



Health in Southampton 2009



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INTRODUCTION BY THE PUBLIC HEALTH DIRECTOR FOR SOUTHAMPTON

Welcome to the Health in Southampton 2009 report which I hope will be helpful to the many people engaged with improving the health and well-being of our local population.

The first chapter of this report takes stock of health inequalities by exploring Professor Marmot's Strategic Review of Health Inequalities, followed by an updated analysis of trends in health inequalities in Southampton City. Programmes to tackle health inequalities have been a priority at a national and local level in the City, and now is the time to reflect on our progress and look to the future.

The second chapter deals with health and employment. The global economic recession has dominated the news agenda this year and continues to impact on the country, region and the city of Southampton. Links between population health and employment have been known for many years and this year's report examines the likely impacts on health and health inequalities of unemployment. It also draws upon the recent work of the new National Director for Health and Work, Dame Carole Black.

The third chapter addresses men's health in Southampton, taking a broad look at different aspects of health, illness and health inequalities. Men's health in the city definitely needs improving. Health inequalities and life expectancy for men present special challenges to the health service and partner agencies and we clearly need to engage men in new ways to encourage them to be more involved with their health in future. Many services could be more men friendly and we need to learn a lot about tailoring health messages and promotions in ways that will get through to men and engage them in ways we have not done before. The chapter suggests a number of ways we might go about this in future, and recommends the establishment of a men's health forum for the city.

The final section of the report describes the three new localities in the city that have been identified to lead the way on Practice Based Commissioning (PBC) – a model devised to engage primary care and other clinicians in the commissioning agenda. These are areas that align with the main partner organisations we work with, and have been created by merging together five previous localities. You will notice that some of the information in the report is described either way – by being broken down into either five or the three more recent localities, depending on when the analysis was performed. The profiles show health issues common to all localities as well as highlighting differences between them. The importance of looking at smaller areas within the localities has also been emphasised as the larger scale geographies can mask some serious local issues.

I hope that you find this report useful and please do not hesitate to contact me or my team if you have any questions or feedback.

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March 2010

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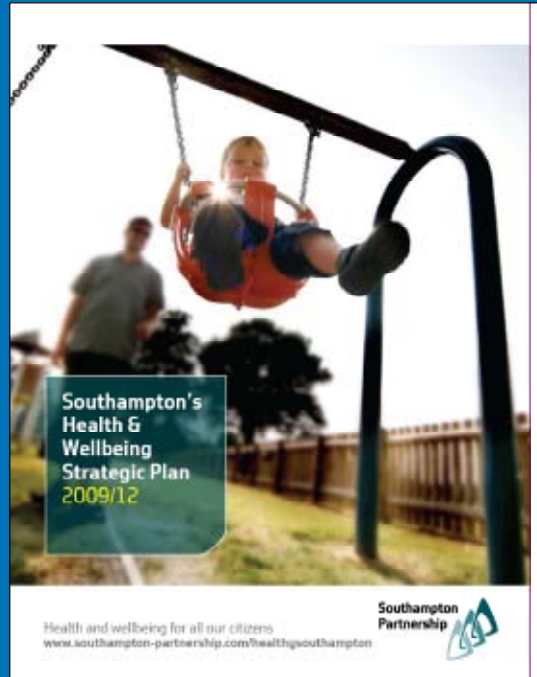
Acknowledgments

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Key priorities for local action



The City's Health and Wellbeing Partnership is committed to:

- achieving a healthy start in life
- ensuring better health for all (and narrowing the health inequalities gap)
- living later life to the full
- promoting independence and choice
- securing better mental health.

Our Joint Strategic Needs Assessment (JSNA) enabled us to develop these five strategic priorities, which will be delivered through the following programmes of work set out in our Health and Wellbeing Strategic Plan 2009-12:

- giving children the best start in life
- improving lifestyles – especially smoking, diet and activity
- alcohol harm reduction
- reducing worklessness and improving health at work
- addressing environmental factors that affect health
- creating an age-friendly City
- personalisation and choice of services
- promoting independence
- improving access to psychological support services
- promoting positive mental health
- improving older people's mental health and services.

CHAPTER 1 HEALTH INEQUALITIES

Introduction

This chapter takes the opportunity to share the context and policy themes to emerge from a national review into inequalities in health. The Secretary of State for Health commissioned Professor Sir Michael Marmot to undertake a Strategic Review of Health Inequalities to inform actions post 2010. We have reviewed the policy themes from the review released in February 2010 (Ref 1). The approach adopted by the National Support Team for Health Inequalities is also summarised below along with the lessons learned to date from its work with Spearhead Primary Care Trusts (PCTs).

The second part of this chapter provides an updated analysis of local trends in health inequalities in Southampton City. Tackling health inequalities has been identified as a priority at both a national and local level in Southampton City. The Southampton Joint Strategic Needs Assessment (JSNA) for health and wellbeing 2008-2011 identified achieving better health and wellbeing for all and tackling health inequalities within the City as a key priority and our strategic commissioning plan focuses explicitly on tackling inequalities in health.

National Picture – The Marmot Review Policy Recommendations

Context

The Review Team were asked to take account of the best global evidence appropriate to England from the World Health Organization (WHO) Commission on the Social Determinants of Health (Ref 2) and other work over the last 10 years. The review had four tasks:

- identify for the health inequalities challenge facing England, the evidence most relevant to underpinning future policy and action
- show how this evidence could be translated into practice
- advise on possible objectives and measures, building on the experience of the current health inequalities targets on infant mortality and life expectancy
- publish a report of the review's work that will contribute to the development of a post 2010 health inequalities strategy.

(Ref 3 Consultation doc)

The key themes and policy recommendations proposed in the review are summarised below.

Progress in tackling health inequalities

The review restates the position around health inequalities – social gradients in health measured by mortality continue to illustrate health inequalities in England. Figures 1 and 2, taken from the review's first phase report illustrate that although life expectancy has increased across the population in England as a whole, the social gradient in life expectancy for men and women between social groups continues. The gap between best and worst off has not narrowed.



Figure 1 Life Expectancy at birth by social class, males, England and Wales, 1972 – 2005

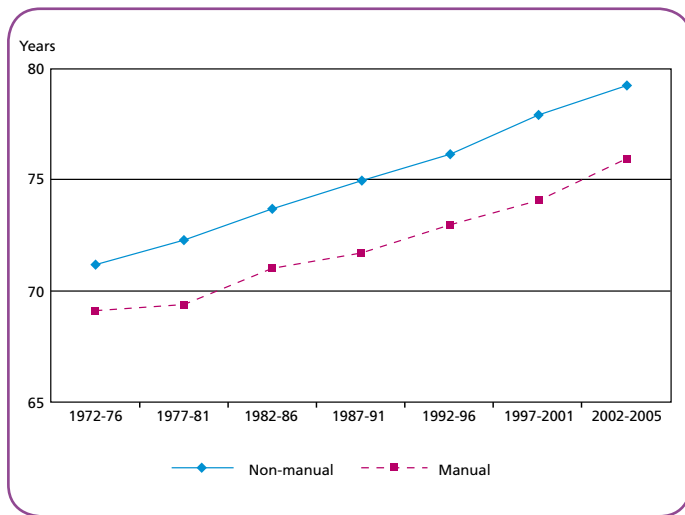
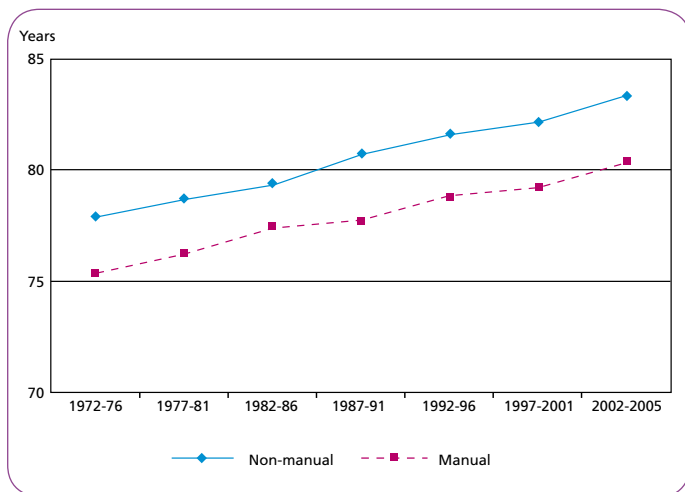


Figure 2 Life Expectancy at birth by social class, females, England and Wales, 1972 - 2005



Current health inequality targets focus on infant mortality and life expectancy at birth:

- Children under one year, by 2010 to reduce by at least 10% the gap in mortality between the routine and manual group and the population as a whole
- Starting with local authorities, by 2010 to reduce by at least 10% the gap between the fifth of areas with the worst health and deprivation indicators (the spearhead group) and the population as a whole.

The latest progress report on target performance was published in December 2008 (Ref 6). Based on data from 2005-07 this showed that compared to the previous period (2004-6) there was a slight narrowing of the infant mortality gap, little change in the gap in male life expectancy and a widening between the richest and the poorest in female life expectancy. Lifestyle risk factors such as smoking, obesity, excess alcohol consumption, unhealthy diets and lack of exercise are well understood as key contributors to the major disease burden in England. Social determinants of health are also recognised as exerting a key impact on health outcomes. The Marmot Review reinforces a social determinants model of health inequalities and reflects the work undertaken by the WHO Commission on the Social Determinants of Health (Ref 2). The Commission endorsed a conceptual framework of health illustrated in Figure 3. This proposes that the distribution of health and wellbeing is caused by material circumstances, social cohesion, psychosocial factors, behaviours and biological factors. The Review suggested that there is a strong body of evidence which shows this global analysis is applicable to England.

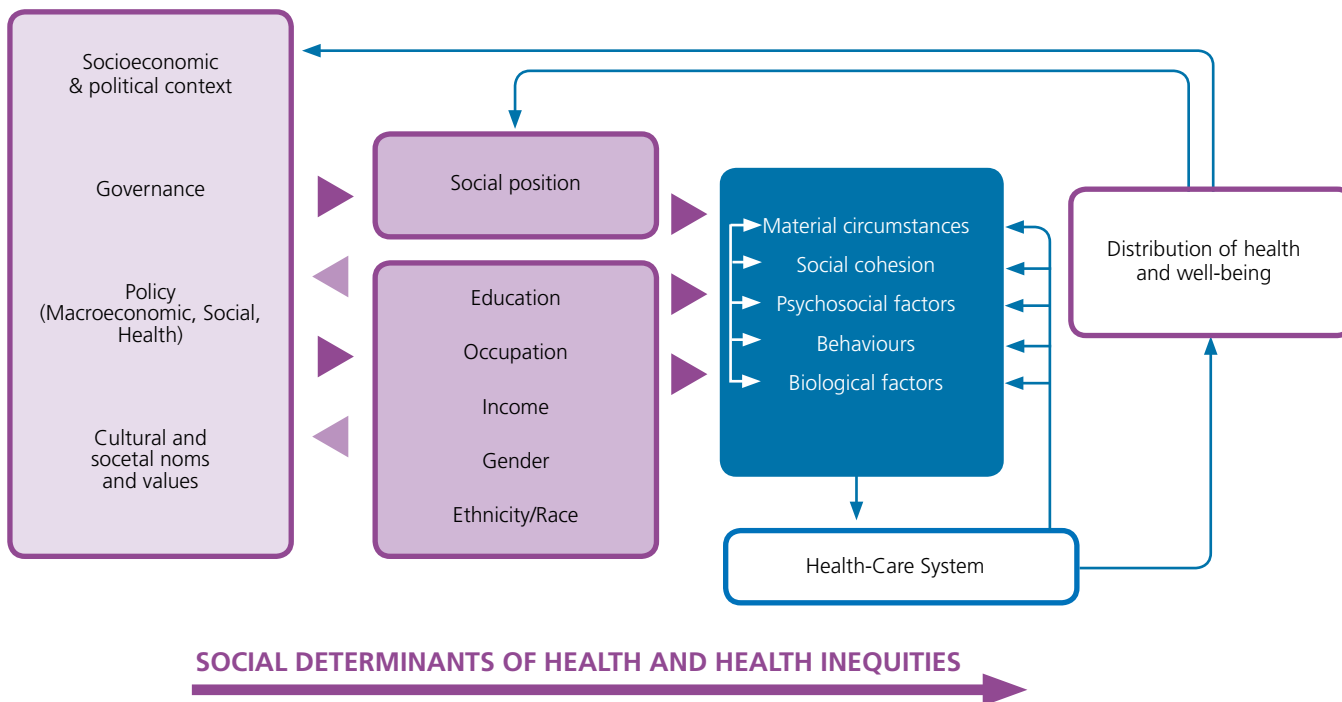
The Acheson Report published in 1998 (Ref 4) has provided the focus for action on health inequalities over the last decade. It underpinned the national inequalities strategy: Tackling Inequalities: A Programme for Action (Ref 5).

The strategy had two aims: to deliver the national health inequalities target for 2010 and support a long-term sustainable reduction in health inequalities.



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Figure 3 Commission on the Social Determinants of Health Conceptual Framework



Key themes from the Review

During the first phase of the Review, nine Task Groups were established to assess the evidence and identify where action is likely to be most effective in reducing health inequalities in the short, medium and long term. Outlined below are the key policy areas addressed by the Task Groups:

Table 1 Marmot Review - Nine Task Groups

Early child development and education	Employment arrangements and working conditions	Social protection
The built environment	Sustainable development	Economic analysis
Delivery systems and mechanisms	Priority public health conditions	Social inclusion and social mobility

This comprehensive review of evidence has generated six key policy areas and objectives for each (Ref 1). These are summarised over the page.

Policy objective A – Give every child the best start in life

- Reduce inequalities in the early development of physical and emotional health, and cognitive, linguistic, and social skills
- Ensure high quality maternity services, parenting programmes, childcare and early years education to meet need across the social gradient
- Build the resilience and wellbeing of young children across the social gradient.

Policy objective B – Enable all children, young people and adults to maximise their capabilities and have control over their lives

- Reduce the social gradient in skills and qualifications
- Ensure that schools, families and communities work in partnership to reduce the gradient in health, well-being and resilience of children and young people
- Improve the access and use of quality life-long learning across the social gradient.

Policy objective C – Create fair employment and good work for all

- Improve access to good jobs and reduce long-term unemployment across the social gradient
- Make it easier for people who are disadvantaged in the labour market to obtain and keep work
- Improve quality of jobs across the social gradient.

Policy objective D – Ensure a healthy standard of living for all

- Establish a minimum income for health
- Reduce the social gradient in the standard of living through progressive taxation and other fiscal policies
- Reduce the cliff edges faced by people moving between benefits and work.

Policy objective E - Create and develop healthy and sustainable places and communities

- Develop common policies to reduce the scale and impact of climate change and health inequalities
- Improve community capital and reduce social isolation across the social gradient.

Policy objective F – Strengthen the role and impact of ill-health prevention

- Prioritise prevention and early detection of those conditions most strongly related to health inequalities
- Increase availability of long-term and sustainable funding in ill health prevention across the social gradient.

Policy objective F above focuses on the key role of prevention in reducing health inequalities. It recommends that investment in prevention and health promotion is prioritised across government departments to reduce the social gradient. It proposes the implementation of evidence-based programmes of preventative interventions that are effective across the social gradient and cites in particular the need for sustained action on smoking, alcohol and obesity.

The final report of the Strategic Review of Health Inequalities in England post-2010 has provided best evidence to support both national and local action. It will inform the direction of a new national strategy and targets. At a local level the recommendations provide the opportunity for NHS Southampton City to review commissioning of health and wellbeing activity both through the NHS and joint commissioning with key partners across the City to ensure best evidence is implemented and best outcomes secured to reduce health inequalities.

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Lessons learned form the work of the National Support Team for Health Inequalities

The National Support Team (NST) for Health Inequalities was set up in 2007 to provide support to local areas focusing principally on the life expectancy element of the 2010 Public Service Agreement (PSA) target – to reduce by at least 10% the gap between the fifth of areas with the worst health and deprivation indicators (spearhead areas) and the population as a whole.

The team use a model to help local areas identify the key interventions they can implement in order to succeed (Ref 7). The three categories of intervention are:

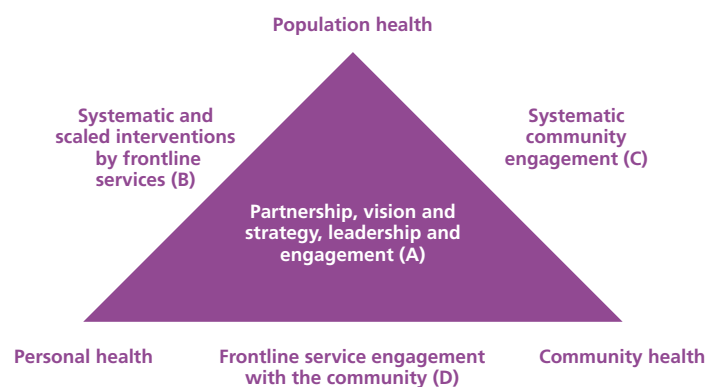
- population health: direct input at population level through legislation, regulation, taxation, mass media etc (for example preventing smoking in enclosed public places)
- personal health: applying effective personal health interventions (for example cholesterol management with statins, affordable warmth) systematically and at a scale that such improvements add up to population level change
- community health: engaging, developing and empowering communities effectively and systematically enough that resulting health-improving and health-seeking behaviours lead to percentage change at population level.



The work of the national team indicates that to succeed in tackling local health inequalities a whole systems approach is required that addresses action across the points in the population triangle shown below in Fig.4.

- A** The whole system must be driven by committed leadership fostering engagement, effective local strategic partnership and a locally owned, coherent vision and strategy
- B** Interventions must be provided effectively with system and scale by frontline services proactively pursuing health outcomes
- C** Community development should be addressed in a systematic way, rather than ad hoc, targeting engagement and support to the weakest and least capable of responding alone
- D** A range of processes should connect frontline services into the heart of communities, reaching out to “seldom seen, seldom heard” groups and individuals.

Figure 4: Producing Percentage Change at Population Level



(Chris Bentley, Health Inequalities Support Team)

This approach has been used with the PCTs in the most deprived areas in England to scope current action and propose systematic, scaled up programmes to address cardiovascular disease, diabetes, cancer, tobacco control, infant mortality and seasonal excess deaths. Work is underway to share the lessons learned beyond “spearhead communities” and to promote this systematic, scaled up approach to tackling health inequalities.

Health inequalities in Southampton

There are 11 areas in Southampton defined as “priority for action” in the City’s Neighbourhood Renewal Strategy (Ref 8) and these are used to measure progress in reducing health inequalities (map in annex). The populations of some of the priority areas are very small so the analysis in this section group together the 11 areas and compare them as a whole with the rest of the City. The information outlined below has been taken from a more detailed report produced by NHS Southampton’s City’s Public Health Team (Ref 9).

Are we narrowing the gap?

Progress in narrowing the gap between the most deprived communities and the rest of the City is summarised below across a range of indicators. Where possible the trends reflect three year rolling averages; these are used to smooth irregularities in trend data making it easier to discern long term trends that might otherwise be obscured by year-on-year fluctuations.

Life expectancy at birth

Figures 6 and 7 show trends in life expectancy at birth for males and females respectively. Between 2002-04 and 2005-07 life expectancy increased across Southampton. Despite this, life expectancy for males has been significantly lower in the priority areas than in the remainder of the City throughout the period, with no evidence to suggest that the gap is reducing. Life expectancy in 2006-08 for males was 75.6 years in priority areas and 79.1 years elsewhere in Southampton, a difference of 3.5 years. The gap in 2002-04 was 3.4 years.



Figure 5: Summary: Progress towards narrowing the gap

Indicates worsening situation	Indicates improving situation
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N.B. Colours indicate improving or worsening situation but these changes may not be statistically significant.

Life expectancy and mortality indicators

Measure	Priority areas improving?	Gap narrowing?	
	Change between 2002-04 and 2006-08	Difference between priority and non-priority areas	
		2002-04	2006-08
Life expectancy for males	Increase of 1.6 years	3.4 years	3.5 years
Life expectancy for females	Increase of 2.4 years	2.8 years	1.4 years
Mortality - all cause, all age	Decrease of 14.4%	28.6% higher	25.7% higher
Premature mortality (under 75) - all cause	Decrease of 11.6%	57.9% higher	62.5% higher
Circulatory disease mortality - all ages	Decrease of 23.4%	24.7% higher	28.1% higher
Circulatory disease mortality - under 75s	Decrease of 14.9%	56.5% higher	92.0% higher
Cancer mortality - all ages	Decrease of 11.1%	28.9% higher	23.8% higher
Cancer mortality - under 75s	Decrease of 11.9%	41.7% higher	37.6% higher
COPD mortality - all ages	Decrease of 30.3%	22.6% higher	109.1% higher

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Figure 6: Male life expectancy at birth: 2002-2004 to 2005-2007

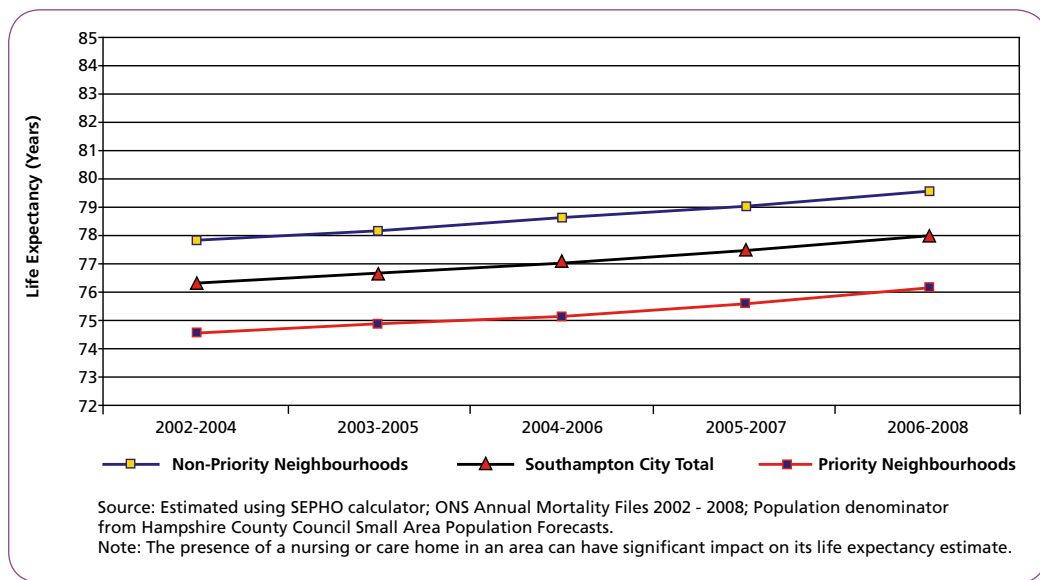
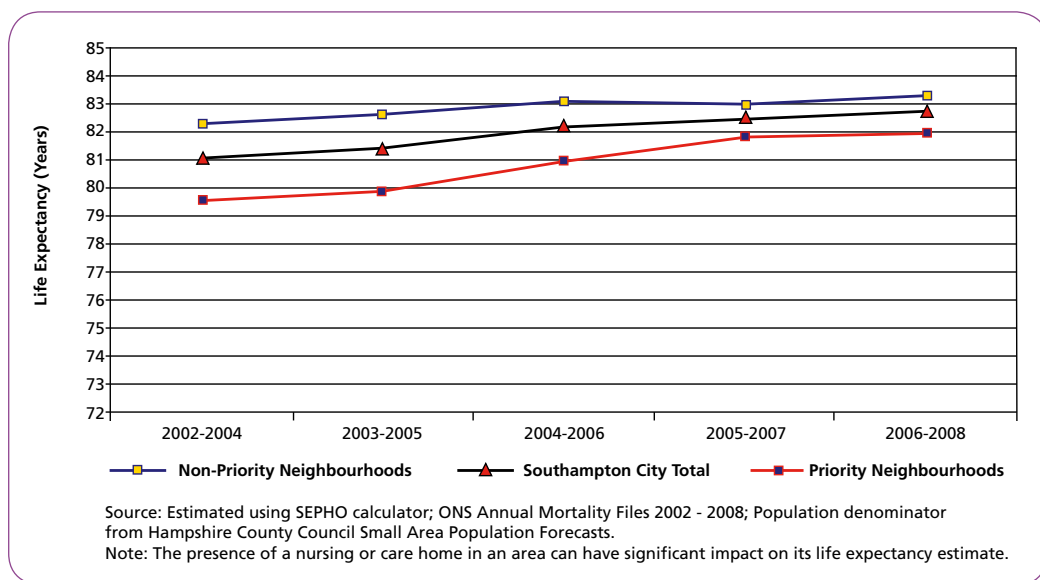


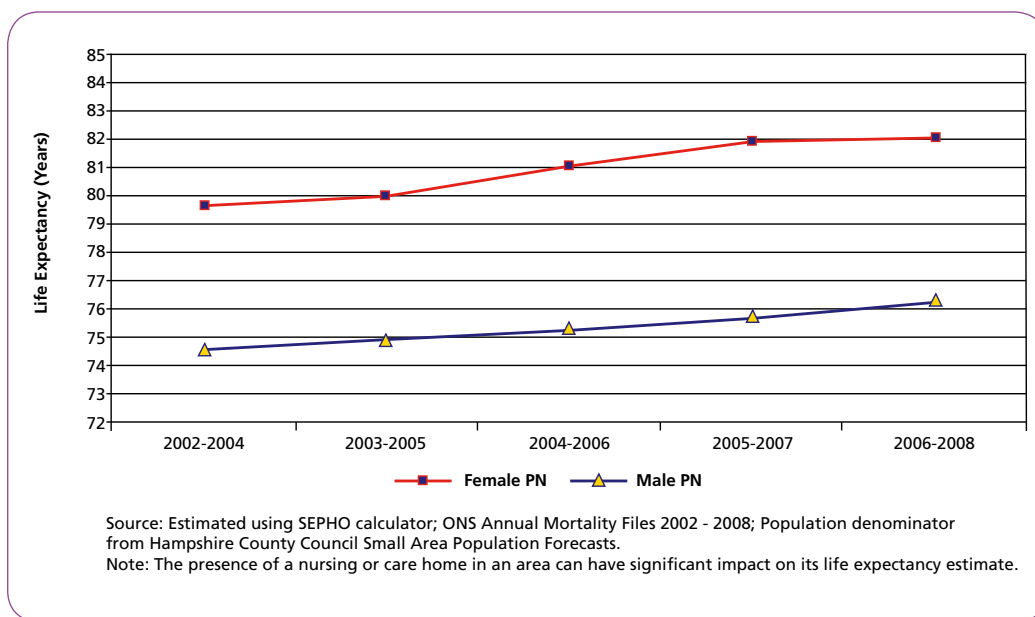
Figure 7: Female life expectancy at birth: 2002-2004 to 2005-2007



Similarly, life expectancy for females has been lower in the priority areas than in the remainder of the City throughout the period. However, there is some evidence to suggest that the gap is closing. In 2002-04, female life expectancy at birth was 79.6 years in priority areas compared to 82.4 elsewhere in the city, a statistically significant gap of 2.8 years. By 2006-08, the gap in female life expectancy between priority areas and the rest of the city had reduced to 1.2 years, a difference which is not statistically significant.

