



Suicide

Cold homes

Lung health

Health in Southampton 2011

www.southamptonhealth.nhs.uk/publichealth

FINDING OUT MORE ABOUT THE HEALTH OF SOUTHAMPTON

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

Please visit our website to access any of these resources:

<http://www.southamptonhealth.nhs.uk/aboutus/publichealth/>

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INTRODUCTION

The health of Southampton people continues to improve, but there are still too many who are missing out. This continues to be the conclusion as we assess the health needs of our city, the disease trends and then factors that affect our health.

This year's annual public health report examines three key issues from the Joint Strategic Needs Assessment (JSNA) which profiles the health and social care needs of the local population, highlighting areas that require particular attention. As the JSNA is updated on a continuing basis, it is planned that each year a different selection of issues will be chosen for greater scrutiny within the annual report. The full JSNA can be accessed at www.southamptonhealth.nhs.uk/jsna

In this 2011 report we have chosen to focus on lung health, suicide and fuel poverty. For each we firstly explain the nature of the issue and the national picture, before focusing on the local context and the relevance to the people of Southampton. For each issue we then describe the ways that it might be addressed before making a summary of recommendations.

Poor lung health affects more people than is often recognised. As well as causing premature death, people with lung disease tend to have a poor quality of life in its later stages and the cost to individuals, families and society is high. Much lung disease can be prevented and, if picked up early, outcomes can be greatly improved.

As well as the personal tragedy that suicide represents, it is a marker of levels of distress in society. Understanding the causes and trends can lead to more focussed action - to improve awareness, identify those most at-risk of being overwhelmed by their personal circumstances, and to provide effective interventions.

Housing affects health in many ways. Overcrowding, poor ventilation, damp and lack of adequate heating are recognised to lead to more respiratory and other illnesses. Cold homes and fuel poverty are linked to excess deaths in winter months. Despite good progress in improving the quality of local housing, many people still face the consequences of cold homes, and more remains to be done to help them.

Before the in-depth look at these three issues, we explain how the public health system in England is changing and what this means for Southampton.

We also include a section summarising the changing overall health picture in Southampton, and some key health facts.

An audit of recommendations from each annual report is maintained by the Public Health Team in Southampton and you will find a summary of progress presented as Appendix 1.



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THE NEW PUBLIC HEALTH SYSTEM FOR ENGLAND

The Health and Social Care Bill proposes major changes to the public health system for England, originally described in the White Paper: *Healthy Lives, Healthy People*. To ensure public health is responsive to the different needs of each community, the government aims to create local freedom, accountability and ring-fenced funding. From April 2013 local public health leadership and responsibility will be returned to and strengthened within local government.

In the new system, each local authority and their individual directors of public health will act as strategic public health leaders for their local population. They will lead discussions about how their ring-fenced money should be spent to improve outcomes for people's health and wellbeing locally. They should be in a position to ensure public health is always considered when local authorities, clinical consortia and the NHS make decisions.

Health and wellbeing boards, based in local authorities, will provide a forum to bring together NHS commissioners, councils and elected councillors with patient champions, to join up the public health agenda with the wider work of the NHS, social care and children's services.

These changes will give three key roles to Southampton City Council.

1. Leading for public health by:

- including health in all policies so that each decision seeks the most health benefit for the investment, and asking key questions such as "what will this do for the health and wellbeing of the population?" and "will this reduce health inequalities locally?"
- investing the new ring-fenced grant in high-quality public health services
- encouraging health-promoting environments, for example, access to green spaces and transport and reducing exposure to environmental pollutants
- supporting local communities – promoting community renewal and engagement, development of social networks (in particular for young families and children, and isolated elderly people), and the Big Society. This will bring a focus on what a healthy population can do for the local community, not least in terms of regeneration.

