

# Health in Southampton 2012



## **FINDING OUT MORE ABOUT THE HEALTH OF SOUTHAMPTON**

As well as publishing an Annual Report and a Joint Strategic Needs Assessment (JSNA), we produce a number of other resources that help build up a more detailed picture of health in Southampton. The back catalogue of annual reports is available on our website; these give in-depth analysis of a range of topics that remain current in our City. We also publish briefing notes which are a comprehensive look at topics such as child growth, inequalities and sexual health. Each month we produce a news bulletin on a subject of topical interest; this might include a new release of data nationally or the development of a public health intelligence tool by our own team. We produce profiles of the sixteen electoral wards in the City; these are available to view on our website.

Please visit our website to access any of these resources:

[www.southamptonhealth.nhs.uk/publichealth](http://www.southamptonhealth.nhs.uk/publichealth)

## **ACKNOWLEDGEMENTS**

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# Southampton City Public Health Annual Report 2012:

## Health is everyone's business

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## Introduction

This annual report comes at the end of an era... as public health functions move from the NHS into local government. This signals recognition that the health and wellbeing of the population is influenced by more than just the health service. Thus this year's report is entitled 'Health is everyone's business' and it looks at case studies from around the city where different organisations and agencies are working on projects that will impact on the health and wellbeing of Southampton's residents.

"The responsibility to improve and protect our health lies with us all – government, local communities and with ourselves as individuals."<sup>1</sup>

The Government has set out what it wants to achieve through the new and reformed public health system with its key vision being 'to improve and protect the nation's health and wellbeing, and improve the health of the poorest fastest'. Realising this vision will be through the achievement of positive outcomes; a framework of these has been developed by the Government (the Public Health Outcomes Framework or PHOF)<sup>2</sup> and we are using these to set the context for this report.

The PHOF has two over-arching outcomes:-

- Increased healthy life expectancy
- Reduced differences in life expectancy and healthy life expectancy between communities

These reflect the focus on not just how long we live but how well we live and also on reducing inequalities between people, communities and areas. The public health team in Southampton has always worked towards these goals but with the reshaping of the system and the development of the PHOF we see new opportunities for engaging, and working with, partners in improving these outcomes.

Measuring improvements in these over-arching outcomes is possible but often significant changes will take years, or even decades, to be measurable. Therefore, the PHOF includes a host of other indicators designed to show year-by-year the progress towards these aims. The indicators are divided into four domains:-

- improving the wider determinants of health
- health improvement
- health protection
- healthcare public health and preventing premature mortality

We have used these domains in the structure of this report but with some changes to terminology to make them more understandable. A full set of the indicators in the PHOF is included in Appendix A where we compare the values for Southampton with those of the local authorities deemed 'most similar'<sup>3</sup>. Some of the indicators

are not yet measureable at a local level. The Government has recently released a tool to present the PHOF data (available at <http://www.phoutcomes.info/>) and we have used some of those visualisations in this report as well local analysis of the data.

The back page of this report includes a 'pocket profile' digest of key statistics for the city; due to revising of population data following the release of the 2011 Census results we are not yet able to update the mortality statistics but when this data does become available later this year we will publish a new version of the pocket profile on our website.

Our website also contains a wealth of detailed, local public health intelligence for the city [www.southamptonhealth.nhs.uk/aboutus/publichealth/hi](http://www.southamptonhealth.nhs.uk/aboutus/publichealth/hi)

The Joint Health and Wellbeing Strategy sets out how Southampton City Council, Southampton City Clinical Commissioning Group (CCG) and the NHS Commissioning Board plan to take action to address the key health and wellbeing needs of the city over a three year period beginning in 2013/14. The strategy was developed through Southampton's Shadow Health and Wellbeing Board.

The actions in the strategy are stratified into three themes:

- Building resilience and preventative measures to achieve better health and wellbeing
- Best start in life
- Living and ageing well

Using these three themes, actions can be linked back to the needs identified in the JSNA. They will secure a life course approach to improve health and wellbeing and provide a means of reducing health inequalities. They also provide scope for improved joint working across health and care systems, and the opportunity to develop a shared ambition and vision of success.



A handwritten signature in black ink that reads "Andrew Mortimore". The signature is written in a cursive, slightly slanted style.

**Dr Andrew Mortimore**  
**Director of Public Health**  
**Southampton City**  
**March 2013**

## **A statistical portrait of Southampton....**

The results of the 2011 Census help us to paint a picture of the diverse population of our city which in turn helps in understanding and designing services to meet the needs of all residents.

Of the 236,882 Southampton residents recorded in the Census:-

- 77.7% describe themselves as White British (compared to 79.8% nationally)
- 82.4% of residents were born in the UK (compared to 86.2% nationally)
- 3.5% (6,222) residents aged 16-74 have never worked (compared to 3.9% nationally)
- 51.5% said they were Christian (compared to 59.4% nationally)
- 4.2% of 16-74 year olds were unemployed and 18.1% (32,517) were students (compared to 4.4% and 9.2% respectively for England)
- Of all people aged 16 and over, 21% (40,991) have no qualifications (compared to 22.5% nationally)
- 16.2% (38,399) reported a long term health problem or disability, with 18,165 of these saying it limits their daily activities a lot
- 8.6% (20,363) of residents provide unpaid care for a family member, friend etc., with 4,802 providing care for more than 50 hours a week

The Census recorded 98,254 households in the city:-

- 29.5% of households have no car or van (compared to 25.8% nationally)
- 13.6% of households are overcrowded (compared to 8.7% nationally)
- 39.9% of dwellings in the city are flats, maisonettes or apartments and 60% are houses
- 33.8% of households are comprised of people living alone (compared to 30.3% nationally)
- 7.0% of households are lone parents with dependent children (compared to 7.1% nationally)
- 7.7% of households have no people for whom English is the main language (compared to 4.4% nationally)
- 49.8% of households own their home (or buying with a mortgage) (compared to 63.4% nationally)

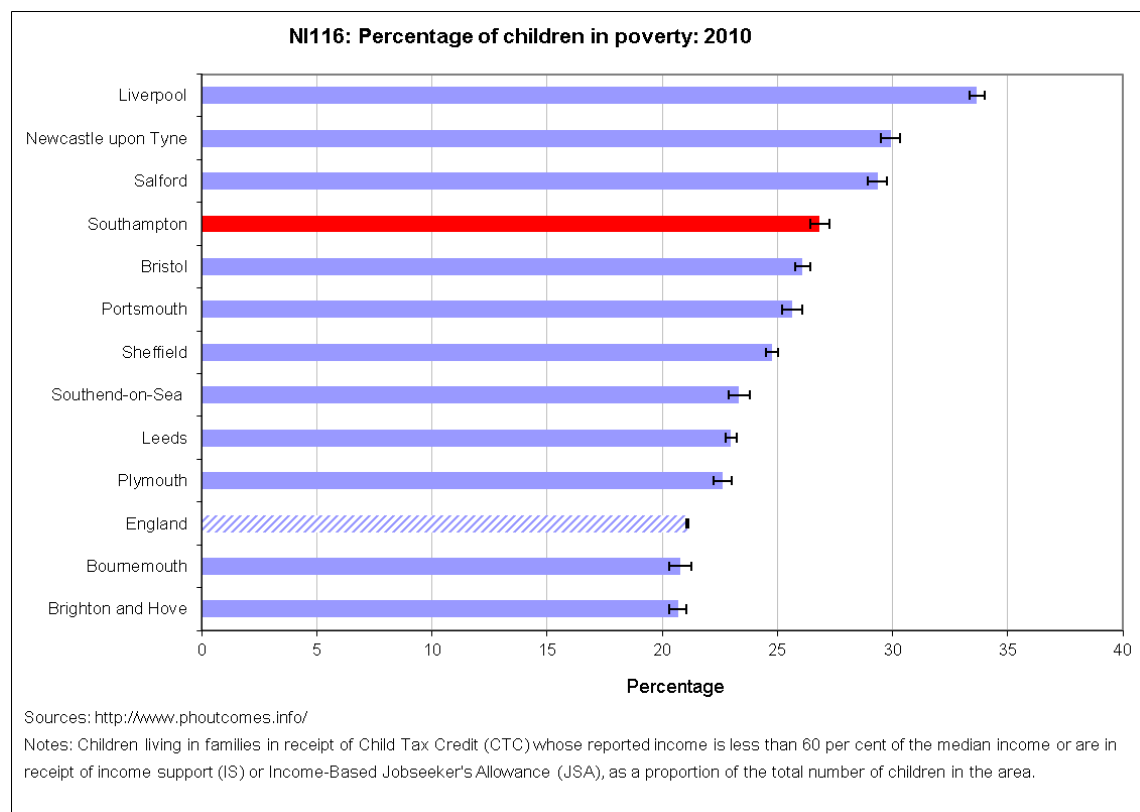
Source: 2011 Census, Office for National Statistics, Crown Copyright

## Domain 1: Impacts on Health and Wellbeing

Sir Michael Marmot in his report *Fair Society, Healthy Lives* in 2010, introduced the concept of the "causes of the causes" of health inequalities. Consideration of the wider social, political, economic and environment context is vital in addressing inequalities in health and wellbeing. In Southampton there is much work going on to tackle some of these wider determinants of health and in this chapter we report on two such initiatives – workplace wellbeing and sustainable transport.

There are two themes within the Southampton Joint Strategic Needs Assessment (JSNA) which dovetail into this domain – ‘Improving Economic Wellbeing’ and ‘Creating a Healthier Environment’. The JSNA webpages [www.southamptonhealth.nhs.uk/jsna](http://www.southamptonhealth.nhs.uk/jsna) contain a wealth of information on these topics and the associated data compendium includes relevant comparative and trend statistics.

For instance, the chart below shows the proportion of children in Southampton who are living in poverty compared to the proportion in similar cities. Worryingly, over 26.8% of children in Southampton are judged to be living in poverty – this is a higher proportion than the national average and than many similar cities.

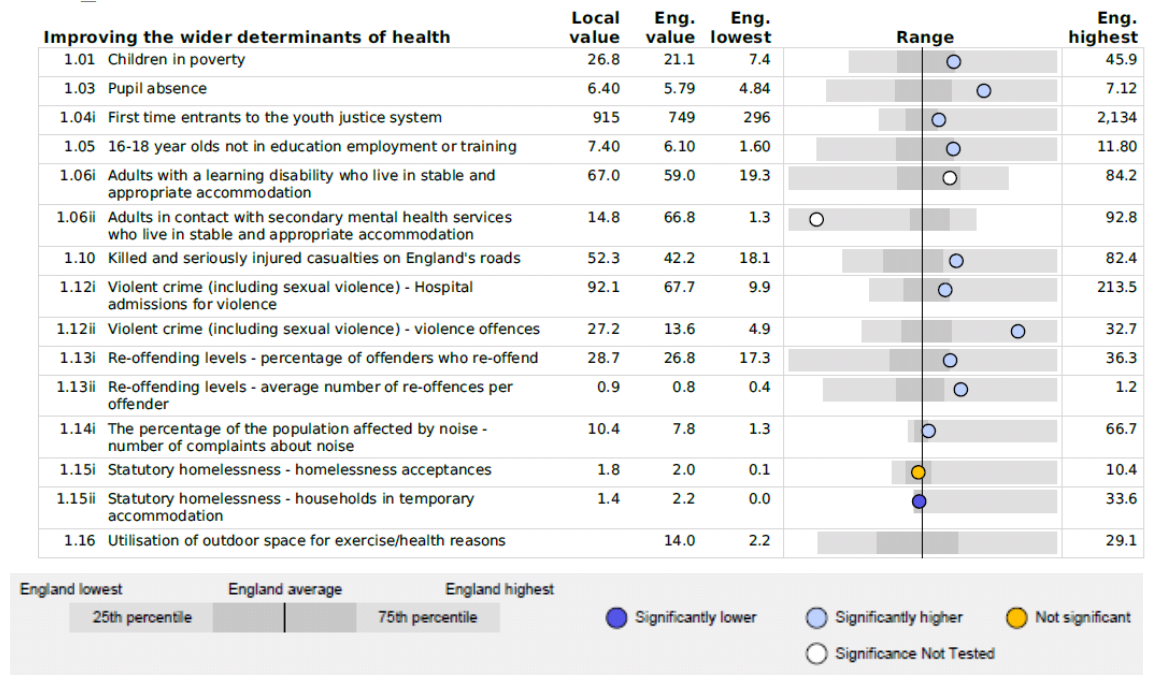


Giving children the best start in life is crucial to reducing inequalities across the life course. Marmot<sup>4</sup> wrote:



“To have an impact on health inequalities we need to address the social gradient in children’s access to positive early experiences. Children who have low cognitive scores at 22 months of age but who grow up in families of high socioeconomic position improve their relative scores as they approach the age of 10. The relative position of children with high scores at 22 months, but who grow up in families of low socioeconomic position, worsens as they approach age 10.”

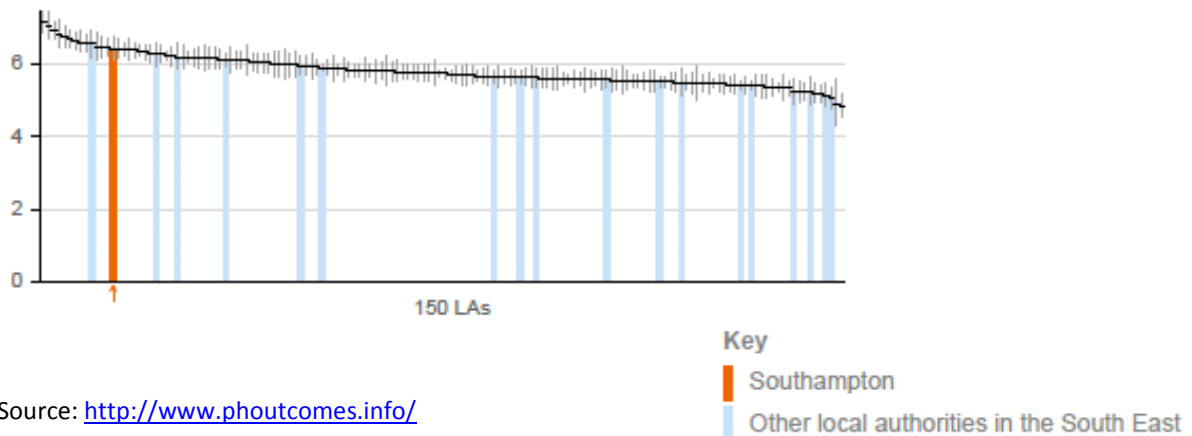
The chart below shows the PHOF indicators in this domain for Southampton and whether the City is significantly higher or lower than the England average. For most indicators Southampton is ‘worse’ than the national average.



Source: <http://www.phoutcomes.info/>

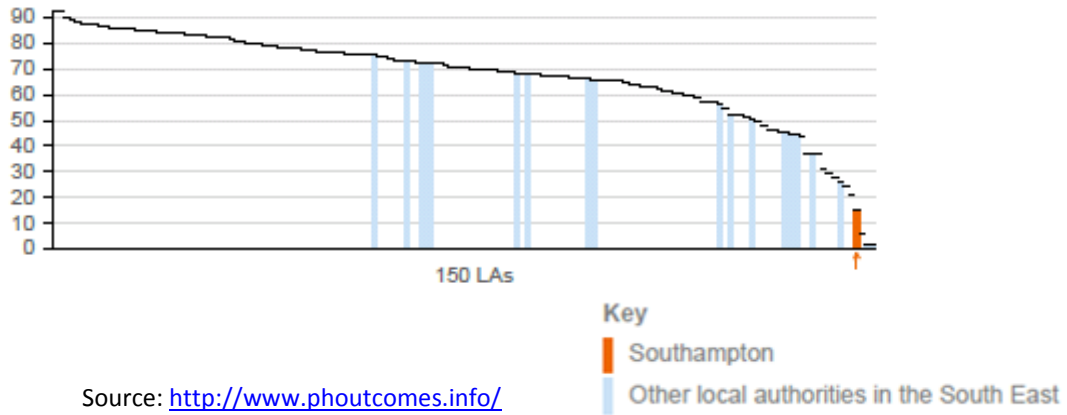
For some of these indicators, Southampton scores amongst the worst in the whole country. For instance, see the charts below on pupil absence and the proportion of adults in contact with mental health services who are living in appropriate accommodation.

### Pupil absence



Source: <http://www.phoutcomes.info/>

**Adults in contact with secondary mental health services who live in stable and appropriate accommodation**



Appendix 2 includes the PHOF measures for Southampton ranked against the authorities considered most similar. In this domain Southampton ranks very poorly against these other 'regional centres' despite being about average in the group in terms of deprivation.

## Case Study 1: Workplace Wellbeing Project

### Why is this issue important?

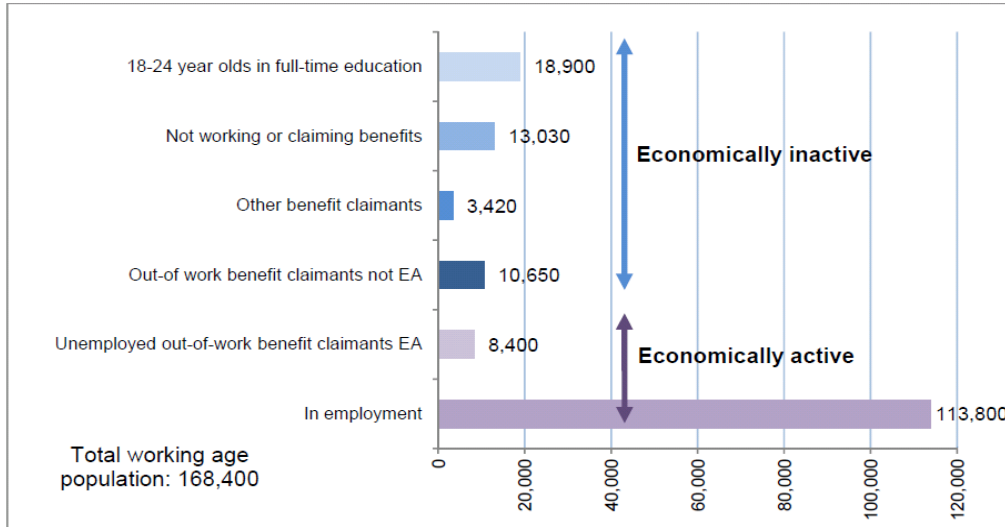
Too often, ill health leads to people falling out of work altogether at great cost to individuals, their families and society. Yet many causes of absence and inactivity due to ill health are relatively mild conditions that are compatible with work – indeed, could often be improved by work and are generally good for both physical and mental health and wellbeing. Evidence shows that work should be 'good work' and that its beneficial effects outweigh the risks and are much greater than the harmful effects of long term worklessness or prolonged sickness absence<sup>5</sup>. In a recent report (2011)<sup>6</sup>, it has been estimated that every year 140 million working days are lost to sickness absence. Although much of that results in a swift return to work, for a significant number of absences, they last longer than they need to with over 300,000 people falling out of work and onto health-related state benefits. The costs of sickness absence are borne by the employers, individuals and the State. The annual costs to employers, of sick pay and associated expenditure, are estimated to be in the region of £9 billion and a further £13 billion to the State for health-related benefits.