Figure 8 compares female and male life expectancy in priority areas over the period 2002-04 to 2006-08. It is clear that female life expectancy has increased faster than life expectancy for males resulting in a widening inequality gap between the genders. In 2002-04, the gap was 5 years (79.6 years compared to 74.5 years) compared to a gap of 6 years in 2006-08 (82 years compared to 76 years). Contrastingly, in non-priority areas of the City, the gap between female and male life expectancy has fallen slightly from 4.5 years in 2002-04 to 3.9 years in 2006-08.

Figure 8: Priority neighbourhood – male v's female life expectancy at birth: 2002-2004 to 2005-2007



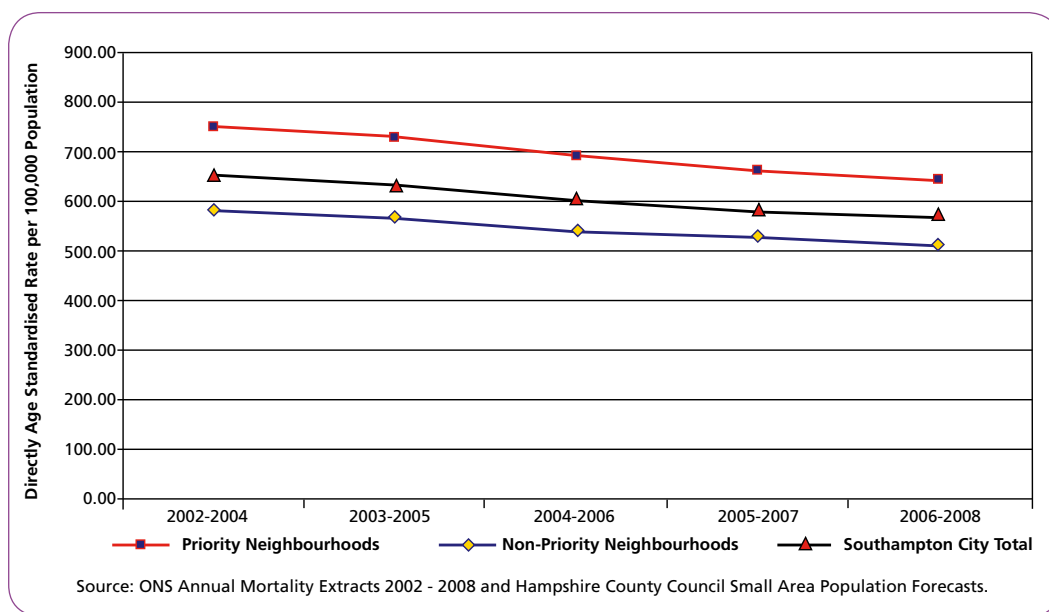
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Mortality

Directly age standardised mortality rates have been calculated as three year averages 2002-04 to 2006-08. Figure 9 shows the all-cause, all-age mortality rates for priority areas, non-priority areas and Southampton as a whole. As with life expectancy, mortality rates have improved over the period for all areas although priority areas continue to have significantly worse mortality rates compared to other areas of the city. By 2006-08 mortality rates in the priority areas had reduced slightly compared to the 28.6% difference measured in 2002-04.

Figure 9: All age, all cause mortality – directly age standardised rate per 100,000 Population: 2002-2004 to 2005-2007



The same is found for premature mortality under 75 years, although here the gap between the priority and non-priority areas is even wider. In 2005-07 premature mortality rates in the priority areas were 60.2% higher than elsewhere in Southampton with no convincing evidence to suggest that the gap reduced (Figure 10).

Figure 10: Under 75's, all cause mortality – directly age standardised rate per 100,000 Population: 2002-2004 to 2005-2007

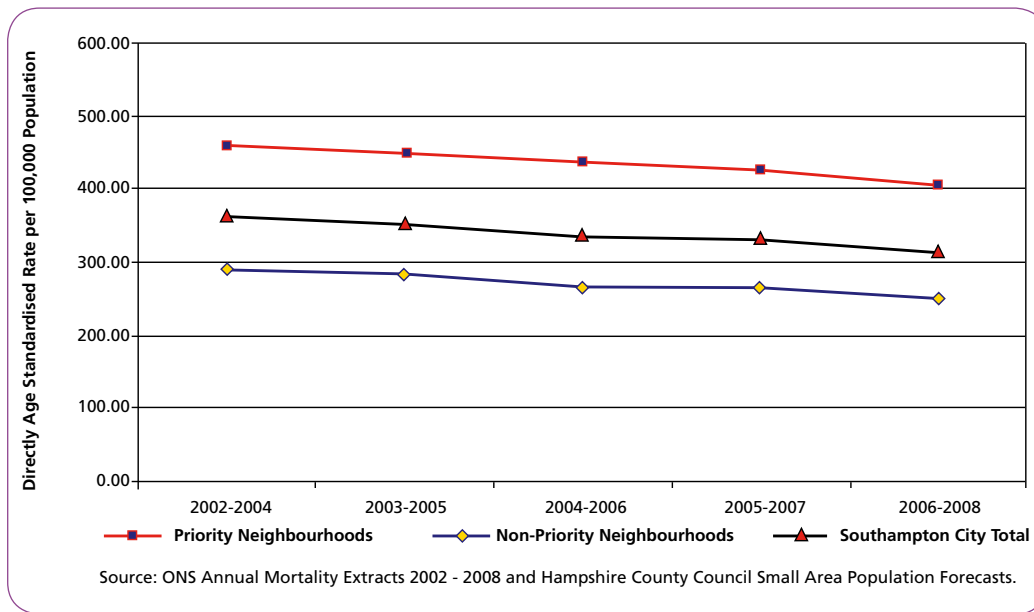
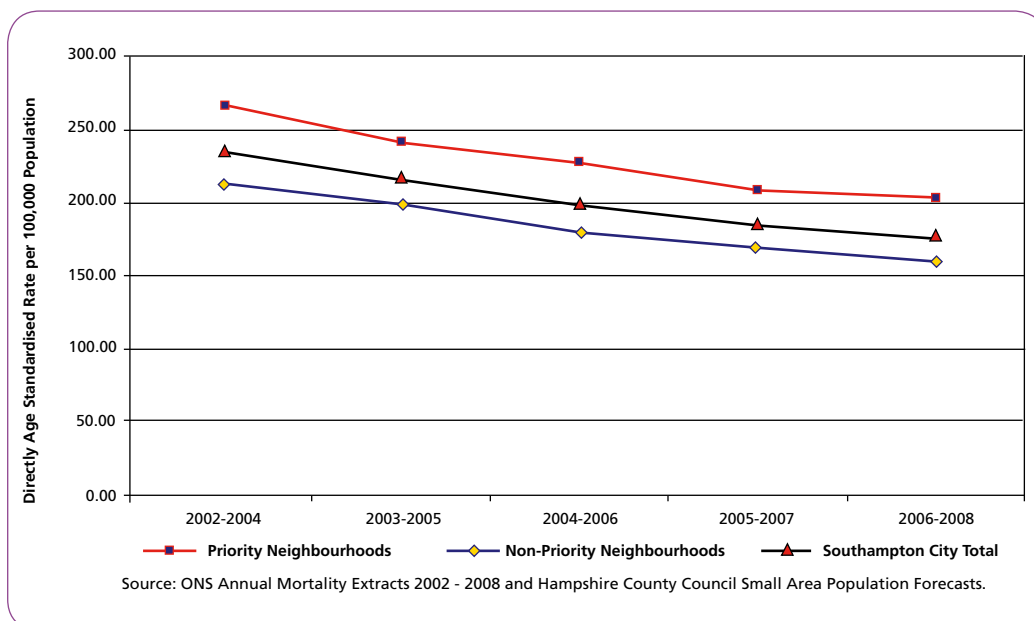


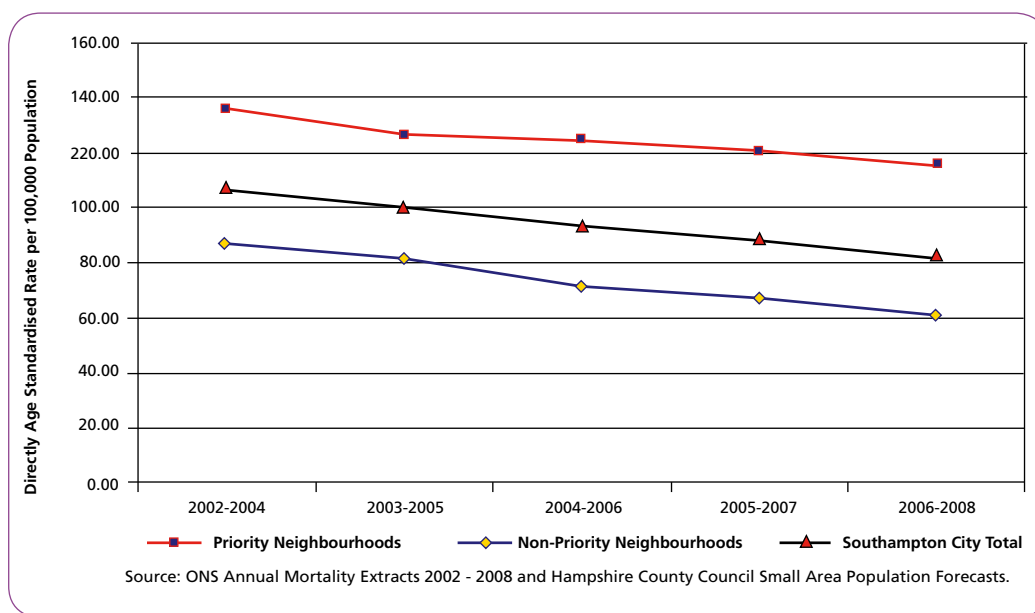
Figure 11 shows mortality rates from circulatory diseases for persons of all ages. There has been a significant reduction in mortality rates between 2002-04 and 2006-08 in both priority and non-priority areas. However, rates are consistently higher in priority areas throughout the period with little evidence to suggest that the gap is reducing (the difference was 24% in both 02-04 and 06-08). When we look at premature mortality (under 75's) from circulatory diseases (Figure 12) it is clear that the inequality gap has increased during the period, due to a steeper fall in the non priority neighbourhoods.

Figure 11: All circulatory disease mortality (all ages) – directly age standardised rate per 100,000 Population: 2002-2004 to 2005-2007



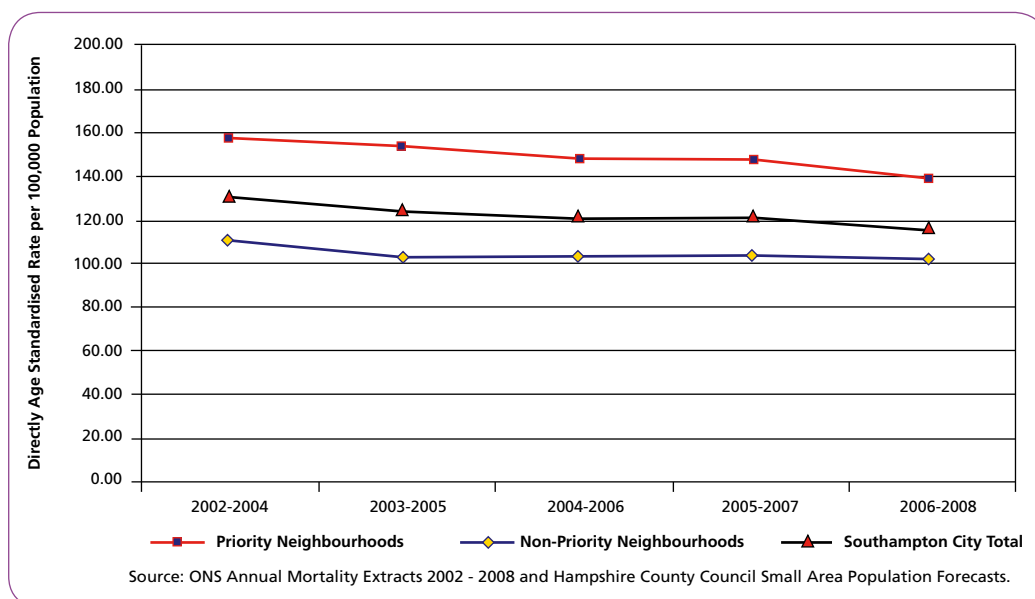
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Figure 12: All circulatory disease mortality (under 75s) – directly age standardised rate per 100,000 Population: 2002-2004 to 2005-2007



Mortality rates from cancer are significantly higher in the priority areas of Southampton (Figure 13). The gap between priority and non-priority areas has reduced slightly for all age mortality but increased slightly for premature cancer mortality. In 2002-04 rates were 41.7% higher in priority areas, but by 2006-08 they were 43.5% higher. However, this is a slight improvement on the 2003-05 gap of over 50% highlighted in previous studies.

Figure 13: All cancer mortality (under 75s) – directly age standardised rate per 100,000 Population: 2002-2004 to 2005-2007



Chronic Obstructive Pulmonary Disease (COPD) is strongly associated with smoking. Figure 14 shows how mortality rates from COPD have increased in the priority areas whereas they have decreased across the rest of the City. In 2002-04 rates in the priority areas were 22.5% higher but by 2006-08 the gap had increased significantly by 102.6%.

Figure 14: COPD mortality (all ages) – directly age standardised rate per 100,000 Population: 2002-2004 to 2005-2007

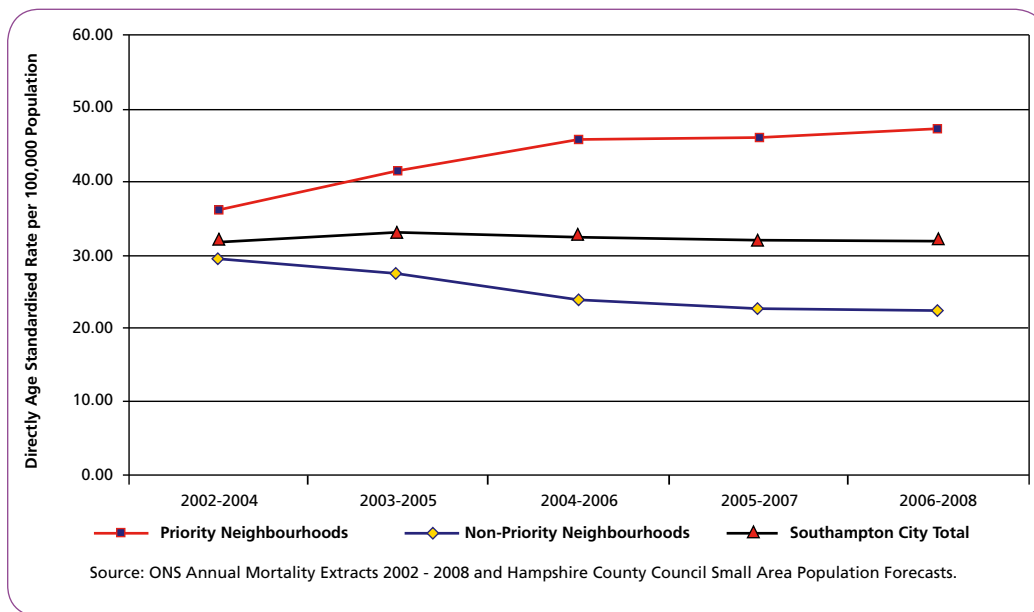
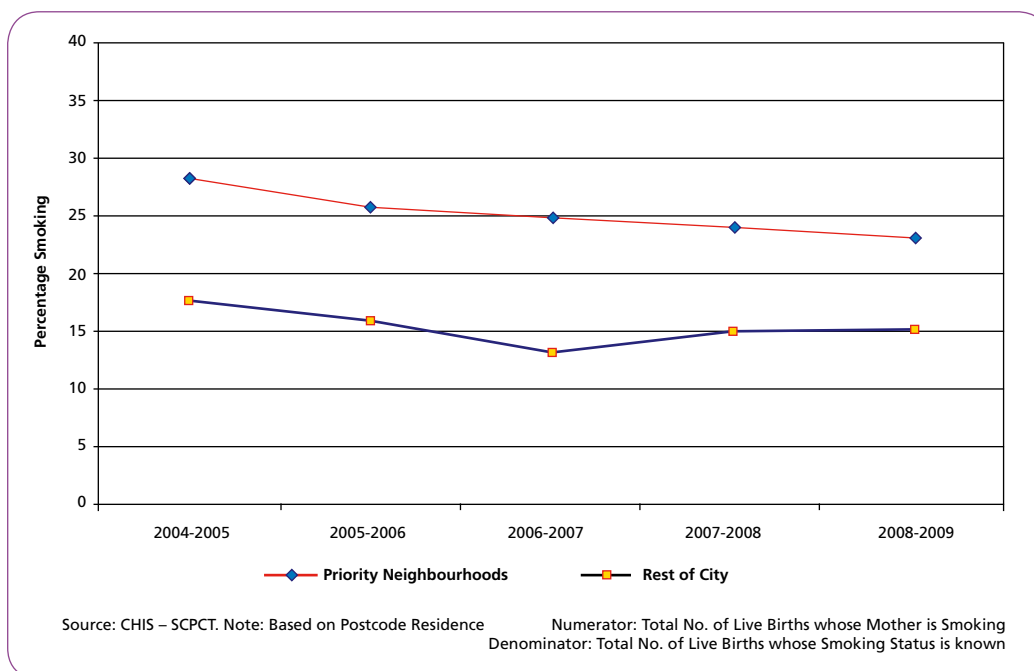


Figure 15: Percentage of mothers smoking at 11-14 days – 2004/05 to 2008/09 Priority neighbourhoods



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Figure 15 shows a time trend of smoking prevalence amongst new mothers recorded at the baby's 11-14 day check with the health visitor. Smoking prevalence has generally declined over the period 2004-05 to 2008-09 in Southampton, although prevalence has been consistently higher in priority areas compared to other areas of the City. Despite this the gap has narrowed slightly, with priority areas having a prevalence 53.8% higher in 2008-09 compared to 59.7% in 2004-05.

Figure 16: Breastfeeding in 2008/09 at initial, 11-14 days and 6 week checks

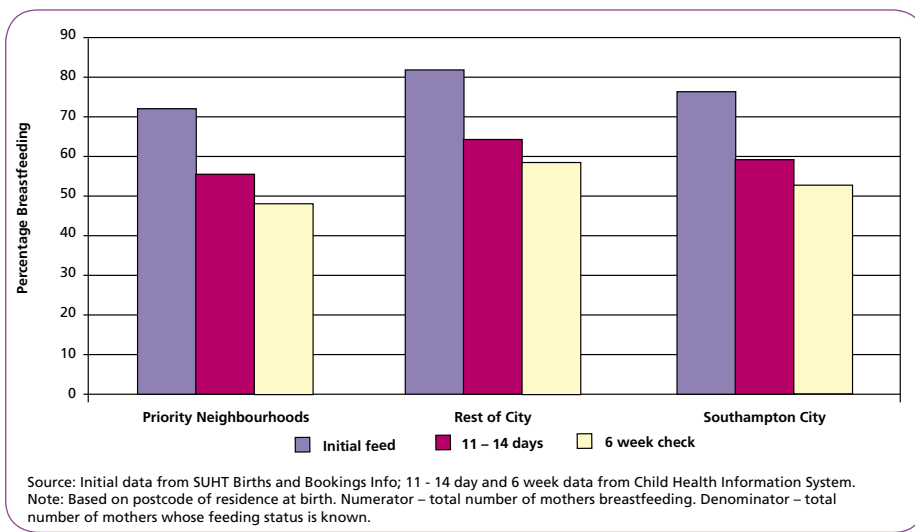
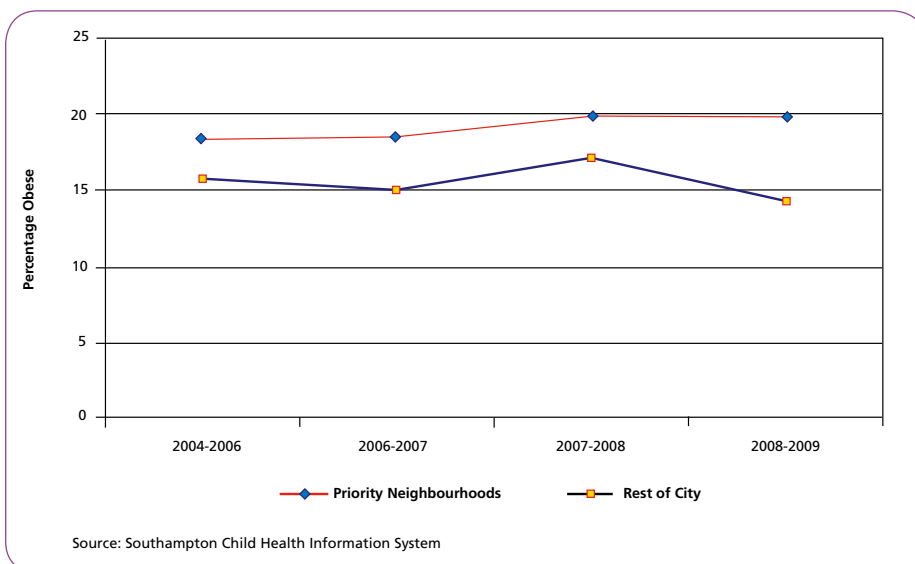


Figure 16 shows breastfeeding rates in 2008-09 recorded straight after birth, at the health visitor 11-14 day check and at the six week check. Only 71.5% of mothers in priority areas breastfed at the first feed after birth compared to 81.7% of mothers from elsewhere in Southampton. The steady reduction in breast feeding at two and six weeks is typical of the rest of the UK and contributes significantly to poor child health and health inequalities.