2. Public health commissioning functions including:

- tobacco control and smoking cessation services
- alcohol and drug misuse services
- public health services for children and young people aged 5-19 (including Healthy Child Programme 5-19), and in the longer term all public health services for children and young people
- the National Child Measurement Programme
- interventions to tackle obesity such as community lifestyle and weight management services
- locally-led nutrition initiatives

- increasing levels of physical activity in the local population
 - NHS Health Check assessments
 - public mental health services
 - dental public health services
 - accidental injury prevention
 - population level interventions to reduce and prevent birth defects
 - behavioural and lifestyle campaigns to prevent cancer and long-term conditions
 - local initiatives on workplace health
 - supporting, reviewing and challenging delivery of key public health funded and NHS delivered services such as immunisation and screening programmes
 - comprehensive sexual health services (including testing and treatment for sexually transmitted infections, contraception outside of the GP contract and sexual health promotion and disease prevention)
 - local initiatives to reduce excess deaths as a result of seasonal mortality
 - the local authority role in dealing with health protection incidents, outbreaks and emergencies
 - public health aspects of promotion of community safety, violence prevention and response
 - public health aspects of local initiatives to tackle social exclusion
 - local initiatives that reduce public health impacts of environmental risks.
3. Specialist public health and population healthcare advice and expertise to local commissioners including the Southampton City Clinical Commissioning Group. This offer will include:
- strategic planning: assessing needs
 - strategic planning: reviewing service provision
 - strategic planning: deciding priorities
 - procuring services: designing shape and structure of supply
 - procuring services: planning capacity and managing demand
 - monitoring and evaluation: supporting patient choice, managing performance and seeking public and patient views.

Other important aspects of the White Paper include:

Tackling health inequalities

Responding to the challenges set out in Professor Sir Michael Marmot's powerful "*Fair Society, Healthy Lives*" report, this White Paper includes a proposal for a new, and simple, health premium that will reward progress on specific public health outcomes.

Driven by a formula to be developed together with key partners, the premium will represent a new approach to fighting health inequalities. The intention is for the formula to recognise that disadvantaged areas face the greatest challenges, and will therefore receive a greater premium for progress made.

National support for local delivery

At a national level, a new dedicated public health service, Public Health England, will integrate leading expertise, advice and influence, into one organisation by combining experts from a range of public health bodies such as the Health Protection Agency, the National Treatment Agency for Substance Misuse and the Department of Health.

Subject to passage of the Health and Social Care Bill, Public Health England will be established within the Department of Health in April 2013, and will set the overall outcomes framework for public health. Working across government, and with the NHS Commissioning Board and national partners, Public Health England will support local action on public health.

Accountable to the Secretary of State for Health, it will focus on national resilience against health threats such as flu pandemics, and will act as a 'knowledge bank' for the best and most up-to-date evidence on what we know works to improve the public's health.

Working with industry and other government departments to shape the wider environment as it affects our health, Public Health England will also provide the resources, ideas, and the funding to support local strategies.