### Local situation

In February 2012 there was a total of 19,550 people claiming key out-of-work benefits in the city, 11.5% of the working age population<sup>7</sup>. This compares with a rate of 8.8% for the South East region. In March 2012 the employment rate in Southampton was 69.3% which compares with a South East average of 74.6% and an England average of 70.3%. Added to that, in 2011 the average weekly gross earnings for a full-time employee in Southampton were estimated at £466. This compares poorly to Portsmouth and the England average, where the average earnings were £470 and £508 respectively. Between 2008 and 2012 the number of people claiming Job Seekers Allowance in the city rose from 3,286 to 6,145; this was in line with the national increase in claimants resulting from the economic recession.

A report published in December 2011<sup>8</sup> looked at the findings of an analysis of the workless population of eight selected neighbourhoods (defined as Lower Super Output Areas) within Southampton with a high incidence of working age benefits claimants; the diagram below details the key findings. Overall, 73% of the Southampton population are economically active. Of the 27% who are economically inactive (i.e. not 'actively' looking for work); the largest groups are students, people looking after home/family and those who are long term sick. Around 6% are economically inactive out-of-work benefit claimants; claiming Incapacity Benefits/ Employment and Support Allowance and Income Support. The residual 2% are likely to be claiming other benefits such as Carers Allowance, Disability Living Allowance or a bereavement allowance.

## Economically active and inactive working age population within Southampton

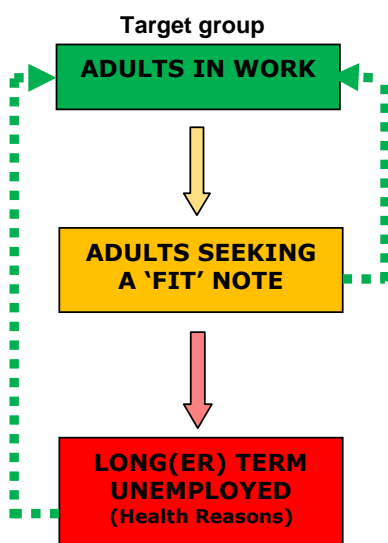


Source: APS April 2009 to March 2010; DWP Longitudinal Study (WPLS) average May 2010 to Feb 2011

### Local project

Southampton has made a clear statement that it sees improving its economic wellbeing as an important priority for the city, bringing with it a number of benefits<sup>9</sup>. The city has a long history of initiatives and activities delivered over a number of years and by a range of partners to try and improve workplace health and wellbeing and to reduce worklessness and its impact. This project aims to build on this experience to date and to co-ordinate and align activities across a range of partners and stakeholders to address three key elements as detailed in the diagram below, in order to reduce overall sickness absence and increase employability.

### Workplace Wellbeing Project Outline Framework



Aim	Who will we work with?	What will we do?
To keep people healthy and in (good) work	Employers from private, public and third sector	Primarily by developing and implementing the national Workplace Wellbeing Charter
To intervene early + get people back into work sooner	Primary Care, Occupational Health Depts	This will look primarily at the use of the 'fit' note by primary care and occupational health colleagues
To get people job ready (with long term aim of getting people back into work)	Primary Care, Occupational Health Depts, Job Centre Plus incl. those contracted by them to delivery related services	This will involve looking at how to get those who have been off sick for quite some time due to health reasons, more job ready

The main aim of the project will be to use the national Workplace Wellbeing Charter<sup>10</sup> to engage with a number of organisations where the employee demographic represents those at increased risk of poor health outcomes, with the aim of keeping people healthy and in work whilst also helping to address health inequalities. The project will also work with primary care colleagues and occupational health departments to better understand the current system of using 'Fit' notes and to see how this can be improved so that individuals are helped back into work sooner. The project will also look at how it can support the work of a range of partners in getting people who have been off work for a long time due to health reasons, more job ready.

### **Recommendations**

Key recommendations are that the work will:

- Raise awareness, across the City, of the importance and impact of health on employment and employees – both in terms of sickness absence and in getting back into work or readiness for work
- Engage a range of employers to measurably improve the health of their workforce
- Share good practice and learning between those within the pilot, and wider, in order to engage others over subsequent years
- Ensure a sustainable approach is developed so that a workplace and workforce wellbeing programme for the city can be continued beyond October 2013

## Case Study 2: Transport and Health

### Why is this issue important?

Transport is one of the wider determinants of health and can impact health in the following ways.<sup>11</sup>

Physical activity reduces the risk of death from any cause and reduces the risk of developing chronic disease such as coronary heart disease, stroke, type 2 diabetes and cancer as well as helping to control weight. It may also have positive effects on mental health and wellbeing.

Rates of road casualties (killed or injured) have been consistently falling over the past 50 years in most industrialised countries. Rates of road casualties vary by mode of transport:

- Bicycle: 534 killed per billion miles travelled
- Walking: 443 killed per billion miles travelled
- Car: 27 killed per billion miles travelled
- Public transport: 10 (bus/coach) killed per billion miles travelled

Evidence from other countries which have experienced a modal shift in cycling have also noted reductions in casualties in cyclists due the effect of “critical mass”.

Traffic contributes to outdoor air pollution. Both short- and long-term exposure to ambient particulate matter (PM) increases the risks of death and disease from cardiorespiratory causes. In Britain, long-term exposure to transport-related air pollution, measured as PM<sub>2.5</sub>, is estimated to reduce life expectancy by a few months, an effect similar to the estimated effect of passive smoking. Around 30% of PM<sub>2.5</sub> particles are due to road transport.

The global climate is changing and most of this change is attributable to human activity since the pre-industrial era, with motorised transport accounting for 22% of CO<sub>2</sub> emissions. Climate change will lead to more extremes of weather, such as heat waves and flooding. Global health impacts due to climate change include injuries, morbidity due to infectious diseases, malnutrition due to crop failure, and illness or death due to displacement.

### Local situation

#### Accidents

The Health Profile for Southampton 2012 shows a rate of road injuries and deaths<sup>12</sup> of 44.8 per 100,000 population which is the same as the national average based on 2008-10 data. The local rate of children age 0-15 years who were killed or seriously injured in road traffic accidents<sup>13</sup>, 28.8 per 100,000 population, is slightly above average but not significantly different to the England average of 23.6. More detailed injury profile data for Southampton<sup>14</sup>, shows that there are some areas of concern

with significantly higher than the national average rates of pedestrian casualties, and also children under age 16 who are injured on the road.

### Physical activity

Sport England has conducted an annual Active People Survey for the past six years.<sup>15</sup> 38.7% of adults in the city were physically active in 2005/06 compared with 42% in 2011/12, a rise which is not statistically significant. (Note that their definition of physical activity is adult participation in at least 4 sessions of at least moderate intensity activity for at least 30 minutes in the previous 28 days, which is well below the NHS recommended levels.)

### Travel attitudes

In a Travel Attitudes Survey conducted in Southampton in 2011, 42% of residents stated that lack of confidence on the roads is the reason they do not cycle more and only 34% agreed that there was adequate provision for cyclists in the area.

Most (76%) felt driving was more convenient than public transport but 69% acknowledged that there are lots of bus routes close to them. Just over half (54%) of respondents felt that the benefits of walking and cycling outweighed the benefits of using the car although 79% felt walking and cycling helped them to relax and feel less stressed. Over half (52%) admitted driving short journeys where they could walk or cycle.

### Air Quality

The Environment Act 1995 introduced a system of local air quality management (LAQM). Since then local authorities have had to periodically review and assess the current and likely future air quality in their areas against national air quality objectives for seven air pollutants. Where any objective is unlikely to be met by the relevant deadline, local authorities must designate those areas as air quality management areas (AQMAS) and take action. Southampton City Council has been monitoring the air quality in the city for many years.<sup>16</sup> There are five fixed monitoring units and over 50 nitrogen dioxide diffusion tubes distributed over the city. In general air quality in Southampton is good because of its coastal location; however, there are hot spots due to heavy traffic. Currently there are 8 AQMA's in the Southampton. These are on Romsey Road, Bitterne Road, Winchester Road, Town Quay, Redbridge Road, Bevois Valley, Winchester Road, Millbrook Road and Commercial Road.

Southampton City Council also offers a free Air Alert service. This provides a personal text message, e-mail or voicemail message to warn people 12 hours before a predicted pollution episode. This allows an individual with a heart or lung condition to change their plans for physical activity or modify their medication dose.

### **Local strategy**

The three Local Transport Authorities of Hampshire County Council, Portsmouth City Council and Southampton City Council have created a South Hampshire Joint

Strategy. The Local Transport Plan 3 contains the strategy and implementation plan for Southampton.<sup>17</sup> There are fourteen core strands within this strategy:

1. Develop transport improvements that support sustainable economic growth and development within South Hampshire
2. Work with the Highways Agency, Network Rail, Ports and Airports to ensure reliable access to and from South Hampshire's three international gateways for people and freight
3. To optimise the capacity of the highway network and improve journey time reliability for all modes
4. To achieve and sustain a high-quality, resilient and well-maintained highway network
5. To deliver improvements in air quality
6. To develop strategic sub-regional approaches to management of parking to support sustainable travel and promote economic development
7. To improve road safety across the sub-region
8. To promote active travel modes and develop supporting infrastructure
9. To encourage private investment in bus, taxi and community transport solutions, and where practical, better infrastructure and services
10. To further develop the role of water-borne transport within the Transport for South Hampshire (TfSH) area and across the Solent
11. To work with rail operators to deliver improvements to station facilities and, where practical, better infrastructure and services for people and freight
12. To work with Local Planning Authorities to integrate planning and transport
13. To develop and deliver high-quality public realm improvements
14. To safeguard and enable the future delivery of transport improvements within the TfSH area

In addition to the core LTP3 strategy Southampton City Council has received a central grant from the Local Sustainable Transport Fund (LSTF), which the government launched in 2010. The core aim of the LSTF strategy is to support modal shift and the fund is being used to support a wide range of initiatives. Some examples of the projects currently underway include:-

- My journey website. [www.myjourneysouthampton.com](http://www.myjourneysouthampton.com)

This is a travel planner for Southampton residents with the additional benefit of promoting physical activity and active travel. A journey planning tool is being launched in April 2013 and will provide users with a range of sustainable and active ways to reach their destination, as well as estimating the calories they might expect to burn if using the active transport options. It also contains up to date information on how to access cycle training for adults and children, led walks, led cycle rides, car sharing and other activities. Travel packages are also on offer for businesses and schools. It also has live traffic and travel information



- Job Centre Plus Back to Work scheme. This project focuses on the 18-24 age group and it aims to provide Solent travel cards for to three months for free



to those where the cost of transport is a barrier to finding or starting employment. As of 1<sup>st</sup> March 2013 305 young people have benefitted from this scheme in Southampton

- Sustrans walking and cycling projects including a new health walk in addition to the six existing walks they run in the city. Also, Bike Doctor sessions have been held in the city, which allow people to learn about bicycle maintenance as well as get their bike repaired. There are also cycle training classes for all ages throughout the city
- Independent travel training and sustainable travel activities for pupils with special educational needs and others reliant on local authority transport. There are six travel initiatives. In one of these a review of all taxis for home to school travel for looked after children was carried out. This led to the development of a transport audit form which is conducted when the child becomes a looked after child and at the beginning of each term, to ensure that their journey to school is being made in a way that supports the sustainability and skills development of the young person. This has led to 23 children travelling more sustainability and independently

### **Recommendations**

- Evaluate projects which aim to increase physical activity to assess potential for expansion
- Conduct focus groups with risk groups (e.g. those with cardiovascular disease or risk factors) and young people to establish their preferences for physical activity
- Identify and work with partners to develop local exercise initiatives
- Promote the Air Alert system to those with cardiorespiratory diseases, to enable them to proactively self manage their conditions
- Support projects that increase coverage of cycle lanes and aim to increase the confidence and competence of people who may want to cycle

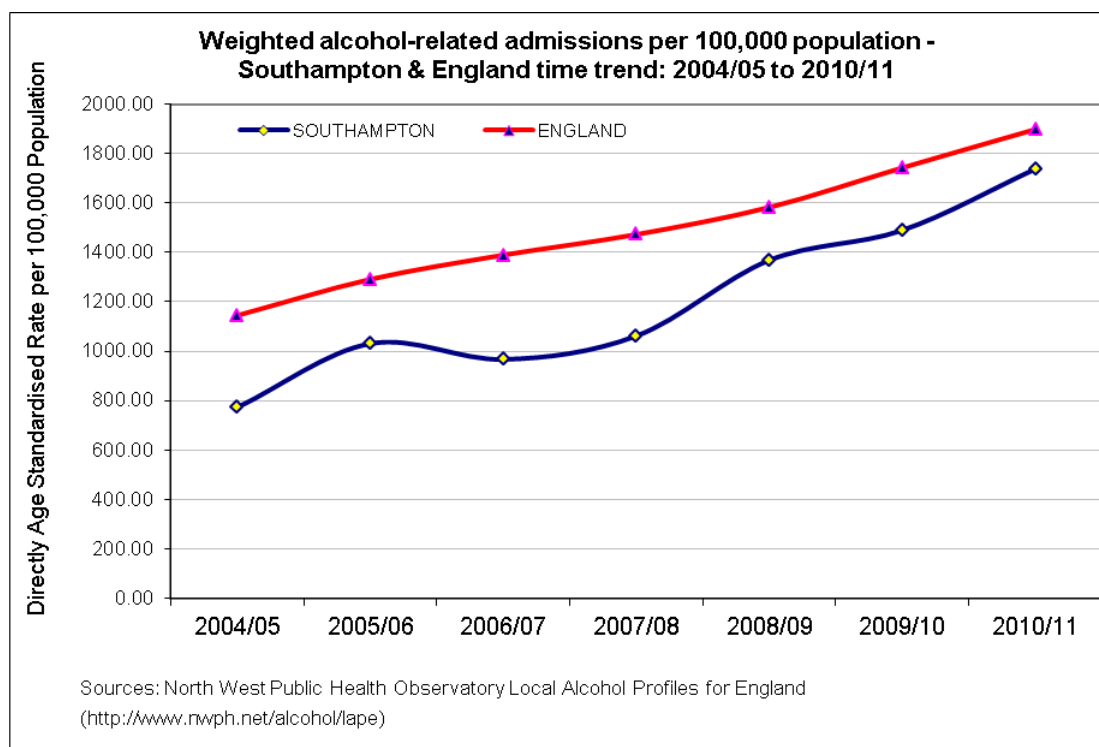
## Domain 2: Health Lifestyles

This domain focuses on actions to help people make healthy choices and lead healthy lifestyles. Following a life course approach, this includes actions from conception (such as smoking in pregnancy and breastfeeding) through childhood (preventing excess weight), adulthood (participation in sport) and into old age (reducing falls).

One of our case studies looks at a new initiative being developed in the city called 'LifeLab' whilst the other explains the work that is going on to develop NHS Health Checks in Southampton.

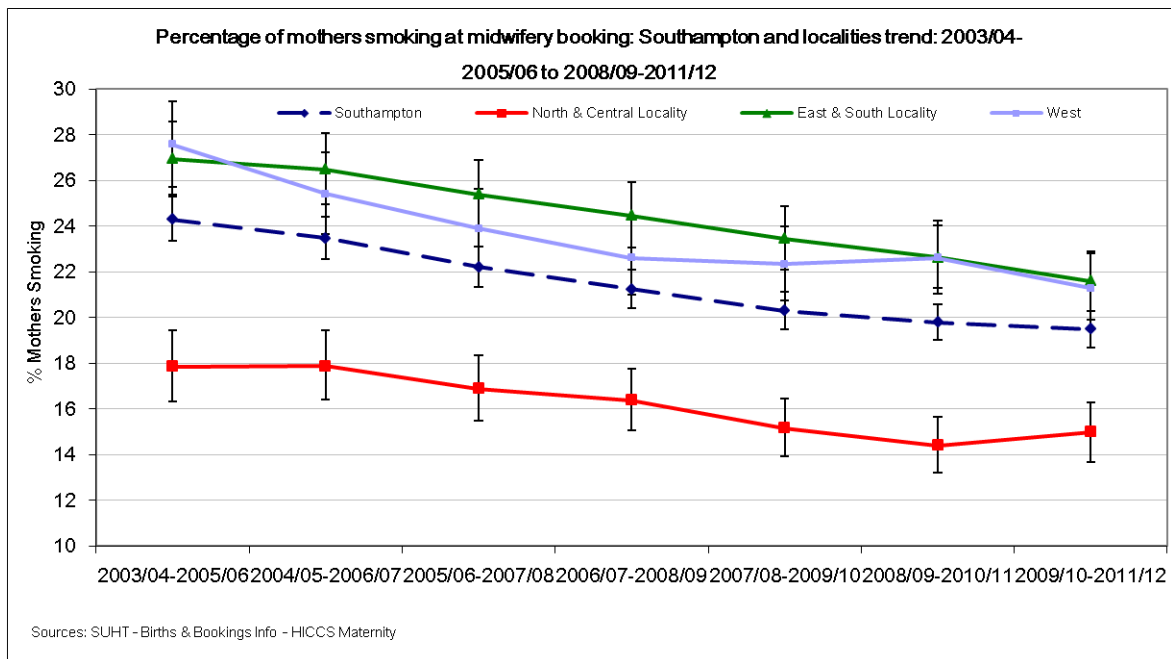
Improvements in these indicators will, in the main, be led locally through health improvement programmes commissioned by local authorities. However, for some, the core role for the delivery of related services might lie with the NHS. For example, the NHS will have responsibility for the delivery of screening services according to specifications set by Public Health England.