Figure 17: Proportion of children in year six found to be obese – 2005/06 to 2008/09 Priority v's non-priority areas



In year six, children from priority neighbourhoods have a higher proportion considered to be obese compared to other areas of the City throughout the period studied. A slight overall increase in the proportion of obese children in priority areas between 2005-06 and 2008-09 coupled with a slight reduction for children in the rest of the City has meant that there is a significant difference between the two groups in the latest year (2008-09). This trend has been reported elsewhere, with overweight children becoming more common in deprived populations.

Figure 18: Percentage of births weighing less than 2500g in Southampton: three year rolling averages 1995-97 to 2006-08

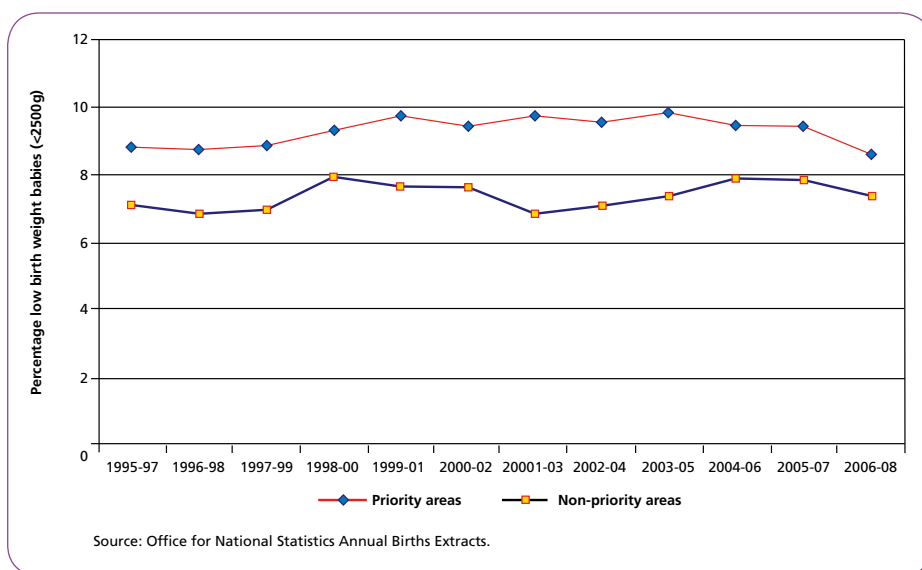


Figure 18 shows the proportion of babies born in Southampton weighing less than 2500g. Over the period 1995-08 low birth weight rates have been consistently higher in the priority areas of the City than elsewhere. In 2006-08 8.6% of babies born to mothers from priority areas were of low weight compared to 7.3% elsewhere. There has been very little change in the proportion of low weight births over the period in either priority and non-priority areas.

Recommendations

- NHS Southampton City and partners review joint strategic and commissioning plans against the best evidence proposed in the Marmot Review to support implementation of best practice across the City
- Southampton's Healthy Living Delivery Group (part of the delivery system of Southampton's Health and Wellbeing Strategic Plan) review current action plans to focus implementation on evidence based interventions to reduce health inequalities
- NHS Southampton City works with partner agencies to pilot the national Health Inequalities Support Team model, focusing on tackling cardiovascular disease as a local priority for reducing inequalities in health
- Ensure that tackling health inequalities continues to underpin the NHS Southampton City Commissioning Framework. Opportunities to maximise health in early years and to target primary and secondary disease prevention in priority neighbourhoods.

CHAPTER 2 EMPLOYMENT AND HEALTH

Introduction

The economic situation in the UK and the wider world has caused a sustained rise in unemployment and consequently an increase in the impact that unemployment has on the health and wellbeing of the population (ref 10). Unemployment is a considerable drain on public resources and has profound negative implications for individuals and households. It is associated with long term poverty and poor mental health. There are also intergenerational effects through child poverty and attitudes towards work which can create successive cycles of social exclusion.

Employment is generally thought to be the most important means of obtaining adequate economic resources, which are essential for material wellbeing and full participation in today's society. In addition work meets psychosocial needs in societies where employment is the norm and is central to individual identity, social roles and social status. Conversely there is a strong association between unemployment and poor health including:

- higher mortality
- poorer general health, long-standing illness, limiting longstanding illness
- poor mental health, psychological distress, minor psychological/psychiatric morbidity
- higher medical consultation, medication consumption and hospital admission rates.



Southampton's economic profile

Southampton is the largest city in the south east outside London and the 16th largest in England as a whole. There are in the region of 120,000 jobs in the city, with the national average of about 2.5% of the population claiming Job Seekers Allowance (JSA). About 75% of the population are classed as economically active. Southampton contributes £4.5 billion to the regional economy. The largest employers in the city are health and education, accounting for some 25% of jobs and in recent years significant growth in the property and retail has replaced engineering, cable production and tobacco/grain processing. The City has two universities but educational attainment in secondary schools is below the county average and 12.3% of Southampton workers has no qualifications. People living in the City fill a high proportion of lower paid jobs, below the national and regional average. The majority of higher paid jobs are filled by people travelling into the city.

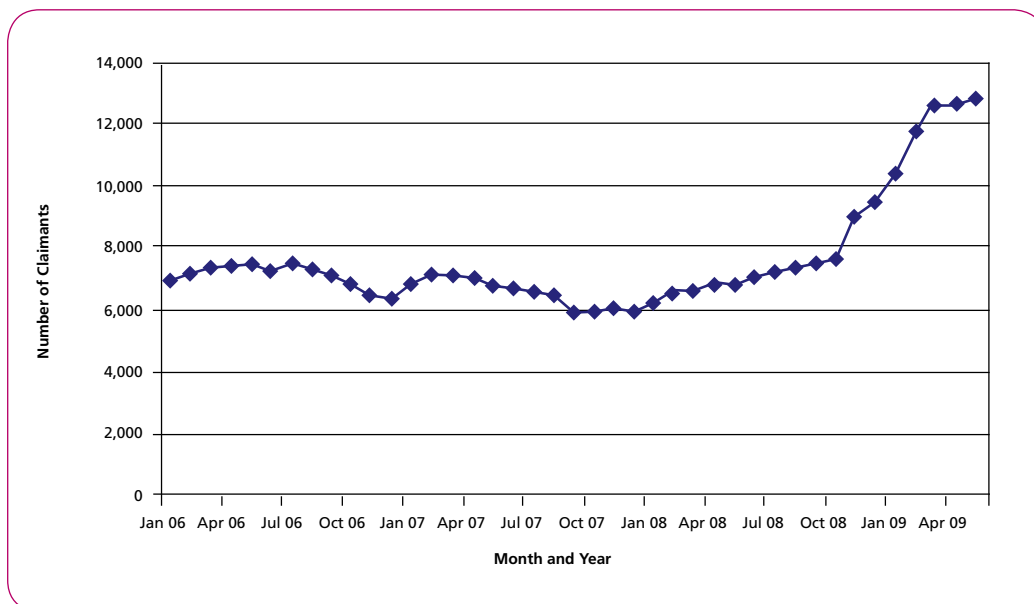
The number of 16-18 year olds 'Not in Education, Employment or Training' (NEET) in Southampton is above national and regional averages. This high number of people NEET has a detrimental impact on the economic wellbeing of the City reducing competitiveness. Being NEET between the ages of 16-18 is a predictor of later unemployment and low income.

Labour market statistics

Southampton statistics

In Southampton the number of people out of work reached over 6,600 during April 2009, at the height of the economic recession with the number of JSA claimants reaching 6,651. There were more than five unemployed people for every job vacancy in the City. Vacancies notified at Jobcentre Plus fell to 1,287 in July 2009 which is 46 less than there were 12 months ago. The economic activity rate in the previous year was 78.4% and the employment rate 74.7%.

Figure 19: Job Seekers Allowance claims



Trends over the last eight years are described in the table below. Average numbers for the year hide some of the swings from one month to another. The largest change in claimant numbers was unequivocally between 2008 and 2009.

Table 2

Average number of claimants in Southampton				
Year ending August	Total out-of-work benefits	Incapacity Benefit	Income Support	Job Seekers Allowance
2002	17,323	9,498	Data unavailable	2,995
2003	17,353	9,645	Data unavailable	3,115
2004	17,048	9,815	9,193	2,853
2005	16,948	9,993	8,988	2,763
2006	17,155	9,688	8,943	3,268
2007	17,098	9,715	9,130	3,063
2008	17,103	9,625	9,075	3,220
2009	19,720	8,628	8,728	5,790

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The recession had the effect of dramatically raising JSA figures whilst incapacity benefit and income support figures declined slightly. In 2008 the total resident population of Southampton was around 235,000. Just over two-thirds were of working age (67%) and consisted of those that are in work or self-employed, those that are unemployed and those that are economically inactive. 75% of the working age population in Southampton are employed or self-employed. Approximately 4% are unemployed but economically active either seeking work; and may therefore be claiming for Job Seekers Allowance (JSA), about to start work or are undertaking work-related training. Around 7% are economically inactive claiming out-of-work benefits (such as Income Support, Incapacity Benefit and ESA). The residual 14% are neither working nor interacting with the state benefits system and may include early-retirees or people looking after their home and children. The distribution of unemployment in the city is asymmetric. Southampton is divided into 16 electoral wards, and sub-divided into 146 Lower Super Output Areas (LSOAs). This enables us to map patterns across the different communities in the city, in this case exploring the areas of high claimant density in Southampton. The table summarises statistics for England, Wales, Southampton and an aggregate of LSOAs where unemployment has the worst impact in the City.

Table 3 Benefit claimant statistics

Location	Number of Incapacity Benefit (IB) and Severe Disablement Allowance (SDA) claimants (% of WAP)	Number of income support claimants (% of WAP)	Number of Disability Living Allowance (DSA) claimants (% of WAP)	Number of JSA claimants (% of WAP)
13 target LSOAs	1,475 (11.4%)	1,965 (15.2%)	1,660 (12.8%)	1,010 (7.8%)
Southampton	8,520 (5.3%)	8,590 (5.3%)	11,190 (7.0%)	6,270 (3.9%)
South East	217,500 (4.2%)	189,950 (3.7%)	298,840 (5.8%)	145,180 (2.8%)
England and Wales	2,097,370 (6.2%)	1,792,090 (5.3%)	2,755,770 (8.2%)	1,320,080 (3.9%)

Estimates of 'worklessness' are now provided by Main Out of Work Benefits (MOWB) data. The groups covered now include those receiving JSA or IB. The IB group includes disability claimants (SDA/DLA) inflating the total claimant count against previous 'worklessness' data. The MOWB groups do not include those on carer allowance only. Source: Annual Population Survey September 2007 ONS.

Table 4 Claimants within Southampton by LSOA

Out-of-work benefit claimants within Southampton by LSOA				
2009 Ranking	Ward	Lower Super Output Area Code	Total benefit claimants per 1,000 working age population	Percentile within E&W (May 2009)
1	Woolston	E01017281	362 (36.2%)	2.1%
2	Bitterne	E01017167	316 (31.6%)	3.0%
3	Millbrook	E01017207	292 (29.2%)	5.9%
4	Bitterne	E01017163	288 (28.8%)	7.3%
5	Bevois	E01017154	283 (28.3%)	6.3%
6	Redbridge	E01017245	272 (27.2%)	9.8%
7	Harefield	E01017202	270 (27.0%)	10.7%
8	Redbridge	E01017240	269 (26.9%)	8.2%
9	Woolston	E01017280	266 (26.6%)	8.4%
10	Redbridge	E01017237	257 (25.7%)	9.5%
11	Bitterne	E01017166	256 (25.6%)	8.4%
12	Bitterne	E01017168	238 (23.8%)	16.1%
13	Shirley	E01017250	237 (23.7%)	11.1%

The LSOA with the highest density of benefit claimants (E01017281 located in Woolston ward) had approximately 362 out-of-work benefit claimants per 1,000 (36.2%). 22 LSOAs in Southampton have a density in excess of 20% (equivalent to 1 in 5 of the working age population). Two exceed 30%. By way of contrast the LSOA with the lowest claimant density was E01017148 (Bassett) in which only 1.6% of the working age population claimed out-of-work benefits.

In May 2009, E01017281 was the 22nd worst performing LSOA for worklessness within the South East region, and was the third worst performing LSOA within Hampshire, ranked behind two areas in Charles Dickens ward, Portsmouth.

Worklessness within the 13 target LSOAs in Southampton is clearly a significant problem. The average proportion of those of working age claiming benefits was almost one third in May 2009, figures that are between two and three times the national and city averages. In each of the 13 LSOAs, the total number of benefit claimants increased between 2008 and 2009, chiefly due to the impact of the recession which resulted in a significant increase in the number of JSA claimants – in some areas the figure doubled. In general, the increase in the 13 target LSOAs was either in line with or smaller than national, regional and local benchmark figures.

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National statistics

Unemployment in the UK reached its highest level since the summer of 1995. The data from the Office for National Statistics (ONS) showed that the number of people claiming JSA increased by 24,900 in July to 1.58 million – its worst level for more than 12 years. This marks the 17th month in a row where the claimant count has increased. The jobless total reached 2,435,000. Youth unemployment rose by 46,000 to 722,000 while the number of people out of work for longer than a year remained at an all year high, up by 36,000 to 543,000. The ONS said the number of people in work fell by 271,000 between April and June to 28.9 million after a fall of 0.9% in the employment rate to 72.7%. This is the same rate seen earlier this year. The number of people classed as economically inactive, including those on long-term sick leave, increased by 127,000 in the latest quarter to 7.95 million.

Definition of unemployment and worklessness

Unemployed claimants includes those claiming JSA. It is based only on those eligible for JSA and therefore excludes large groups of people who may consider themselves to be unemployed and who are looking for work, such as the partners of JSA claimants. This is a limited definition of unemployment.

Worklessness goes further than this. It includes those who are 'economically inactive'. The economically inactive are 'people of working age who are not working, are not in full-time education or training and are not actively seeking work'. Many are outside the labour market voluntarily – because of family responsibilities or early retirement for example. But the evidence suggests that many others want a job and would work if they had the right opportunity, incentive or path back into employment. In thinking about target groups for local initiatives it is very important to consider different groups of 'the workless' as well as the 'unemployed'.

Defining the impact of employment on physical and mental health

In the UK an estimated £77 billion is lost to the economy each year as a result of people with stress-related and mental health problems being unable to work. The South East region has the third highest sickness absence rate in England, which has a major impact on the efficiency, productivity and competitiveness of the region. Stress related conditions and musculoskeletal disorders are now the most common cause of absence from work. The working environment, work culture and management styles all contribute to stress in the workplace and sickness absence.

Around 175 million working days were lost to sickness in 2006, despite life expectancy and numbers in employment being higher in Britain than ever before, and against a background of one of the best workplace health and safety records in the world. Currently around 7% of the working age population are workless and receiving incapacity benefits because of long-term health conditions and disabilities. These figures are of significance not only for the economy but also reflect patterns of poverty and social exclusion which blight entire communities and future prospects of children and young people.

Good health should improve an individual's chances of finding and staying in work and of enjoying the consequent financial and social advantages. There is also compelling evidence that work has a benefit impact on an individual's health.

In the recent review 'Is work good for your health and wellbeing?' (2006) it was concluded that work was generally good for both physical and mental health and wellbeing. It showed that work should be 'good work' which is healthy, safe and offer the individual some influence over how work is done and a sense of self-worth. Overall, the beneficial effects of work were shown to outweigh the risks and to be much greater than the harmful effects of long-term worklessness or prolonged sickness absence.



Impact of ill-health and worklessness on families and children

Families without a member in employment are much more likely to suffer persistent low income and poverty. For example the child of a lone parent who does not work is three times more likely to be living in poverty than the child of a lone parent who works part time and eight times more likely to be in poverty than the child of a lone parent working full time. Low parental income is not only associated with children living in poverty but also with poorer health outcomes. The prevalence of psychiatric disorders among children ages 5-15 years old in families whose parents have never worked is almost double that of children with parents in low-skilled jobs and around five times greater than children with parents in professional occupations.

Southampton has recently been successful in securing a Child Poverty Pilot Bid for work focused services in Children's Centres in Southampton. The aim of the project is to provide families with a clearer route out of poverty through a continuum of training by raising incomes, accessing high quality child care, improving skills, confidence and employability. This is to be achieved by the appointment of Job Centre Plus Advisors to work within Children's Centres and Sure Start work teams.

Employment and mental health

Many people with mental health conditions want to work. In 2004 the Social Exclusion Unit pointed to the Labour Force Survey analysis to show that more adults with long-term mental health problems (35%) were motivated to work than people with other health problems (28%). Despite the health benefits of work and the willingness of many people with mental health conditions to take up employment, welfare to work programmes such as the New Deal for Disabled People and more recently, Pathways to Work have helped more people with physical health conditions into work than those with mental health conditions. It is generally acknowledged by people with mental health conditions that having a job provides psychological benefits of pride, dignity and self-esteem as well as feeling that they are contributing to society (Ref 11).

There are barriers and challenges for those people with mental health conditions wishing to return to work after a period of unemployment. Some people have found counselling to be beneficial in improving their mental health and others have found that having a flexible and understanding approach by employers to be the most satisfactory approach to sustaining their return to work. Concern is frequently expressed by people with mental health conditions about the impact on their welfare benefits during a gradual transition to work. This can sometimes result in withdrawal of benefits during this critical period. Some people with mental health conditions are reluctant to reveal to their existing or potential employer of their mental health condition as they feel that they will be judged or be seen as a 'risky' appointment. They feel it could also jeopardise their chances of promotion.

Time to Change is an ambitious campaign to end the discrimination faced by people who experience mental health problems as well as improve the nation's wellbeing. The campaign, which has been adopted in Southampton, recognises that stigma and discrimination ruin lives. It denies people with mental health problems the opportunity to live their lives to the full. It also denies people relationships, work, education, hope and the chance to live an ordinary life that others take for granted. The campaign included local community projects, a high profile anti-stigma campaign, training and a range of activities.

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Mental health also influences physical health through its influence on health behaviour, which is socially patterned and deeply embedded in people's social, cultural and material circumstances (National Institute of Clinical Excellence (NICE) 2007). Positive mental health is associated with improved sleep, exercise, diet. Improving positive mental health reduces:

- alcohol intake
- smoking
- delinquent activity.

Stress, anxiety and depression combined are the single greatest cause of sickness absence in the United Kingdom. There is strong evidence that re-employment leads to improved self-esteem, improved general and mental health and reduced psychological distress. The magnitude of this improvement is more or less comparable to the adverse effects of job loss. For those people with common mental health problems the benefits of remaining in employment or re-entering work are :

- therapeutic benefits
- helps to promote recovering and rehabilitation
- leads to better health outcomes
- minimizes the harmful physical, mental and social effects of long-term sickness absence
- reduces the risk of long term incapacity
- promotes full participation in society, independence and human rights
- reduces poverty
- improves quality of life and wellbeing.

Southampton provides a range of employment projects which aim to help people with mental health problems to return to meaningful employment.

Addressing common mental health problems

The Steps to Wellbeing programme (also known as Improving Access to Psychological Therapies (IAPT)) programme has the principal aim to help primary care trusts implement NICE guidelines for people suffering from depression and anxiety disorders, commonly linked with people who are not working.

Mental health accounts for a third of all illness in Britain and almost 40% of people in receipt of IB experience mental health problems. The programme is about improving health and wellbeing and promoting social inclusion. Southampton has had a primary care mental health service in place for some time serving all GP Practices to provide assessment, brief intervention and signposting to appropriate services. The service is planned to develop later in 2009 to provide a more comprehensive service. The treatment options include:

- cognitive behaviour therapy
- problem solving
- counselling
- solution focused therapy
- anxiety management
- lifestyle skills.

There are a large number of statutory, private and third sector organisations providing employment, education and training interventions. The Government's intention is to link the work of Pathways to Work and the IAPT programme where possible. Stress, anxiety and depression combined are the single greatest cause of sickness absence in the United Kingdom (Ref 14).

Work-life balance

Work life balance describes how you combine work with the other areas of your life, such as childcare, socialising or exercise.

Work life balance is an issue for all workers, not just parents and deals with when we work and for how long.

The pressure of an increasingly demanding work culture in the UK is perhaps the biggest and most pressing challenge to the mental and physical health of the general population.

It is estimated that nearly three in every ten employees will experience a mental health problem in any one year.

Stress related sick leave costs British industry £370 million every year or approximately 91 million working days.

Anxiety about the current economic climate and future of employment is an increased cause for stress and likely to increase pressure to commit more time to work and thus neglect other aspects of life.

What employees can do

- Recognise the importance of protective factors including exercise, leisure activities and friendships
- Try to ensure that these are not sacrificed in working longer hours, or try to ensure that spare time is spent on these things. The cumulative effect of deciding to work long hours can have a negative impact on physical and mental health
- Ensure that proper breaks are taken during work time and getting out of the workplace if possible
- Ensure there is a clear division between work and leisure. Working at home can be an additional stress and having a designated work area can help
- By reducing work-related stress through exercise, relaxation or hobbies.

What employers can do

The workplace can contribute to improving work-life balance by:

- Promoting the prior messages to individuals in the workplace
- Develop policies that acknowledge the association between work related stress and mental health
- Encourage a culture of openness about time constraints and workloads, by ensuring that employees feel able to speak up if the demands made on them are too great
- Improve training for managers so that they are able to spot stress, poor work-life balance and its effects on the individual
- Encourage activities that promote good mental health e.g. lunchtime exercise or relaxation classes.

NHS Southampton City has begun a programme of Mental Health First Aid – this is a programme to help someone experiencing a mental health problem before professional help is obtained. The aims of Mental Health First Aid are to:

- preserve life where a person may be a danger to themselves or others
- provide help to prevent the mental health problems developing into a more serious state
- promote the recovery of good mental health
- provide comfort to a person experiencing a mental health problem.

Working for a healthier tomorrow – new approaches to health and work

“Working for a healthier tomorrow” was the first major publication from Dame Carole Black, in her new role as the National Director for Health and Work (Ref 16). In this she emphasised the importance of health among the working age population and the consequences of poor health reaching beyond the individual – “touching families, communities, the workplace and society.” Minimising the risk of illness, helping those who become ill to continue or resume work is again recognised as an important public health endeavour.

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Effective action to improve these types of outcome is essential to improve physical and mental health of the individuals that make up the workforce, effectiveness of the UK population workforce and equally critical to financial health of the economy and success of business of all sizes, from small to very large. In the current circumstance, it is also likely to be a key factor in moving the economy out of recession and back into economic growth and prosperity.

Putting a cost on ill health in terms of working days lost and worklessness came to over £100 billion– the annual cost of the NHS. Absence alone accounted for £172 million of lost working days, costing employers £13 billion (source Confederation of British Industry). Particular emphasis has been directed at prevention of long term sickness absence, with the threat of permanent and damaging unemployment, because this is a major factor in widening social inequalities that had impacts across future generations.

The emerging framework from this work focuses on three areas:

- Creating new perspectives on health and work
- Improving work and work places
- Supporting people to work.

This has ramifications for many different agencies, not least clinicians who have been encouraged to take a much more proactive approach to the importance of work in planning treatment and defining the important outcomes for patients that result from choices of different treatment options. Some GPs are engaging with initiatives like practice based employment advisors, and a shift from medical certification for illness to a “fit note” aimed at encouraging people back into employment.

