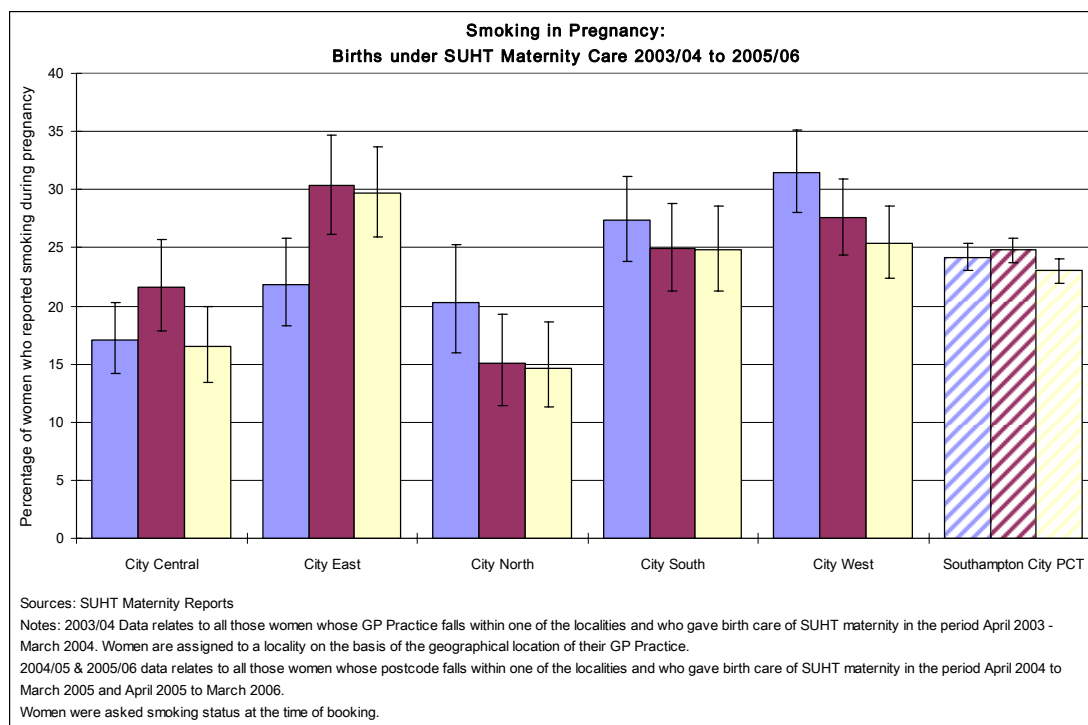
Smoking in pregnancy

Although it is suggested that pregnancy and motherhood provide an opportunity for women to quit smoking, pregnant women in Southampton have proved a challenging group to engage; levels of motivation appear to be low. Pregnant women can access the service through their midwife and SureStart.

It is important to remember the effect of passive smoking on pregnant women and their babies, and to ensure that we focus our efforts on both parents, not just on mothers. A baby exposed to smoke in the home is six times more likely to die of cot

death than a baby in a non-smoking home. If a woman has a partner who continues to smoke it will also make it more difficult for her to quit.

It is a concern that there is little evidence locally that women stop smoking once they are pregnant. There are slightly fewer women smoking when they are pregnant compared to 2003, but almost 30% of pregnant women in the priority neighbourhoods reported smoking at their booking appointment for antenatal care. Although this figure fell to 25% at 11 days after giving birth, it reached 30% again six weeks after their baby's birth. We do not yet fully understand the reasons women return to smoking after pregnancy.



Smoking rates at booking for 2005/06 are highest in the East (30%) and lowest in the North and Central localities (16%). In the Thornhill and Millbrook, Redbridge and Maybush Sure Start regeneration areas over 40% of women were smoking at their booking visit.

In England in 2005, 32% of mothers reported smoking in the 12 months before or during pregnancy, 17% of whom continued to smoke throughout pregnancy.

About two thirds of women attending the service will quit and this is no different to the success rate for men. Success in quitting generally increases with age.

Smokefree legislation

In February 2006 MPs voted by a huge margin to introduce a smoking ban in all indoor public places in England. From 1 July 2007, the whole of the UK will have smokefree legislation in place, making it the biggest jurisdiction in the world (by population) to have legally-enforced protection from secondhand smoke. This means that all employees in offices, shops, factories, restaurants or pubs will be able to work in a clean, smokefree environment.

This legislation will have a lasting impact on health. In the long term it is expected that there will be a substantial reduction in the number of deaths from heart disease and cancer as a result of people quitting smoking in response to the smoking ban and a reduction in the number of people being affected by second-hand smoke. There will also be significant improvements in health in the short to medium term. In Scotland, for example, just five months after the smoking ban a study found improvements in the lung function of people working in bars³. We may expect up to 20% of smokers to make an attempt at quitting following the ban.

Domestic violence

Domestic violence is a serious public health problem and the statistics are shocking. Two women die every week in the UK as a result of domestic violence and for women aged 19 - 44 it is the leading cause of morbidity, greater than cancer or traffic accidents.

All communities in Southampton are potentially affected by domestic violence and the effects are far reaching and destructive of relationships and families.

Each week there is an average of 65 domestic violence reports in Southampton. Domestic violence accounts for 11.5% of all violent crime in the City and around half of all child protection cases involve domestic violence.

Domestic violence and abuse is found across all sectors of society, affecting every socio-economic group, culture, religion, class, age, sexuality, disability and educational level. We know that domestic violence is more likely to occur where there are other difficulties, such as poor physical or mental health, alcohol, drug or substance misuse and problems with housing and homelessness. Each month in Southampton the City Council receives five homelessness applications involving domestic violence.

While domestic violence has a disproportionate effect on women we know that it affects the lesbian, gay, bisexual and transgender community as well as men. Nationally, one in four women and one in six men will experience domestic abuse by a current or former partner during their lifetime.

There is growing recognition of the damaging effect on the lives of children. In every classroom three out of five children have witnessed domestic violence, with 90% of incidents taking place in the same room as they have been in. Children and young people who have witnessed domestic abuse are 14 times more likely to experience physical mistreatment than those who have not.

The Southampton Domestic Violence Forum, which represents 66 services across the Southampton area, has been highly successful in improving services and responses to domestic violence in the City through its first *Strategy Against Domestic Violence (2003-07)*. This is being updated for 2007-10 in order to continue and build on the existing multi-agency partnership working in this area.

Recommendations

The work of the Health and Well-being Action Plan on lifestyle problems such as healthy eating and exercise must be supported. Young women with poor educational attainment are a key group to be involved with that work, in various settings across the whole City

The strong work on teenage pregnancy must be maintained, especially in areas with high conception rates and high numbers of young people at risk of teenage pregnancy

The PCT should continue to work with education to improve the quality of sex and relationships education in schools, linked to the National Healthy Schools Standard Award and support the work of the education authority to increase educational attainment

The PCT should ensure that women, especially young women, are targeted in the quit smoking initiatives that are brought in to support the national ban on environmental tobacco smoke in 2007

We should continue to target both pregnant women, and their partners, through SureStart and strengthen work within the Princess Anne Hospital, reinforcing the message about the harm to children of maternal and paternal smoking in line with the national campaign through midwives, health visitors, SureStart children's centres, pharmacies and primary care

The PCT should support the local strategic priorities for tackling domestic violence, and increase awareness of the issue by the public and health professionals

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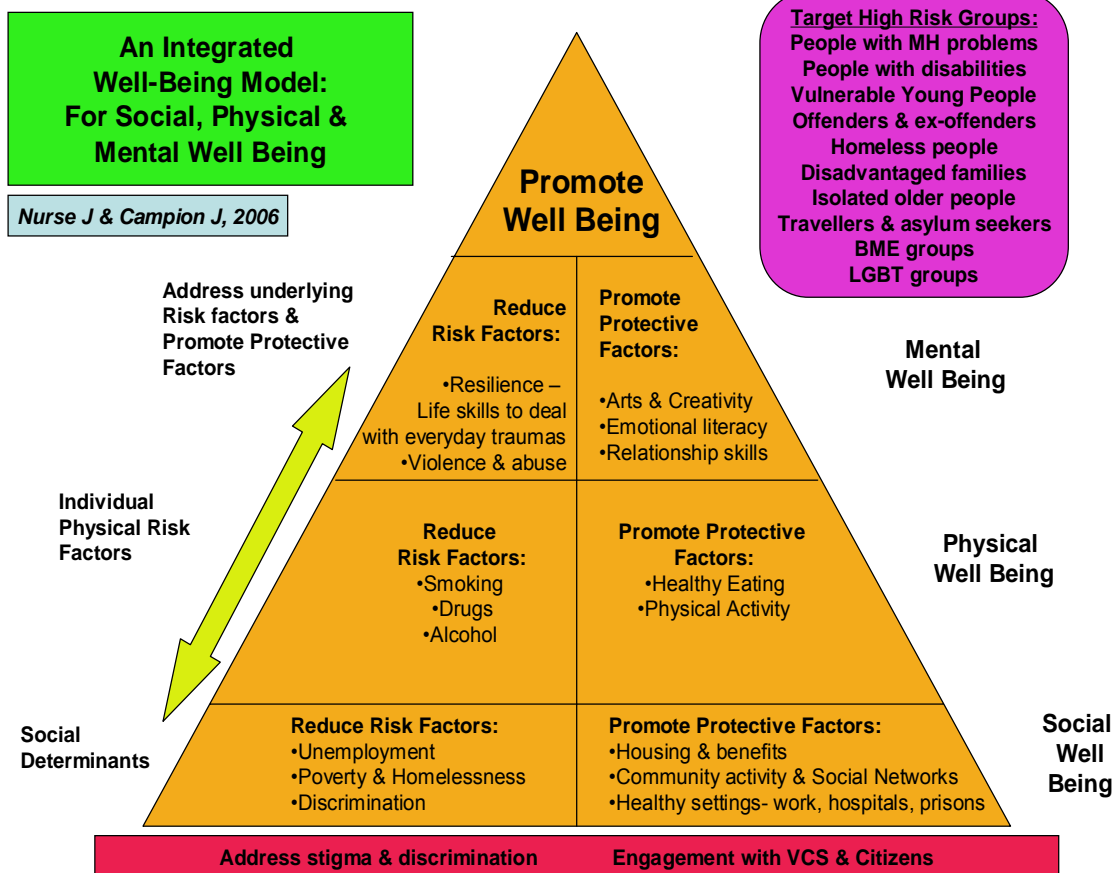
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Mental Health of Children and Adults

Introduction

Mental health is important for the health of individuals and communities. It is a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community¹. People are unable to fulfil their potential in life or play an active role in society when they suffer from poor mental health. Mental health is therefore important, along with physical health, for quality of life and life expectancy. Poor mental health also leads to poor physical health. It increases the risk of serious disease and reduces life expectancy, particularly for those with serious mental illness. Mental health historically has not been given the same importance as physical health, and until relatively recently, it has not been a priority in health or social policy. This is being reversed by policy makers locally and nationally, initially via *The Health of the Nation Strategy* (1991)², then *Our Healthier Nation* (1999)³ and more specifically by the *National Service Framework (NSF) for Mental Health* (1999)⁴.

Mental health in the South East Region has been reviewed recently in a report entitled *Promoting Well-being for People at Risk of Mental Health Problems*⁵. This lists the personal and societal costs of poor mental health and goes on to develop a conceptual model for tackling mental health at population level:



The model highlights the need for a multi-faceted approach to reduce the impact of risk factors whilst actively promoting protective factors at an individual mental, physical and social level in order to achieve well-being. This approach extends beyond mental health services to prevention, promotion, and psychosocial aspects of health and well-being. The report provides summary statistics on mental health at national and regional level:

- At an individual level, mental illness is one of the biggest causes of personal unhappiness in our society
- The wider cost of mental health problems in England are estimated to be £77 billion a year, mainly due to people with stress-related and mental health problems being unable to work. This compares with Treasury spending on the NHS as a whole of £76 billion in 2005-06
- Approximately 850,000 people claim incapacity benefit for a mental health problem, costing the economy 2% of Gross Domestic Product
- Work stress is responsible for 30% of staff sickness in the NHS, costing the service over £300m each year
- Ill-health or stress in the workplace can lead to a reduction in efficiency and productivity, leading to sickness, absence and job loss
- Sickness absence costs UK employers around £12.2 billion each year, of which the South East region has the highest rates of sickness absence in the country

Mental health, well-being and illness

Mental well-being is hard to define and therefore hard to measure. A working description involves:

- Being at ease with oneself
- Having a sense of purpose, meaning and fulfilment
- Experiencing positive emotions and having the resilience to deal with life's difficulties
- Belonging to a respectful community

Mental illness is the opposite of this and spans a wide range of severity and diagnostic categories. Common ailments such as depression, anxiety and phobias (known as neurotic disorders) are often mild, but can be disabling, particularly if they last for a long time. Some psychiatric disorders such as schizophrenia, bipolar disorder, and other severe forms of depressions, are less common but can be severe, disabling, and long-lasting. One of the more severe outcomes of mental illness is suicide, but life expectancy can also be shortened for many suffering chronic mental illness due to associated risk factors and behaviours such as smoking, alcohol, being overweight and obesity. Drug and alcohol dependency, severe learning disability and anti-social personality disorders all come under mental ill health.

There are problems in measuring mental ill health in the population. There are agreed criteria for diagnosis, but these are more subjective than the diagnostic tests used in physical disorders and may be unevenly applied. Many people with mental health problems do not seek medical help and therefore go unrecognised by local health services. Consequently, it is difficult to have an accurate picture of the size of the problem and the real burden of mental illness.

Mental health information at local level is limited and patchy. We know the number of people admitted to hospital for mental illness and the number of people whose death is recorded as suicide. Local data on use of services and prescribed medication is also available at general practice level. National surveys and regional reports help us to estimate the likely burden of disease.

Mental health policy and legislation

The UK continues to implement the mental health policy formulated in 1998. The main elements of this include advocacy, mental health promotion, prevention, treatment and rehabilitation. Emphasis is placed on primary care and access to services, improving effectiveness of treatments for people with severe mental illness, services for carers, and reducing suicide. A separate policy also exists for substance misuse.

The NSF for Mental Health (1999)⁴ and the NHS Plan for England (2000)⁶ set out the priorities for improving mental health outcomes:

- All people in a crisis will have access to crisis resolution/home treatment teams by 2005
- All people with a first episode of acute psychosis will have access to intensive treatment for the first three years from early intervention teams by 2006
- All people with intensive needs will have access to assertive outreach teams by 2004

In addition, there has been a strong drive to reduce the social isolation experienced by people with mental health problems from the Office of the Deputy Prime Minister, since 2004. Approximately 10% of the national health budget goes on mental health, supplemented by private insurance, and out of pocket expenditure by patients and their families. Approximately 85% of public funding spent on mental health comes from the NHS, the remainder from local authorities. Some local authority services can charge, but they remain free for patients with severe mental illness. Most residential care is provided by the voluntary and private sectors. Patients can receive support from disability benefits, and the *Disability Discrimination Act (1995)*⁷ introduced laws to tackle discrimination faced by disabled people. Disability Living Allowance provides an extra tax free allowance for people with physical and mental disability.

The *Mental Health Act* was last enacted in 1983, and at that time the main focus was on detention in hospital. Proposals are under way to reform the Act. The areas under consideration include:

- Managing risk
- Providing better outcomes
- Balancing public safety and rights of individuals

One major change supports compulsory treatment in the community, where an increasing proportion of care is delivered.

