

Director of Public Health annual report 2013-14



Healthy Southampton 

Contents

Introduction	3
Technical note	4
Summary of health and wellbeing needs in Southampton	5

Section 1: Wider impacts on health and wellbeing 8

1.1 Housing	10
1.2 Violent crime	13

Section 2: Healthy lifestyles 17

2.1 Smoking	19
2.2 Happiness	21

Section 3: Protection from health threats 24

3.1 Sexual health	26
3.2 Common infectious diseases	30

Section 4: Living long, living well 32

4.1 Diabetes	34
4.2 Chronic kidney disease	37

References	39
------------	----

Appendix 1: Public Health Outcomes Framework	45
--	----

Appendix 2: Ward Profiles	47
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Pocket Profile	66
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Finding out more about the health of Southampton

As well as publishing an Annual Report and a Joint Strategic Needs Assessment (JSNA), we also 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 an 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. We produce profiles of the sixteen electoral wards in the city; these are available as an interactive mapping tool on our website. Please visit our website to access any of these resources: www.publichealth.southampton.gov.uk

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Special thanks also to guest contributors Simon Fraser, Lisa Raison-Trehy, Paul Roderick and Derek Stevens.

Introduction

Welcome to my first report since Public Health leadership and responsibilities transferred from the NHS back to councils on 1 April 2013. Throughout I report on the state of Southampton's health, underlying trends and future challenges, and make recommendations for how health can be improved.

Southampton is a great city, whether you live here, work here or are a visitor. Many health indicators are moving in the right direction – life expectancy is improving, deaths from heart disease and stroke are falling and cancer survival rates are improving. However there has been limited progress in narrowing the health gap between the wealthy and those who are on low incomes, and many challenges remain or have increased in significance. The economic problems faced by the UK over the last five years have increased the likelihood that the least well off will continue to have poorer health.

Improving the public's health and tackling these challenges require "the organised efforts of society". Public Health in the council will work in partnership for a healthier city, a place which is safe, healthy and where people thrive. I hope this report will make clear what these challenges are and point the way to how we can make further progress.

There is now a wealth of information that helps us understand the health of people in Southampton. For five years the council has worked with the local NHS on a Joint Strategic Needs Assessment (JSNA). This resource is regularly updated and paints a picture of what life is like in Southampton and what the health challenges are. The full JSNA is a web-based resource and can be found at www.publichealth.southampton.gov.uk/jsna

As well as data and analysis, there are mapping tools and summaries which enable a detailed picture to be built up on a wide range of topics.

For the purpose of the annual report, we are presenting a highlight report which sets out the key health issues the city

faces, whether the situation is improving or worsening and the key factors that need to be addressed to improve health.

There are four sets of outcomes that we need to focus on to make progress in improving health. As with last year's report, we devote a chapter to each of these, and feature some examples of work that is going on to improve these outcomes.


Shelter and security are basic needs and health suffers when these are not met. Section Two looks at how housing can affect health through overcrowding, insecure tenancies, poor insulation, lack of affordable or effective heating, damp and homelessness. There are many challenges to making more and better housing available in the city, but the opportunities that do exist need to be grasped.

Being safe and feeling safe in our homes and neighbourhoods is an essential part of wellbeing. Every year crime and disorder in the city is assessed and plans and actions agreed by a range of agencies to make the city a safer place to live in, work in or visit. Community safety has direct impacts on health and this is explored in the report.

Our health is affected by our behaviours and the way we choose to live our lives. Although fewer people are smoking, it is still the single biggest cause of early deaths. Further action to reduce the burden of disease it causes is discussed in Section three. There has been much recent discussion about what causes happiness and enables people to be content. The links between wellbeing and mental health are explored and approaches that would improve mental wellbeing are outlined.

The fourth section focuses on threats to health that are related to infection. Much can be done to reduce risks linked to common infectious diseases. Sexual health is more than just the avoidance of infections, and this is also discussed in the chapter.

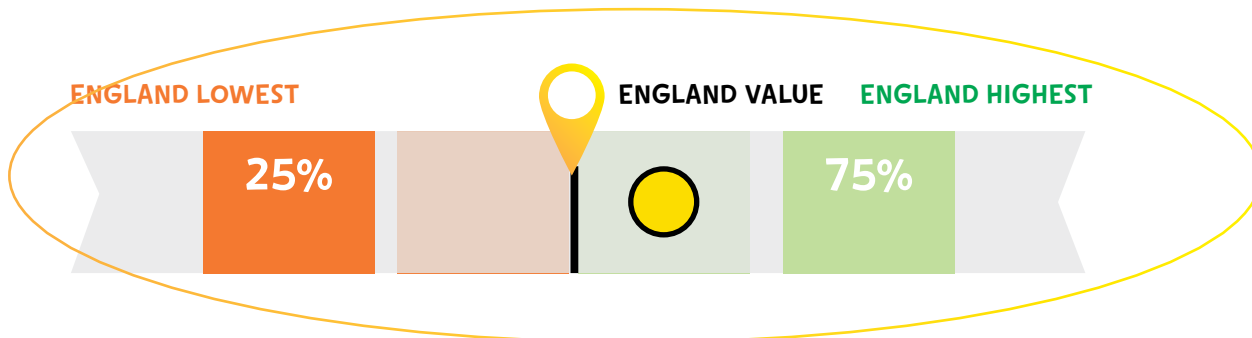
The final section focuses on two chronic illnesses that affect both the quality and length of life – diabetes and kidney disease. Much can be done to prevent these problems and to limit their impact if they are detected early and managed well.



Andrew Mortimore, Director of Public Health

Technical note

This report uses the four themes of the Public Health Outcomes Framework (PHOF) as its structure. At the start of each theme a 'spine chart' of the relevant indicators for Southampton is presented. The diagram below shows how to interpret the spine charts and further information is available at www.phoutcomes.info



Data has now been published for the over-arching PHOF indicators of life expectancy and healthy life expectancy. Southampton has significantly lower healthy life expectancy than the national average for men (61.1 years compared with 63.2 years).

Data has also been published for the 'slope index of inequality' - this is the difference (in years) in life expectancy between the most and least deprived 10% of the population. For men over the past few years.

in Southampton this is 9.4 years and for females it is 5.8 years. The confidence intervals are wide around these figures so it is difficult to draw conclusions about changes over time or differences between areas. This data relates to 2009-11. Previous data for this indicator was for the 5 year period 2006-10 and for males was 8.0 years but the confidence intervals are too wide to conclude that inequality amongst men is definitely increasing. Indeed, local analysis¹ shows very little change in the gap for male life expectancy

Overarching indicators	Period	Local value	Eng. value	Eng. lowest	Range	Eng. highest
0.1i Healthy life expectancy at birth - Male	2009 - 11	61.1	63.2	55.0		70.3
0.1i Healthy life expectancy at birth - Female	2009 - 11	64.6	64.2	54.1		72.1
0.1ii Life Expectancy at birth - Male	2010 - 12	78.5	79.2	74.0		82.1
0.1ii Life Expectancy at birth - Female	2010 - 12	82.7	83.0	79.5		85.9
0.2i Slope index of inequality in life expectancy at birth based on national deprivation deciles within England (provisional) - Male	2009 - 11	-	9.65	-		-
0.2i Slope index of inequality in life expectancy at birth based on national deprivation deciles within England (provisional) - Female	2009 - 11	-	7.18	-		-
0.2ii Slope index of inequality in life expectancy at birth within English local authorities, based on local deprivation deciles within each area (provisional) - Male	2009 - 11	9.4	-	-		-
0.2iii Slope index of inequality in life expectancy at birth within English local authorities, based on local deprivation deciles within each area (provisional) - Female	2009 - 11	5.8	-	-		-
0.2iv Gap in life expectancy at birth between each local authority and England as a whole - Male	2010 - 12	-0.71	0.00	-5.21		2.89
0.2iv Gap in life expectancy at birth between each local authority and England as a whole - Female	2010 - 12	-0.31	0.00	-3.51		2.89

Appendix 1 includes an alternative representation of the PHOF indicators; this time shown as a 'tartan rug' that compares Southampton with the local authorities considered 'most similar'².

Appendix 2 provides profiles of the 16 electoral wards in Southampton.

Appendix 3 is a summary of statistics for the city which can be cut-out and folded into a credit card sized 'pocket profile'.

Summary of health and wellbeing needs in Southampton

The Secretary of State for Health has placed a duty on local government and clinical commissioning groups to conduct an assessment of the current and future health needs of the population. Southampton's JSNA is available at www.publichealth.southampton.gov.uk/jsna

Through consultation with stakeholders, nine key themes were developed as the structure of the Southampton JSNA. This section summarises the key findings within each of the themes.

mental wellbeing
children
economic
protecting people
chronic conditions
environment
safeguarding
elderly
lifestyle

Economic Wellbeing

With 26% of children living in poverty in Southampton, the JSNA has identified a key need to maximise family incomes.

Recent analysis¹ of health status in the most deprived communities in the city compared to the least deprived shows evidence of a narrowing of the gap for some indicators such as breastfeeding and premature mortality from circulatory disease. However, for key measures, such as early deaths from cancer and life expectancy amongst women, the inequalities gap appears to be widening. The basic human need for shelter is examined in the JSNA and highlighted in section 1.1 on housing.

Mental Health

In Southampton there are 2,758 people registered with their GP as having a severe and enduring mental illness (schizophrenia, bipolar disorder and other psychoses) and 13,800 people have been diagnosed with depression since 2006. Not all mental illness has been diagnosed by a GP so the true population prevalence is likely to be higher.

Indeed it is estimated that one in four people will have a mental illness at some time in their lives. Over the 2010-12 period there were an average of 28 suicides per year among Southampton residents. Mental wellbeing is about more than just new possessions and expensive holidays; for instance, section 2.2 of this report talks about happiness and 'five steps to wellbeing'.

Early Years

The past few years have seen some positive changes in children's outcomes in the city; for instance, smoking in pregnancy has reduced from 25.1% in 2003/04 to 19.4% in 2011/12 whilst breastfeeding has increased over the same period from 69.4% to 76.5%.

The inequalities gap for these indicators has also reduced. There have been recent improvements in GCSE and Key Stage 2 results for Southampton's children but educational attainment remains a concern with school absence and exclusions being particular issues for the city³.

Although there has been a decline in teenage pregnancy since 1998-2000, this remains a very significant issue for Southampton with 170 under 18 year old girls becoming pregnant in 2011 giving a higher rate than amongst the city's statistical peers (see section 3.1 sexual health). The JSNA identifies a need to support young parents to reduce the cyclical nature of teenage pregnancy.

Taking responsibility for health

Smoking was at its peak in the late 1940's when 82% of men and 41% of women smoked. Rates fell steadily between the mid-1970's and early 1980's. The rate of decline then slowed and since 2000 prevalence has been declining at a rate of about 0.4% a year. Smoking prevalence in Southampton tends to be higher than the national average, largely because of the demographic and socio-economic make up of the city.

In 2003/05 Southampton's smoking prevalence was estimated to be 27% compared to around 24% nationally. By 2011/12 prevalence in the city had fallen to 23% whereas the national rate was 20%. Despite this decline, smoking remains the biggest cause of premature mortality; accounting for around 340 deaths per year in the city and an estimated 2,100 hospital admissions. The JSNA identified a need for a Tobacco Control Plan in the city; read more about this in section 2.1 on smoking.

Other lifestyle factors are also of huge importance to health and wellbeing. The JSNA covers obesity, sexual health and substance misuse. Alcohol harm needs to be tackled at individual, family, community and city levels.

Over the period 2009-11 there were 100 deaths to Southampton residents from liver disease that were considered preventable. Overall alcohol is estimated to cost the health service in Southampton about £12 million each year⁴.

Long term conditions

Around 86,000 people in Southampton (32% of the population) are estimated to be living with a long term condition such as asthma, diabetes or heart disease. Over time there have been significant improvements in mortality from some of these conditions; for instance, between 1998-00 and 2008-10 mortality rates from CHD have reduced by about 49% which is equivalent to 200 fewer deaths per year.

The recorded prevalence of certain conditions continues to rise for instance there were 7,563 people on GP's diabetes registers in 2004/05 but this had grown to 11,545 in 2012/13 (although this is partly as a result of increased recording rates).

Nevertheless, the true underlying prevalence is much higher (about 14,000 people in Southampton). Diabetes is further examined in Section 4.1 of this report.

With much co-morbidity the JSNA identified person centred care as a priority for the city and the local clinical commissioning group (CCG) now have a program in place to work towards a better model of integrated care⁵.

In 2012/13 there were 946 people with learning disabilities (LD) on primary care registers yet population prevalence in Southampton (including mild LD) is estimated to be over 4,900. The JSNA identified this group and their carers as needing better co-ordination of care.

Nationally there is a 'dementia gap' between the numbers diagnosed and the true prevalence; in Southampton there were 1,376 people recorded on GP dementia registers in 2012/13 but the true numbers are estimated to be nearer to 2,400. The JSNA highlights a key need for early dementia diagnosis and better services.

More years, better lives

The population is ageing which presents a reason to celebrate but also many challenges; by 2030 there will be 51% more people age 65+ in England compared to 2010 and currently 10.7 million people in Great Britain can expect inadequate retirement incomes⁶. In Southampton the number of people aged over 85 is expected to increase from 5,300 to 6,000 between 2011 and 2018 and then to over 10,000 by 2035. The JSNA emphasises that longer lives should be better lives and not spent in ill health.

End of life care is about enabling people to live their life to the end with dignity and having their choices respected. The proportion of people dying at home has increased very slightly over the past few years in the city but the JSNA recommends more be done to raise public awareness around death and support people to express their preferences for end of life care and place of death.

Creating a healthier environment

The environment theme covers a wide range of factors so has been subdivided into Community Safety, Transport and Place.

Violent crime rates are high in Southampton; this may be partly an affect of local recording practices but nonetheless crime, and fear of crime, represents a very real issue for the city with impacts reaching beyond the victims to the whole of society (see section 1.2 on violent crime).

Active travel offers huge potential health benefits such as reducing the risk of coronary heart disease or stroke and

improving mental well-being. In 2011 61% of employed residents in Southampton were traveling to work in a car or van – little change from in 2001. However, the proportion walking to work had increased from 13.3% to 16.5%. The layout of our city can influence opportunities to be physically active so planning policy has a key role to play. Studies have found that income-related inequality in health is affected by exposure to green space – people with close access to green space live longer, even after adjusting for social class, employment and smoking.

Improving safeguarding

The JSNA identifies key needs around the protection of vulnerable children and adults. There has been an on-going increase in the referrals of children and young people at risk of abuse or neglect over the past few years. Over the period 2009 to 2013 the rate of children in care increased by 58% in Southampton compared to an 11% increase nationally⁷. In the year ending March 2013 Southampton City Council carried out 285.7 Section 47 Child Protection investigations for every 10,000 children (compared with 111.5 per 10,000 nationally) and the city had 91.6 per 10,000 children subject to an initial child protection conference compared with 52.7 per 10,000 nationally⁸.

These high rates in Southampton reflect both the level of need in the City and children's service provision. To ensure that children's needs are met at the earliest stage, a children's services transformation programme was initiated in September 2013. Historically economic hardship has been linked to pressure on families and increased demand for safeguarding services so there is a very real risk of a worsening situation as the global economic recession and national welfare reforms start to impact.

Protecting people

Health protection includes communicable diseases – such as the common infections covered in Section 3.2 of this report – and other risks to health such as environmental health hazards, extreme weather and trading standards. Being a port city means Southampton has particular needs in terms of the risks to health that the movement of people and cargo can present. Fortunately the widespread implementation of immunisation programmes has led to huge improvements in health. There is still work to be done in promoting the uptake of vaccinations.

For instance, MMR uptake in the city whilst higher than the national average, is still below the 95% target that would offer 'herd immunity'. Additionally, coverage of seasonal flu vaccine amongst health and care workers must be improved to ensure patients are protected.

Section 1 Wider impacts on health and wellbeing

The first theme of this report is based on the wider determinants of health which include the environment, the economy and society.

The World Health Organisation (WHO) describes social determinants of health as the conditions in which people

are 'born, grow, live, work and age'. Lack of income, inappropriate housing, unsafe workplaces and poor access to healthcare are just some of the influences on the

health of individuals and communities. Improving educational attainment, clever use of planning policy and enabling communities to work together can all have a positive impact on health and reduce inequalities. These issues are dealt with in more detail in the Southampton JSNA www.publichealth.southampton/jsna.

Wider determinants of health	Period	Local value	Eng. value	Eng. lowest	Eng. highest
1.011 Children in poverty (all dependent children under 20)	2011	25.3	20.1	46.1	6.6
1.011 Children in poverty (under 16s)	2011	25.9	20.6	43.6	6.9
1.021 School Readiness: The percentage of children achieving a good level of development at the end of reception	2012/13	50.8	51.7	27.7	69.0
1.022 School Readiness: The percentage of children with free school meal status achieving a good level of development at the end of reception	2012/13	37.9	36.2	17.8	60.0
1.023 School Readiness: The percentage of Year 1 pupils achieving the expected level in the phonics screening check	2012/13	70.8	69.1	68.8	79.0
1.024 School Readiness: The percentage of Year 1 pupils with free school meal status achieving the expected level in the phonics screening check	2012/13	62.0	65.8	37.2	70.9
1.03 Pupil absence	2011/12	5.87	5.11	6.66	4.30
1.04 First time entrants to the youth justice system	2012	968	537	1,427	151
1.05 16-18 year olds not in education employment or training	2012	6.3	5.8	10.5	2.0
1.061 Adults with a learning disability who live in stable and appropriate accommodation	2011/12	90.4	70.0	30.9	93.8
1.061 % of adults in contact with secondary mental health services who live in stable and appropriate accommodation	2012/13	27.4	55.5	5.5	64.1
1.061 Gap in the employment rate between those with a long-term health condition and the overall employment rate	2012	5.1	7.1	-5.3	21.7
1.061 Gap in the employment rate between those with a learning disability and the overall employment rate	2011/12	62.7	63.2	40.2	73.1
1.061 Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate	2012/13	65.7	62.3	53.1	75.1
1.091 Sickness absence - The percentage of employees who had at least one day off in the previous week	2009 - 11	2.2	2.2	3.5	0.6
1.091 Sickness absence - The percent of working days lost due to sickness absence	2009 - 11	1.5	1.5	2.7	0.3
1.10 Killed and seriously injured casualties on England's roads	2010 - 12	54.7	40.5	81.8	16.9
1.11 Domestic Abuse	2011/12	16.2	18.2	5.2	34.4
1.121 Violent crime (including sexual violence) - hospital admissions for violence	2010/11 - 12/13	88.9	57.6	167.5	9.3
1.121 Violent crime (including sexual violence) - violence offences per 1,000 population	2012/13	19.0	10.6	4.1	27.1
1.121 1.121 Violent crime (including sexual violence) - Rate of sexual offences per 1,000 population	2012/13	1.06	0.63	0.34	2.01
1.131 Re-offending levels - percentage of offenders who re-offend	2011	30.2	25.9	14.4	36.3
1.131 Re-offending levels - average number of re-offences per offender	2011	0.97	0.78	0.31	1.27
1.141 The percentage of the population affected by noise - Number of complaints about noise	2011/12	10.5	7.5	58.4	2.5
1.141 The percentage of the population exposed to road, rail and air transport noise of 65dB(A) or more, during the daytime	2006/07	7.7	5.4	0.3	29.8
1.141 The percentage of the population exposed to road, rail and air transport noise of 55 dB(A) or more during the night-time	2006/07	34.3	12.6	0.8	57.5
1.151 Statutory homelessness - homelessness acceptances	2011/12	1.9	2.3	0.2	6.7
1.151 Statutory homelessness - households in temporary accommodation	2011/12	1.5	2.3	32.4	0.0
1.15 Utilisation of outdoor space for exercise/health reasons	Mar 2012 - Feb 2013	15.0	15.3	0.5	41.2
1.17 Fuel Poverty	2011	9.8	10.9	18.0	3.8
1.181 Social Isolation: % of adult social care users who have as much social contact as they would like	2012/13	40.8	43.2	31.9	53.5
1.181 Loneliness and isolation in adult carers	2012/13	47.4	41.3	23.9	58.5

The first domain of the PHOF covers these wider impacts on health and wellbeing. Southampton has poorer outcomes than nationally in terms of children in poverty, pupil absence, youth offending, road traffic accidents, violent crime and complaints about noise (see spine chart below).

This shows that although the number of accidents has fallen over the past decade, the proportion that are serious accidents has increased – see the full report for further details www.publichealth.southampton.gov.uk/healthintelligence/briefings.aspx.

As rates of injury and death from road traffic accidents are significantly higher in Southampton than in many of its similar authorities (see chart below) further work has been done on this by the Public Health information team.

This year’s report focuses in on two very important wider impacts on health –housing and violent crime.

Number of people reported killed or seriously injured on the roads, all ages, per 100,000 resident population

Southampton and ONS comparators: 2010-12



DATA SOURCE: Department for Transport.

NOTES: Data quality varies as there are differences between police forces in procedures for recording, collecting and collating. Not all road casualties are reported to police. Areas with low resident populations but which have high inflows of people or traffic may have artificially high rates because at-risk resident population is not an accurate measure of exposure or transport. This is likely to affect the results for employment centres and sparsely populated rural areas which have a high number of visitors or though traffic.

1.1 Housing

Why is this issue important?

Shelter is a primary need. Decent and accessible housing is a fundamental starting point for people to enjoy better health; it allows them to connect with employment and social activities which themselves mitigate against social isolation and mental and physical ill health.

The relationship between housing and health is multi-layered: for example, poor quality building materials can affect a resident's health; poor design can lead to hazards; and overcrowding can lead to spread of disease and poor mental health. However, poor housing conditions often coexist with other forms of deprivation (unemployment, poor education, ill health, social isolation etc), making it difficult to isolate, modify and assess the overall health impact of housing conditions.

The effects of housing on health¹⁰

Poor housing conditions are estimated to cost the NHS at least £600 million per year¹¹. The conditions associated with poor housing are summarised above but the strongest links are with accidents (of which 45% occur in the home) and cold (as covered in the 2011 Public Health Annual Report www.publichealth.southampton.gov.uk/healthintelligence/phar.aspx)

There are broader aspects of housing that affect health such as overcrowding, sleep deprivation, community safety and features of the local infrastructure including proximity to parks and shops selling affordable, healthy food¹². Housing can have a huge impact on mental wellbeing; Bonnefoy¹³ explains "poor quality housing, providing insufficient protection from the outside, from noise, from scrutiny, and intrusion can be the source of major suffering".



Poor housing conditions are estimated to cost the NHS at least £600 million per year¹¹. The conditions associated with poor housing are summarised above but the strongest links are with accidents (of which 45% occur in the home) and cold (as covered in the 2011 Public Health Annual Report www.publichealth.southampton.gov.uk/healthintelligence/phar.aspx)

Houses in Multiple Occupation (HMOs) are defined as dwellings containing more than one household and residents of HMOs have been found to be four times more likely to suffer injury and twice as likely to die in a fire than people living in single dwellings¹².

In Southampton 25% of all households live in privately rented accommodation, the national average is just 17%. Of the privately rented homes in the city, over 7,000 are HMOs.

In 2011, 13.6% of households in the city were defined as over-crowded according to the definition used in the Census. This is higher than the national average of 8.7% and also higher than many of the city's most similar authorities. In the city centre wards of Bargate and Bevois more than a quarter of households are defined as over-crowded and in some neighbourhoods in these wards the proportion rises to over 40%.

Over 28,000 (38%) of privately owned and rented homes in the city do not meet the Decent Homes Standard, of which 8,500 are occupied by vulnerable people. Older properties (pre-1919) are generally in the worst condition. The chart below shows that Southampton has a relatively high percentage of non-decent private housing stock compared to its most similar authorities. The total cost to make decent the private dwellings in the city that have health and safety hazards, or significant repair issues, poor amenities or are lacking in adequate energy efficiency measures is estimated at £111 million¹⁴.

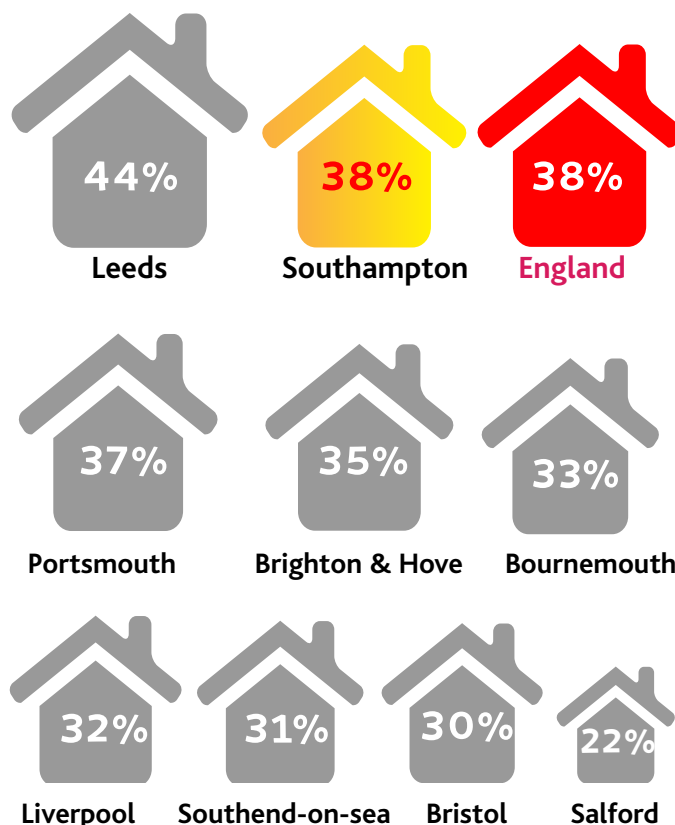
There is an estimated need for 3,900 adaptations for disabled people which is anticipated to cost around £21 million.

Nearly a quarter (23%) of all homes in the city are in the social housing sector of which over 17,000 are in the ownership and management of Southampton City Council (SCC). Whilst 96% of SCC properties meet the Decent Homes standard, there will still be an investment of over £200 million needed to maintain and improve homes in the next four years.

SCC has over 14,000 households on its housing waiting list; even though 1,600 properties are let each year there are, on average, 400 new applications each month. The average wait for 1 bed property is 7 years and the average wait for three bed house is six to seven years. Therefore the city has about 2,000 overcrowded households within social housing. In 2011/12 over 1,500 homeless households were assessed with the majority being supported to maintain their

Percentage of private household in non-decent homes

Southampton and ONS comparator authorities



SOURCE: Local Authority Housing Condition Survey.
 NOTES: Definition according to national decent homes standards as defined in Housing act 2004. Figures related to 2008 except for Liverpool (2010), Salford (2010), Bristol (2011) and Southend (2011). Data not available for Newcastle, Plymouth and Sheffield.

accommodation. However, 250 single homeless people are seen each month by the Street Homeless Prevention Team and on average 10 to 12 rough sleepers are found on outreach each week.

SCC also has over 3,300 properties specifically designated for older people. The population is ageing and longer term population projections predict a 42% increase in over 65s in Southampton between 2010 and 2035, with numbers aged over 85 reaching 10,000 by 2035.

What can be done?

There is already much work going on to improve housing for the residents of Southampton. For instance, in 2011, SCC was awarded £6.2m in grant funding from the Community Energy Saving Programme (CESP) via British Gas. This funding was to make considerable energy saving improvements and reduce tenants' heating and hot water bills in the four tower blocks in International Way (Oslo Towers, Havre Towers, Hampton Towers and Copenhagen Towers). Rotterdam was initially excluded from the CESP works and was later funded separately from the Energy Company Obligation (ECO) part of Ofgem for an identical programme of work.

An additional £3m was added to this budget by SCC to enable a 'whole building' approach to both improving residents' homes and reducing the carbon footprint of the 520 homes (including Rotterdam).

Additionally SCC now has an additional licensing scheme for smaller HMOs in four wards of the city – Bargate, Bevois, Swaythling and Portswood which aims to ensure well managed and safe properties. This will protect the welfare of the residents and reduce impacts on the neighbourhood.

In the 2015/16 Spending Review the government allocated a budget of £3.8bn for health and social care services, shared between NHS and local authorities to provide more integrated services. Social housing is well placed to be a partner in developing local integrated services as the close relationship with tenants mean staff can be involved in prevention work.

Other housing initiatives that could improve health and wellbeing include tackling the hardest to heat properties and giving tenants training on energy saving strategies plus more control over their own heating.

Key recommendations

- Mitigating the impact of overcrowding and poor housing on efforts of parents to help their children succeed
- Designing out crime through town planning and estate regeneration
- Social housing providers should be fully engaged in local plans to develop more integrated health and social care services
- Social housing staff should be trained and help to promote health campaigns in order to support tenants and enhance their wellbeing
- The government's move towards integrated services should be used as an opportunity for social housing to become a service provider for wider health commissions as it is for sheltered housing supported care
- Designing and prioritising specialist homes for older people, along with services that help people adapt their homes and increase use of assistive technology to reside at home for longer
- Adopt an affordable warmth policy which prioritises energy efficiency measures in council accommodation along with access to information and training about how to reduce energy costs and keep the home warm, damp and draught free
- Expand the programme of retrofit measures for SCC properties to improve heating and insulation systems.

1.2 Violent Crime

Why is this issue important?

Violence is estimated to cost the NHS £2.9 billion every year. This figure underestimates the total impact of violence on health as, for instance, exposure to violence as a child can increase risks of substance abuse, obesity and illnesses such as cancer and heart disease in later life. The total costs of violence to society are estimated at £29.9 billion per year.¹⁵

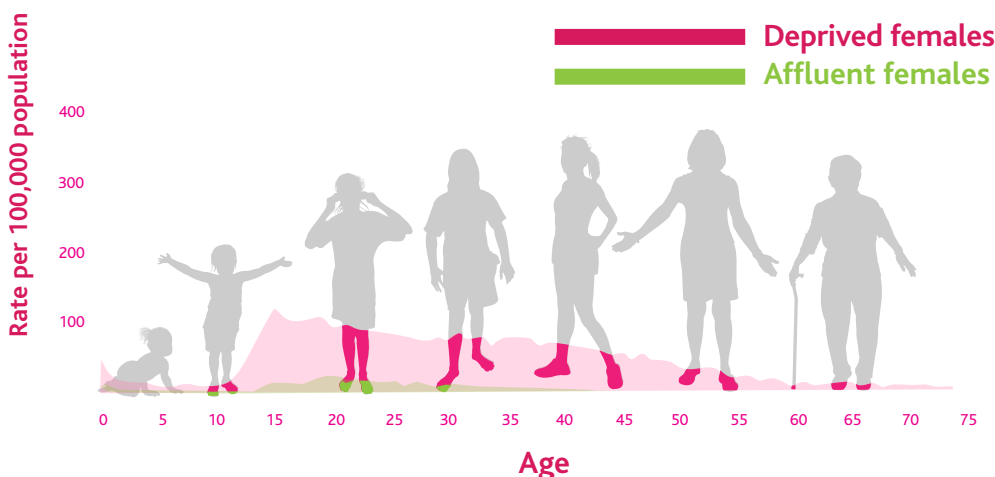
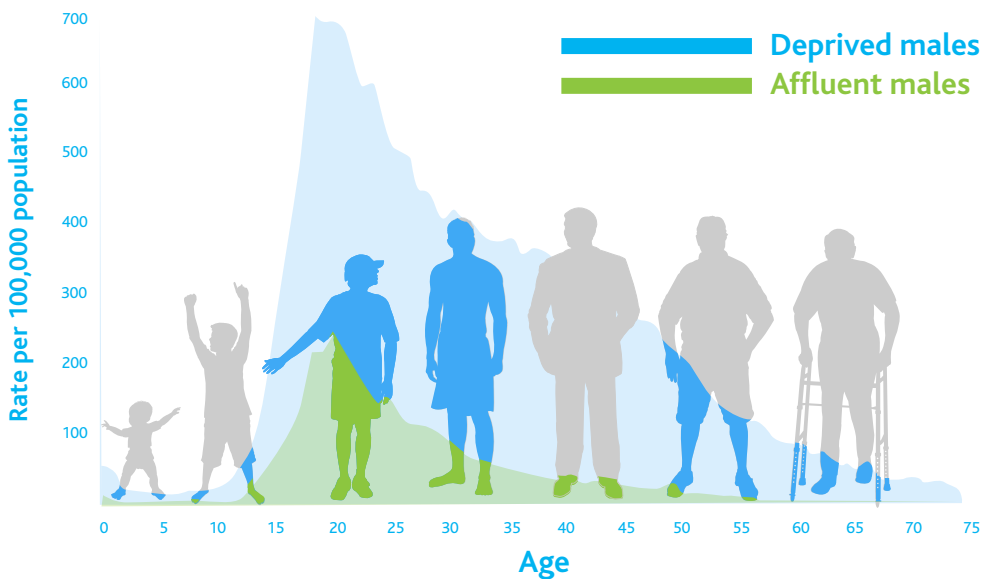
Violence has immediate impacts; firstly the obvious physical and emotional injury but also wider effects on education, employment and housing. In the short term it can also lead to disrupted eating or sleeping patterns and use of alcohol or drugs as a coping mechanism. Fear of violence in the community can limit the use of parks and open spaces for recreation and physical exercise. Longer term impacts of childhood violence include poor educational attainment, reduced economic prospects, behavioural problems, substance

misuse and poor physical and mental health. Also, violence is contagious; exposure to violence, especially as a child, makes individuals more likely to be involved in violence in later life.

Violence frequently has a disproportionate impact on older people. Despite the absolute number affected by violence being lower than amongst younger adults and teenagers, the fear of crime and violence for older people can be especially disabling and give rise to significant emotional distress, anxiety and social isolation.

Violence shows one of the strongest inequalities gradients; emergency hospital admission rates for violence are around five times higher in the most deprived communities than in the most affluent (see chart below).

Annual rates of emergency hospital admissions for violence across England, by age sex and deprivation¹⁶



Violence prevention is a critical element in tackling other public health issues. Violence impacts on mental wellbeing and quality of life, prevents people using outdoor space and public transport and inhibits the development of community cohesion.