Occupational health services were targeted in the report also, recognising their potential to support primary care as a means of safeguarding the health and wellbeing of the NHS and other employees and gearing up for future challenges. In particular, Dame Carole sees special challenges in improving the understanding of care pathways for working people and novel ways to provide support before, during

and after illness at work. This will involve coordinated efforts between healthcare professionals, employers, unions and individuals that will promote health of working age people. One important step on this journey is the introduction of “Fit for Work Service” pilots that will work as early intervention services backed by case management multidisciplinary support for individuals and enabling better access to work related health support. These should provide valuable insights in to how health professionals, employment services, employers and employees can best work together on health and work (*Ref 17*). To have maximum impact, this approach will call for changes in attitudes and societal behaviour, and structural changes bridging employment and clinical practice.

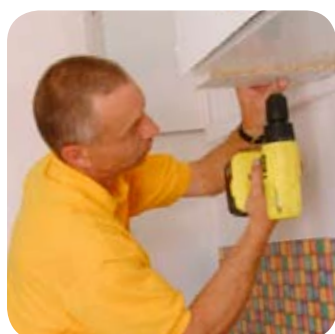
Southampton Health and Wellbeing Strategy

Southampton Health and Wellbeing Strategic Plan will ensure that the health and social care community plays its full part in achieving the 2026 vision for the City as outlined in the City of Southampton Strategy. The main focus of the Health and Wellbeing Partnership is to establish Southampton as ‘a place which promotes health and wellbeing and continuously improves the life of all its people’. The strategy embraces a number of occupational approaches to health improvement, by identifying strategic priorities that include:

- reducing worklessness and promoting health at work
- identifying opportunities for SCC and SCPCT workforce health promotion initiatives
- maximising the health and social care community’s contribution to reducing worklessness
- promoting mental health at work
- tackling stigma and discrimination amongst employers.

Recommendations

- Improve health in the workplace to create a more productive workforce and promote greater population wellbeing by:
 - Providing information and support to people to help prevent moving on to IB
 - Develop and progress a self-reported measure of people's overall health and wellbeing
 - Promote and support training and volunteering opportunities
 - Work to promote skills development in workforce and increase proportion of older people in employment.
- Improve mental wellbeing in the workplace by:
 - Increase access to improving access to Psychological Therapies (IAPT) for those people with common mental health problems
 - Support and develop mental wellbeing initiatives e.g. Mindful Employer
 - Progress Mental Health First Aid training within NHS Southampton City.
- Develop and progress Worklessness and Impact on Health initiative within the NHS Southampton City and Practice Based Commissioning (PBC)
- Primary care and partner organisations need to target and promote healthy lifestyles for people who are unemployed.



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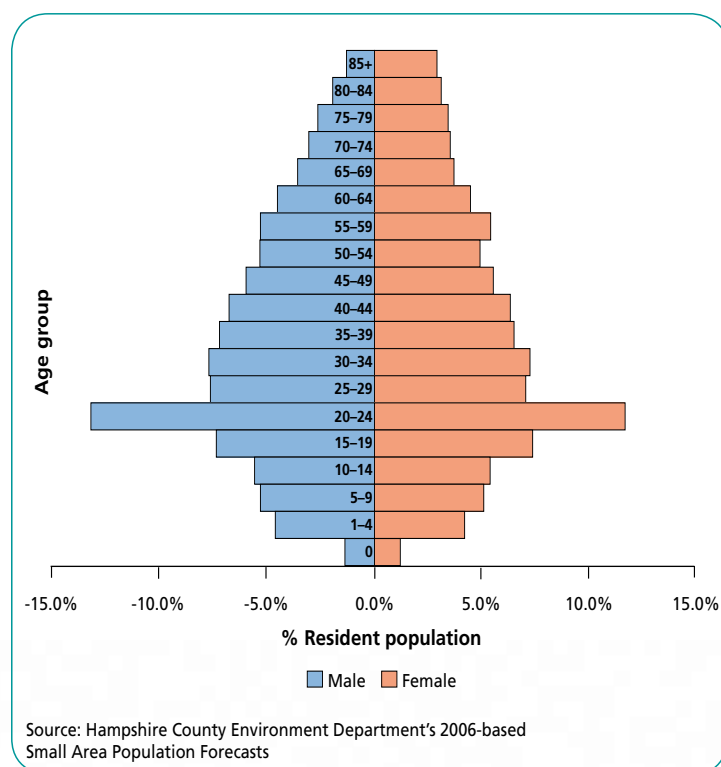
Introduction

The NHS mission statement frames two broad concepts – to add years to life and life to years. This is a special challenge in Southampton, because locally men do not enjoy life expectancy equal to that of the country as a whole, and significantly less than the average in areas surrounding the city. Although the trend is improving, life expectancy has trailed behind the England average for a decade. This chapter of the annual report explores some of the reasons why this could be and identifies ways in which it could be addressed. The solutions to this problem will not be simple, however, and the NHS is unlikely to make a radical difference on its own. The Men's Health Forum explains about the reluctance of men to come forward with early symptoms of serious illnesses or to adopt healthy lifestyles in response to simple health messages.

This report also shows some positive trends with lower than average mortality among males under 35 years and over 75 years and this bodes well for the future. In the meantime, we need to concentrate on improving the lifestyles and reducing the risks taken by men in their teenage and adult years in an effort to improve quality of life and to avoid premature death. This will not only improve men's health, but it could also reduce the rising demand on the health service.

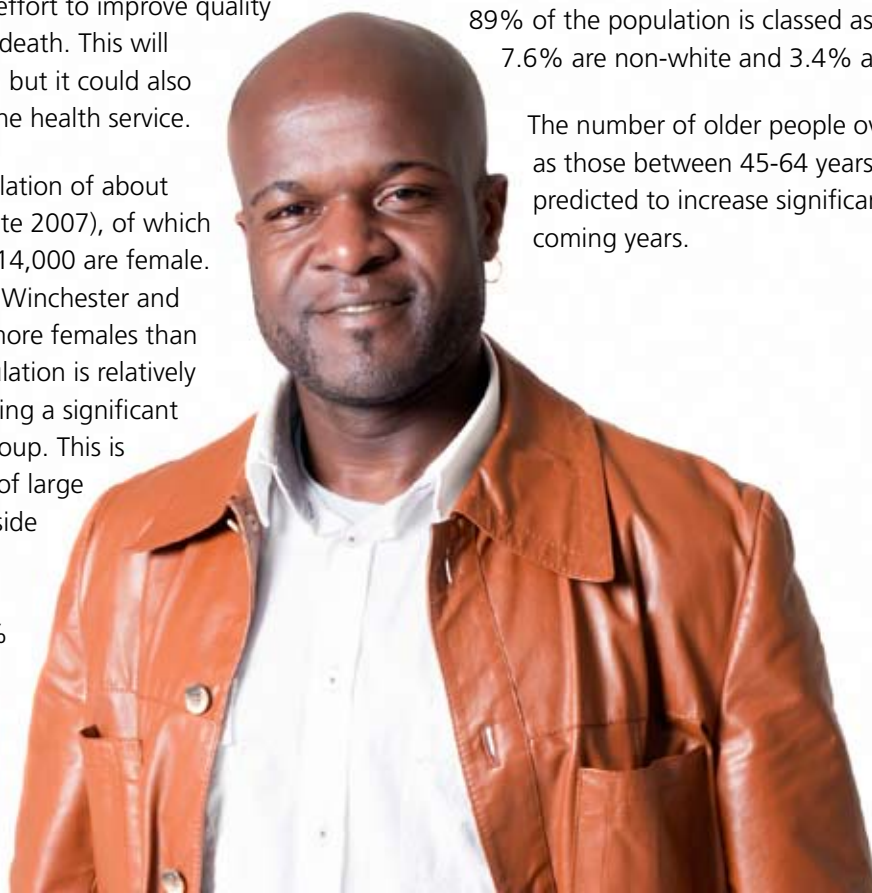
Southampton has a total population of about 231,000 (ONS mid-year estimate 2007), of which about 117,000 are men and 114,000 are female. This is reverse of areas such as Winchester and Portsmouth, where there are more females than males. The Southampton population is relatively young, the age structure showing a significant bulge in the 20-29 year age group. This is largely explained by the influx of large numbers of students from outside the area into the universities in the city. According to the 2001 census, students make up 12% of Southampton's population.

Figure 20: Southampton population pyramid of Southampton Unitary Authority. Resident population estimated in 2006 to be 223,030



89% of the population is classed as white British; 7.6% are non-white and 3.4% as other.

The number of older people over 65, as well as those between 45-64 years of age, is predicted to increase significantly over the coming years.

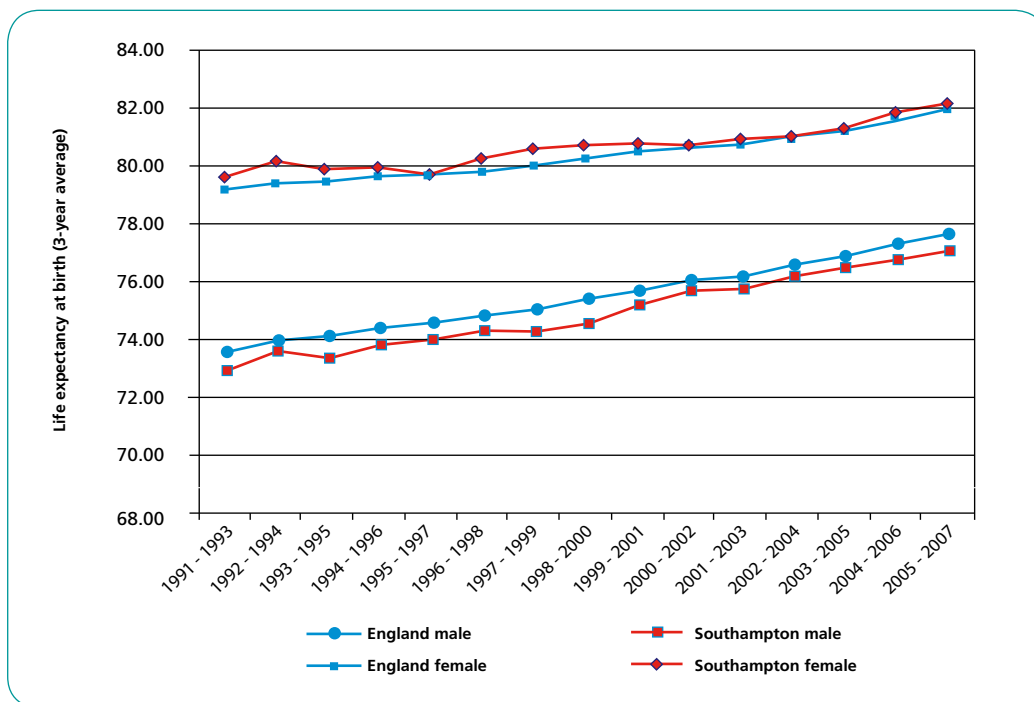


Life expectancy of men

Life expectancy at birth is a useful measure of current health in an area. It is the average number of years babies would be expected to live if the current death rates for that area applied over their entire life. This is not a predictor of how many years a person will live, because death rates may change in the future or the person may move out of the area.

Life expectancy of men has always been poorer than women all over England, although the gap is gradually narrowing over the last decade. While female life expectancy for Southampton is slightly greater than for England, male life expectancy lags behind as seen in the chart below. Life expectancy for both men and women is increasing over the last decade in line with that for England.

Figure 21: Life expectancy trend – England/Southampton

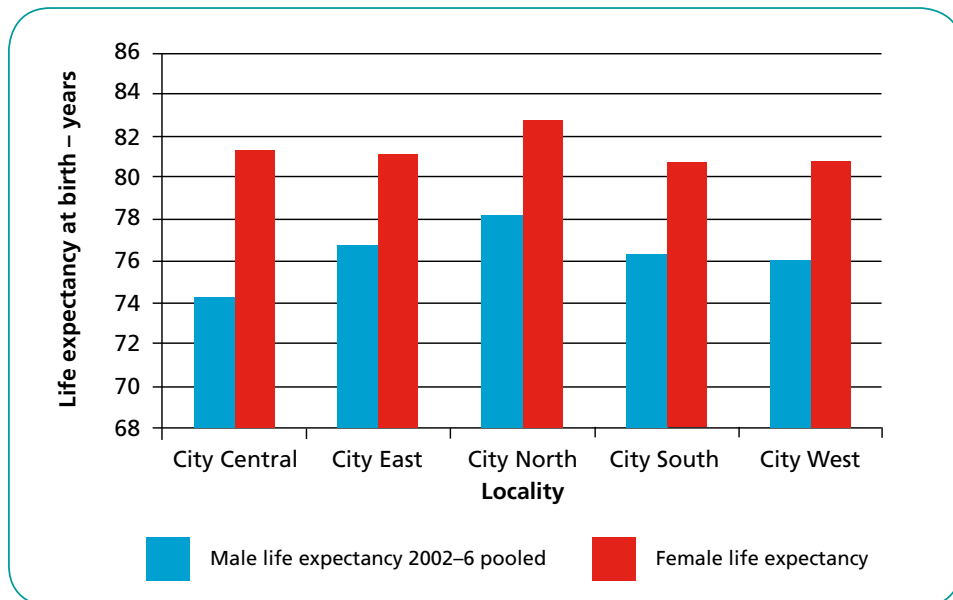


Life expectancy varies by PCT areas in England, ranging from the highest male life expectancy of 83.7 years for Kensington and Chelsea PCT to 73.4 for Manchester PCT - a difference of over 10 years (2005-7 pooled life expectancy- National Centre for Health Outcomes Development (NCHOD). It might be said that male life expectancy can never catch up with female life expectancy because of biological differences. However, it should certainly be a goal to achieve the best possible life expectancy that males have attained elsewhere in the country.

Life expectancy varies greatly by city areas and more so for men (see figure 22). This chart clearly shows the best life expectancy for men in the North area and the worst figure in the central area. When localities are merged, as the south, central and North have been, it is important to remember the differences within them and not be misled by the averaging of figures that may show a very different picture to the reality.

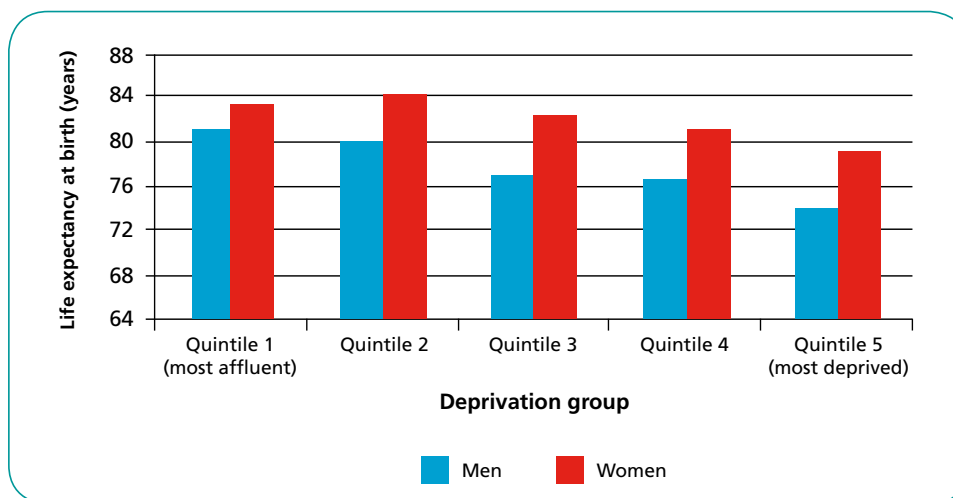
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Figure 22: Life expectancy by city areas: 2002-06 pooled



Life expectancy also varies by deprivation, with those most deprived having poorest life expectancy and those most affluent having the highest life expectancy. Life expectancy of Southampton men in the most deprived fifth of the population is nearly seven years lower than that of men in the most affluent fifth; the difference is four years for women.

Figure 23: Life expectancy 2003-07 (by deprivation)

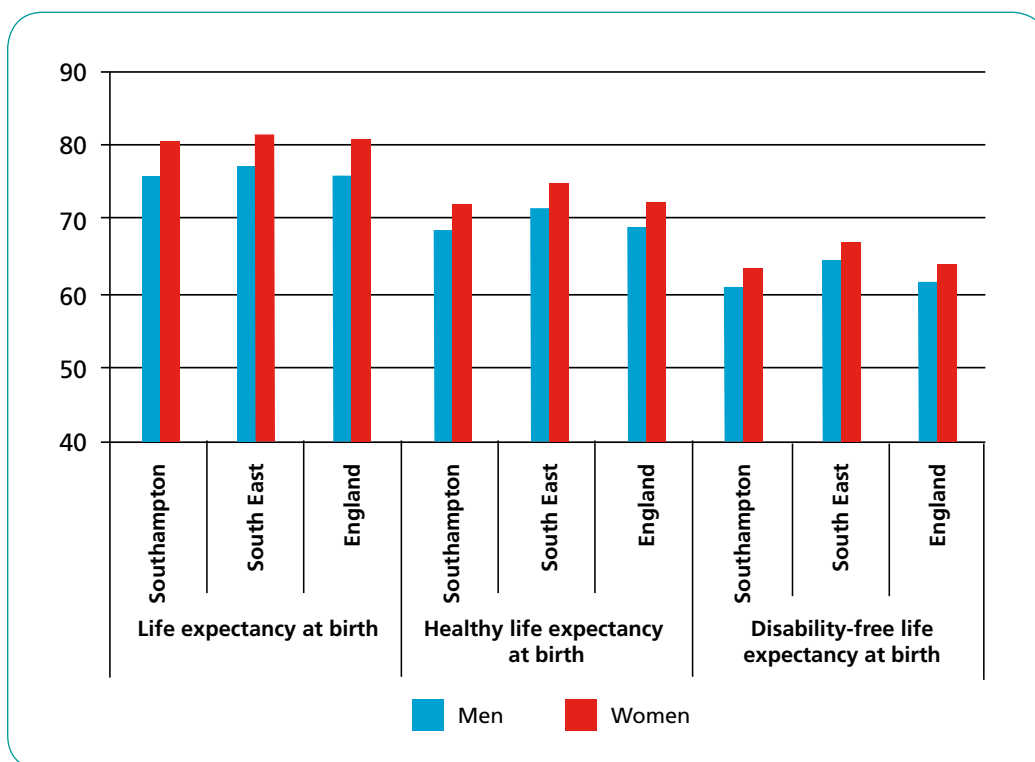


Healthy Life Expectancy and Disability Free Life Expectancy

Healthy Life Expectancy (HLE) and Disability Free Life Expectancy (DFLE) are the number of years of life expected to be lived in good/ fairly good health or free of disability by people born at that time. Both these measures add a quality of life component to life expectancy.

Both HLE and DFLE were calculated by the Office of National Statistics (ONS) from the 2001 census data on life expectancy, good/ fairly good general health rates and 'without limiting long-term illness' rates. The figures below in figure 24 are for 2001. Life expectancy has increased since then, and both HLE and DFLE would have increased too, though not necessarily to the same extent. In 2001, Southampton had a significantly lower HLE and DFLE compared to both the South East region and England as a whole. However, the gap in HLE and DFLE between Southampton and England is greater than the gap in life expectancy, which means proportionately more men in Southampton are living with long term illness or disability.

Figure 24: Healthy life expectancy/Disability-free life expectancy: England, South-east, Southampton



Source- ONS neighbourhood statistics.

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Age-specific mortality among Southampton men is greater in the 35-64 year and 65-74 year age bands compared to England, while mortality rates in younger age groups and in those older than 75 years are less than for England. The lower mortality rates in the younger population may partly be explained by the inflation of the denominator by the influx of a large number of mostly healthy young people into the university, who may not have past exposure to the same lifestyle factors or deprivation as the local population.

Table 5: Age-specific mortality comparison – Southampton, England and ONS comparator group: 2005-7 pooled. Mortality/100,000 population. NCHO

	Age bands (years)					
	1-4	5-14	15-34	35-64	65-74	75+
England	24.2	12.9	70.6	425.9	2308.4	8599.2
Southampton	13.9	8.6	45.7	523.6	2631.5	8229.1
ONS Comparator	18.6	15.0	67.5	512.4	2574.1	8941.8

Table 6: Excess deaths annually in Southampton men, by cause- based on 2005-7 pooled average deaths*

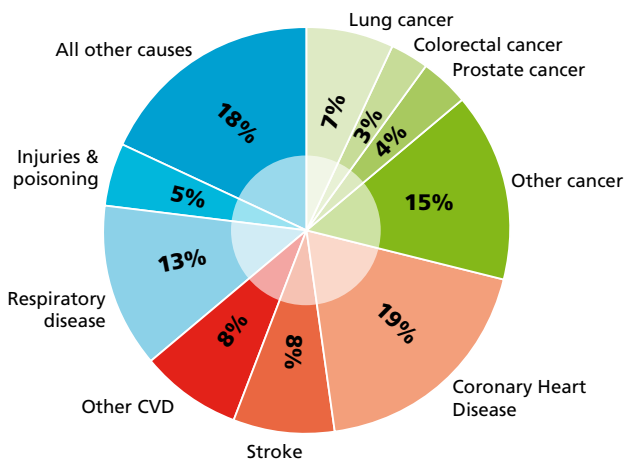
Cause		Excess deaths in men annually in Southampton	
		35-64 age group	65-74 age group
Circulatory diseases	All	11	9
	CHD	11	4
	Stroke	1	1
Cancer	All	10	6
	Lung	4	3
Chronic liver disease		4	1
Suicides		4	0
Accidents		2	0
Bronchitis, emphysema and other COPD		2	6
Infectious and parasitic disease		1	1
All causes (rounded to whole number)		39 (total deaths= 207)	23 (total deaths=184)

The table above shows the number of excess deaths each year among Southampton men, and the major contributory causes (based on 2005-7 average). This shows that circulatory diseases and cancer account for most of the excess deaths, followed by chronic liver disease. Chronic liver disease is on the rise, mainly due to alcohol abuse, Hepatitis C and rising obesity. Suicides account for a significant number of excess deaths in the 35- 64 age group. Although numbers of suicides are small, they have a disproportionately greater impact on life expectancy and years of life lost, because most of these are in younger men, as is the case with drug-related deaths.

Main contributors to mortality

It is important to understand the major contributors to mortality, as influencing these will have the greatest impact on life expectancy. The major contributors to male mortality in Southampton are similar to those for England as a whole; circulatory disease (including CHD, stroke and others) and cancer account for 35% and 29% of male mortality respectively, and together cause almost two thirds of male deaths. In addition, circulatory disease and cancer cause around 55% of the excess mortality in the 35- 64 year population.

Figure 25: Causes of death, men all ages



Lung cancer causes 8% of all deaths and a quarter of cancer deaths in men. Prostate and bowel cancer are the next biggest cancer killers, together accounting for almost 7% of all deaths and nearly 24% of cancer deaths in Southampton men.



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Cardiovascular Disease

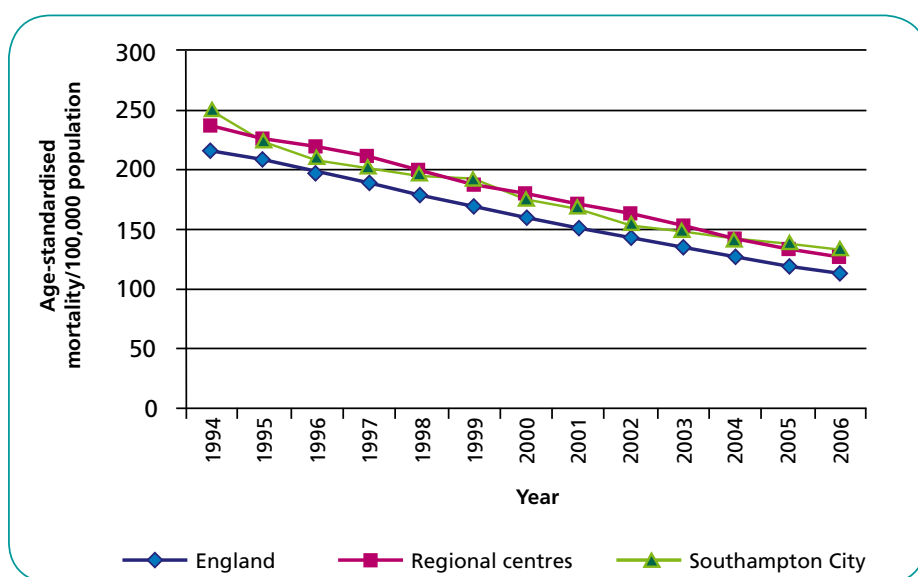
Men are at greater risk of Cardiovascular Disease (CVD) than women and CVD in men occurs about 10-15 years earlier than in women. Prevalence estimates for chronic diseases can be obtained from the chronic disease registers in general practice; this is the best source of data we have, but there are inaccuracies in terms of completeness and time delay in completion.