Mental health services

Mental health hospitals have largely been phased out in the UK, with over 110 closures. The number of mental health beds has been reduced by 75% over four to five decades. Most acute beds are now commissioned in general hospitals. About 1,500 high security beds remain, but these are gradually reducing, with increasing capacity in medium secure units, numbering approximately 1,000 placements.

The primary care system in the UK provides a significant range of mental health services. The NSF aims to improve effectiveness of primary care treatments, and encourages better support from specialist services where appropriate. Training on mental health for professionals in primary care is an essential part of the delivery of high quality care. There are over 800 community care teams in the UK, over 300 work and employment rehabilitation schemes and over 50,000 residential places available. The proportion of these resources in hospital compared to the community varies geographically.

The care planning approach (CPA) was introduced widely in 1991 as the cornerstone of mental health policy. This required mental health services to initiate explicit, individually tailored care programs that included social service links. These covered hospital discharge and all new patients referred to specialist psychiatric services.

CPA involves:

- Systematic assessment of health and social care needs
- An agreed care plan
- Allocation of a key worker – responsible for co-ordinating care, follow-up, and monitoring
- Regular review of progress

CPA has become established in practice locally and nationally.

Non governmental organisations (NGOs) and the voluntary sector

NGOs provide essential elements of the mental health system in the UK and around the world, with advocacy, treatment and rehabilitation programmes. User and carer movements have been strengthened in recent years, and have grown in capacity and capability. Policy and practice are heavily influenced by collaborations between users, carers, voluntary organisations and professional groups.

Specialist provision

Separate services have developed for children and adolescents (CAMHS), elderly and forensic patients (offenders), with well-developed sub-specialities in mental health. Southampton City also provides programmes for homeless people and asylum seekers, catering for the more specialised needs and interventions in these target groups. Traditionally strong boundaries have existed between substance misuse and mental health services, but some integrated care does occur for patients with “dual diagnosis”. This is particularly important in prisons, where there is a very high prevalence of mental health need associated with addiction to alcohol and drugs.

Patients with dual diagnosis (mental illness associated with alcohol or drug misuse and addiction), frequently present special challenges to health services. The historic separation between drug funding and services (local authority Drug Action Teams - DATs), and Primary Care Trust commissioning for alcohol and mental health services) has been a problem, resulting in fragmented services and separate access criteria for services. Recent collaboration between Southampton City PCT, the DAT, and Hampshire Partnership NHS Trust (HPT) - the local specialist mental health trust - has enabled a more co-ordinated approach to this complex area.

Substance misuse, mental and physical health

The links between mental health and substance misuse are many:

- Common mental disorders are associated with two-fold higher levels of alcohol dependency
- Substance misuse is common amongst people with severe mental illness
- Thirty one per cent of adults receiving mental health care report problem drug use
- Alcohol is the most frequent drug of abuse in mental illness, and can be associated with poor outcomes and treatment failure
- Smoking is associated with higher levels of neurotic symptoms, and higher depression and anxiety scores can be documented in smokers compared to non-smokers
- Regular cannabis use in adolescence is associated with a higher incidence of psychosis

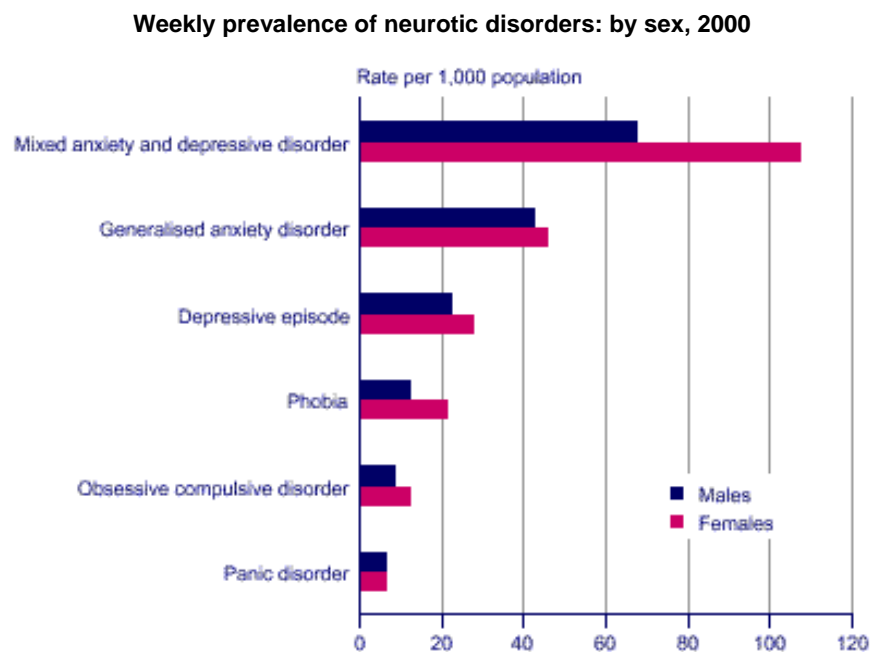
The increasing use of cannabis and other drugs like ecstasy during teenage years is a cause for concern. Case reports of serious mental illness triggered by the use of high potency cannabis and treatment-resistant depression following use of ecstasy are increasing. European surveys identify higher prevalence of cannabis use and an earlier age of users in the UK compared to Europeans - worrying statistics when it comes to promoting the health of teenagers and young adults. Our local smoking

cessation services report high levels of cannabis use among the population attending sessions locally, confirming the prevalence of cannabis use in the local community, and its association with smoking tobacco.

Alcohol use and alcohol addiction are common in the general population and play an important role in the lives of people with mental illness, where alcohol abuse is more prevalent. At population level, this addiction affects greater numbers than drug abuse, and gives rise to greater burdens of morbidity and mortality. Robust management and prevention of alcohol addiction has to play an important part in prevention and the ongoing management of mental illness.

Mental health in England

We do not have robust information from surveys at a local level to indicate the overall numbers of people suffering from poor mental health and well-being. Furthermore, indicators of mental health and illness remain underdeveloped and un-standardised. Figures taken from national surveys for the Office for National Statistics suggest that one in six people suffers from a neurotic disorder at any one time. These conditions are shown in the figure below:



(Source ONS: Focus on Health: Mental Health)

Risk factors and causes of poor mental health

A tendency towards severe mental illness can be inherited, and stress factors can trigger episodes. Stresses of various sorts can also predispose to common, or neurotic illness. There is reliable research on the risk factors for mental illness, including the Office for National Statistics' *Better or worse: a longitudinal study of the mental health of adults living in private households in Great Britain (2003)*⁸.

This identified the major risk factors as:

- Poverty and socio-economic deprivation including unemployment, although mental illness can also lead to unemployment and economic disadvantage
- Poor or no education
- Major life events such as bereavement, redundancy, childbirth and being victims of crime or violence
- Social isolation, including discrimination
- Learning disability and physical or sensory disabilities
- Poor parenting and family upbringing
- Drug and alcohol misuse
- Genetic predisposition

Variation by personal characteristics:

Age: Prevalence of mental illnesses varies with different age groups. Psychosis is uncommon in childhood but increases sharply during adolescent years from one in 10,000 at 13 years old to 17.5 per 10,000 at the age of 19. Conduct and emotional disorders are the most common reasons for referral to mental health services in children and young people under 16 years old in Southampton. The prevalence of neurotic disorders is about 16% in teenagers and young adults rising to 20% between the ages of 40-54 years.

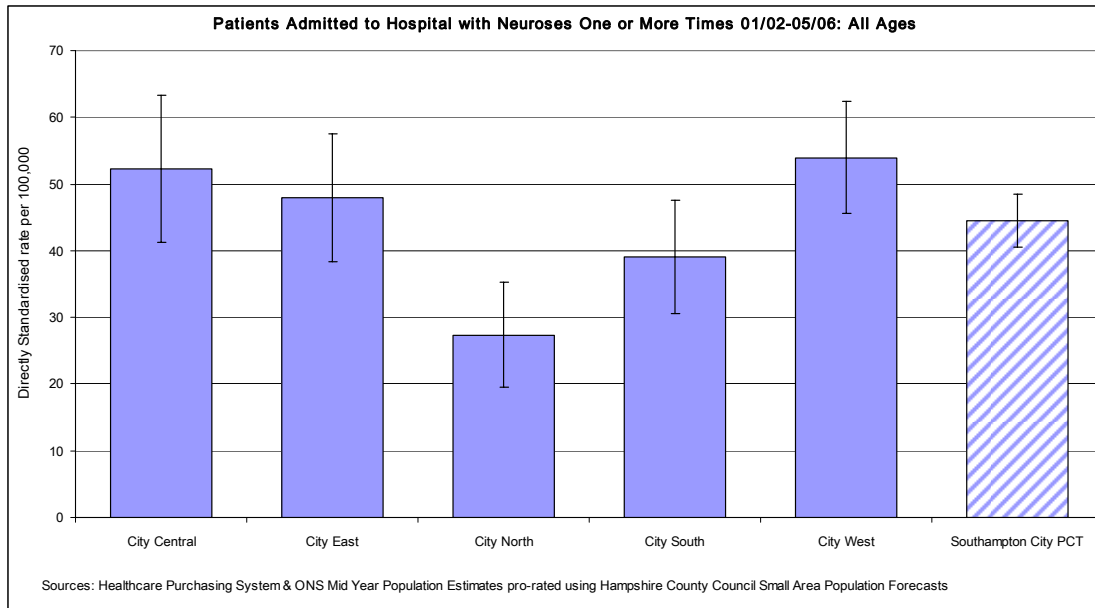
Gender: There are differences in the occurrence of mental illness between men and women. Obsessive compulsive disorders, anxiety and depression are higher in women, with anti-social personality disorders and substance misuse more common in men.

Ethnicity: *The National Psychiatric Morbidity Survey*⁹ found a prevalence of psychotic illness of 1.8% for black people and 0.5% for white people. The Department of Health's *Report on Ethnic Minority Psychiatric Illness in the Community* (2002)¹⁰ shows highest rates of a psychotic illness in Black Caribbeans and higher than average rates for Indians, Pakistanis and the White Irish. Chinese people appear to have a similar incidence of mental health problems to white people in Britain¹¹. Ethnicity monitoring by the Hampshire Partnership NHS Trust gives a very similar picture to the national survey.

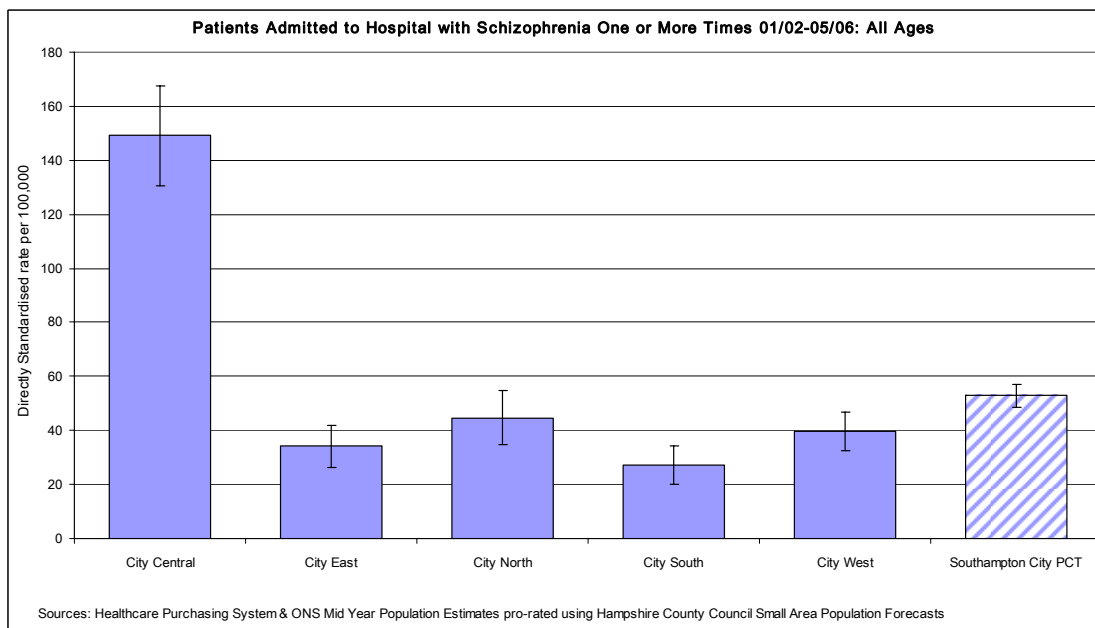
Refugees and asylum seekers experience multiple mental health problems, although symptoms of mental distress are common but may be a natural response to a highly abnormal situation¹².

Mental illness in Southampton

We can get a feel for the burden of mental illness in the City by profiling the patterns of treatment being undertaken, and looking at both morbidity and mortality statistics. Over five years from 2001/02 to 2005/06, 489 PCT patients were admitted for 1,213 episodes of neurotic disorder. As most cases will be managed in the community, and these data only relate to the most severe cases, the results do not give us a clear picture of the prevalence or incidence of the condition in the community. People in the north of the City appear to be less likely to be admitted than those living in the City centre and West localities but the difference is not very significant given the relatively low numbers being counted. Prescriptions for depression were more evenly spread in the City and the North still had the lower rate suggesting the prevalence of depression might well be lower in that area.

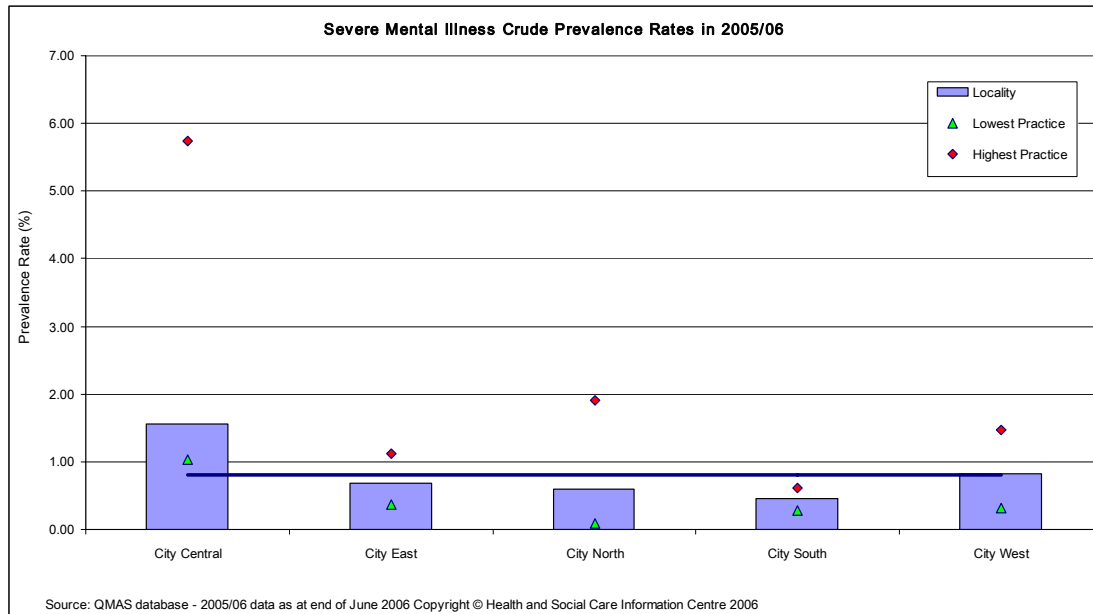


In the same period 508 patients were admitted 1,151 times for schizophrenia, a much less common condition than depression, but one that tends to require a higher rate of hospitalisation and intervention. The high rate in the centre of the City is significantly more than the other City localities. This might reflect the tendency for people with severe mental illness to move to a City centre (so called “social drift”), but there will be other factors that are less well understood, such as differences in ethnicity and homelessness.