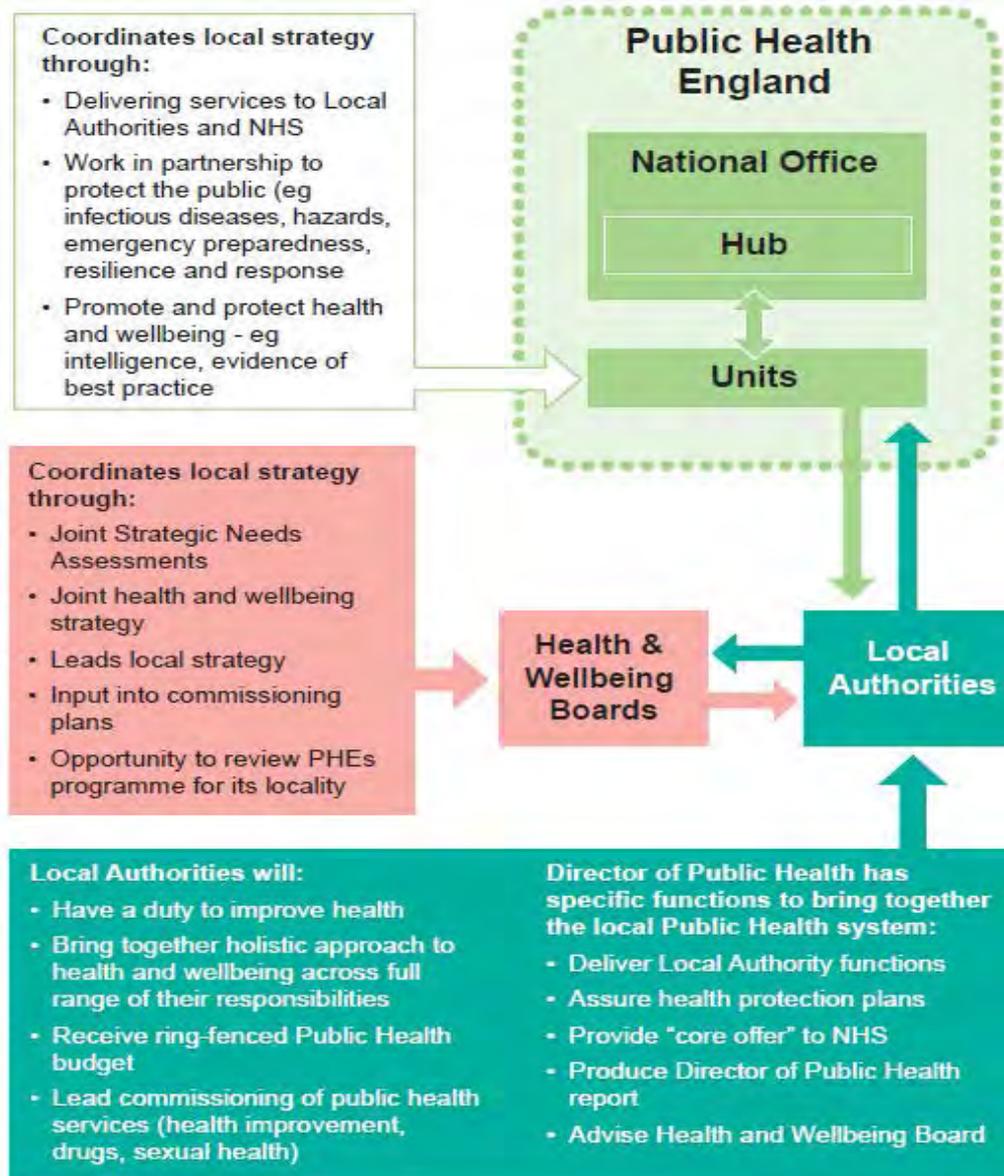
Public health responsibility deal

The government's view is that society, government and individuals share collective responsibility for public health and the new public health system will encourage all to play their part in improving and protecting the nation's health and wellbeing.

With the aim of making it easier for people to make healthy choices and live healthier lives, the public health Responsibility Deal is being driven forward by the Secretary of State.

Working with industry, the voluntary sector, non-governmental organisations, and leading experts from the field, it should lead to, for example, better food labelling, more information about the harmful effects of alcohol, and a much greater contribution from industry into campaigns such as Change4Life.