Prevalence = $\frac{\text{Number of persons on disease register} \times 100}{\text{Number of persons over 65 years on practice list}}$

Number of persons over 65 years on practice list

Coronary Heart Disease (CHD) estimated prevalence for Southampton was 22.8%, while stroke prevalence was 11% (of the over-65 population). This translates to over 7,500 people on CHD registers and over 3,600 people on stroke registers in 2006-7. Over half of these are men. There are over 1,600 hospital admissions for all circulatory diseases annually among Southampton men, of which 180 are for stroke and over 600 for coronary heart disease.

Figure 26: Early deaths from all circulatory diseases in men (Age under 75)



The ONS provides an area classification known as 'regional centres'. This groups PCT areas which are similar in demographic and socio-economic characteristics. They have been grouped to make comparisons between PCTs

and benchmarking more meaningful. NHS Southampton City is classified as a "Regional centre", the others being Liverpool, Leeds, Salford, Sheffield, Newcastle, Brighton, Bristol, Plymouth, Bournemouth and Portsmouth.

CVD is responsible for a large proportion of deaths under the age of 75 among men. Although early deaths from CVD have been reducing in Southampton over the last decade, there remains a small gap between Southampton and England which has not narrowed over time (see figure 26).

There are several known risk factors for cardiovascular disease. These include lifestyle factors such as smoking, alcohol consumption, diet and physical activity; other important factors are high blood pressure, diabetes and raised cholesterol level. The risk of CVD can be reduced by influencing these modifiable risk factors. Thus, good control of diabetes, blood pressure and cholesterol with the help of appropriate diet, medication and regular monitoring can reduce risk. Also, giving up smoking, drinking within limits and maintaining a healthy weight can also reduce risk of several diseases.





Unfortunately, the prevalence of many of these risk factors is higher in men. Men are more likely to smoke and more likely to drink heavily than women. Prevalence of doctor-diagnosed diabetes was greater in men than women (5.6% and 4.2% respectively in men and women over 16 years) in the Health Survey for England (HSE) 2006; more men are overweight; fewer men eat five portions of fruit or vegetables a day.

While on the one hand, the prevalence of risk factors is greater in men, on the other hand men are less likely to access primary care than women, less likely to access health trainers and weight management programmes. They are more likely to have undiagnosed high blood pressure and are less likely to be on treatment for it than women. In the HSE 2006, over half of men and two-thirds of women with survey-defined hypertension (55% and 66% respectively) reported doctor-diagnosed hypertension. 42% of men and 54% of women who had survey-defined hypertension were on treatment to reduce their blood pressure.

The male/female difference in mortality is not completely explained by biological differences and factors such as lifestyle and help-seeking behaviour can and should be addressed in order to reduce the difference.

Abdominal Aortic Aneurysm screening

An Abdominal Aortic Aneurysm (AAA) is an abnormal bulging of the largest artery in the body. If this enlarges significantly, it has the potential to rupture, which is associated with very high mortality. This condition is far commoner and occurs earlier in older men than women and is one of the preventable causes of death.

NHS Southampton City is working with other PCTs and the vascular units in Hampshire to implement a new AAA screening programme. This will involve an ultrasound scan of the abdomen offered to men at 65 years of age, with 3 main outcomes:

- Normal scan - no further action
- Large aneurysm (>5.5 cm) - either surgical repair or stenting options
- Small aneurysm- repeat scans at periodic intervals; further action depends on increase in size.

Research has demonstrated that offering men screening in their 65th year could reduce the rate of premature death from ruptured AAA by up to 50%. This will positively impact on male mortality in the over-65 age group and contribute to narrowing the life expectancy gap between men and women.

NHS Southampton City and partners should:

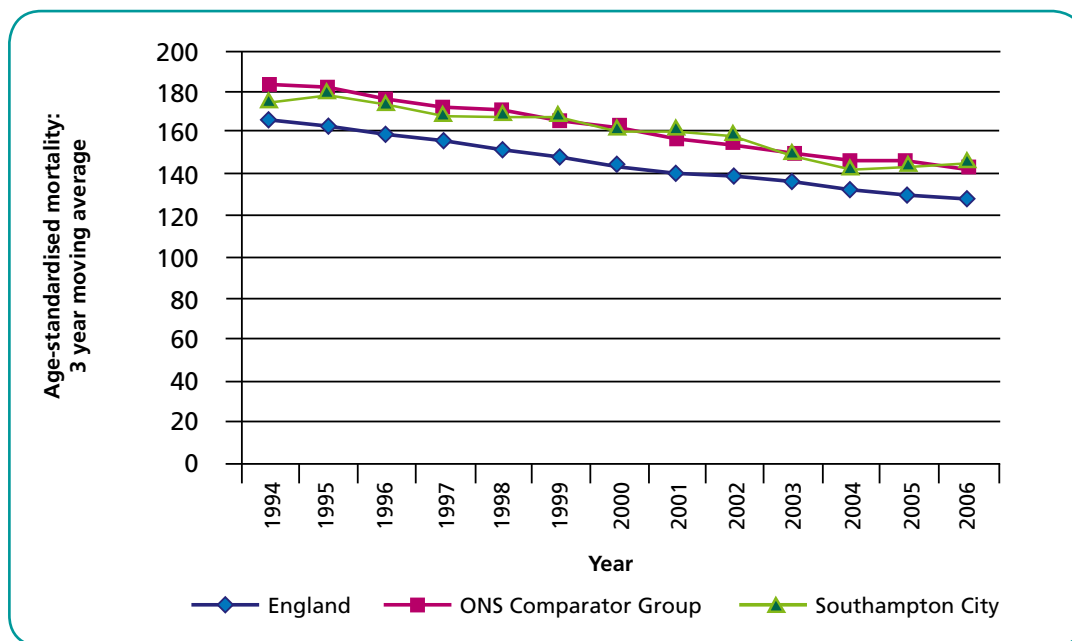
- Actively seek feedback from men to gain better understanding of their needs and barriers
- Design men-friendly health promotion services for targeting lifestyle factors such as smoking and physical activity. This should include attention to location and timing of services and framing of messages
- Remove barriers for men to access primary care, and make it easy for men to present for monitoring of cardiovascular disease risk factors
- Ensure primary care Quality Outcome Framework data is available by gender, so that gender equity can be monitored
- Actively promote men to uptake AAA screening once the programme is rolled out

CHAPTER 3 MEN'S HEALTH IN SOUTHAMPTON

Cancer

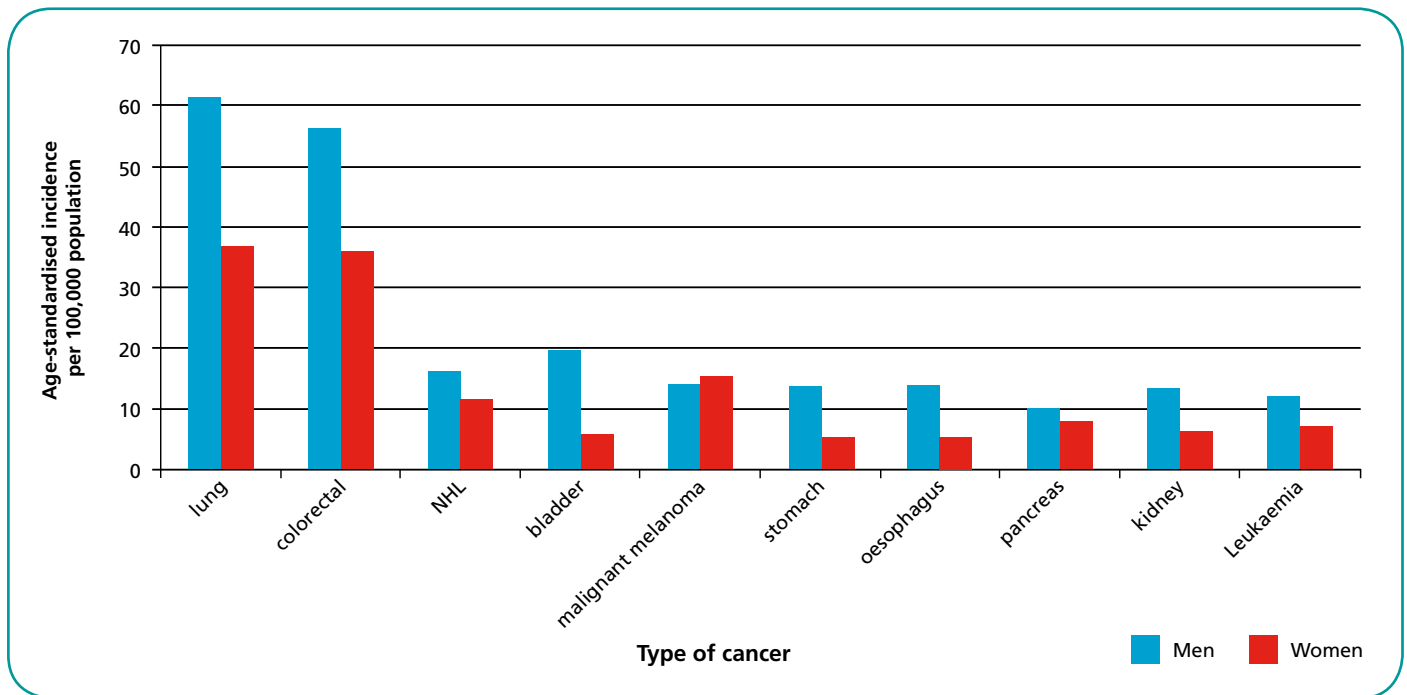
Cancer is the second most common cause of death in our population and many people live having survived cancer. There were nearly 2000 people on the GP cancer registers in 2006-07. Unfortunately, we do not have prevalence by gender. There are almost 120 new prostate cancers, 90 new lung cancers and 60 new bowel cancers diagnosed among men in Southampton each year. Although early deaths due to cancer in men (deaths under 75 years) have been reducing from 1994 to 2007, Southampton has a greater number compared to England. It is too early to say whether the trend is worsening at this stage, however, when compared to the ONS comparator group of similar cities, Southampton is at an equivalent level. The overall reduction in cancer deaths is due to many factors, including healthier lifestyles, long term reductions in tobacco use and better diagnosis and more effective treatment.

Figure 27: Early deaths from cancer in men



Men are over 60% more likely to develop cancer and 70% more likely to die from it compared to women (excluding breast and sex-specific cancers), according to a recent report from the National Cancer Intelligence Network (NCIN) and Cancer Research UK (*Ref 18*). After excluding breast and sex-specific cancers, the incidence of almost all cancers is significantly greater in men (figure 27). Similarly, the mortality from almost all cancers (excluding breast and sex-specific cancers) is also greater in men. The reasons for greater incidence of cancer in men are not clear; unhealthy lifestyle factors such as smoking, alcohol consumption and poor diet are likely to play a significant role and there may be others including genetic pre-disposition and occupational causes. On top of the greater incidence, men present late with symptoms due to reluctance to access healthcare and therefore have poorer outcomes. An example is malignant melanoma, where more women get the cancer but more men die from it.

Figure 28: Age-standardised cancer incidence: top 10 cancers (excluding breast and sex-specific cancers)



The bowel cancer screening programme was introduced a year ago in Southampton, offering screening to men and women between the ages of 60-69 years. From 2010, it will be extended to people up to age 75. Figures for the past year (April 2008-April 2009) show that Southampton men's uptake of colorectal cancer screening is lower than women's (45.7% compared to 53.3%).

It is essential to reduce the risk factors that we know are associated with cancer, these include avoiding smoking and asbestos, reducing obesity and encouraging good diet and exercise. Healthy lifestyles can effectively reduce cancer incidence.

NHS Southampton City and partners should:

- Target further reduction in smoking among men in Southampton
- Further reduce occupational exposure to asbestos
- Promote bowel cancer screening and specifically target men to increase uptake
- Increase boys' and men's awareness of cancer symptoms
- Be innovative in their approach to providing primary care services for men, so as to remove barriers and to encourage men to seek help early for cancer symptoms.

CHAPTER 3 MEN'S HEALTH IN SOUTHAMPTON

Mental health

Mental health is not just the absence of mental disorder. It is defined as a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to her or his community (World Health Organization).

Mental illness is a spectrum, from mild and transient mental health problems which may be largely undiagnosed, to severe and enduring illness that significantly affects quality of life. It is known that men are reluctant to talk about mental health problems or seek help early. This may be one of the reasons why many more women are diagnosed with depression, yet more men commit suicide each year. This also means that men's mental illness tends to become more severe before it is diagnosed, and that there may be many more with milder illness who are undiagnosed and struggling to cope.

Within Southampton, it has been found that the city central locality has the greatest prevalence of mental illness and hospitalisations for schizophrenia and alcohol-related mental disorders. Mental illness is more common among BME (black and minority ethnic) communities, along with greater stigma attached to mental health issues. Psychotic illnesses such as schizophrenia are much more common among men compared to women. Drug and alcohol-related mental health disorders are also much more common among men, particularly in the 35-54 year age group.

Patients with schizophrenia tend to exhibit 'social drift', where they drift down the social scale, being unable to maintain employment or study. It is common for such patients to gradually move into inner city areas, which offer most of the low rent or social housing as well as bedsits or hostels. This may in part explain the high level of schizophrenia identified in the city central area.

Figure 29: Hospital episodes for Schizophrenia: 2003/04 – 2007/08 pooled

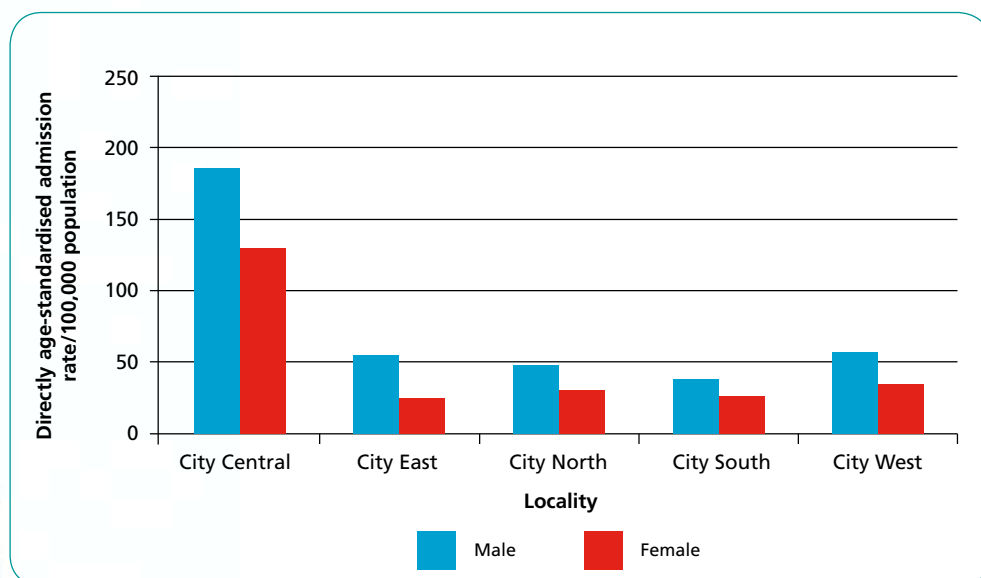
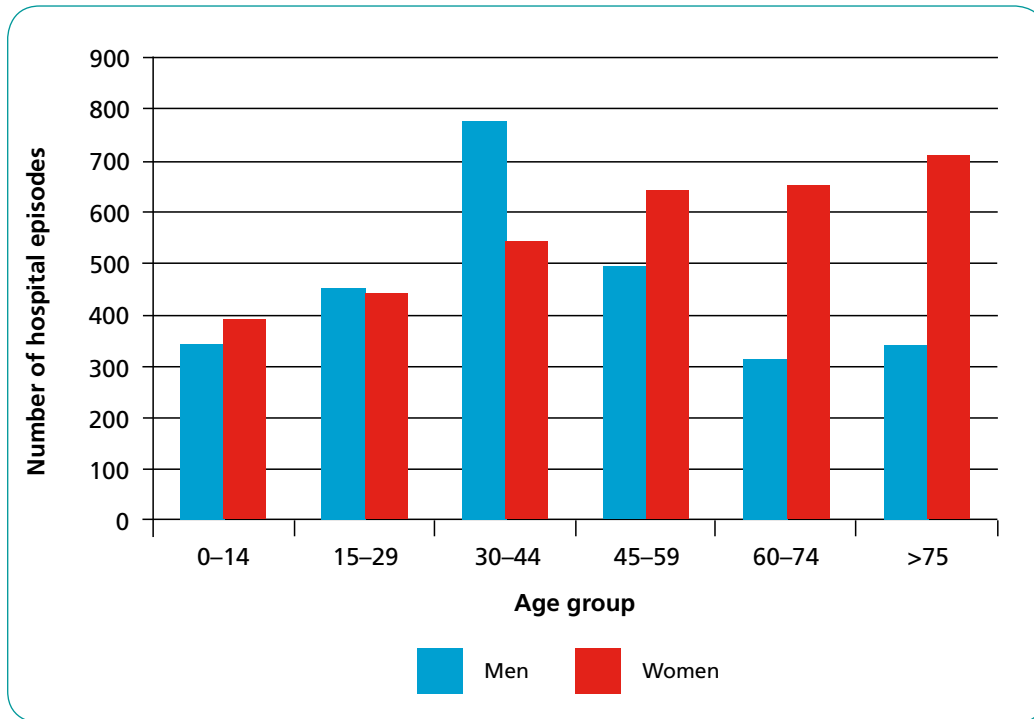


Figure 30: Hospital episodes for all mental health diagnoses: 2003/04 – 2007/08 pooled



NHS Southampton City has a large mental health programme budget, providing for a very large number of people affected by milder but chronic mental illness and a much smaller number with serious mental illness requiring high-cost, intensive specialist or forensic mental health input.

NHS Southampton City and partners should:

- Raise awareness of men's mental health issues both among men as well as NHS staff in order to improve early diagnosis and management
- Engage with BME men to understand their specific needs and barriers with regard to mental health issues
- Tailor mental health services so that men are encouraged to access them without attached stigma.

CHAPTER 3 MEN'S HEALTH IN SOUTHAMPTON

Lifestyle factors

Boys and men are "socialised to be tough and strong, to appear in control and to take risks" (Men's Health Forum). Many men neglect their health, and are reluctant to seek medical help for suspected health problems because this may be seen as weakness. Lifestyle factors such as smoking, alcohol consumption, obesity, insufficient physical activity, a diet low in fruit and vegetables and high in fat and salt are all risk factors for CVD and also many cancers. It is a challenge to address lifestyle issues in men because of their attitude to risk-taking.

Smoking

Overall smoking prevalence in England has reduced over the years, from 39% in 1980 to 22% in 2006 (General Household Survey). Although prevalence remains higher in men than women (23% and 21% respectively), the gap is narrowing. Prevalence is much higher among men in routine and manual groups (29%). Smoking prevalence varies by ethnicity and ranges from 20% among Indian men to 40% among Bangladeshi men. Prevalence is also higher in deprived areas.

Table 7

Year	Number accessing			Number quitting (Quit rate %)		
	Men	Women	Total	Men	Women	Total
2007-8	1587	2038	3625	850 (53.5%)	1112 (54.5%)	1962 (54.1%)

In England in 2007 among adults aged 35 and over:

- 18% of all deaths of adults aged 35 and over were estimated to be caused by smoking with a larger proportion of men (23%) estimated to die from smoking-related diseases than women (14%). 29% of cancer deaths, 35% of deaths from respiratory diseases, 14% of deaths from circulatory diseases and 6% of deaths from diseases of the digestive system were attributable to smoking.
- For 2008-09, nearly 70% of the Southampton GP registered population had smoking history recorded, of which the overall smoking prevalence was 20.4%. Four percent more men are current smokers, compared to women (men- 22.5%, women- 18.7%). The smoking rate varies from 16.7% of men in the North locality, to 27.8% in city central.
- In the Southampton Health Survey 2006, 30% of the surveyed population said they were current smokers and an additional 9% smoked occasionally. In addition, 47% were ex-smokers. However, the response rate for the survey was only 38%. Synthetic estimates for smoking prevalence for Southampton (2003-2005), modelled on the social and demographic characteristics of the city suggested a prevalence of 27.3%, significantly below the survey findings. The different estimates illustrate smoking prevalence is difficult to measure precisely, but we do know it is a major threat to the health of men in the city.
- The Southampton Quitters service has been running some innovative interventions to encourage men to quit. Their sessions at the City common depot in the town centre targeting men have been very well received.

Southampton Quitters data

Southampton Quitters offer information and support to anyone who wants help to quit smoking for good. For more information call: **023 8051 5221** or visit www.southamptonquitters.nhs.uk.

Southampton Quitters data shows a better quit rate compared to nationally (about 52 % overall quit rate in 2007-8 for England). However, while the England data shows higher quit rates among men compared to women, in Southampton the trend is in the opposite direction by a small margin.

Table 8

Year	Number accessing			Number quitting (quit rate %)		
	Men	Women	Total	Men	Women	Total
2007-8	1587	2038	3625	850 (53.5%)	1112 (54.5%)	1962 (54.1%)
2008-9	1553	2014	3567	826 (53.2%)	1092 (54.2%)	1918 (53.8%)



CHAPTER 3 MEN'S HEALTH IN SOUTHAMPTON

Alcohol

Harm from use of alcohol can be described in two categories:

- Short-term harm due to intoxication (binge-drinking). This may lead to alcohol poisoning and increased risk-taking behaviour, resulting in injuries, road accidents, unprotected sex and assault
- Long-term harm due to alcohol dependence is associated with numerous medical problems, including liver cirrhosis, pancreatitis, type II diabetes, gout, overweight, gastrointestinal cancers, liver cancer, breast cancer, high blood pressure, stroke, heart rhythm irregularities, cardiomyopathy, increased risk of respiratory distress syndrome, impaired immune system, anxiety and sleep disorders, depression and cognitive impairment.