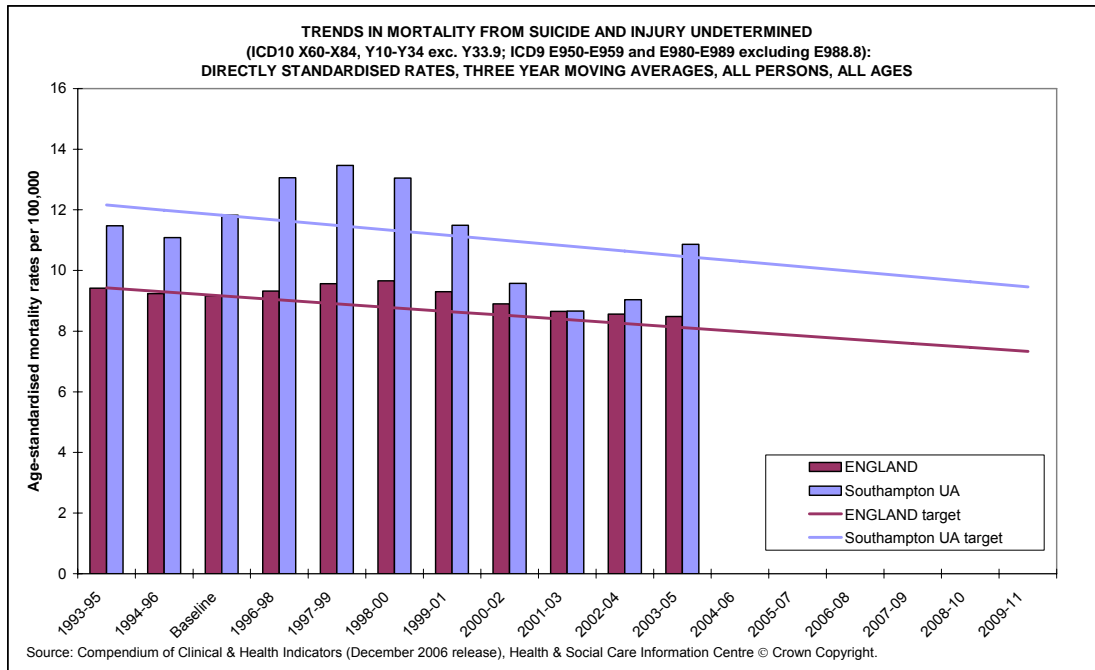
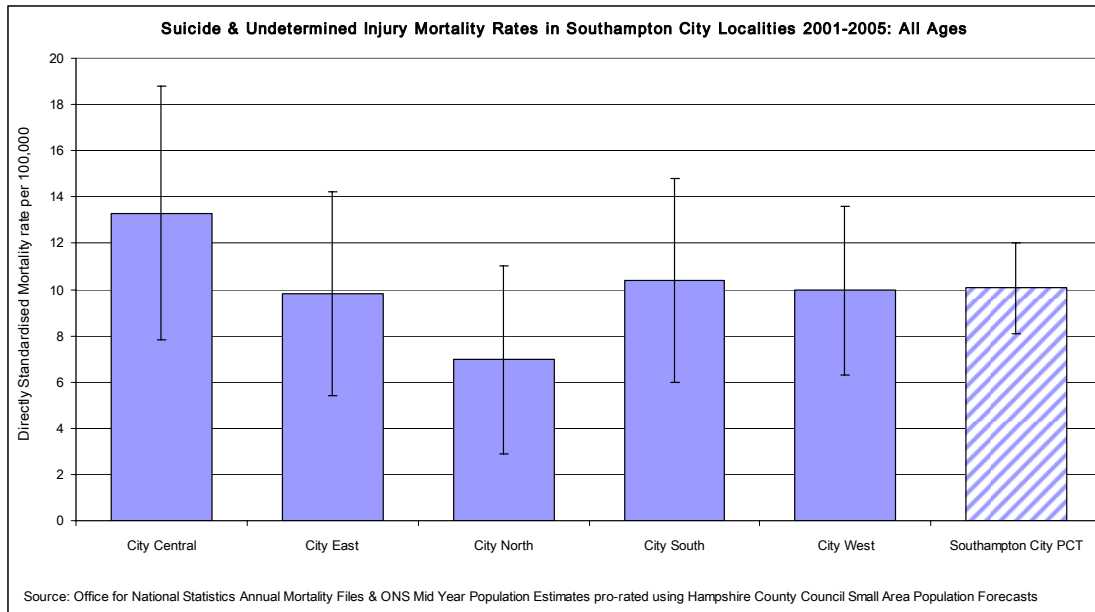
One recent development in general practice is the creation of disease registers for a variety of illnesses, including severe depression. These include new indicators of primary care, encouraging screening for depression in high risk groups, and monitoring the severity of depression in recently diagnosed patients. These, combined with guidance from NICE on the management of depression should help improve treatment of depression in primary care.

The aggregated results from registers in Southampton estimate the number of people with severe mental illness at 2,021, or 0.8% of the registered population. The pattern across City localities identifies a higher concentration of people on registers in the Central locality. The detail and accuracy of the registers has been questioned by the Sainsbury Trust, because approaches to completing the registers vary, but the information may be improving over time. The spatial pattern from the localities looks similar to other population mental health profiles in Southampton, but the variations between practices within each locality is several degrees larger than the differences between them.



Rates in Southampton have fluctuated around target reduction, but there has been an increase over the last few years. Further work to construct confidence intervals around these rates has shown that no statistically significant trend can be observed. Nevertheless the recent upturn leaves no room for complacency. The *National Suicide Prevention Strategy for England* has been in place for four years and continues to be implemented and monitored closely. Most suicides occur in young male adults, and there has been a sustained fall in this risk group. A similar fall has occurred in patients in contact with mental health services and in prisons, but the trends in these groups have not been consistent.

Based on information gathered from death certificates between 2001 and 2005, 108 people are estimated to have committed suicide. As with severe mental illness, the Central locality has the highest rate, with a lower rate in the north of the City. None of these differences are statistically significant, however, due to the relatively low numbers across each locality.



It is reassuring to see the local suicide rate fall to national levels, but the recent upturn leaves no room for complacency, particularly as the data is several years old.

How to improve mental health in the population

The evidence of what works has been recently summarised in the South East Region's report⁵. A comprehensive mental health improvement programme includes actions to:

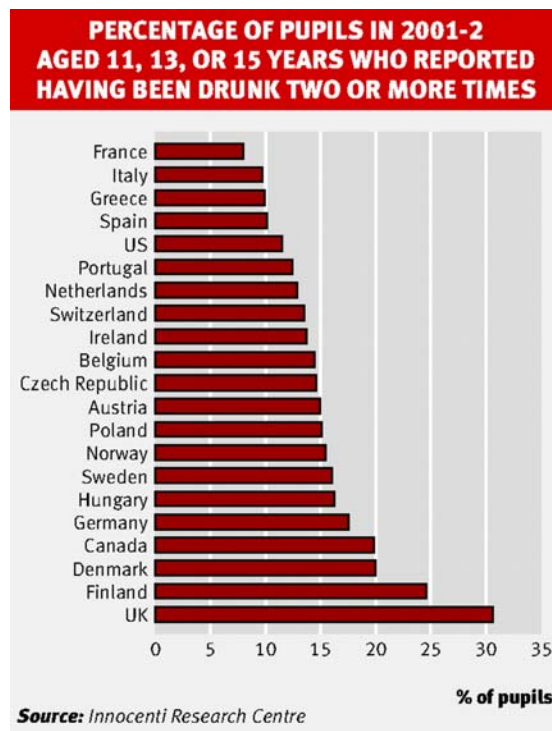
- Help children to develop physically and emotionally so as to reduce their risk in later life
- Reducing risk factors for mental illness including drug and alcohol abuse

- Creating environments which promote good mental health, including safer communities, good social networks and healthy work places
- Promoting good physical health, including diet and exercise
- Ensuring effective and cost-effective treatment services are provided

This is incorporated in plans at a national level through the *NSF* for Mental Health and a wide range of guidance and guidelines from NICE. Standard one in the *NSF* promotes mental health for everyone, working at community and individual level. It also aims to combat discrimination against individuals and groups of people with mental health problems, and promote social inclusion.

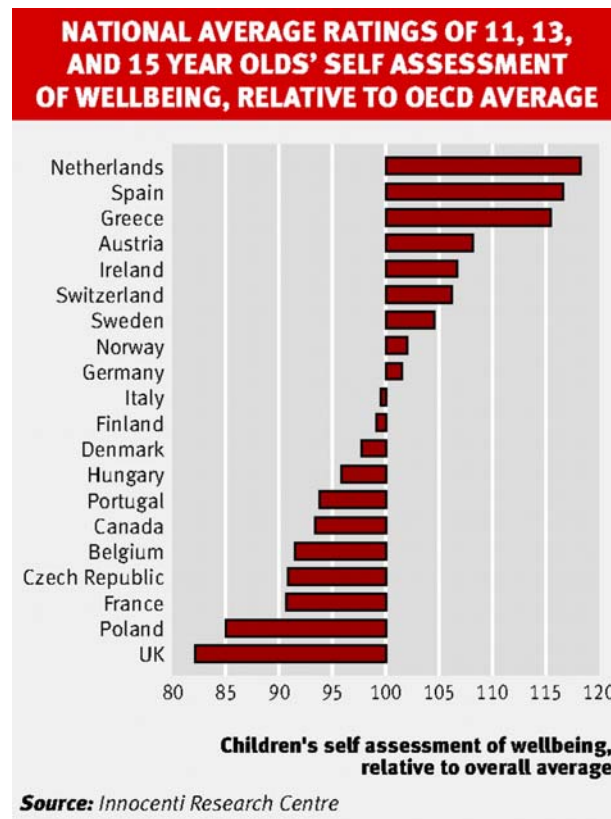
A recent UNICEF report¹³ has ranked the UK lowest overall of 21 industrialised countries in a new assessment of children’s welfare. The assessment used six categories, and the UK came last in the ranking on average scores. The best of the UK scores was for health and safety in the UK, but the remainder were consistently bad.

Examples of the scores are presented below, taken from The United Nations Children’s Fund, 2007 *Child Poverty in Perspective: An Overview of Child Well-being in Rich Countries*, Florence, Italy (p.30).



This chart illustrates that in the UK underage teenage drunkenness is three times higher than in France, Italy, Greece and Spain.

Moreover, the self-assessed well-being is the lowest in UK children than the other rich developed countries.



Taken from The United Nations Children's Fund, 2007 *Child Poverty in Perspective: An Overview of Child Well-being in Rich Countries*, Florence, Italy (p.34).

The ranking on well-being places the UK alongside Poland at the bottom of the table, with scores a long way below the best countries, mainly from northern Europe. The report concluded that there was little or no relationship between national wealth (Gross Domestic Product) and levels of child well-being. Given this poor assessment, the environment in the UK is likely to be one in which the mental health of children and young people is unlikely to flourish.

Southampton city health and well-being and mental health promotion strategies

The Health and Well-Being Strategy includes interventions that will support mental health promotion and protection. The strategy includes a broad base of objectives, including several key areas that will impact positively on mental health and well-being by:

- Offering children the best start in life
- Prolonging life and maintaining a high quality of life into later years
- Increasing community ownership and responsibility for health
- Support thriving and supportive communities and social networks
- Ensuring the highest possible standards of health and social care service provision

- Engendering communal happiness and positive approaches to mental health

The Strategy is one of a new generation of partnership-based plans that take forward the City's Community Strategy. It provides a bridge between plans produced by the local health and social care system and other plans developed elsewhere that impact on the City's health and well-being. In July 2004 Southampton City Council agreed Stage 1 of the Health & Well-being Strategy that had been produced by the Health & Social Care Partnership. Stage 2 was finalised a year later after extensive consultation, and this has three programme areas which reflect the Government's proposals in the *Independence, Well-being and Choice* Green Paper and the *Choosing Health: Making Healthier Choices Easier* White Paper.

The Southampton Mental Health Promotion Strategy and action plan helps the local implementation team to deliver a programme of action, and to link with the Southampton Health and Well-being Strategy. The action plans focus on children and families, and include:

- World mental health day – targeting year nine students to raise awareness of mental health
- Positive mental health awareness in schools
- Two-day local mental health conference on training for mental health and well-being in secondary schools
- Survey of young people's attitudes to mental health linked to the City youth parliament
- Targeted work on young carers and looked after children, aiming to improve mental health and life chances

Local mental health services

Southampton, in common with other parts of the UK, provides a range of mental health services integrating approaches from the PCT with social services, the voluntary sector, and the specialised Hampshire Partnership NHS Trust (HPT). HPT is a large mental health provider organisation that covers an area larger than Hampshire and the Isle of Wight.

Service re-design, with a further shift in focus from hospital to community services, has been driven by HPT over the last year following a comprehensive consultation exercise. This aims to mobilise more resources for priority areas such as assertive outreach and home-based intervention, in line with policy recommendations in the NSF. The specialist facility providing services for dual diagnosis in Southampton (the Department of Psychiatry or DOP) is also being developed on the site of the Royal South Hampshire Hospital in the centre of the City.

The PCT has health delivery plans and service level agreements to commission specific mental health service changes such as:

- Assertive Outreach – this is a bespoke, proactive, approach to helping people with severe and enduring mental health problems in their own homes and community. It is used when the relationship between the services and the user is complex and where service users might have difficulties managing their daily life. In particular, repetitive admissions to hospital can lead to a breakdown in someone's social networks and that can exacerbate an already complex set of problems. 101 contacts are planned for the City PCT area,

and this has already been achieved with 105 events completed before the year end

- Home Treatment is aimed at supporting mental health patients at home, and helps to manage patients who find it hard engaging with clinic or hospital based services. 505 episodes have been planned for this year and current activity has reached 342 at the end of quarter 3 (Sept-Dec 2006). It is anticipated this target should be met by year end (March 2007)
- Early Intervention in psychosis has been shown to help improve outcomes and in some cases may improve the natural history of the condition. Proponents of early intervention have argued that outcome might be improved if more therapeutic efforts were focused on the early stages of schizophrenia. Early intervention in schizophrenia has two elements: early detection and phase - specific treatment. Both elements may be offered as supplements to standard care, or may be provided through a specialised early intervention team. Early intervention is now well established as a therapeutic approach in America, Europe and Australasia, but it is unclear how far early detection and phase - specific treatments are underpinned by evidence of effectiveness. Current activity in Southampton stands at 19 interventions during this year, less activity than expected at the start of the year

Primary and community mental health care

The focus on primary care interventions in mental health has resulted in the recruitment of six primary care mental health practitioners working across different localities. They will be focussing on common mental health problems, providing assessment and brief interventions, such as cognitive behavioural therapy (CBT), signposting, and health promotion advice. In addition a menu or mini-directory of services is being developed and this will help people access exercise on prescription, computerised CBT, self-help books, and singing for health programmes.

Southampton also has a youth mental health service (Brookvale) that provides more specialist assessment, advice and interventions. The service deals with a wide range of conditions, including:

- Depressive disorders with low self esteem and/or self harming
- Eating disorders
- Obsessive compulsive and phobic disorders
- Acute trauma e.g. sexual abuse or post traumatic stress
- Psychosis
- Attention deficit disorder

Training and supervision of youth workers and school based professionals helps to build capacity, improve mental health and ensures earlier diagnosis of emergent mental health problems. The service offers a 24 hour service seven days a week, and a self-harm rota for young people who present at Accident and Emergency. The service is provided by a multi-disciplinary team, including health, social services and education.