Our local JSNA covers this domain in its themes of 'Taking responsibility for health' and 'Improving Early Years Experience'. For instance, indicators around lifestyles show how alcohol-related hospital admissions in the city are rising in line with the national trend.



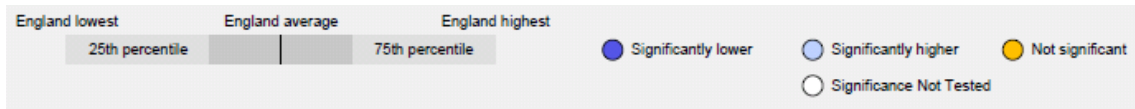
Children must be given the best start in life and this domain of the PHOF measures key outcomes to support this aim. The chart below shows how smoking in pregnancy (measured at midwifery booking) has fallen in the city. However

Southampton rates are still significantly worse than the national average (in Q3 2012/13 15.6% of mothers were smoking at time of delivery locally compared with England average of 12.6%).



The PHOF indicators for this domain are summarised in the spine chart below with Southampton’s performance shown against the national average. Some of the early years indicators and cancer screening rates stand out as an issue for the city compared with the national average. The ‘tartan rug’ in Appendix 2 shows that Southampton is about average compared to its most similar authorities for many of the indicators in this domain.

Health improvement	Local value	Eng. value	Eng. lowest	Range	Eng. highest
2.01 Low birth weight of term babies	3.2	2.8	1.8		7.8
2.02i Breastfeeding - Breastfeeding initiation	74.6	73.7	38.4		92.9
2.02ii Breastfeeding - Breastfeeding prevalence at 6-8 weeks after birth	42.9	46.0	19.2		83.1
2.03 Smoking status at time of delivery	16.6	13.2	2.9		29.7
2.04 Under 18 conceptions	49.2	35.4	6.2		64.7
2.06i Excess weight in 4-5 and 10-11 year olds - 4-5 year olds	23.7	22.6	14.9		28.5
2.06ii Excess weight in 4-5 and 10-11 year olds - 10-11 year olds	31.9	33.4	24.6		41.9
2.08 Emotional well-being of looked after children	22.8	13.9	10.1		22.8
2.14 Smoking prevalence - adults (over 18s)	22.6	20.0	13.2		29.3
2.15 Successful completion of drug treatment	11.3	12.3	5.1		33.6
2.17 Recorded diabetes	4.9	5.5	3.4		7.7
2.20i Cancer screening coverage - Breast cancer	70.8	76.9	59.4		85.1
2.20ii Cancer screening coverage - Cervical cancer	72.9	75.3	60.3		81.4
2.21vii Access to non-cancer screening programmes - Diabetic retinopathy	70.6	79.2	20.2		97.0
2.22i Take up of NHS Health Check Programme by those eligible - Health check offered	14.6	13.9	0.0		91.1
2.22ii Take up of NHS Health Check programme by those eligible - Health check take up	69.5	51.6	8.6		100.0
2.23i Self-reported well-being - people with low satisfaction score	24.4	24.3	14.6		30.5
2.23ii Self-reported well-being - people with a low worthwhile score	22.6	20.1	12.8		25.4
2.23iii Self-reported well-being - people with a low happiness score	29.5	29.0	19.2		36.6
2.23iv Self-reported well-being - people with a high anxiety score	38.0	40.1	34.4		48.3
2.24i Injuries due to falls in people aged 65 and over (persons)	1,900	1,642	923		3,127
2.24i Injuries due to falls in people aged 65 and over (males)	1,414	1,269	610		2,647
2.24i Injuries due to falls in people aged 65 and over (females)	2,386	2,014	1,237		3,694
2.24ii Injuries due to falls in people aged 65 and over - Aged 65-79	1,238	959	487		1,822
2.24iii Injuries due to falls in people aged 65 and over - Aged 80+	4,877	4,711	2,831		9,097



Source: <http://www.phoutcomes.info/>

## Case Study 3: LifeLab

### Why is this issue important?

One of the underlying principles of Southampton's Joint Health and Wellbeing Strategy is the need to adopt a life course or 'cradle to grave' approach to improving health and reducing health inequalities. It is well established that exposures and behaviours early in life are important in determining health outcomes throughout later life. For example, poor diet in childhood can increase the risk of cardiovascular disease, diabetes and osteoporosis in adulthood. However, there are also consequences of exposures in childhood and adolescence for the next generation. For example, the Southampton Women's Survey, led by the Medical Research Council's Lifecourse Epidemiology Unit, found that dietary quality in women before pregnancy is strongly associated with their educational attainment, but hardly changes through pregnancy and influences the diet and lifelong health of the child<sup>18,19,20,21,22,23</sup>. The household diet is strongly influenced by the father too, thus affecting the child<sup>24</sup>.

### Local Project

There are clear opportunities for organisations working with young people in Southampton to take an overview across the life course and promote not only the importance of an individual's behaviour on their own health but also the effect on their future generations. LifeLab<sup>25</sup>

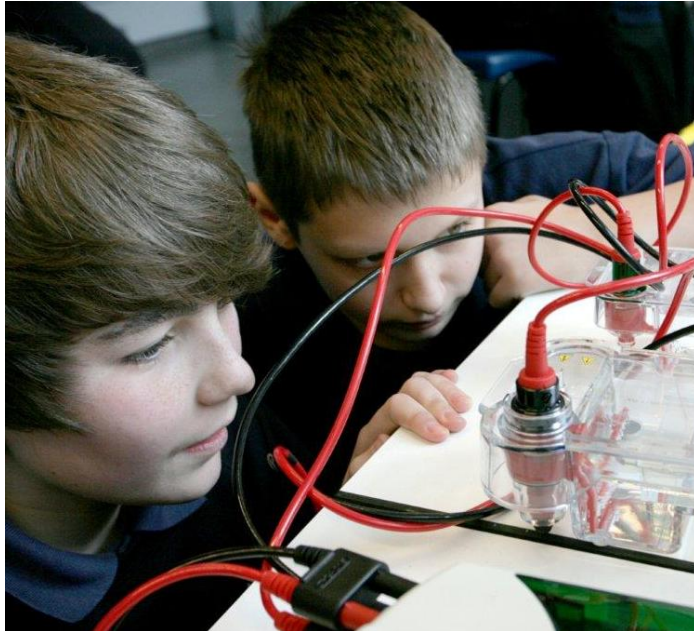


is an innovative educational programme developed in Southampton which takes a life course approach to health improvement, through promoting the health of young people and enabling them to understand the impact that their current health may have on children they have in the future. The programme is targeted at 11-16 year olds and offers them the opportunity to visit a research laboratory at the Southampton General Hospital site, participate in practical activities and meet with researchers working in a range of scientific disciplines. LifeLab has also developed educational materials which are designed to complement and enhance teaching that already takes place in the school environment.

The aims of the LifeLab programme are to enable students to:

- Experience for themselves some of the latest exciting developments in science with a focus on understanding how early lives have effects on later health

- Learn about how they can improve their own health and the health of their future children under a framework of 'Me, my health and my children's health'
- Become enthusiastic about science so that they consider further study and careers in scientific disciplines



Since the launch of LifeLab in 2008, over 300 students from schools across Southampton have taken part in the programme. Results from pilot studies have indicated that six months after visiting LifeLab, students had a significantly greater understanding of the impact of health behaviours in early life on their future health, compared with peers who did not attend LifeLab<sup>26</sup>. In addition, the LifeLab students were significantly more likely to consider pursuing science and healthcare subjects after their GCSEs, compared to their peers.

A new, purpose-built LifeLab is due to open in the Southampton Centre for Biomedical Research on the site of Southampton General Hospital in 2013. This will provide a permanent base for the programme, and enable further expansion and evaluation, and allow every child in Southampton to experience LifeLab during their time at school. A formal evaluation of LifeLab is planned, which will aim to recruit schools from across Southampton and neighbouring areas to participate in the project. The LifeLab students will be followed up to measure diet and physical activity outcomes as well as their attitudes and beliefs around health, in comparison to students who did not participate.

### **Recommendations**

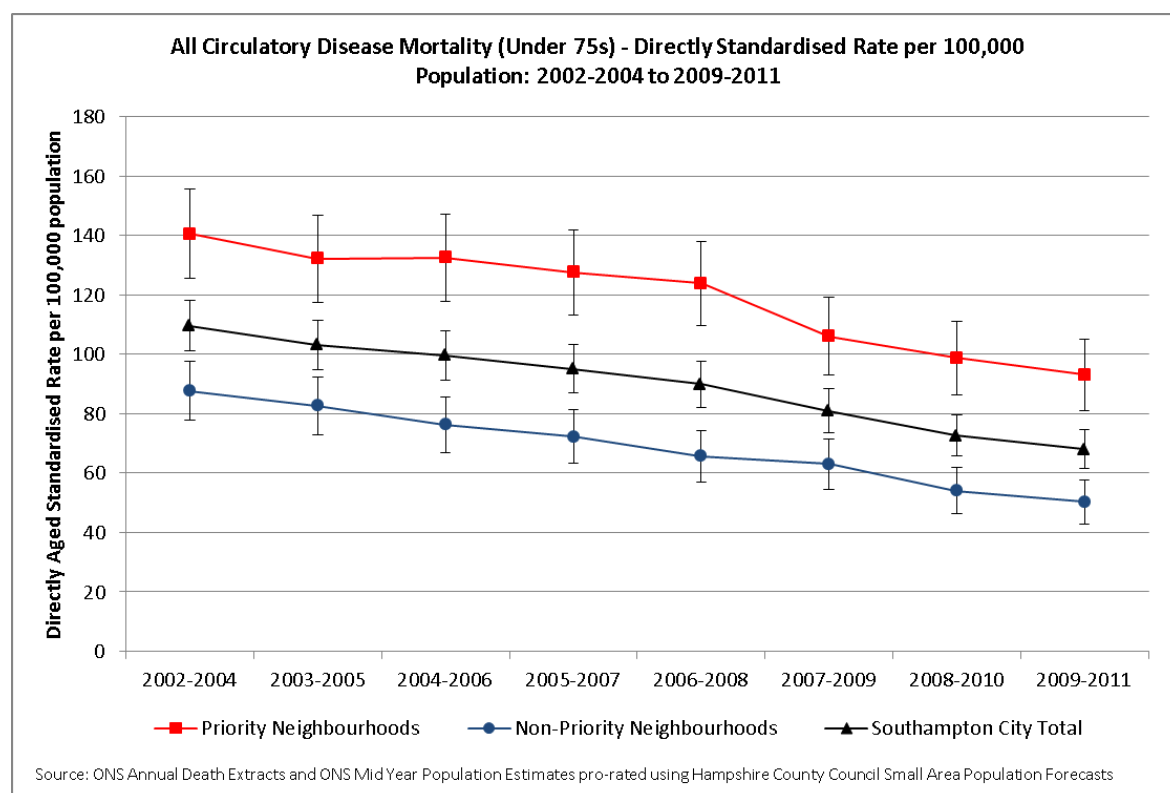
- Partners should support schools across the city to participate in LifeLab
- Organisations working with young people should integrate life course principles into existing public health interventions, and promote the life-long importance of health behaviours at a young age

## Case Study 4: NHS Health Checks

### Why is this issue important?

The NHS Health Checks programme aims to screen all of the population aged 40-74 years every five years for cardiovascular disease. Vascular conditions include coronary heart disease, stroke, chronic kidney disease and type 2 diabetes.

Along with the rest of the country, premature death rates (deaths in under 75s) caused by coronary heart disease and circulatory disease are improving. However, there continues to be a higher burden of disease and premature death among those from the most deprived communities. The chart below illustrates the trend in premature deaths for circulatory disease in the city's most deprived areas<sup>27</sup> compared with the rest of the city. These data indicate that deaths from cardiovascular disease represent a key health inequalities issue for the City.



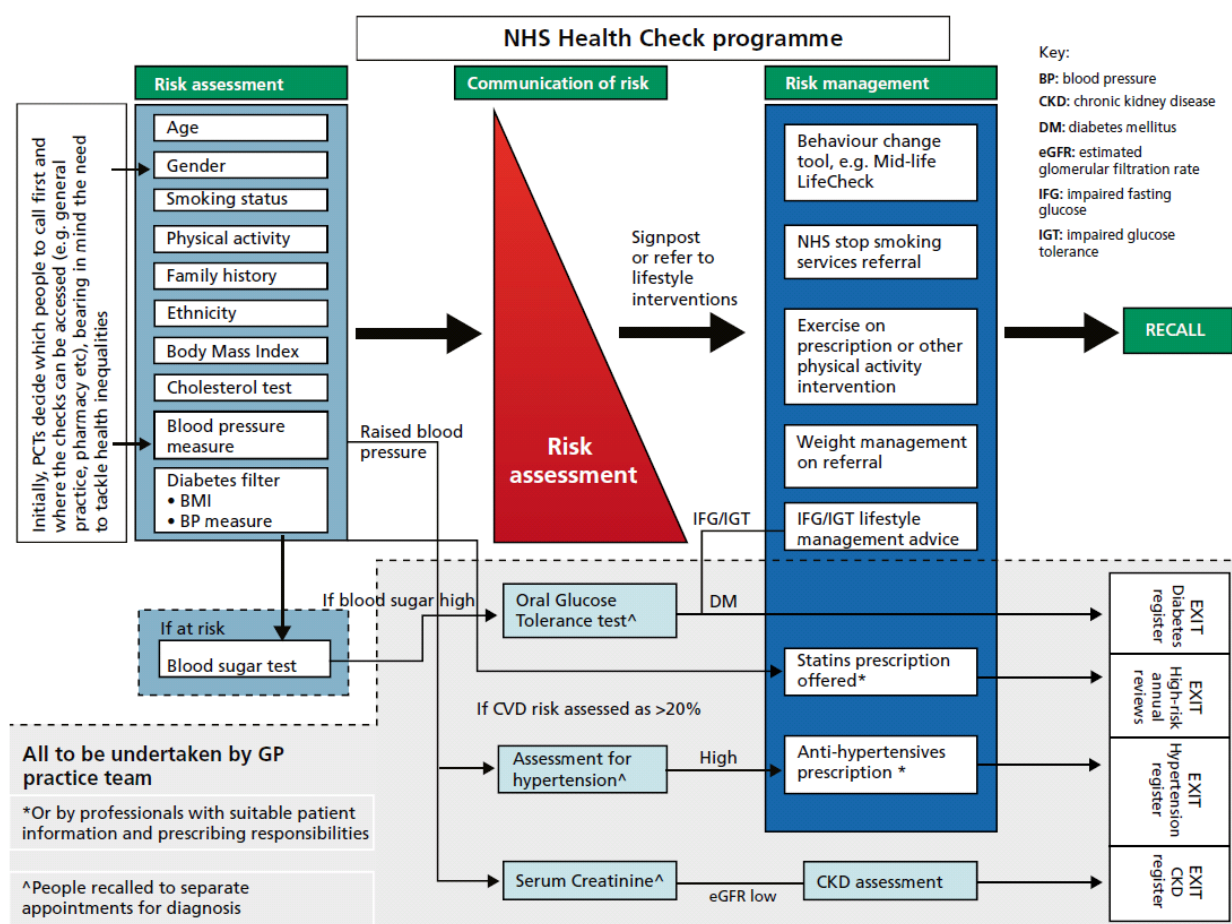
Systematic implementation of the national NHS Health Checks programme will support earlier detection and intervention to reduce risks, disease and premature deaths in the City.

### Local Project

In Southampton there has been a strong history of implementing a coronary heart disease risk assessment programme through GPs in general practice in advance of the launch of the national NHS Health Checks programme. This has formed the basis for developing the local Health Checks programme. Further development and enhancement of the programme is currently underway. This will support the

establishment of a centralised call and recall programme for the five-yearly check. It will also ensure compliance with the national quality standards and the data collection guidelines. The diagram below outlines the nationally defined pathway for the programme. Further national guidance is also awaited to support the integration of alcohol and dementia as two further risk areas within the health check.