Government recommendations are that adult men should not regularly drink more than 3–4 units of alcohol a day and adult women should not regularly drink more than 2–3 units a day. In 2007, 33% of men and 16% of women (24% of adults) were classified as hazardous drinkers. Hazardous drinkers are defined as those exceeding weekly safe levels (21 units in men and 14 in women) or those binge drinking (exceeding 8 units for men and 6 for women in a single day). This includes 6% of men and 2% of women estimated to be harmful drinkers, the most serious form of hazardous drinking, which means that damage to health is likely. Among adults aged 16 to 74, 9% of men and 4% of women showed some signs of alcohol dependence. In England in 2007/8, 62% of alcohol related admissions were men. (Statistics on alcohol: England, 2009; NHS Information Centre for health and social care)

Figure 31: Hospital admissions for mental and behavioural disorders due to use of alcohol – 2003/04 - 2007/08

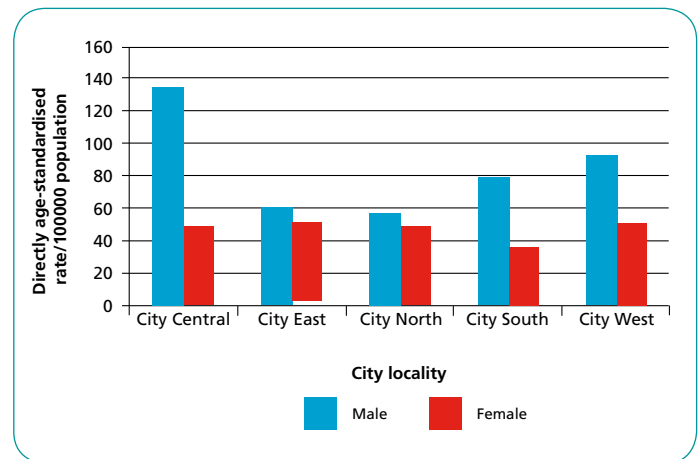
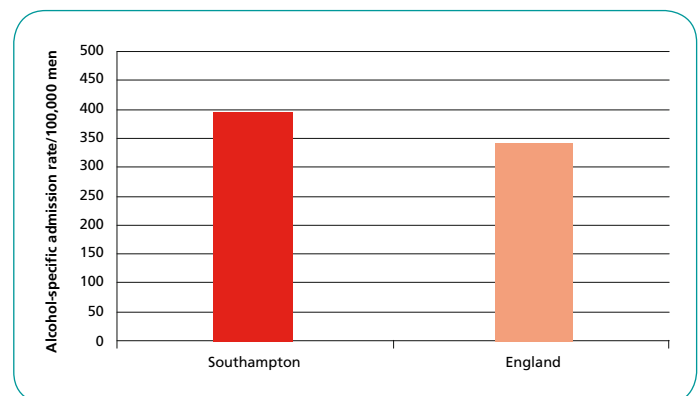


Figure 32: Alcohol-specific admission rate per 100,000 men – 2005/06



Model-based synthetic estimate for prevalence of binge drinking (adults, both sexes) in Southampton (2003-2005) is 21.9%. The percentage of binge drinking as well as harmful drinking is higher in the UK compared to the rest of Europe. There is also a worrying trend of teenagers and younger children drinking more and more, leading to earlier onset of alcohol-related liver disease. Figure 32 shows a varying pattern of alcohol-related mental disorder across Southampton, with highest levels in city centre, reflecting a worrying rising trend in alcohol-related hospital admissions nationally. Southampton has significantly greater numbers of alcohol-specific hospital admissions compared to England. This has serious implications for NHS commissioners, in terms of the costs of treating alcohol-related chronic diseases.

Drug misuse

Drug misuse is another problem with a differential impact on men and women. Over 70% of IV drug users are men. About 30-40% IV drug users are infected with Hepatitis C and 1 in 90 with HIV. An analysis of drug related deaths in the City in 2007 showed a trend toward rising deaths from substance misuse, giving rise to more premature deaths than other public health concerns such as suicide, accidents and liver cirrhosis. Again the impact on men overshadowed that for women.

Figure 33: Hospital episodes for mental and behavioural disorders due to drug use 2001/02 – 2006/08: All ages

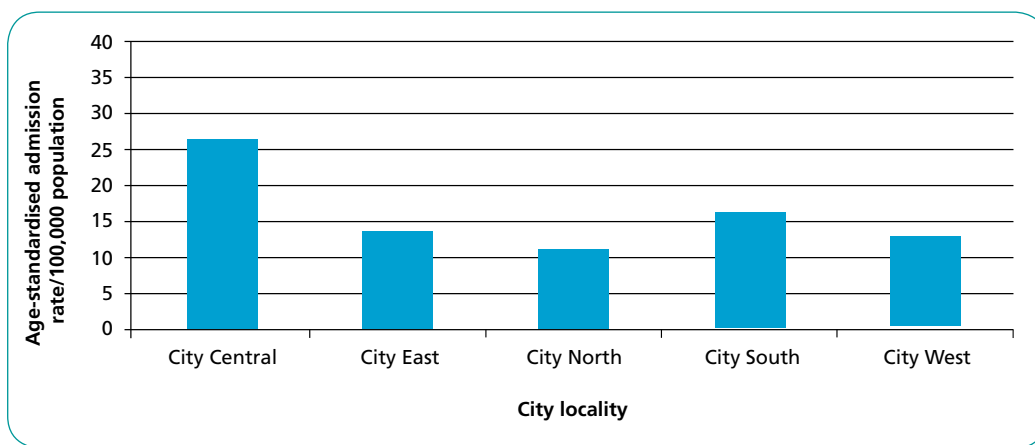
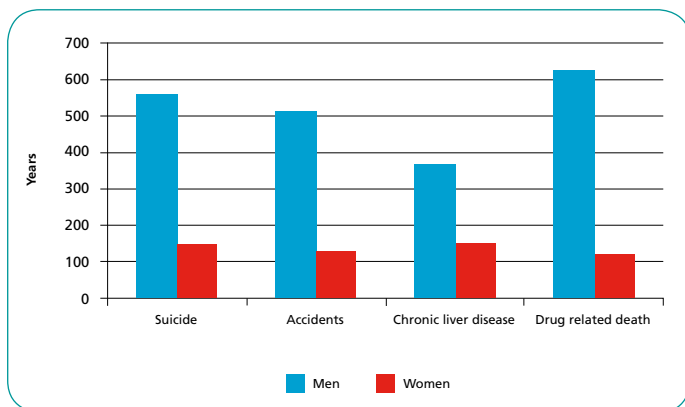


Figure 34: Potential years of life lost due to varied causes



Since the peak drug deaths in 2007 we have seen a 20% fall in the annual total, but drug abuse remains a serious problem in the city and there are signs nationally that the number of deaths related to cocaine abuse is rising, alongside the existing problems related to opiate addiction. The last count of drug deaths under review by the coroner suggest the trend may be levelling off at 14-15 deaths per year.

Cocaine drug related deaths present as sudden death due to heart attack, hemorrhagic stroke (cerebral bleed), or lung haemorrhage. Recent research in Spain confirmed the link between sudden death and cocaine by use of a standard protocol for investigating and toxicology testing in all cases. They found that 3% of total premature mortality from all causes was linked to cocaine abuse. This research is particularly relevant to the UK and Italy, where similar high levels of cocaine use exist in the different populations. Left unchecked, in the UK this will pose an increasing risk in the future. Analysis of toxicology reports in Southampton has confirmed a similar picture in the City, with cocaine a contributing factor among the drug deaths locally (source Southampton Drug Action Team and Drug Deaths Audits).

CHAPTER 3 MEN'S HEALTH IN SOUTHAMPTON

Figure 34 shows significant and consistent male – female differences in potential years of life lost. The largest difference occurred in relation to drug-related deaths. The difference was less in relation to chronic liver disease, but the trend still is worse for men. These health statistics are stark and point to the main causes of poor men's health in the City and why we have a high mortality among men in late middle age and early retirement. We need this understanding to frame new approaches to tackling these problems in a way that engages men and gets them involved in making healthier choices about their lifestyles and developing more positive attitudes and behaviours in relation to health and health services.

NHS Southampton City and key partners should:

- Make effective use of the workplace in order to target health improvement in men
- Work with schools to improve boys' awareness of health and health services
- Be innovative and seize opportunities, such as major sport events, to develop new settings for improving men's health
- Work with schools to increase boys' awareness of risks from smoking, alcohol and drugs, with the aim of reducing uptake, and improving skills that are necessary to ensure their safe and limited use
- Ensure early detection and management of alcohol-dependence and reduce harm
- Work together in partnership to reduce levels of harmful drinking in the city and prevent underage sales
- Target improvement in outcomes for drug services, such as testing of IV drug users for blood-borne viruses, greater use of needle exchange schemes and numbers successfully coming off drugs.



Obesity

Obesity is one of the major challenges to health today. Obesity is measured in terms of the Body Mass Index (BMI).

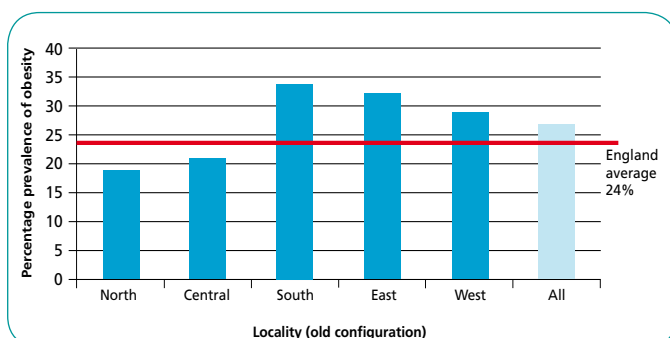
$$\text{BMI} = \frac{\text{Weight in Kg}}{(\text{Height in metre})^2}$$

In order to facilitate measurement and comparison, obesity has been defined as a BMI of greater than 30. However, overweight/ obesity in reality are a continuous spectrum, like blood pressure. The health risks associated with obesity would be expected to increase continually across the weight range and not limited to just those with the most severe obesity. Thus addressing the obesity problem requires a population-wide and not just a high-risk approach. It is estimated that 24% of adults in England are obese, with equal rates among men and women. However, men are more likely than women (41% compared to 32%) to be overweight (BMI 25-30).

As seen in the chart below (primary care data 2008-9), the prevalence of obesity in Southampton men overall is 26.8% (national average 24%). The rate of obesity varies greatly between localities, with the south (highest 33.6%), east and West localities showing significantly greater rates than the North (lowest 18.5%) and central localities.

BMI was recorded in only 31.5% of the registered population. The above obesity figures may be an over or underestimate depending on whether this sample was truly representative of the population. Almost one-fifth of year six boys in Southampton were found to be obese in 2006-07, slightly more than England figures. There has been a continuous rising trend in childhood as well as adult obesity for over a decade, signalling the risks of future negative impacts on population health, especially CVD and cancer.

Figure 35: Obesity prevalence in Southampton men



Tackling this huge problem requires multi-pronged action at all levels, targeting not just individuals but the “obesogenic” environment as well. NHS Southampton City has a new Fit 4 Life Strategy that outlines a five year plan for tackling diet, physical activity and obesity. This will involve partnership working across all major organisations. The NHS in Southampton provides the following services:

- Specialist intervention- bariatric surgery for those most at risk from their obesity. This involves surgical operations such as gastric bypass and banding that are now routine surgical procedures
- A specialist weight management service is currently being commissioned to support primary care
- Health trainers and health promotion services, which help with behaviour change and provide practical support. (Unfortunately, men are reluctant to access health trainers for help with diet and physical activity. Only one-fifth of their clients are men, while four-fifths are women.)
- Advice and prescribing in primary care. Private sector and internet-based weight loss programmes such as Weight Watchers are also available locally.

The Government has the ambitious aim of being the first major nation to reverse the rising tide of obesity.

NHS Southampton City and key partners should:

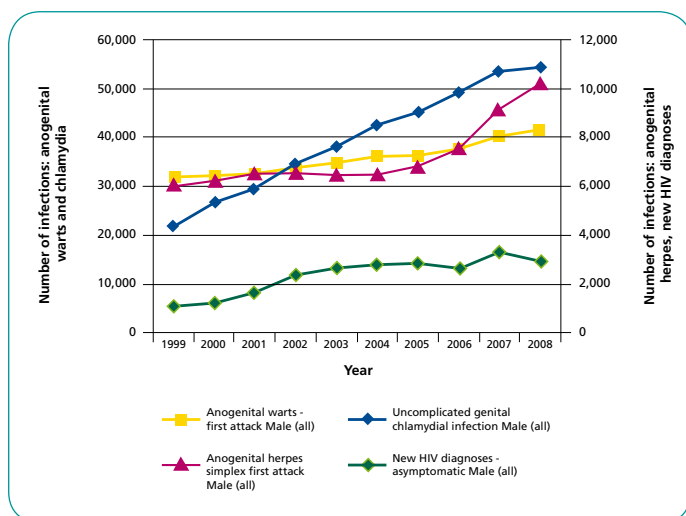
- Demonstrate commitment to reducing obesity, and ensure obesity features prominently in Local Area Agreement (LAA) targets
- Focus on working together to create a non-obesogenic environment for the people of Southampton
- Continue working with children and schools to reduce childhood obesity
- Provide a clear patient pathway for those that need help and are at high health risk due to their weight.

CHAPTER 3 MEN'S HEALTH IN SOUTHAMPTON

Sexual health

The number of new diagnoses for all major sexual infections except gonorrhoea has increased in England over the last decade. This includes chlamydia, syphilis, HIV, hepatitis B and genital warts. Of all the new HIV diagnoses in the UK in 2008, 38% were men who have sex with men, while 57% acquired the infection heterosexually. While the heterosexual numbers were declining from a peak in 2004, the number of infections in homosexual men continues at a high level. This is another example of risk-taking behavior. The Health Protection Agency (HPA) estimates that more than a quarter of people with HIV in the UK are unaware of their infection.

Figure 36: Trends in sexually transmitted infections: England - men



The increasing trend in the above chart partly reflects better ascertainment, but also an increase in unsafe sexual practices.

According to a report from the Men's Health Forum in 2006, the National Chlamydia Screening Programme has screened 14 times more women than men. In Southampton for 2008-09 the screening programme processed 5650 screens, of which men were 26%. However, chlamydia occurs equally in men and women and can lead to infertility in both. The report states that men can be encouraged to screen by targeting workplaces, making screening "easy", using men-friendly promotion materials and offering pharmacies as options for treatment, rather than having to make appointments with GPs or GUM clinics. Southampton Community Healthcare (from April 2010 Solent Healthcare) has been running contraceptive and sexual health clinics which are predominantly attended by women. Some interventions do specifically target men, such as an intensive residential course for gay men. This intervention aims to increase awareness of risks and encourage safe sexual practices among this high-risk group that is not accessible in the usual healthcare settings.

Promoting sexual health and safe sexual practices among men will also have a positive knock-on effect on teenage pregnancy, as well as sexually transmitted infections among women.

NHS Southampton City and partners should:

- Target sexual health promotion to men with tailored messages and in locations that men frequent, including the workplace and increase men's awareness of sexual health problems and the dangers of late diagnosis
- Target specific issues including Chlamydia screening, testing for HIV in homosexual men and importantly, messages regarding safe sexual practices, which need to be framed in a male-friendly way
- Make sexual health advice to men easily accessible, such as on the internet.

Men's Health Forum

The Men's Health Forum (MHF) (Ref 19) is an independent body founded in 1994 that has a mission to provide a voice for and tackle the issues affecting the health and wellbeing of men and boys in England and Wales. They organise a men's health week annually, to raise awareness and focus on a different aspect of men's health each year.

National Men's Health Week 2009 – Men and access to services

NHS Southampton City and Southampton Community Healthcare actively participated in the National Men's Health Week (15 - 21 June) 2009, by supporting the MHF through various initiatives during the week. The focus this year was on "men and access to services". The objectives were twofold; firstly to increase men's awareness of health services and encourage them to access these, and secondly to improve understanding of health policy makers and practitioners about how to develop and deliver services that men will use.

Men's health week was launched by a "health kicks six-a-side world cup", organised by Southampton Football Club at Thornhill Primary School. The event was used as a platform for raising awareness of the services available to men, to improve health and wellbeing. The day included a men's health quiz, and innovative "beer mat" information materials were given away to those who attended. Further activities included a "diabetes wellness day" and sports activities throughout the week on Hinkler Green.

NHS Southampton City and Southampton Community Healthcare will continue to use Hayne's Health Manuals which are specially produced by the MHF, in order to make men aware of health issues. The MHF is a valuable resource for men's health issues, and provides several reports that look at barriers and needs for men with pertinent suggestions for improvement in services.

Health Kicks

Health Kicks is a new health initiative aimed at men aged 18–35. Thornhill Plus You, Southampton Football Club and Social Health Ltd have teamed up to give the men in Thornhill the opportunity to improve their football skills and train with professionals, thanks to funding from the Football Foundation, Thornhill Community Health Fund and Motiv8-14 Thornhill. This project proved the success of the Health Kicks initiative and a partnership including Southampton Community Healthcare is bidding to roll the programme out across the City, link it to health trainers and develop a local men's health forum for Southampton to champion men's health promotion and improvement.

Conclusion

Men's health in the City needs improving. Health inequalities and life expectancy for men can be improved, but we need to engage men in new ways to encourage them to be involved with the health agenda in the future. All healthcare providers need to think more carefully about how they can reach men more effectively, making their services more men-friendly and tailoring health messages and promotions in ways that will get through to men in ways we currently cannot. Health promotion and screening programmes must take special care to target and tailor their efforts to reach men, in particular in terms of smoking cessation and health trainer programmes. The national MHF has good experience in these areas, and has developed some excellent products specifically tailored to men's health. Adapting and developing a similar approach locally in Southampton should have a significant positive impact on men's health and the health of the City population as a whole.

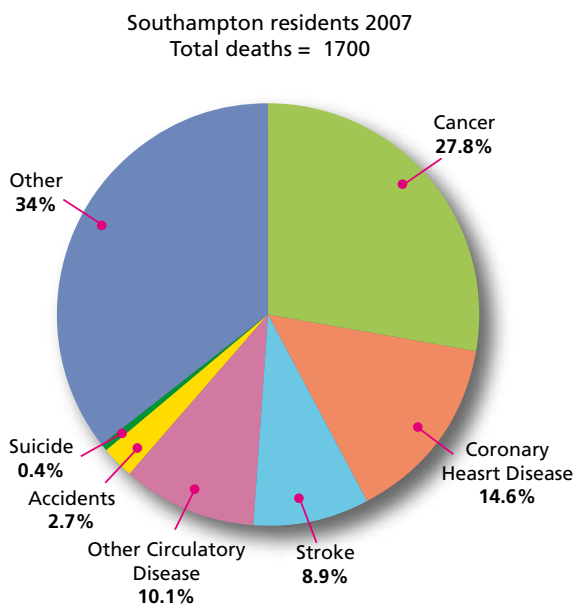
CHAPTER 4 SOUTHAMPTON CITY LOCALITY PROFILE

Introduction

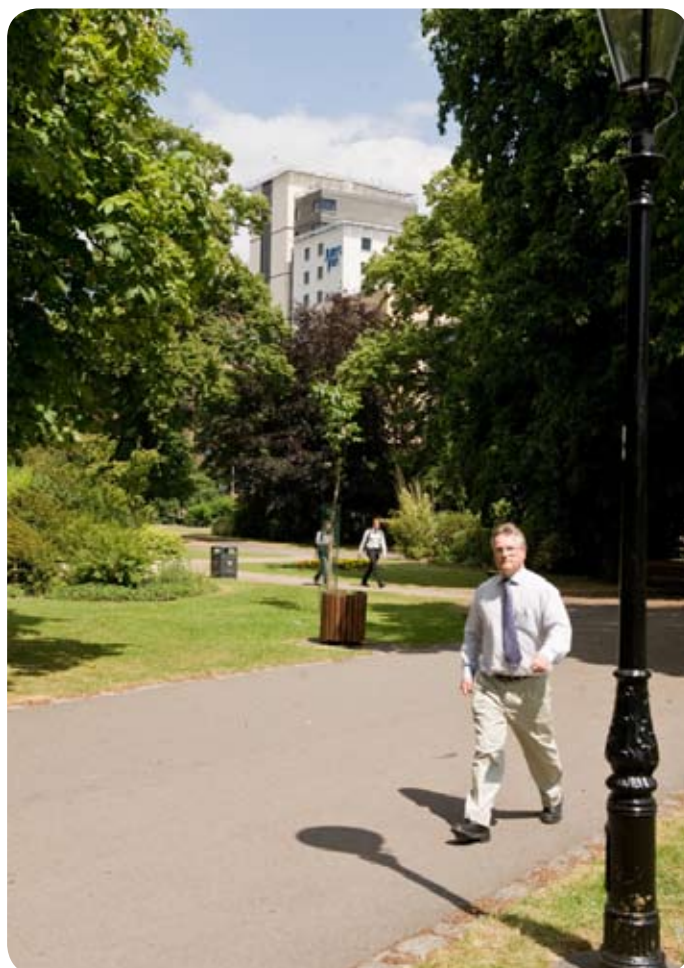
The aim of these profiles is to highlight the important public health issues in each locality. Of course the major causes of ill health and death are common to all localities. However, there are some particular local issues and differences to note. It is hoped that this information will aid health professionals in improving health through services targeted to the particular needs of the local population. For more data on a locality basis please refer to Local Health Comparisons available online at www.southamptonhealth.nhs.uk/publichealth/lhc

There are three localities in Southampton – North and Central, South and East and the West. The map below shows the boundaries of these localities. They are constructed geographically from electoral wards and much of the data presented in this report is built up from ward or postcode level information (relates to the resident population of the locality). Each locality can also be defined in terms of the GP practices that serve it and for some indicators the data has been aggregated from GP practice level figures. However, it should be borne in mind that the GP practice population can live anywhere so are not constrained by the geographical boundary of the locality or even of the City itself.

In 2008 Southampton's resident population was estimated to be 227,189 (Ref 20) this compares to 258,786 people registered with GPs in the City. In 2007 there were 3,078 live births to Southampton residents and 1,799 deaths. The main causes of death in the City are illustrated in the pie chart below.

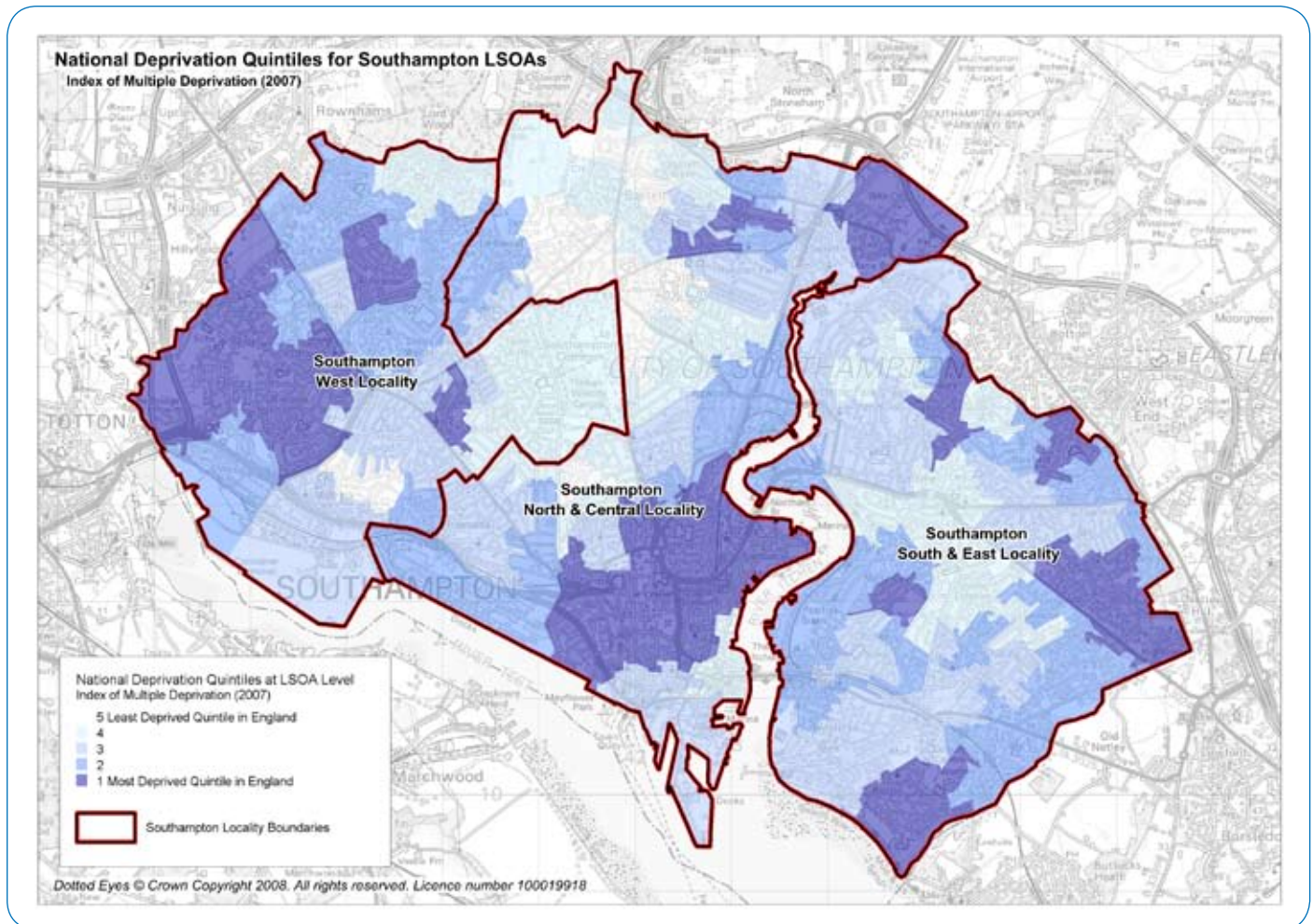


Source: Compendium of Clinical and Health Indicators December 2008
Health & Social Care Information Centre © Crown Copyright.