Child and Adolescent Mental Health Services 2005-06: Referrals to Southampton services

Referral Source	Number
General practitioner	585
Medical "other"	298
Education	218
Internal referral	103
Social Services	64
Legal services	28
Voluntary services	5
Self referral	2
Total	1303

General practitioners are the highest referral source, then other clinicians, followed by education. A relatively low proportion of referrals come via social services. The numbers referred increase steadily from the age of three, peaking between 14 and 15 years. The referral patterns are listed below. Conduct disorder, emotional problems, and hyperkinetic disorders predominate. Only 31/1303 children were referred with psychotic disorders, reflecting the usual onset of the disorder later in life.

Child and Adolescent Mental Health Services 2005-06: Referral patterns

Referral /condition	Number
Conduct disorders	359
Emotional disorder	292
Hyperkinetic disorder	241
Family or relationship problems	109
Deliberate self harm	97
Autistic spectrum disorder	52
Psychotic disorder	45
Eating disorder	33
Developmental disorder	30
Educational problems	14
Other	31
Total	1303

A behaviour resource service in Southampton deals with acute need and complex problems that place the teenagers beyond mainstream service provision. The service caters for children aged 8 - 18, and can provide residential facilities for children over the age of 13. Referral criteria are explicit, and include the display of extreme behaviour due to serious mental health problems or emotional difficulties, often where the family is at risk of breakdown. The interventions require a consistent and co-ordinated multi-agency effort to provide both residential and community approaches for children and their families.

An innovative primary care service has been developed for children and teenagers in the community in Southampton (Saucepans, community child and adolescent mental health service). This aims to signpost more specialist mental health services, where

necessary, and acts as an early intervention and prevention service. Their remit is broad, aiming to:

- Reduce substance misuse
- Reduce anti-social behaviour
- Increase inclusion in school
- Prevent problems that may lead on to mental health problems in later life

The project appears to be the first of its kind to be set up by a PCT, and aims to accept and assess 600 referrals rapidly each year.

The national mental health director has defined ten high impact changes for mental health services to develop in future¹⁴, listed below. Many of the changes have been embraced by mental health services in the City. During the winter of 2006, adult community health services were reviewed by the Healthcare Commission's Annual Health-check, and gained an excellent rating, among the top 9% nationally.

10 High Impact Changes for Mental Health Services

- 1** Treat home based care and support as the norm for delivery of mental health services.
- 2** Improve flow of service users and carers across health and social care by improving access to screening and assessment.
- 3** Manage variation in service user discharge processes.
- 4** Manage variation in access to all mental health services.
- 5** Avoid unnecessary contact for service users and provide necessary contact in the right care setting.
- 6** Increase the reliability of interventions by designing care based on what is known to work and that service users and carers inform and influence.
- 7** Apply a systematic approach to enable the recovery of people with long-term conditions.
- 8** Improve service user flow by removing queues.
- 9** Optimise service user and carer flow through an integrated care pathway approach.
- 10** Redesign and extend roles in line with efficient service user and carer pathways to attract and retain an effective workforce.

Recommendations (see 10 High Impacts Changes)

The PCT should continue to commission and develop services within the PCT and with Hampshire Partnership NHS Trust that will have a high impact on mental health

Strengthen the partnership work already underway to reduce the impact of alcohol and drugs on health. Strengthen the co-ordination between mental health services and the drug and alcohol action team

Ensure that the Children and Young People's Strategy delivers effective action on, supporting good parenting skills, developing emotional literacy as part of Healthy Schools and reducing bullying and violence

Extend the work of the Health and Well-being Strategy on healthy eating and exercise. This is aimed at achieving a healthy weight, but there are important benefits to mental health too

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Health of People in Ethnic Minority Groups

Introduction

Southampton has a long history as a centre for international migration and refugees. South Asian, Caribbean and Chinese communities have long been established here, alongside refugees from World War II (particularly Polish refugees). In 2001 Southampton City Council began accommodating asylum seekers through the Home Office National Asylum Seeker Support Service. By 2004 there were asylum seekers of 46 different nationalities helped through this service.

'Ethnicity' is a multi-dimensional concept, and usually encompasses one or more of the following:

- Shared origins or social background
- Shared culture and traditions that are distinctive, and maintained between generations, and lead to a sense of identity in groups; and/or
- A common language or religious tradition¹

Ethnicity is linked to health in a number of ways. The determinants of health may differ between ethnic groups, for example different population structures, genetics, and cultural, generational and socio-economic factors. The incidence, prevalence, and death rates of many diseases are known to vary by ethnic group. The prevalence of illness and of health-related behaviours can also be quite distinct for different ethnic groups. There are well-documented inequities in access to prevention, treatment, and palliative health and social care services based on ethnic group. There are also reported differences in the quality of services received by different ethnic groups and of outcomes of treatment and care. Many of these inequities could be changed, for example by making sure appropriate, accessible services are provided².

There are other factors that impact on the health of ethnic minorities, such as prejudice and discrimination. Racial harassment and discrimination may affect health in two ways: through the immediate physical and psychological consequences of harassment itself; and in the way racism leads to the identification of individuals as members of devalued ethnic minority groups, which leads to their exclusion and their consequent social disadvantage.

Profile of ethnic minorities in the UK and Southampton

Demographics

The demographic profile of the ethnic minority population in Southampton is very similar to England as a whole. The ethnic minority population is younger than the

general population, has more dependent children, experiences more unemployment, is less well-educated and has poorer self-reported health.

In England, about 9% of the population is from a non-white minority group; in Southampton (according to the Census 2001), this was 7.6%. Southampton has a higher proportion of people describing themselves as being of mixed and other ethnicity, but fewer in the Black and Asian groups compared to England as a whole (table 1).

Table 1: Southampton's population by ethnicity, compared to the UK

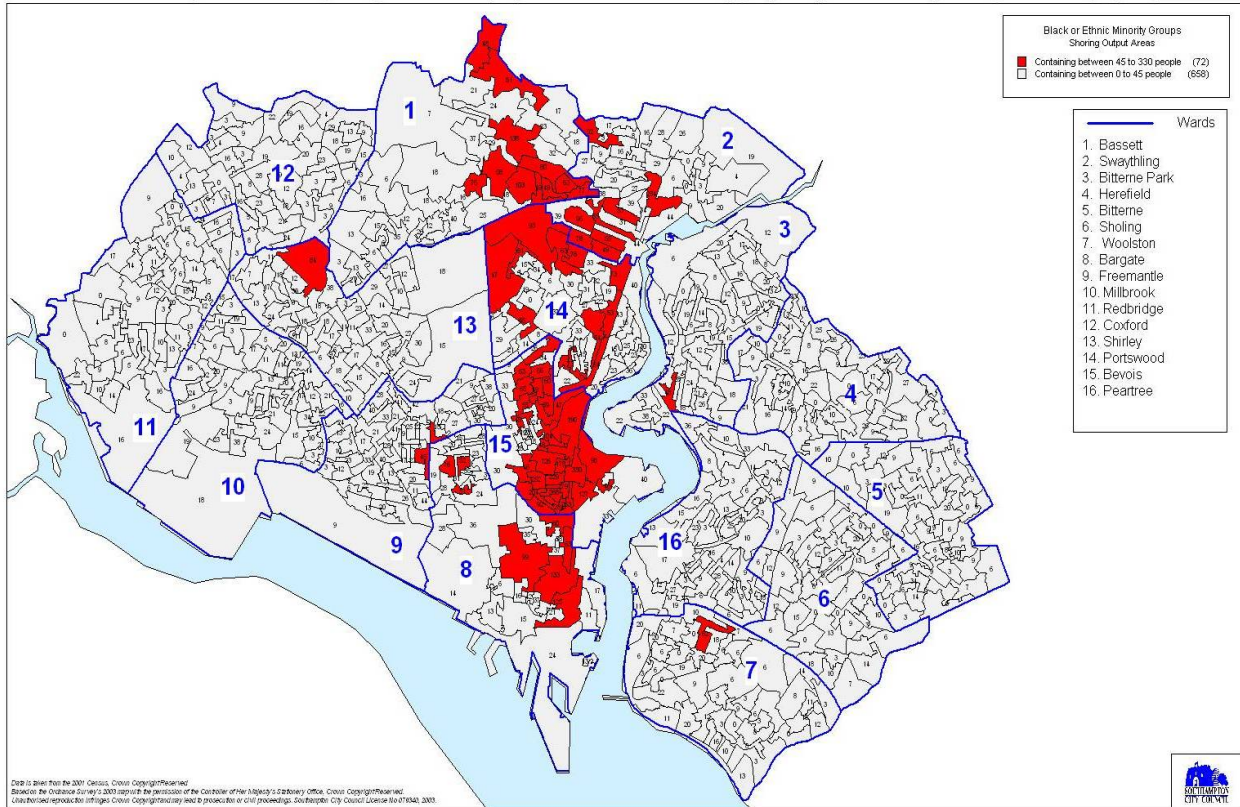
Ethnicity	Total % Southampton	Total % UK	Number	Ethnic group	% Southampton
White	92.4	92.1	200,859	White British	88.75
				Other White	2.57
				Irish	1.06
Mixed	1.50	1.2	3,267	White and Asian	0.49
				White and Black African	0.22
				White and Black Caribbean	0.46
				Other Mixed	0.33
Black	1.03	2.0	2,245	Black Caribbean	0.48
				Black African	0.48
				Other Black	0.07
Asian	3.79	4.0	8,254	Indian	2.17
				Pakistani	0.80
				Bangladeshi	0.44
				Other Asian	0.38
Other	1.30	0.8	2,820	Chinese	0.75
				Other ethnic group	0.55
Total	100	100	217,445		100

Source: 2001 Census, Office for National Statistics © Crown Copyright

The black and minority ethnic (BME) population in Southampton has changed markedly since the 2001 Census, with an influx of New Communities including Somalis, Afghans, Kurds and Iranians. The biggest change has been amongst migrant workers from the EU accession states, particularly the Polish community. These new communities may have different needs to established communities. The New Communities Team based at Southampton City Council has produced a report which shows current population estimates in Southampton for a number of different new communities³. While there is a tendency to presume new communities are transient, in fact at least 50% have settled permanently in Southampton.

The BME population is not evenly spread throughout the City. The map below shows the parts of the City with the highest number of people from these communities.

2001 Census Results. Output Areas containing the highest number of people from black or ethnic minority groups. Output Areas with top 10% highest count highlighted.



Refuge communities

There are thought to be 1,500 - 2,000 Somali people in Southampton, 40% of whom are families. The Afghan community is a similar size (1,000 - 1,500 people), but only 5% are families. The Kurdish and Iranian populations are slightly smaller at around 500 - 700 people, and again only 5% are families. Finally, there are around another 1,500 refugees in Southampton from 40 other ethnic backgrounds. Refugees' general health needs are the same as other ethnic minorities (for example, basic treatment, vaccinations, health promotion), but may also include physical and mental health needs related to experiences in their home countries, such as rape and torture.

Labour migrant communities

These communities consist mainly of 700 – 1,000 Filipinos and the European Union accession state nationals from Eastern Europe, conservatively estimated at 10,000 to 14,000 people. This makes Eastern Europeans by far the greatest number of new migrants to Southampton, with an estimated 81% of these from Poland.

Common causes of death amongst ethnic minorities

In the past data on ethnic minorities have been presented in a way that highlights differences to the white population, rather than similarities. Tables 2 and 3 show the

most common causes of death for different ethnic minorities, compared to the white population (this information is based on the 1991 Census, but is unlikely to be markedly different today). These tables show that the top five causes of death are very similar for all people, regardless of ethnicity, and include heart disease, stroke, various cancers and diabetes¹.

Table 2: main causes of death in men, by ethnicity

England & Wales	Indian	Pakistani	Bangladeshi	Chinese	Caribbean	African
Heart disease	Heart disease	Heart disease	Heart disease	Heart disease	Heart disease	Heart disease
Stroke	Stroke	Stroke	Stroke	Lung cancer	Stroke	Stroke
Lung cancer	Lung cancer	Diabetes	Lung cancer	Stroke	Lung cancer	Lung cancer
Pneumonia	COPD	Lung cancer	Diabetes	Liver cancer	Diabetes	Prostate cancer
Embolism/thrombosis	Diabetes	COPD	COPD	Colorectal cancer	Prostate cancer	Hypertensive disease

Table 3: main causes of death in women, by ethnicity

England & Wales	Indian	Pakistani	Bangladeshi	Chinese	Caribbean	African
Stroke	Heart disease	Heart disease	Heart disease	Stroke	Heart disease	Heart disease
Heart disease	Stroke	Stroke	Stroke	Heart disease	Stroke	Breast cancer
Pneumonia	Breast cancer	Diabetes	Stomach cancer	Breast cancer	Diabetes	Stroke
Breast cancer	Diabetes	COPD	Lung cancer	Colorectal cancer	Breast cancer	Cancer lymphatic/haematopoietic
Colon cancer	COPD	Breast cancer	Breast cancer	Blood cancer	Cancer lymphatics/haematopoietic	Cancer trachea, bronchus/lung

Common causes of poor health amongst ethnic minorities

Heart disease

Heart disease is most common amongst Irish men (14.5%) and women in the general population (13%). Black African men and Chinese women are significantly less likely than the general population to have any heart condition. Black Caribbean women showed the highest rates of angina symptoms, and Black Caribbean men had the highest rates of symptoms of a possible heart attack. Between 1999 and 2004 the prevalence of heart disease doubled in Pakistani men (from 4.8% to 9.1%) and Indian women (2.3% to 4.2%).

Diabetes

There is a very high prevalence of diabetes in Pakistani women (44%), and a higher prevalence in all ethnic groups (apart from Irish) compared to the general population. These figures may be even higher when undiagnosed diabetes is taken into account - a recent report from the Healthcare Commission suggests that one in four people may have undiagnosed diabetes, rising to almost 50% in women.

Smoking and tobacco use

There is great variation between ethnic groups and men and women with regards to smoking. Bangladeshi men are the most likely to smoke (40%), followed by Pakistani men (29%) and Black Caribbean men (25%) with the prevalence in the general population at 24% (although this hides inequalities in smoking prevalence between lower and higher socio-economic status groups). For women, there is a marked contrast in smoking prevalence between ethnic groups. The highest prevalence is seen amongst Irish women (26%), followed by Black Caribbean women (24%), compared to the general population (23%). Smoking prevalence amongst Indian, Pakistani, Bangladeshi and Chinese women is low. However, this may change over time as subsequent generations adopt more Western lifestyles. Chewing tobacco is predominantly used by Bangladeshi women (28% women aged 35 - 54, 29% women aged 55+), and this seems to be instead of smoking cigarettes, rather than in addition to smoking (only 2% and 3% respectively chew tobacco and smoke cigarettes). Bangladeshi men also use chewing tobacco more than Indian or Pakistani men (10% and 14% of men aged 35 - 54 and 55+, respectively). Chewing tobacco is not a safe alternative to smoking cigarettes; the risk of oral cancer (cancer of the mouth) from chewing tobacco is increased by as much as five times. People who chew tobacco are also at increased risk of gum problems, damage to teeth, and heart disease.