Figure 1



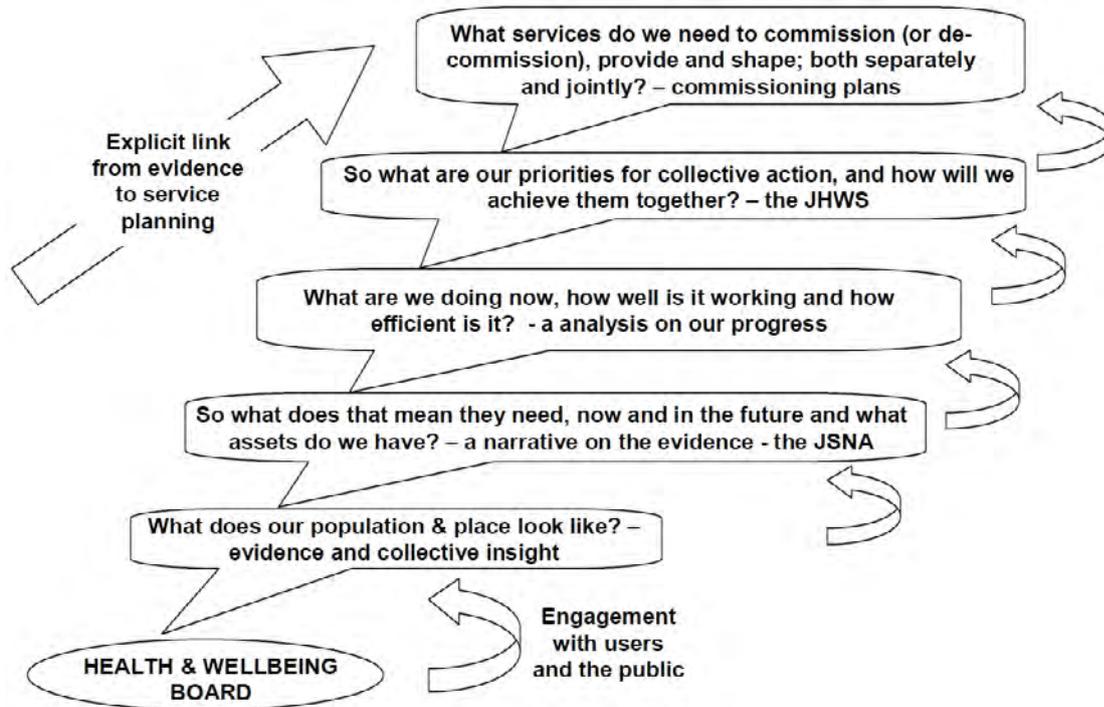
For the city of Southampton there is a long history of close working between the City Council, the primary care trust and its public health team, with a jointly appointed Director of Public Health since 2003. Joint programmes of work, brought together in two Health and Wellbeing Plans, have helped drive improvements over the past decade. The City Council already has a strong portfolio of services that support local health improvement. While much still remains to be done, there is a good basis for moving into the new system as described above, and ensuring that the most is made of the new opportunities.

Draft guidance from the Department of Health¹ sets out the way in which effective plans can be developed, based on the understanding created by the JSNA and a locally determined consensus of the priorities for improvement. Bringing about change has always

¹ Department of Health (2012) JSNAs and joint health and wellbeing strategies – draft guidance <http://healthandcare.dh.gov.uk/files/2012/01/JSNAs-and-joint-health-and-wellbeing-strategies-draft-strats.pdf>

been challenging, but the Health and Wellbeing Board enables all those involved in potential solutions to agree approaches, and align their plans and use of resources. In Southampton collaborative commissioning arrangements and integrated working by providers has enabled many improvements to be made in the past, and the new arrangements give a framework for building on past successes and being more ambitious for the future.

Figure 2 JSNA and Joint Health and Wellbeing Strategies (JHWS) - a vehicle for shared leadership



SOUTHAMPTON'S HEALTH...A CHANGING PICTURE

There are many ways of summarising the overall health of Southampton's population as you will find on the Health Intelligence pages of our website <http://www.southamptonhealth.nhs.uk/aboutus/publichealth/hi/> In this year's annual report we want to draw your attention to the following key facts and we have then presented data diagrammatically on illness, deaths and expenditure. At the back of this report you will find our updated 'pocket profile' which gives a useful summary of key health indicators for the city benchmarked against our most similar authorities².

Health in Southampton at a glance...

Southampton is a diverse city where...