For every hospital admission for violence, a further ten assault victims require treatment at emergency departments (EDs). Violent crime represents, on average, just under a quarter of all crime.

The Southampton context

The chart below shows that violent crime in Southampton has been declining over the past few years.

However, police recording of violent crime shows rates in Southampton are still very high compared to the national average and other similar authorities (see chart below). Clearly this indicator is subject to variation according to the recording practices of each police force. It is also important to consider that a large proportion of violent crimes are not reported to the police.

In order to better understand the scale of the violent crime problem in Southampton we can also look at other sources such as hospital statistics. During 2009/10-2011/12 the rate

of admissions due to violence was higher in Southampton (directly age standardised rate of 92.1 per 100,000) than the national average (67.7 per 100,000).

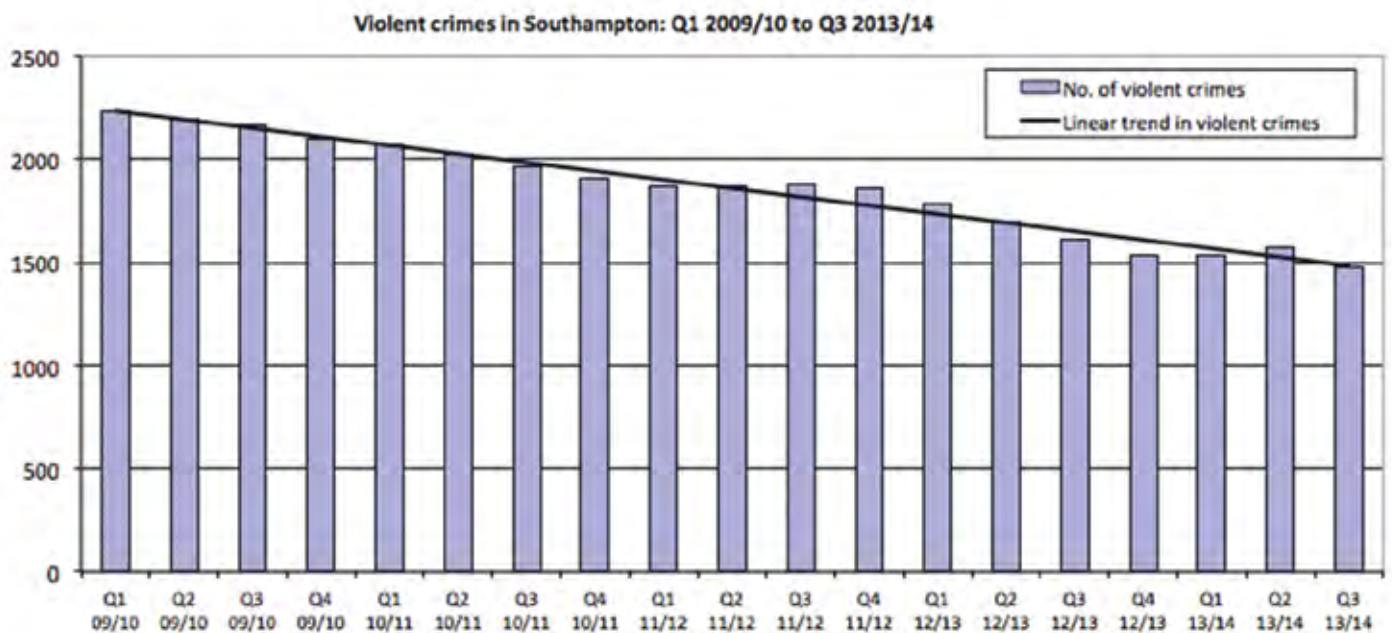
The city rates were also significantly above some of its most similar authorities (e.g. Sheffield, Brighton and Portsmouth) but lower than Leeds, Salford and Liverpool. Hospital admissions generally represent the more serious forms of violence.

The Southampton Community Safety Strategic Assessment¹⁷ identifies the key components of violent crime as:

- Night time economy alcohol-related violence which makes up about 11.5% of all violent crime
- Domestic violence which accounts for 20% of all violent crime
- Serious sexual violence
- Drug related violence.

Southampton is a leading city in collecting Emergency Department (ED) data on assaults during peak night time economy periods which are thus linked to predominantly alcohol-related incidents. This data is a valuable indicator

Violent crimes in Southampton: Q1 2009-10 to Q4 2012-13



SOURCE: Hampshire Police

Violent crime (including sexual violence) offences

Southampton and ONS Comparators: 2011/12



SOURCE: Office for National Statistics and Home Office

as it captures unreported incidents and, therefore, together with police data provides a more accurate picture of the prevalence of alcohol-related violence in the city. ED assault data (between the hours of 6pm and 9am) show a fall from 862 presentations in 2011 to 758 in 2012: a 12% reduction.

There were 196 sexual offences reported to police in the Southampton Strategic Assessment period and this represents a 27.7% fall on the previous year. This also continues a reducing trend over the last two years. Detection rates for this crime in Southampton have increased. However, it is known that rape and other serious sexual offences are under-reported. Although the number of recorded crimes of this type is relatively low, and the potential risk of 'stranger' attacks exceptionally low, this crime-type has a high impact on victims and a high public profile with media coverage often fuelling fear of crime especially amongst young people.

With respect to drug crime, transient Class A suppliers continue to infiltrate the city, primarily from London, bringing a risk of violence. Areas most vulnerable are Newtown, St. Marys and Millbrook. Knives and bladed articles remain the most common weapons. There are currently 24 overt investigations and 10 networks believed to be at increased risk of committing drug-related violence within the city.

Victims of violence are more likely to become perpetrators of violence so it is worrying that in a recent survey of Southampton school pupils, over 30% of those respondents from years 4 and 6 had been bullied.

What can be done?

Much is already being done in the city to reduce violent crime and its impacts:

- The Safe City Partnership has over the last three years ensured that there are a suite of initiatives to tackle this issue. High visibility and targeted police patrols taking early and robust action to deal with crime and disorder obviously play a big part in reducing violent crime alongside other key measures including the regular deployment of Taxi Marshalls, Street Pastors and the ICE (In Case of Emergency) Bus. In addition the Licensing Trade, supported by SCC and the Police has introduced the Red Card scheme.
- The ICE Bus has been in operation since December 2009 and has dealt with over 1,300 clients.
- Safe in Sound is a volunteer peer led project primarily based in the City Centre and looks at raising awareness of

health related issues and potential risk taking behaviours in the night time economy. Their work focuses on substance and alcohol use, sexual health and the personal safety of those people who are using venues in town.

- Over the last year the number of volunteers who are now patrolling as Street Pastors has increased. They continue to patrol the Night Time Economy every Friday and Saturday between 10pm and 4pm, as well as one Tuesday a month.
- In May 2012 Hampshire Constabulary launched Operation Fortress, a two-year programme to reduce the harm of organised and violent crime linked to drugs in Southampton. The programme worked closely with partner agencies, and has successfully targeted dealers and the drug supply chain, specifically those that engaged in violent and exploitative behaviours. Numerous arrests and prosecutions have resulted, a local crack house has been closed and a significant amount of drugs and money has been recovered in this period.

There are other prevention approaches to violence which could be adopted in Southampton. For instance, interventions that develop parenting skills, support families and strengthen relationships between parents, carers and children can have long lasting violence prevention benefits. Such interventions are cost-effective; they can prevent child abuse and improve child behaviour, reducing children's risks of involvement in violence in later life.¹⁵

Delinquent behaviour, criminal activity and gang membership in youth are key risk factors for involvement in violence. Interventions that work with high risk youth to change their behaviour can be important in preventing future violence.

The consumption of alcohol is strongly associated with violence. Measures to limit access to alcohol and reduce alcohol consumption among hazardous and harmful drinkers can have important violence prevention impacts. The criminal justice system does direct offenders into addiction treatment (both alcohol and drugs) on discharge from court or prison, but the widespread availability of low cost alcohol, and a culture that supports binge drinking and excess alcohol use perpetuates the problem and makes prevention difficult.

Pricing of alcohol affects consumption; based on a review of the evidence, the former Chief Medical Officer for England recommended a minimum price of 50p per unit in his 2008 Annual Report¹⁸.

Community interventions are important including neighbourhood infrastructure and access to green space. It is also crucial to offer care and support to the victims of violence to break the cycle.

Through the Health and Social Care Act, Directors of Public Health in local authorities are responsible for the public health aspects of the promotion of community safety, violence prevention, responses to violence, and local initiatives to tackle social exclusion.

Key recommendations

- Increase violence prevention measures such as family support and community action
- Explore the potential of the late night levy (a way licensing authorities can raise a contribution from late-opening alcohol suppliers towards policing the night-time economy (Police Reform and Social Responsibility Act 2011))
- Work with schools to raise awareness on anti bullying and 'youth on youth' violence
- Promote safe drinking awareness with teenagers and young adults in areas where high rates of violence occur
- Increase access to alcohol treatment for those that drink harmful levels of alcohol, and target individuals who cause alcohol offenses
- Continue advocacy and lobbying on minimum pricing for alcohol.

Section 2

Health lifestyles

This section examines the health improvement domain of the PHOF which covers 30 outcome areas relating to healthy lifestyle choices and mental wellbeing across the life course.

Health Improvement	Period	Local value	Eng. value	Eng. lowest	Range	Eng. highest
2.01 Low birth weight of term babies	2011	2.7	2.8	5.3		1.6
2.02 Breastfeeding - breastfeeding initiation	2012/13	74.6	73.9	40.8		94.7
2.02i Breastfeeding - breastfeeding prevalence at 6-8 weeks after birth	2012/13	43.5	47.2	17.5		93.3
2.03 Smoking status at time of delivery	2012/13	15.2	12.7	30.8		2.3
2.04 Under 18 conceptions	2011	47.4	30.7	58.1		9.4
2.04i Under 18 conceptions: conceptions in those aged under 16	2011	10.5	6.1	11.5		3.2
2.06i Excess weight in 4-5 and 10-11 year olds - 4-5 year olds	2012/13	22.3	22.2	32.2		16.1
2.06ii Excess weight in 4-5 and 10-11 year olds - 10-11 year olds	2012/13	36.4	33.3	44.2		24.1
2.07i Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-14 years)	2012/13	100.0	103.8	191.3		61.7
2.07ii Hospital admissions caused by unintentional and deliberate injuries in young people (aged 15-24)	2012/13	141.2	130.7	277.3		63.8
2.08 Emotional well-being of looked after children	2011/12	-	13.6	9.5		20.1
2.12 Excess Weight in Adults	2012	64.8	63.8	74.4		45.9
2.13i Percentage of physically active and inactive adults - active adults	2012	56.0	56.0	43.8		66.5
2.13ii Percentage of active and inactive adults - inactive adults	2012	30.9	28.5	40.2		15.2
2.14 Smoking Prevalence	2012	22.5	19.5	29.8		12.1
2.14i Smoking prevalence - routine & manual	2012	30.3	29.7	44.3		14.2
2.15i Successful completion of drug treatment - opiate users	2010	8.5	8.2	3.8		17.6
2.15ii Successful completion of drug treatment - non-opiate users	2012	95.0	40.2	17.4		95.4
2.17 Recorded diabetes	2012/13	5.37 *	6.01	3.69		6.42
2.20i Cancer screening coverage - breast cancer	2013	69.9	78.3	56.2		84.3
2.20ii Cancer screening coverage - cervical cancer	2013	71.1	73.9	58.6		79.9
2.21vii Access to non-cancer screening programmes - diabetic retinopathy	2011/12	75.5	80.9	66.7		95.0
2.22i Take up of NHS Health Check Programme by those eligible - health check offered	2012/13	14.2	16.6	0.7		42.5
2.22ii Take up of NHS Health Check programme by those eligible - health check take up	2012/13	61.4	49.1	7.7		100.0
2.23i Self-reported well-being - people with a low satisfaction score	2012/13	4.4	5.8	10.1		3.4
2.23ii Self-reported well-being - people with a low worthwhile score	2012/13	3.7	4.4	8.2		2.9
2.23iii Self-reported well-being - people with a low happiness score	2012/13	10.1	10.4	15.8		5.5
2.23iv Self-reported well-being - people with a high anxiety score	2012/13	33.0	21.0	29.0		10.9
2.24i Injuries due to falls in people aged 65 and over (Persons)	2011/12	2257	1666	2,585		1,070
2.24ii Injuries due to falls in people aged 65 and over (males/females) - Male	2011/12	1763	1302	2,538		704
2.24iii Injuries due to falls in people aged 65 and over (males/females) - Female	2011/12	2751	2028	3,713		1,296
2.24iv Injuries due to falls in people aged 65 and over - aged 65-79	2011/12	1402	941	1,726		545
2.24v Injuries due to falls in people aged 65 and over - aged 80+	2011/12	6107	4924	8,965		2,892

The foundations for virtually every aspect of human development – physical, intellectual and emotional are laid in early childhood. What happens during these early years (starting in the womb) has lifelong effects on many aspects of health and wellbeing¹⁹.

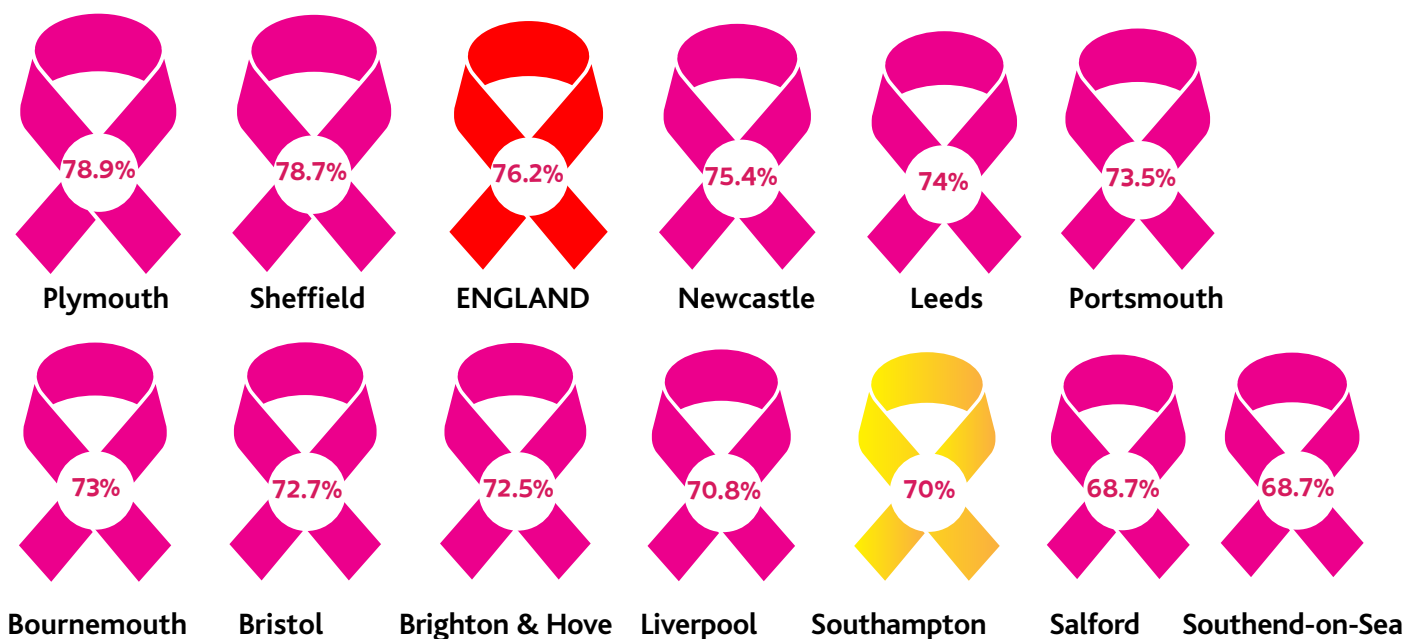
In Southampton many outcomes for children and young people are poor. For instance, injuries to children are an issue and teenage conceptions are very high in the city (a matter which is covered in more detail in Section 3.2 on Sexual Health).

Adult smoking prevalence and smoking in pregnancy are higher than the national average and in a recent, local school survey over 46% of children surveyed said that one or both of their parents smoke²⁰. Section 2.1 of this report explores the issues around smoking and what can be done.

Amongst adults PHOF monitors uptake of the NHS Health Check programme which was described in last year's report²¹ as well as screening programmes. Southampton has poorer uptake of breast cancer, cervical cancer and diabetic retinopathy screening rates than nationally (see chart below).

Breast cancer screening coverage

Southampton and ONS Comparators 2013



SOURCE: PHOF www.phoutcomes.info

2. 1 Smoking

Why is this issue important?

Smoking remains the main cause of preventable death in England, and is a major cause of health inequalities.

There is a high cost from smoking both to individuals and local economies, causing nearly 80,000 deaths in England during 2011²². Smoking harms nearly every organ of the body and dramatically reduces both quality of life and life expectancy. Smoking impacts on the families of smokers; every year in the UK second hand smoke results in over 20,000 cases of lower respiratory tract infection, 120,000 cases of middle ear disease and around 9,500 admissions to hospital²³.

Nearly one quarter of people still smoke in Southampton. Compared to the national picture where smoking prevalence has decreased to 20%, prevalence in Southampton is 22.6%. More people die in Southampton as a result of smoking than the national average (age standardised rate of 234 per 100 000, compared to 201 in England), and deaths from lung cancer and chronic obstructive pulmonary disease are also higher than the national average.

Southampton's Health and Wellbeing Strategy²⁴ has identified

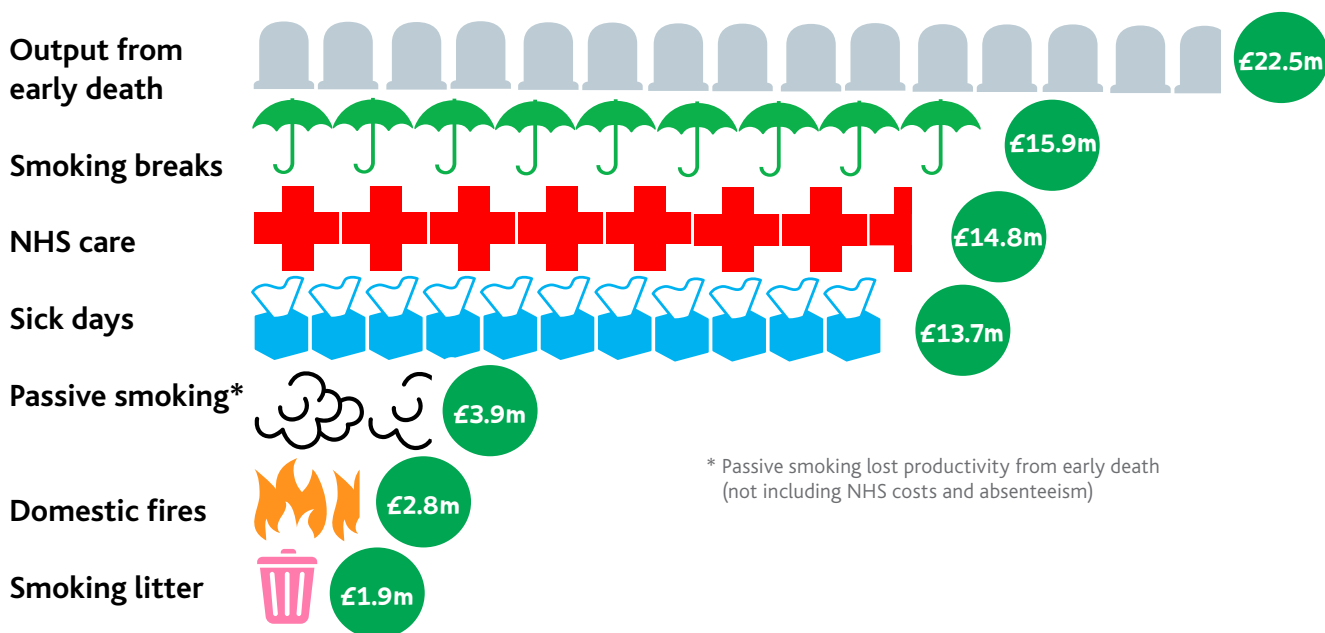
smoking as one of the key challenges in the city to be addressed. For this reason there continues to be investment in helping smokers to quit, educating young people about the dangers of smoking and prevention of long term conditions by reducing the harmful effects of tobacco. An estimated 870 children start smoking each year in the city²⁵.

We know that smoking is a major cause of health inequalities and that prevalence rates vary across the city, with the highest rates estimated to be in Redbridge, Weston and Thornhill. Hospital admissions due to smoking are higher than the national average, and the highest rates are in Bitterne and Redbridge wards (2426 per 100,000 and 2,369 per 100,000 respectively for 2009/10-2011/12) compared to the city average of 1,747 per 100,000. Smoking rates are higher amongst the city's routine and manual classes at 36.8% compared to the national average of 30.3%²⁶. Smoking in pregnancy rates are also higher than average at 16.6%, compared to the national average of 13.2%.

Smoking in Southampton is estimated to cost our population £70.9m annually²⁷. Someone smoking 20 cigarettes a day spends £2,555 a year on tobacco (based on the average cost of £7 a pack). Local employers and businesses lose from increased sickness, and an estimated £81.1m annually is lost to Southampton's local economy by spending on cigarettes and tobacco. Around £1.9m is spent by SCC each year on picking up litter from tobacco products.

The cost of Smoking in Southampton

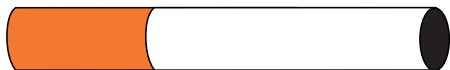
Action on smoking and health 2013²⁷



* Passive smoking lost productivity from early death (not including NHS costs and absenteeism)

Estimated cost to smokers and society in Southampton

£81.1million



Smokers spending on tobacco

£75.5 million



Total costs to society

What can be done?

There are some positive actions that can be taken and smoking is now one of the key priorities of the Health and Wellbeing Strategy. SCC has shown its commitment to reducing the harm done by tobacco by joining the Smoke Free Action Coalition in October 2013. We do need to do better in this area and the Council is currently developing its first Tobacco Control Plan to support this work, outlining key priorities for 2014–2016 to reduce the harmful effects of tobacco in the city.

The key work streams of the Tobacco Control Plan are:

1. Stopping the promotion of tobacco

Supporting the work of Trading Standards and Environmental Health, in partnership with the local business community, to ensure compliance with legislation in local businesses.

2. Effective regulation of tobacco products

Partnership working with Trading standards, Police and HMRC to improve local intelligence on illicit tobacco to control smuggled and counterfeit tobacco. Local authority support for the Local Government Declaration on Tobacco Control, and the campaign for plain standardised tobacco packaging through the Smoke Free Action Coalition.

3. Helping tobacco users to quit

- Commissioning specialist services to support all smokers wanting to quit ensuring open access, and in particular:
- Pregnant women who smoke. Ensuring that local Maternity services actively work alongside other partners to reduce smoking rates among pregnant women
- Young people. Building on existing work to deliver targeted evidence-based interventions to ensure all schools in the city comply with legislation and have smoke free policies in place, and in addition the delivery of educational and quitting programmes in schools and colleges.

4. Reducing exposure to second hand smoke, especially children.

Promotion of smoke free environments and raising awareness of the harm caused by tobacco through smoke free homes campaign work with Sure Start children's centres and early years settings.

5. Effective communications for tobacco

Ensuring a robust approach to working with the media, communications and public education about smoking by harnessing local authority communications and delivering local support for key national campaigns, such as No Smoking Day in March, Stoptober and Smokefree homes.

Quote from a Stoptober participant

"My family had nagged me to give up for a long time and my daughter had me on a 'reduction' programme earlier this year, so the next step for me was definitely Stoptober. I had support from a Public Health Practitioner and went to Quitters for advice and nicotine replacement therapy before the big day. Throughout October I also attended weekly Quitters sessions.

I made it through Stoptober and have now gone for nearly 2 months without a cigarette. I highly recommend it!! It's not been easy but I now have more money and can run further, I've stopped coughing and generally feel fitter. I still can't believe I've quit – it feels great. Thanks to Stoptober and everyone else who supported me."



Key recommendations

- Adoption and implementation of the SCC Tobacco Control Plan
- Continued investment to tackle smoking with young people
- Investment to support work with families on smoke free homes and cars
- Support for the implementation of NICE recommendation for routine carbon monoxide screening for all pregnant women in maternity settings (<http://guidance.nice.org.uk/PH26>).

2.2 Happiness

Why is this issue important?

In recent years there have been substantial advances in the science of wellbeing with increasing evidence as to the factors that affect happiness and new ways of measuring happiness more accurately. We now have the opportunity to use this evidence to increase wellbeing in our personal lives, workplaces, schools and communities.

Added to this is an emerging body of proof showing a link between positive emotions, happiness and our state of health right across the life course. In childhood issues such as neglect, violence or living in poor accommodation can affect the developing brain and other organ systems, which can lead to a faster heart rate, higher blood pressure and a rise in stress hormones. Anxiety or depression increases the risk of dying in people with heart disease. Loneliness and social isolation can have a major impact on older people's health.

Financial difficulties have a profound impact on happiness and wellbeing. Mental health is affected by the psychological effects of low income and unemployment as well as by the material consequences of financial pressures. The global economic downturn plus the impact of benefit reforms in this country are likely to have a significant impact on the population's wellbeing.

The Office of National Statistics (ONS) started to measure 'how society is doing' in 2010²⁸ when there was recognition that measures such as Gross Domestic Product (GDP) were inadequate as indicators of the state of the nation. The new national measures were designed to assist the government in developing positive policies to improve wellbeing. According to the UK's statisticians the factors most associated with personal wellbeing are health, employment and relationship status.

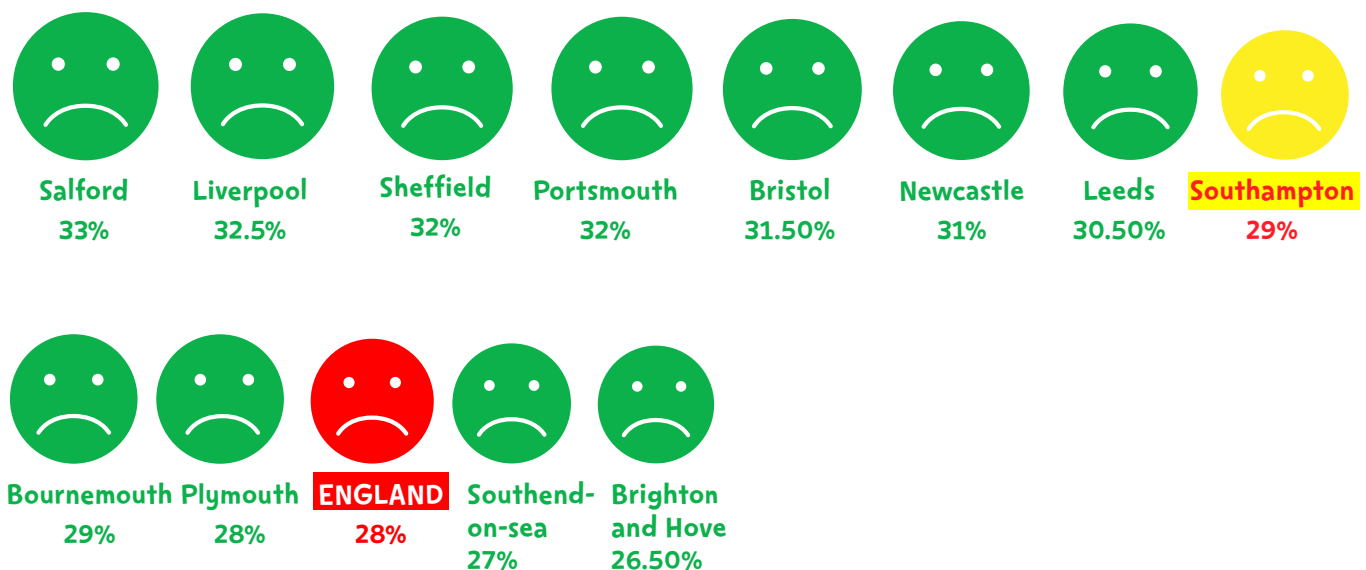
The graph below shows how Southampton compares to its statistical neighbours in terms of self reported wellbeing – people with a low happiness score. The city value is close to the national average.

This overall measure masks persistent health inequalities in the city and the number of people living with a severe mental illness is higher than the rate for England; these issues clearly have an impact on the physical health and wellbeing of those affected and their families.

Data from 12 GP practices in Southampton has been analysed to show how more deprived areas have higher rates of recorded depression even after age has been accounted for (see chart on the right).

Self-reported well-being – people with a low happiness score

Southampton and its ONS peers 2011-12

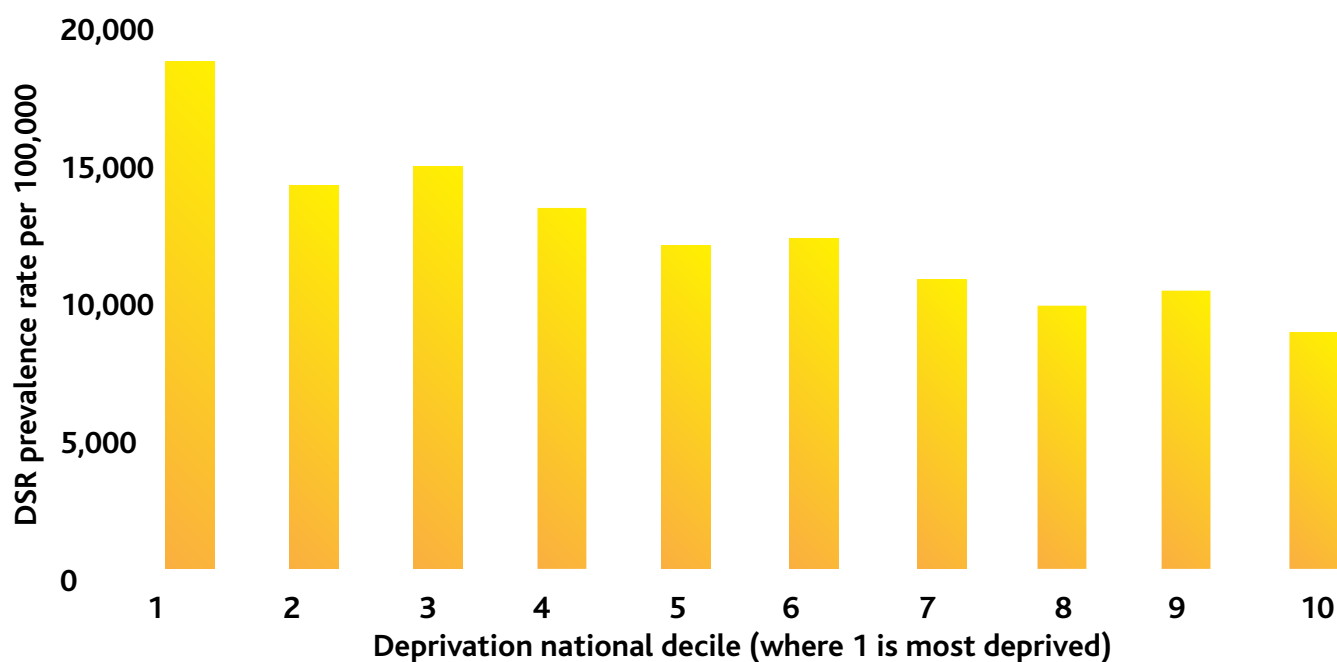


Percentage with a low happiness score

SOURCE: Office for National Statistics experimental Annual Population Survey (APS) access via www.phoutcomes.info

NOTES: Estimates of subjective wellbeing from the first annual experimental Annual Population survey (APS) Subjective well-being dataset.

Prevalence of recorded depression by deprivation decile: 12 practices in Southampton



SOURCE: ACG tool extract September 2012

A recent survey of school children in Southampton used a 'happiness scale' developed by Ofsted²⁹ in consultation with children and young people. The survey found that 12.7% of children surveyed in Year 4 had a score of 'unhappy' rising to 17.6% amongst children surveyed from Years 9 and 11.

According to a study carried out for the Office for National Statistics in 2004/05³⁰ one in ten children aged 5 to 16 has a clinically significant mental health problem. Research has identified two main dimensions termed resilience and risk factors that influence whether a child is likely to develop mental health problems.

- Resilience refers to protective factors enabling some children to cope
- Risk factors increase the probability of a child developing a mental health problem.

There is a growing evidence base around building on the protective factors which enable children to become more resilient in order to promote mental health³¹.

In Southampton welfare reforms are estimated to result in an overall financial impact of £53 million in 2015/16 which equates to 34,157 households having an average loss of £1,551 per year³². The impacts of these changes on mental wellbeing are likely to be significant.

What can be done?

The return of public health to local authorities brings with it greater opportunities to improve wellbeing by tackling health inequalities and supporting innovative partnerships and plans to improve peoples health and wellbeing.

The 'Be Well' Public Mental Health and Wellbeing Strategy for Southampton³³ identified ten key areas, based on local need, that seek to improve people's wellbeing over the next three years. At the heart of this strategy are the Five Ways to Wellbeing³⁴.

Five Ways to Wellbeing

- 1 Be Connected** – try and find ways to connect with the people around you. With family, friends, colleagues and neighbours. At home, work, school or in your community. Building these connections will support and enrich you every day.
- 2 Be Active** – go for a walk or run. Step outside. Cycle, play a game, garden, dance. Exercising makes you feel good. Discover an activity you enjoy that suits your level of fitness.
- 3 Be Curious** – Explore what is going on around you, notice the changing seasons. Reflecting on your experiences will help you appreciate what matters to you.
- 4 Be Keen to learn new things** – Sign up for that course, learn to cook your favourite food or play a musical instrument. Learning new things will make you feel more confident as well as having fun.
- 5 Be Helpful** – do something nice for someone. Thank someone. Volunteer your time, join a community group. Seeing yourself and your happiness links to the wider community, can be rewarding and creates connections with people around you.

Key recommendations

- Adopt a public health approach in the development of strategies which promote wellbeing for the whole population including activities which build social capital and community resilience
- Develop and deliver an anti-stigma work stream that reduces the discrimination experienced by people with mental health issues
- Continue to publicise and promote the five ways to wellbeing across the city
- Expand and develop the successful local emotional first aid programme so that more young people, families and school communities benefit from this approach to mental health resilience.