Alcohol

Pakistani adults (89% of men, 95% of women) and Bangladeshi adults (97% of men, 98% of women) are the most likely to be non-drinkers. However, this self-reported measure may hide drinking behaviours amongst different ethnic and faith groups. There is anecdotal evidence in Southampton that alcohol consumption may be high amongst some Indian and Sikh adults.

Overweight and obesity

Levels of overweight and obesity vary between different ethnic groups, between men and women, and between different age groups. Amongst the general population, 66.5% of men are overweight or obese. This compares to 62% of Black African men, 53% of Indian men, 55% of Pakistani men, 44% of Bangladeshi men, and 37% of Chinese men. Amongst women, Black Africans have the greatest levels of overweight and obesity at 70%, followed by Black Caribbeans (64%) and Pakistanis (62%), with the prevalence of overweight and obesity in the general population at 57%. Chinese women have the lowest levels of overweight and obesity at 25%.

Exercise

Amongst the general population, 32% of men and 39% of women have low activity levels. Particularly low activity levels are seen amongst Indian (44%), Pakistani (51%) and Bangladeshi men (51%), and Indian (45%), Pakistani (52%), Bangladeshi (68%), and Chinese women (47%).

In summary, ethnic minorities are not uniformly at greater risk of death or poor health. For example, both mortality and morbidity data suggest that Indians have reasonably good overall health. For some diseases ethnic minorities appear to be significantly better off than the ethnic majority (for example, respiratory disease and lung cancer). However, particular ethnic groups appear to be particularly disadvantaged by different diseases. For example, Caribbeans have high rates of stroke and high

blood pressure, whilst South Asians have high rates of heart disease. Importantly, all ethnic minorities have higher rates of diabetes than the white population.

Local information on ethnic minorities in Southampton

Hospital data

Data on admissions to hospital are routinely collected and made available, so it is possible to see who has been admitted to hospital, what was wrong with them, what treatment they had, and what the outcome was. However, in common with most other areas in the UK, Southampton's hospital data are very poorly coded for ethnicity. It is therefore not possible to use this data as a way of finding out about poor health in ethnic minorities in Southampton.

Primary care data

General practices have not been required to collect ethnicity data in the past. However, the new General Medical Services (GMS) contract rewards general practitioners if ethnic origin is recorded for new patients registering with their practice. Previous work was done by Southampton City Primary Care to encourage general practices to collect more ethnicity data, but unfortunately so far this has not led to an increase in useable information about ill health in ethnic minorities in the City. However, Nicholstown surgery is currently doing some pioneering work in ethnicity data collection of their patients, and should have a breakdown of certain diseases by ethnicity by April 2007.

Survey data on lifestyle issues

A Health and Lifestyle survey is underway in Southampton and towards the end of 2007 there should be some useful local data on issues like smoking, obesity, and diet and exercise amongst ethnic minorities.

Screening data

There is no information on the uptake of breast and cervical screening by ethnicity, as this information is not routinely collected.

Ongoing work in Southampton

The Health and Well-being Strategy is a ten year plan to improve the health and well-being of those who live in Southampton. Addressing the needs of ethnic minorities was identified as one priority within this strategy.

The SCPCT Public Health Team, in conjunction with Southampton City Council, Southampton Voluntary Services, and Primary Care have undertaken a health needs assessment of ethnic minorities in Southampton over the past year in order to try to achieve this.

Health needs assessment has been described by the National Institute for Health and Clinical Excellence (NICE) as "a systematic method for reviewing the health issues facing a population, leading to agreed priorities and resource allocation that

will improve health and reduce inequalities”⁴. Undertaking a health needs assessment is one way health and local authority organisations can assess the health and service delivery needs of their populations, and ensure that non-discriminatory services are provided.

The needs assessment has involved holding focus groups with members of different ethnic minorities to find out their concerns about health and health services. Their suggestions, along with those from professionals working with ethnic minorities in Southampton, have been used to create an action plan. This action plan will become the work stream for the Black and Ethnic Minority task group as part of the Health and Well-being Strategy.

The findings from the needs assessment show that mental well-being, diabetes and heart disease, and access to interpreting and translation services were the areas of greatest concern for ethnic minorities and professionals alike.

Recommendations

General practices across Southampton should be encouraged to collect ethnicity data from existing as well as new patients

Physical activity opportunities available to ethnic minorities should be reviewed, and changes made to improve service provision

The current diabetic retinopathy screening service should be reviewed, with changes made accordingly to increase the uptake of the service among ethnic minorities, and improve the service in general for the population as a whole

Review the interpreting and translation service ‘Access to Communication’ and make any changes identified that would enhance the service

Create an overview of projects/services available to support those from ethnic minorities to lead healthier lives, which can be shared with communities and professionals involved in delivering services

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Health and Sustainability

What is sustainability?

Over the past 20 years there has been a growing realisation that current lifestyles and development across the world are unsustainable: the way we live today is damaging our ecosystem and some of this damage is irreversible. Sustainable development looks at how we can live today without causing irreversible change that will threaten the lives and health of future generations. The most widely accepted definition of sustainable development is from the *Brundtland Report*¹, written following a commission to review environmental issues convened by the United Nations in 1983:

‘development that meets the needs of the present without compromising the ability of future generations to meet their own needs.’

Sustainability is not just an environmental issue. Degraded environments, floods, droughts and climate change put pressure on resources and are linked with poverty, unemployment, social exclusion and conflicts, which in turn directly impact on the health and well being of communities. More recently the 2002 *World Summit on Sustainable Development*² identified "three overarching objectives of sustainable development" to be:

- Eradicating poverty
- Protecting natural resources
- Changing unsustainable production and consumption patterns

This moves sustainability beyond purely environmental issues and acknowledges that all aspects of human life need to be reviewed. Another definition describes sustainability as:

‘the short-hand expression for the long-term social and economic changes required to re-establish global ecological integrity, the foundation for the planet’s life-support systems, thus also of the health of the human population.’³

‘Global warming’ and ‘climate change’ are also familiar phrases, and are used with sustainability to summarise many different, complex and inter-related issues resulting from the pressure that our lifestyles are putting on our ecosystem: ‘climate change, deforestation, loss of biodiversity, fisheries depletion, and other consequences of environmental degradation.’ In summary, sustainability is about how human life on earth can continue to exist and develop in the future, within the finite resources available, to ensure the continued health and well-being of the population.

Measuring sustainability

The most widely used indicator of sustainability is the Ecological Footprint (EF), which measures 'how much nature we have, how much nature we use, and who uses what.' An EF is calculated by adding up the amount of energy or resource that a task or lifestyle uses in a given period, working out the amount of land that is required to support this, to give the resources required and to absorb the pollution and waste that is created. The measure used for this is global hectares or gha. It can be used to calculate the average annual resource use for different countries, or communities and gives a clear indicator of what is sustainable. Globally there are 1.8 gha (global hectares) to support each person in the world, although as the population increases, this amount will decrease. The average consumption in the UK is 6.7 gha and in the US is 9.5. If everyone was to live as we do in the UK, we would need more than 3 worlds to support us. Globally, the average EF is 2.2 gha: we are using more than 1 world's resource each year. We are using resources more quickly than they can be replenished and this is unsustainable. A study calculated the EF of Southampton as 6.1 gha⁴. This study also identified the main contributors to the EF as:

- The food sector – 18% of EF
- Household energy consumption – 17% of EF
- Manufactured durables and consumables – 14% of EF
- Transport – 13% of EF

This also raises issues of fairness, justice and equity, since it is the developed world that is over-consuming, whilst the developing world uses less than one quarter of the world's resources. The *Stern Review: The Economics of Climate Change*⁵ describes this situation as an economic externality: 'Those who produce greenhouse gas emissions are bringing about climate change, thereby imposing costs on the world and on future generations, but they do not face the full consequences of their actions themselves.' It is not just the economic consequences, but also the health consequences that will affect future generations.

How does sustainability link with health?

Health is much more than the absence of disease and is defined by the World Health Organisation (WHO) as 'a state of physical, mental, and social well-being, and not merely the absence of disease or infirmity⁶.' Health is directly affected by environmental factors, including water, sanitation, environmental conditions, food, housing, peace or conflict, as well as the provision of health care services, as the model of determinants of health overleaf illustrates.

Dahlgren and Whitehead's model of the determinants of health⁷



Sustainability issues already affect our health in a number of different ways and will continue increasingly to do so. The time scale for these health impacts is unclear: some changes, for example warmer weather, are already relevant, and others are based on modeling that climate scientists have published. Some examples of the health effects of climate change are given in the table below.

Environmental change	Direct effect on health	Indirect effect on health
Warmer temperatures, particularly in summer due to climate change	<ul style="list-style-type: none"> Increased excess deaths in higher temperatures, particularly in summer Increasing numbers and prevalence of infectious diseases associated with warmer climates, e.g. malaria, enteric illnesses, Lyme's disease and other tropical diseases 	<ul style="list-style-type: none"> More enteric disease due to the increasing challenge of maintaining water quality and availability Detrimental affect on mental health and well-being – increased anxiety, stress etc
Depletion of the ozone layer	<ul style="list-style-type: none"> Increasing incidence of skin cancer Increasing number of cataracts 	

Increasing risk of flooding due to rising sea levels and also increasing risks of extreme gales and weather in UK	<ul style="list-style-type: none"> • Risk of deaths caused by major disasters • Increasing risk of infection due to difficulties of maintaining sanitation in times of flooding 	<ul style="list-style-type: none"> • Detrimental affect on mental health and well-being – increased anxiety, stress etc
Drought in the UK and in other countries	<ul style="list-style-type: none"> • Effect on mental health 	<ul style="list-style-type: none"> • Increasing challenge of maintaining water quality and availability • Pressure on land due to famine caused by drought, could cause international conflicts and wars • Deaths and injuries, and the effect on health from forest fires
Poor air quality due to increasing emissions, particularly in cities.	<ul style="list-style-type: none"> • Increase in respiratory disease, e.g. asthma, COPD 	<ul style="list-style-type: none"> • Poor air quality drives people inside, increasing social isolation and reducing exercise taken.

The health impacts of environmental change have already been experienced in Southampton, the UK and the rest of the world. Some recent examples are:

- The heat wave in August 2003 caused over 35,000 excess deaths in Europe
- Increasing incidence of Lyme borreliosis and tickborne encephalitis in the UK and Northern Europe
- Recent gales in UK, and floods in other European countries
- Increasing numbers of forest fires in areas of drought, for example, Australia and Indonesia
- Famine in Africa

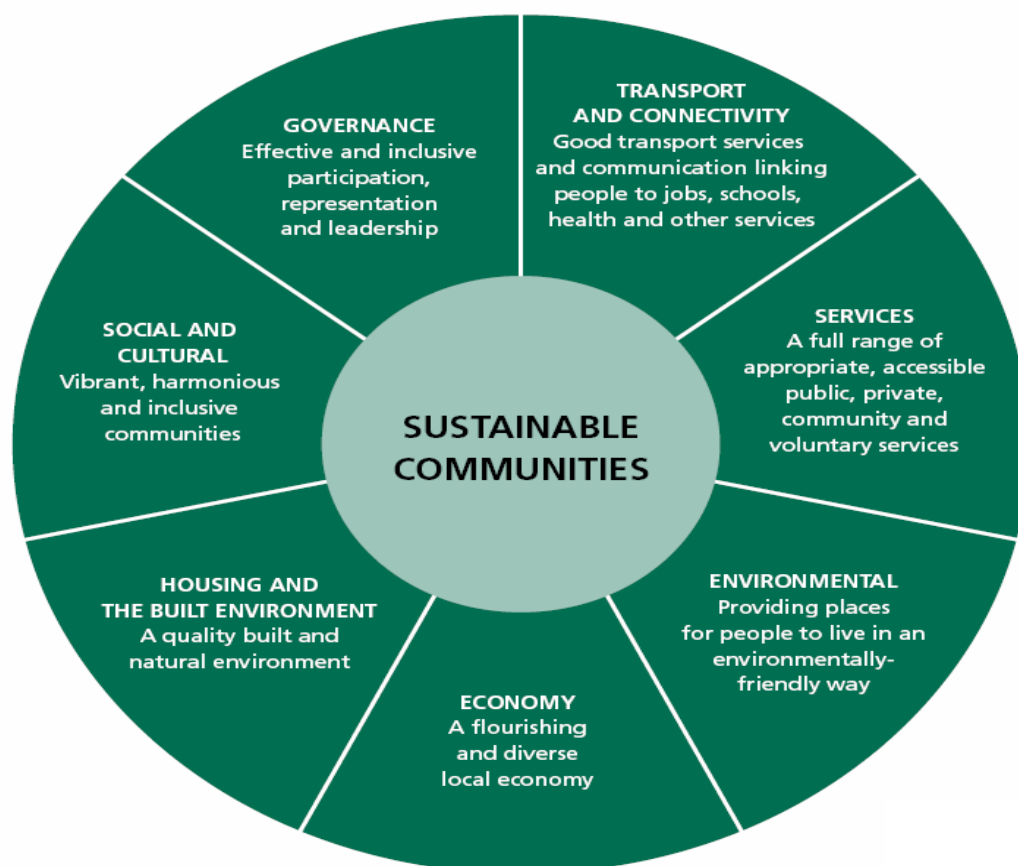
There will be other effects on health from climate change. As resources become scarce there will be an increasing demand for food, water and fuel, which could destabilise countries. The possibility of conflict resulting from a scarcity of resources poses a major threat to health. It would be naive to assume that the consequences of these issues will not affect us in Southampton. The world has become a smaller place, and we will be affected by changes in other countries and by world markets.

Sustainable communities

The Office of the Deputy Prime Minister in 2005 described sustainable communities as:

‘places where people want to live and work, now and in the future, that meet the diverse needs of existing and future residents, are sensitive to their environment and contribute to a high quality of life, are safe and inclusive, well planned, built and run, and offer equality of opportunity and good services for all.’

Sustainability is not just about the pressure our lifestyle is putting on our physical environment, but also the pressure our lifestyle is putting on our communities. Sustainability is about the interaction of man, his environment and the future well-being of both. The *Egan Review*⁸ identifies seven components of sustainable communities, which together constitute a common goal. This model is illustrated below.



The *Egan Review* suggests that this common goal should be adopted as a tool by all stakeholders, so that planning and development decisions can be informed by, reviewed and measured by these standards. Each of these seven components is a determinant of health, and this model has strong links with the Dahlgren and Whitehead model, showing the link between sustainability and health.

What should we be doing?

'Action on climate change has been likened to teenage sex. Everyone claims to be in on the action, but only a few are, and those not very effectively⁹.'

The task of public health has always been to respond to threats to human health. Most recently, these have been lifestyle challenges, particularly smoking, increasing alcohol consumption and lifestyle factors causing obesity. But in the past public health was predominantly concerned with environmental threats to health. The early

champions of public health included John Snow, who famously linked the spread of cholera to drinking water at the Broad Street pump, and Edwin Chadwick who championed public sanitation. Sanitation was recently voted the most important contributor to improving health in the 20th century by a British Medical Journal survey. It remains a priority for public health practitioners to identify threats to health and to work to understand and prevent these¹⁰. Public health work has always taken place on a spectrum of scales – from local to international. As we become more aware of the challenges that sustainability poses to health and well being, it is important that public health takes a lead role to understand and prevent this threat.

The *Stern Review*⁵ makes a clear case for action now to tackle climate change and improve sustainability. Its key finding is that ‘the benefits of strong, early action on climate change outweigh the costs.’ These costs include the health and well-being costs.