### National NHS Health Check Pathway<sup>28</sup>



The performance of the Southampton NHS Health Checks programme is detailed below:-

Month	Year	Eligible Population (over 5 year period)	Eligible Population (for 1 year cycle of programme)	Total Offered	Total Received	Uptake (no. received as a percentage of the eligible population in 1 year)
June	2011	58,321	11,664	3,013	1,891	16.2
September	2011	58,321	11,664	2,616	1,622	13.9
December	2011	58,321	11,664	2,299	1,173	10.1
March	2012	58,321	11,664	583	1,233	10.6
June	2012	55,020	11,004	1,823	1,276	11.6
September	2012	55,020	11,004	2,074	1,452	13.2



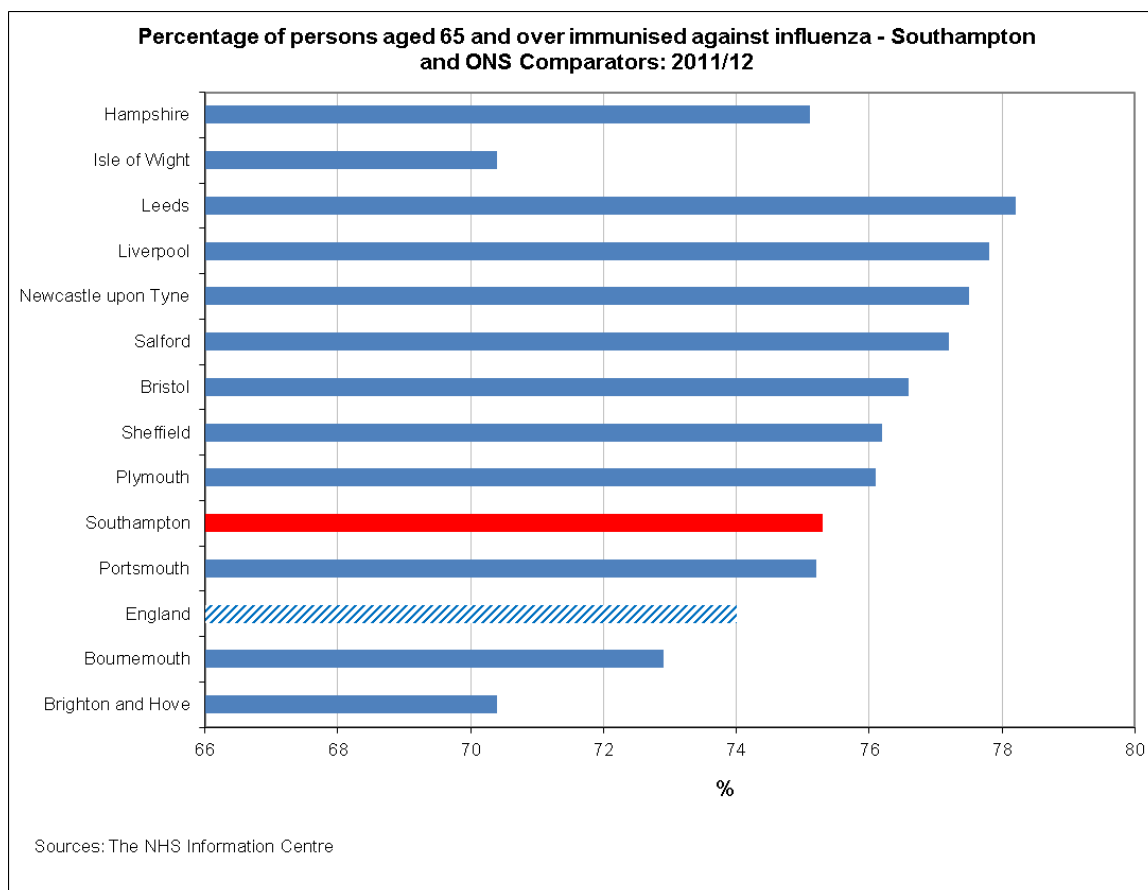
## **Recommendations**

- Review, update and relaunch the local NHS Health Checks programme early 2013 and sustain delivery model through GP practices
- Strengthen the process for referral and support provided through local health improvement services to ensure community based support is available and accessible to those screened and identified as needing behaviour change or lifestyle modification support
- Embed national quality and data collection requirements into the revised NHS Health Checks agreement with GP practices and implement robust review and monitoring against the key performance indicators to support programme monitoring from 2013/14 onwards
- Enhance support to clinicians through a local network and a dynamic website to ensure up-to-date national and local guidance and information is available to all

### Domain 3: Protection from Health Threats

This domain focuses on those essential actions to be taken to protect the public’s health. The overall objective is the protection of the population’s health ‘from major incidents and other threats, while reducing health inequalities’. Public Health England will have a core role to play in delivering improvements in these indicators; this will be in support of the NHS and local authorities’ responsibility in health protection locally.

The Southampton JSNA also has a theme dedicated to ‘Protecting people from threats to health’ where information on infections, vaccinations and Port Health is available. For instance, in 2011/12 75.3% of Southampton residents aged over 65 years were given influenza vaccine compared to a national rate of 74.0%.

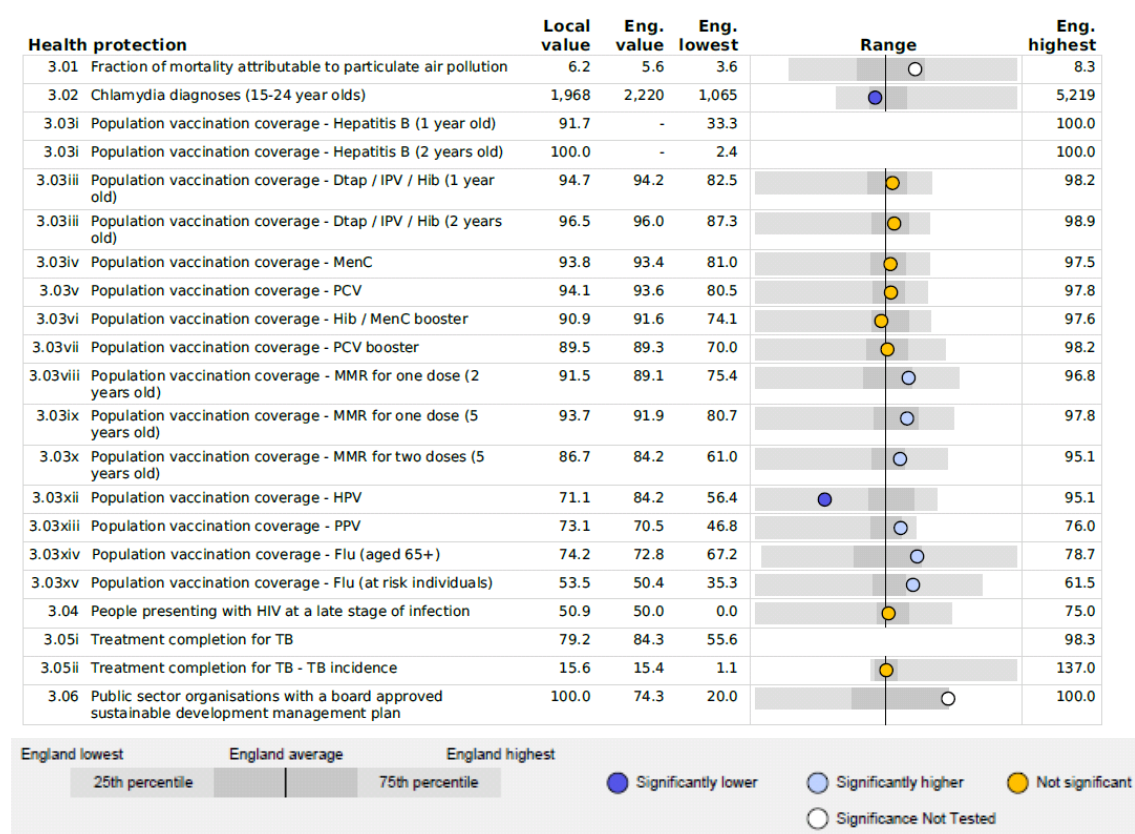


The spine chart below shows Southampton’s performance in this domain of the PHOF. For population vaccination coverage the city is similar to or above the national average apart from for human papilloma virus (HPV).

HPV is a common sexually transmitted infection that can cause genital warts and cervical cancer. In 2008/9 academic year a new national HPV vaccination was made available to all girls in the Year 8 cohort. A course of three vaccinations is given in Southampton schools and a catch up programme offered initially to young women

up to 18 years. The number of girls completing the course of three vaccinations has varied from 78.7% to 94.4%. In 2011/12 this figure was 89.2% and every encouragement is made to increase this to over 95% completion rate. For the 2012/13 academic year the vaccine was changed from Cervarix to Gardasil vaccine and besides offering protection for the high risk strains of the HPV viruses that cause 70% of cervical cancers, Gardasil also offers protection against genital herpes (warts).

Southampton scores more poorly than average on the fraction of mortality attributable to particulate air pollution but it should be noted that this is a modelled estimate.



Source: <http://www.phoutcomes.info/>

Appendix 2 shows that compared to its most similar authorities, Southampton rates about average for many indicators. Notably though the city performs more poorly for tuberculosis (TB) incidence and treatment completion and this is the subject of the first case study in this chapter. The second case study focuses on Port Health.

## Case Study 5: Tuberculosis

### Why is this issue important?

Before antibiotics were introduced, TB was a major health problem in England. Nowadays, the condition is much less common. However, in the last 20 years TB cases have gradually increased, particularly among ethnic minority communities originally from places where TB is widespread.<sup>29</sup>

Globally, TB remains a major public health problem; it is the leading cause of death among curable infectious disease worldwide. There were 9.4 million new cases of TB in 2009, and 1.7 million deaths from the condition. Countries with high numbers of HIV cases also often have high numbers of TB cases. This is because HIV weakens a person's immune system, which means they are more likely to develop a TB infection.

It is also estimated that one-third of the world's population is infected with latent TB; this is where the immune system cannot kill the bacteria, but manages to prevent it from spreading so there are no symptoms but the bacteria does remain in the body. Up to 1 in 10 of people with a latent TB infection (but who do not have HIV) will develop active TB at some point.

In the UK in 2010, a total of 8,483 TB cases were reported, a rate of 13.6 cases per 100,000 population. In the same year, 73% of cases were in people born outside the UK.

In humans tuberculosis (TB) is caused by the *Mycobacterium tuberculosis* complex (which includes *M. tuberculosis*, *M. bovis* and *M. Africanum*). Infection is spread by droplets expelled through coughing, talking or smoking in close proximity. Around two thirds of UK cases are pulmonary, but bacteria can pass through the bloodstream to infect any part of the body.

All forms of TB are notifiable in England and Wales. Enhanced Tuberculosis Surveillance (ETS), managed by the Health Protection Agency (HPA), and gathered by local TB services provides detailed information on the disease and demography of sufferers.

### Local situation

Following a recent recommendation from NICE on *Identifying and Managing Tuberculosis among hard-to-reach groups*<sup>30</sup> that annual local needs assessments be conducted, a comprehensive needs assessment was carried out in Southampton.

This can be accessed in full at

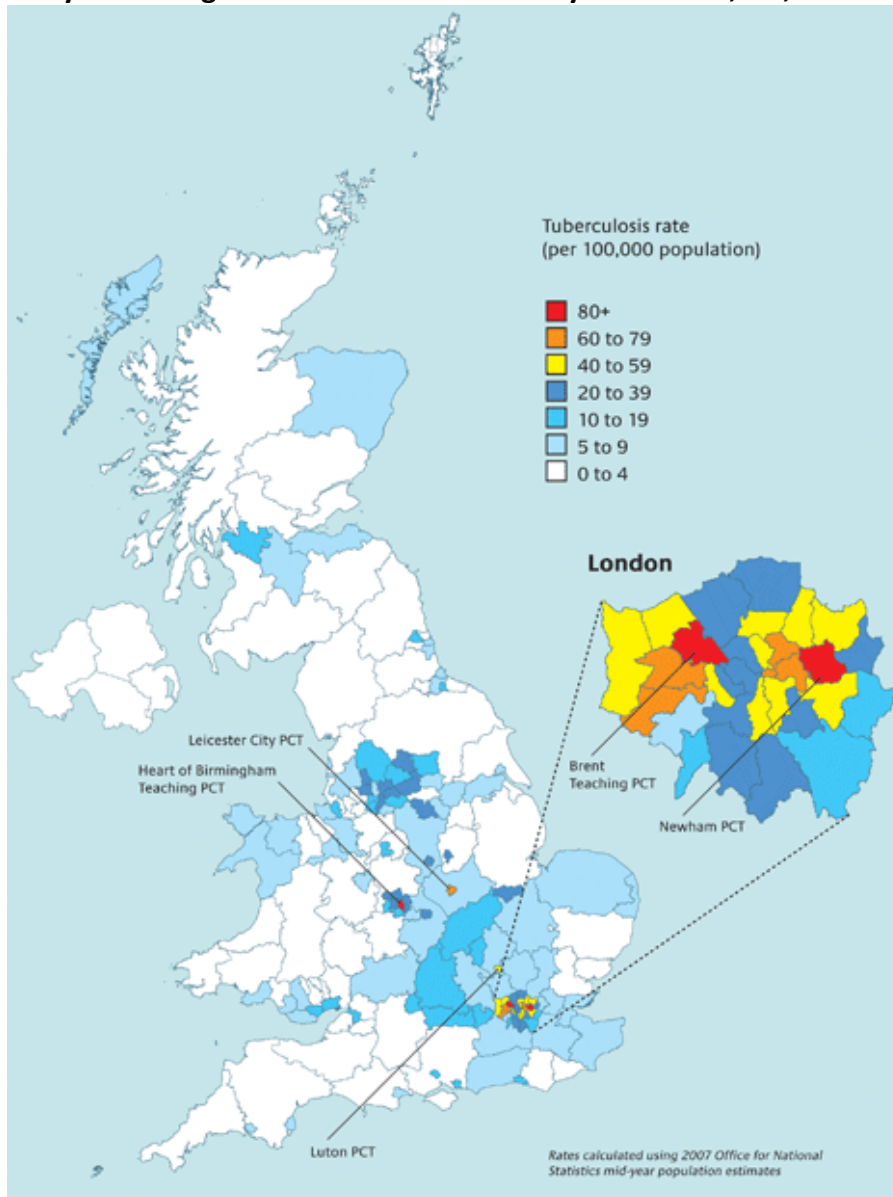
[www.southamptonhealth.nhs.uk/aboutus/publichealth/hi/briefings/](http://www.southamptonhealth.nhs.uk/aboutus/publichealth/hi/briefings/)

This summarised the local TB situation:

“Cases of TB in Southampton are rising. In 2010, the rate per 100,000 population of new TB notifications in Southampton was 12.1, under the national average. This figure rose to 23.4 per 100,000 in 2011, largely due to the existence of a large and growing cluster of cases. In 2011, there were 51 cases resident in Southampton recorded onto the Enhanced TB Surveillance system. In 2009, the majority of cases in Southampton had entered the UK before 2004, indicating a latent period of infection.”

The outbreak is male dominated; cases are mainly under 25 years of age (six are children) and cases are predominately of Black African ethnicity. A number of social links have been identified.

### Three-year average tuberculosis case rates by local areas, UK, 2009-2011



Sources: Health Protection Agency Enhanced Tuberculosis Surveillance and Office for National Statistics mid-year population estimates

Notes: Data as at July 2012 see

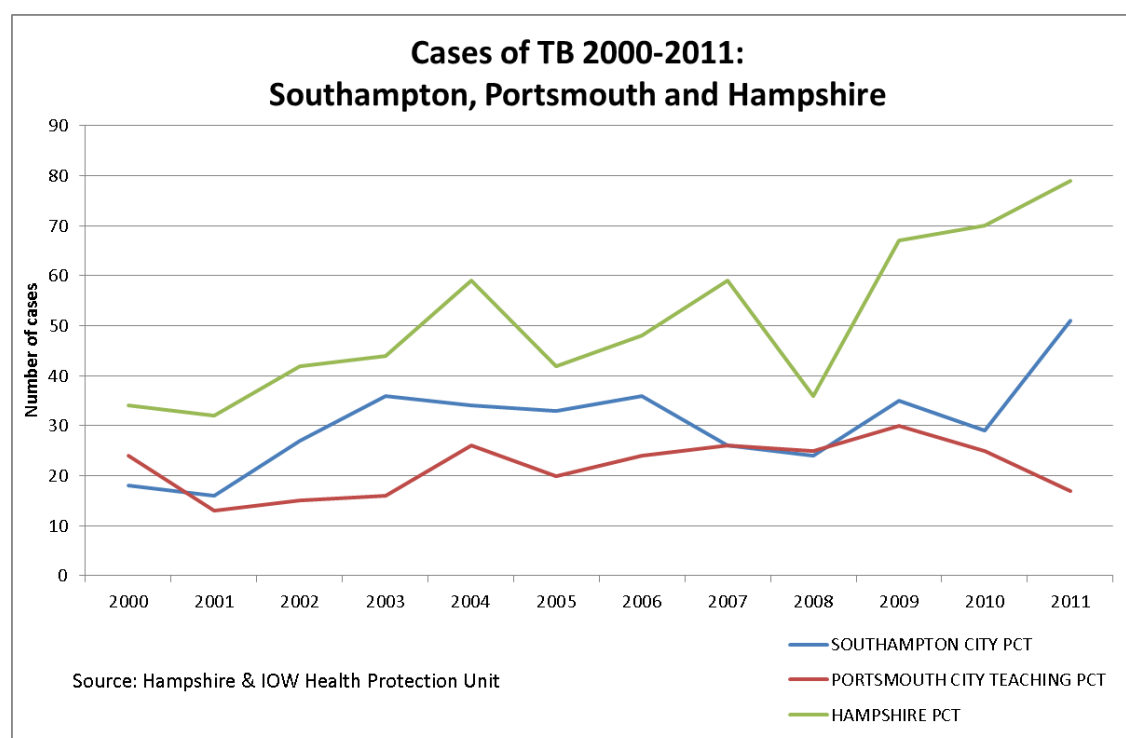
[http://www.hpa.org.uk/webw/HPAweb&HPAwebStandard/HPAweb\\_C/1287147469741](http://www.hpa.org.uk/webw/HPAweb&HPAwebStandard/HPAweb_C/1287147469741)

## Local services

Local TB services have the aim of controlling TB by reducing the number of TB cases and reducing onward transmission of the disease. The key objectives of the service are to:

- Identify and treat cases through clinical identification and case finding among the local at risk population
- Chemoprophylaxis (preventive drugs) for those at risk
- Offer selective immunisation with BCG vaccine for high risk individuals

The TB service is currently meeting most national and local targets for service delivery, despite the greatly increased work load in the past year.



Public health action is carried out working closely with the local HPA and City Council Environmental Health Service and aims to raise awareness and ensure early diagnosis including extended contact tracing and screening of close contacts. Contact investigations follow a so-called 'stone-in-the-pond' approach by which contacts at the highest risk are screened, and when evidence of transmission is established a further group of contacts are screened. GPs are alerted to any outbreak and local groups and institutions are provided with TB information.

In the event of an identified confirmed case that is not accepting treatment and determined to be a significant risk to human health, then the City Council's authorised officer can exercise the powers specified in the Public Health (Control of Diseases) Act 1984 and associated regulations to ensure appropriate treatment.