There are also a number of local initiatives in the city that aim to reduce negative factors, build resilience and improve people's wellbeing across the life course. These can relate directly to mental health such as the Emotional First Aid courses being delivered in all Southampton Secondary Schools and the "Talking Therapies" service for people with anxiety and depression; through to partnership approaches that seek to address the negative impacts of the economic downturn, job losses and benefit changes.

The Supported Housing Volunteers scheme provides activities for more than 600 people in the city which enrich the lives of the recipients and the volunteers alike. The activities include lunch clubs, music sessions, technology workshops and day trips. Marge (pictured) is an 81 year old volunteer whose involvement in the scheme has had a really positive impact on her mental and physical wellbeing. Marge says that if it were not for the volunteering she does and the inclusion with local community she would be far less happy.

Section 3

Protection from health threats

The third theme of this report, and of the PHOF, is concerned with protecting the population's health from major infectious diseases and environmental threats to health.

The reduction of the infectious disease burden, through improved hygiene, vaccination and antibiotics, has been one

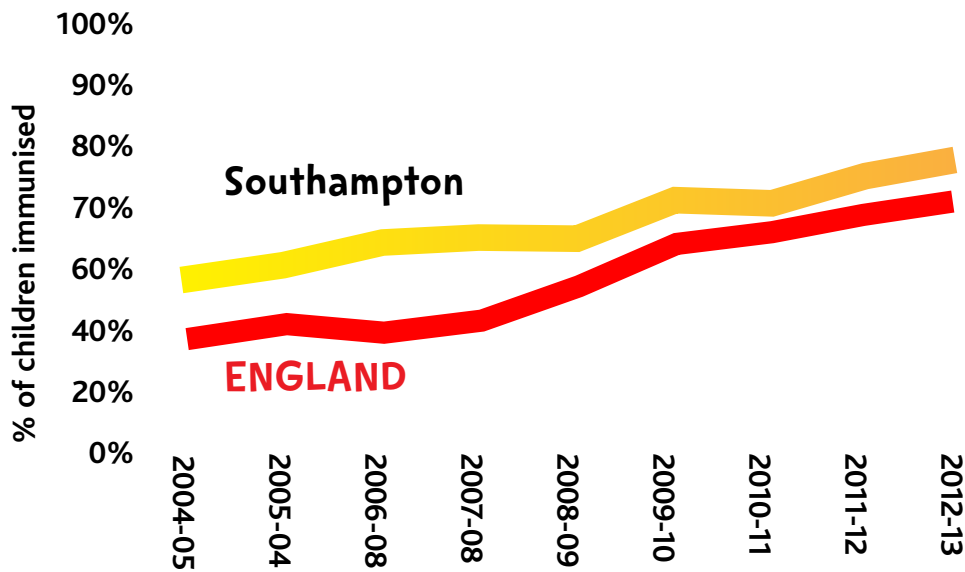
of the success stories of the 20th century. Yet, infectious disease is still a major problem, accounting for 10% of the NHS budget³⁵.

The recent update of the 'protecting people' theme in the Southampton JSNA covered all aspects of infectious diseases including Port Health and immunisation information. The JSNA also now includes more detail about environmental health and trading standards in the city plus emergency planning for major incidents and extreme weather.

In the PHOF, Southampton's performance in this theme is generally similar to the national average although Chlamydia diagnosis rates are significantly lower and this is discussed further in Section 3.1 on Sexual Health.

Health protection	Period	Local value	Eng. value	Eng. lowest	Range	Eng. highest
3.01 Fraction of mortality attributable to particulate air pollution	2011	6.3	5.4	3.0		8.3
3.02 Chlamydia diagnoses (15-24 year olds) - Old NCSP data	2011	2096	2125	763		5,995
3.02ii Chlamydia diagnoses (15-24 year olds) - CTAD - Female	2012	1680	2568	987		7,314
3.02ii Chlamydia diagnoses (15-24 year olds) - CTAD	2012	1500	1979	703		6,132
3.02ii Chlamydia diagnoses (15-24 year olds) - GTAD - Male	2012	1137	1368	363		4,364
3.03i Population vaccination coverage - Hepatitis B (1 year old)	2012/13	100 ^	-	-		-
3.03i Population vaccination coverage - Hepatitis B (2 years old)	2012/13	81.8 ^	-	-		-
3.03iii Population vaccination coverage - Dtap / IPV / Hib (1 year old)	2012/13	95.3 ^	94.7	79.0		99.0
3.03iii Population vaccination coverage - Dtap / IPV / Hib (2 years old)	2012/13	97.0 ^	96.3	81.9		99.4
3.03iv Population vaccination coverage - MenC	2012/13	94.3 ^	93.9	75.9		98.8
3.03v Population vaccination coverage - PCV	2012/13	94.9 ^	94.4	78.7		99.0
3.03vi Population vaccination coverage - Hib / MenC booster (2 years old)	2012/13	93.1 ^	92.7	77.0		98.3
3.03vi Population vaccination coverage - Hib / Men C booster (5 years)	2012/13	90.5 ^	91.5	75.7		98.1
3.03vii Population vaccination coverage - PCV booster	2012/13	94.6 ^	92.5	75.1		97.5
3.03viii Population vaccination coverage - MMR for one dose (2 years old)	2012/13	94.1 ^	92.3	77.4		98.4
3.03ix Population vaccination coverage - MMR for one dose (5 years old)	2012/13	95.3 ^	93.9	82.1		98.3
3.03x Population vaccination coverage - MMR for two doses (5 years old)	2012/13	91.2 ^	87.7	68.9		97.0
3.03xii Population vaccination coverage - HPV	2012/13	89.1 ^	86.1	62.1		96.2
3.03xiii Population vaccination coverage - PPV	2012/13	70.5 ^	69.1	55.3		77.0
3.03xiv Population vaccination coverage - Flu (aged 65+)	2012/13	75.5 ^	73.4	65.5		80.8
3.03xv Population vaccination coverage - Flu (at risk individuals)	2012/13	53.2 ^	51.3	44.2		68.8
3.04 People presenting with HIV at a late stage of infection	2010 - 12	48.9	48.3	0.0		80.0
3.05i Treatment completion for TB	2012	88.2	82.8	22.6		100.0
3.05ii Incidence of TB	2010 - 12	16.8	15.1	0.0		112.3
3.06 Public sector organisations with a board approved sustainable development management plan	2011/12	75.0	84.1	20		100

MMR coverage at age 5



SOURCE: NHS immunisation statistics.

Vaccination is a way of protecting the whole population. If enough people in a community are vaccinated it becomes harder for the disease to pass between those who have not been vaccinated. This is called 'herd immunity'. The proportion of people who have to be vaccinated to achieve herd immunity varies depending on the characteristics of the disease and the effectiveness of the vaccine.

Before immunisation programmes began, measles claimed approximately 1000 lives in the UK each year³⁵. For measles the UK recommendation is that at least 95% of children should have the MMR vaccine before age two and a booster before age five to achieve herd immunity and prevent outbreaks. The chart shows that vaccination rates have increased over the past few years and the Southamptton rate is higher than the national average but remains below the 95% threshold.

There have been no confirmed measles cases in Southamptton since March 2010 but a drop in coverage rates nationally in the late 1990's and early 2000's (when concern around the discredited link between autism and the vaccine was widespread) means the potential for cases and outbreaks is at its highest. This has led to a national programme to 'catch-up' children in the age range 11-16 years.

This year has seen the introduction of several new vaccination schedules including a new shingles vaccine for people aged 70 to 79 and a new oral vaccine for babies to protect against rotavirus, a common cause of diarrhoea and sickness, there is more about this in Section 3.2 on Common Infections.

3. 1 Sexual health

Why is this issue important to health?

Most adults in England are sexually active but despite this, sexual health remains a sensitive subject which many find difficult to talk about. This can affect how people access good quality information about sexual health and how they access services. This is particularly important for some groups who experience disproportionately worse sexual health. For example, we know that men who have sex with men and some black and ethnic minority groups are at considerably higher risk of poor sexual health.

Reducing sexually transmitted infections (STIs) and avoiding unwanted pregnancies are two key goals within the wider context of promoting a sexually healthy population. STIs affect health in different ways, from the minor inconvenience of taking antibiotics to long term chronic illness or infertility. Unplanned pregnancies can have significant health and emotional impacts on the individual, particularly young people, but are also an important societal issue when costs

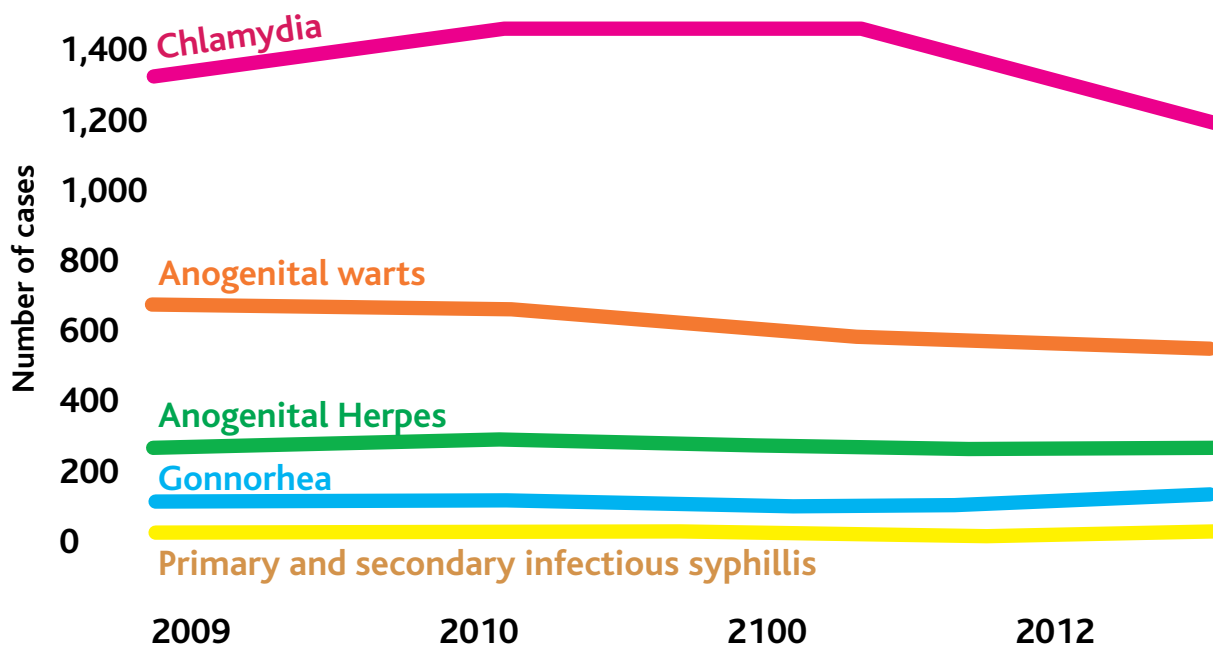
of terminations and supporting vulnerable parents are taken into account.

The PHOF contains three indicators specific to sexual health, highlighting the need to continue and sustain efforts in these areas:

1. Chlamydia diagnoses
2. People presenting with HIV at a late stage of infection
3. Under 18 conceptions

Southampton is ranked 43 out of 326 local authorities in England for rates of acute STIs, (where 1 has the highest rates). The most commonly diagnosed STI is chlamydia, followed by anogenital warts and herpes (see chart below). Although the incidence of syphilis and gonorrhoea is lower than the other STIs, they are important infections because we know that a relatively high proportion of men who have sex with men are affected.

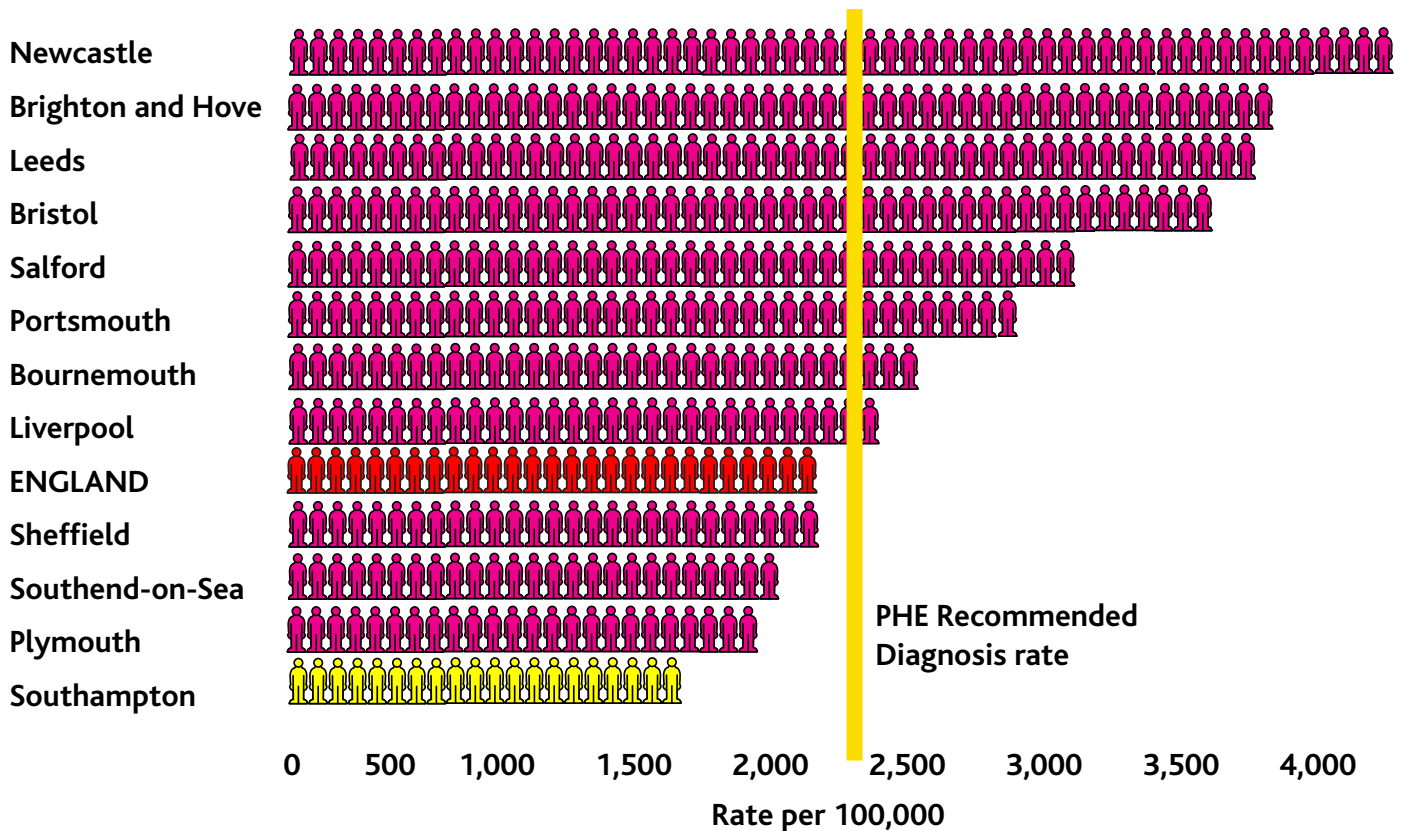
Number of new diagnosis of selected STIs (all ages) time trend: 2009-12



SOURCE: Health Protection Agency

Rate of Chlamydia diagnosis per 100,000 residents: 15-24 year olds

Southampton and ONS comparators 2012



SOURCE: Health Protection Agency. NOTES: Numbers of diagnoses are adjusted for missing GUM clinic data, rates are calculated using 2010 PCT population estimates, data on unknown age groups are included and data are presented for England residents only.

In 2012, the rate of chlamydia diagnoses per 100,000 young people aged 15-24 in Southampton was 1,500. We have a considerable challenge to achieve the diagnosis rate of 2,300 recommended by Public Health England and a delivery plan is in place locally to increase the rate of positive tests. This plan aims to embed chlamydia screening in sexual health services, general practice, pharmacies and antenatal services, as well as target those who might be at particular risk of sexually transmitted infections through outreach testing.

HIV

Delayed identification and treatment for HIV is associated with higher morbidity and short-term mortality. For this reason, we monitor the proportion of HIV diagnoses that are made at a late stage of infection (where the CD4 count is less than 350 cells/mm³). In Southampton, around half of all HIV diagnoses are made at a late stage, which is very similar to the national average.

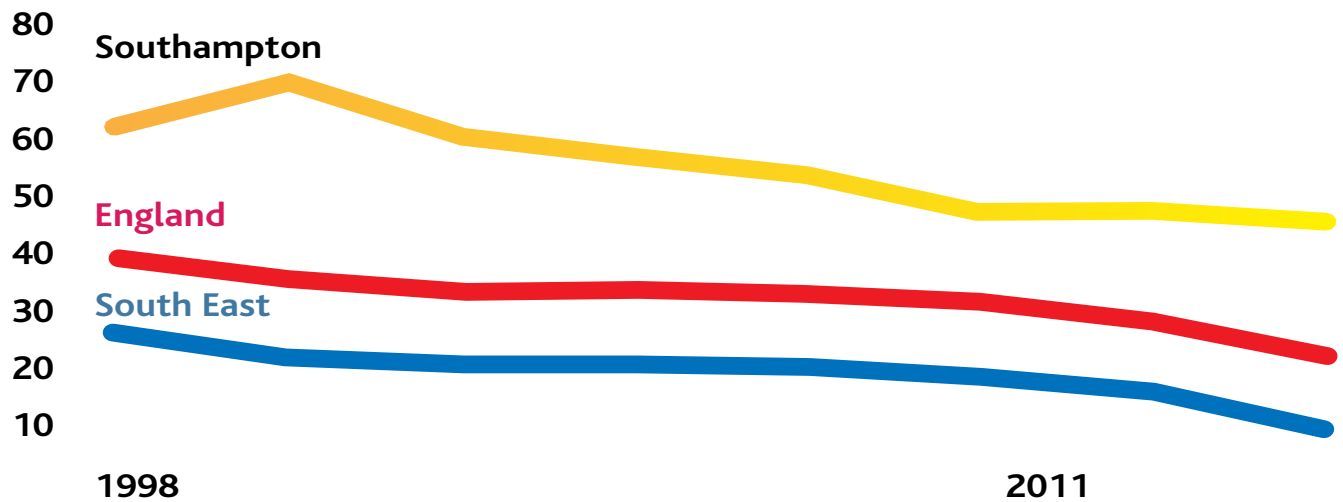
In 2012, the HIV prevalence in Southampton was 1.95 per 1,000 population compared to 2.05 per 1,000 in England. If the prevalence rises above 2.0 per 1,000, national recommendations state that routine HIV testing should be implemented for all general medical admissions and for all new registrants in primary care.

Teenage conceptions

For most young women who become pregnant under the age of 18, this is an unintentional consequence of sexual relationships. National data suggests that around three quarters of teenage pregnancies are unplanned and half end in abortion. Unfortunately, teenage parents experience poor outcomes in education and employment and are at risk of economic difficulties and mental health problems. In addition, the children of teenage parents are also vulnerable to health and social problems; they are at a higher risk of infant mortality, poor health, low educational attainment and growing up in poverty.

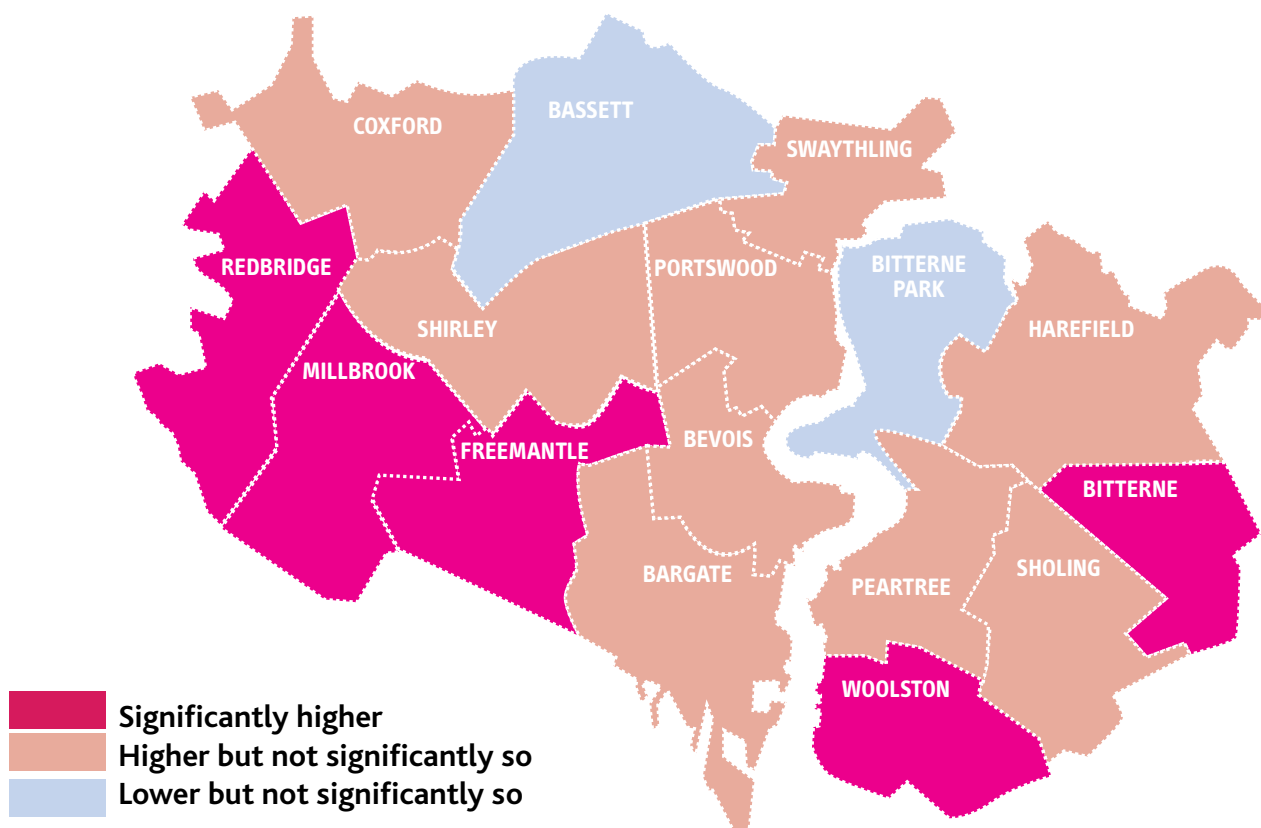
Although under 18 conceptions have decreased in Southampton over the last decade, they remain significantly higher than rates for both England and the South East (see chart below). The rate of decline had been slower in Southampton than in England, the South East, and most of its statistical neighbours but this has improved in recent years. At ward level, Redbridge, Millbrook, Freemantle, Woolston and Bitterne have under 8 conception rates that are significantly higher than the England average.

Under 18s conception rate for Southampton, South East and England trend: 1998-00 to 2009-11



SOURCE: Office for National Statistics and Teenage Pregnancy Unit. Crown copyright. NOTES: Rates are per 1,000 female population aged 15-17

Under 18s conception rate 2009-11: Southampton Wards: Difference from the England average



The under 16 conception rate in Southampton is of particular concern. In 2011, Southampton had an under 16 conception rate of 10.5 per 1,000 females aged 13-15, ranking the city in the seventh worst position in England. In 2012, the under 16 conception rate decreased but remains significantly higher than the South East and England. While the under 16 conception rate is based on small numbers and therefore subject to annual variation, the relatively high rate in Southampton alerts us to the critical importance of focussing efforts and resources on reducing unplanned pregnancies, particularly in this younger age group.

What can be done about it

Since April 2013, the commissioning arrangements for sexual health services have changed significantly. SCC is now responsible for many aspects of sexual health services but the Southampton City CCG and NHS England also have a role. These changes have given us a timely opportunity to review sexual health in Southampton and identify how we can work together to improve outcomes for our population.

The reasons behind sexual risk taking which could lead to unplanned pregnancy or the acquisition of sexually transmitted infections are complex, and influenced by a combination of behavioural, familial and social factors. Despite this, we know that two key approaches can help reduce the risk:

1. The provision of high quality sex and relationship education for all young people, including targeted work with vulnerable groups, with clear links to contraceptive and sexual health services
2. Good access to all methods of contraception, including long acting reversible contraception and condoms, for all ages.

In 2014, we will be launching a new sexual health strategy for Southampton which will set out how we will work together to improve sexual health in the city. We want this strategy to underpin accessible, effective and integrated sexual health education, advice and services which help us to:

- reduce STIs
- avoid unwanted pregnancies
- reduce inequalities in sexual health
- promote healthy sexual relationships.

Key recommendations

- Continue commitment to invest in sexual health services across the city
- Promote STI and HIV testing in a variety of settings
- Strategic coordination of school-based sex and relationship education
- Multi disciplinary engagement in the new sexual health strategy.

3. 2. Common infectious diseases

Why is this issue important?

All infectious diseases are potentially preventable. Better living conditions, improvements in sanitation and hygiene, mass vaccination and improvements in medical treatments have resulted in decreases in infectious disease in England for several decades.

However, infectious disease is still a significant issue; for instance, around 50% of children's GP consultations are for infectious diseases³⁵. People who have underlying health problems, compromised immune systems and the youngest and eldest in our community are the most vulnerable to the complications of infectious disease. Infectious disease is a marker for social and economic disadvantage. Those people who are worse off economically experience higher rates of disease and poor outcomes.

Two of the most common infectious diseases are respiratory and gastrointestinal infections. Respiratory infections, particularly pneumonia and exacerbations of chronic bronchitis, are the leading cause of infectious disease mortality and morbidity, particularly among the elderly and those with underlying chronic disease. Influenza or 'flu' is a respiratory illness associated with infection by influenza virus. Symptoms frequently include headache, fever, cough, sore throat, aching muscles and joints. There is a wide spectrum of severity of illness ranging from minor symptoms through to pneumonia and death.

Gastrointestinal infections are a major cause of potentially preventable illness, and cause outbreaks in both community and healthcare settings. Every year in the UK there are an estimated 17 million cases, affecting around 25% of the population, leading to about a million GP consultations and nearly 19 million days lost from school or work³⁶.

Gastrointestinal infection due to verocytotoxin producing *E. coli* (VTEC) can be fatal, particularly in young children or the elderly, and is the commonest cause of acute kidney failure in children, complicating approximately 10% of reported infections each year. Every year, particularly in the winter months, outbreaks of norovirus infection result in closures of hospital wards, with a significant impact on the healthcare system.

The economic burden from infectious diseases in England, including costs to the health service, to the labour market and to individuals themselves, is estimated at £30 billion each year, with a large proportion of these costs incurred because of respiratory or gastrointestinal infections.

Surveillance of infectious diseases is undertaken by Public Health England. Notification of infectious disease will underestimate the true number of cases. It has been estimated that for each reported case of gastrointestinal infection, there are 147 unreported cases.

Influenza is seasonal and more common in the winter months. The number of cases usually increases markedly from October until December/January. In the Winter of 2012/13, the 'flu' season started later and was more prolonged than previous years. There were approximately 20 cases per 100,000 population across the South East region during this time.

There are a number of gastro-intestinal infectious diseases. By far the most common is infection with *Campylobacter*; 285 cases were reported in Southampton City in 2012/13. Collectively, other forms of gastro-intestinal disease contributed to 91 reported cases during this time.

Norovirus infection outbreaks accounted for 64% of all outbreaks notified to Public Health England in Southampton. Thirty nine outbreaks of Norovirus were reported between April 2012 and March 2013.

Norovirus Outbreaks in Southampton City between April 2012 and March 2013

Principal Context	Count of Principal Context
Care Home	16
Hospital	14
Cruise Ships*	5
Nursery/School	4
Grand Total	39

Data source: PHE Centre Wessex HPZone Database

*Home Port of Southampton.

What can be done?

Vaccination

Vaccination has had a major impact on the reduction in infectious diseases and resulting reductions in health inequalities over time. However, differences in vaccine uptake persist. The NHS Influenza vaccination programme³⁷ aims to protect those who are at most risk of serious illness or death from Influenza and reduce transmission of the infection. Over 75% of people aged 65 years and over received the vaccination in 2012/13. Yet only 53% of people 'at risk' and 40% of pregnant women were vaccinated.

This year, for the first time, children aged 2 to 3 years have been offered the vaccine. This childhood flu vaccination programme will be extended to children and young people up to the age of 16 years in the near future. It is an employer's responsibility to ensure staff are vaccinated.

Rotavirus is a highly infectious gastrointestinal disease. Vaccination for rotavirus has very recently been incorporated into the childhood immunisation programme. It is offered to babies aged two and three months alongside their other routine vaccinations.

Hygiene standards

There are simple measures that can be undertaken to reduce the risk of infection. These include adequate hand washing, disinfecting of surfaces and covering the mouth and nose when coughing or sneezing. National and local campaigns continue to raise awareness of these measures.

Through following robust infection control standards in healthcare settings, residential care settings, schools, children's centres and other establishments where vulnerable people gather infection risk can be reduced.

School nurses and health visitors are well placed to provide advice to teachers, parents and children about prevention of infectious disease. There are educational programmes such as 'e-bug' that provide a useful learning tool for school children. Further work is required within settings to encourage a more robust preventative approach to infectious disease management.

Outbreak management

Public Health England co-ordinates response and provides guidance to schools and residential care homes on actions required in the event of an infectious disease outbreak. Surveillance mechanisms are in place to ensure that outbreaks are identified at the earliest opportunity.

Other preventative measures

Breastfeeding has a large impact on the risk of gastrointestinal disease in the young. National research³⁸ shows that if 45% of women exclusively breastfed for four months, and if 75% of babies in neonatal units were breastfed at discharge, every year there could be an estimated 3,285 fewer gastrointestinal infection-related hospital admissions and 10,637 fewer GP consultations. This would result in over £3.6 million saved in treatment costs annually.

Key recommendations

- Address inequalities due to infectious diseases in the local Health and Wellbeing strategy
- Work with PHE Wessex to raise local awareness of infectious disease control and to support local action
- Work with employers to encourage influenza vaccination of staff and raise local public awareness of vaccination
- Appoint an Infection Control Nurse to co-ordinate education and training of Health and Social Care staff on infection prevention
- Work with local children's centres, schools and care homes to raise awareness of common infectious diseases and benefits of prevention including immunisation.

Section 4

Living long, living well

This final theme is concerned with reducing preventable ill health and premature mortality.

The chart below shows the main causes of disability and ill health in the UK; it is clear to see the importance of lifestyle and early intervention in preventing premature morbidity and mortality.

Note: The negative percentage for alcohol is the protective effect of mild alcohol use on ischaemic heart disease and diabetes.

The PHOF measures for this final theme show that Southampton has poorer outcomes than average in terms of children's tooth decay, mortality from preventable causes and premature mortality from cancer and respiratory disease.

Rates of preventable sight loss are also higher in the city than nationally; one of the major causes of sight loss is diabetic eye disease and section 4.1 looks in more detail at diabetes in the city.

Over the 2009-11 period there were nearly 100 deaths from preventable kidney disease to Southampton residents aged under 65. This issue is looked at more closely in section 4.2.

Burden of disease attributable to 20 leading risk factors in both sexes in 2010 expressed as a percentage of UK disability adjusted life years³⁹

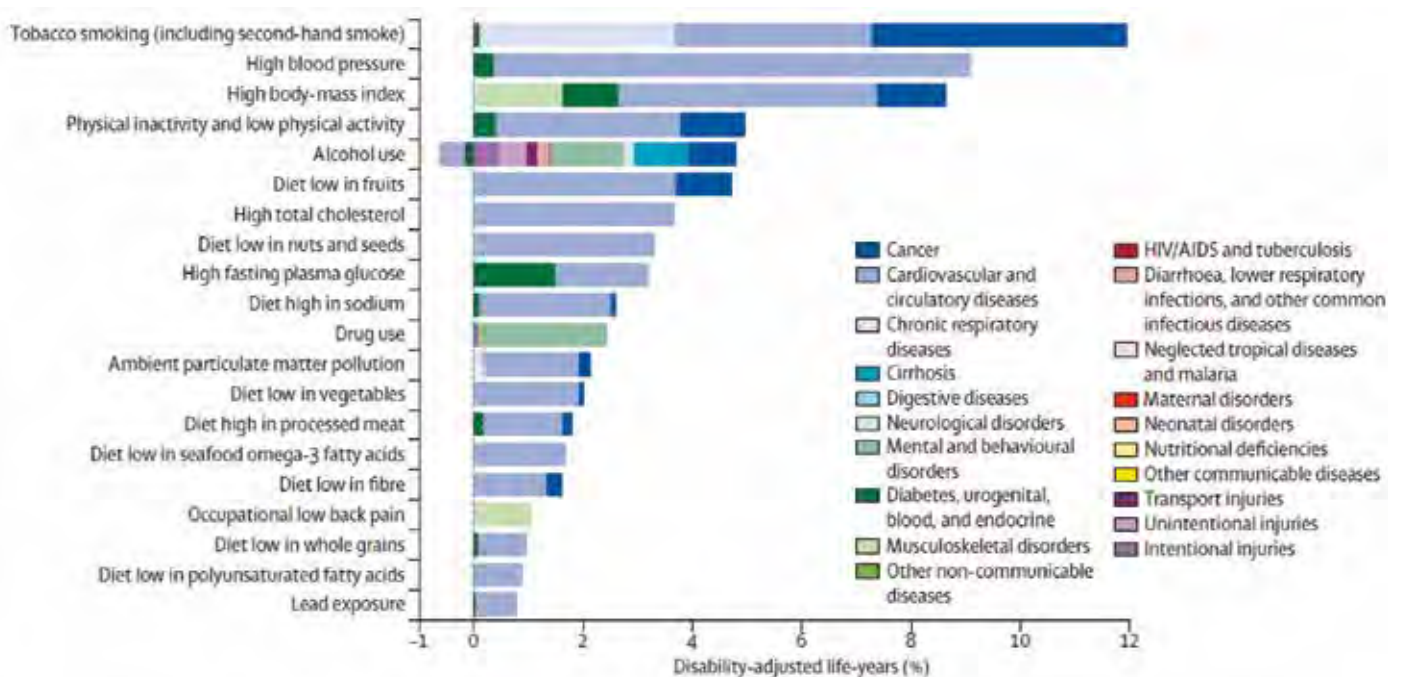


FIGURE 7: Burden of disease attributable to 20 leading risk factors for both sexes in 2010, expressed as percentage of UK disability-adjusted life-years. The negative percentage for alcohol is the protective effect of mild alcohol use on ischaemic heart disease and diabetes.