Major causes of death

The map also shows how deprivation varies across the City with each locality having some areas classified as amongst the most deprived 20% in England.



As can be seen the localities are relatively large areas with much diversity within them. Therefore, looking at locality level statistics can result in an 'averaging out' effect and actually mask some of the differences. In some instances analysis is made at smaller geographical areas within the localities themselves.

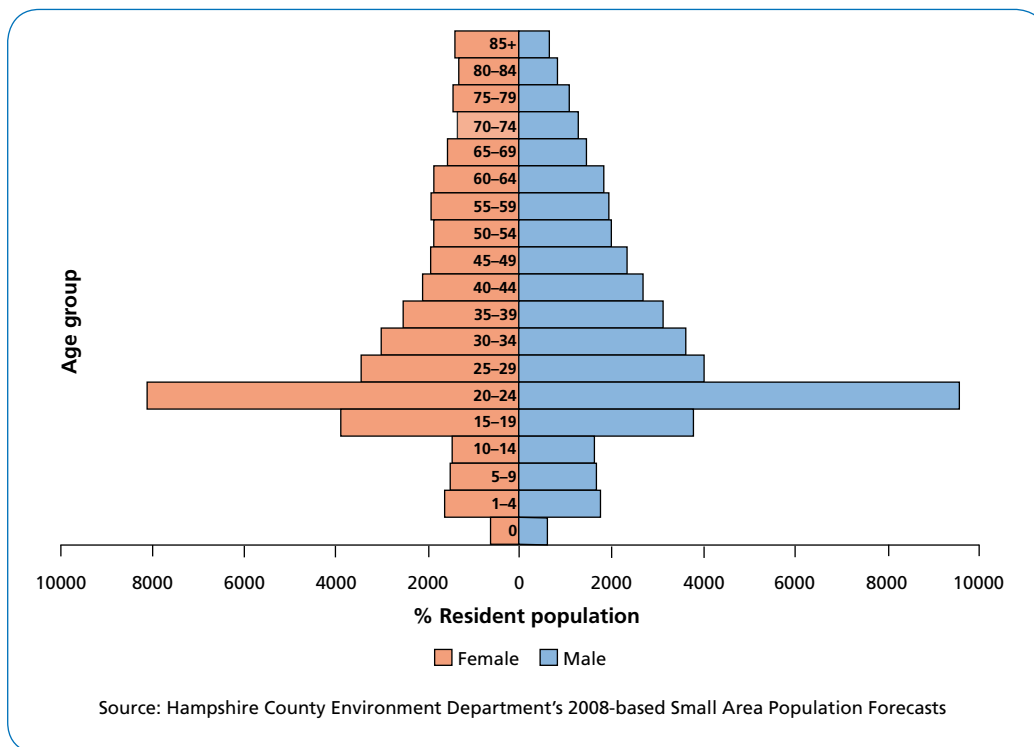
CHAPTER 4 SOUTHAMPTON CITY LOCALITY PROFILE

North and Central locality

The North and Central locality of Southampton has a resident population of 87,008 which equates to 38% of Southampton's total. There are 82,118 people registered with the 14 GP practices in this locality.

This locality has a young age profile which is particularly skewed by the large number of students living here as the population pyramid below shows. With over 5,000 new dwellings planned between 2008 and 2015, this locality is expected to see a population increase of 7% which is greater than elsewhere in the City (Ref 20).

Southampton North and Central locality resident population 2008



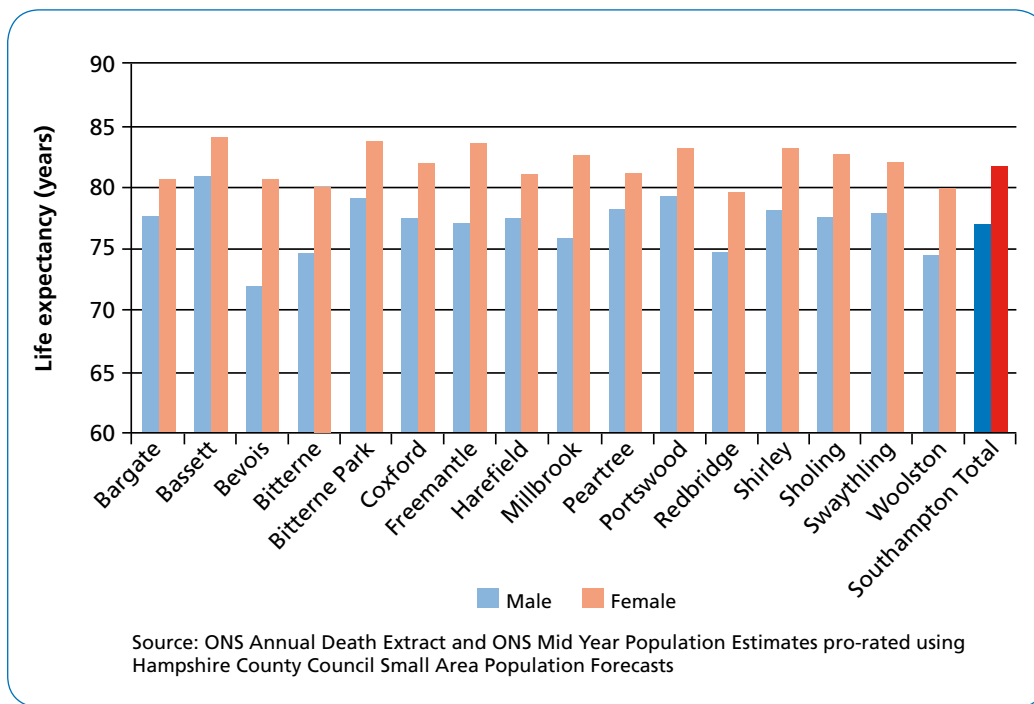
The North and central locality also has greater ethnic diversity than other areas of Southampton; the 2001 Census recorded 13.8% of residents here as being of an ethnic group other than white compared to 7.6% for the City as a whole.

Some of Southampton's highest levels of deprivation are found in the North and central locality according to the Index of Deprivation 2007. The pockets of deprivation are generally within the central neighbourhood, for instance, one area of Bevois ward is ranked in the 10% most deprived in England. The North neighbourhood by contrast contains some of the least deprived parts of the City.

GP register information can give us some indication of the burden of disease in a locality. For instance, in June 2008 GPs in North and central recorded 1,599 patients on their CHD registers, 2,160 on diabetes registers, 4,276 on obesity registers and 845 on registers for mental illness¹. Without knowing the age and sex details of these patients it is impossible to calculate age standardised rates which would allow robust comparison of prevalence rates between areas. Crude prevalence rates, calculated using list sizes as the denominator, show low prevalence of most conditions in this locality but this is likely to be a consequence of the large number of mainly young and healthy students registered here.

Life expectancy at birth² (2003-07) for males and females in this locality are comparable to other areas of the City, at 77 and 82 years respectively. However, these overall figures mask some extreme differences within the area. The chart below shows that life expectancy for males in Bevois ward is just 71.9 years which is significantly lower than the Southampton average.

Life expectancy at birth 2003 - 2007 pooled: Southampton City wards



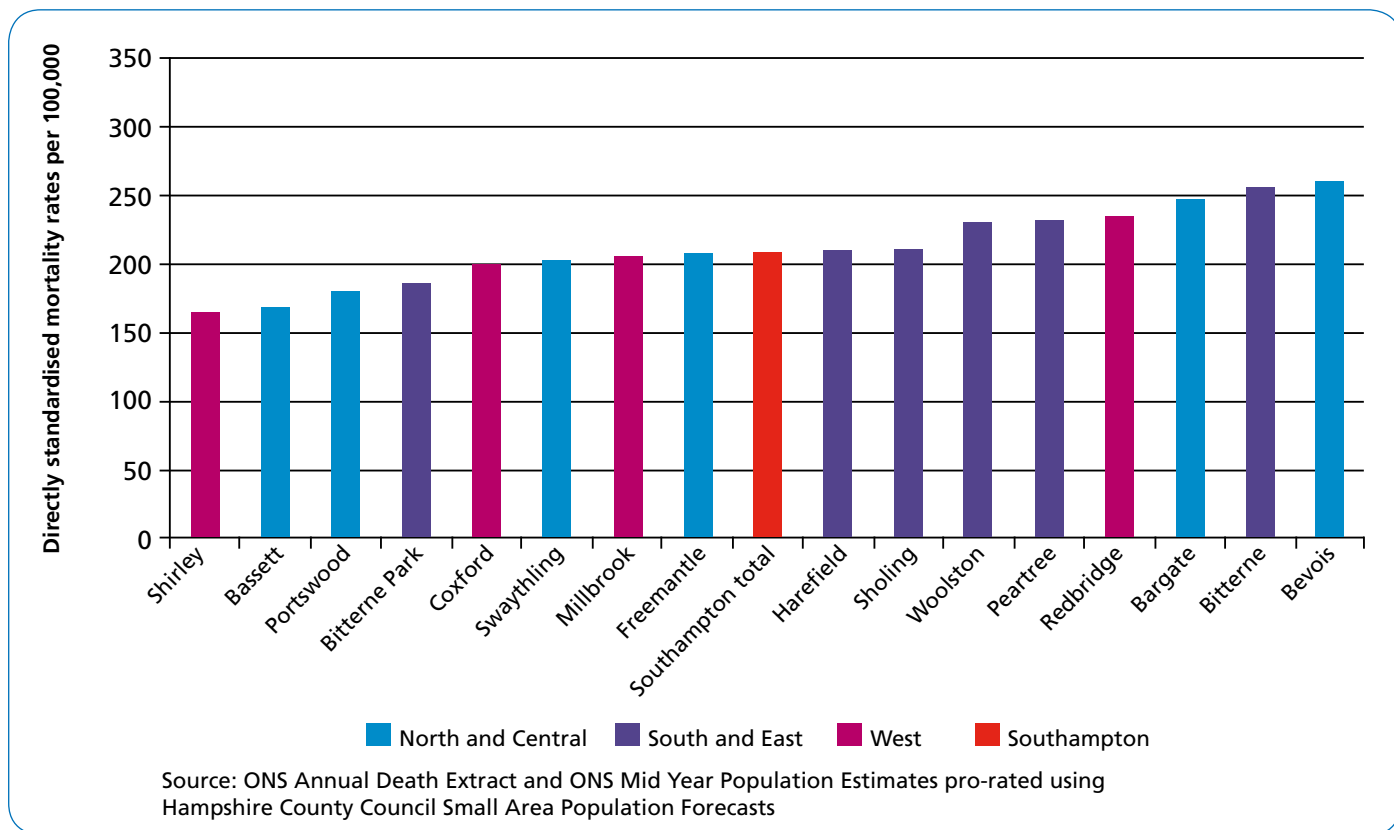
In 2007 there were 609 deaths of residents of North and central locality; of these 145 were from cancer and 205 from diseases of the circulatory system. For the locality as a whole, age standardised mortality rates are not generally significantly different in this locality compared to the rest of the City. However, as previously mentioned, there are areas within the locality where health is much worse; the chart below shows that both Bevois and Bargate wards in this locality have significantly higher mortality rates from circulatory disease than the Southampton average.

¹ Schizophrenia, bipolar disorder and other psychoses

² Life expectancy at birth is the average number of years a person would live if he or she experienced that area's age-specific mortality rates for that time period throughout his or her life.

CHAPTER 4 SOUTHAMPTON CITY LOCALITY PROFILE

Mortality from circulatory diseases: All ages, 2003 - 2007 pooled



Breastfeeding rates are significantly higher in this locality compared to the rest of the City; in 2008-09 84.6% of mothers, whose feeding status was known, reported breastfeeding at initial feed compared to 76.3% in the rest of the City. Similarly reported rates of smoking in pregnancy are lower here than elsewhere in Southampton.

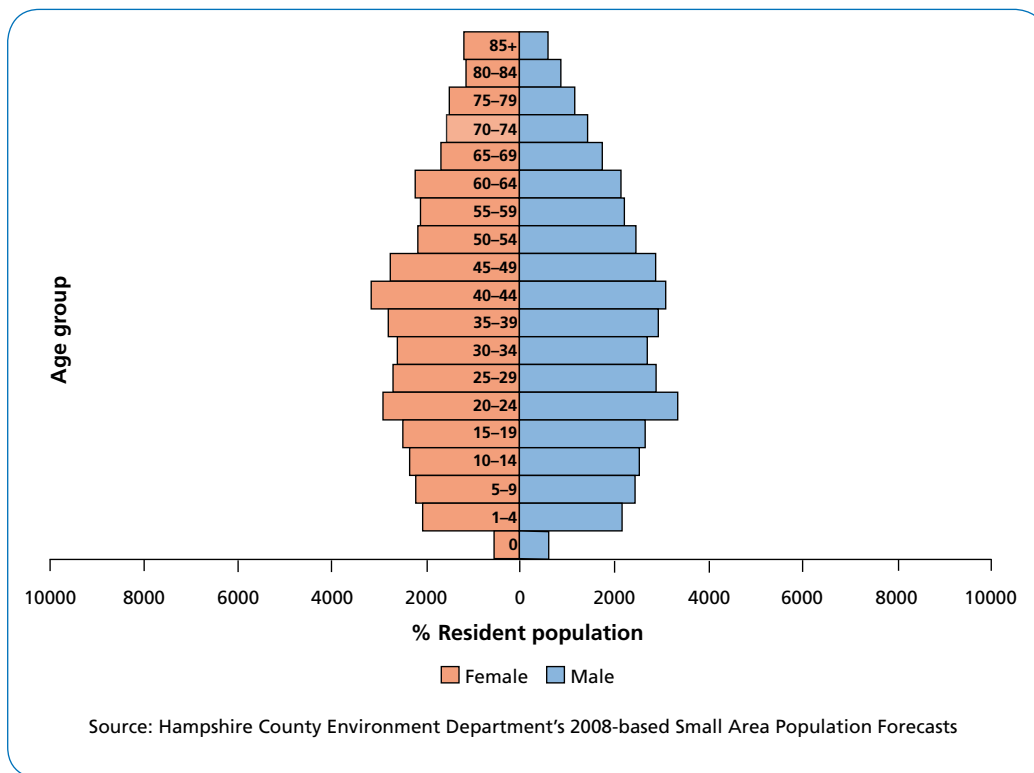


South and East locality

In 2008 there were 81,856 people living in the South and East locality accounting for 36% of the City's total population. The 12 GP practices in the area had 93,360 patients registered with them in October 2008.

The population pyramid for this locality has more of a column shape indicating more equal proportions of each age group; nearly 16% of the South and East residents are aged 65+ years compared with 14.8% across Southampton as a whole.

Southampton South and East locality resident population 2008



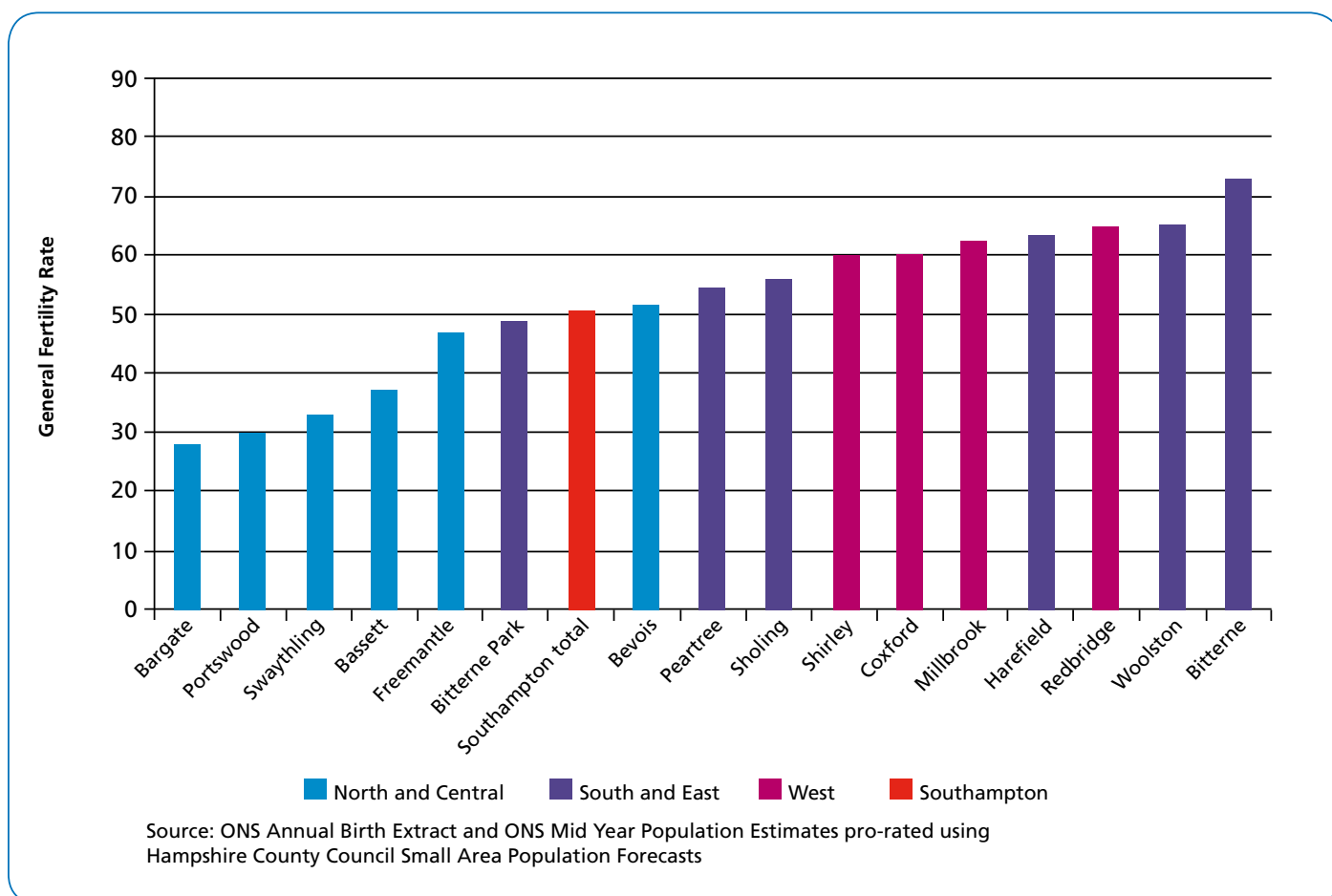
Between 2008 and 2015 there are 1,710 new dwellings planned for the South and East locality; over half of these will be in the Woolston ward and these will be predominantly flats. Modelling population change based on this assumes low occupancy rates for these flats and this, coupled with the general trend of falling house size, results in negligible (0.4% increase) population change over the 2008-2015 period.

In the 2001 Census the South and East locality was found to have less ethnic diversity than the rest of the City, with only 3.7% of people describing their ethnic origin as something other than white.

In 2007 there were 1,194 live births in the South and East locality. In particular, Bitterne and Woolston wards have high fertility rates as the chart below shows. However, please note that some wards, particularly in the North and central locality, have very low fertility rates because of the high number of students in the denominator population.

CHAPTER 4 SOUTHAMPTON CITY LOCALITY PROFILE

**General Fertility Rate (live births per 1000 females aged 15 - 44 years):
2003-2007 pooled**



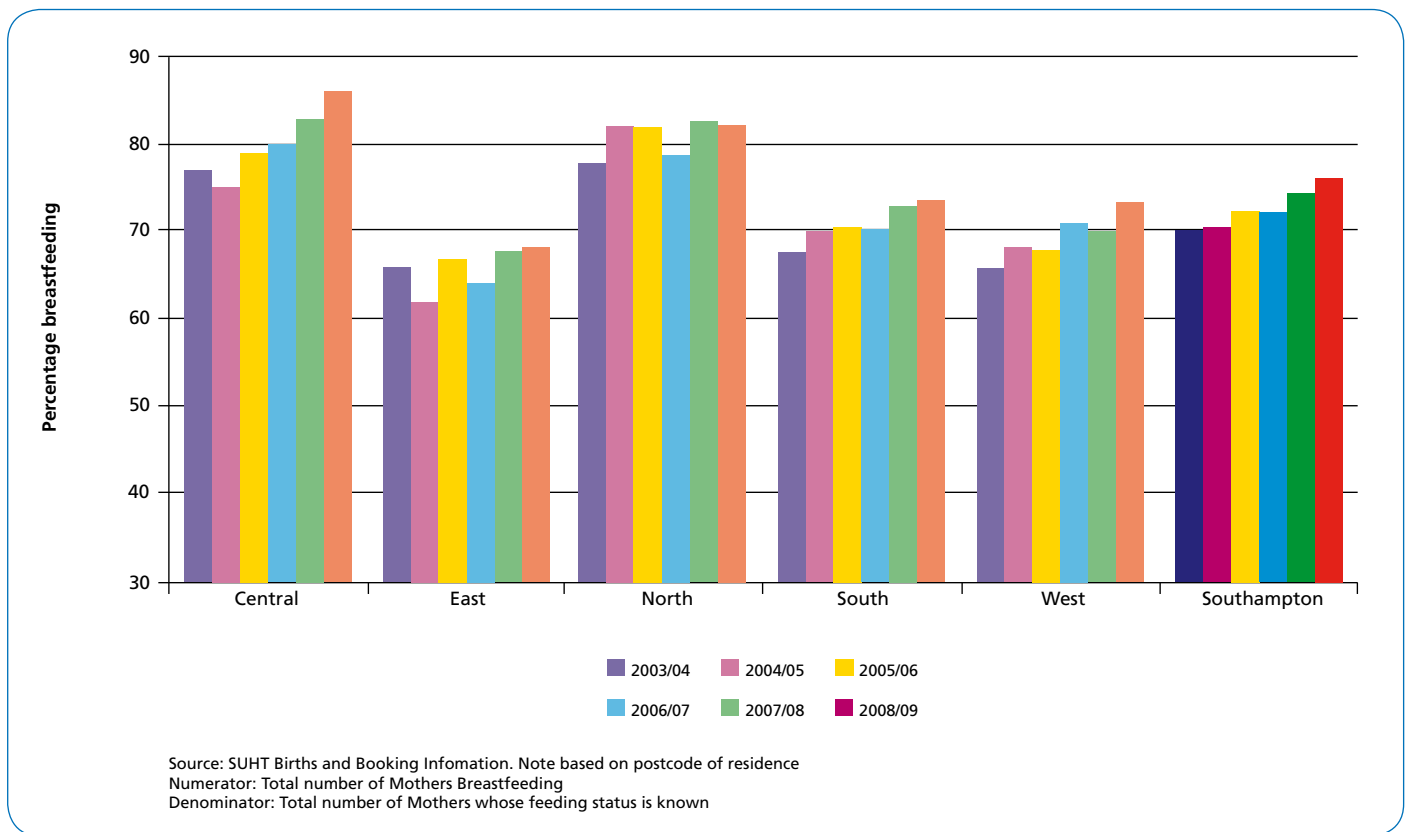
The deprivation map shows that the South and East have some considerable pockets of deprivation. Woolston ward contains the most deprived LSOA in Southampton. The Index of Deprivation 2007 also includes a supplementary index for children and the LSOA in Southampton with the highest proportion of children (64%) estimated to be living in income deprivation is in Thornhill (Bitterne ward). In November 2008 nearly 12% of 16-59 year olds in the Bitterne ward (which is within this locality) were claiming income support– this compares with an average of 6.1% across Southampton and 5.5% nationally.

In the South and East GPs have recorded 3,193 on CHD registers, 3,554 on diabetes registers, 7,291 on obesity registers and 801 on mental illness registers. As previously mentioned robust comparison of prevalence rates is not possible from the information available.

In 2007 there were 574 deaths to residents of the South and East locality. 173 of these were cancer, 90 from CHD and 119 from other diseases of the circulatory system. Age standardised rates of mortality show that this locality does not generally have significantly different mortality rates from the City average. However, as shown previously, these average figures for the locality do mask differences within it; for example males in Woolston ward have significantly lower life expectancy than the Southampton average.