## **Recommendations**

- Health promotion campaigns should focus initially on increasing BCG take up among high risk families
- Consider revising the local child health information system so that BCG vaccination coverage can be recorded and utilised for epidemiological monitoring and service development. If this is not possible, regular reports from the TB service back to Child Health and midwifery staff at Princess Anne Hospital would serve the same purpose
- There is a need to reduce the stigma surrounding TB and to raise awareness particularly among black and minority ethnic groups in the city so that they come forward for screening
- Liaison with universities to promote TB awareness to students arriving from high risk countries in the autumn to encourage attendance for latent TB screening
- To meet good practice guidance, the TB service should implement its plans to repeat TB screening for all patients registered with Homeless Healthcare after three years

## Case Study 6: Port Health

### Why is this issue important?

International travel is undertaken by large and ever increasing numbers of people. More people travel greater distances and at greater speed than ever before, and this upward trend looks set to continue. Travellers are thus exposed to a variety of known and unknown health risks in an unfamiliar environment.

The crew of aircraft and ships, travellers, cargo and transported animals can also spread infectious diseases. The UK is the fourth largest food-importing nation in the world. Thousands of tonnes of imported food arrive daily and many millions of passengers pass through our ports and airports every year. Both passengers and food volumes are expected to increase in parallel with globalization and consequent international trade. In addition, food and people now travel over far greater distances than ever before, creating the conditions necessary for widespread and rapidly occurring outbreaks of disease. Infectious diseases such as cholera persist and return, and recent decades have shown an unprecedented rate of emergence of new zoonoses.

### Local Services

The Port of Southampton is the second largest container port in the UK handling around 1.5 million containers per year. The Border Inspection Post within the Port is approved by the Department for Environment, Food and Rural Affairs for the importation of Products of Animal Origin and is a Designated Point of Entry for high risk foods and the importation of other restricted imported food and feed materials. Inspections of these products occur on a daily basis which includes the sampling of food and feed to ensure their compliance with relevant food and feed law. There are over 70,000 commercial shipping movements annually and the City being the largest cruise liner port is the centre of the UK's cruise liner industry attracting over 1 million passengers each year.



Local Authorities and Port Health Authorities are responsible for the enforcement of infectious disease control. Port Health Authorities were constituted with the primary objective of preventing the introduction into the country of dangerous



epidemic diseases through shipping activity without creating unnecessary disruptions to world trade.

There are over 30 regular cruise liners using Southampton as their home port, requiring at least an annual inspection and six-monthly Ship Sanitation Certificate. The cruise liner business is growing rapidly with further growth expected, placing a significant additional demand on the service. The service which provides 24/7 cover works in partnership with the Health Protection Agency (soon to become Public Health England), to identify, investigate and control cases and outbreaks of infectious disease. The service protects public health by ensuring compliance with regulations and, when notification of an infectious agent is provided, by identifying the source of infection and taking action to prevent further spread of disease.

Local Authorities and Port Health Authorities are responsible for food standards and food safety checks on imported foods at points of entry. Import controls on food arriving into the UK are usually applied to countries outside the European Union. The types of checks depend upon the country of origin and the type of product. At often very short notice new sampling requirements in relation to various foods are imposed on the Port Health service by either the Food Standards Agency or DEFRA. These are usually due to Emergency Control Orders and/or European Union Requirements.

The Port Health Service is linked electronically to the Food Standards Agencies National Food Alert System and EU Rapid Alert System for Food and Feed (RASFF) which enable notification of any issue affecting products within the UK and EU. There are out of hours arrangements to deal with incidents requiring an immediate response.

### **Recommendations**

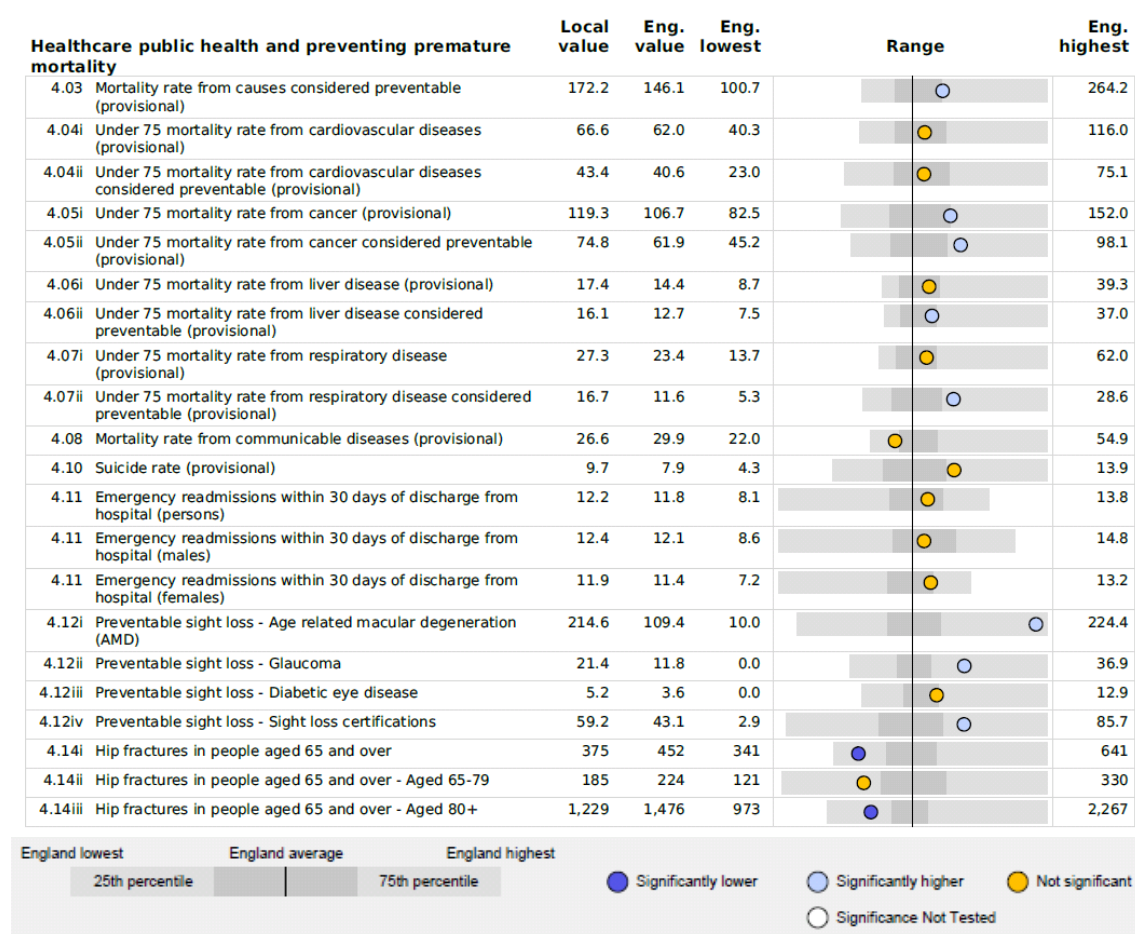
- Maintain the provision of the Border Inspection Post and Designated Point of Entry to enable the adequate control of foods entering into the EU and ensuring they are safe for human consumption
- Maintain the 24/7 ability to receive relevant infectious disease notifications potentially arriving on incoming aircraft and vessels into the airport and port respectively
- Liaise with shipping lines, cruise lines and airport to ensure their continual understanding and responsibilities in relation to the early notification of infectious disease or contamination (including chemical and radiation) that present (or could present) a significant risk to health
- Maintain the involvement of Port Health as a level 1 responder in relation to Emergency Planning in the event of a serious incident

## Domain 4: Living Long, Living Well

This is the domain that brings together many of the goals of public health as its focus is to reduce the numbers of people living with preventable ill health and people dying prematurely, while reducing the gap between communities.

Many of the premature mortality indicators measured in the PHOF are also shared by the NHS outcomes framework where contributions will focus on avoiding early deaths through healthcare interventions. Public health in local authorities, supported by Public Health England, will lead work to prevent early deaths through health improvement actions – such as those reflected in indicators in the other domains.

The spine chart below shows how Southampton performs on the indicators in this domain of the PHOF compared to the national average. Mortality rates are consistently higher in the city than nationally as are emergency re-admission rates and measures of preventable sight loss. Rates of emergency hospital admissions for hip fracture are lower in Southampton than nationally.



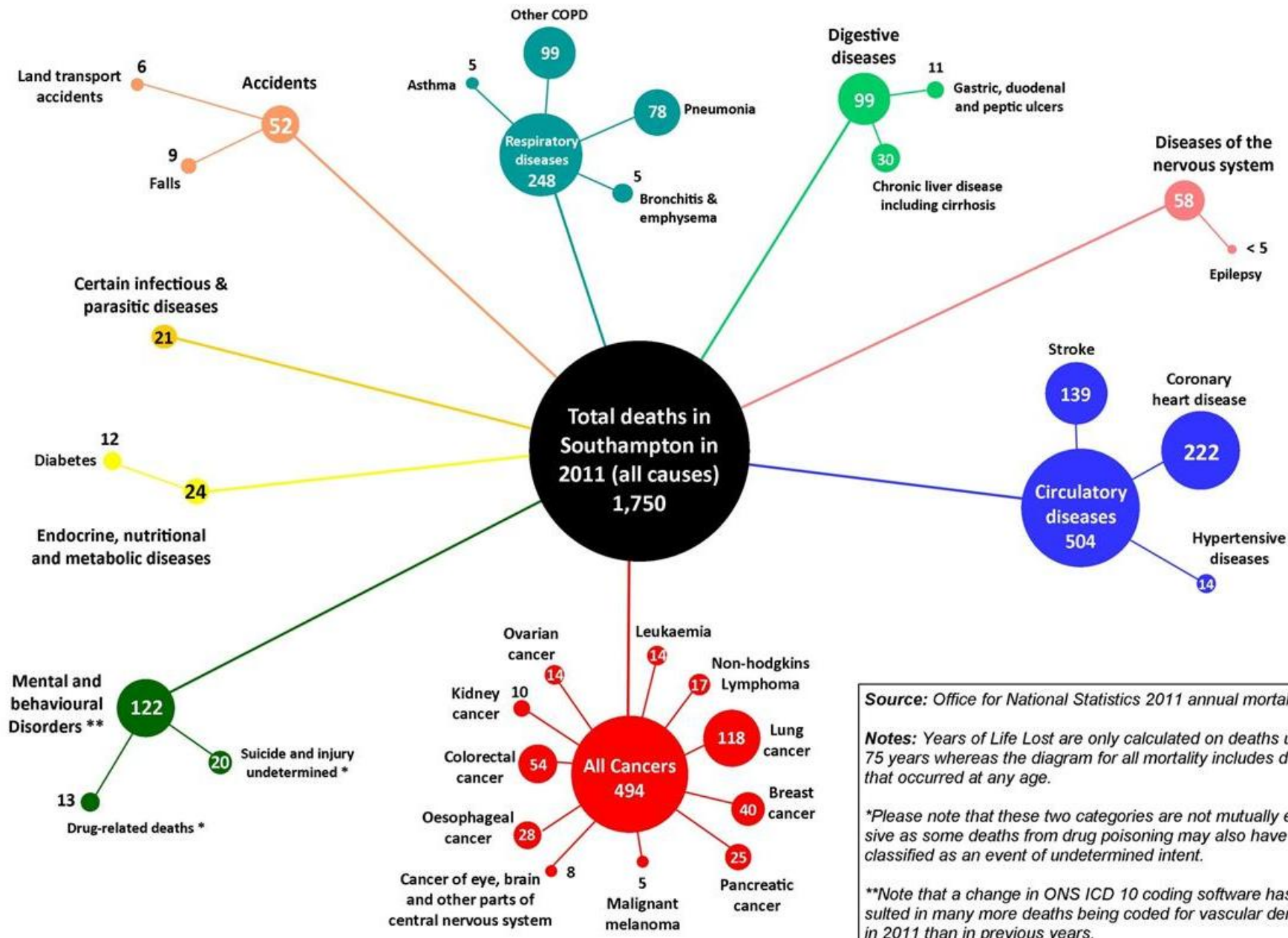
Source: <http://www.phoutcomes.info/>

Appendix 2 compares Southampton's performance in the PHOF with its most similar authorities. Generally in this domain Southampton scores fairly average amongst its peers but the indicators around preventable sight loss stand out as a particular issue. Preventable sight loss has many causes, but two conditions give rise to most cases. Diabetes causes more sight loss under retirement age, whereas wet age related macular degeneration (AMD) causes a lot of sight loss in older people. Optimal diabetes control does much to avoid retinal and macular damage in the eye, but effective eye screening is also needed to reduce sight loss by identifying abnormalities that can be treated by laser or other eye procedures. The way to reduce sight loss from diabetes is to optimise blood sugar control and to ensure high population uptake of the screening service. The wet form of AMD presents suddenly with sight loss, but this can respond well to new injectable treatments that can restore sight in most patients. In genetically susceptible people tobacco smoking can increase the incidence of AMD fourfold, so smoking cessation is very important in people with AMD. Some vitamins may also reduce the eye damage in AMD and have been used in treatment for many years.

The following 'bubble' diagrams show deaths in Southampton by cause and the relative contribution of different causes to premature death through a measure called 'years of life lost' (YLL)<sup>31</sup>. The concept of YLL is to estimate the length of time a person would have lived had they not died prematurely. It is calculated by counting the number of deaths by cause up to age 75 and then giving greater weight to those that occurred at younger ages.

Comparing the two diagrams shows that causes such as accidents, suicide and drug related deaths make a more significant contribution to premature mortality than is obvious from simply looking at the total number of deaths.

In this domain we examine two case studies; the first is around drug-related deaths, which accounted for over 1,200 YLL in Southampton over the 2009-11 period. The second case study is on a new screening programme for Abdominal Aortic Aneurysms which was introduced after research showed it should reduce the number of deaths from burst aneurysms among men aged 65 and over by up to 50%<sup>32</sup>.

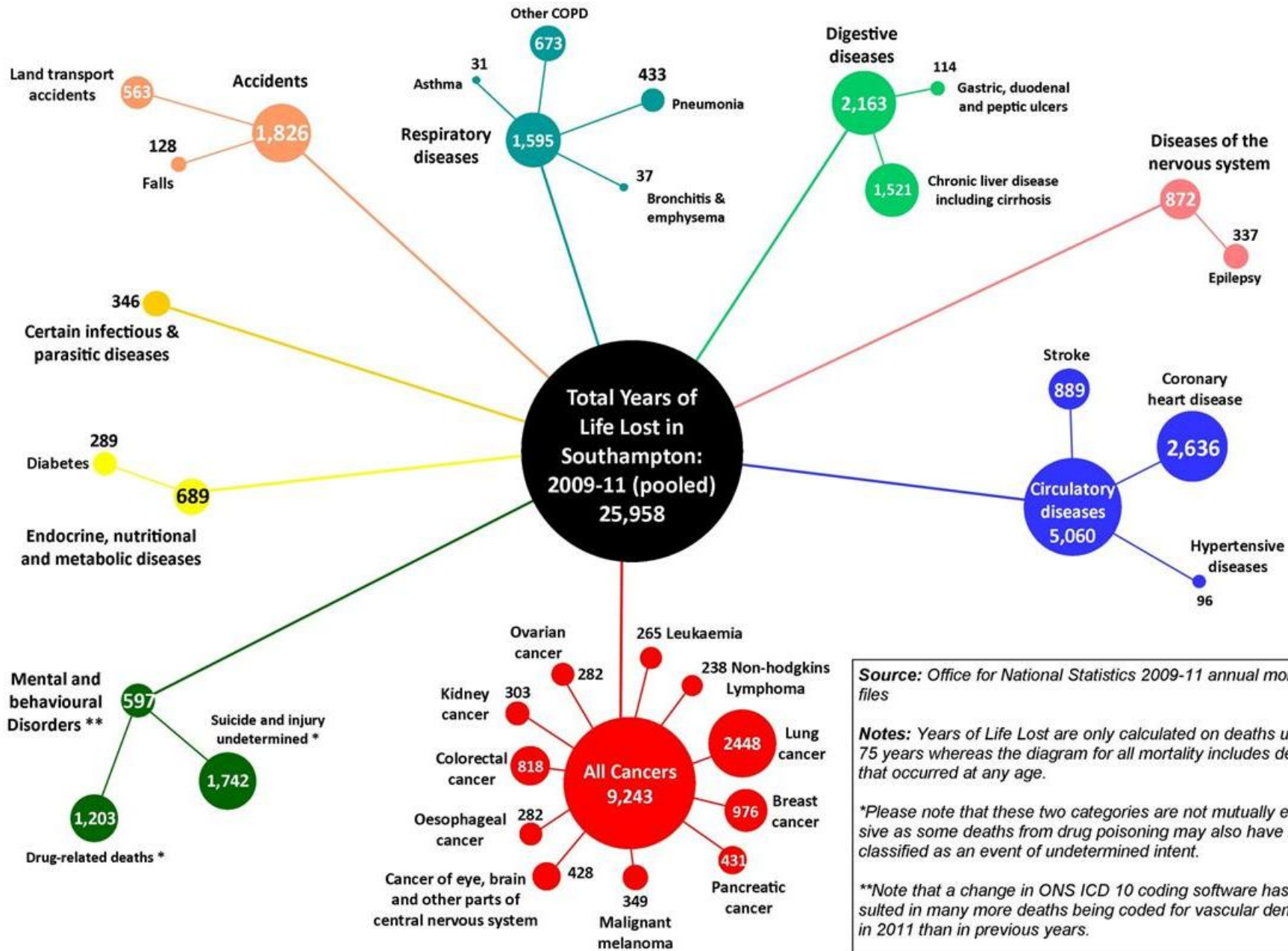


**Source:** Office for National Statistics 2011 annual mortality file

**Notes:** Years of Life Lost are only calculated on deaths up to 75 years whereas the diagram for all mortality includes deaths that occurred at any age.

\*Please note that these two categories are not mutually exclusive as some deaths from drug poisoning may also have been classified as an event of undetermined intent.

\*\*Note that a change in ONS ICD 10 coding software has resulted in many more deaths being coded for vascular dementia in 2011 than in previous years.



**Source:** Office for National Statistics 2009-11 annual mortality files

**Notes:** Years of Life Lost are only calculated on deaths up to 75 years whereas the diagram for all mortality includes deaths that occurred at any age.