Healthcare and premature mortality	Period	Local value	Eng. value	Eng. lowest	Range	Eng. highest
4.01 Infant mortality	2006 - 11	4.30	4.29	8.02		2.28
4.02 Tooth decay in children aged 5	2011/12	1.14	0.94	2.10		0.36
4.03 Mortality rate from causes considered preventable	2010 - 12	222.6	167.8	340.5		130.2
4.03 Mortality rate from causes considered preventable - Male	2010 - 12	276.2	238.4	430.9		164.9
4.03 Mortality rate from causes considered preventable - Female	2010 - 12	170.4	140.6	253.9		94.7
4.04 Under 75 mortality rate from all cardiovascular diseases	2010 - 12	93.8	81.1	144.7		55.7
4.04 Under 75 mortality rate from all cardiovascular diseases - Male	2010 - 12	131.6	114.0	204.4		79.3
4.04 Under 75 mortality rate from all cardiovascular diseases - Female	2010 - 12	57.7	50.1	88.4		28.0
4.04i Under 75 mortality rate from cardiovascular diseases considered preventable	2010 - 12	60.1	53.5	95.2		29.3
4.04i Under 75 mortality rate from cardiovascular diseases considered preventable - Male	2010 - 12	89.9	80.8	142.5		44.5
4.04i Under 75 mortality rate from cardiovascular diseases considered preventable - Female	2010 - 12	31.7	27.6	54.4		15.0
4.05 Under 75 mortality rate from cancer	2010 - 12	161.6	146.5	207.3		113.5
4.05 Under 75 mortality rate from cancer - Male	2010 - 12	182.1	163.6	238.9		122.8
4.05 Under 75 mortality rate from cancer - Female	2010 - 12	143.0	130.8	181.3		105.3
4.05i Under 75 mortality rate from cancer considered preventable	2010 - 12	96.1	84.9	134.9		53.8
4.05i Under 75 mortality rate from cancer considered preventable - Male	2010 - 12	106.6	92.7	164.4		53.1
4.05i Under 75 mortality rate from cancer considered preventable - Female	2010 - 12	90.4	77.9	121.4		54.8
4.06 Under 75 mortality rate from liver disease	2010 - 12	20.5	18.0	41.6		10.3
4.06 Under 75 mortality rate from liver disease - Male	2010 - 12	29.0	23.7	58.4		13.0
4.06 Under 75 mortality rate from liver disease - Female	2010 - 12	12.0	12.6	25.0		6.9
4.06i Under 75 mortality rate from liver disease considered preventable	2010 - 12	18.3	15.6	38.2		9.0
4.06i Under 75 mortality rate from liver disease considered preventable - Male	2010 - 12	27.1	21.1	54.9		10.8
4.06i Under 75 mortality rate from liver disease considered preventable - Female	2010 - 12	- x	10.6	21.4		6.3
4.07 Under 75 mortality rate from respiratory disease	2010 - 12	42.6	33.5	61.6		20.5
4.07 Under 75 mortality rate from respiratory disease - Male	2010 - 12	53.5	39.6	92.1		24.6
4.07 Under 75 mortality rate from respiratory disease - Female	2010 - 12	32.2	27.9	71.5		12.6
4.07i Under 75 mortality rate from respiratory disease considered preventable	2010 - 12	26.1	17.6	45.0		7.9
4.07i Under 75 mortality rate from respiratory disease considered preventable - Male	2010 - 12	29.4	20.1	50.4		10.6
4.07i Under 75 mortality rate from respiratory disease considered preventable - Female	2010 - 12	23.0	15.2	40.2		7.3
4.08 Mortality from communicable diseases	2010 - 12	54.8	64.8	97.9		47.0
4.08 Mortality from communicable diseases - Male	2010 - 12	65.9	75.1	116.9		56.2
4.08 Mortality from communicable diseases - Female	2010 - 12	45.6	56.7	69.6		37.3
4.10 Suicide rate	2010 - 12	12.5	8.5	14.5		4.8
4.10 Suicide rate - Male	2010 - 12	17.1	13.3	22.6		7.6
4.10 Suicide rate - Female	2010 - 12	7.9	4.0	8		2
4.11 Emergency readmissions within 30 days of discharge from hospital	2010/11	12.2	11.6	13.6		8.1
4.11 Emergency readmissions within 30 days of discharge from hospital - Male	2010/11	12.4	12.1	14.8		8.6
4.11 Emergency readmissions within 30 days of discharge from hospital - Female	2010/11	11.9	11.4	13.2		7.2
4.12i Preventable sight loss - age related macular degeneration (AMD)	2011/12	197.1	110.5	12.8		225.2
4.12i Preventable sight loss - glaucoma	2011/12	11.6	12.8	3.0		34.5
4.12i Preventable sight loss - diabetic eye disease	2011/12	8.3	3.8	0.9		15.8
4.12iv Preventable sight loss - sight loss certifications	2011/12	69.1	44.5	5.1		82.5
4.14i Hip fractures in people aged 65 and over	2011/12	450.5	457.2	599.5		337.9
4.14i Hip fractures in people aged 65 and over - aged 65-79	2011/12	726.5	777.7	346.7		135.7
4.14ii Hip fractures in people aged 65 and over - aged 80+	2011/12	1449	1515	2,021		993
4.15i Excess Winter Deaths Index (Single year, all ages)	Aug 2011 - Jul 2012	21.9	16.1	30.7		2.1
4.15ii Excess Winter Deaths Index (single year, ages 85+)	Aug 2011 - Jul 2012	21.3	22.9	53.1		-7.6
4.15iii Excess Winter Deaths Index (3 years, all ages)	Aug 2009 - Jul 2012	21.6	16.5	27.4		6.4
4.15iv Excess Winter Deaths Index (3 years, ages 85+)	Aug 2009 - Jul 2012	29.8	22.6	38.5		11.3

4. 1. Diabetes

Why is this issue important?

Diabetes mellitus is a common condition in the general population, affecting approximately 1 in 20 people. It is becoming more common, partly as a result of better diagnosis and partly due to changes in population structure and risk factor prevalence. A small proportion of people may be able to stop the onset of diabetes by making changes in lifestyle, and with the help of certain drugs, but for most people, once established, they will have to live with diabetes for the rest of their lives. If it is well controlled, life expectancy may be unaffected, but a large proportion of people living with diabetes will develop complications and this may shorten lives and reduce the quality of life. Diabetes when present for many years can increase the risk of a number of other conditions, such as stroke, peripheral vascular disease and heart disease; diabetes also contributes to multi morbidity. For those under 65 years, it is also the commonest cause of blindness and partial sight and kidney failure.

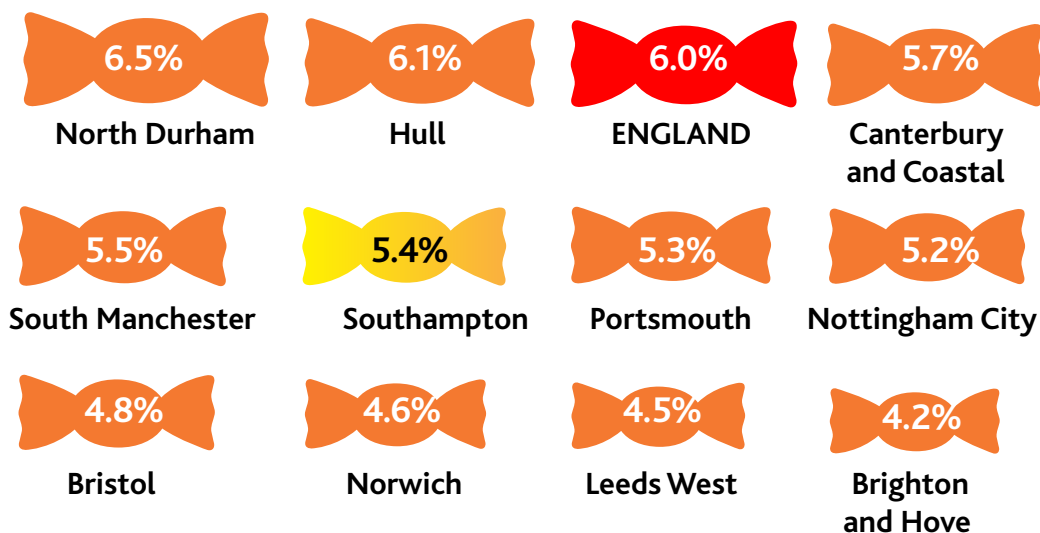
The onset of diabetes may be insidious for those who develop the condition later in life (predominantly "type 2" Diabetes) and it is estimated nationally that 800,000 people have diabetes without knowing it. Symptoms may be non-specific, or unrecognised at this stage. Sometimes recurring infections may raise suspicion (e.g. troublesome skin infection) or excessive thirst and frequent passage of urine may be a warning of raised blood sugars and high levels of glucose in the urine. Roughly 90% of people with diabetes have a form called Type 2, characterised by raised blood sugars, high levels of insulin and other changes such as raised fats in the blood.

Type 1 diabetes occurs in a smaller number of people (roughly 10% of all the people affected by diabetes) and it usually occurs in childhood or early adult years. Symptoms are more obvious, the onset is rapid, caused by a sudden rise in blood sugar, with a build-up of acids called ketones in the blood. Insulin levels are usually very low, blood sugar very high, and the blood and urine becomes more acid. This can make a person very ill, progressing if untreated to a diabetic coma, collapse and death. People may present as an emergency, with diabetic keto-acidotic coma and this has to be treated as an emergency by a specialist team. Type 1 diabetes is usually diagnosed rapidly and insulin treatment started immediately. This will need to continue for the rest of that person's life in most cases.

A more recent type of diabetes called MODY – maturity onset diabetes of the young - has been found in children who are obese. This variant of diabetes was first described in the USA, but cases in the UK have been diagnosed over the last five years as childhood obesity increases.

Higher levels of diabetes occur in different communities, but the main risk factor is advancing age (Type 2 cases increase steadily in late adult and retirement years) followed by ethnicity (diabetes is linked to ethnicity – with an especially high prevalence amongst people of South Asian, African and African-Caribbean origin). Populations that gain weight easily, and especially those that become obese, are at increased risk of diabetes.

Crude diabetes prevalence - Southampton and CCG comparators: 2012-13



SOURCES: Quality and Outcomes Framework as at end of July 2013 via NHS Information Centre Copyright © 2013, The Health and Social Care Information Centre, Prescribing Support Unit. All rights reserved.

Notes: These are crude rates and therefore do not take account of the underlying age structure of the population.

As both overweight and obesity increase in the general population (including younger children) then we can expect more diabetes to occur in the future, including the MODY condition described above. Southampton is a population that includes significant numbers of Asians and Africans; between 2001 and 2011 the percentage of Asian residents in the city rose from 4.5% to 8.4%. Southampton has levels of obesity equivalent to the UK average and our population is ageing. As the risk factors for diabetes are becoming more prevalent in the local population, it is likely to increase as a problem in future.

GP practices in Southampton collect data on people aged over 17 years with diabetes. This is used to measure standards of care in the Quality and Outcomes Framework (QOF). Using this data, we can estimate and compare the prevalence of diabetes in the city with other similar urban populations in England. The chart above shows Southampton has a mid-position when crude prevalence is compared to other areas, and at 5.4% is significantly below the average for England.

These figures should be interpreted with caution as the QOF data provides only a crude rate for adults only (i.e. the age structure of the adult population has not been taken into account). Additionally the accuracy and completeness of the QOF registers is unknown. We have seen year on year increases in the numbers on the QOF register, so it is probably a more accurate measure of true prevalence now than several years ago, but it is likely to still under-represent the true prevalence.

Public Health England has produced Diabetes Community Health Profiles for every CCG⁴⁰. The Southampton profile uses data from the National Diabetes Audit which shows that people in the city with diabetes have a 57% greater chance of dying in a one year period than the general population (this compares with an increased risk nationally of 40%).

What can be done?

The onset of diabetes can be delayed or prevented in some, but once established, the best outcomes can only be achieved by good control of blood sugar through diet, oral hypoglycaemic tablets, or insulin and careful control of blood pressure and vascular risk factors. Control of vascular risk is especially important because people affected by diabetes have an increased risk of cardiovascular problems, and research shows the importance of keeping blood sugars within an acceptable range, whilst also controlling blood pressure and blood lipids optimally. A key component of good quality diabetes care is education for the patient and their carers or partners. There are carefully structured education programmes designed specifically for people with diabetes, and it is important that these are accessed by anyone newly diagnosed. Research shows this affects outcomes for the better when delivered in a structured way.

Despite the ease with which a blood or urine sugar can be measured, we do not have an effective population screening programme to reliably detect the onset of diabetes. The national screening committee is keeping this under review, but has no plans to introduce population screens⁴¹. Current policy encourages opportunistic testing in people at increased risk, for example those from ethnic minorities or those with a family history.

The diabetes charity Diabetes UK⁴² has established a partnership with Tesco to encourage opportunistic testing, and they have made available a free diabetes self-assessment online and at local pharmacies. During 2013 Diabetes UK carried out 212 risk assessments at road shows in Southampton. These provide the public with advice on managing risk factors and what to do in case risk is high and they need a GP assessment. GPs test patients for diabetes if they have symptoms that might suggest the condition, and in addition the health check programme promotes vascular risk assessment and glucose testing in adults whose risk is elevated. Southampton is actively promoting this approach www.publichealth.southampton.gov.uk/healthimprovement/healthchecks/

One subgroup of patients with very severe obesity complicated by diabetes may benefit from bariatric surgery. This reliably reduces weight, and in selected patients can reverse the diabetes completely. This additional benefit of obesity surgery is recognized in the bariatric surgery policy in our area, which includes diabetes in the eligibility for surgery.

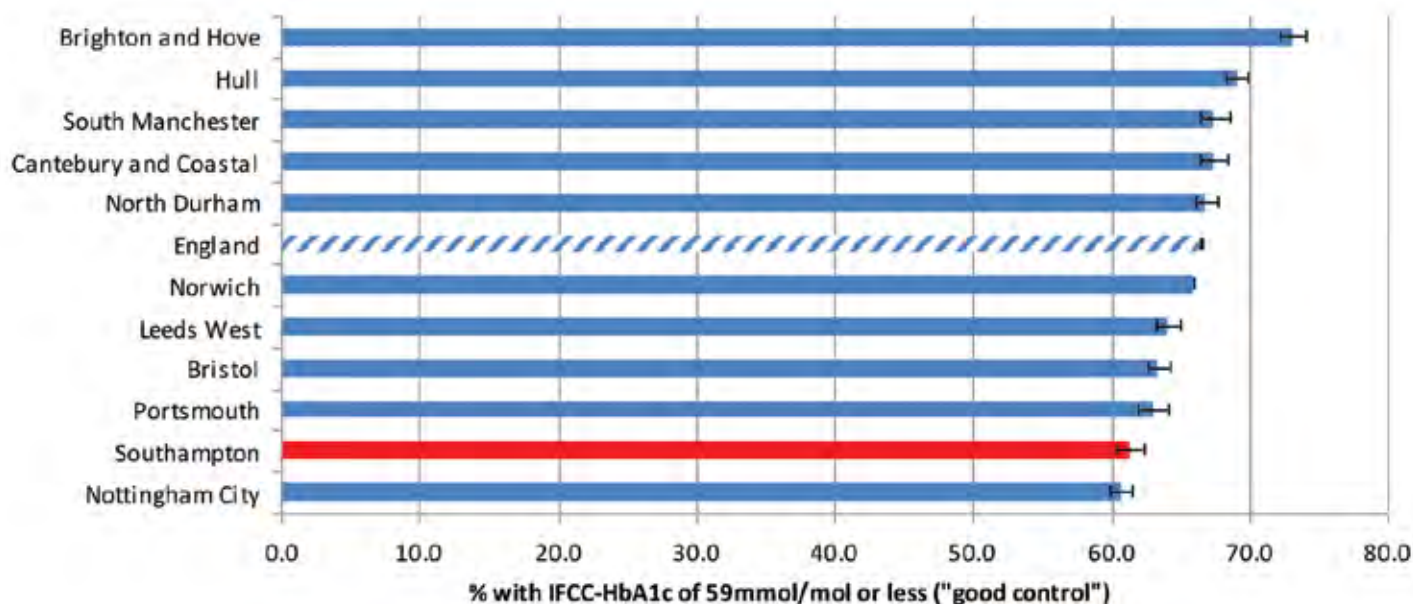
A more recent approach to diabetes prevention is focusing on people who have "pre diabetes". In this group blood sugar is not yet raised, but there are signs of insulin resistance and a raised blood insulin level that may be linked to raised fats in the blood also. Researchers have been studying the effects of intensive physical activity⁵¹ and use of medication (for example metformin) to see if the onset of diabetes can be delayed or prevented in this high risk group. The benefits appear promising in a number of initial research studies.

From a more public health perspective we encourage increasing physical activity (most of us are too sedentary for optimal health), and maintaining an optimal body weight and healthy diet to reduce the risk of vascular disease and cancers in all people. This more generic approach should reduce the prevalence of diabetes, but requires a concerted effort on the part of the population, and especially those struggling with overweight and sedentary lifestyles.

Stopping smoking plays an especially important role in diabetes management, because smoking increases complications such as vascular disease and blindness several fold.

Southampton City CCG has made diabetes management

Control of diabetes: Southampton and CCG comparators, 2012-2013



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Notes: QOF indicator DM26 = the percentage of patients with diabetes in last IFCC-HbA1c is 59mmol/mol or less in the preceding 15 months.

a priority this year, and is working hard on improving the quality of care provided in primary and secondary care. A local clinical network has been established to engage clinicians and patients in this programme of quality improvement.

The chart above shows that control of blood sugar amongst diabetic patients is lower in Southampton than amongst other similar CCGs.

The roles of primary care specialist nurses, podiatrists, GPs, vascular and diabetes specialists in hospitals are included in the work of the network.

The challenge of improving quality and achieving better population outcomes is a significant one, which depends equally on effective testing, earlier diagnosis, and delivering high quality care. To achieve this, clinicians need to work in partnership with people affected by diabetes, and those at higher risk, to ensure earlier diagnosis and high quality effective long term care.

Key recommendations

- Increase uptake of the NHS Health Check and subsequent opportunistic testing for diabetes amongst those found to be at higher risk
- Encourage use of the free self-assessment and testing service on offer from the Diabetes UK and Tesco partnership to reduce the number of undiagnosed cases in the city
- The CCG should continue to promote the clinical network, focusing on population outcomes that will benefit the most from quality improvement initiatives
- Public health approaches to encourage healthy eating, and reduce sedentary behaviour are essential to avoid increasing obesity, overweight and continuing rises in the prevalence of diabetes in the local population
- Proactive management of people with pre diabetes needs to be optimized to reduce risk in those at highest risk. Smoking cessation in this group should remain an especially high priority alongside exercise promotion.

4.2 Kidney disease

Why is this issue important?

Chronic kidney disease (CKD) is a common long term condition. It is strongly associated with other chronic conditions like cardiovascular disease and diabetes, and is more common in ageing populations and some BME groups.

Blood pressure is a common risk factor in all three conditions. Diabetes is now the commonest cause of kidney failure in the UK. Internationally, the burden of disease from high blood pressure is being recognised as one of the most important factors contributing to poor health and premature mortality.

A proportion of people with CKD may progress to end stage renal disease (ESRD) when dialysis or kidney transplantation is required. The majority live with sufficient reserve kidney function to manage without dialysis, but the different kidney conditions can cause a wide range of symptoms with varied complications. This makes CKD hard to diagnose from clinical symptoms alone, and this means the condition may be under diagnosed and treated in the general population.

Kidneys play a complex role in regulating fluid and electrolytes in our body, controlling blood pressure, bone mineral content, and production of red blood cells. Nitrogen waste products are removed in urine, while the kidneys can also secrete hormones and excrete drugs from the body. We are unaware of our kidneys when they are working normally.

Kidney diseases are diverse and may present few outward symptoms, despite complex metabolic changes that may accompany kidney damage. Therefore, kidney disease is hard

to diagnose. Kidney stones are an exception, causing acute loin pain.

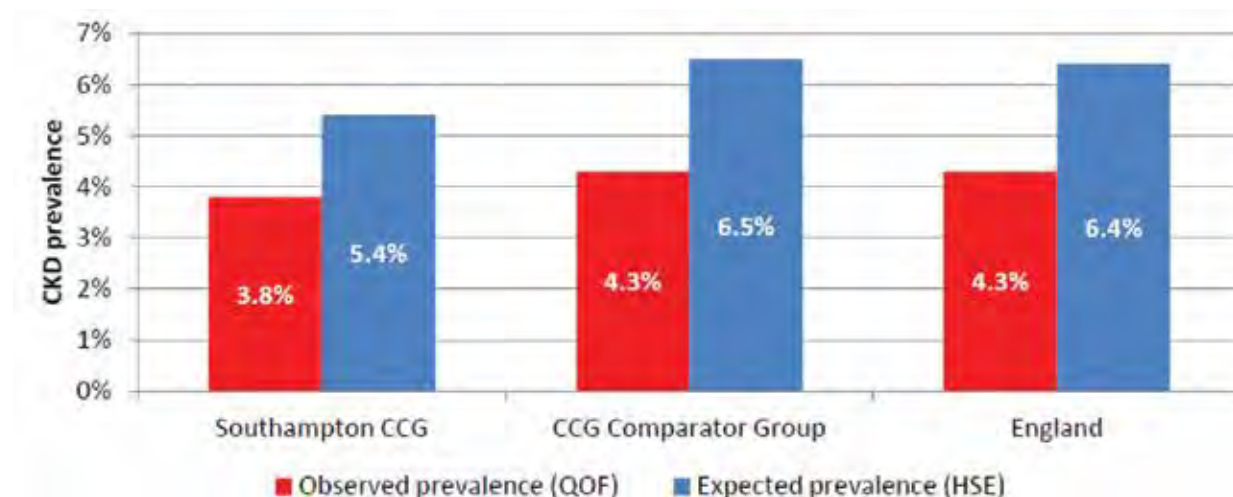
Microscope examination of the urine can also pick up abnormal cells, blood cells and crystals, and has been used to test and diagnose kidney diseases for hundreds of years. Ultrasound imaging, more sophisticated blood and urine laboratory tests, and tests on the immune system enable more sophisticated diagnosis and management. These tests are available to GPs.

The Quality and Outcomes Framework (QOF)⁴³ encourages GPs to test patients to see if they have renal diseases, and sets targets for certain aspects of treatment. QOF registers enable a crude estimate of the prevalence of CKD in the population, and comparison between different populations.

A recent publication⁴⁴ provided a comparison between the QOF registers in different CCGs in England. Southampton has a significantly lower number of recorded CKD cases than would be expected, as is the case both nationally and amongst the city's comparator group. This raises concern over the potential for under-diagnosis across the city population, and under reporting in the QOF registers.

Southampton spends a significant amount on care of renal disease in the community, but a lot more on expensive hospital care, including dialysis and transplantation. Renal disease is included in the broader classification of genitourinary diseases and is included in programme budget analysis by the Right Care programme⁴⁵. This provides information on expenditure in different programme areas. The analysis ranks our population against other similar areas. In this case it uses the former PCT areas for comparison. Southampton is in the fifth quintile for spending.

Observed and expected CKD prevalence (2011-12)⁴⁴



Programme budget spending

The challenge from these analyses appears two-fold: the first is under-diagnosis, and the attendant loss of opportunities to treat the renal condition and prevent deterioration. The second points to a higher expenditure in hospital, suggesting renal conditions have presented at a more severe stage and require more expensive care in hospital or the specialised renal unit.

A research study has been under way for two years at the University of Southampton into this issue across Hampshire. Use of the Hampshire Health Record has enabled people with signs of renal disease to be identified from an electronic record, and this used to compare with the GP register of cases. The preliminary findings show that many people with CKD have been diagnosed and investigated appropriately, but that there are also significant numbers of people whose CKD may not have been recognised and have therefore not been included on the practice QOF registers. Important aspects of their care, such as urine testing for protein and control of blood pressure, may therefore not have been ideal.

What can be done?

Earlier identification of people with CKD and more complete registration will help focus efforts on improving care for cases of CKD, and this in turn should reduce the number of people requiring hospital care.

In general CKD is not reversible, but the rate at which it deteriorates can be modified if diagnosed at a sufficiently

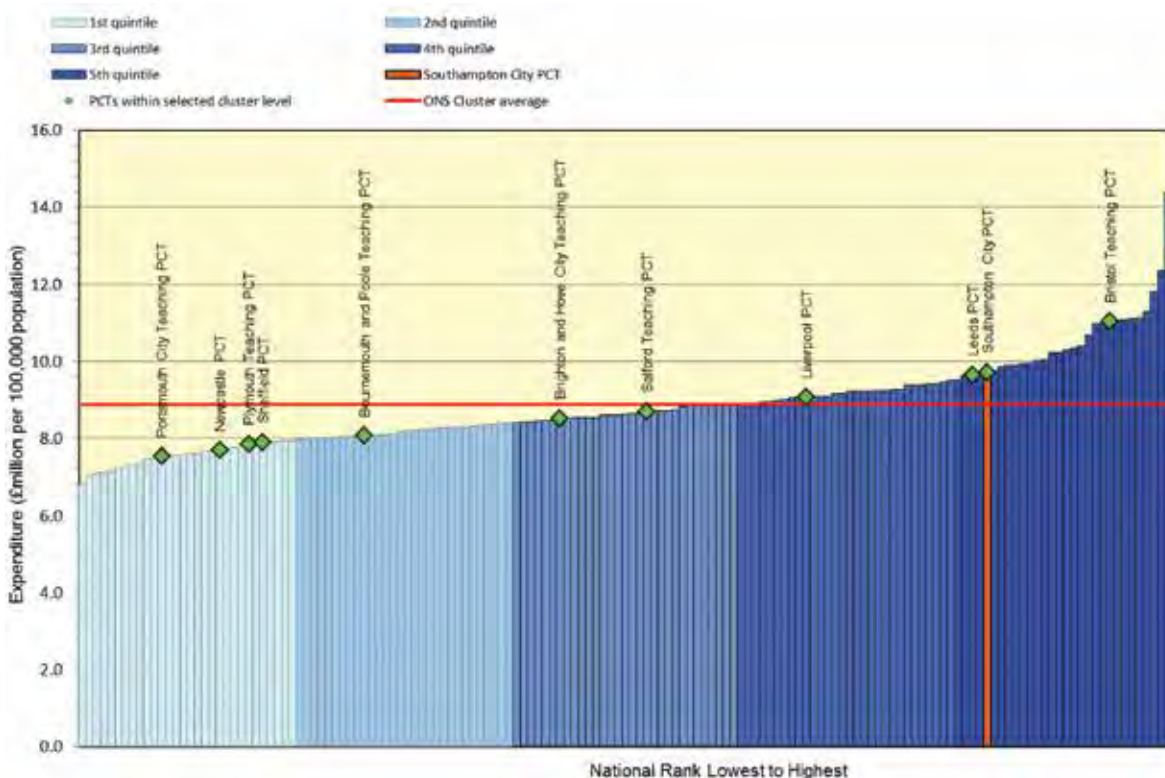
early point in the natural history of the disease. In this context blood pressure (BP) is especially important, with strong evidence that optimal control of raised BP can reduce the rate of deterioration of kidney function.

An important aspect for future research is to identify ways to detect and prevent acute kidney injury (AKI) – a common cause of hospital admission for people with CKD.

Key recommendations

- The CCG is encouraged to take note of the national and local analyses that suggest under-registration of renal conditions on QOF registers
- Local research will soon be available to help practices identify a greater number of cases with CKD. Use of the Hampshire Health Record, still widely available to clinicians and researchers, is an important opportunity to target treatment more effectively, and its use should be encouraged
- The findings of research locally must be fed back proactively to local GPs and others who diagnose renal conditions locally.

More structured care, and especially improved control of high blood pressure can reduce progression of kidney disease and is cost effective, especially in people with diabetes who are at increased risk of kidney failure.



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Appendix 1: Public Health Outcomes Framework

Key

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



Value suppressed

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

Southampton compared to England



Significantly worse than England

No statistically significant difference

Significantly better than England

Significance could not be calculated

Value not recorded

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Over-arching indicators

Indicator

Ranked order of deprivation (Index of Multiple Deprivation, 2010)

- 0.1i - Healthy life expectancy at birth
- 0.1i - Healthy life expectancy at birth
- 0.1ii - Life Expectancy at birth
- 0.1ii - Life Expectancy at birth
- 0.2iii - Slope index of inequality in life expectancy at birth within English local authorities, based on local deprivation deciles within each area (provisional)
- 0.2iii - Slope index of inequality in life expectancy at birth within English local authorities, based on local deprivation deciles within each area (provisional)

Local Authority	Southampton	Portsmouth	Brighton and Hove	Southend-on-Sea	Bournemouth	Southampton Compared to England	Portsmouth Compared to England
Liverpool	5.8	11.1	11.5	11.5	11.5	+	+
Salford	7.9	8.0	8.0	8.0	8.0	+	+
Sheffield	7.6	8.3	8.3	8.3	8.3	+	+
Newcastle upon Tyne	9.9	10.2	10.2	10.2	10.2	+	+
Leeds	10.1	10.1	10.1	10.1	10.1	+	+
Sheffield	10.2	10.2	10.2	10.2	10.2	+	+
Leeds	10.3	10.3	10.3	10.3	10.3	+	+
Plymouth	10.4	10.4	10.4	10.4	10.4	+	+
Leeds	10.5	10.5	10.5	10.5	10.5	+	+
Leeds	10.6	10.6	10.6	10.6	10.6	+	+
Leeds	10.7	10.7	10.7	10.7	10.7	+	+
Leeds	10.8	10.8	10.8	10.8	10.8	+	+
Leeds	10.9	10.9	10.9	10.9	10.9	+	+
Leeds	11.0	11.0	11.0	11.0	11.0	+	+
Leeds	11.1	11.1	11.1	11.1	11.1	+	+
Leeds	11.2	11.2	11.2	11.2	11.2	+	+
Leeds	11.3	11.3	11.3	11.3	11.3	+	+
Leeds	11.4	11.4	11.4	11.4	11.4	+	+
Leeds	11.5	11.5	11.5	11.5	11.5	+	+
Leeds	11.6	11.6	11.6	11.6	11.6	+	+
Leeds	11.7	11.7	11.7	11.7	11.7	+	+
Leeds	11.8	11.8	11.8	11.8	11.8	+	+
Leeds	11.9	11.9	11.9	11.9	11.9	+	+
Leeds	12.0	12.0	12.0	12.0	12.0	+	+
Leeds	12.1	12.1	12.1	12.1	12.1	+	+
Leeds	12.2	12.2	12.2	12.2	12.2	+	+
Leeds	12.3	12.3	12.3	12.3	12.3	+	+
Leeds	12.4	12.4	12.4	12.4	12.4	+	+
Leeds	12.5	12.5	12.5	12.5	12.5	+	+
Leeds	12.6	12.6	12.6	12.6	12.6	+	+
Leeds	12.7	12.7	12.7	12.7	12.7	+	+
Leeds	12.8	12.8	12.8	12.8	12.8	+	+
Leeds	12.9	12.9	12.9	12.9	12.9	+	+
Leeds	13.0	13.0	13.0	13.0	13.0	+	+
Leeds	13.1	13.1	13.1	13.1	13.1	+	+
Leeds	13.2	13.2	13.2	13.2	13.2	+	+
Leeds	13.3	13.3	13.3	13.3	13.3	+	+
Leeds	13.4	13.4	13.4	13.4	13.4	+	+
Leeds	13.5	13.5	13.5	13.5	13.5	+	+
Leeds	13.6	13.6	13.6	13.6	13.6	+	+
Leeds	13.7	13.7	13.7	13.7	13.7	+	+
Leeds	13.8	13.8	13.8	13.8	13.8	+	+
Leeds	13.9	13.9	13.9	13.9	13.9	+	+
Leeds	14.0	14.0	14.0	14.0	14.0	+	+