In the South and East only 70.9% of mothers were recorded as initially breastfeeding compared with 76.3% across Southampton as a whole. The chart below shows that in particular the East neighbourhood of this locality has consistently had low rates of breastfeeding.

Percentage of mothers breastfeeding at initial feed: 2003/04 – 2006/09
Southampton Neighbourhoods Partnerships



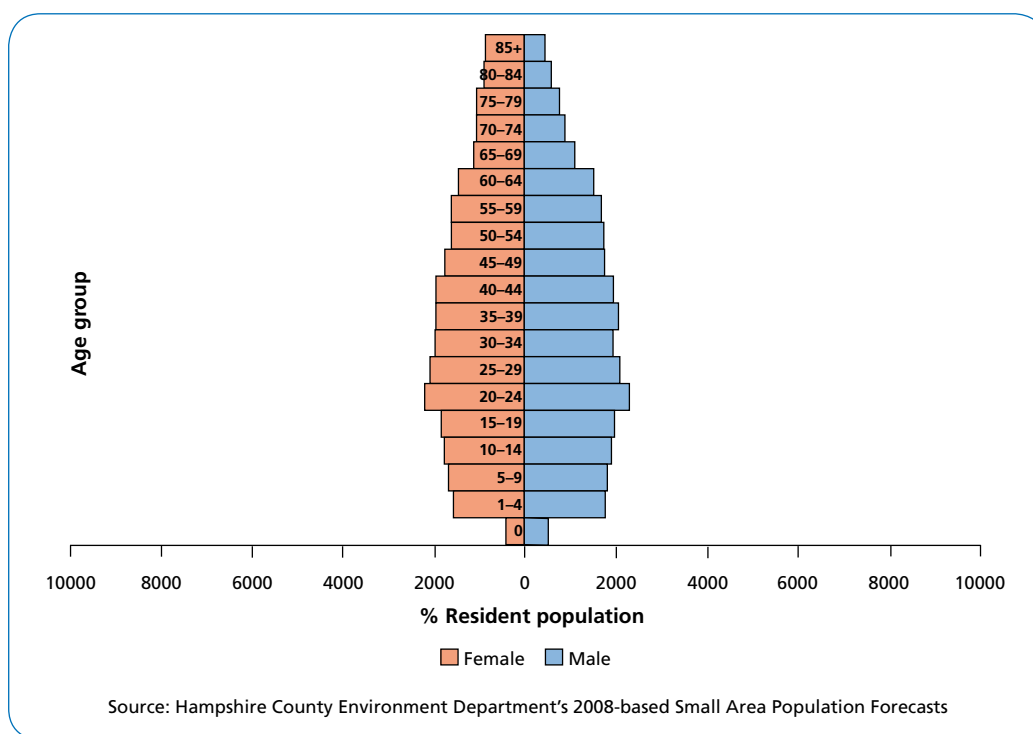
CHAPTER 4 SOUTHAMPTON CITY LOCALITY PROFILE

West locality

In 2008 there were an estimated 58,330 people living in the West locality (26% of the City total) and 83,308 patients were registered with the 10 GP practices in the area. This locality is forecast to see very little population change over the 2008 to 2015 period despite plans to build 1,036 new dwellings (as before this is an effect of the assumption that average household sizes will continue to fall).

The age profile of this locality is relatively young; over 21% of residents are children (aged 0-15 years) compared with 17.6% across Southampton as a whole. In 2007 there were 869 live births in this locality with the Redbridge ward in particular having a high fertility rate of 64.6 live births per 1000 females aged 15-44 years in 2003-07 compared with a rate of 50.7 for the City as a whole.

Southampton West locality resident population 2008

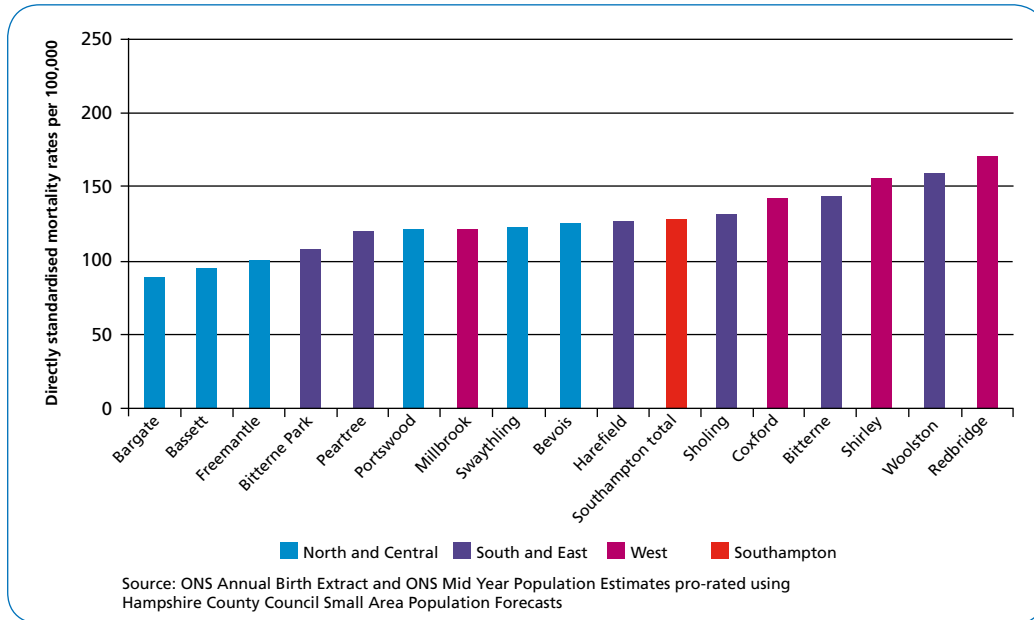


The West has some high levels of deprivation particularly around the Millbrook and Redbridge areas. In November 2008 10.2% of 16-59 year olds in Redbridge ward were claiming income support. In April 2007 over 28% of children living in the West locality were dependent on families in receipt of worklessness benefits – this compares with a national average of 19.7%.

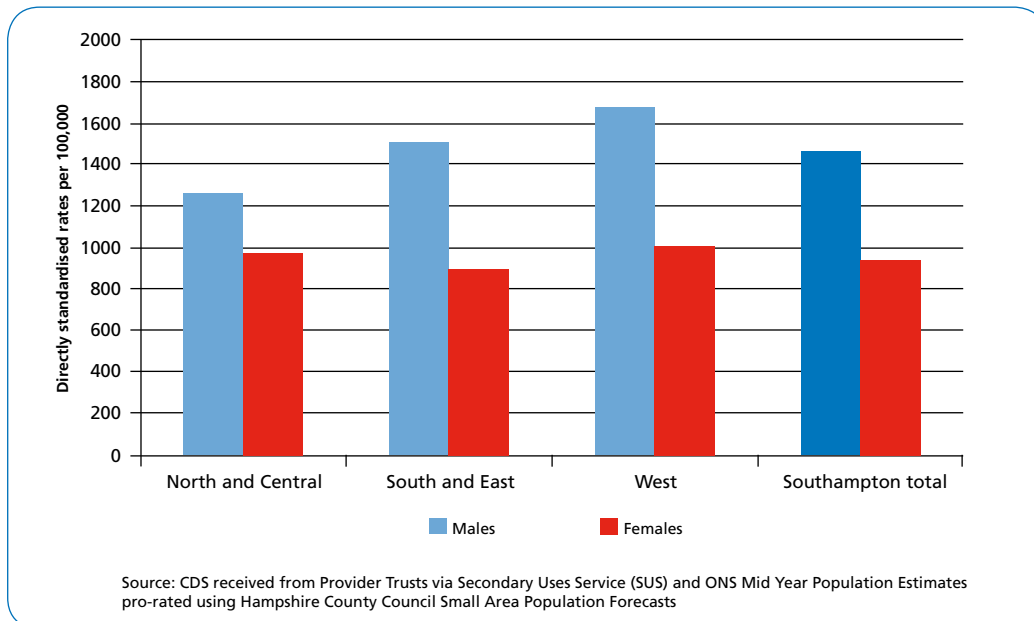
As at June 2008 GPs in the West locality had recorded 2,670 patients on their CHD registers, 3,002 on their diabetes registers, 6,185 on their obesity registers and 753 on their mental illness registers.

In 2007 there were 616 deaths to residents of the West locality; 183 of these were from cancer and 192 from diseases of the circulatory system. Generally age standardised mortality rates for the West locality area are not significantly different from the rest of the City but there are areas within the locality that do experience higher mortality. For instance, Redbridge ward has an age standardised mortality rate from cancer amongst under 75s of 170.8 per 100,000 which is significantly higher than the Southampton rate of 127.8 (see chart opposite).

Mortality from cancer: Persons aged under 75 years. 2003 - 2007 pooled



Hospital admissions for circulatory disease are higher in the West locality than elsewhere in the City. This is particularly the case for males as the chart below shows.

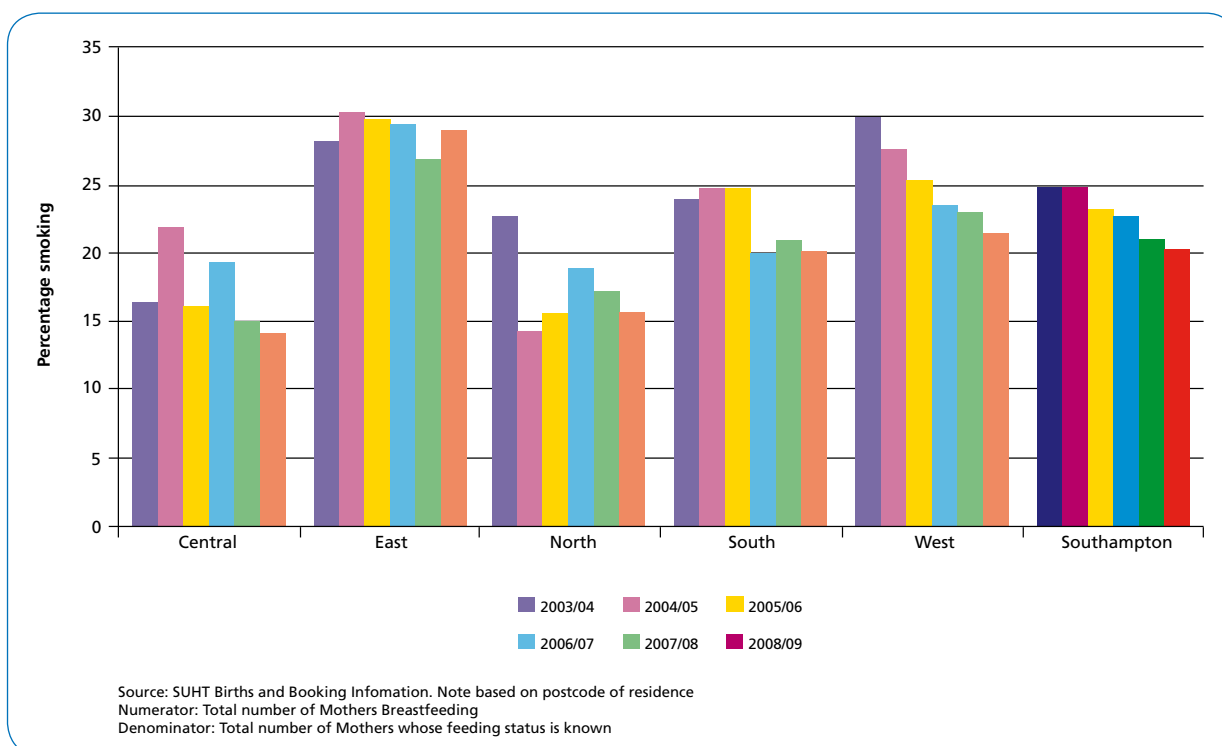


In 2007-08 24% of school-entry age children living in the West locality were found to be overweight (including obese), this is higher than both the Southampton and national averages, but not significantly so. However, for the three year period 2005-06 to 2007-08 the proportion of overweight children in Coxford ward, within the West locality, was 28.5% which is significantly higher than the England average of 22.6%.

CHAPTER 4 SOUTHAMPTON CITY LOCALITY PROFILE

Smoking in pregnancy has reduced significantly in the West over the last few years as the chart below shows. By 2008-09 21.4% of expectant mothers within the West locality reported smoking in pregnancy which was not significantly different from the Southampton average of 20.3%.

Percentage of mothers smoking at midwifery booking – 2003/04 - 2008/09 by Southampton Neighbourhoods Partnerships



Conclusion

These profiles have shown key health issues common to all localities as well as highlighting some differences between them. The importance of looking at smaller areas within the localities has also been emphasised as the larger scale geographies can mask some very serious local issues.

Further work on profiling locality areas will be carried out by NHS Southampton City's Public Health Information Team and will be published on our website www.southamptonhealth.nhs.uk/publichealth

Any further questions about these profiles or public health information generally should be addressed to:

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NHS

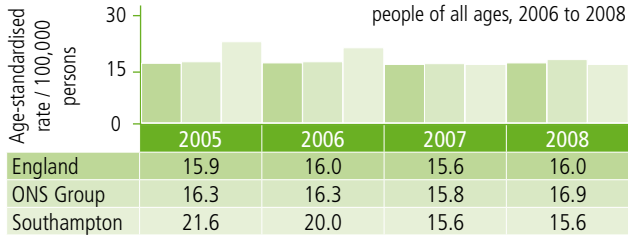
Southampton City

The health of the people of
Southampton City
2009



A pocket profile

Accidents



Number of deaths per year

	2005	2006	2007	2008
Southampton	64	60	49	49

Source: Compendium of Clinical & Health Indicators Health & Social Care Information Centre. © Crown copyright. ONS Group for Southampton is 'Regional Centres'

Life expectancy*

Life Expectancy at Birth (years) 2006-2008

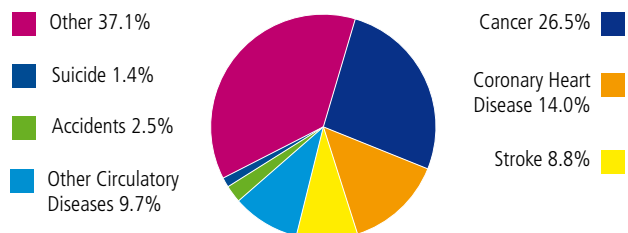
	Males	Females
Southampton	77.6	82.1
South East	79.2	83.0
England	77.9	82.0

*Life expectancy at birth is an estimate of the number of years a new-born baby would be expected to live if they experienced that area's 2006-08 mortality rates throughout their life.

Source: Office for National Statistics, 2009. © Crown Copyright.

Major causes of death

Southampton Residents 2008 (No. of deaths=1,963)



Source: Compendium of Clinical & Health Indicators Health & Social Care Information Centre. © Crown copyright.

Jobs and unemployment

Claimant count (as % of working age resident population)

	Southampton	South East	England
Oct 2009	4.1	3.0	4.1
Jul 2009	4.1	3.0	4.1
Apr 2009	3.9	3.0	4.1
Jan 2009	3.3	2.3	3.3
Oct 2008	2.4	1.6	2.5

Jobs Density (no. of filled jobs per working age resident)

	Southampton	South East	England
2007	0.82	0.86	0.84

Source: National Statistics (from Nomis website: www.nomisweb.co.uk) © Crown copyright material is reproduced with the permission of the Controller of HMSO.

Index of deprivation 2007

Ranking of the worst five Super Output Areas (SOAs) out of 146 SOAs in Southampton for overall score and each domain

Also within the 10% most deprived SOAs in England

Source: Index of Deprivation 2007, Office of the Deputy Prime Minister

	Woolston	Bevois	Bitterne	Millbrook	Bitterne	Redbridge	Redbridge	Bevois	Bevois	Bargate	Woolston	Millbrook	Redbridge	Woolston	Bassett	Bargate	Bassett	Sholing	Bassett	Bargate	Portsmouth	Bitterne	Freemantle	Pear Tree	Portsmouth	Bassett	
	E01017281	E01017154	E01017167	E01017207	E01017163	E01017245	E01017240	E01017161	E01017155	E01017141	E01017274	E01017210	E01017237	E01017280	E01017145	E01017142	E01017148	E01017263	E01017146	E01017139	E01017230	E01017166	E01017189	E01017218	E01017227	E01017149	
Overall IMD Score	1	2	3	4	5																						
Income	1	3	2	4		5																					
Employment	1	3	2		4		5																				
Health	2	3						1	4	5																	
Education				5							1	2	3	4													
Housing / Access											1	2	3	4	5												
Crime				3										4							1	2	5				
Environment							4																	1	2	3	5

Educational attainment

	2006	2007	2008	2009
Southampton LEA schools				
KS2 English	75	77	73	74
KS2 Mathematics	71	76	74	74
5+ GCSEs A*-C	36.2	38.8	42.3	43.1
All England LEA schools				
KS2 English	79	80	81	80
KS2 Mathematics	76	77	79	79
5+ GCSEs A*-C	45.8	46.8	47.6	49.8

Notes: KS2 = % of children gaining at least level 4 at Key Stage 2
GCSEs = % of 15 yr olds gaining 5+ GCSE/GNVQ grades A*-C inc English and Maths
Source: Dept. for Education & Skills www.dfes.gov.uk © Crown Copyright.

This Pocket Profile summarises the most recent comparative indicators of the health of residents of Southampton.

We have compared Southampton to the ONS group of 19 'most similar' authorities which includes Portsmouth, Bristol and Exeter. Other comparisons have been made with the South East Region and with the England average.

We hope you find this profile useful and welcome your comments.

Dan King and Sarah Hedges
Public Health Information

Andrew Mortimore
Director of Public Health

Resident population 2009

Age band	Male	Female	Persons	%
0-4	7,355	7,003	14,358	6.3
5-14	11,862	11,216	23,078	10.2
15-24	23,536	21,639	45,175	19.9
25-49	39,833	36,842	76,675	33.7
50-64	17,399	16,822	34,221	15.7
65-74	7,831	8,250	16,081	7.1
75-84	5,171	7,365	12,536	5.5
85+	1,606	3,463	5,069	2.2
Total	114,593	112,600	227,193	100

Population resident in NHS Southampton City

Source: Hampshire County Environment Department's 2008 Based Small Area Population Forecasts (Figures may not sum due to rounding)

Registered population 2009

Age band	Male	Female	Persons	%
0-4	7,659	7,435	15,094	5.8
5-14	13,082	12,366	25,448	9.8
15-24	23,917	23,987	47,904	18.5
25-49	53,857	44,641	98,498	37.9
50-64	20,417	18,849	39,266	15.1
65-74	8,329	8,437	16,766	6.5
75-84	4,969	6,895	11,864	4.6
85+	1,526	3,275	4,802	1.8
Total	133,756	125,886	259,642	100

Population registered with Southampton City GPs

Source: Patient & Practitioner Services Authority (Figures may not sum due to rounding)

Births General Fertility Rate and Number of Births

	2005	2006	2007	2008
Live births per 1,000 women aged 15-44				
Southampton	50.3	51.1	54.5	56.3
South East	56.7	59.2	60.8	62.5
England	58.4	60.3	62.1	63.9
Number of live births				
Southampton	2,775	2,907	3,078	3,279

Source: ONS, Mid year estimates and Vital Statistics VS1.
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Teenage conceptions

	2004	2005	2006	2007
No. of conceptions to girls aged under 18				
Southampton	204	216	227	185
Rate of under 18 conceptions per 1000 girls aged 15-17				
Southampton	55.4	57.8	60.7	49
South East	33.3	34.1	32.9	32.9
England	41.6	41.3	40.4	41.7

Source: Teenage Pregnancy Unit & ONS
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Infant mortality*

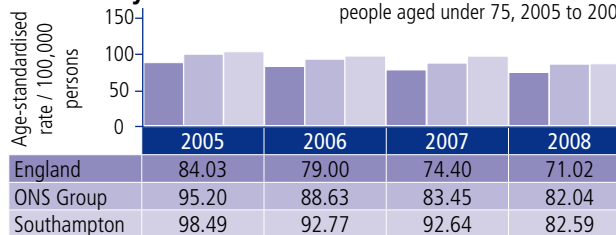
	2004-06	2005-07	2006-08
Number of deaths (in 3 year period)			
Southampton	33	41	44
South East	1,140	1,170	1,220
England	9,339	9,397	9,503
Mortality per 1,000 live births			
Southampton	4.0	4.7	4.7
South East	4.0	4.0	4.0
England	5.0	4.9	4.8

*includes deaths of infants aged less than 1 year

Source: ONS, Vital Statistics VS1. © Crown Copyright.

Circulatory disease

All circulatory diseases mortality rate, people aged under 75, 2005 to 2008



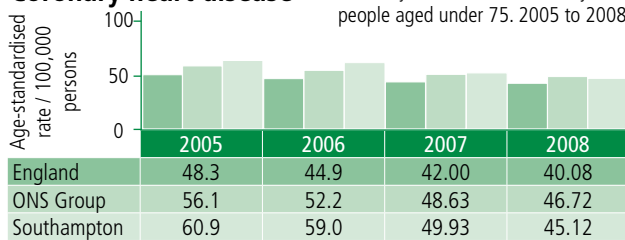
Number of deaths per year

Southampton	190	180	180	164
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Source: Compendium of Clinical & Health Indicators Health & Social Care Information Centre © Crown Copyright. ONS Group for Southampton is 'Regional Centres'

Coronary heart disease

Coronary heart disease mortality rate, people aged under 75, 2005 to 2008



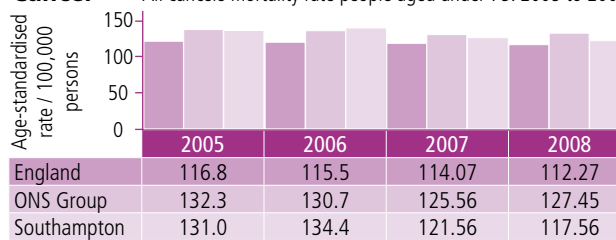
Number of deaths per year

Southampton	117	113	98	90
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Source: Compendium of Clinical & Health Indicators Health & Social Care Information Centre. © Crown Copyright. ONS Group for Southampton is 'Regional Centres'

Cancer

All cancers mortality rate people aged under 75, 2005 to 2008



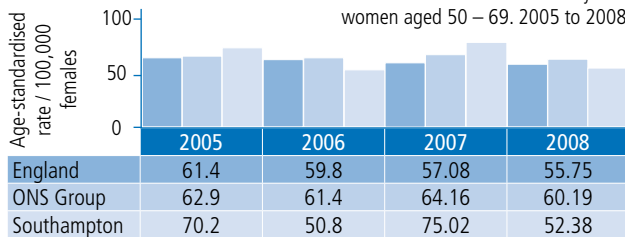
Number of deaths per year

Southampton	249	257	233	230
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Source: Compendium of Clinical & Health Indicators Health & Social Care Information Centre. © Crown Copyright. ONS Group for Southampton is 'Regional Centres'

Breast cancer

Breast cancer mortality rate women aged 50 - 69, 2005 to 2008



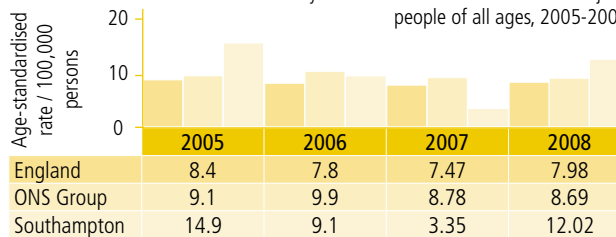
Number of deaths per year

Southampton	14	10	15	11
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Source: Compendium of Clinical & Health Indicators Health & Social Care Information Centre. © Crown Copyright. ONS Group for Southampton is 'Regional Centres'

Suicide

Mortality due to suicide and undetermined injury, people of all ages, 2005-2008



Number of deaths per year

Southampton	31	20	7	27
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Source: Compendium of Clinical & Health Indicators (May 2008) Health & Social Care Information Centre. © Crown Copyright. ONS Group for Southampton is 'Regional Centres'

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