*\*Please note that these two categories are not mutually exclusive as some deaths from drug poisoning may also have been classified as an event of undetermined intent.*

*\*\*Note that a change in ONS ICD 10 coding software has resulted in many more deaths being coded for vascular dementia in 2011 than in previous years.*

## Case Study 7: Drug Related Deaths

### Why is this issue important?

Drug use and drug dependence are known causes of premature mortality; nationally drug poisoning accounted for nearly one in eight deaths among people in their 20s and 30s in 2011<sup>33</sup>.

The Office for National Statistics (ONS) is able to search the wording on the death records and can, therefore, categorise those deaths that are specifically related to drug misuse using the definition from the Advisory Council on the Misuse of Drugs (2000):

‘Deaths where the underlying cause is poisoning, drug abuse or drug dependence and where any of the substances controlled under the Misuse of Drugs Act (1971) are involved.’

Locally we do not have access to this level of detail from the death records so in terms of recorded deaths we cannot calculate those drug-related deaths that were caused by drug misuse. However, we would anticipate a similar proportion locally as nationally; over the 2009-11 period 63% of drug poisonings nationally were due to drug misuse.

### The local situation

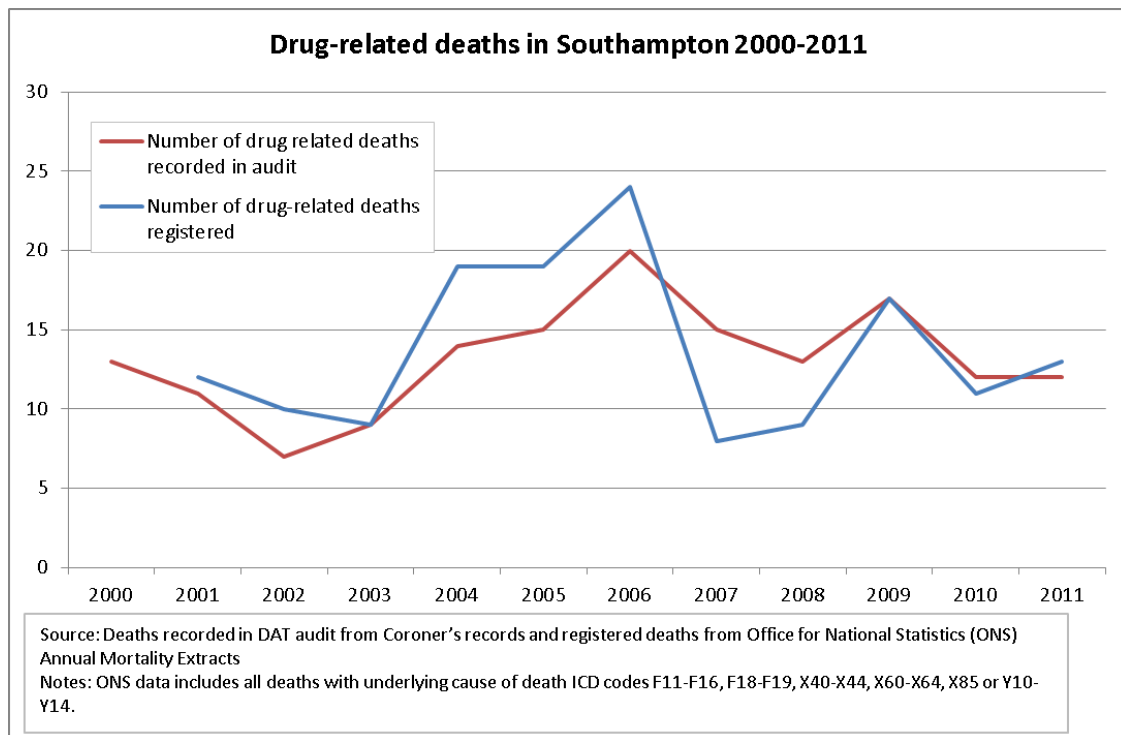
The Drug Action Team (DAT) is responsible for commissioning services within Southampton City. It is estimated that there are approximately 1,526 Opiate and Crack Users (OCUs) in Southampton. Approximately 866 people who use drugs had been in drug treatment through the year 2011<sup>34</sup>.

Locally we have two sources of data on drug-related deaths: the data recorded in death registrations each year via the ONS and the data from audits conducted by the DAT.

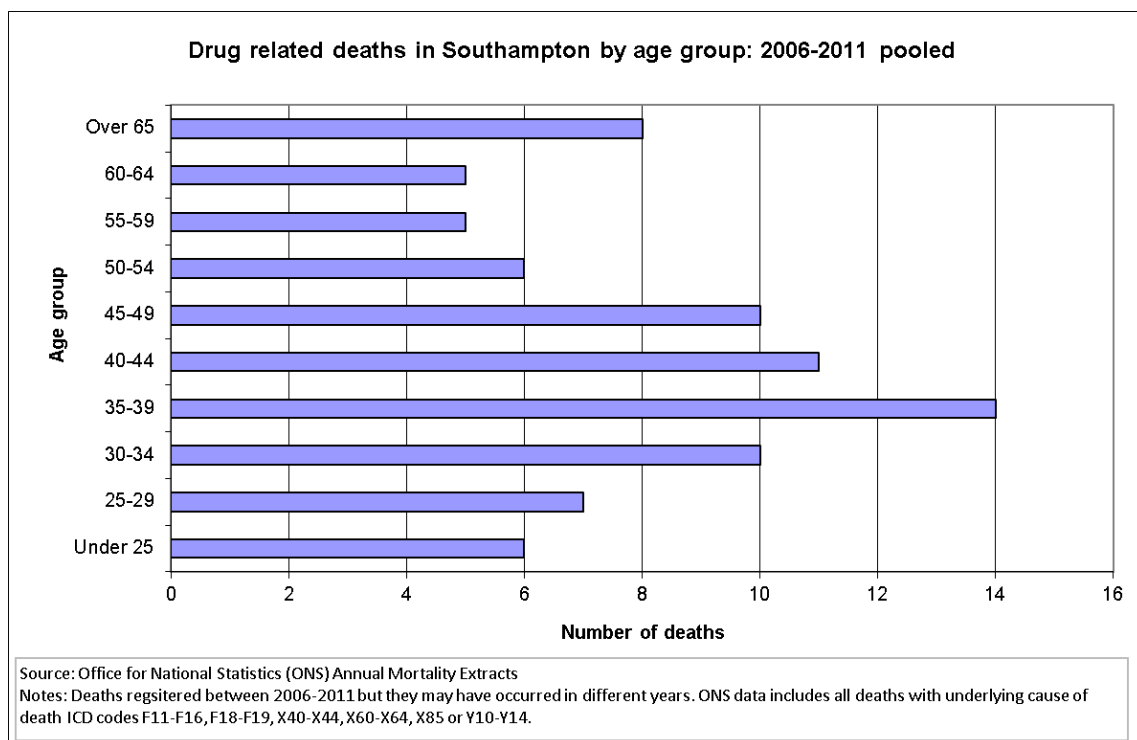
The DAT audit aims to increase the knowledge and understanding of deaths due to illicit drug use in Southampton City in order to inform future harm-minimisation policy. The audits were conducted by accessing data on the circumstances of death, post mortem, toxicological findings and cause of death from files held in the coroner’s office. Additional information on each person’s clinical and social circumstances was obtained from specialist drug treatment services, mental health services and non-statutory agencies based in Southampton City.

Almost all drug-related deaths are certified by a coroner, and due to the length of time it takes to hold an inquest, there is a significant time lag between when the death occurs and when it is registered; nationally, about half of drug-related deaths registered in 2011 will have actually occurred prior to 2011.

The following chart shows the numbers of drug-related deaths in Southampton between 2000 and 2011 as recorded from the Coroner's records in the DAT audits and as registered each year through ONS.



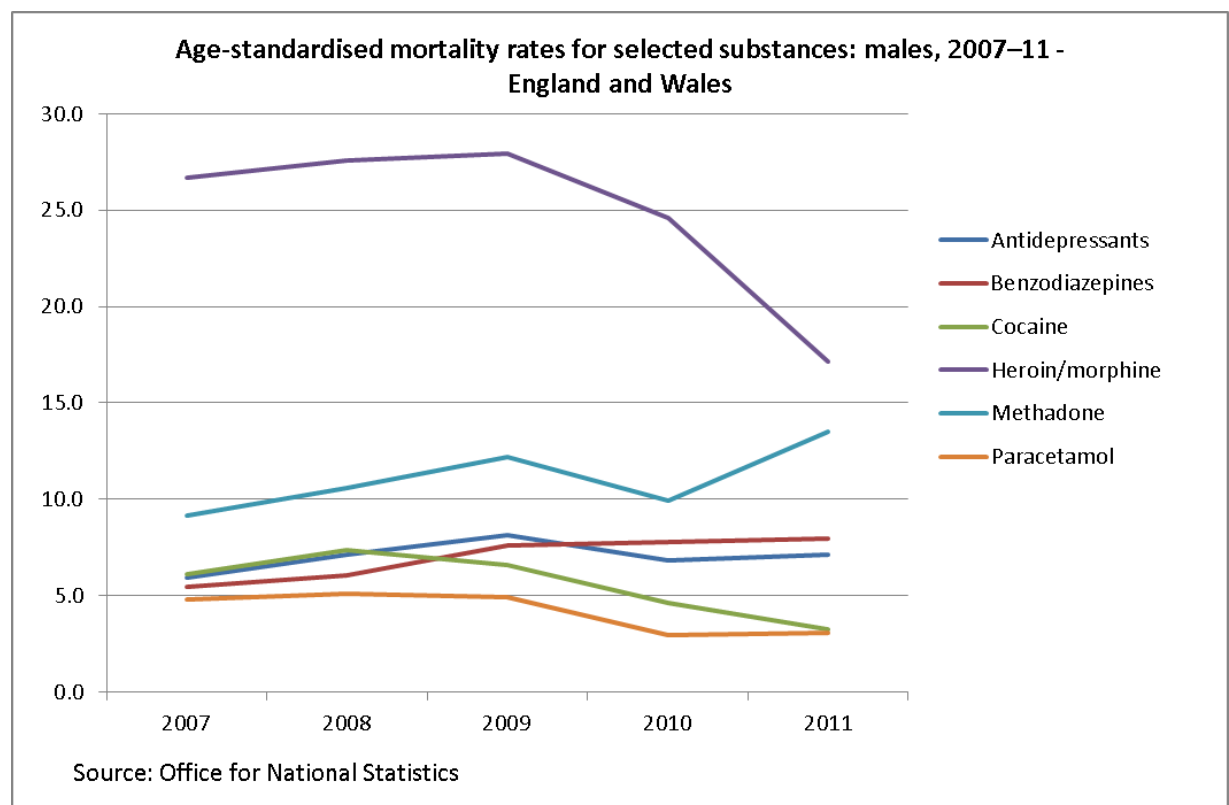
The DAT audits have found that, as is the case nationally, the majority of drug-related deaths occur in males; over the period 2006-2011 80% of the deaths in the city were in men.



In the 2011 audit the mean age at death was 42 years; nationally the most drug-related deaths occurred in the 30-39 age group in this year. During 2006-2011 the highest number of registered deaths occurred in the 35-39 year age group as the chart above shows.

Of the Southampton drug-related deaths registered between 2006 and 2011, 40% were from accidental poisonings, 26% were intentional self-poisoning and a further 24% from mental or behavioural disorders due to drug use<sup>35</sup>. This echoes the findings from the DAT audits where in the vast majority of cases the coroner concluded a verdict of accidental death.

Nationally deaths to men from heroin or morphine have fallen over the past few years as the chart below shows. The DAT audits found that opiate use was the cause of the majority of Southampton’s drug-related deaths since 2000 but numbers are too small to be certain of trends.



Research has highlighted several risk factors which are directly associated with the high incidence of drug related deaths.

- The release of offenders from custody or discharge from drug treatment programmes, who are at risk of overdose due to lowered tolerance, injecting use, mixing depressants including alcohol, using stimulants and depression.
- High prevalence of poly-drug use (including methadone, benzodiazepines and alcohol)
- Homelessness



- Involvement of alcohol
- History of mental illness
- Deaths occurring in the presence of others and /or in home environment
- Co-morbidity

A drug related deaths audit group meets regularly in Southampton to review audit outcomes and to promote innovations that reduce risk of death from drug misuse. Members of the audit group successfully piloted use of pre-loaded syringes of an opiate antagonist called Naloxone. Given in an overdose situation, the intramuscular drug injection can reverse the effects of opiates and save lives. Since the pilot programme there have been regular reports from drug treatment services and local hostels where drug clients have been successfully resuscitated by staff or friends using the Naloxone syringes. Other related initiatives include resuscitation training, awareness of what to do in an overdose situation, and development of a mobile phone app that provides practical support showing how to get someone into the recovery position during an overdose.

### **Recommendations**

- Southampton City Council, Public Health and Drug Services should work towards launching a campaign highlighting the risks of stroke and to the cardiac health of stimulant drug users targeting recreational and problematic stimulant drug users, their families and carers with a view not only to educate but also to attract more stimulant users into treatment
- The promotion of Naloxone pre-filled syringes, together with resuscitation training, needs to be encouraged more widely across the Southampton area, in order to reach those at greatest risk of drug related death. The policy and prescribing implications of Naloxone distribution in the city should be explored further
- The rising number of deaths linked to prescription methadone in recent years may be explained by the reduced availability of street heroin. This needs to be monitored carefully to see if there might be safer alternative prescribing substitutes for opiate addiction

## **Case Study 8: Screening Programme for Abdominal Aortic Aneurysms**

### **Why is this issue important?**

The aorta is the main blood vessel that supplies blood to the body. It runs from the heart down through the chest and abdomen. In some people, as they get older, the wall of the aorta in the abdomen can become weak. It can then start to expand and form what is called an abdominal aortic aneurysm (AAA)<sup>36</sup>.

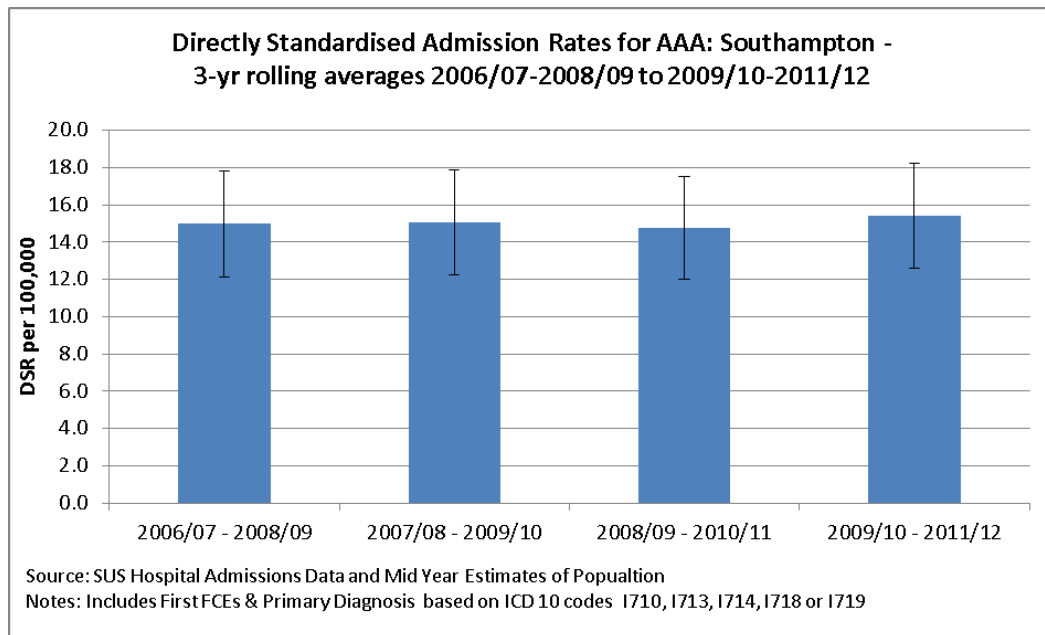
Large aneurysms are rare but can be very serious. As the wall of the aorta stretches it becomes weaker and could burst. If this happens, the chance of survival is only about 20 out of 100. An aorta which is only slightly larger than normal is not dangerous. However, it is still important to know about it and to monitor its growth at regular intervals.

AAAs can be picked up simply and effectively by an ultrasound scan. They start off very small, and then grow at a varying rate over several years or decades. By the time an aneurysm measures 5.5cm across, most surgeons would advise a repair before rupture occurs. Surgery is the most common treatment to repair large aneurysms; approximately 97 to 98 out of every 100 patients make a full recovery from AAA repair surgery.

The abdominal ultrasound is the test for the new screening programme for AAA. It has been introduced in phases across England, with Southampton, as part of the Hampshire and Isle of Wight (HIOW) programme, joining the second wave of implementation two years ago. The aim of screening is to identify and operate on large aneurysms before they can rupture, reducing premature death and serious complications. Men aged 65 are the target population, and systematic screening over a decade should pick up an increasing proportion of aneurysms before they cause problems in the retirement years.

### **The local situation**

In the last five years, there have been 124 deaths from abdominal aortic aneurysms in Southampton and the rate of hospital admissions relating to the condition has remained constant as shown below.