- In just a few years there has been a change in the number of babies being born to city residents each day from seven in 2003 to nine in 2009
- Five Southampton residents die each day
- In 2010 there were over 5,000 people in the city aged over 85 years – by 2017 this will have risen to more than 6,000
- Over 3,200 pupils in Southampton schools speak a first language other than English
- According to its demographic and socio-economic characteristics, the UK cities considered most similar to Southampton are Bristol, Portsmouth, Exeter and Norwich
- Southampton covers an area of 5,181 hectares of which over 20% is open space.

Improvements in health and wellbeing over the past decade include...

- Compared with 10 years ago, men are 19% and women are 3% more likely to live to the age of 75 (the probability of survival to age 75 in 1997-99 was 56% for males and 74% for females, in 2007-09 the figures were 67% and 77% respectively)
- Compared with 10 years ago, male life expectancy is four years longer and women's life expectancy is two years longer
- Death rates have fallen by 22% (342 fewer deaths each year in the city)
- Deaths from heart disease have fallen by 49% (202 per year fewer)
- Deaths from stroke are 38% lower
- Cancer death rate has fallen by 9%
- Smoking prevalence is estimated to have fallen from 32% to 22% over the past decade
- Since 2003/04 smoking in pregnancy has reduced from 25.1% to 19.5% whilst breastfeeding rates have increased from 69.6% to 74.5%
- Every day now an average of 15 eligible women are screened for breast cancer, 25 for cervical cancer and a further 23 eligible adults screened for bowel cancer
- Educational attainment has improved – in 2005 34.6% of Southampton pupils gained 5 or more GCSEs at grades A*-C (including English and Maths), and by 2011 this had increased to 51.7%.

² Similar authorities defined using ONS 2001 Classification of Areas www.statistics.gov.uk

However, many challenges remain for our city including...

- Men from the most deprived areas of Southampton have a life expectancy eight years less than men from the least deprived areas
- In Southampton there is one teenage conception every two days
- Every day a Southampton resident dies from a cause related to smoking
- Every day in Southampton an average of three people are newly diagnosed with cancer
- Gross annual pay for full-time workers in Southampton was just over £23,000 on average in 2010, compared with a national average of over £26,000
- Every 13 hours there is a net gain of one additional person to Southampton GPs' diabetic risk registers
- Only 31.7% of adults access NHS dentistry with extra provision being under-used.

Figure 3 below shows how NHS Southampton has spent its financial allocation across the categories used in 'programme budgeting'³. Mental health disorders have accounted for a significant share of the budget. This year's report has a chapter focused specifically on suicide, which is the extreme end of a wide spectrum of mental wellbeing issues.

Figure 4 presents data on causes of death. Cancers and circulatory diseases account for the majority of mortality in the city. Respiratory disease is also a significant cause and we look at this in more detail in the lung health chapter of the report.

Figure 5 represents the 'disability-adjusted life years' (DALY) from each major disease category⁴. Essentially, DALYs are used to summarise the burden of disease across a population by measuring the gap between current health status and an ideal health situation where the entire population lives to an advanced age, free of disease and disability. One DALY can be thought of as one lost year of 'healthy' life⁵. The striking thing about this diagram is the large contribution that mental ill-health and behaviour disorders make to the burden of disease in the city.