Wider impacts on health and wellbeing

Indicator	Liverpool	Salford	Howarth upon Tyne	Sheffield	Leeds	Plymouth	Southampton	Derby, City of	Portsmouth	Brighton and Hove	Southeast-on-Sea	Bournemouth	Portsmouth	Southampton
1.001 - Children in poverty (all dependent children under 20)	37.5	27.6	38.4	23.9	31.6	20.6	25.1	24.9	24.4	13.6	22.8	19.7		
1.001i - Children in poverty (under 16s)	33.0	26.2	30.0	24.4	29.0	20.4	23.9	23.3	25.2	11.1	23.5	19.7		
1.002 - School Readiness: The percentage of children achieving a good level of development at the end of reception	50.5	54.8	43.1	51.0	51.3	51.1	50.8	50.1	54.2	41.8	41.0	57.7		
1.020 - School Readiness: The percentage of children with free school meal status achieving a good level of development at the end of reception	36.0	41.0	29.3	36.9	33.0	33.4	37.9	33.7	46.3	26.5	30.0	45.2		
1.021 - School Readiness: The percentage of Year 1 pupils achieving the expected level in the phonics screening check	52.6	69.1	66.6	64.0	60.1	65.1	69.9	69.7	66.8	61.8	60.6	61.0		
1.021i - School Readiness: The percentage of Year 1 pupils with free school meal status achieving the expected level in the phonics screening check	40.1	51.1	55.5	54.1	50.0	55.5	52.9	51.7	56.1	40.8	48.1	57.9		
1.03 - Pupil absence	2.5	5.1	5.7	5.5	4.1	5.5	5.9	5.7	5.1	5.4	5.1	5.5		
1.04 - First time entrants to the youth justice system	277.9	521.3	419.8	445.8	648.8	669.8	483.8	493.8	598.7	406.0	459.0	470.7		
1.05 - 16-18 year olds not in education employment or training	8.1	0.7	8.8	7.7	6.1	6.8	6.3	7.8	6.9	6.7	5.6	5.4		
1.06 - Adults with a learning disability who live in stable and appropriate accommodation	66.3	41.7	47.8	48.0	88.7	67.8	80.4	59.0	68.4	72.0	87.8	58.0		
1.06i - % of adults in contact with secondary mental health services who live in stable and appropriate accommodation	10.1	16.2	16.4	10.1	52.5	53.0	27.4	59.2	40.0	58.4	70.2	18.1		
1.08 - Gap in the employment rate between those with a long-term health condition and the overall employment rate	13.6	13.6	9.0	8.9	16.5	8.7	11.1	10.0	11.1	16.1	11.5	11.6		
1.08i - Gap in the employment rate between those with a learning disability and the overall employment rate	50.6	59.8	27.0	19.0	60.5	52.6	62.7	60.3	64.0	53.7	61.2	68.4		
1.08ii - Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate	17.3	40.8	14.8	12.9	16.8	13.0	16.1	10.4	10.1	13.9	13.8	18.1		
1.09 - Sickness absence - The percentage of employees who had at least one day off in the previous week	3.2	2.3	3.3	2.5	3.1	3.3	2.3	1.8	2.4	3.1	2.4	3.1		
1.09i - Sickness absence - The percentage of employees who had at least one day off in the previous week	2.1	1.7	1.2	1.8	2.0	2.0	1.3	1.2	1.6	1.1	1.5	2.1		
1.10 - Killed and seriously injured casualties on England's roads	43.7	39.6	47.0	37.0	40.1	25.2	64.7	33.9	33.4	37.5	36.5	46.9		
1.11 - Domestic Abuse	33.7	30.0	34.1	34.3	21.4	19.0	16.2	19.7	16.2	14.1	20.0	14.4		
1.12i - Violent crime (including sexual violence) - hospital admissions for violence	107.6	109.3	82.3	65.5	98.1	69.2	58.9	77.5	67.3	53.4	49.9	61.5		
1.12ii - Violent crime (including sexual violence) - violence offences per 1,000 population	10.6	10.4	9.6	7.0	10.1	7.3	10.0	10.1	10.3	12.8	11.8	11.3		
1.12iii - Violent crime (including sexual violence) - Rate of sexual offences per 1,000 population	0.4	0.7	0.8	0.8	1.1	1.4	1.1	1.2	1.0	1.1	1.1	1.0		
1.13 - Re-offending levels - percentage of offenders who re-offend	16.3	17.1	16.3	28.2	27.8	27.5	16.3	16.6	25.6	27.7	16.0	28.2		
1.13i - Re-offending levels - average number of re-offences per offender	1.0	1.0	1.0	1.8	1.8	1.7	1.0	1.0	1.0	1.0	1.0	1.0		
1.14 - The percentage of the population affected by noise - Number of complaints about noise	5.1	3.0	5.9	5.8	10.0	8.7	10.8	10.2	6.6	12.1	15.1	7.4		
1.14i - The percentage of the population exposed to road, rail and air transport noise of 55dB(A) or more, during the daytime	5.8	13.7	5.1	1.0	1.0	4.1	2.7	4.3	11.3	8.7	5.5	5.5		
1.14ii - The percentage of the population exposed to road, rail and air transport noise of 55 dB(A) or more during the night-time	14.0	41.8	16.6	6.8	8.8	7.0	14.1	10.5	42.0	26.5	8.1	8.3		
1.15 - Statutory homelessness - homelessness acceptances	1.0	2.6	1.7	1.0	2.1	2.0	1.9	1.6	1.0	1.1	1.1	1.7		
1.15i - Statutory homelessness - households in temporary accommodation	0.7	0.6	0.7	0.7	0.8	0.8	0.9	0.9	0.8	0.6	0.5	0.9		
1.16 - Utilisation of outdoor spaces for exercise/health reasons	14.1	11.1	15.8	15.2	17.5	17.1	16.0	15.8	14.8	19.4	19.1	19.6		
1.17 - Fuel Poverty	11.1	11.1	12.1	11.0	11.0	10.7	9.8	11.3	10.7	11.9	11.6	11.2		
1.18 - Social isolation: % of adult social care users who have as much social contact as they would like	61.9	37.6	45.5	44.9	47.5	48.7	40.8	42.5	48.1	46.9	46.3	46.2		
1.18i - Loneliness and isolation in adult carers	27.1	40.0	51.0	48.0	42.1	55.1	47.4	46.2	51.1	54.1	40.5	55.2		

Indicator	Portsmouth	Southampton
1.001 - Children in poverty (all dependent children under 20)	21.1	21.1
1.001i - Children in poverty (under 16s)	19.7	19.7
1.002 - School Readiness: The percentage of children achieving a good level of development at the end of reception	57.7	57.7
1.020 - School Readiness: The percentage of children with free school meal status achieving a good level of development at the end of reception	45.2	45.2
1.021 - School Readiness: The percentage of Year 1 pupils achieving the expected level in the phonics screening check	61.0	61.0
1.021i - School Readiness: The percentage of Year 1 pupils with free school meal status achieving the expected level in the phonics screening check	57.9	57.9
1.03 - Pupil absence	5.5	5.5
1.04 - First time entrants to the youth justice system	470.7	470.7
1.05 - 16-18 year olds not in education employment or training	5.4	5.4
1.06 - Adults with a learning disability who live in stable and appropriate accommodation	58.0	58.0
1.06i - % of adults in contact with secondary mental health services who live in stable and appropriate accommodation	18.1	18.1
1.08 - Gap in the employment rate between those with a long-term health condition and the overall employment rate	11.6	11.6
1.08i - Gap in the employment rate between those with a learning disability and the overall employment rate	68.4	68.4
1.08ii - Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate	18.1	18.1
1.09 - Sickness absence - The percentage of employees who had at least one day off in the previous week	3.1	3.1
1.09i - Sickness absence - The percentage of employees who had at least one day off in the previous week	2.1	2.1
1.10 - Killed and seriously injured casualties on England's roads	46.9	46.9
1.11 - Domestic Abuse	14.4	14.4
1.12i - Violent crime (including sexual violence) - hospital admissions for violence	61.5	61.5
1.12ii - Violent crime (including sexual violence) - violence offences per 1,000 population	11.3	11.3
1.12iii - Violent crime (including sexual violence) - Rate of sexual offences per 1,000 population	1.0	1.0
1.13 - Re-offending levels - percentage of offenders who re-offend	28.2	28.2
1.13i - Re-offending levels - average number of re-offences per offender	1.0	1.0
1.14 - The percentage of the population affected by noise - Number of complaints about noise	7.4	7.4
1.14i - The percentage of the population exposed to road, rail and air transport noise of 55dB(A) or more, during the daytime	5.5	5.5
1.14ii - The percentage of the population exposed to road, rail and air transport noise of 55 dB(A) or more during the night-time	8.3	8.3
1.15 - Statutory homelessness - homelessness acceptances	1.7	1.7
1.15i - Statutory homelessness - households in temporary accommodation	0.9	0.9
1.16 - Utilisation of outdoor spaces for exercise/health reasons	19.6	19.6
1.17 - Fuel Poverty	11.2	11.2
1.18 - Social isolation: % of adult social care users who have as much social contact as they would like	46.3	46.3
1.18i - Loneliness and isolation in adult carers	40.5	40.5

Health lifestyles

Indicator	Liverpool	Salford	Newcastle upon Tyne	Sheffield	Leeds	Plymouth	Southampton	Bristol, City of	Portsmouth	Brighton and Hove	Southend-on-Sea	Bournemouth	Portsmouth Compared to England	Southampton Compared to England
Ranked order of deprivation (Index of Multiple Deprivation, 2010)	34.1	86.1	88.4	84.1	26.6	25.9	23.5	25.3	21.7	22.5	21.8	13.6		
2.01 - Low birth weight of term babies	1.1	1.1	1.1	2.0	1.1	2.0	2.7	2.1	1.5	2.7	1.1	1.6		
2.02i - Breastfeeding - Breastfeeding initiation	50.4	38.2	33.8	77.7	16.7	69.1	74.6	86.7	75.4	16.7	73.0	76.9		
2.02ii - Breastfeeding - Breastfeeding prevalence at 6-8 weeks after birth	29.1	36.2	44.9	50.9	47.3	34.2	43.5	-	46.5	70.5	36.7	52.1		
2.03 - Smoking status at time of delivery	28.1	16.2	17.1	14.0	13.0	16.7	15.2	12.3	17.3	6.7	11.5	13.2		
2.04 - Under 18 conceptions	39.6	41.9	42.8	35.2	38.1	41.9	47.4	13.7	31.3	29.4	34.8	11.7		
2.04 - Under 18 conceptions: conceptions in those aged under 16	8.7	8.5	11.1	6.7	8.5	7.7	10.3	5.1	6.1	6.8	9.8	5.1		
2.06i - Excess weight in 4-5 and 10-11 year olds - 4-5 year olds	38.4	33.0	36.6	101.6	22.8	38.8	22.3	21.0	38.2	21.3	22.9	27.4		
2.06ii - Excess weight in 4-5 and 10-11 year olds - 10-11 year olds	23.1	30.0	17.8	33.7	33.8	23.1	34.4	33.9	25.2	25.6	23.0	41.3		
2.07i - Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-14 years)	107.0	143.9	118.4	83.9	114.0	115.1	130.8	104.3	104.4	110.8	84.0	116.6		
2.07ii - Hospital admissions caused by unintentional and deliberate injuries in young people (aged 15-24)	105.0	120.2	115.9	97.4	111.5	127.1	141.2	137.3	121.8	118.3	132.2	109.0		
2.08 - Emotional well-being of looked after children	12.5	23.1	18.5	-	13.3	17.3	-	14.0	11.7	14.8	14.3	13.8		
2.12 - Excess Weight in Adults	67.2	63.8	60.3	59.9	62.2	60.0	64.8	69.1	57.9	49.7	64.4	56.1		
2.13i - Percentage of physically active and inactive adults - active adults	52.0	45.4	57.6	54.6	61.3	59.2	56.0	55.4	51.0	63.4	55.5	64.1		
2.13ii - Percentage of active and inactive adults - inactive adults	31.9	31.1	37.6	30.4	26.9	27.6	30.9	28.4	31.2	24.9	31.8	20.4		
2.14 - Smoking Prevalence	18.5	20.2	22.9	23.2	23.6	21.0	22.5	21.7	21.5	23.7	22.0	19.5		
2.14 - Smoking prevalence - routine & manual	32.5	34.3	34.5	33.0	30.2	33.5	30.3	27.0	33.8	35.0	30.8	29.9		
2.15i - Successful completion of drug treatment - opiate users	6.0	4.6	5.2	2.8	7.2	6.3	6.5	9.1	6.0	9.7	6.8	7.8		
2.15ii - Successful completion of drug treatment - non-opiate users	55.1	31.4	30.5	37.9	33.5	36.0	36.0	38.7	36.6	37.6	39.9	41.6		
2.17 - Recorded diabetes	5.0	3.9	5.3	6.0	5.1	5.5	5.4	4.3	5.3	4.1	5.4	5.1		
2.20i - Cancer screening coverage - breast cancer	70.9	18.9	79.4	70.7	74.0	70.7	69.9	72.8	73.6	72.7	68.7	73.3		
2.20ii - Cancer screening coverage - cervical cancer	98.2	20.1	72.6	74.6	75.3	75.7	71.1	59.1	93.0	71.5	73.6	73.2		
2.21ii - Access to non-cancer screening programmes - diabetic retinopathy	86.3	25.2	89.1	99.0	87.9	77.8	75.8	83.3	83.1	81.7	79.0	93.2		
2.22i - Take up of NHS Health Check Programme by those eligible - health check offered	42.5	21.0	12.9	6.1	77.0	63.2	14.2	6.1	20.7	13.6	12.8	1.9		
2.22ii - Take up of NHS Health Check Programme by those eligible - health check take up	20.4	18.7	47.6	11.8	33.0	65.0	61.4	53.1	28.8	43.7	47.1	47.6		
2.23i - Self-reported well-being - people with a low satisfaction score	8.4	6.3	7.0	7.1	6.1	6.5	4.4	5.4	6.2	3.8	6.4	6.7		
2.23ii - Self-reported well-being - people with a low worthwhile score	8.0	5.1	6.1	3.4	4.5	3.4	3.7	-	-	5.3	-	4.0		
2.23iii - Self-reported well-being - people with a low happiness score	15.2	13.8	11.9	11.5	9.7	10.4	10.3	11.8	13.7	11.1	9.9	10.1		
2.23iv - Self-reported well-being - people with a high anxiety score	21.9	22.8	21.0	23.5	21.7	24.1	23.0	23.9	17.5	25.8	22.0	20.6		
2.24i - Injuries due to falls in people aged 65 and over (Persons)	796.1	1170.7	2055.3	1418.3	1193.5	1747.3	2187.2	1993.4	2034.8	1901.1	1879.3	1311.8		
2.24ii - Injuries due to falls in people aged 65 and over (males/females)	393.1	2183.9	1508.0	1066.4	1696.9	1307.7	2161.4	1541.8	1621.8	1031.8	1361.0	509.7		
2.24iii - Injuries due to falls in people aged 65 and over (males/females)	303.5	1891.8	2322.5	1771.7	2223.8	2106.9	2380.0	2444.9	2447.8	2508.3	2375.6	1381.1		
2.24iv - Injuries due to falls in people aged 65 and over - aged 65-79	122.8	1356.2	1388.0	642.5	1259.1	1196.1	2401.8	1245.8	1234.9	1203.2	1125.6	1046.6		
2.24v - Injuries due to falls in people aged 65 and over - aged 80+	673.3	115.1	513.6	4013.7	1640.1	6927.2	4107.8	5387.1	5634.2	5401.5	5718.7	4011.1		

Protection from health threats

Indicator	Liverpool	Stafford	Newcastle upon Tyne	Sheffield	Leeds	Plymouth	Southampton	Bright City of	Portsmouth	Brighton and Hove	Southend-on-Sea	Bournemouth	Portsmouth Compared to England	Southampton Compared to England
Ranked order of deprivation (Index of Multiple Deprivation, 2010)	54.1	44.1	34.3	34.3	28.6	25.9	25.5	25.3	25.7	22.5	21.8	14.6		
3.01 - Fraction of mortality attributable to particulate air pollution	2.7	5.5	4.1	5.1	5.2	9.7	6.3	5.3	3.9	1.8	5.7	4.0		
3.02i - Chlamydia diagnoses (15-24 year olds) - CTAD	2776.4	4985.0	3333.8	2302.2	3475.3	1447.4	1979.8	4111.0	3013.8	4488.6	4352.4	2816.2		
3.02ii - Chlamydia diagnoses (15-24 year olds) - CTAD	1627.4	1794.1	2507.1	1113.5	1820.0	1257.0	1136.7	1831.0	1795.7	3107.0	4020.7	1765.0		
3.02iii - Chlamydia diagnoses (15-24 year olds) - CTAD	2241.7	2642.0	3643.0	1095.7	1657.6	1169.7	1500.2	3343.8	2175.3	5195.8	4781.0	2290.1		
3.05i - Population vaccination coverage - Hepatitis B (1 year old)	83.8	108.0	100.0	100.0	97.8	100.0	100.0	-	83.8	100.0	-	-		
3.05ii - Population vaccination coverage - Hepatitis B (2 years old)	100.0	100.0	100.0	92.0	95.1	81.8	-	-	100.0	-	-	-		
3.03iii - Population vaccination coverage - Drap / IPV / Hib (1 year old)	96.3	99.9	94.9	94.5	96.8	96.8	95.3	96.4	94.7	93.9	95.2	94.9		
3.03iii - Population vaccination coverage - Drap / IPV / Hib (1 year old)	93.1	99.0	93.7	96.7	98.0	91.1	97.0	96.7	95.6	94.4	97.0	98.0		
3.03iv - Population vaccination coverage - Drap / IPV / Hib (2 years old)	95.4	96.5	91.3	93.8	96.3	96.8	94.9	95.8	94.1	93.0	96.3	94.4		
3.03v - Population vaccination coverage - MenC	91.5	96.3	94.5	93.6	95.7	95.0	93.1	95.8	92.6	91.1	95.1	93.3		
3.03vi - Population vaccination coverage - Hib / MenC booster (2 years old)	88.6	96.9	91.8	95.3	94.7	91.7	90.5	92.5	91.7	95.9	95.8	94.7		
3.03vi - Population vaccination coverage - Hib / Men C booster (5 years)	96.7	97.5	93.9	92.8	95.3	91.2	94.0	91.9	90.8	89.5	94.1	93.1		
3.03vii - Population vaccination coverage - PCV booster	96.0	98.4	93.8	93.8	94.7	92.6	94.1	95.7	93.5	90.9	92.5	93.1		
3.03ix - Population vaccination coverage - MMR for one dose (2 years old)	97.4	98.3	95.0	95.1	95.1	96.4	95.3	93.1	92.0	93.0	94.1	95.2		
3.03ix - Population vaccination coverage - MMR for one dose (5 years old)	91.8	97.0	90.3	88.6	89.6	89.0	91.2	83.1	85.2	87.0	91.1	88.1		
3.03xii - Population vaccination coverage - HPV	87.8	86.0	92.9	93.4	92.8	79.0	89.1	88.3	87.4	88.9	87.8	89.1		
3.03xiii - Population vaccination coverage - PPV	68.4	67.8	73.0	72.8	72.8	70.9	70.5	73.7	67.9	67.0	67.4	70.3		
3.03xiv - Population vaccination coverage - Flu (aged 65+)	77.4	77.1	77.7	75.3	78.7	75.3	75.5	75.1	75.1	69.1	69.1	71.7		
3.03xv - Population vaccination coverage - Flu (at risk individuals)	59.8	58.2	33.3	51.3	54.2	54.1	53.2	53.7	52.9	54.1	61.0	63.1		
3.04 - People presenting with HIV at a late stage of infection	70.7	50.5	48.9	48.7	51.6	39.1	48.9	58.0	54.8	75.9	78.9	10.0		
3.05 - Treatment completion for TB	86.1	91.8	88.8	88.4	81.4	-	88.2	87.8	86.3	83.3	85.1	-		
3.05ii - Incidence of TB	10.9	12.0	13.1	13.8	13.8	9.6	14.3	13.0	10.7	6.5	11.5	6.8		
3.06 - Public sector organisations w/ board approved sustainable development management plan	80.0	80.0	100.0	85.7	83.3	100.0	70.0	100.0	88.7	88.7	80.0	100.0		

Living long, living well

Indicator	Liverpool	Salford	Newcastle upon Tyne	Sheffield	Leeds	Plymouth	Southampton	Distric City of	Portsmouth	Brighton and Hove	Southern-on-Sea	Bournemouth	Portsmouth Compared to England	Southampton Compared to England
Ranked order of deprivation (Index of Multiple Deprivation, 2010)	44.1	40.1	38.6	44.1	28.6	25.9	25.5	25.3	35.3	22.5	21.5	19.4		
4.01 - Infant mortality	146	133	131	147	4.6	3.4	4.3	3.3	3.0	4.3	4.0	3.0		
4.02 - Tooth decay in children aged 5	14	16	16	16	106	87	113	0.8	0.8	0.4	0.7	0.9		
4.03 - Mortality rate from causes considered preventable	282.2	483.5	282.2	196.6	219.2	217.2	222.6	208.4	252.2	213.9	187.5	202.8		
4.03 - Mortality rate from causes considered preventable	193.7	333.6	188.2	133.3	284.5	276.5	276.2	270.1	311.1	272.8	208.7	203.4		
4.03 - Mortality rate from causes considered preventable	20.0	111.7	117.7	160.9	199.1	169.1	176.4	180.1	170.3	211.9	160.4	200.7		
4.04 - Under 75 mortality rate from all cardiovascular diseases	112.9	177.5	110.0	89.3	96.0	86.3	93.8	96.1	98.1	95.5	83.1	82.4		
4.04 - Under 75 mortality rate from all cardiovascular diseases	106.4	169.8	101.6	127.3	136.8	130.3	131.6	122.1	134.5	117.2	121.1	114.9		
4.04 - Under 75 mortality rate from all cardiovascular diseases	68.9	73.0	64.3	53.6	69.7	55.3	57.7	53.1	58.6	44.0	47.7	40.7		
4.05 - Under 75 mortality rate from cardiovascular diseases considered preventable	73.1	89.8	89.8	62.5	68.1	60.7	60.1	57.9	63.7	49.5	56.5	43.8		
4.05 - Under 75 mortality rate from cardiovascular diseases considered preventable	79.7	104.4	102.2	56.2	77.1	67.7	69.9	63.9	51.8	77.3	69.1	70.5		
4.05 - Under 75 mortality rate from cardiovascular diseases considered preventable	30.1	49.5	34.8	30.3	33.1	31.3	31.7	31.0	36.1	21.6	33.2	34.1		
4.05 - Under 75 mortality rate from cancer	101.0	164.0	134.1	159.0	165.0	166.1	163.6	161.1	169.1	154.5	138.7	132.8		
4.05 - Under 75 mortality rate from cancer	109.0	187.7	132.1	176.1	187.8	189.2	182.1	182.0	189.1	169.2	144.1	146.1		
4.05 - Under 75 mortality rate from cancer	110.0	192.1	136.1	143.6	144.7	145.3	143.0	144.1	146.1	133.3	142.0	122.0		
4.05 - Under 75 mortality rate from cancer considered preventable	119.6	118.2	129.1	91.9	100.1	101.0	98.1	97.6	101.1	96.5	84.1	79.8		
4.05 - Under 75 mortality rate from cancer considered preventable	111.9	111.0	101.1	113.3	111.6	113.0	106.6	109.6	108.0	103.0	84.6	83.4		
4.05 - Under 75 mortality rate from cancer considered preventable	109.8	108.9	108.9	81.5	85.9	90.5	90.4	86.3	88.6	85.2	83.1	78.1		
4.06 - Under 75 mortality rate from liver disease	11.9	26.8	13.8	17.7	21.2	17.1	20.5	19.0	23.4	22.8	17.0	16.1		
4.06 - Under 75 mortality rate from liver disease	14.1	22.8	16.5	14.7	18.8	13.2	29.0	29.3	31.4	29.1	25.3	16.7		
4.06 - Under 75 mortality rate from liver disease	12.0	10.8	12.5	10.0	14.4	11.0	12.0	10.8	15.5	10.5	11.0	14.2		
4.06 - Under 75 mortality rate from liver disease considered preventable	10.4	11.1	10.1	11.3	17.9	14.3	18.3	18.6	20.4	20.3	15.0	13.1		
4.06 - Under 75 mortality rate from liver disease considered preventable	10.8	10.9	11.2	10.7	14.7	13.1	27.1	28.2	27.9	26.2	18.1	13.1		
4.06 - Under 75 mortality rate from liver disease considered preventable	11.4	17.8	9.8	9.0	11.4	9.7	-	9.6	12.9	10.1	13.7	12.3		
4.07 - Under 75 mortality rate from respiratory disease	107.7	109.9	111.8	111.4	106.8	101.1	102.6	107.3	113.3	101.1	110.1	107.6		
4.07 - Under 75 mortality rate from respiratory disease	117.7	111.1	113.7	106.1	107.7	101.1	103.5	104.1	109.8	100.8	102.1	101.6		
4.07 - Under 75 mortality rate from respiratory disease	101.4	101.8	111.0	101.8	101.1	101.8	102.2	101.1	101.8	101.1	101.1	101.1		

Living long, living well

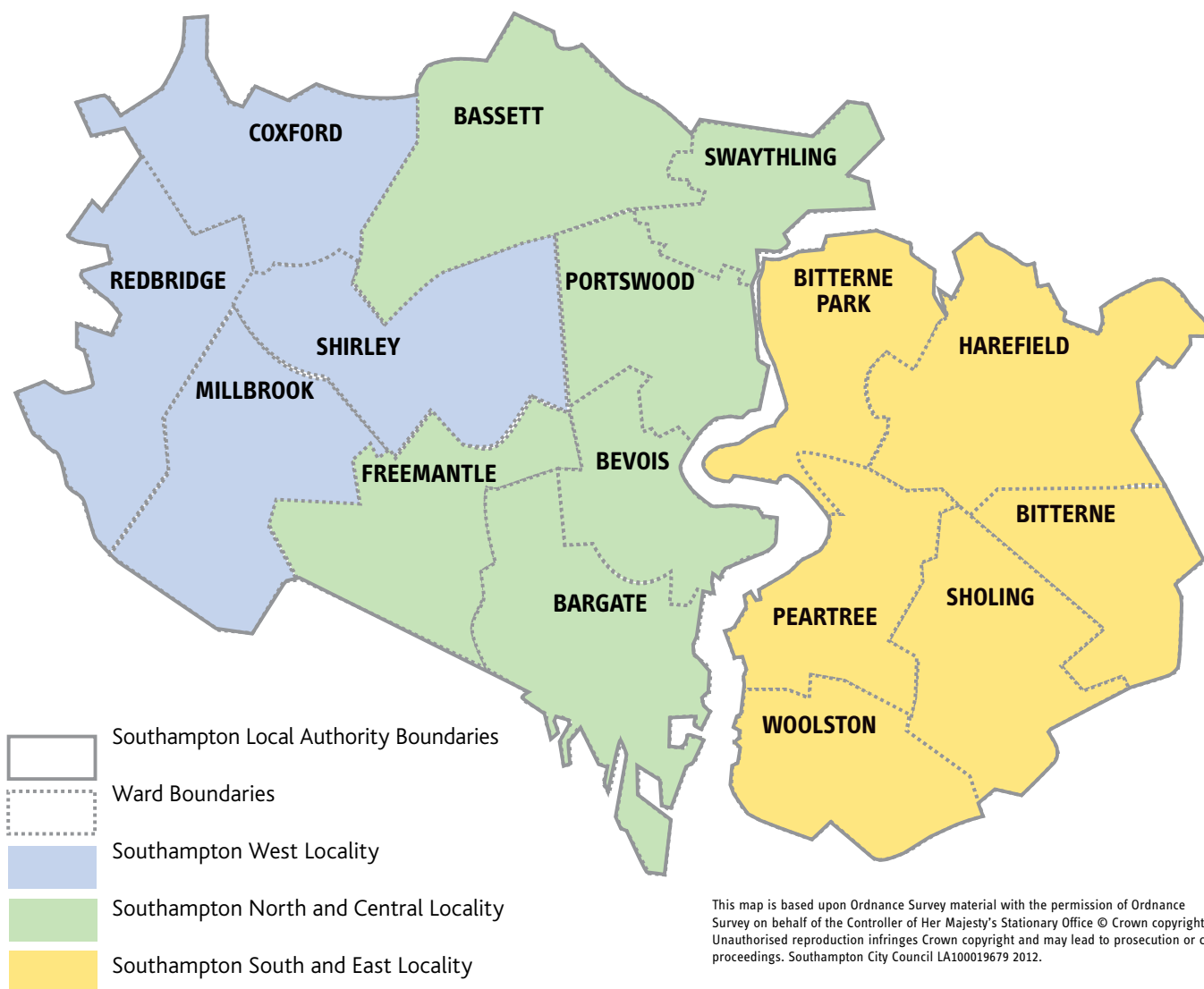
Indicator	Liverpool	Salford	Newcastle upon Tyne	Sheffield	Leeds	Plymouth	Southampton	Great, City of	Portsmouth	Brighton and Hove	Southend-on-Sea	Bournemouth	Portsmouth Compared to England	Southampton Compared to England
Ranked order of deprivation (Index of Multiple Deprivation, 2010)	81.1	78.1	78.3	84.3	88.6	25.9	25.5	25.3	33.7	23.5	21.6	33.6		
4.07a - Under 75 mortality rate from respiratory disease considered preventable	11.1	14.7	16.6	10.1	23.8	21.7	26.1	25.3	18.1	23.0	16.4	24.6		
4.07b - Under 75 mortality rate from respiratory disease considered preventable	11.8	14.8	16.1	20.9	26.0	23.5	28.1	15.1	20.1	24.8	13.7	21.8		
4.07c - Under 75 mortality rate from respiratory disease considered preventable	19.2	22.2	27.2	17.9	20.0	23.8	23.0	15.7	23.7	21.2	14.9	-		
4.08 - Mortality from communicable diseases	10.1	10.4	12.3	10.4	15.2	9.9	14.9	10.9	14.8	10.6	10.1	14.5		
4.09 - Mortality from communicable diseases	11.9	13.1	12.3	15.8	18.7	11.6	16.9	10.4	15.3	11.0	10.3	17.5		
4.08 - Mortality from communicable diseases	11.8	11.8	17.1	17.1	14.2	11.8	13.6	16.3	18.2	11.5	10.3	15.9		
4.10 - Suicide rate	9.9	9.5	8.5	9.3	9.7	10.8	11.6	10.8	9.1	9.3	11.8	9.3		
4.10 - Suicide rate	11.8	15.8	17.3	111.9	15.3	18.1	13.1	16.2	13.1	18.3	-	13.9		
4.10 - Suicide rate	-	-	-	-	3.4	-	1.6	4.1	-	-	-	-		
4.11 - Emergency readmissions within 30 days of discharge from hospital	14.8	12.2	22.9	10.3	16.7	16.9	12.2	14.8	12.5	20.5	20.0	12.1		
4.11 - Emergency readmissions within 30 days of discharge from hospital	14.8	13.3	14.4	12.4	19.1	16.1	11.4	12.7	13.0	13.2	17.4	11.8		
4.11 - Emergency readmissions within 30 days of discharge from hospital	14.8	11.3	17.6	11.7	10.1	10.3	11.9	11.8	12.1	13.2	11.6	11.1		
4.12 - Preventable sight loss - age related macular degeneration (AMD)	121.3	99.0	131.1	149.8	109.4	121.8	103.1	121.3	107.8	119.9	119.9	109.9		
4.12a - Preventable sight loss - glaucoma	10.1	8.7	12.2	11.6	10.2	8.5	11.6	11.4	-	11.7	10.1	8.3		
4.12b - Preventable sight loss - diabetic eye disease	5.4	-	8.7	4.4	9.4	4.5	8.4	-	10.9	7.9	6.0	-		
4.12c - Preventable sight loss - diabetic eye disease	45.5	11.9	45.5	8.9	10.0	20.0	10.1	20.7	10.0	42.1	47.1	13.1		
4.12d - Preventable sight loss - sight loss certifications	103.8	108.7	132.7	139.6	140.7	101.3	100.5	100.3	100.3	100.3	100.3	100.3		
4.14 - Hip fractures in people aged 65 and over	133.8	246.3	134.0	143.1	235.0	107.4	108.5	132.3	100.0	236.4	208.4	139.6		
4.14a - Hip fractures in people aged 65 and over - aged 65-79	1491.1	1078.0	1509.5	1477.2	1302.5	1375.0	1493.1	1338.8	1393.6	1469.2	1321.3	1371.9		
4.14b - Hip fractures in people aged 65 and over - aged 80+	13.4	10.5	13.1	10.9	16.1	16.1	21.3	18.2	10.1	14.9	15.0	13.1		
4.15 - Excess Winter Deaths Index (Single year, all ages)	11.6	22.2	13.1	21.7	18.1	14.0	21.3	17.8	10.9	14.7	22.1	10.8		
4.15a - Excess Winter Deaths Index (Single year, all ages)	11.8	14	15.7	12.7	16.5	13.1	21.3	16.0	13.8	15.0	13.8	11.1		
4.15b - Excess Winter Deaths Index (3 years, all ages)	15.1	20.2	23.6	18.9	21.1	18.1	29.4	20.2	23.4	19.0	21.0	11.1		

Appendix 2: Ward Profiles

Introduction

Ward profiles have been produced as spine charts in order to summarise a great deal of information into a relatively succinct format. Spine charts have been used for the health profiles produced by Public Health England (PHE) for a number of years. The profiles have been produced for Southampton's three localities and 16 wards in order to meet a need for more information at these levels.

The Southampton profiles include data for 33 indicators grouped into 7 topics:



1. Demography
2. Economic
3. Healthy Start
4. Lifestyle
5. Community Safety
6. Disability and Poor Health
7. Mortality

Please note that the profiles are attempting to provide information about the population

How to interpret the ward level

spine charts

- The red line down the centre of the chart represents the Southampton City average value for each indicator. The data has been normalised which means that values to the left of the red line are 'worse' than the City average and those to the right are 'better' (although note that for the Demography indicators these terms are not appropriate and instead the right side of the line indicates higher values and the left side lower).
- The circles on the chart are the ward values. Circles coloured blue indicate that the ward value is statistically significantly different from the city average. Yellow circles indicate that any difference is not significant and white circles indicate that significance could not be calculated.
- The white diamonds on the spine chart give the locality average.
- The light grey bar for each indicator shows the range of values for the wards in the city (i.e. it stretches from the value for the 'worst' ward to the value for the 'best' ward).
- The darker grey shading shows the range of values for the middle 50% of wards.

The width of the confidence interval depends on three things:-

1. The size of the sample from which the estimate is derived (or population size if from a complete dataset).
A larger sample means a more precise estimate and, therefore, smaller confidence interval.
2. The degree of variability in the phenomenon being measured. This is often known (or assumed) to follow a certain probability distribution which means that the amount of variability can be built into the confidence interval calculation.
3. The required level of confidence – this is an arbitrary value set by the analyst giving the desired probability that the interval includes the true value. These profiles use 95% confidence intervals which are conventionally used in public health.

The wider the confidence interval, the greater the level of uncertainty of the estimate. When comparing the estimates from two areas, if the confidence intervals do not overlap you can assume a statistically significant difference. However, more caution is needed in interpreting overlapping confidence intervals as this does not always mean no statistically significant difference.

Frequently asked questions

Q. Why have you used the terms 'best' and 'worst'?

- A. These are the same terms as used in the Public Health England Health Profiles and we have used the same template for our Profiles. However, we do acknowledge that for some indicators (such as the Demography indicators) these terms are not appropriate.