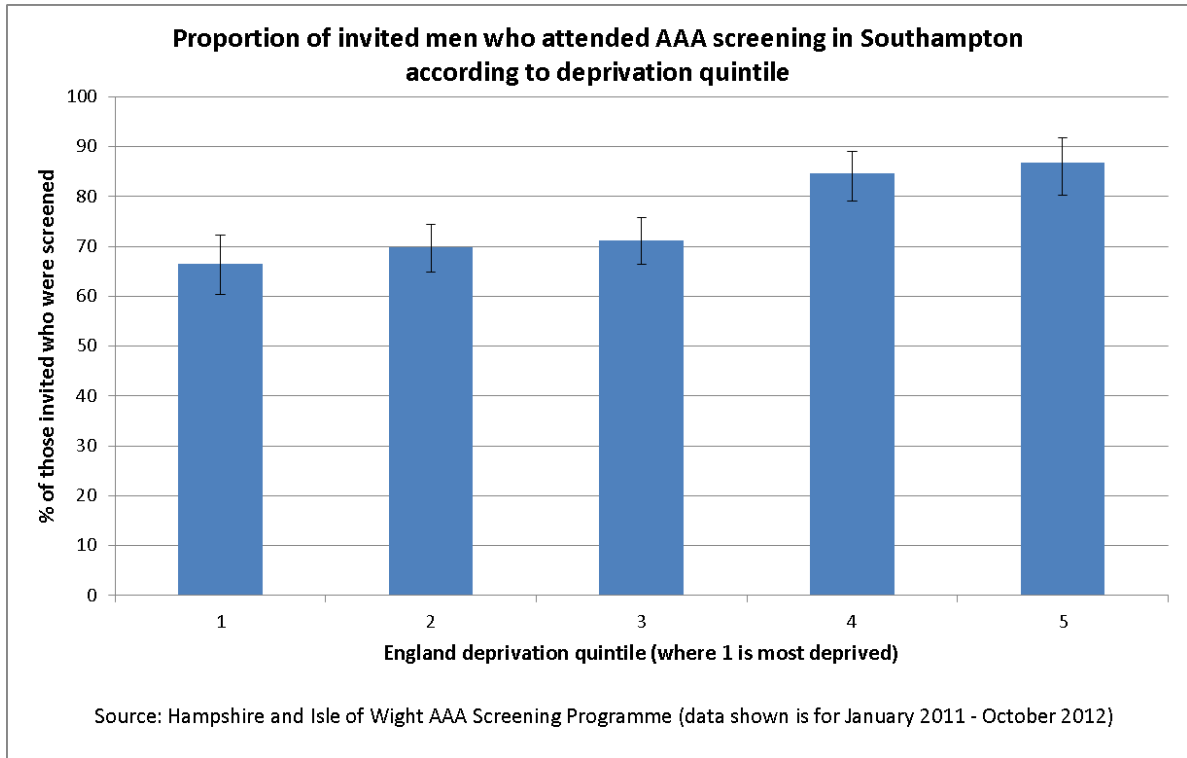


The screening programme is in its early stages, and the impact on rupture prevention will take some years to be fully appreciated. This will be monitored on an on-going basis using hospital admission and mortality data.

In its first year the programme screened over 8,000 men across Hampshire and the Isle of Wight and found an aneurysm in just over 1% of the male population. This was lower than expected prevalence. Eleven large aneurysms were repaired using stents or an open surgical repair as a result of screening in the first year. In addition, screening found a further 100 smaller aneurysms that will continue to be monitored in case they enlarge into the range where surgery is indicated at a later date.

In year two the programme has picked up higher prevalence, 1.5% positive screens for AAA so far, but this may change by the year end. The slightly higher prevalence is more in line with the results of previous studies.

To date the screening programme has been popular, with almost 80% attending invites for screens. A high acceptance rate is a vital part of the longer term success of the programme. However, the uptake of AAA screening does vary between different areas within Southampton. The chart below shows that the least deprived areas, covered by the screening programme, have an uptake of 87% whereas in the most deprived areas uptake is significantly lower at 67%. Equitable access throughout the city must remain a priority as the programme develops over the next year.



**Recommendations**

- Ensure that the screening programme continues to optimise uptake, particularly in those areas which have lower attendance

## **Appendix 1: Audit of recommendations from Public Health Annual Reports 2003-2011**

Since the appointment of a Director of Public Health for Southampton in 2002 there has been a requirement to produce an annual report on the most important health problems in the city. From the first report in 2003 through to last year's report recommendations have been made to improve the health of Southampton. Each chapter of each report has included a number of recommendations, which vary from specific targets to whole policy areas of work. This appendix reviews these recommendations to see what has been achieved.

Overall there has been significant progress on many of the Director of Public Health's recommendations. For instance, the 2011 report highlighted the issue of suicide in the city and made a number of recommendations around increasing awareness, reducing stigma, joining-up work across the city and improving local data collection. Actions taken since the publication of the report include:-

- Commissioning two suicide prevention training courses in 2012 that trained over thirty people working in front line services. For 2013 there is a plan to train over forty local people in suicide awareness
- The Action Against Suicide Group meets regularly to co-ordinate joint work and promote multi-agency initiatives
- The recently published 'Be Well Public Mental Health and Wellbeing Strategy 2012-2015' adopts a Public Health approach to suicide, and has a reduction in the number of suicides in the city as one of ten key pledges
- The Public Health team are developing, and will deliver, an anti-stigma work stream, coordinated by service users and are working with employers to make mental health discrimination in the workplace a thing of the past
- The Public Health team is also now working with the coroner's office to produce yearly suicide audits; these will inform the prevention strategy

The 2011 report explained the impacts of cold homes on health and wellbeing and made a series of recommendations to tackle these. Since the publication of the report, the 'Stop the Cold and Keep Warm' campaign, aimed at helping Southampton residents to keep warm and healthy during the winter months, has been partially evaluated and the City Council, together with Public Health, successfully bid for further funding.

Lung health was the other major topic considered in the 2011 report and there were many recommendations for improving detection and clinical pathways. Lung health is one of Southampton Clinical Commissioning Group's (CCG) top clinical priorities. In the last year the CCG commissioned a new integrated pathway for the management of Chronic Obstructive Pulmonary Disease (COPD), contributed to by partners across the health economy, and there is now a community COPD team in place.

The 2011 report also recommended that better use be made of intelligence around COPD. As a result of this, the Public Health Intelligence team is exploring new sources of data such as the Hampshire Health Record which links primary and secondary care data for many of the GP practices in the city.

The work around smoking cessation is vital to improve lung health and reduce early deaths, and there have been some key developments in this area. For example, a new post for Tobacco Control has been funded in order to provide designated capacity to progress prevention, tobacco control and specialist cessation support programmes across the city. Additionally, Fitness for Surgery/Secondary Care Smoking Cessation programme has been piloted with Solent Smoking Cessation Service. This will be mainstreamed during 2013/14 as part of service specification for Southampton Quitters Service.

Health inequalities have been a major focus for the public health team for many years. A number of policy documents including the Acheson Report and more recently the Darzi recommendations and the Marmot Review have brought inequalities to the fore.

Despite the recommendations made in 2003 and significant investment over the years there has been little improvement in narrowing the gap for men's life expectancy and premature mortality. This is a theme that was re-visited in the 2009 Annual Report and in the 2010 report we reported on the progress made (see <http://www.southamptonhealth.nhs.uk/aboutus/publichealth/hi/phar/>).

The impact of the 2013 welfare benefit reforms in Southampton has been assessed by the City Council who concluded that:-

- 2,068 individuals and families face hardship as a result of under occupancy reductions
- 214 families face hardship as a result of benefit cap reductions
- 15,000 individuals also potentially impacted by the changes to a local Council Tax Reduction Scheme

These impacts, coupled with the global economic downturn, raise serious concerns that inequalities will continue to widen in the future. Therefore, this continues to be highlighted as a major public health issue for Southampton.

In 2010 the Director of Public Health in Southampton included a section on disability in his annual report. Since then the capacity of the Diabetic Eye Screening service has been increased in response to the demand from the rising diabetic population in the city; around 11,000 people are now screened each year. Also, staffing levels for the specialist education service for deaf children have improved. However, there remains a need for better recording of disabilities so that services can be planned and delivered more appropriately.

# Appendix 2: Ranked order of Public Health Outcomes Framework measures for 12 local authorities in the ONS Regional Centres group

Local authorities in ONS Regional Centres Group ranked in descending order of deprivation

Fourth highest or worst values  
 Fifth to eighth highest worst values values  
 Lowest four values

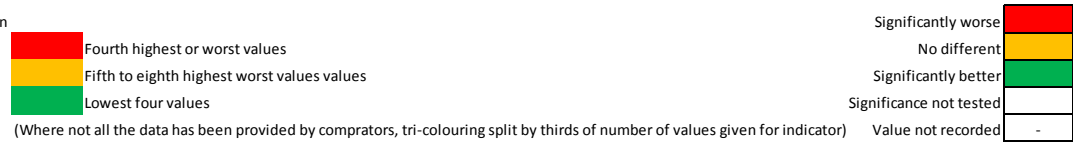
(Where not all the data has been provided by comparators, tri-colouring split by thirds of number of values given for indicator)

Significantly worse  
 No different  
 Significantly better  
 Significance not tested  
 Value not recorded

		Liverpool	Salford	Newcastle upon Tyne	Sheffield	Leeds	Plymouth	<b>Southampton</b>	Bristol, City of	Pertsmouth	Brighton and Hove	Southend-on-Sea	Bournemouth	Southampton Compared to England
<b>Ranked order of deprivation (Index of Multiple Deprivation, 2010)</b>		64.1	46.1	38.4	34.1	28.6	25.9	<b>25.5</b>	25.3	23.7	22.5	21.8	15.6	
<b>Improving the wider determinants of health</b>	1.01 - Children in poverty	33.7	29.3	29.9	24.8	23.0	22.6	<b>26.8</b>	26.1	25.6	20.7	23.3	20.8	
	1.03 - Pupil absence	6.9	6.1	6.8	6.4	6.4	6.0	<b>6.4</b>	6.7	6.3	6.0	5.8	6.0	
	1.04 - First time entrants to the youth justice system	923.7	836.8	898.5	576.2	898.6	928.4	<b>914.9</b>	1219.5	800.2	501.1	490.9	768.1	
	1.05 - 16-18 year olds not in education employment or training	11.5	6.0	11.8	8.2	8.1	8.4	<b>7.4</b>	8.8	7.2	7.9	6.0	5.1	
	1.06i - Adults with a learning disability who live in stable and appropriate accommodation	79.9	67.7	84.2	45.4	71.1	58.1	<b>67.0</b>	39.1	71.2	60.6	81.4	61.9	
	1.06ii - Adults in contact with secondary mental health services who live in stable and appropriate accommodation	72.0	84.5	78.3	73.5	48.3	52.1	<b>14.8</b>	75.3	50.7	67.8	59.7	69.4	
	1.10 - Killed and seriously injured casualties on England's roads	47.0	29.5	32.3	32.0	38.5	23.1	<b>52.3</b>	30.2	53.3	59.0	46.8	43.6	
	1.12i - Violent crime (including sexual violence) - hospital admissions for violence	213.5	137.6	94.8	68.1	107.3	79.3	<b>92.1</b>	86.5	62.4	67.0	57.4	65.8	
	1.12ii - Violent crime (including sexual violence) - violence offences	14.6	15.3	12.8	9.3	12.9	21.4	<b>27.2</b>	23.0	27.4	16.5	19.0	21.1	
	1.13i - Re-offending levels - percentage of offenders who re-offend	32.8	28.3	34.4	28.2	29.6	28.8	<b>28.7</b>	32.5	30.5	24.5	26.3	28.3	
	1.13ii - Re-offending levels - average number of re-offences per offender	1.0	0.8	1.2	0.8	0.8	0.8	<b>0.9</b>	1.0	1.0	0.8	0.7	0.9	
	1.14i - The percentage of the population affected by noise - Number of complaints about noise	6.2	4.0	6.1	3.7	9.4	5.8	<b>10.4</b>	10.0	7.0	15.3	17.0	8.4	
	1.15i - Statutory homelessness - homelessness acceptances	1.1	2.5	1.9	4.7	1.7	2.5	<b>1.8</b>	1.2	4.8	3.7	1.1	0.9	
	1.15ii - Statutory homelessness - households in temporary accommodation	0.3	0.3	0.3	0.8	0.4	0.6	<b>1.4</b>	0.9	0.8	4.4	0.5	0.1	
	1.16 - Utilisation of outdoor space for exercise/health reasons	8.8	9.4	11.7	11.4	19.2	9.7		17.7	20.6	18.2			-

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Local authorities in ONS Regional Centres Group ranked in descending order of deprivation

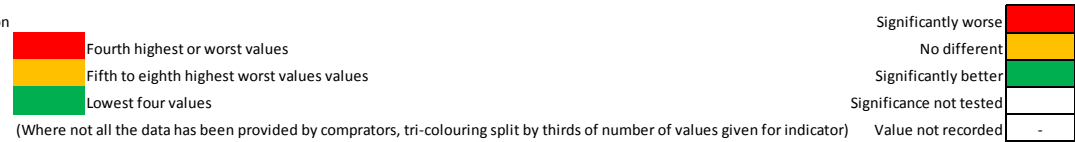


	Liverpool	Salford	Newcastle upon Tyne	Sheffield	Leeds	Plymouth	Southampton	Bristol, City of	Portsmouth	Brighton and Hove	Southend-on-Sea	Bournemouth	Southampton Compared to England
<b>Ranked order of deprivation (Index of Multiple Deprivation, 2010)</b>	64.1	46.1	38.4	34.1	28.6	25.9	25.5	25.3	23.7	22.5	21.8	15.6	
2.01 - Low birth weight of term babies	3.0	2.9	3.2	2.8	3.0	2.6	3.2	3.1	2.0	2.8	2.7	2.1	
2.02i - Breastfeeding - Breastfeeding initiation	52.6	64.2	62.4	77.6	72.2	67.1	74.6	79.3	75.4	85.5	73.3	76.7	
2.02ii - Breastfeeding - Breastfeeding prevalence at 6-8 weeks after birth	27.2	34.3	42.2	51.4	48.8	35.0	42.9	55.6	44.4	70.5	37.3	50.7	
2.03 - Smoking status at time of delivery	18.3	16.4	18.7	14.1	12.2	18.3	16.6	10.6	17.5	7.6	11.9	10.9	
2.04 - Under 18 conceptions	44.5	57.9	46.8	41.4	43.5	44.5	49.2	42.2	43.3	36.9	39.0	37.5	
2.06i - Excess weight in 4-5 year olds	25.8	22.8	25.9	22.8	23.0	25.1	23.7	23.1	24.3	21.5	23.3	21.9	
2.06ii - Excess weight in 10-11 year olds	37.6	38.1	38.4	34.5	33.9	33.7	31.9	32.5	34.4	28.9	31.5	31.5	
2.08 - Emotional well-being of looked after children	12.5	13.2	12.3	15.4	14.5	16.0	22.8	14.8	14.5	15.7	14.2	15.6	
2.14 - Smoking prevalence - adults (over 18s)	22.4	11.2	13.5	6.9	6.0	7.7	11.3	9.5	10.2	9.5	15.7	10.3	
2.15 - Successful completion of drug treatment	22.4	11.2	13.5	6.9	6.0	7.7	11.3	9.5	10.2	9.5	15.7	10.3	
2.17 - Recorded diabetes	5.4	5.3	5.0	5.7	4.9	5.1	4.9	4.5	4.9	3.8	5.4	4.8	
2.20i - Cancer screening coverage - breast cancer	71.8	70.7	76.2	79.0	73.8	80.1	70.8	73.7	72.6	70.1	69.2	72.7	
2.20ii - Cancer screening coverage - cervical cancer	69.8	72.1	74.5	75.8	76.8	76.5	72.9	72.2	71.9	73.7	72.1	74.8	
2.21vii - Access to non-cancer screening programmes - diabetic retinopathy	81.3	81.9	82.1	73.7	87.2	78.7	70.6	81.0	79.7	85.4	81.7	89.3	
2.22i - Take up of NHS Health Check Programme by those eligible - health check offered	91.1	14.9	9.7	0.0	17.3	4.2	14.6	3.8	21.3	15.9	22.8	13.8	
2.22ii - Take up of NHS Health Check programme by those eligible - health check take up	32.7	18.4	68.4		88.7	69.7	69.5	47.9	10.5	48.9	51.6	30.6	
2.23i - Self-reported well-being - people with a low satisfaction score	27.2	27.2	25.2	26.1	26.2	21.9	24.4	26.1	24.5	18.7	26.5	20.8	
2.23ii - Self-reported well-being - people with a low worthwhile score	21.1	22.8	21.6	21.1	20.7	19.0	22.6	24.3	24.2	16.2	18.6	20.2	
2.23iii - Self-reported well-being - people with a low happiness score	31.5	32.0	30.9	31.3	30.3	29.1	29.5	31.2	31.3	27.5	28.0	29.4	
2.23iv - Self-reported well-being - people with a high anxiety score	41.1	43.1	41.8	42.3	39.9	42.8	38.0	38.0	37.0	40.5	36.1	37.4	
2.24i - Injuries due to falls in people aged 65 and over (Males)	2646.8	2069.0	1223.9	1058.4	1619.8	1504.1	1413.8	1573.0	1499.0	1707.4	1448.9	1289.8	
2.24i - Injuries due to falls in people aged 65 and over (Females)	3165.6	3009.6	1998.9	1785.0	2574.3	2166.6	2386.1	2368.6	2491.8	2500.7	2591.8	1666.8	
2.24i - Injuries due to falls in people aged 65 and over (Persons)	2906.2	2539.3	1611.4	1421.7	2097.1	1835.3	1899.9	1970.8	1995.4	2104.0	2020.3	1478.3	
2.24ii - Injuries due to falls in people aged 65 and over - aged 65-79	1822.3	1574.5	1071.7	820.3	1253.8	1132.5	1238.3	1162.6	1156.9	1307.1	1073.8	840.1	
2.24iii - Injuries due to falls in people aged 65 and over - aged 80+	7783.6	6881.0	4039.8	4128.0	5891.8	4998.0	4877.3	5607.4	5768.6	5690.2	6279.7	4349.9	