*The Ottawa Charter*¹¹, the WHO’s guidelines for health promotion, identifies five key areas for action, which are very relevant to the challenge of climate change:

- Build healthy public policies
- Create supportive environments
- Strengthen community action
- Develop personal skills
- Reorient health services

This framework suggests that effective action needs to be taken at many levels: at an international and national level, as well as at a City, community and individual level. Improving sustainability is fundamentally about achieving lifestyle changes, and this model draws from experience in health promotion achieving this.

There is a key role for government action, and international action to tackle factors affecting sustainability, particularly carbon emissions, and this is highlighted by the *Stern Review*. However, there is also a key role for local and individual action. Many important changes have been achieved by individual and local action which has powered and driven political change at a national and international level. For example, the abolition of slavery 200 years ago was achieved because of the action of a few committed individuals, including William Wilberforce, which changed national and international policies.

Local action - sustainability in Southampton

Steps are already being taken in Southampton to improve sustainability and the local NHS needs to work closely with partner organisations to achieve change.

The City of Southampton Strategy

The *City of Southampton Strategy*¹² is a plan for Southampton until 2026, and has sustainability as a key underlying principle. The Southampton Strategy seeks to ensure that plans for the City reflect these principles ‘by planning the City’s future in a way which ensures that future generations benefit from – rather than suffer because of – actions taken by this generation’. It identifies nine principles of sustainability, based on the common goals identified by the *Egan Review*⁸, to be used to guide decision making in Southampton, shown in the table overleaf. These clearly

demonstrate the link between health and sustainability as many of these principles are known to also be determinants of health.

Principle of sustainability	Description	Determinant of health
Governance	Decisions to be based on the principles of sustainable development	Empowering communities to improve their environment will improve health
Natural common goods	Maintaining and enhancing the quality of the natural environment	Improving the quality of the environment will improve health and encourage people to spend more time outside, increasing exercise
Local action for health	Addressing the wider determinants of health and integrating health impact assessment into planning	Making health a priority will improve health
Planning and design	Planning to improve the local environment and minimise resource use	Strong link between health and housing. Crime reduction can be achieved through well designed urban environments and better health in high quality environments
Better mobility, less traffic	Reducing dependence on cars and encouraging alternative transport choices	Encouraging active transport will encourage a more active lifestyle
Vibrant and sustainable local economy	Supporting local employment and implementing sustainability principles for business in the city, creating markets for sustainable technology	Strong link between employment and health
Responsible consumption and production	Reducing waste, increasing re-use and recycling and reducing unnecessary energy consumption	
Social equity and justice	Fostering inclusive and supportive communities, alleviating poverty and ensuring equitable access to opportunities and good quality homes	Reducing inequalities and tackling the poverty improve health. Strong link between housing and health: improving housing will improve health
Local to global	Commitment to the global aim of reducing carbon emissions and tackling climate change through local action	

These principles also raise issues about corporate social responsibility: The decisions we make as individuals, such as the mode of transport to use; as organisations, like where to procure products from, and as a society, for example whether to accept policies and legislation which will restrict our lifestyles. If we are to achieve the goals of sustainability then this will need to become a priority for everyone, not just for a few.

Southampton Sustainability Forum

This is a voluntary organisation working closely with the City Council and Southampton Partnership, local businesses and community groups and individuals to promote sustainability in Southampton. (www.southampton-sustainability.org)

The role of the local NHS

The NHS is a major local employer and business. Southampton City PCT working with Southampton University Hospitals NHS Trust and Hampshire Partnership NHS Trust should review their policies to ensure that they are compatible with the principles of sustainability, as outlined in the Southampton Strategy and the *Egan Review*. Below are some examples of best practice from other NHS organisations, which have changed the way they work and reduced their EF, and in many cases, improved the health of their staff, patients and visitors as well.

Purchasing	Buying locally grown food helps to support the local economy and reduces transport costs and carbon emissions	<ul style="list-style-type: none"> • Cornwall Hospitals source all their food locally
Buildings	Ensuring that all new health facilities are built to sustainable standards: high energy efficiency, incorporating recyclable materials and to a design that will improve and enhance the local area	<ul style="list-style-type: none"> • The new wing at Lewisham Hospital has been built to a high environmentally friendly specification • Bronllys Hospital, Powys, has some solar power
Travel	Developing and implementing travel plans that encourage active transport and public transport	<ul style="list-style-type: none"> • Addenbrooke's Hospital, Cambridge has a 'green travel plan'
Reducing energy use	Encouraging the whole organisation to engage in reducing energy use	<ul style="list-style-type: none"> • A Trust in North Glamorgan has cut costs and emissions by creative energy management

Individual action

One person cannot make a difference, but if everybody is willing to take sustainability seriously and to make lifestyle changes, this will make a difference. Stott and Godlee, writing in the British Medical Journal, call on health professionals to 'act now, collectively and individually' so that 'by personal and collective action health professionals can contribute to the health of our own and future generations⁹.'

The story below tells of one person's decision and impact on their community that is now having a national and international impact, and also demonstrates the principles of the global village; the purchasing decisions we make individually in this country will impact on economies and communities in other countries¹³.

In Choco, Columbia, large scale industrial gold mining had devastated the local rainforest, displacing the topsoil and the vegetation and polluting the environment and water supplies through the use of chemicals, including mercury and cyanide, in the extraction process. As most of the local people live by fishing the contamination by mercury has posed a long term health threat in this region. Local artisan miners traditionally operated on a scale that did not damage the local ecosystem, but they were employed by the industrial mines. When the mines were no longer viable, they were abandoned, and the miners returned to their communities unemployed.

Catalina was a young graduate who saw what was happening in these communities and in response started the Green Gold programme. She developed a certification system that rewards artisan miners and protects the rainforest. The criteria for certification include not using toxic chemicals, replacing topsoil after use, and ensuring mining is conducted with the agreement of local community councils. Green Gold is sold to jewellers in Europe, and has secured a financial future for local miners and a sustainable future for the rainforest in Columbia and the communities that live there.

Purchasing decisions we make as individuals will affect communities like Choco in Columbia.

Summary

Our current lifestyle in Southampton and in the UK is unsustainable, and this will have an increasingly important impact on health and well-being. We need to take action now to use fewer resources to protect our environment, and to ensure the health and well-being of future generations. This requires not only national and international action, but local, community and individual action. Action to promote sustainability will also promote health.

Recommendations

The PCT and partner NHS organisations should adopt the sustainability principles outlined in The City of Southampton Strategy

The PCT should work with partner organisations to learn from best practice in other parts of the NHS, particularly reviewing purchasing, building, travel and energy policies

Public Health should work with colleagues across the UK to plan for changing health needs resulting from climate change

In Southampton, Public Health and the Health and Well-Being Action Group should make sustainability a priority to ensure that every opportunity to make changes to improve sustainability is used

Health professionals should lead by example, making lifestyle changes and using opportunities to advocate for sustainability and for health

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Communicable Diseases

Introduction

Infectious diseases continue to be a public health challenge. Good hygiene and effective immunisation and treatments have brought many under control. Despite this, new problems are emerging and old ones re-emerging.

Health Protection is the branch of public health concerned with protecting the public from communicable and non-communicable hazards. This is carried out by the Health Protection Agency (HPA) on behalf of the PCT. Our local unit is the Hampshire and Isle of Wight Health Protection Unit, with an office in Southampton where it works closely with Southampton City Council's Environmental Health Department.

This chapter gives an overview of communicable disease control and some comments on important problems for Southampton. It is part of the information available in the more detailed annual report produced by the HPA in Hampshire and the Isle of Wight¹. Due to the delay in data becoming confirmed, the HPA report for each year is published in the spring of the following year. The most recent is the 2005 report, published in June 2006. This chapter draws on that and also uses some information from the draft 2006 report. A link to the published HPA 2006 report will be made available in the public health section of the PCT web site.

Notification of infectious disease

The table overleaf gives the number of notifications of infectious disease to the HPA in Southampton residents by year. The notifications of tuberculosis and bacterial meningitis are likely to be complete or nearly complete, due to the combination of laboratory and clinical channels of communication. However, for less severe infections the numbers are only a proportion of cases occurring in the community.

The data shows that:

- Campylobacter is by far the most frequent cause of bacterial food poisoning, as is the case nationally
- Meningococcal infection is the most common cause of bacterial meningitis. The immunisation programme for Haemophilus influenzae B (HIB) has prevented meningitis from this organism
- The epidemic of mumps was at its peak in 2005. It persisted into 2006, although cases were fewer. Mumps was particularly common in teenagers and young adults, so people in schools, colleges and universities were offered MMR vaccine
- A small number of confirmed measles cases emerged in 2006 due to the increasing pool of unimmunised children. Locally the uptake of MMR vaccine is above the regional and national average rates

Table 1: Notifications of Infectious disease in Southampton and South West Hampshire 2006

Disease	Year	
	2005	2006
Campylobacter	239	238
Salmonella	52	42
Cryptosporidium	21	23
Giardia lamblia	12	17
E coli O157	1	
Other Food Poisoning	45	37
Dysentery		
Shigella sonnei	0	2
Shigella flexneri	0	0
Shigella boydii	0	1
Entamoeba histolytica	1	0
Typhoid Fever		1
Paratyphoid Fever	1	0
Hepatitis		
A	0	1
B	2	6
C	2	1
E	7	5
Unknown	2	0
Meningococcal Infection		
Meningitis	9	2
Septicaemia	11	5
Other Meningitis		
Haemophilus influenzae	0	0
Pneumococcal meningitis	5	1
Viral Meningitis	1	2
Other specified	1	0
unspecified	7	1
Measles	10	9
Mumps	375	185
Rubella	5	5
Scarlet Fever	9	15
Whooping Cough	5	10
Malaria	1	1
Legionellosis	0	4
Ophthalmia neonatorum	2	2
Cholera	0	1
Tuberculosis and atypical mycobacteria	51	54
Other non-notifiable	23	8

Highlighted communicable diseases:

Tuberculosis (TB)

Tuberculosis is one of the most important public health challenges facing the world today. The Chief Medical Officer (CMO) has highlighted tuberculosis as an infection needing intensified action. The CMO published a national action plan *Stopping Tuberculosis in England*² in October 2004 which details ten major areas for action. These include increased awareness, improvement in surveillance and a first class service for the diagnosis and management of tuberculosis cases.

The National Institute for Health and Clinical Excellence (NICE) has issued guidelines for TB prevention and control including new entrant screening and BCG immunisation³.

Nationally, the incidence of TB is rising with almost half the cases in London. Most cases of TB are in young adults and in people born outside the UK.

Southampton had the largest number of cases in Hampshire and the Isle of Wight in 2006. There were 54 notified cases, of which 22 were confirmed in the laboratory. This is a slight rise from the 51 notified in 2005, but fewer than the 65 notified in 2004.

The priorities for the development of TB services are:

- To jointly commission uniformly high quality treatment services across Hampshire and the Isle of Wight
- To ensure that a high quality testing and immunisation service is provided. The universal programme for teenagers has been stopped nationally and replaced by a selective programme for high risk individuals, particularly infants. The testing method prior to immunisation has also been changed. All these changes mean that the new programme should be quality assured

Health Care Associated Infection

These are infections that are acquired (by patients or staff) following admission to hospital or as a result of healthcare interventions in other healthcare facilities.

Being in hospital or receiving treatment has always carried a risk of infection. The HPA reports a number of factors that contribute to this risk:

- Underlying illnesses in the patient receiving treatment, e.g. cancer, diabetes, heart disease, can increase their vulnerability to infection and impair the ability of their immune system to deal with it
- Treatments used to manage the patient's illness, enable them to survive, or prolong their life may leave the patient more vulnerable to infections:
 - Invasive procedures such as surgery, renal dialysis, intravenous therapy, artificial ventilation provide opportunities for micro-organisms to enter the body and cause infection
 - Some drug treatments necessary for patients to survive life-threatening disease severely impair their immune system, placing them at greater risk of infection
 - The use of antibiotics to treat one infection can enable other micro-organisms to cause harm e.g. *Clostridium difficile*
- The widespread use of antibiotics to treat infection, particularly in hospitalised patients, encourages antibiotic-resistant micro-organisms to emerge. These can cause infections that are more difficult to treat
- Caring for many patients together in hospitals provides opportunities for micro-organisms to spread between patients

The greatest risk of infection is associated with hospital patients. However, increasingly complex care is now provided in clinics or the patient's own home and these are also associated with the risk of infection.

Two infections that are a problem in hospitals treating patients with complex medical problems are methicillin resistant Staphylococcus aureus (MRSA) and Clostridium difficile associated infection (CDAD). Southampton General hospital is one such hospital, and the Trust reports high rates of these infections.

MRSA

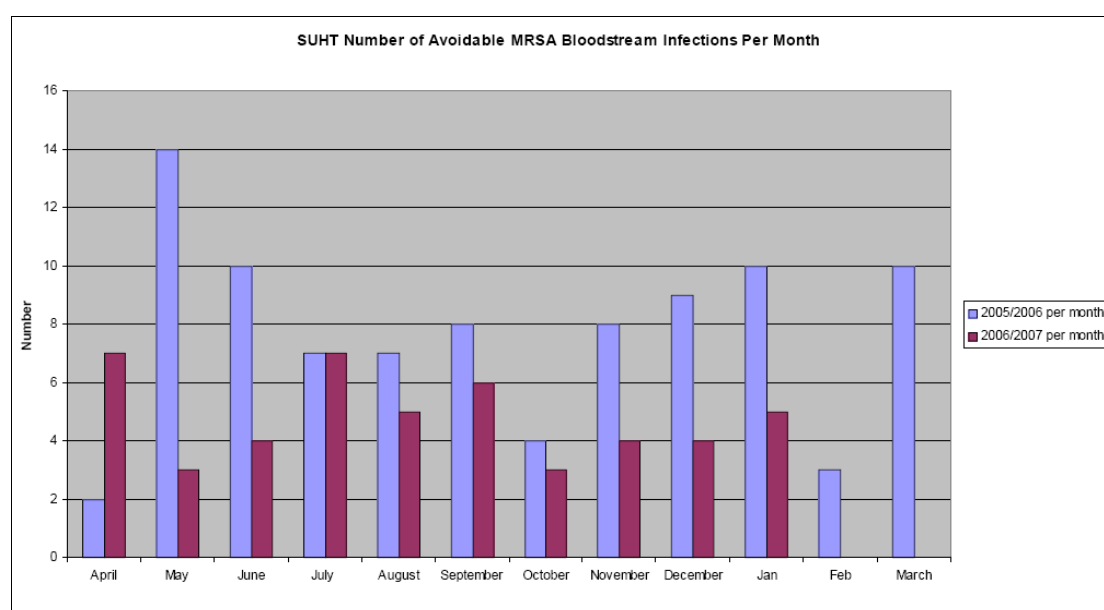
The table below shows the MRSA bloodstream cases reported as part of the national surveillance programme. The rise may be due to improved detection, but it does highlight the need for action to reduce the problem.

Table 2: MRSA Bacteraemia at Southampton University Hospitals NHS Trust

	MRSA bacteraemia reports	Rate per 10,000 bed days
April 2001 - March 2002	45	1.13
April 2002 - March 2003	53	1.29
April 2003 - March 2004	62	1.45
April 2004 - March 2005	75	1.79
April 2005 - March 2006	92	2.28

Source: HPA web site

- Data from Southampton University Hospital Trust (see graph below) suggest that recent infection rates are lower in 2006/07 than in the previous year. The national surveillance system reports 15 and 19 cases in the first two quarters of 2006/07 which supports this. A report to the Strategic Health Authority (SHA) noted a reduction between the first half of 2005 to the same period in 2006 in the numbers of bacteraemia by 54% and reduced rate per 10,000 bed-days to 1.05.