Q. How do you calculate a statistically significant difference?

- A. Statistical significance has been measured by calculating 95% confidence intervals around the indicator values. A confidence interval is a range of values that is used to quantify the imprecision in the estimate of a particular value.

Q. Does the size and demographic breakdown of the population impact on the indicators?

- A. Wherever possible indicators are calculated as rates to ensure that the relative size of each ward's population is taken into account when making comparisons. In addition, Directly Standardised Rates have been calculated where relevant to account for the varying age structure between electoral wards.

Q. How have the admissions attributable to smoking been calculated?

- A. The total number of smoking attributable admissions is the sum of the Smoking Attributable Fractions (SAF) for all of the admissions with smoking attributable diagnoses. The SAF for each admission is calculated using the relative risk of death (for fatal diseases) or illness (for non-fatal diseases) from these diagnoses for smokers and ex-smokers, and the prevalence of smoking and ex-smoking in the local authority, where the patient resides.

We have used the same methodology as the Local Tobacco Control Profiles see www.lho.org.uk/LHO_Topics/Analytic_Tools/Tobaccocontrolprofiles/ The relative risks used are taken from the report published by the NHS Information Centre for Health and Social Care, Statistics on Smoking: England, 2010 <https://catalogue.ic.nhs.uk/publications/public-health/smoking/smok-eng-2010/smok-eng-2010-rep.pdf>

Q. How can the deprivation indicators be interpreted?

- A. The 'Least Deprived LSOA in ward' and 'Most Deprived LSOA in ward' indicators can be read together to show the range of deprivation within a ward. The grey bar represents all LSOA's (Lower Super Output Areas) in the city from the most deprived to the least, whilst the white circle shows the relative position of that ward's most/least deprived LSOA. Therefore, the difference between these two circles represents the range of deprivation experienced within that ward.

Q. Why were these indicators chosen and others of interest not included?

- A. Indicators have been chosen to cover a range of topics which as far as possible give the ward level picture of the Public Health Outcomes Framework and the PHE Profiles. Inevitably we are restricted by what data is available to us.

Public Health Ward Profiles: 2012/13

Southampton North & Central Locality

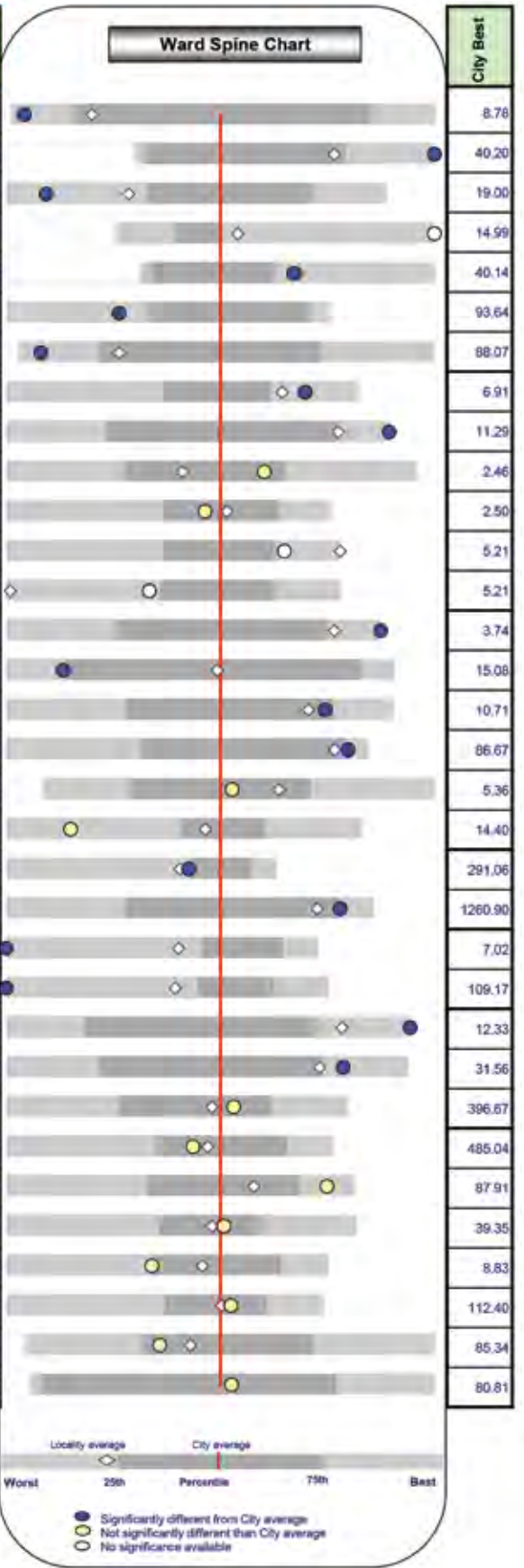
00MSMR - Bargate

Main Menu

Metadata

Print

Indicator		Ward no.	Ward Value	Locality Average	City Average	City Worst
Demography	1 % Resident Population aged 0-4 years ^a	829	4.42	5.14	6.50	4.27
	2 % Resident Population aged 18-24 years ^a	7543	40.20	29.29	16.88	7.58
	3 % Resident Population aged over 65 years ^a	1258	6.71	9.69	12.99	5.25
	4 Forecast % change in population 2011-18 ^a	2759	14.99	4.10	3.14	-2.56
	5 % Population from minority ethnic groups ^a	4317	23.01	23.59	14.08	4.20
	6 % Population born in the UK ^a	13542	72.18	71.97	82.42	60.70
	7 General Fertility Rate ^a	1007	37.47	47.52	60.53	34.56
Economic	8 Working Age Claimant Rate	1465	9.53	10.68	13.73	24.31
	9 Adults with No Qualifications	1931	11.29	14.21	20.96	33.24
	10 16-18 year old NEET	11	4.58	5.72	5.19	8.17
	11 Long Term Unemployed	105	6.63	6.08	6.30	13.67
	12 Least Deprived LSOA in Ward	-	14.43	5.21	24.98	60.32
	13 Most Deprived LSOA in Ward	-	36.68	59.63	24.98	60.32
Healthy Start	14 Lone Parent Families	297	3.74	4.69	7.03	11.42
	15 Child Poverty	615	34.55	25.48	25.31	37.91
	16 % Smoking in Pregnancy	82	13.90	14.68	18.78	28.78
	17 % Breastfeeding	502	85.08	84.01	74.92	57.89
	18 Year R Child Obesity	30	9.15	8.27	9.36	12.69
	19 Year 6 Child Obesity	38	25.68	20.46	19.88	28.17
Lifestyle	20 Alcohol Specific Hospital Admissions (DSR)	609	833.26	888.98	638.81	1971.63
	21 Smoking Related Hospital Admissions (DSR)	312	1367.35	1440.27	1747.38	2426.06
Safety	22 Violent Crime	1014	54.25	28.14	21.82	54.25
	23 Road KSIs	328	602.21	343.35	274.71	602.21
Disability and Poor Health	24 Limiting illness	1896	12.33	16.07	22.74	34.48
	25 DLA Claimants	670	40.29	43.49	56.74	85.39
	26 Injuries due to Falls (65+)	52	485.12	501.82	495.41	661.77
Mortality	27 All Age All Cause Mortality (DSR)	563	588.69	577.76	568.54	727.02
	28 Premature Mortality from Cancer	62	94.18	110.87	118.46	167.23
	29 Premature Mortality from CVD	47	70.18	72.93	71.01	120.57
	30 Premature Mortality from Respiratory Disease	26	40.69	31.56	28.34	66.99
	31 Mortality from Preventable Causes	118	167.77	173.24	173.99	301.11
	32 Life Expectancy Females	-	81.69	82.09	82.49	79.88
	33 Life Expectancy Males	-	78.47	78.47	78.34	76.14



^a The terms 'best' and 'worst' are not appropriate for these indicators instead the right side of the chart indicates the highest value and the left side the lowest.

Public Health Ward Profiles: 2012/13

Southampton North & Central Locality

00MSMS - Bassett

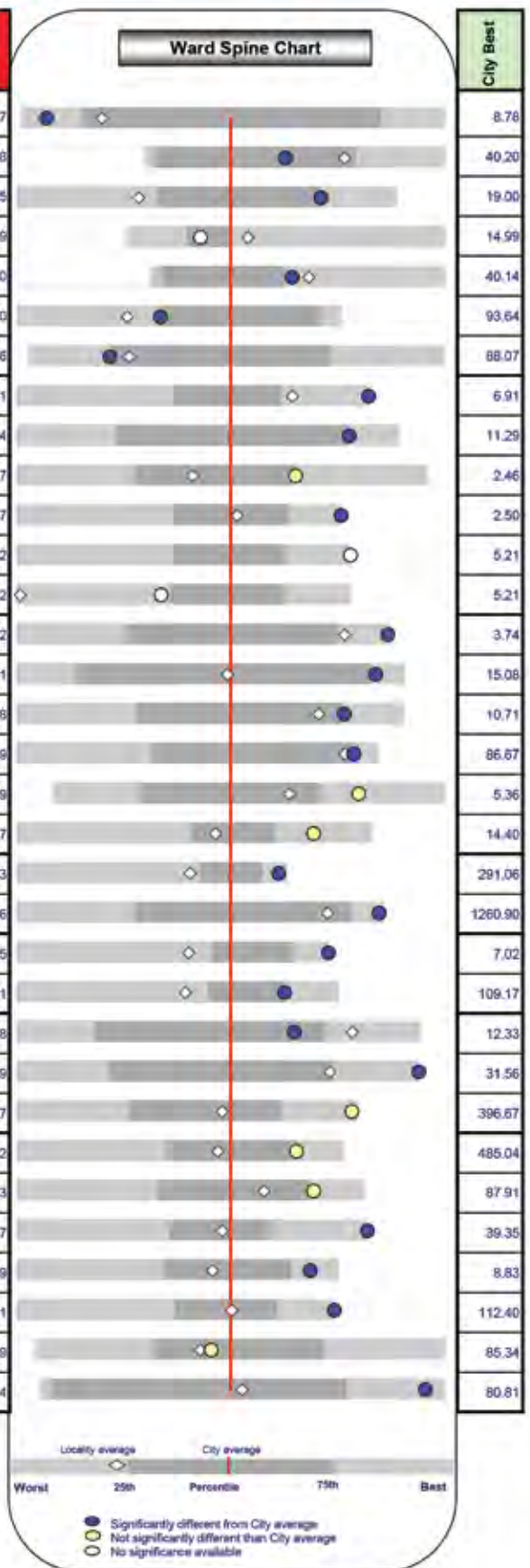
Public Health Southampton

Main Menu

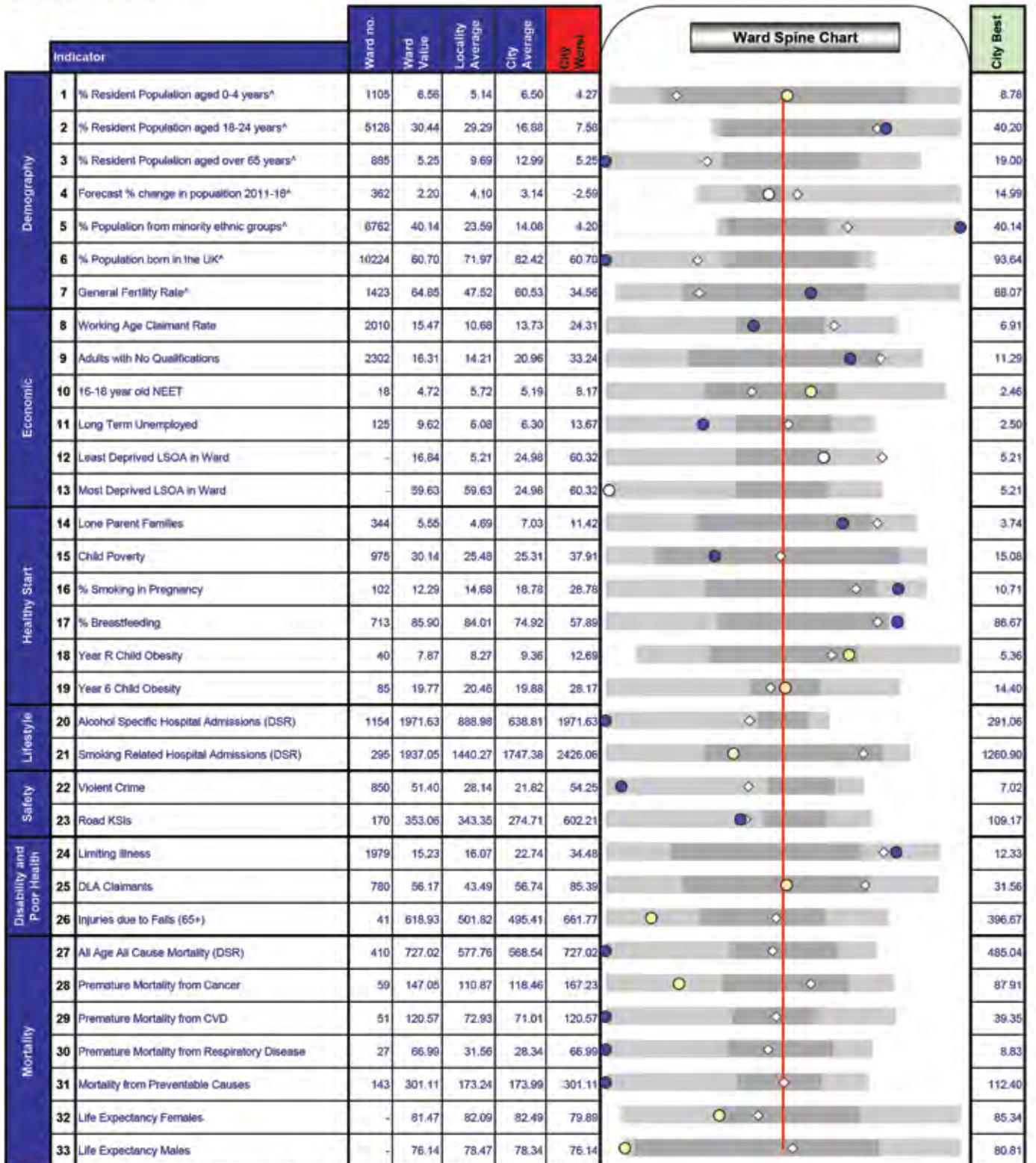
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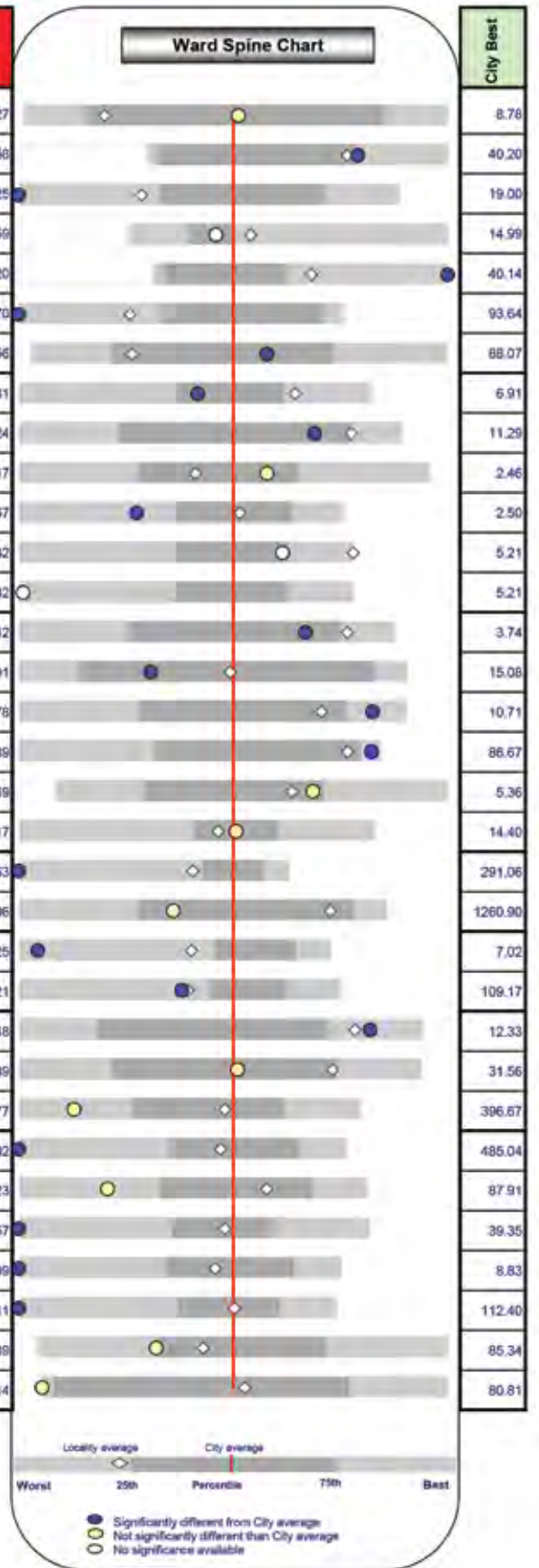
Indicator		Ward no.	Ward Value	Locality Average	City Average	City Worst	City Best
Demography	1 % Resident Population aged 0-4 years ^a	661	4.55	5.14	6.50	4.27	8.78
	2 % Resident Population aged 18-24 years ^a	3321	22.85	29.29	16.88	7.58	40.20
	3 % Resident Population aged over 65 years ^a	2363	16.26	9.69	12.99	5.25	19.00
	4 Forecast % change in population 2011-18 ^a	215	1.48	4.10	3.14	-2.59	14.99
	5 % Population from minority ethnic groups ^a	3132	21.55	23.59	14.08	4.20	40.14
	6 % Population born in the UK ^a	10948	75.34	71.97	82.42	60.70	93.64
	7 General Fertility Rate ^a	770	45.05	47.52	60.53	34.56	88.07
Economic	8 Working Age Claimant Rate	690	6.91	10.68	13.73	24.31	6.91
	9 Adults with No Qualifications	1789	14.16	14.21	20.96	33.24	11.29
	10 16-18 year old NEET	13	4.29	5.72	5.19	8.17	2.46
	11 Long Term Unemployed	25	2.50	6.08	6.30	13.67	2.50
	12 Least Deprived LSOA in Ward	-	5.21	5.21	24.98	60.32	5.21
Healthy Start	13 Most Deprived LSOA in Ward	-	36.37	59.63	24.98	60.32	5.21
	14 Lone Parent Families	209	3.80	4.69	7.03	11.42	3.74
	15 Child Poverty	360	16.78	25.48	25.31	37.91	15.08
	16 % Smoking in Pregnancy	60	13.48	14.68	18.78	28.78	10.71
	17 % Breastfeeding	377	84.72	84.01	74.92	57.89	86.67
Lifestyle	18 Year R Child Obesity	20	6.97	8.27	9.36	12.69	5.36
	19 Year 6 Child Obesity	42	16.67	20.46	19.88	28.17	14.40
	20 Alcohol Specific Hospital Admissions (DSR)	240	338.83	888.98	638.81	1971.63	291.06
Safety	21 Smoking Related Hospital Admissions (DSR)	354	1276.93	1440.27	1747.38	2426.06	1260.90
	22 Violent Crime	102	7.02	28.14	21.82	54.25	7.02
	23 Road KSIs	83	192.36	343.35	274.71	602.21	109.17
Disability and Poor Health	24 Limiting illness	1923	19.26	16.07	22.74	34.48	12.33
	25 DLA Claimants	390	31.56	43.49	56.74	85.39	31.56
	26 Injuries due to Falls (65+)	52	401.20	501.82	495.41	661.77	396.67
Mortality	27 All Age All Cause Mortality (DSR)	618	519.78	577.76	568.54	727.02	485.04
	28 Premature Mortality from Cancer	68	99.57	110.87	118.46	167.23	87.91
	29 Premature Mortality from CVD	26	39.35	72.93	71.01	120.57	39.35
	30 Premature Mortality from Respiratory Disease	10	13.99	31.56	28.34	66.99	8.83
	31 Mortality from Preventable Causes	83	112.40	173.24	173.99	301.11	112.40
	32 Life Expectancy Females	-	82.24	82.09	82.49	79.89	85.34
	33 Life Expectancy Males	-	80.59	78.47	78.34	76.14	80.81



^a The terms 'best' and 'worst' are not appropriate for these indicators instead the right side of the chart indicates the highest value and the left side the lowest.

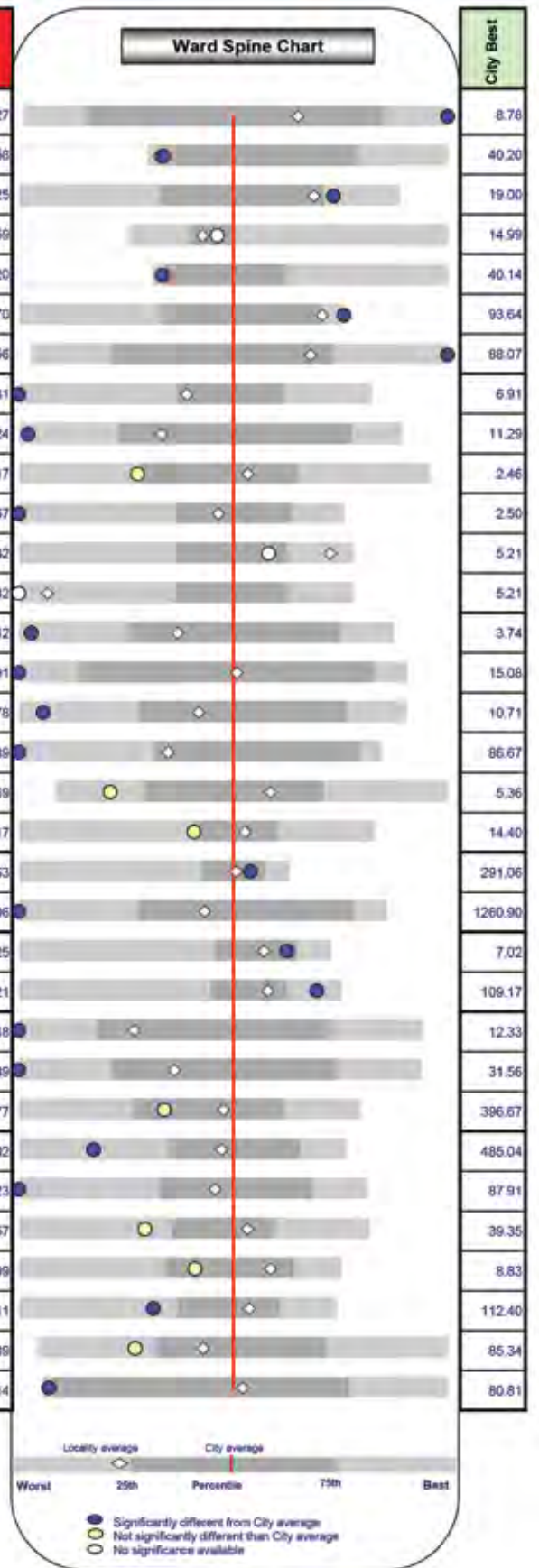


[^] The terms 'best' and 'worst' are not appropriate for these indicators instead the right side of the chart indicates the highest value and the left side the lowest.



	Indicator	Ward no.	Ward Value	Locality Average	City Average	City Worst	City Best
Demography	1 % Resident Population aged 0-4 years ^a	1212	8.78	7.19	6.50	4.27	8.78
	2 % Resident Population aged 18-24 years ^a	1281	9.28	8.76	16.88	7.58	40.20
	3 % Resident Population aged over 65 years ^a	2292	16.61	15.90	12.99	5.25	19.00
	4 Forecast % change in population 2011-16 ^a	312	2.27	1.46	3.14	-2.59	14.99
	5 % Population from minority ethnic groups ^a	755	5.47	6.11	14.08	4.20	40.14
	6 % Population born in the UK ^a	12922	93.64	91.41	82.42	60.70	93.64
	7 General Fertility Rate ^b	1265	88.07	70.46	60.53	34.56	88.07
Economic	8 Working Age Claimant Rate	2045	24.31	16.02	13.73	24.31	6.91
	9 Adults with No Qualifications	3507	32.71	25.06	20.96	33.24	11.29
	10 16-18 year old NEET	33	6.52	4.99	5.19	8.17	2.46
	11 Long Term Unemployed ^c	115	13.67	6.81	6.30	13.67	2.50
	12 Least Deprived LSOA in Ward	-	19.16	9.03	24.98	60.32	5.21
	13 Most Deprived LSOA in Ward	-	60.32	55.60	24.98	60.32	5.21
Healthy Start	14 Lone Parent Families	675	11.17	8.16	7.03	11.42	3.74
	15 Child Poverty	1395	37.91	25.10	25.31	37.91	15.08
	16 % Smoking in Pregnancy	210	27.63	20.39	18.78	28.78	10.71
	17 % Breastfeeding	440	57.89	69.77	74.92	57.89	86.67
	18 Year R Child Obesity	73	11.66	8.67	9.36	12.69	5.36
Lifestyle	19 Year 6 Child Obesity	95	21.40	19.43	19.88	28.17	14.40
	20 Alcohol Specific Hospital Admissions (DSR)	347	533.12	621.01	638.81	1971.63	291.06
Safety	21 Smoking Related Hospital Admissions (DSR)	548	2426.06	1837.60	1747.38	2426.06	1260.90
	22 Violent Crime	192	13.71	17.21	21.82	54.25	7.02
Disability and Poor Health	23 Road KSIs	61	146.94	221.74	274.71	602.21	109.17
	24 Limiting illness	2900	34.48	28.15	22.74	34.48	12.33
	25 DLA Claimants	915	85.39	64.57	56.74	85.39	31.56
Mortality	26 Injuries due to Falls (65+)	58	548.88	502.80	495.41	661.77	396.67
	27 All Age All Cause Mortality (DSR)	605	671.62	576.97	568.54	727.02	485.04
	28 Premature Mortality from Cancer	98	167.23	122.99	118.46	167.23	87.91
	29 Premature Mortality from CVD	54	91.39	67.76	71.01	120.57	39.35
	30 Premature Mortality from Respiratory Disease	20	35.19	21.64	28.34	66.99	8.83
	31 Mortality from Preventable Causes	137	221.24	164.51	173.99	301.11	112.40
	32 Life Expectancy Females	-	81.19	82.09	82.49	79.89	85.34
	33 Life Expectancy Males	-	76.21	78.45	78.34	76.14	80.81

^a The terms 'best' and 'worst' are not appropriate for these indicators instead the right side of the chart indicates the highest value and the left side the lowest.



Public Health Ward Profiles: 2012/13

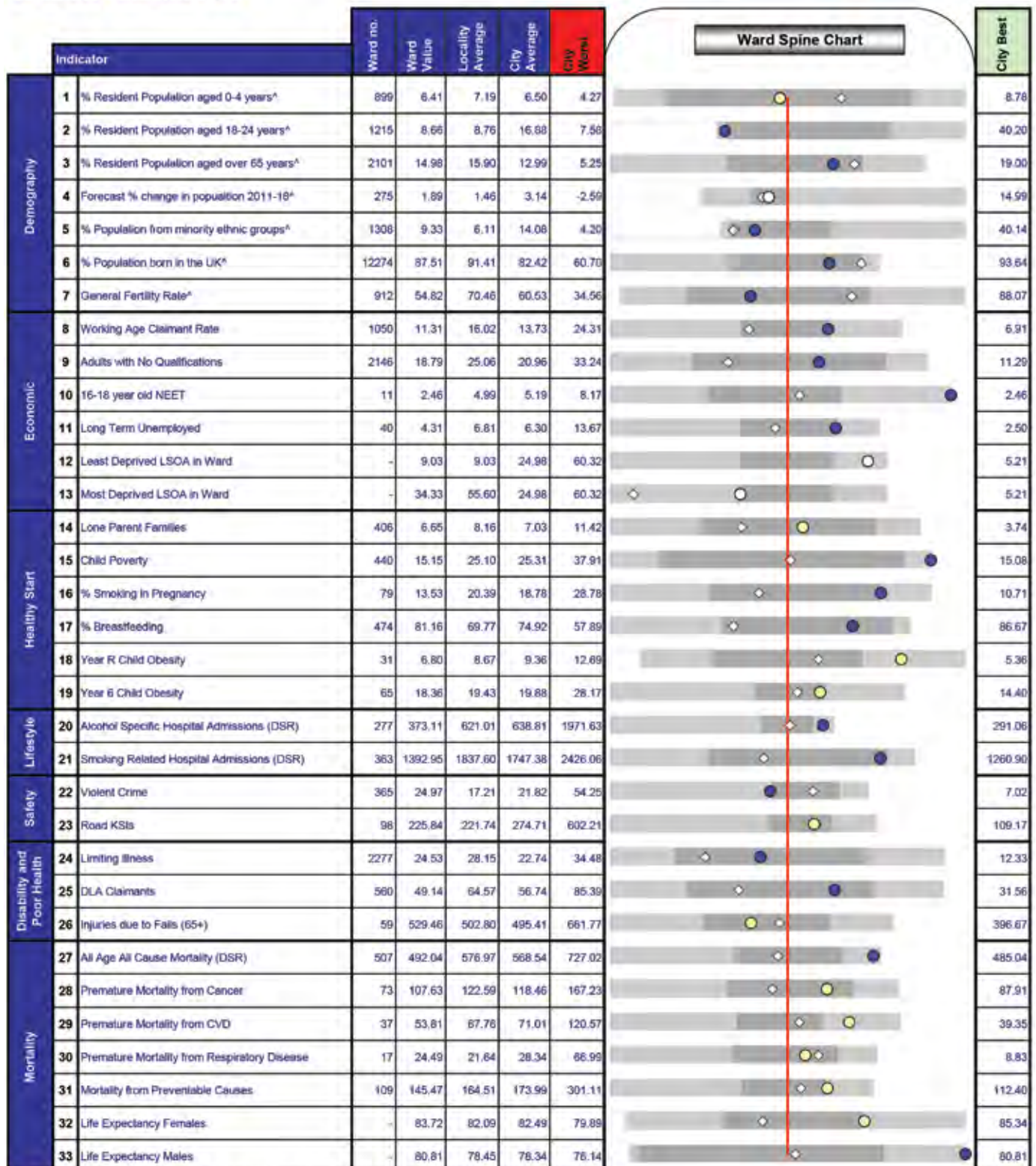
Southampton South & East Locality

00MSMW - Bitterne Park

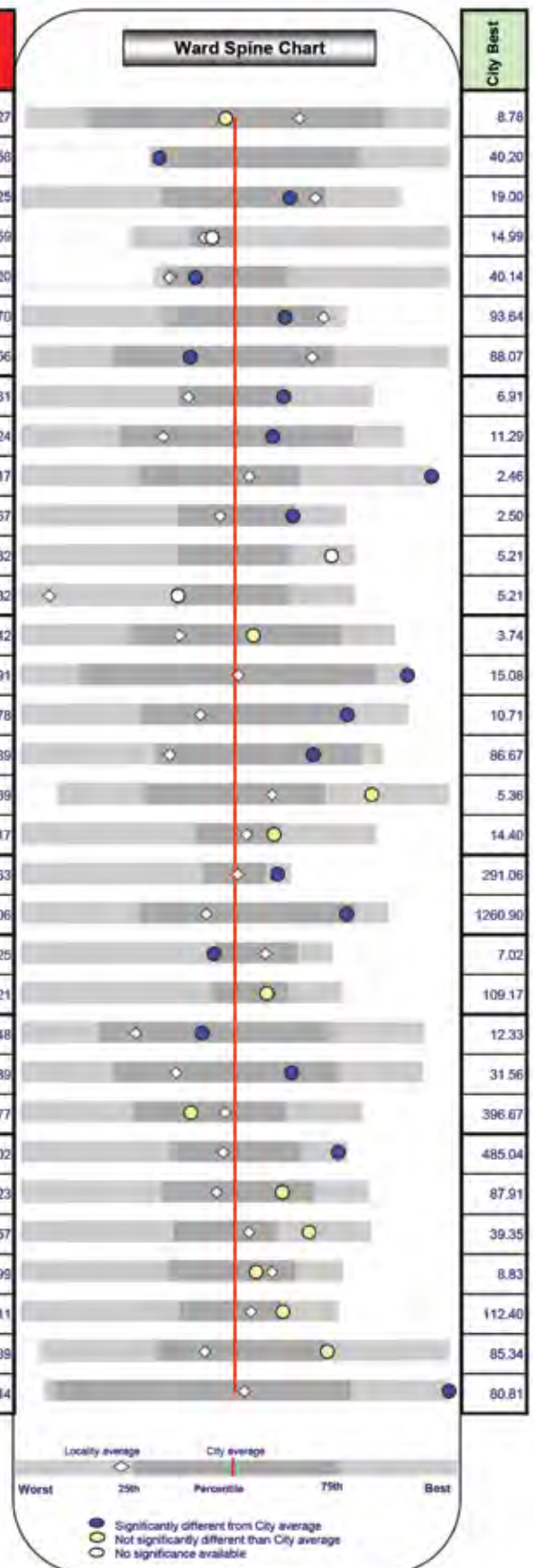
Main Menu

Metadata

Print



^a The terms 'best' and 'worst' are not appropriate for these indicators instead the right side of the chart indicates the highest value and the left side the lowest.