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		Liverpool	Salford	Newcastle upon Tyne	Sheffield	Leeds	Plymouth	Southampton	Bristol, City of	Pertsmouth	Brighton and Hove	Southend-on-Sea	Bournemouth	Southampton Compared to England
<b>Ranked order of deprivation (Index of Multiple Deprivation, 2010)</b>		64.1	46.1	38.4	34.1	28.6	25.9	25.5	25.3	23.7	22.5	21.8	15.6	
Health Protection	3.01 - Fraction of mortality attributable to particulate air pollution	5.4	5.9	4.9	5.5	5.5	4.5	6.2	5.8	5.9	5.4	6.1	5.1	
	3.02 - Chlamydia diagnoses (15-24 year olds)	2276.9	2841.1	2099.8	2164.7	2405.2	2090.1	1967.9	2179.5	2630.7	1856.5	2422.6	2081.0	
	3.03i - Population vaccination coverage - Hepatitis B (1 year old)	100.0	94.6	66.7		100.0	70.4	91.7						
	3.03i - Population vaccination coverage - Hepatitis B (2 years old)	100.0	57.1	23.5		56.7		100.0						
	3.03iii - Population vaccination coverage - Dtap / IPV / Hib (1 year old)	95.4	97.3	94.0	94.7	95.4	95.4	94.7	95.0	94.5	91.2	94.7	84.4	
	3.03iii - Population vaccination coverage - Dtap / IPV / Hib (2 years old)	97.2	98.6	96.5	96.6	97.0	97.6	96.5	96.3	97.3	93.7	96.3	94.9	
	3.03iv - Population vaccination coverage - MenC	94.5	94.5	93.1	93.7	94.8	95.1	93.8	94.1	94.2	90.2	94.2	84.2	
	3.03v - Population vaccination coverage - PCV	95.2	95.0	93.6	93.9	95.0	95.2	94.1	94.5	94.5	90.3	94.3	85.0	
	3.03vi - Population vaccination coverage - Hib / MenC booster	94.0	97.6	93.4	94.4	94.2	93.7	90.9	90.1	93.2	89.3	94.2	84.9	
	3.03vii - Population vaccination coverage - PCV booster	93.2	95.4	90.7	92.3	90.9	91.8	89.5	85.1	88.6	86.5	89.5	79.7	
	3.03viii - Population vaccination coverage - MMR for one dose (2 years old)	92.1	96.8	89.7	91.4	90.6	91.8	91.5	85.8	89.4	85.9	88.6	79.9	
	3.03ix - Population vaccination coverage - MMR for one dose (5 years old)	94.5	97.3	93.6	92.8	92.1	94.6	93.7	91.3	93.8	88.8	90.4	92.5	
	3.03x - Population vaccination coverage - MMR for two doses (5 years old)	85.6	95.1	87.0	86.4	84.5	87.3	86.7	77.8	83.8	76.8	86.4	82.8	
	3.03xii - Population vaccination coverage - HPV	82.7	80.6	84.3	92.9	92.0	76.6	71.1	69.1	84.8	84.9	79.1	84.8	
	3.03xiii - Population vaccination coverage - PPV	67.6	68.1	73.4	73.3	73.3	72.5	73.1	74.5	72.0	68.7	64.7	73.8	
	3.03xiv - Population vaccination coverage - Flu (aged 65+)	74.8	74.1	76.0	74.7	76.5	73.6	74.2	75.6	74.4	68.9	70.3	71.9	
	3.03xv - Population vaccination coverage - Flu (at risk individuals)	53.4	50.7	53.3	50.6	48.2	54.3	53.5	50.2	51.7	48.8	46.9	49.9	
	3.04 - People presenting with HIV at a late stage of infection	63.5	50.5	48.6	48.2	50.9	45.1	50.9	52.6	54.7	34.1	58.1	30.4	
	3.05i - Treatment completion for TB	83.3	81.8	81.0	89.3	75.0		79.2	90.0	87.0	82.6	84		
	3.05ii - Treatment completion for TB - TB incidence	11.1	13.1	13.3	15.0	14.9	5.2	15.6	18.6	11.7	10.7	13.3	10.7	
3.06 - Public sector organisations with a board approved sustainable development management plan	44.4	100.0	60.0	85.7	100.0	75.0	100.0	100.0	75.0	83.3	60.0	80.0		

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Fourth highest or worst values  
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(Where not all the data has been provided by comparators, tri-colouring split by thirds of number of values given for indicator)

Significantly worse  
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	Liverpool	Salford	Newcastle upon Tyne	Sheffield	Leeds	Plymouth	Southampton	Bristol, City of	Pertsmouth	Brighton and Hove	Southend-on-Sea	Bournemouth	Southampton Compared to England
<b>Ranked order of deprivation (Index of Multiple Deprivation, 2010)</b>	64.1	46.1	38.4	34.1	28.6	25.9	25.5	25.3	23.7	22.5	21.8	15.6	
4.03 - Mortality rate from causes considered preventable (provisional)	224.2	222.0	193.0	155.3	170.1	167.8	172.2	162.6	179.9	172.0	149.2	150.2	
4.04i - Under 75 mortality rate from all cardiovascular diseases (provisional)	92.0	92.8	79.7	66.7	72.2	67.5	66.6	64.4	72.3	57.8	62.6	59.7	
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable (provisional)	58.1	62.7	52.8	46.0	49.4	45.2	43.4	42.6	47.4	35.4	42.0	38.2	
4.05i - Under 75 mortality rate from cancer (provisional)	147.5	133.8	131.2	116.2	115.6	118.8	119.3	119.1	120.1	115.6	104.1	98.7	
4.05ii - Under 75 mortality rate from cancer considered preventable (provisional)	91.5	85.1	84.0	67.6	70.7	73.0	74.8	71.0	72.7	69.1	62.1	57.9	
4.06i - Under 75 mortality rate from liver disease (provisional)	25.8	22.7	19.3	14.0	17.9	13.6	17.4	13.6	18.5	20.4	14.9	19.4	
4.06ii - Under 75 mortality rate from liver disease considered preventable (provisional)	22.8	21.1	18.1	12.8	15.5	12.0	16.1	12.6	16.8	17.6	13.1	17.5	
4.07i - Under 75 mortality rate from respiratory disease (provisional)	41.8	49.1	31.6	24.0	29.2	25.4	27.3	25.9	28.5	25.7	23.7	25.1	
4.07ii - Under 75 mortality rate from respiratory disease considered preventable (provisional)	23.4	26.5	16.8	14.2	14.8	12.5	16.7	12.6	16.9	15.3	11.7	12.1	
4.08 - Mortality from communicable diseases (provisional)	40.6	49.0	30.1	23.3	31.1	35.9	26.6	34.0	25.1	26.4	37.9	29.4	
4.10 - Suicide rate (provisional)	6.2	10.7	7.5	6.4	7.9	10.3	9.7	9.6	8.6	11.1	8.4	10.2	
4.11 - Emergency readmissions within 30 days of discharge from hospital (persons)	13.4	12.2	12.8	12.1	13.2	10.5	12.2	11.8	12.5	13.2	12.0	12.1	
4.11 - Emergency readmissions within 30 days of discharge from hospital (males)	14.8	13.3	13.4	12.4	13.9	10.7	12.4	12.3	13.0	13.2	12.4	13.4	
4.11 - Emergency readmissions within 30 days of discharge from hospital (females)	12.2	11.3	12.2	11.7	12.7	10.3	11.9	11.4	12.1	13.2	11.6	11.1	
4.12i - Preventable sight loss - age related macular degeneration (AMD)	111.0	83.9	128.2	94.6	143.6	85.2	214.6	58.0	212.1	152.2	108.8	125.0	
4.12ii - Preventable sight loss - glaucoma	8.1	6.9	13.1	12.0	12.1	9.2	21.4	9.8	9.4	12.2	10.7	9.9	
4.12iii - Preventable sight loss - diabetic eye disease	1.8	0.0		2.1	2.9	2.7	5.2	1.6	2.8	2.2	5.7	3.4	
4.12iv - Preventable sight loss - sight loss certifications	40.7	21.0	43.1	40.1	44.6	33.6	59.2	20.6	54.6	49.9	50.2	48.8	
4.14i - Hip fractures in people aged 65 and over	555.7	525.3	480.3	505.5	449.5	481.3	375.0	460.3	468.7	449.8	452.0	537.1	
4.14ii - Hip fractures in people aged 65 and over - aged 65-79	325.9	278.8	247.0	227.4	242.0	246.5	185.3	223.5	256.1	239.2	247.4	299.1	
4.14iii - Hip fractures in people aged 65 and over - aged 80+	1589.8	1634.2	1530.0	1757.1	1383.4	1537.5	1228.6	1526.2	1425.5	1397.7	1372.9	1608.3	

## References

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- <sup>1</sup> Department of Health (2012) Improving outcomes and supporting transparency Part 1: A public health outcomes framework for England, 2013-2016
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- <sup>13</sup> <http://www.southamptonhealth.nhs.uk/EasySiteWeb/GatewayLink.aspx?allid=129951>
- <sup>14</sup> [http://www.apho.org.uk/addons/\\_115501/atlas.html](http://www.apho.org.uk/addons/_115501/atlas.html)
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## RESIDENT POPULATION, 2011

Population resident in Southampton City PCT

Age band	Male	Female	Persons	%
0-4	8,000	7,500	15,500	6.6
5-14	12,100	11,400	23,500	10.0
15-24	23,700	22,400	46,100	19.5
25-49	44,400	40,900	85,300	36.2
50-64	17,400	17,200	34,600	14.7
65-74	7,400	8,100	15,500	6.6
75-84	4,500	6,200	10,700	4.5
85+	1,500	3,200	4,700	2.0
<b>Total</b>	<b>119,000</b>	<b>116,900</b>	<b>235,900</b>	<b>100</b>

Source: Office for National Statistics Mid Year Estimate of the Population 2011, © Crown Copyright. (Figures may not sum due to rounding)

## REGISTERED POPULATION, 2011

Population registered with Southampton City GPs

Age band	Male	Female	Persons	%
0-4	8,300	7,800	16,100	6.1
5-14	13,100	12,500	25,500	9.6
15-24	24,400	24,700	49,000	18.5
25-49	54,900	45,200	100,100	37.8
50-64	20,800	19,200	40,000	15.1
65-74	8,600	8,800	17,400	6.6
75-84	5,000	6,700	11,700	4.4
85+	1,700	3,400	5,100	1.9
<b>Total</b>	<b>136,700</b>	<b>128,100</b>	<b>264,900</b>	<b>100</b>

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

## BIRTHS

### General Fertility Rate and Number of Births

	2008	2009	2010	2011
<b>Live births per 1,000 women aged 15-44</b>				
Southampton	56.3	54.1	57.0	63.4
South East	62.5	62.6	64.4	63.8
England	63.9	63.8	65.5	64.2
<b>Number of live births</b>				
Southampton	3,279	3,230	3,448	3,550

Source: Office for National Statistics, Mid year estimates and Vital Statistics VS1.

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## TEENAGE CONCEPTIONS

	2007	2008	2009	2010
<b>No. of conceptions to girls aged under 18</b>				
Southampton	185	198	188	181
<b>Rate of under 18 conceptions per 1000 girls aged 15-17</b>				
Southampton	49	51.4	49.2	49.2
South East	32.9	32.9	30.1	28.3
England	41.7	40.4	38.2	35.4

Source: Teenage Pregnancy Unit & Office for National Statistics, © Crown Copyright.

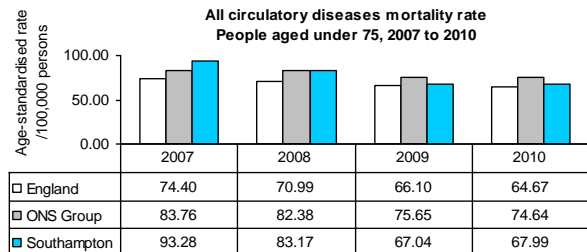
## INFANT MORTALITY\*

	2007-09	2008-10	2009-11
<b>Number of deaths (in 3 year period)</b>			
Southampton	43	49	46
South East	1,214	1,204	1,167
England	9,421	9,260	9,062
<b>Mortality per 1000 live births</b>			
Southampton	4.5	4.9	4.5
South East	3.9	3.8	3.7
England	4.7	4.6	4.4

\*includes deaths of infants aged less than 1 year

Source: Office for National Statistics, Vital Statistics VS1. © Crown Copyright.

## CIRCULATORY DISEASE

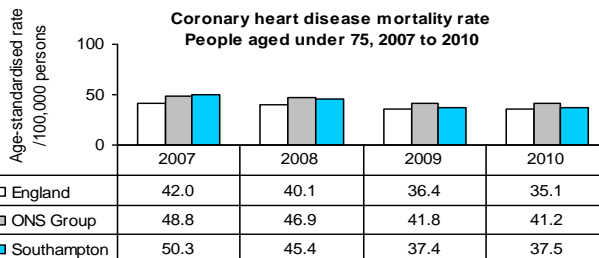


**Number of deaths per year**

	2007	2008	2009	2010
Southampton	180	164	133	136

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

## CORONARY HEART DISEASE

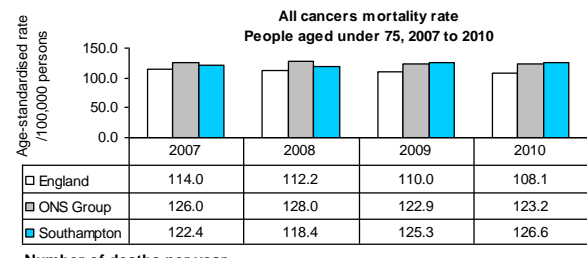


**Number of deaths per year**

	2007	2008	2009	2010
Southampton	98	90	74	74

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## CANCER

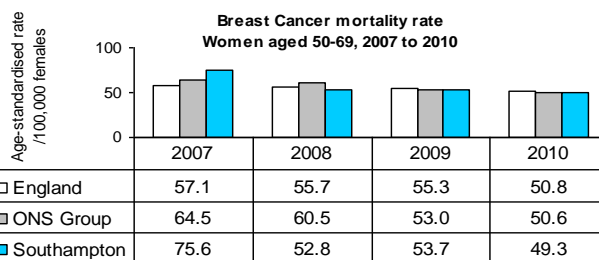


**Number of deaths per year**

	2007	2008	2009	2010
Southampton	233	230	247	256

Source: Compendium of Clinical & Health Indicators Health & Social Care Information Centre © Crown Copyright.  
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## BREAST CANCER

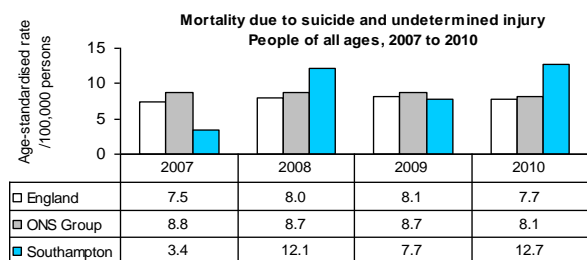


**Number of deaths per year**

	2007	2008	2009	2010
Southampton	15	11	11	11

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## SUICIDE



**Number of deaths per year**

	2007	2008	2009	2010
Southampton	7	27	18	32

Source: Compendium of Clinical & Health Indicators Health & Social Care Information Centre © Crown Copyright.  
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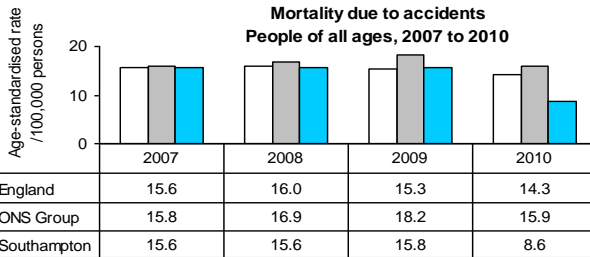
**Contact**

**The Health of  
the People of  
Southampton City  
2012**



**A Pocket Profile**

**ACCIDENTS**



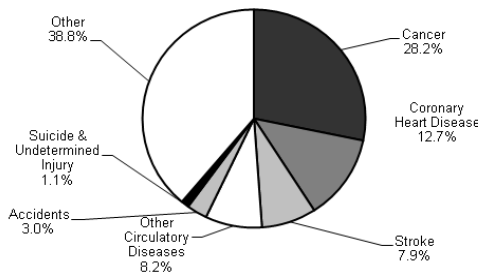
**Number of deaths per year**

Year	Southampton
2007	49
2008	49
2009	48
2010	30

Source: Compendium of Clinical & Health Indicators Health & Social Care Information Centre © Crown Copyright.  
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**MAJOR CAUSES OF DEATH**

**Southampton Residents 2011 (No. of deaths = 1,750)**



Source: Office for National Statistics, Vital Statistics VS3 © Crown Copyright.

**LIFE EXPECTANCY\***

**Life Expectancy at Birth (years) 2008-10**

	Males	Females
Southampton	78.7	82.7
South East	79.7	83.5
England	78.6	82.6

\*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 2008-10 mortality rates throughout their life.  
Source: Office for National Statistics, 2011 © Crown Copyright.

**JOBS AND UNEMPLOYMENT**

**Job Seekers Claimant count (as % of working age resident population)**

	Southampton	South East	England
Dec 2012	3.2	2.4	3.6
Sep 2012	3.3	2.4	3.7
Jun 2012	3.3	2.5	3.7
Mar 2012	3.8	2.7	4.0
Dec 2011	3.5	2.5	3.8

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

	Southampton	South East	England
2010	0.71	0.80	0.78

Source: National Statistics (from Nomis website: [www.nomisweb.co.uk](http://www.nomisweb.co.uk))  
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**INDEX OF DEPRIVATION 2010**

Ranking of the worst 5 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

	E01017167	E01017154	E01017281	E01017207	E01017163	E01017240	E01017280	E01017161	E01017140	E01017137	E01017210	E01017237	E01017274	E01017145	E01017148	E01017142	E01017257	E01017146	E01017139	E01017227	E01017218	E01017189	E01017225	E01017160
Overall IMD Score	1	2	3	4	5																			
Income	2	3	1	4	5																			
Employment	2	3	1			4	5																	
Health		3	1					2	4	5														
Education	1				5						2	3	4											
Housing/Access														1	2	3	4	5						
Crime	1			4						2	3								5					
Environment																				1	2	3	4	5

Source: Index of Deprivation 2010. Department for Communities and Local Government.

**EDUCATIONAL ATTAINMENT**

	2008	2009	2010	2011
<b>Southampton</b>				
KS2 English	73	74	77	79
KS2 Mathematics	74	74	78	79
5+ GCSEs A*-C	42.3	43.1	47.5	51.0
<b>England</b>				
KS2 English	81	80	80	81
KS2 Mathematics	79	79	79	80
5+ GCSEs A*-C	47.6	49.8	53.5	58.3

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 [www.education.gov.uk](http://www.education.gov.uk)  
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**HEALTH IN SOUTHAMPTON CITY**

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.

Rebecca Wilkinson  
Head of Public Health Intelligence

Andrew Mortimore  
Director of Public Health