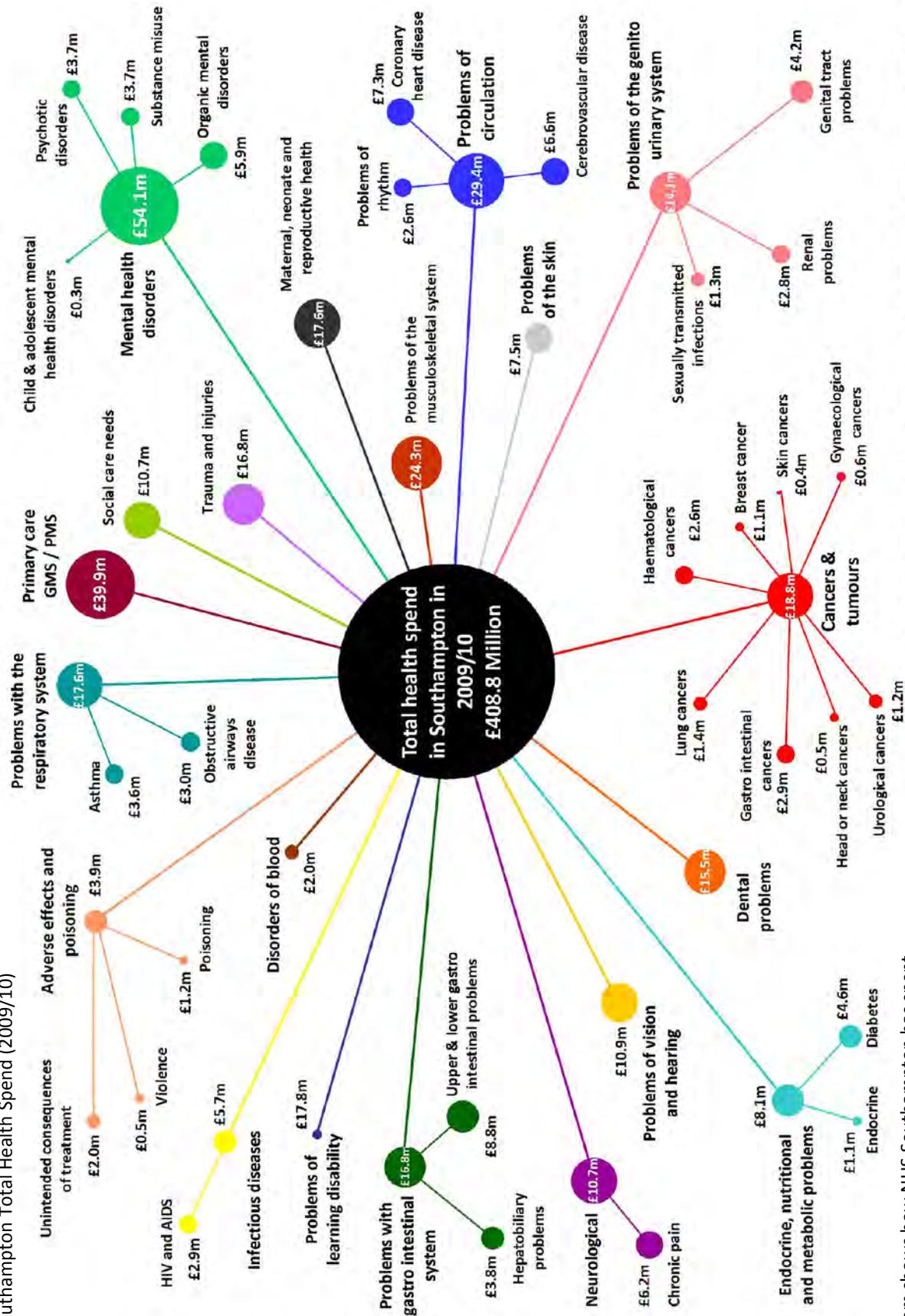
³ Department of Health Programme Budgeting PCT Benchmarking Tool

http://www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/Programmebudgeting/DH_075743

⁴ Please note that it was impossible to calculate DALYs specifically for Southampton so instead we used the same proportions as had been calculated by WHO for the UK and applied them to the Southampton population.