Public Health Ward Profiles: 2012/13

Southampton City West Locality

00MSMX - Coxford

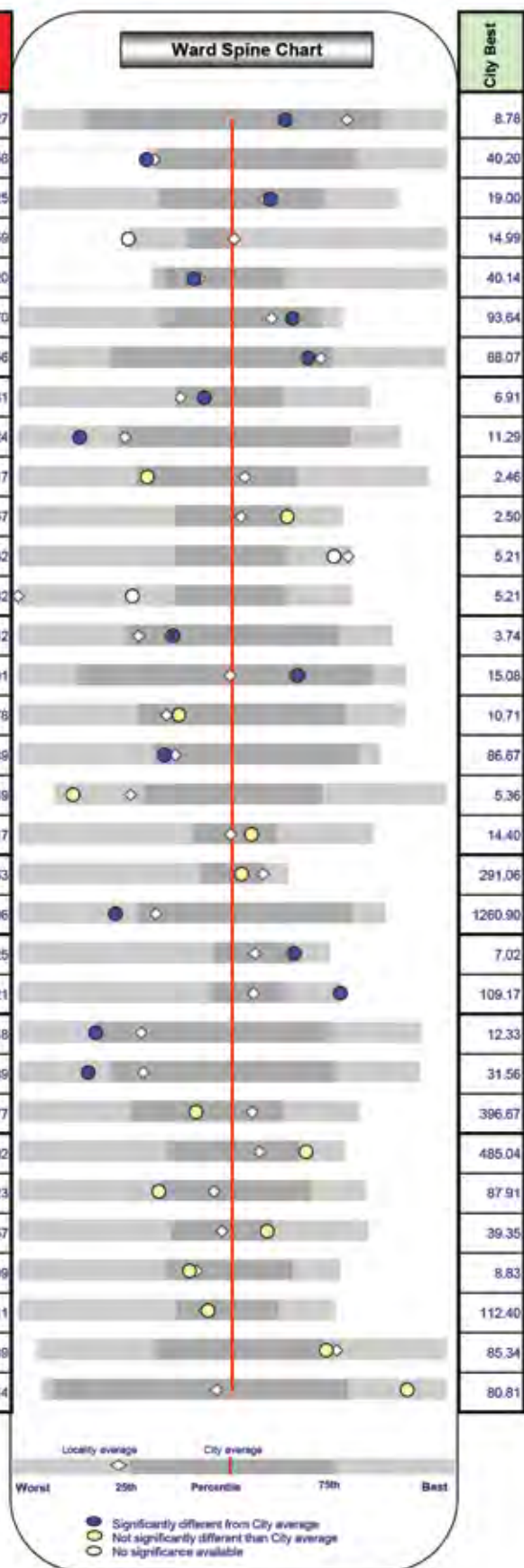
Main Menu

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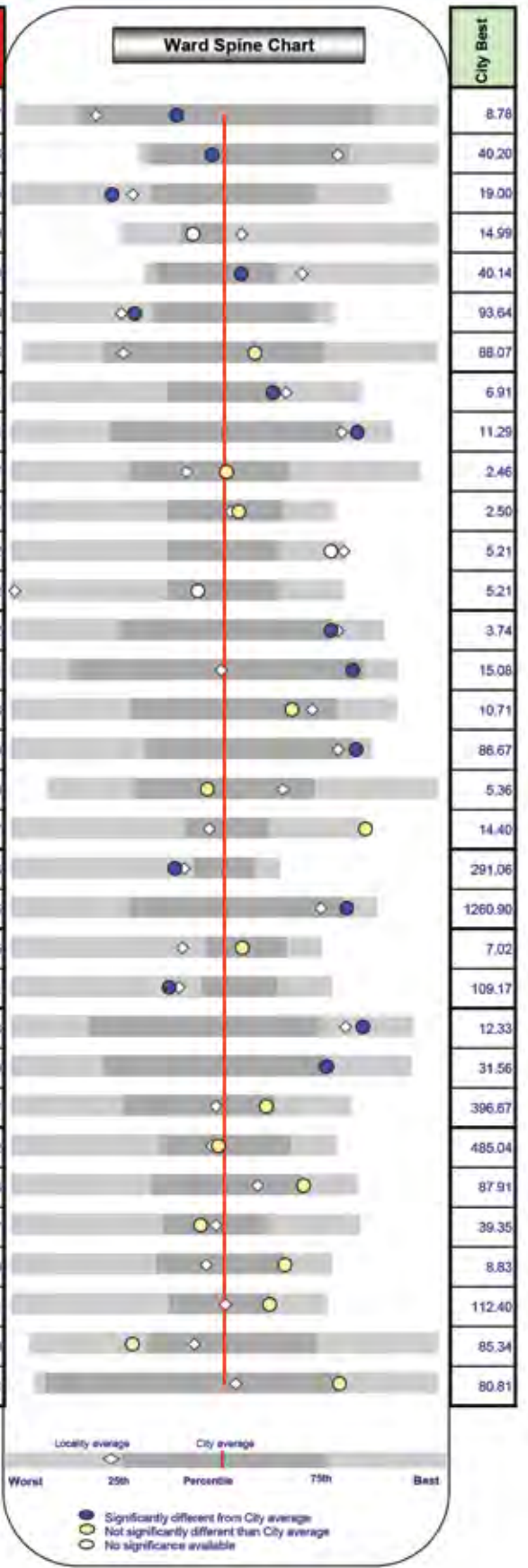
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	Indicator	Ward no.	Ward Value	Locality Average	City Average	City Worst		City Best
Demography	1 % Resident Population aged 0-4 years [^]	993	7.07	7.73	6.50	4.27		8.78
	2 % Resident Population aged 18-24 years [^]	1065	7.58	8.44	16.68	7.58		40.20
	3 % Resident Population aged over 65 years [^]	2019	14.37	14.16	12.99	5.25		19.00
	4 Forecast % change in population 2011-16 [^]	Under 5	-2.59	3.26	3.14	-2.59		14.99
	5 % Population from minority ethnic groups [^]	1328	9.45	10.13	14.08	4.20		40.14
	6 % Population born in the UK [^]	12438	88.55	86.41	82.42	60.70		93.64
	7 General Fertility Rate [^]	1010	70.35	71.94	60.53	34.56		68.07
Economic	8 Working Age Claimant Rate	1370	15.09	16.28	13.73	24.31		6.91
	9 Adults with No Qualifications	3310	29.70	27.10	20.96	33.24		11.29
	10 15-18 year old NEET	33	6.37	5.02	5.19	8.17		2.46
	11 Long Term Unemployed	40	4.41	6.01	6.30	13.67		2.50
	12 Least Deprived LSOA in Ward	-	8.15	5.84	24.98	60.32		5.21
	13 Most Deprived LSOA in Ward	-	41.41	60.32	24.98	60.32		5.21
Healthy Start	14 Lone Parent Families	483	8.24	8.95	7.03	11.42		3.74
	15 Child Poverty	715	21.47	25.43	25.31	37.91		15.08
	16 % Smoking in Pregnancy	132	21.26	21.83	18.78	28.78		10.71
	17 % Breastfeeding	432	69.57	70.40	74.92	57.89		86.67
	18 Year R Child Obesity	58	12.34	11.27	9.36	12.69		5.36
Lifestyle	19 Year 6 Child Obesity	79	19.13	19.94	19.88	28.17		14.40
	20 Alcohol Specific Hospital Admissions (DSR)	413	579.42	444.65	638.81	1971.63		291.06
Safety	21 Smoking Related Hospital Admissions (DSR)	567	2116.24	1988.49	1747.38	2426.06		1260.90
	22 Violent Crime	175	12.37	18.37	21.82	54.25		7.02
Disability and Poor Health	23 Road KSIs	46	109.17	242.00	274.71	602.21		109.17
	24 Limiting Illness	2742	30.21	27.72	22.74	34.48		12.33
	25 DLA Claimants	845	75.99	68.62	56.74	85.39		31.56
	26 Injuries due to Falls (65+)	58	523.31	479.89	495.41	661.77		396.67
Mortality	27 All Age All Cause Mortality (DSR)	519	513.82	648.19	568.54	727.02		485.04
	28 Premature Mortality from Cancer	99	135.09	122.54	118.46	167.23		87.91
	29 Premature Mortality from CVD	48	62.88	73.31	71.01	120.57		39.35
	30 Premature Mortality from Respiratory Disease	27	35.99	34.72	28.34	66.99		8.83
	31 Mortality from Preventable Causes	154	188.11	190.18	173.99	301.11		112.40
	32 Life Expectancy Females	-	83.75	83.88	82.49	79.89		85.34
	33 Life Expectancy Males	-	80.36	78.16	78.34	76.14		80.81

[^] The terms 'best' and 'worst' are not appropriate for these indicators instead the right side of the chart indicates the highest value and the left side the lowest.



Indicator		Ward no.	Ward Value	Locality Average	City Average	City Worst	City Best
Demography	1 % Resident Population aged 0-4 years [^]	956	8.00	5.14	6.50	4.27	8.78
	2 % Resident Population aged 18-24 years [^]	2482	15.57	29.29	16.88	7.58	40.20
	3 % Resident Population aged over 65 years [^]	1423	8.93	9.69	12.99	5.25	19.00
	4 Forecast % change in population 2011-16 [^]	222	1.42	4.10	3.14	-2.59	14.99
	5 % Population from minority ethnic groups [^]	2570	16.13	23.59	14.08	4.20	40.14
	6 % Population born in the UK [^]	11695	73.32	71.97	82.42	60.70	93.64
	7 General Fertility Rate [^]	1216	64.48	47.52	60.53	34.56	88.07
Economic	8 Working Age Claimant Rate	1365	11.32	10.68	13.73	24.31	6.91
	9 Adults with No Qualifications	1826	13.31	14.21	20.96	33.24	11.29
	10 16-18 year old NEET	16	5.16	5.72	5.19	8.17	2.46
	11 Long Term Unemployed	70	5.80	6.08	6.30	13.67	2.50
	12 Least Deprived LSOA in Ward	-	7.32	5.21	24.98	60.32	5.21
	13 Most Deprived LSOA in Ward	-	29.31	59.63	24.98	60.32	5.21
Healthy Start	14 Lone Parent Families	355	4.83	4.69	7.03	11.42	3.74
	15 Child Poverty	445	17.73	25.48	25.31	37.91	15.08
	16 % Smoking in Pregnancy	119	15.62	14.68	18.78	28.78	10.71
	17 % Breastfeeding	651	85.43	84.01	74.92	57.89	86.67
	18 Year R Child Obesity	39	9.68	8.27	9.36	12.89	5.36
Lifestyle	19 Year 6 Child Obesity	37	14.40	20.46	19.88	28.17	14.40
	20 Alcohol Specific Hospital Admissions (DSR)	687	945.42	888.98	638.81	1971.63	291.06
Safety	21 Smoking Related Hospital Admissions (DSR)	319	1357.64	1440.27	1747.38	2426.06	1260.90
	22 Violent Crime	299	19.11	28.14	21.82	54.25	7.02
	23 Road KSIs	168	359.08	343.35	274.71	602.21	109.17
Disability and Poor Health	24 Limiting Illness	1824	15.12	16.07	22.74	34.48	12.33
	25 DLA Claimants	580	42.98	43.49	56.74	85.39	31.56
	26 Injuries due to Falls (65+)	49	462.74	501.82	495.41	661.77	396.67
Mortality	27 All Age All Cause Mortality (DSR)	584	572.73	577.76	568.54	727.02	485.04
	28 Premature Mortality from Cancer	65	100.34	110.87	118.46	167.23	87.91
	29 Premature Mortality from CVD	48	76.44	72.93	71.01	120.57	39.35
	30 Premature Mortality from Respiratory Disease	11	17.37	31.56	28.34	66.99	8.83
	31 Mortality from Preventable Causes	108	146.92	173.24	173.99	301.11	112.40
	32 Life Expectancy Females	-	81.27	82.09	82.49	79.89	85.34
	33 Life Expectancy Males	-	79.67	78.47	78.34	76.14	80.81



[^] The terms 'best' and 'worst' are not appropriate for these indicators instead the right side of the chart indicates the highest value and the left side the lowest.

Public Health Ward Profiles: 2012/13

Southampton South & East Locality

00MSMZ - Harefield

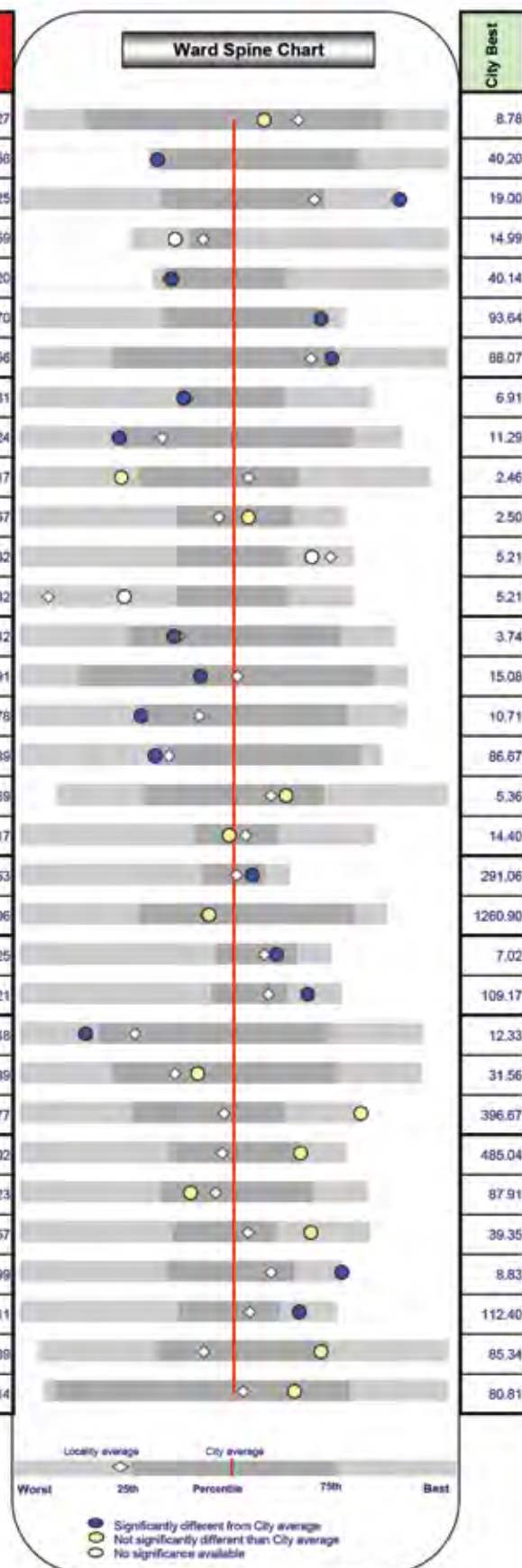
Public Health Southampton

Main Menu

Metadata

Print

	Indicator	Ward no.	Ward Value	Locality Average	City Average	City Worst
Demography	1 % Resident Population aged 0-4 years ^A	958	6.83	7.19	6.50	4.27
	2 % Resident Population aged 18-24 years ^A	1206	8.59	8.76	16.88	7.58
	3 % Resident Population aged over 65 years ^A	2666	19.00	15.90	12.99	5.25
	4 Forecast % change in population 2011-18 ^A	Under 5	-0.10	1.46	3.14	-2.59
	5 % Population from minority ethnic groups ^A	915	6.52	6.11	14.08	4.20
	6 % Population born in the UK ^A	12807	91.25	91.41	82.42	60.70
	7 General Fertility Rate ^A	987	73.15	70.48	60.53	34.56
Economic	8 Working Age Claimant Rate	1395	16.20	16.02	13.73	24.31
	9 Adults with No Qualifications	3116	27.52	25.06	20.96	33.24
	10 16-18 year old NEET	34	6.76	4.99	5.19	8.17
	11 Long Term Unemployed	50	5.81	6.81	6.30	13.67
	12 Least Deprived LSOA in Ward	-	12.09	9.03	24.98	60.32
	13 Most Deprived LSOA in Ward	-	43.05	55.60	24.98	60.32
Healthy Start	14 Lone Parent Families	502	8.26	8.16	7.03	11.42
	15 Child Poverty	860	27.26	25.10	25.31	37.91
	16 % Smoking in Pregnancy	135	23.12	20.39	18.78	28.78
	17 % Breastfeeding	401	68.66	69.77	74.92	57.89
	18 Year R Child Obesity	41	8.38	8.67	9.36	12.69
	19 Year 6 Child Obesity	77	20.05	19.43	19.88	28.17
Lifestyle	20 Alcohol Specific Hospital Admissions (DSR)	364	524.83	621.01	638.81	1971.63
	21 Smoking Related Hospital Admissions (DSR)	560	1825.46	1837.60	1747.38	2426.06
Safety	22 Violent Crime	220	15.34	17.21	21.82	54.25
	23 Road KSIs	68	161.69	221.74	274.71	602.21
Disability and Poor Health	24 Limiting illness	2657	30.86	28.15	22.74	34.48
	25 DLA Claimants	695	61.56	64.57	56.74	85.39
	26 Injuries due to Falls (65+)	56	396.67	502.80	495.41	661.77
Mortality	27 All Age All Cause Mortality (DSR)	658	519.06	578.97	568.54	727.02
	28 Premature Mortality from Cancer	96	128.27	122.59	118.46	167.23
	29 Premature Mortality from CVD	40	53.17	67.76	71.01	120.57
	30 Premature Mortality from Respiratory Disease	7	8.83	21.64	28.34	66.99
	31 Mortality from Preventable Causes	115	135.12	164.51	173.99	301.11
	32 Life Expectancy Females	-	83.65	82.09	82.49	79.89
	33 Life Expectancy Males	-	79.04	78.45	78.34	76.14



^A The terms 'best' and 'worst' are not appropriate for these indicators instead the right side of the chart indicates the highest value and the left side the lowest.

Public Health Ward Profiles: 2012/13

Southampton City West Locality

00MSNA - Millbrook

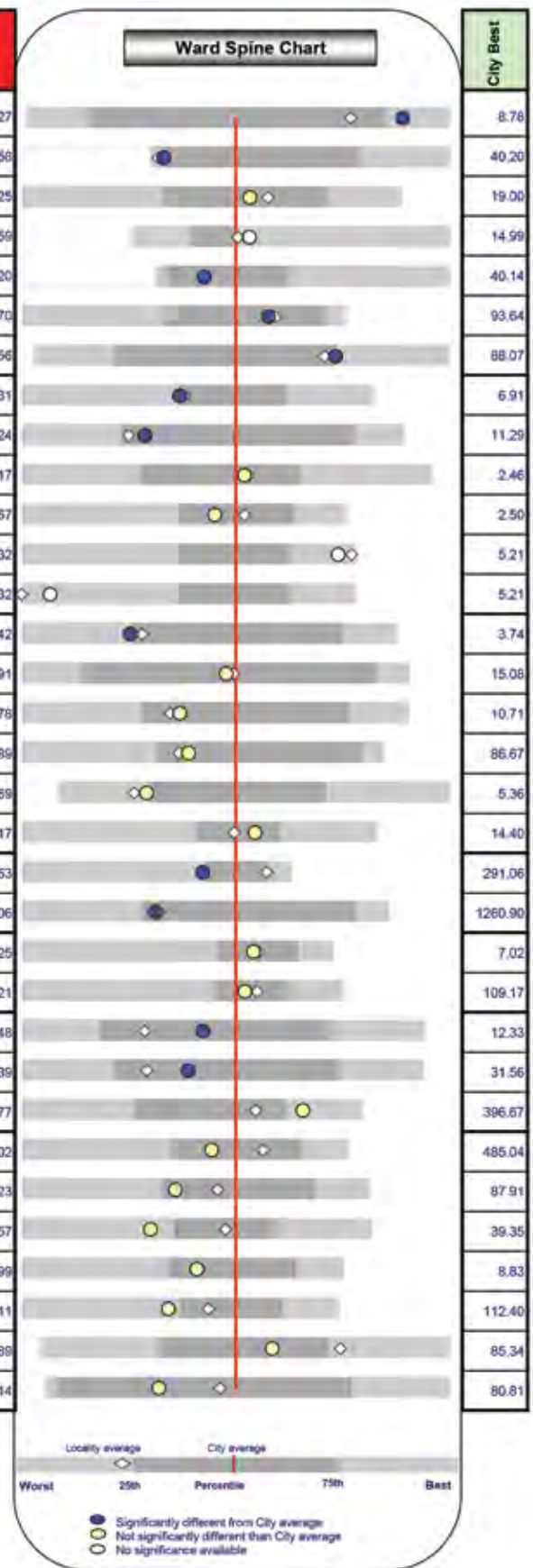
Main Menu

Metadata

Print



^A The terms 'best' and 'worst' are not appropriate for these indicators instead the right side of the chart indicates the highest value and the left side the lowest.



Public Health Ward Profiles: 2012/13

Southampton South & East Locality

00MSNB - Peartree

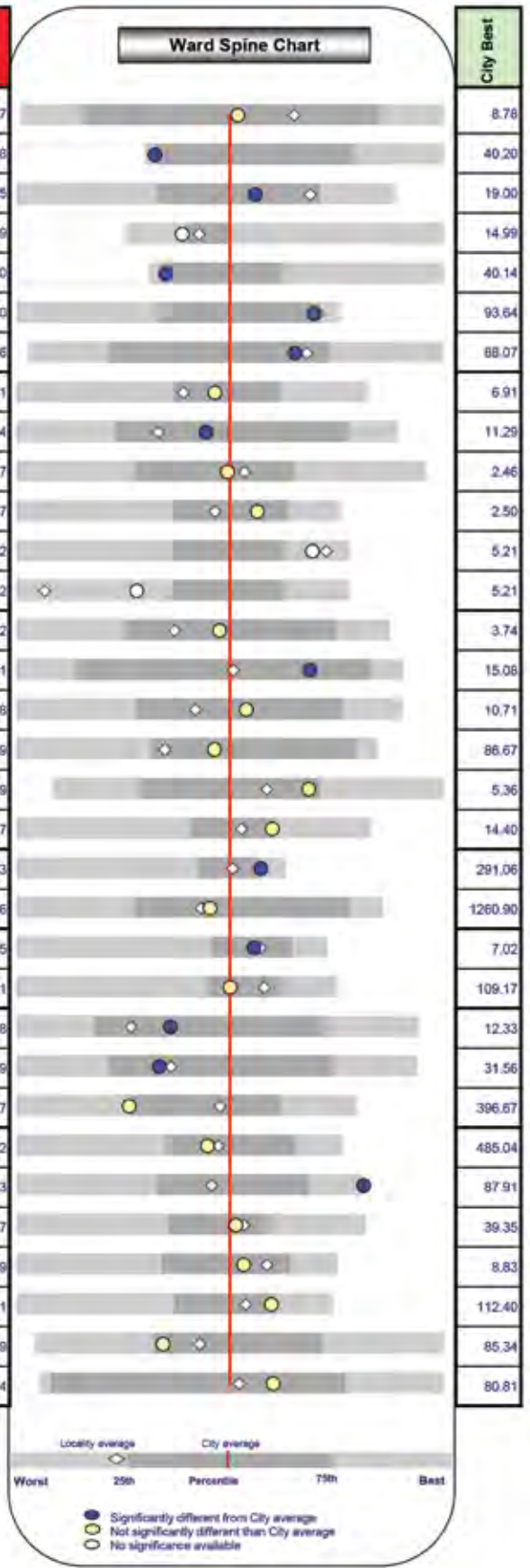
Public Health Southampton

Main Menu

Metadata

Print

	Indicator	Ward no.	Ward Value	Locality Average	City Average	City Worst	City Best
Demography	1 % Resident Population aged 0-4 years ^a	936	6.59	7.19	6.50	4.27	8.76
	2 % Resident Population aged 18-24 years ^a	1239	8.72	8.76	16.68	7.56	40.20
	3 % Resident Population aged over 65 years ^a	1976	13.91	15.90	12.99	5.25	19.00
	4 Forecast % change in population 2011-16 ^a	72	0.52	1.46	3.14	-2.59	14.59
	5 % Population from minority ethnic groups ^a	893	6.29	6.11	14.08	4.20	40.14
	6 % Population born in the UK ^a	12918	90.95	91.41	82.42	60.70	93.64
	7 General Fertility Rate ^a	1016	68.95	70.46	60.53	34.56	88.07
Economic	8 Working Age Claimant Rate	1350	14.45	16.02	13.73	24.31	6.91
	9 Adults with No Qualifications	2539	22.31	25.06	20.96	33.24	11.29
	10 16-18 year old NEET	26	5.22	4.99	5.19	8.17	2.46
	11 Long Term Unemployed	50	5.35	6.61	6.30	13.67	2.50
	12 Least Deprived LSOA in Ward	-	11.31	9.03	24.98	60.32	5.21
13 Most Deprived LSOA in Ward	-	40.33	56.60	24.98	60.32	5.21	
Healthy Start	14 Lone Parent Families	426	7.23	8.16	7.03	11.42	3.74
	15 Child Poverty	655	20.60	25.10	25.31	37.91	15.08
	16 % Smoking in Pregnancy	109	16.02	20.39	18.78	26.78	10.71
	17 % Breastfeeding	446	73.72	69.77	74.92	57.89	86.67
	18 Year R Child Obesity	35	7.88	8.67	9.36	12.69	5.36
19 Year 6 Child Obesity	74	18.23	19.43	19.88	26.17	14.40	
Lifestyle	20 Alcohol Specific Hospital Admissions (DSR)	312	444.89	621.01	638.81	1971.63	291.06
	21 Smoking Related Hospital Admissions (DSR)	445	1809.18	1637.60	1747.38	2426.06	1260.90
Safety	22 Violent Crime	252	18.15	17.21	21.82	54.25	7.02
	23 Road KSIs	113	273.85	221.74	274.71	602.21	109.17
Disability and Poor Health	24 Limiting illness	2427	25.98	28.15	22.74	34.48	12.33
	25 DLA Claimants	750	66.16	64.57	56.74	85.39	31.56
	26 Injuries due to Falls (65+)	56	573.52	502.80	495.41	661.77	396.67
Mortality	27 All Age All Cause Mortality (DSR)	538	584.78	576.97	568.54	727.02	485.04
	28 Premature Mortality from Cancer	60	87.91	122.59	118.46	167.23	87.91
	29 Premature Mortality from CVD	47	69.61	67.76	71.01	120.57	39.35
	30 Premature Mortality from Respiratory Disease	16	25.81	21.64	28.34	66.99	8.83
	31 Mortality from Preventable Causes	109	149.25	164.51	173.99	301.11	112.40
	32 Life Expectancy Females	-	81.60	82.09	82.49	79.89	85.34
	33 Life Expectancy Males	-	78.84	78.45	78.34	76.14	80.81



^a The terms 'best' and 'worst' are not appropriate for these indicators instead the right side of the chart indicates the highest value and the left side the lowest.

Public Health Ward Profiles: 2012/13

Southampton North & Central Locality

00MSNC - Portswood

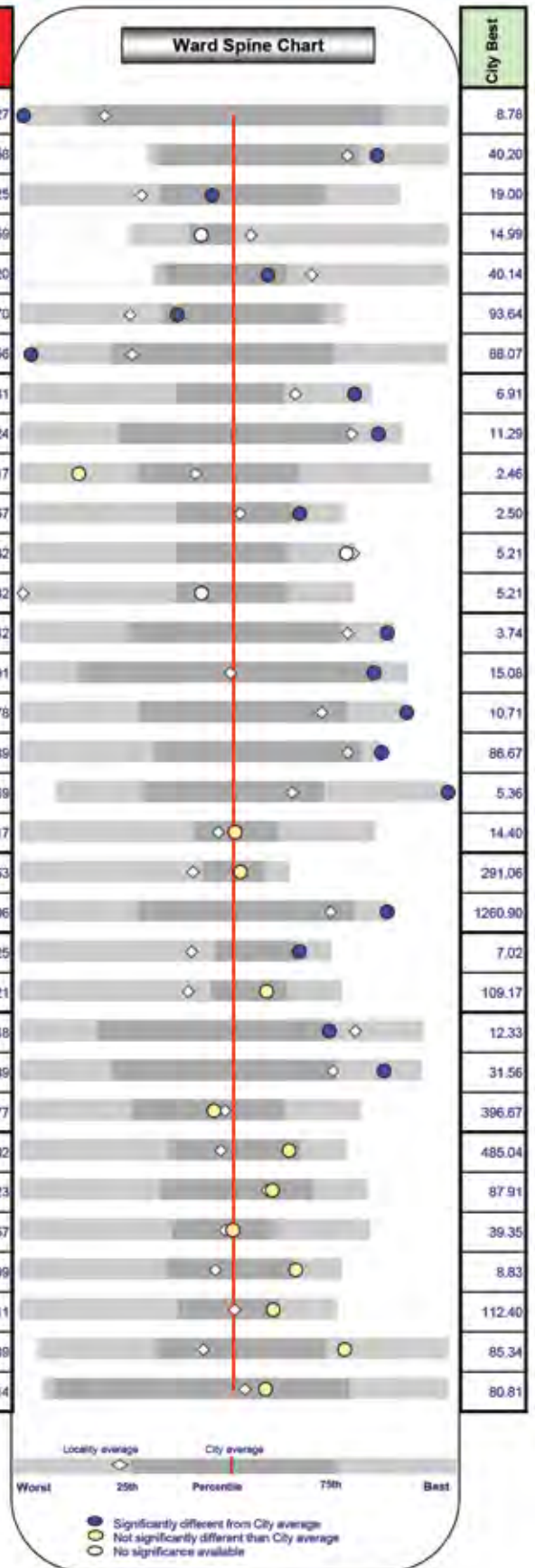
Public Health Southampton

Main Menu

Metadata

Print

Indicator		Ward no.	Ward Value	Locality Average	City Average	City Worst	City Best
Demography	1 % Resident Population aged 0-4 years ^a	634	4.27	5.14	6.50	4.27	8.76
	2 % Resident Population aged 18-24 years ^a	4821	32.51	29.29	16.88	7.56	40.20
	3 % Resident Population aged over 65 years ^a	1814	12.23	9.69	12.99	5.25	19.00
	4 Forecast % change in population 2011-18 ^a	208	1.36	4.10	3.14	-2.56	14.99
	5 % Population from minority ethnic groups ^a	2710	18.27	23.59	14.08	4.20	40.14
	6 % Population born in the UK ^a	11362	76.74	71.97	82.42	60.70	93.64
	7 General Fertility Rate ^a	744	34.56	47.52	60.53	34.56	88.07
Economic	8 Working Age Claimant Rate	865	7.75	10.68	13.73	24.31	6.91
	9 Adults with No Qualifications	1669	12.67	14.21	20.96	33.24	11.29
	10 16-18 year old NEET	16	7.34	5.72	5.19	8.17	2.46
	11 Long Term Unemployed	45	4.03	6.08	6.30	13.67	2.50
	12 Least Deprived LSOA in Ward	-	6.37	5.21	24.98	60.32	5.21
	13 Most Deprived LSOA in Ward	-	30.20	59.63	24.98	60.32	5.21
Healthy Start	14 Lone Parent Families	230	3.88	4.69	7.03	11.42	3.74
	15 Child Poverty	300	17.05	25.48	25.31	37.91	15.08
	16 % Smoking in Pregnancy	45	10.71	14.68	18.78	28.78	10.71
	17 % Breastfeeding	364	86.67	84.01	74.92	57.89	86.67
	18 Year R Child Obesity	15	5.36	8.27	9.36	12.69	5.36
	19 Year 6 Child Obesity	44	19.82	20.46	19.88	28.17	14.40
Lifestyle	20 Alcohol Specific Hospital Admissions (DSR)	359	595.74	888.98	638.81	1971.63	291.06
	21 Smoking Related Hospital Admissions (DSR)	302	1260.90	1440.27	1747.38	2426.06	1260.90
Safety	22 Violent Crime	181	11.85	28.14	21.82	54.25	7.02
	23 Road KSIs	101	224.28	343.35	274.71	602.21	109.17
Disability and Poor Health	24 Limiting illness	1952	17.49	16.07	22.74	34.48	12.33
	25 DLA Claimants	475	36.62	43.49	56.74	85.39	31.56
	26 Injuries due to Falls (65+)	54	510.44	501.82	495.41	661.77	396.67
Mortality	27 All Age All Cause Mortality (DSR)	591	527.58	577.76	568.54	727.02	485.04
	28 Premature Mortality from Cancer	57	109.62	110.87	118.46	167.23	87.91
	29 Premature Mortality from CVD	37	71.12	72.93	71.01	120.57	39.35
	30 Premature Mortality from Respiratory Disease	9	17.11	31.56	28.34	66.99	8.83
	31 Mortality from Preventable Causes	91	150.44	173.24	173.99	301.11	112.40
	32 Life Expectancy Females	-	83.97	82.09	82.49	79.89	85.34
	33 Life Expectancy Males	-	78.71	78.47	78.34	76.14	80.81



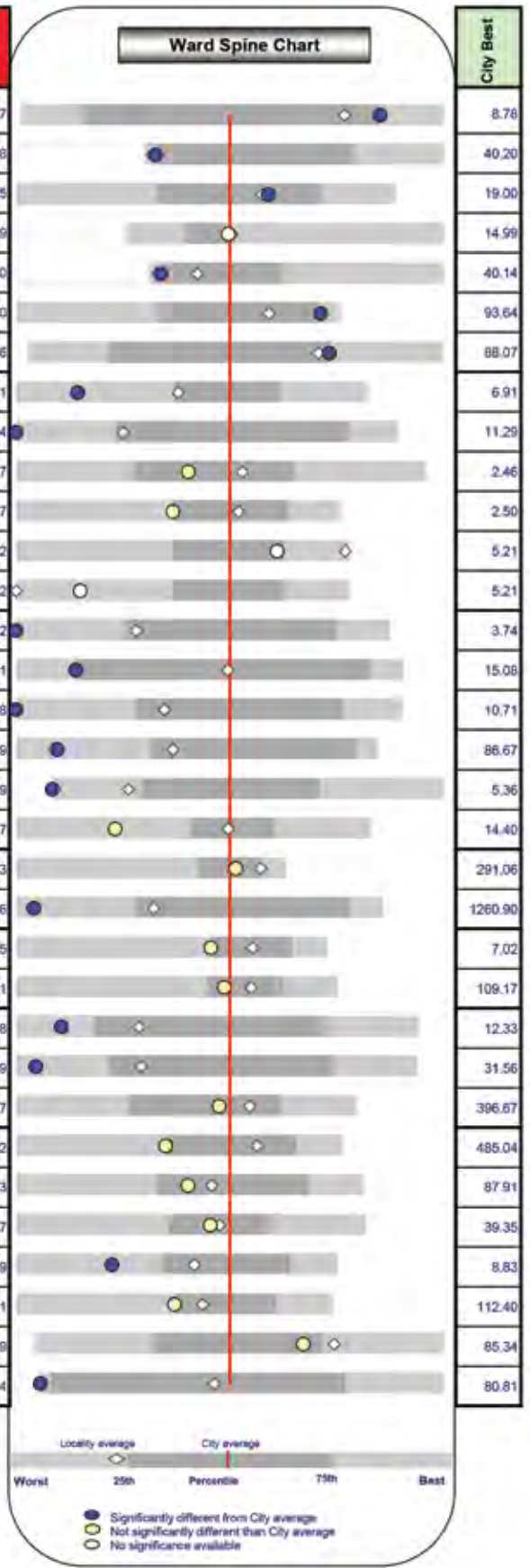
^a The terms 'best' and 'worst' are not appropriate for these indicators instead the right side of the chart indicates the highest value and the left side the lowest.