Source SUHT web site

***Clostridium difficile* associated disease (CDAD)**

The position on CDAD in SUHT is a major challenge for the Trust. The data is shown in the table below.

Table 3: Notifications of *Clostridium difficile* associated disease (CDAD)

<i>Teaching Trusts</i>	CDAD reports for patients ≥65 Jan-Dec 2005	Estimated rate per 1000 bed-days	CDAD reports for patients ≥65 Jan-Sep 2006	Estimated rate per 1000 bed-days	National Position by Trust type, 2006
Southampton University Hospitals	765	3.41	628	3.76	23rd out of 25
Oxford Radcliffe Hospitals	799	3.56	433	2.59	15th out of 25

Source HPA reports

There is much that can be done to prevent many of these infections. The key is preventing the transmission of micro-organisms between patients and preventing their introduction during invasive procedures or other treatments. Transfer of micro-organism on the hands of healthcare workers is an important factor, as many micro-organisms are readily transferred by touch.

These are some examples of some of the most important measures:

- Preventing the transfer of micro-organisms between patients by washing or decontaminating hands between contact with patients, especially before undertaking a procedure that may risk introducing infection to the patient e.g. inserting an intravenous catheter or dressing a wound
- Having systems in place to ensure that the greatest possible care is taken to avoid introducing or transmitting infection during invasive procedures e.g. use of sterile supplies, decontamination of equipment
- Use of protective clothing to protect healthcare workers from exposure to micro-organisms from the patient and minimise the risk that they will be transferred on clothing
- Ensuring that micro-organisms are not allowed to build up in the environment by regular cleaning
- Correct use of antibiotics to minimise the risk of antibiotic resistant micro-organisms emerging

To reduce Healthcare Associated Infection (HCAI) and deliver the national target to reduce MRSA bacteraemias by 60%, every Trust is required to have a comprehensive and prioritised action plan that incorporates national guidance and good practice, engages staff and makes it 'everyone's business'. The national programme to reduce HCAI is: *Saving Lives: a delivery programme to reduce Healthcare Associated Infection including MRSA*⁴. Where fully implemented, this programme is producing impressive results. Further improvements could be achieved locally by enhanced partnership working between SUHT and the local HPA unit.

SUHT is undertaking measures to improve performance in the control of HCAI. A Department of Health/Strategic Health Authority Improvement team review was

completed in December 2006 and an action plan agreed between Trust/SHA/Department of Health.

Recommendations

The PCT should participate in the joint commissioning of a high quality TB service in Hampshire and the Isle of Wight

The PCT should continue to use its commissioning and clinical governance processes to ensure further reductions in HCAI in SUHT. The PCT's own infection control measures should be maintained and should adapt to make sure that increased transfer of care to the community does not lead to more community acquired HCAI

Further recommendations will be made in the HPA 2006 annual report (to follow in Spring 2007), and should be turned into local action plans

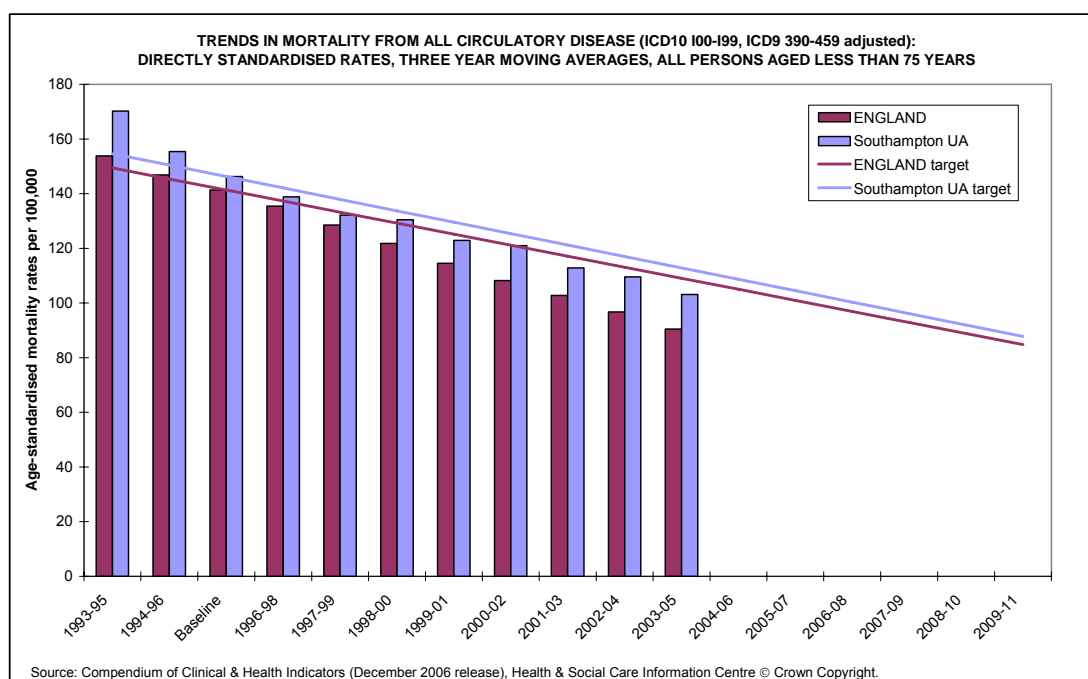
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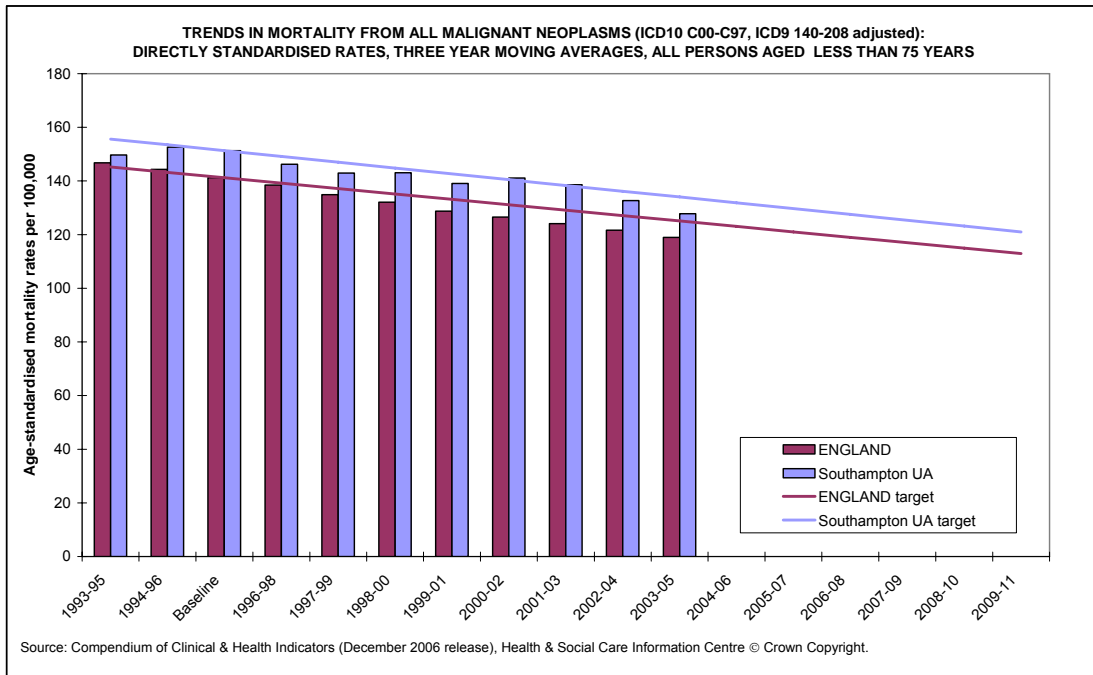
Key Public Health Indicators for Southampton

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.

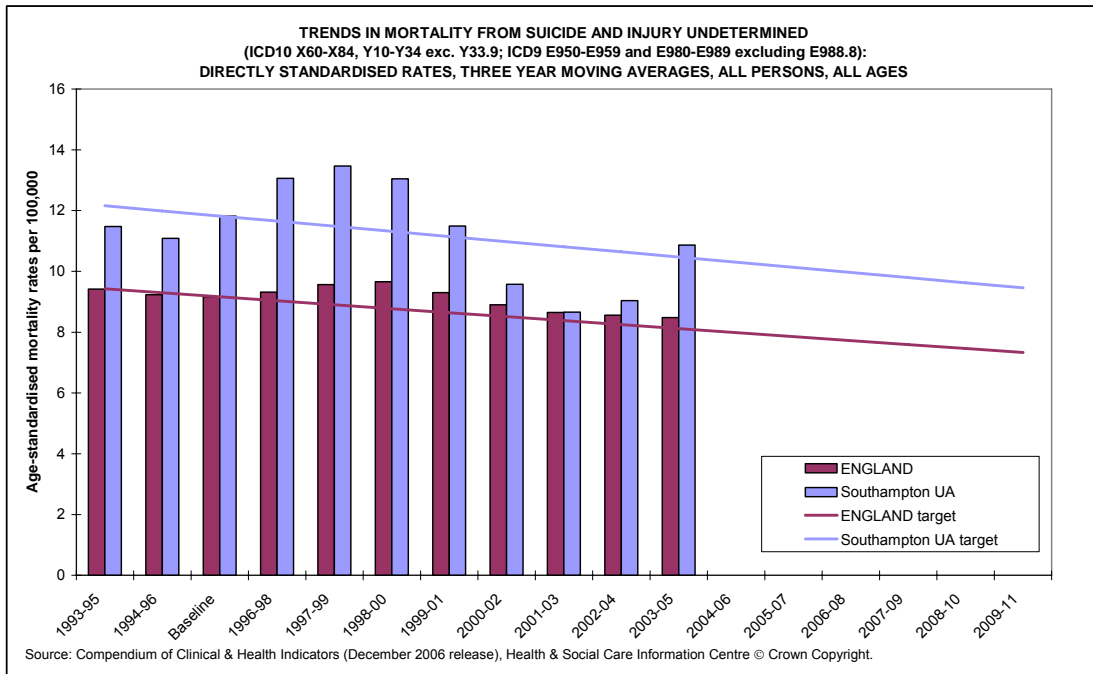
Circulatory diseases are a major cause of illness and death both locally and nationally. In 2005 there were 659 deaths amongst Southampton residents from circulatory diseases; of these, 317 were from coronary heart disease and 186 were from stroke. The Government set a target for reducing mortality from 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 2005 26.6% of deaths amongst Southampton residents were due to cancer. The next chart shows that mortality from cancer amongst the under 75's in Southampton is just about 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)

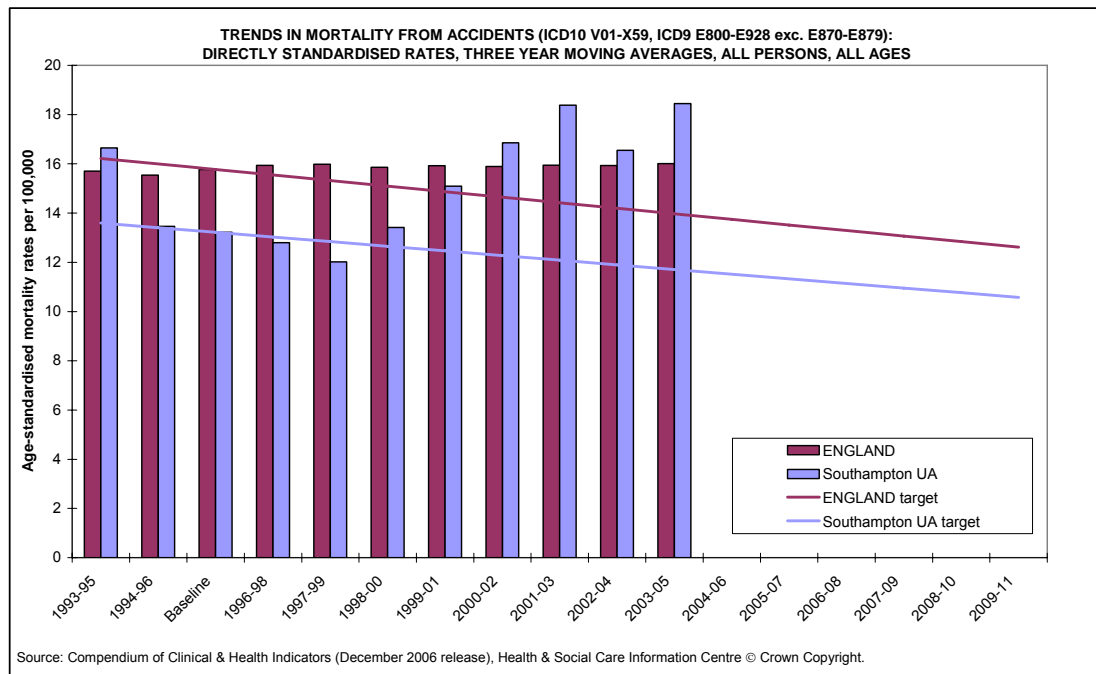


It is more difficult to monitor trends in mortality from suicide and accidents as these account for a much smaller number of deaths and, therefore, the year-on-year variability is much greater.



In 2005 there were 31 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 fluctuating around the target reduction set in 'Our Healthier Nation'.

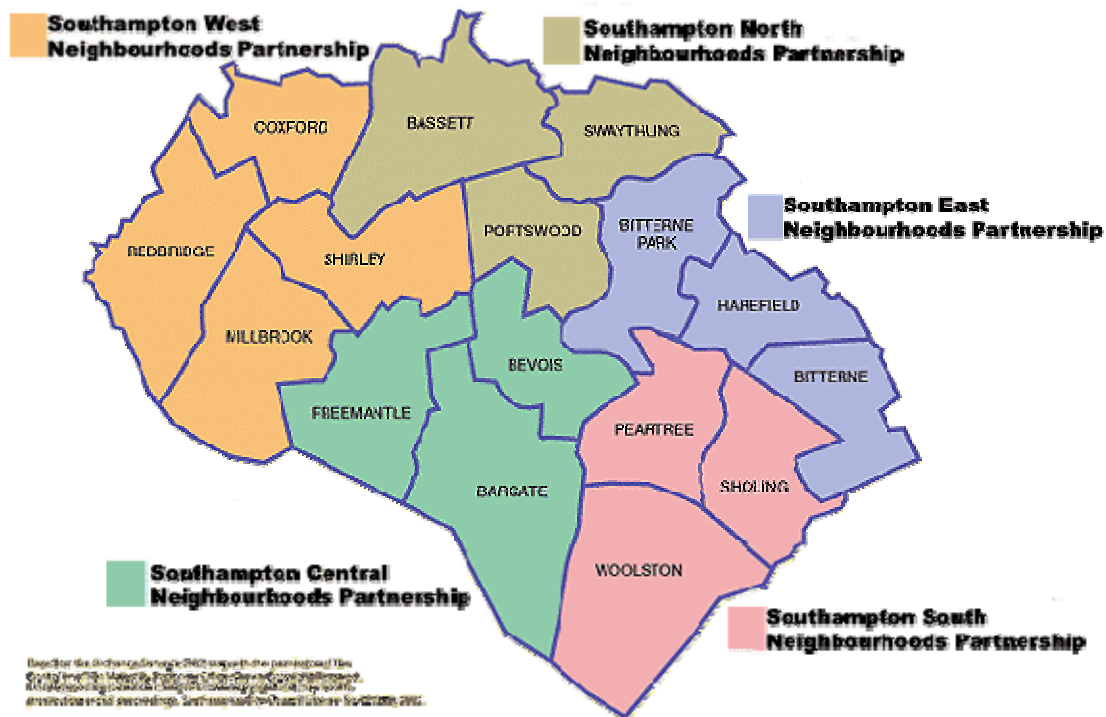
In 2005, 64 Southampton residents died from an accidental cause. The chart below shows the variability in accident mortality rate over the past few years. Rates appear to have risen since 1999 but further analysis of the data shows that the confidence intervals around these rates are so large that the differences observed are not statistically significant.