Main Menu

Metadata

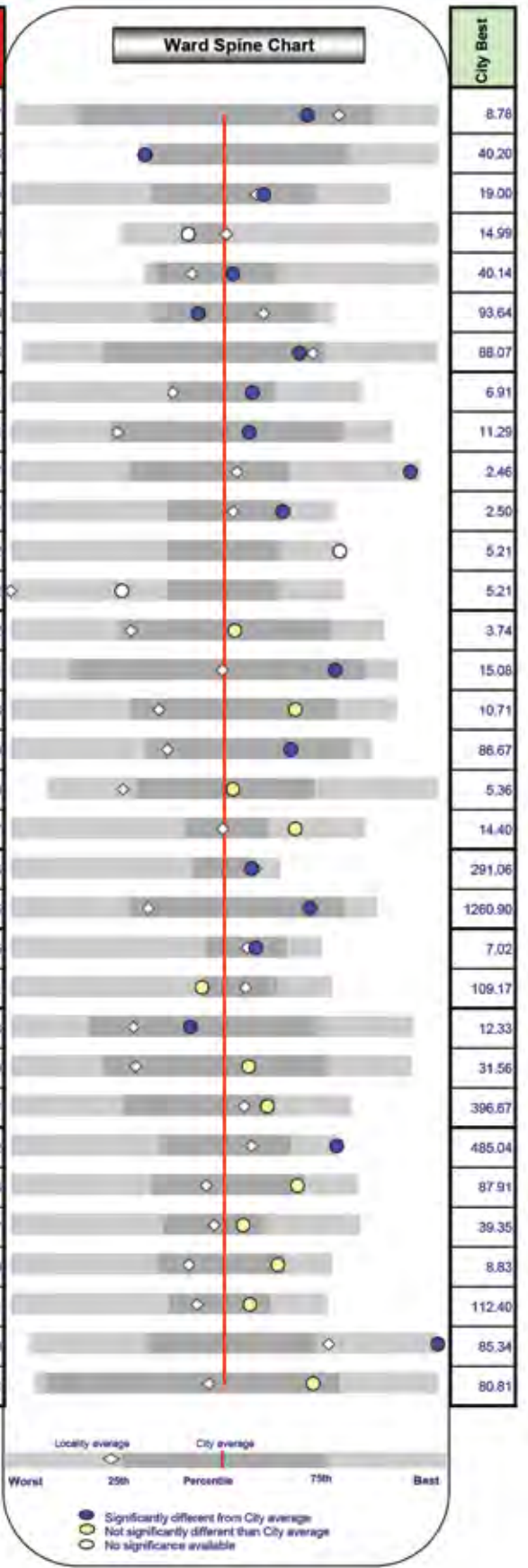
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Indicator		Ward no.	Ward Value	Locality Average	City Average	City Worst
Demography	1 % Resident Population aged 0-4 years [^]	1175	8.11	7.73	6.50	4.27
	2 % Resident Population aged 18-24 years [^]	1275	8.80	8.44	16.88	7.58
	3 % Resident Population aged over 65 years [^]	2084	14.38	14.16	12.99	5.25
	4 Forecast % change in population 2011-18 [^]	453	3.06	3.26	3.14	-2.59
	5 % Population from minority ethnic groups [^]	817	5.64	10.13	14.08	4.20
	6 % Population born in the UK [^]	13281	91.66	86.41	82.42	60.70
	7 General Fertility Rate [^]	1172	73.37	71.94	60.53	34.56
Economic	8 Working Age Claimant Rate	1930	21.26	16.28	13.73	24.31
	9 Adults with No Qualifications	3726	33.24	27.10	20.96	33.24
	10 16-18 year old NEET	30	5.77	5.02	5.19	8.17
	11 Long Term Unemployed	75	8.26	6.01	6.30	13.67
	12 Least Deprived LSOA in Ward	-	17.13	5.84	24.98	60.32
	13 Most Deprived LSOA in Ward	-	49.72	60.32	24.98	60.32
Healthy Start	14 Lone Parent Families	706	11.42	8.95	7.03	11.42
	15 Child Poverty	1315	34.38	25.43	25.31	37.91
	16 % Smoking in Pregnancy	200	28.78	21.83	18.78	28.78
	17 % Breastfeeding	425	61.15	70.40	74.92	57.89
	18 Year R Child Obesity	75	12.69	11.27	9.36	12.69
Lifestyle	19 Year 6 Child Obesity	108	24.32	19.94	19.88	28.17
	20 Alcohol Specific Hospital Admissions (DSR)	427	601.72	444.65	638.81	1971.63
Safety	21 Smoking Related Hospital Admissions (DSR)	612	2369.21	1988.49	1747.38	2426.06
	22 Violent Crime	362	24.66	18.37	21.82	54.25
Disability and Poor Health	23 Road KSIs	125	282.79	242.00	274.71	602.21
	24 Limiting illness	2903	31.98	27.72	22.74	34.48
	25 DLA Claimants	925	82.74	68.62	56.74	85.39
Mortality	26 Injuries due to Falls (65+)	58	503.43	479.89	495.41	661.77
	27 All Age All Cause Mortality (DSR)	624	616.01	548.19	568.54	727.02
	28 Premature Mortality from Cancer	86	127.96	122.54	118.46	167.23
	29 Premature Mortality from CVD	52	75.46	73.31	71.01	120.57
	30 Premature Mortality from Respiratory Disease	35	49.63	34.72	28.34	66.99
	31 Mortality from Preventable Causes	151	206.88	190.18	173.99	301.11
	32 Life Expectancy Females	-	83.47	83.88	82.49	79.89
	33 Life Expectancy Males	-	76.15	78.16	78.34	76.14



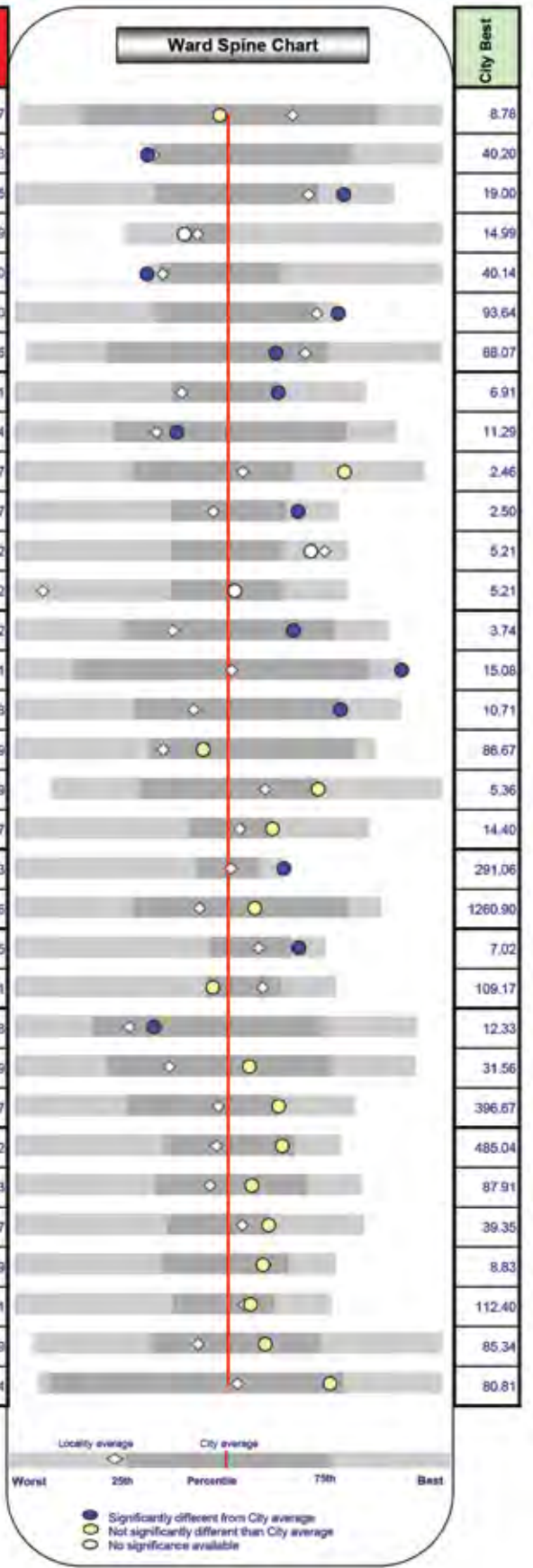
[^] The terms 'best' and 'worst' are not appropriate for these indicators instead the right side of the chart indicates the highest value and the left side the lowest.

Indicator		Ward no.	Ward Value	Locality Average	City Average	City Worst	City Best
Demography	1 % Resident Population aged 0-4 years [^]	1066	7.39	7.73	6.50	4.27	8.78
	2 % Resident Population aged 18-24 years [^]	1187	8.23	8.44	16.88	7.58	40.20
	3 % Resident Population aged over 65 years [^]	2081	14.43	14.16	12.99	5.25	19.00
	4 Forecast % change in population 2011-16 [^]	170	1.15	3.26	3.14	-2.59	14.99
	5 % Population from minority ethnic groups [^]	2184	15.14	10.13	14.08	4.20	40.14
	6 % Population born in the UK [^]	11508	79.78	86.41	82.42	60.70	93.64
	7 General Fertility Rate [^]	1077	70.24	71.94	60.53	34.56	88.07
Economic	8 Working Age Claimant Rate	1150	12.34	16.28	13.73	24.31	6.91
	9 Adults with No Qualifications	2238	19.54	27.10	20.96	33.24	11.29
	10 16-18 year old NEET	12	2.60	5.02	5.19	8.17	2.46
	11 Long Term Unemployed	40	4.29	6.01	6.30	13.67	2.50
	12 Least Deprived LSOA in Ward	-	5.84	5.84	24.98	60.32	5.21
	13 Most Deprived LSOA in Ward	-	41.91	60.32	24.98	60.32	5.21
Healthy Start	14 Lone Parent Families	408	6.81	8.95	7.03	11.42	3.74
	15 Child Poverty	640	18.77	25.43	25.31	37.91	15.08
	16 % Smoking in Pregnancy	100	15.46	21.83	18.78	28.78	10.71
	17 % Breastfeeding	519	80.22	70.40	74.92	57.89	86.67
	18 Year R Child Obesity	53	9.20	11.27	9.36	12.89	5.36
Lifestyle	19 Year 6 Child Obesity	75	17.12	19.94	19.88	28.17	14.40
	20 Alcohol Specific Hospital Admissions (DSR)	335	469.21	444.65	638.81	1971.63	291.06
Safety	21 Smoking Related Hospital Admissions (DSR)	408	1475.53	1988.49	1747.38	2426.06	1260.90
	22 Violent Crime	252	17.06	18.37	21.82	54.25	7.02
	23 Road KSIs	135	308.66	242.00	274.71	602.21	109.17
Disability and Poor Health	24 Limiting illness	2291	24.58	27.72	22.74	34.48	12.33
	25 DLA Claimants	610	53.48	68.62	56.74	85.39	31.56
	26 Injuries due to Falls (65+)	57	461.81	479.89	495.41	661.77	396.67
Mortality	27 All Age All Cause Mortality (DSR)	537	485.04	548.19	568.54	727.02	485.04
	28 Premature Mortality from Cancer	70	101.73	122.54	118.46	167.23	87.91
	29 Premature Mortality from CVD	45	66.66	73.31	71.01	120.57	39.35
	30 Premature Mortality from Respiratory Disease	13	18.65	34.72	28.34	66.99	8.83
	31 Mortality from Preventable Causes	114	158.78	190.18	173.99	301.11	112.40
	32 Life Expectancy Females	-	85.34	83.88	82.49	79.89	85.34
	33 Life Expectancy Males	-	79.37	78.16	78.34	76.14	80.81



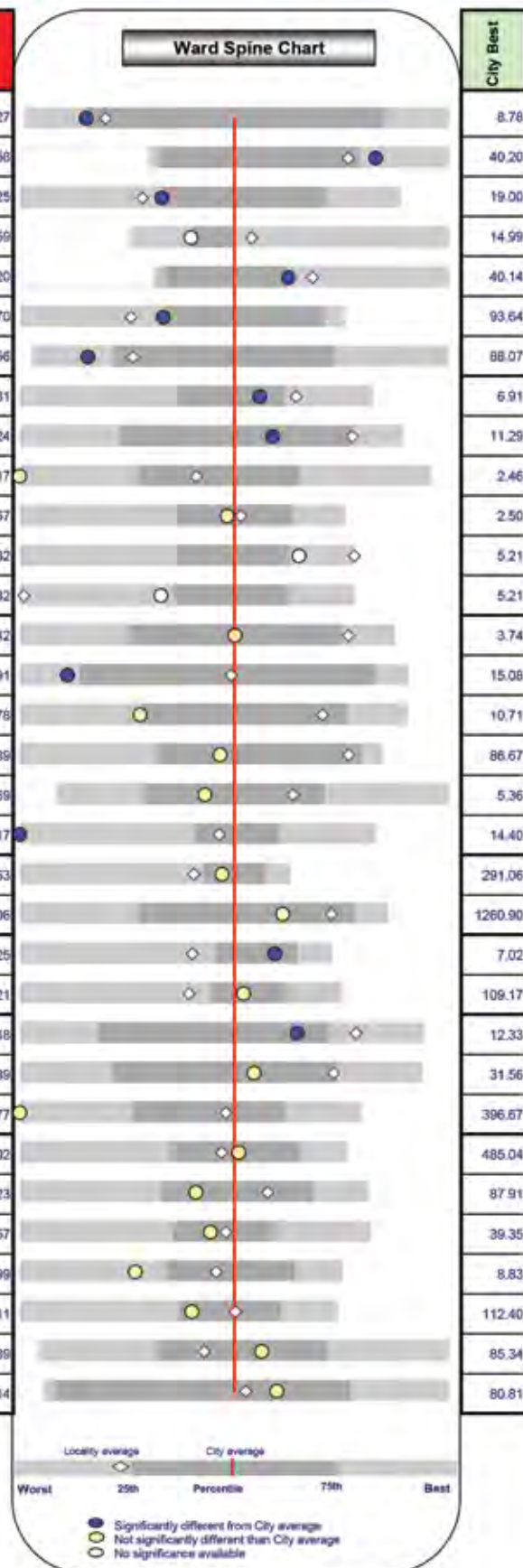
[^] The terms 'best' and 'worst' are not appropriate for these indicators instead the right side of the chart indicates the highest value and the left side the lowest.

Indicator		Ward no.	Ward Value	Locality Average	City Average	City Worst	City Best
Demography	1 % Resident Population aged 0-4 years [^]	902	6.42	7.19	6.50	4.27	8.78
	2 % Resident Population aged 18-24 years [^]	1135	8.08	8.76	16.88	7.58	40.20
	3 % Resident Population aged over 65 years [^]	2414	17.18	15.90	12.99	5.25	19.00
	4 Forecast % change in population 2011-18 [^]	104	0.73	1.46	3.14	-2.59	14.99
	5 % Population from minority ethnic groups [^]	590	4.20	6.11	14.08	4.20	40.14
	6 % Population born in the UK [^]	13156	93.62	91.41	82.42	60.70	93.64
	7 General Fertility Rate [^]	988	66.68	70.46	60.53	34.56	88.07
Economic	8 Working Age Claimant Rate	1010	11.24	16.02	13.73	24.31	6.91
	9 Adults with No Qualifications	2736	23.90	25.06	20.96	33.24	11.29
	10 16-18 year old NEET	17	3.57	4.99	5.19	8.17	2.46
	11 Long Term Unemployed	35	3.90	6.81	6.30	13.67	2.50
	12 Least Deprived LSOA in Ward	-	11.33	9.03	24.98	60.32	5.21
	13 Most Deprived LSOA in Ward	-	23.88	55.60	24.98	60.32	5.21
Healthy Start	14 Lone Parent Families	344	5.68	8.16	7.03	11.42	3.74
	15 Child Poverty	450	15.08	25.10	25.31	37.91	15.08
	16 % Smoking in Pregnancy	76	13.52	20.39	18.78	28.78	10.71
	17 % Breastfeeding	410	72.95	69.77	74.92	57.89	86.67
	18 Year R Child Obesity	33	7.67	8.67	9.36	12.89	5.36
Lifestyle	19 Year 6 Child Obesity	69	18.16	19.43	19.88	28.17	14.40
	20 Alcohol Specific Hospital Admissions (DSR)	213	291.06	621.01	638.81	1971.63	291.06
	21 Smoking Related Hospital Admissions (DSR)	436	1662.63	1837.60	1747.38	2426.06	1260.90
Safety	22 Violent Crime	159	11.09	17.21	21.82	54.25	7.02
	23 Road KSIs	125	297.79	221.74	274.71	602.21	109.17
Disability and Poor Health	24 Limiting illness	2408	26.81	28.15	22.74	34.48	12.33
	25 DLA Claimants	615	53.89	64.57	56.74	85.39	31.56
	26 Injuries due to Falls (65+)	54	455.99	502.80	495.41	661.77	396.67
Mortality	27 All Age All Cause Mortality (DSR)	540	528.30	578.97	568.54	727.02	485.04
	28 Premature Mortality from Cancer	80	113.01	122.59	118.46	167.23	87.91
	29 Premature Mortality from CVD	44	61.60	67.76	71.01	120.57	39.35
	30 Premature Mortality from Respiratory Disease	16	22.02	21.64	28.34	66.99	8.83
	31 Mortality from Preventable Causes	123	160.73	164.51	173.99	301.11	112.40
	32 Life Expectancy Females	-	82.99	82.09	82.49	79.89	85.34
	33 Life Expectancy Males	-	79.52	78.45	78.34	76.14	80.81



[^] The terms 'best' and 'worst' are not appropriate for these indicators instead the right side of the chart indicates the highest value and the left side the lowest.

Indicator		Ward no.	Ward Value	Locality Average	City Average	City Worst	City Best
Demography	1 % Resident Population aged 0-4 years ^A	674	4.93	5.14	6.50	4.27	8.76
	2 % Resident Population aged 18-24 years ^A	4408	32.26	29.29	16.88	7.56	40.20
	3 % Resident Population aged over 65 years ^A	1419	10.38	9.69	12.99	5.25	19.00
	4 Forecast % change in population 2011-18 ^A	106	0.75	4.10	3.14	-2.56	14.99
	5 % Population from minority ethnic groups ^A	2820	20.64	23.59	14.08	4.20	40.14
	6 % Population born in the UK ^A	10282	75.25	71.97	82.42	60.70	93.64
	7 General Fertility Rate ^A	788	41.76	47.52	60.53	34.56	88.07
Economic	8 Working Age Claimant Rate	1240	12.47	10.68	13.73	24.31	6.91
	9 Adults with No Qualifications	2169	18.77	14.21	20.96	33.24	11.29
	10 16-18 year old NEET	30	8.17	5.72	5.19	8.17	2.46
	11 Long Term Unemployed	65	6.54	6.08	6.30	13.67	2.50
	12 Least Deprived LSOA in Ward	-	14.29	5.21	24.98	60.32	5.21
	13 Most Deprived LSOA in Ward	-	37.04	59.63	24.98	60.32	5.21
Healthy Start	14 Lone Parent Families	326	7.01	4.69	7.03	11.42	3.74
	15 Child Poverty	795	35.10	25.48	25.31	37.91	15.08
	16 % Smoking in Pregnancy	107	23.16	14.68	16.78	28.78	10.71
	17 % Breastfeeding	341	73.81	84.01	74.92	57.89	86.67
	18 Year R Child Obesity	32	9.91	8.27	9.36	12.69	5.36
	19 Year 6 Child Obesity	80	28.17	20.46	19.88	28.17	14.40
Lifestyle	20 Alcohol Specific Hospital Admissions (DSR)	383	712.84	888.98	638.81	1971.63	291.06
	21 Smoking Related Hospital Admissions (DSR)	282	1593.81	1440.27	1747.38	2426.06	1260.90
Safety	22 Violent Crime	221	15.68	28.14	21.82	54.25	7.02
	23 Road KSIs	108	260.66	343.35	274.71	602.21	109.17
Disability and Poor Health	24 Limiting illness	1918	19.29	16.07	22.74	34.48	12.33
	25 DLA Claimants	615	54.09	43.49	56.74	85.39	31.56
	26 Injuries due to Falls (65+)	55	861.77	501.82	495.41	661.77	396.67
Mortality	27 All Age All Cause Mortality (DSR)	396	565.26	577.76	568.54	727.02	485.04
	28 Premature Mortality from Cancer	61	127.16	110.87	118.46	167.23	87.91
	29 Premature Mortality from CVD	37	76.48	72.93	71.01	120.57	39.35
	30 Premature Mortality from Respiratory Disease	22	46.17	31.56	28.34	66.99	8.83
	31 Mortality from Preventable Causes	103	199.09	173.24	173.99	301.11	112.40
	32 Life Expectancy Females	-	82.86	82.09	82.49	79.89	85.34
	33 Life Expectancy Males	-	78.83	78.47	78.34	75.14	80.81



^A The terms 'best' and 'worst' are not appropriate for these indicators instead the right side of the chart indicates the highest value and the left side the lowest.

Public Health Ward Profiles: 2012/13

Southampton South & East Locality

00MSNH - Woolston

Public Health Southampton

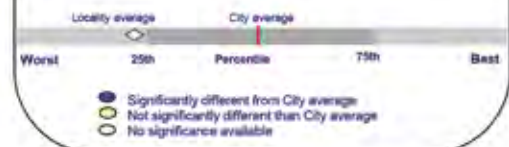
Main Menu

Metadata

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Indicator		Ward no.	Ward Value	Locality Average	City Average	City Worst	Ward Spine Chart		City Best
Demography	1 % Resident Population aged 0-4 years ^a	1133	8.18	7.19	6.50	4.27			8.76
	2 % Resident Population aged 18-24 years ^a	1283	9.26	8.76	16.88	7.58			40.20
	3 % Resident Population aged over 65 years ^a	1904	13.75	15.90	12.99	5.25			19.00
	4 Forecast % change in population 2011-18 ^a	2017	14.50	1.46	3.14	-2.59			14.99
	5 % Population from minority ethnic groups ^a	671	4.84	6.11	14.08	4.20			40.14
	6 % Population born in the UK ^a	12677	91.52	91.41	82.42	60.70			93.64
	7 General Fertility Rate ^b	1216	73.45	70.48	60.53	34.56			88.07
Economic	8 Working Age Claimant Rate	1740	19.35	16.02	13.73	24.31			6.91
	9 Adults with No Qualifications	2804	25.62	25.06	20.96	33.24			11.29
	10 16-18 year old NEET	25	5.05	4.99	5.19	8.17			2.46
	11 Long Term Unemployed	75	8.34	6.81	6.30	13.67			2.50
	12 Least Deprived LSOA in Ward	-	13.72	9.03	24.98	60.32			5.21
13 Most Deprived LSOA in Ward	-	59.23	55.60	24.98	60.32			5.21	
Healthy Start	14 Lone Parent Families	597	9.99	8.16	7.03	11.42			3.74
	15 Child Poverty	1030	30.84	25.10	25.31	37.91			15.08
	16 % Smoking in Pregnancy	166	23.51	20.39	18.78	28.78			10.71
	17 % Breastfeeding	481	68.13	69.77	74.92	57.89			86.67
	18 Year R Child Obesity	43	8.46	8.67	9.36	12.69			5.36
19 Year 6 Child Obesity	69	20.12	19.43	19.88	28.17			14.40	
Lifestyle	20 Alcohol Specific Hospital Admissions (DSR)	378	663.85	621.01	638.81	1971.63			291.06
	21 Smoking Related Hospital Admissions (DSR)	464	2047.98	1837.60	1747.38	2426.06			1260.90
Safety	22 Violent Crime	281	19.82	17.21	21.82	54.25			7.02
	23 Road KSIs	94	224.40	221.74	274.71	602.21			109.17
Disability and Poor Health	24 Limiting illness	2427	26.99	28.15	22.74	34.48			12.33
	25 DLA Claimants	795	72.91	64.57	56.74	85.39			31.56
	26 Injuries due to Falls (65+)	58	589.40	502.80	495.41	661.77			396.67
Mortality	27 All Age All Cause Mortality (DSR)	690	724.94	576.97	568.54	727.02			485.04
	28 Premature Mortality from Cancer	84	140.91	122.59	118.46	167.23			87.91
	29 Premature Mortality from CVD	51	85.36	67.76	71.01	120.57			39.35
	30 Premature Mortality from Respiratory Disease	11	17.84	21.64	28.34	66.99			8.83
	31 Mortality from Preventable Causes	125	190.36	164.51	173.99	301.11			112.40
	32 Life Expectancy Females	-	79.89	82.09	82.49	79.89			85.34
	33 Life Expectancy Males	-	76.26	78.45	78.34	76.14			80.81

^a The terms 'best' and 'worst' are not appropriate for these indicators instead the right side of the chart indicates the highest value and the left side the lowest.



RESIDENT POPULATION, 2012

Population resident in Southampton City

Age band	Male	Female	Persons	%
0-4	8,200	7,700	15,900	6.6
5-14	12,100	11,500	23,600	9.9
15-24	25,100	23,200	48,300	20.2
25-49	44,200	40,900	85,200	35.6
50-64	17,500	17,200	34,700	14.5
65-74	7,800	8,500	16,300	6.8
75-84	4,500	6,100	10,600	4.4
85+	1,600	3,200	4,800	2.0
Total	121,200	118,200	239,400	100

Source: Office for National Statistics Mid Year Estimate of the Population 2012. © Crown Copyright. (Figures may not sum due to rounding)

REGISTERED POPULATION, 2012

Population registered with Southampton City GPs

Age band	Male	Female	Persons	%
0-4	8,700	8,000	16,700	6.3
5-14	13,200	12,600	25,800	9.7
15-24	24,300	24,600	48,800	18.3
25-49	54,800	45,700	100,400	37.6
50-64	20,900	19,200	40,100	15.0
65-74	9,000	9,200	18,200	6.8
75-84	5,100	6,500	11,600	4.3
85+	1,700	3,400	5,100	1.9
Total	137,600	129,100	266,700	100

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

BIRTHS

General Fertility Rate and Number of Births

	2009	2010	2011	2012
Live births per 1,000 women aged 15-44				
Southampton	54.1	57.0	63.4	60.2
South East	62.6	64.4	63.8	64.5
England	63.8	65.5	64.2	64.9
Number of live births				
Southampton	3,230	3,448	3,550	3,420

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

TEENAGE CONCEPTIONS

	2008	2009	2010	2011
No. of conceptions to girls aged under 18				
Southampton	198	188	181	170

Rate of under 18 conceptions per 1000 girls aged 15-17

	2008	2009	2010	2011
Southampton	58.0	54.3	51.7	47.4
South East	33.0	29.9	28.0	26.1
England	39.7	37.1	34.2	30.7

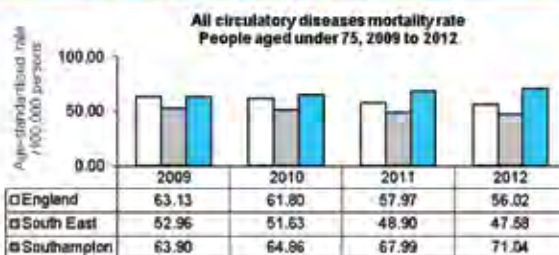
Source: Teenage Pregnancy Unit & Office for National Statistics, © Crown Copyright.

INFANT MORTALITY*

	2008-10	2009-11	2010-12
Number of deaths (in 3 year period)			
Southampton	49	46	43
South East	1,204	1,167	1,126
England	9,260	9,062	8,822
Mortality per 1000 live births			
Southampton	4.9	4.5	4.1
South East	3.8	3.7	3.5
England	4.6	4.4	4.3

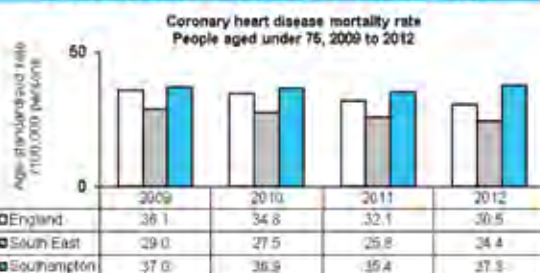
*includes deaths of infants aged less than 1 year
Source: Office for National Statistics, Vital Statistics VS1. © Crown Copyright.

CIRCULATORY DISEASE



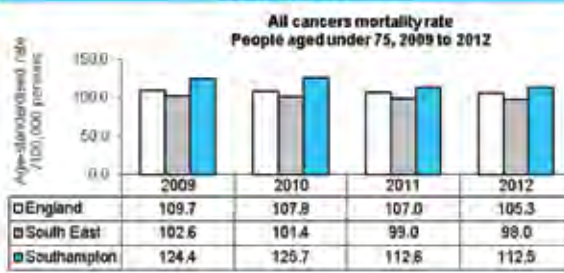
Number of deaths per year
Southampton 127 131 138 149
Source: Compendium of Clinical & Health Indicators Health & Social Care Information Centre © Crown Copyright.

CORONARY HEART DISEASE



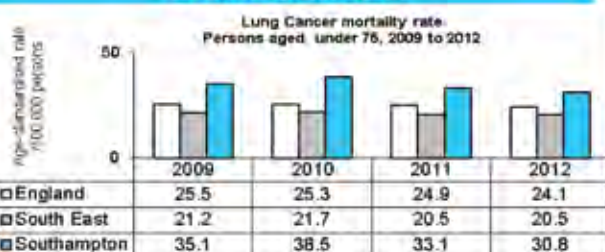
Number of deaths per year
Southampton 73 74 72 79
Source: Compendium of Clinical & Health Indicators Health & Social Care Information Centre © Crown Copyright.

CANCER



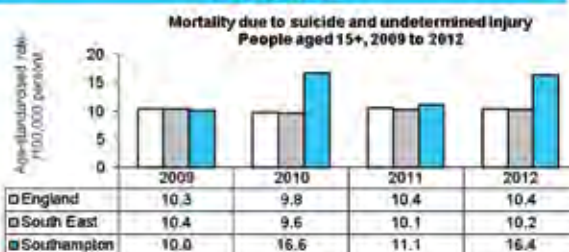
Number of deaths per year
Southampton 247 256 230 234
Source: Compendium of Clinical & Health Indicators Health & Social Care Information Centre © Crown Copyright.

LUNG CANCER



Number of deaths per year
Southampton 69 77 67 64
Source: Compendium of Clinical & Health Indicators Health & Social Care Information Centre © Crown Copyright.

SUICIDE



Number of deaths per year
Southampton 18 32 20 32
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The Health of the People of Southampton City 2013

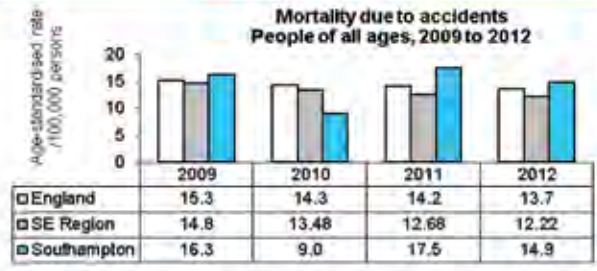
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Email: rebecca.wilkinson@southampton.gov.uk
 For more health information please visit our website: www.publichealth.southampton.gov.uk

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ACCIDENTS



Number of deaths per year
 Southampton 48 30 52 45
 Source: Compendium of Clinical & Health Indicators Health & Social Care Information Centre © Crown Copyright.

LIFE EXPECTANCY*

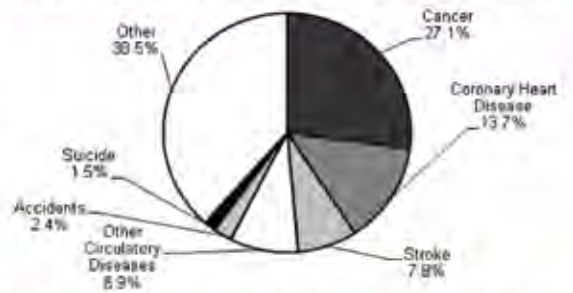
Life Expectancy at Birth (years) 2009-11

	Males	Females
Southampton	78.6	82.9
South East	80.0	83.8
England	78.9	82.9

*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 2009-11 mortality rates throughout their life.
 Source: Office for National Statistics, 2013 © Crown Copyright.

MAJOR CAUSES OF DEATH

Southampton Residents 2012 (No. of deaths = 1,846)



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

JOBS AND UNEMPLOYMENT

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

	Southampton	South East	England
Sep 2013	2.7	2.0	3.1
Jun 2013	3.0	2.2	3.4
Mar 2013	3.5	2.5	3.8
Dec 2012	3.2	2.4	3.6
Sep 2012	3.2	2.4	3.7

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

	Southampton	South East	England
2011	0.72	0.78	0.80

Source: National Statistics (from Nomis website: 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	E01017245	E01017280	E01017161	E01017140	E01017137	E01017210	E01017237	E01017274	E01017145	E01017148	E01017142	E01017257	E01017146	E01017138	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

	2009	2010	2011	2012
Southampton				
KS2 English	74	77	79	83
KS2 Mathematics	74	78	80	83
5+ GCSEs A*-C	43.1	47.5	51.7	54.4
England				
KS2 English	80	80	82	86
KS2 Mathematics	79	79	80	84
5+ GCSEs A*-C	49.8	53.5	58.9	59.4

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
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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 South East Region and with the England average.

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

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 Head of Public Health Intelligence

Andrew Mortimore
 Director of Public Health

www.publichealth.southampton.gov.uk