Key data from *Compendium of Clinical & Health Indicators* (December 2006 release), and other government sources are set out in an appendix to this report.

The Major Health Issues for Southampton's Localities

Summary Findings from Local Health Comparisons 2006¹



Central locality

- The Central locality is characterised by large numbers of students, a greater ethnic mix and high levels of deprivation. It is also contains the areas of the City forecast to see the most residential development (22.5% between 2005 and 2012) and, therefore the largest population increases (15% between 2005 and 2012)
- The 2006 Locality Health Comparisons update confirms the generally poorer health, higher mortality rates and lower life expectancy (particularly for males) experienced by residents in the Central locality, compared to the national or local average. Although this area saw a significant decline in mortality rates between 1999 and 2004, the rate increased in 2005. However, it is difficult to draw conclusions about a trend as the confidence intervals around the rate are large
- Although childhood obesity rates are not significantly different from the Southampton average, the average BMI centile (Body Mass Index) for children of school entry age in this locality is the lowest in South West Hampshire. This might be explained by the relatively large percentage of people in this locality who are from an ethnic group other than white, as obesity is known to vary with ethnicity. It is also possible that the low BMI indicates a hidden pocket of undernourished children in the locality. However, further analysis is needed before this can be confirmed

- The Central locality also has the highest rate of low birth weight in South West Hampshire. There is a known association between ethnicity and low birth weight, and so the ethnic makeup of this locality may explain this to some extent
- This locality has the highest levels of dental decay amongst 5 year olds in Southampton, whilst also having the lowest levels of treatment
- Cancer and circulatory diseases are a big issue here, as they are in the rest of the City. The uptake of breast and cervical cancer screening is low and fell again in 2005. Despite this, hospital admissions for cancer, as well as cancer mortality rates, have fallen significantly in recent years
- There are indications that patients with circulatory disease are being less well managed here; for instance, although the proportion of patients with Coronary Heart Disease (CHD) or stroke who have blood pressure controlled has increased in the last year, it is still the lowest in Southampton, and there continue to be fewer revascularisation procedures to every death from CHD
- The Central locality 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. Social renting is high and there are a high proportion of lone parent families
- A big public health issue for Southampton East is infant health as levels of smoking in pregnancy continue to be higher than elsewhere in the City and, despite an increase in 2005/06, breastfeeding rates are lower
- Cancer and circulatory disease are the major causes of illness and death. Hospital admissions for all cancers have increased significantly in the last year. There has been no statistically significant improvement in mortality from either cancer or circulatory disease 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 is more ethnically diverse than the City average
- Although the North has generally lower levels of deprivation than other City localities there are pockets of very high need and overall deprivation levels are significantly higher than in the South West Hampshire localities outside the City
- Life expectancy is the highest in Southampton for both males and females. Illness and mortality rates are generally lower than the City average, but compared to the remainder of South West Hampshire the locality scores worse on many health indicators
- Childhood obesity is no less an issue in the North locality than it is elsewhere in the City
- Cancer and circulatory disease are the major causes of morbidity and mortality in the North locality. Mortality rates from circulatory diseases have fallen over the 1999/01 to 2003/05 period but cancer mortality has not improved during this time

South locality

- The South of Southampton is characterised by a younger population and some areas have very high levels of deprivation

- The population is forecast to increase by 4.3% between 2005 and 2012 which is related to a forecast 8.7% increase in dwellings. The majority of this growth is expected to be in Woolston ward following re development of the Vosper's site.
- Data from the maternity units indicate high levels of smoking in pregnancy and low levels of breastfeeding. 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. However, this locality has the highest rates of people accessing NHS Quitters services and the highest prescribing rates of nicotine replacement therapy (NRT) and bupropion (Zyban) in South West Hampshire
- After adjusting for the underlying age profile, the South has the highest prevalence of CHD in the City. Management of CHD and stroke through blood pressure control is slightly lower here than in the rest of the City. The South locality has seen no evidence of a decline in mortality from circulatory diseases over the last few years
- Rates of prescribing of anti-depressants continue to be higher than average in this locality

West locality

- The West of Southampton has a relatively young population and high levels of deprivation. Social renting is high and there is a high proportion of lone parent families
- The population is more likely to be claiming benefits and to have poor general health. There have been no significant improvements in mortality rates, and premature mortality rates remain high particularly for women
- Infant health is a major issue in this area. Despite improvements over the last two years, smoking rates during pregnancy continue to be high, and breastfeeding rates remain low. Childhood obesity continues to be an issue, with little sign of improvement. Between 2001 and 2005 the childhood obesity rates in this locality have been consistently amongst the highest in Southampton
- Hospital admissions for serious accidental injuries have risen consistently in recent years, with the current rates being the highest in South West Hampshire
- Cancer, especially lung cancer, is one of the main causes of ill health and mortality. This locality has the highest breast cancer mortality rate in Southampton
- Prevalence of circulatory diseases is high but there has been a significant fall in the circulatory disease mortality rate between 1999-2001 and 2003-05
- Respiratory illnesses, such as asthma and chronic obstructive pulmonary disease, are a bigger issue in the West of the City than elsewhere in South West Hampshire

References

1. King D, Wilkinson R. *Local Health Comparisons 2006*. Southampton City PCT 2006. Available at <http://www.southamptonhealth.nhs.uk/publichealth/lhc/lhc2006>



Appendix - Data Tables

1. GENERAL HEALTH

	ENGLAND		SOUTH EAST REGION		SOUTHAMPTON	
	MALES	FEMALES	MALES	FEMALES	MALES	FEMALES
LIFE EXPECTANCY AT BIRTH (YEARS) 2003-2005						
Life expectancy	76.9	81.1	78.1	82.0	76.5	81.2
HEALTHY & UNHEALTHY LIFE EXPECTANCY (2003)						
Unhealthy Life Expectancy	14.3		12.5		15.2	
Healthy Life Expectancy	64.4		67.3		63.0	
LIMITING LONG TERM ILLNESS IN 2001						
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	
GENERAL HEALTH IN 2001						
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%	
PROVISION OF UNPAID CARE IN 2001						
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	
FERTILITY RATE IN 2005								
General Fertility Rate*	58.5		57.3		52.7		52.6	
*Live Births to women aged 11-49 years per 1000 women aged 15-44								
NUMBER AND PERCENTAGE OF LIVE BIRTHS BY MATERNAL AGE IN 2005								
MATERNAL AGE	Number	%	Number	%	Number	%	Number	%
Under 16	1102	0.18%	135	0.14%	125	0.23%	7	0.25%
16-19	40621	6.63%	4997	5.32%	4294	7.92%	240	8.65%
20-24	114882	18.74%	14578	15.52%	11233	20.72%	646	23.28%
25-34	335438	54.72%	52827	56.25%	28934	53.38%	1511	54.45%
35-39	99663	16.26%	17654	18.80%	8019	14.79%	315	11.35%
40+	21322	3.48%	3730	3.97%	1598	2.95%	56	2.02%
Total	613028	100.00%	93921	100.00%	54203	100.00%	2775	100.00%
PERCENT OF BIRTHS UNDER 2500 GRAMS IN 2005								
<2500 grams	7.9%		7.1%		7.9%		9.0%	
*Includes live and still births								
UNDER 18 CONCEPTIONS IN 2005 (provisional)								
Number of conceptions	39683		5316		n/a		215	
Conception Rate*	41.1		34.2		n/a		58.8	
Percentage leading to abortion	46.9%		50.2%		n/a		42.8%	
*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 (December 2006 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
PERINATAL* MORTALITY RATE (PER 1000 TOTAL BIRTHS) IN 2003-2005				
*Includes stillbirths and deaths in the first week of life				
Observed	14941	1943	1301	66
Rate	8.2	6.9	8.2	8.3
MORTALITY RATES IN INFANCY (PER 1000 LIVE BIRTHS) AND NUMBER OF DEATHS IN 2003-2005				
UNDER 1 YEAR				
Observed	9292	1125	843	25
Rate	5.1	4.0	5.3	3.2
UNDER 28 DAYS				
Observed	6368	775	559	19
Rate	3.5	2.8	3.5	2.4
UNDER 7 DAYS				
Observed	4900	588	409	15
Rate	2.7	2.1	2.6	1.9

Notes:

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

Source:

Compendium of Clinical & Health Indicators (December 2006 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
AVERAGE ANNUAL NUMBER OF DEATHS FROM SELECTED CAUSES BY AGE AND SEX (average for 2003-2005 period)									
All cancer (all ages)	C00-C97	65994	60533	10469	9778	6361	5980	265	244
Lung Cancer (under 75s)	IC33-C34	8709	5547	1193	739	904	651	38	27
Lung Cancer (all ages)	C33-C34	15834	10901	2232	1512	1689	1280	75	48
Breast cancer (50-69 yr olds)	C50		3554		621		277		12
Breast cancer (all ages)	C50		10362		1780		910		37
Cervical cancer (15-64 yr olds)	C53		410		58		41		#
Cervical cancer (all ages)	C53		875		130		93		5
Coronary heart disease (under 75s)	I20-I25	20685	7488	2810	966	1964	735	91	30
Coronary heart disease (all ages)	I20-I25	48162	38776	7285	6062	4544	3884	205	151
Stroke (under 65s)	I60-I69	1982	1550	269	209	175	140	6	7
Stroke (all ages)	I60-I69	19147	31178	2959	5218	1793	3024	72	123
Accidents (all ages)	V01-X59	5806	4717	895	763	559	433	25	29
Suicide and self-inflicted injury and injury undetermined (all ages)	X60-X84, Y10-Y34 exc. Y33.9	3289	1175	513	188	330	119	19	#
Suicide and self-inflicted injury (all ages)	X60-X84	2344	742	376	117	234	74	15	#
All Causes (all ages)	A00-Y99	231565	256609	36096	41861	22223	25276	960	1021
All Causes - under 15 years	A00-Y99	2434	1906	312	247	223	169	9	5
All Causes - 15-64 years	A00-Y99	48215	30136	6859	4491	4817	2834	225	128
All Causes - 65-74 years	A00-Y99	49303	34775	7132	5085	4634	3366	197	138

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
CRUDE DEATH RATE (PER 100,000 POPULATION) IN 2005									
Rate per 100,000	A00-Y99	921.37	979.82	884.19	996.23	966.85	1053.59	849.47	914.68
AVERAGE DIRECTLY AGE-STANDARDISED DEATH RATES (PER 100,000 POPULATION) AND NUMBER OF DEATHS FROM ALL CAUSES (ICD 001-999) IN THE PERIOD 2003-2005									
Rate per 100,000	A00-Y99	759.67	532.09	690.84	492.52	821.82	559.92	789.45	537.89
Observed number of deaths (3 years)	A00-Y99	694694	769828	108289	125583	66668	75828	2881	3063
DIRECTLY AGE-STANDARDISED DEATH RATES (PER 100,000 POPULATION) FOR SELECTED CAUSES OF DEATH IN THE PERIOD 2003-2005									
(Rates are for all ages unless otherwise specified)									
All cancer	C00-C97	216.95	154.05	203.14	146.75	238.84	166.13	224.17	161.29
Lung Cancer (under 75s)	C33-C34	33.84	20.14	28.22	16.42	42.04	27.57	40.73	27.07
Breast cancer (50-69 yr olds)	C50		61.99		65.60		58.45		61.71
Cervical cancer (15-64 yr olds)	C53		2.42		2.10		2.87		[3.29]
Coronary heart disease (under 75s)	I20-I25	80.70	26.09	66.49	20.38	91.44	29.62	96.41	28.76
Stroke (under 65s)	I60-I69	9.06	6.91	7.42	5.65	9.58	7.60	6.82	8.71
Accidents	V01-X59	21.46	10.59	20.25	10.12	22.63	10.55	21.12	15.19
Suicide and self-inflicted injury and injury undetermined	X60-X84, Y10-Y34 exc. Y33.9	12.86	4.28	12.33	4.15	14.48	4.98	17.19	[4.20]
Suicide and self-inflicted injury	X60-X84	9.14	2.71	9.03	2.56	10.20	3.08	13.75	[1.68]

Notes:

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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
STANDARDISED AVERAGE ANNUAL YEARS OF LIFE LOST PER 10,000 RESIDENT POPULATION AGED UNDER 75 BY SELECTED CAUSE OF DEATH IN THE PERIOD 2003-2005									
All cancer	C00-C97	161.9	151.4	149.7	146.2	181.1	162.1	166.9	168.3
Lung cancer	C33-C34	36.0	23.3	30.6	19.7	45.4	31.7	45.2	31.9
Skin cancer	C43	4.0	3.0	4.4	3.3	4.3	3.3	2.4	3.9
Breast cancer	C50		37.3		38.5		35.7		32.4
Cervical cancer	C53		4.8		4.2		5.9		7.3
Coronary heart disease	I20-I25	95.3	25.1	78.2	19.2	111.0	29.5	117.7	26.3
Stroke	I60-I69	23.1	17.7	18.8	14.9	24.0	19.2	20.6	24.7
Accidents	V01-X59	59.1	17.8	58.4	18.0	59.5	17.8	47.0	14.5
Suicide and self- inflicted injury and injury undetermined	X60- X84,Y10- Y34 exc. Y33.9	42.4	13.2	39.9	12.8	47.3	15.3	49.0	12.1
Suicide and self- inflicted injury	X60-X84	29.4	8.2	28.6	7.6	33.2	9.3	40.7	4.0
Infectious and parasitic diseases	A00-B99	8.6	6.3	6.9	5.2	9.3	6.6	10.1	10.1
Stomach cancer	C16	6.0	2.9	4.6	2.5	7.2	3.6	3.7	2.0
Pneumonia	J12-J18	11.0	7.1	8.9	5.5	12.8	8.1	15.5	4.7
Chronic liver disease and cirrhosis	K70, K73- K74	27.1	13.6	20.9	10.4	38.5	17.3	40.5	18.6
All causes	A00-Y99	587.8	355.6	514.0	322.1	675.8	393.1	649.4	398.8

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
INDIRECTLY STANDARDISED MORTALITY RATIOS FOR "AVOIDABLE" AND OTHER POTENTIALLY REDUCIBLE CAUSES OF DEATH IN THE PERIOD 2003-2005									
Cervical cancer (ages 15-64)	C53		100		86		117		[130]
Asthma (ages 5-44)	J45-J46	100	100	93	106	94	105	#	#
Tuberculosis (ages 5-64)	A15-A19	100	100	74	83	[54]	[85]	#	#
Hodgkin's disease (ages 5-64)	C81	100	100	99	95	110	[73]	#	#
Breast cancer (ages 50-64)	C50		100		106		96		99
Acute myocardial infarction (ages 35-64)	I21-I22	100	100	81	71	119	113	102	[81]
Other ischaemic heart disease (ages 35-64)	I20, I23-I25	100	100	83	77	118	123	143	[119]

Notes:

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