⁵ WHO http://www.who.int/healthinfo/global_burden_disease/metrics_daly/en/

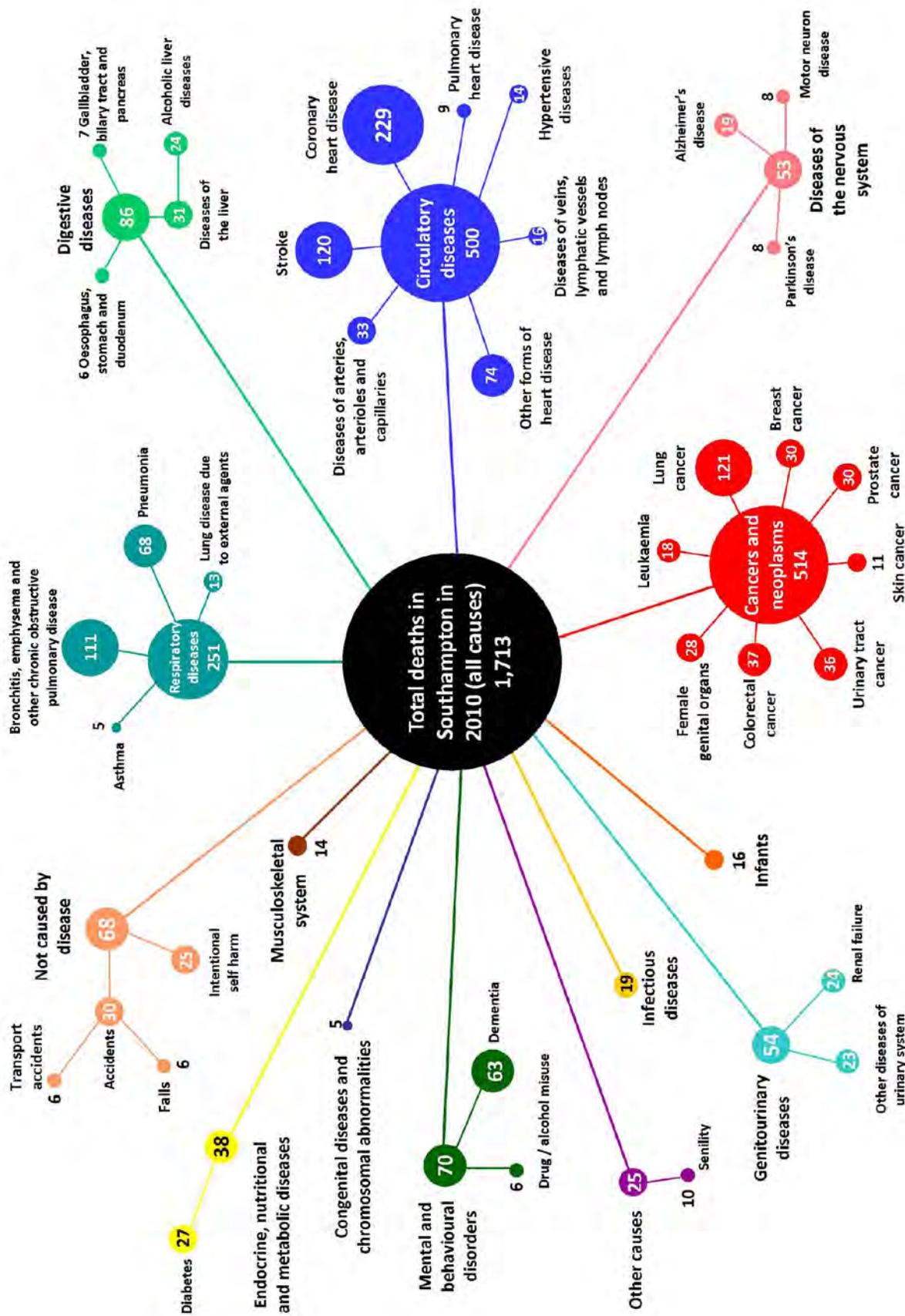
Figure 3: NHS Southampton Total Health Spend (2009/10)



Note: This diagram shows how NHS Southampton has spent its financial allocation across the categories used in 'programme budgeting'.

Source: Department of Health Programme Budgeting PCT Benchmarking Tool 2009/10

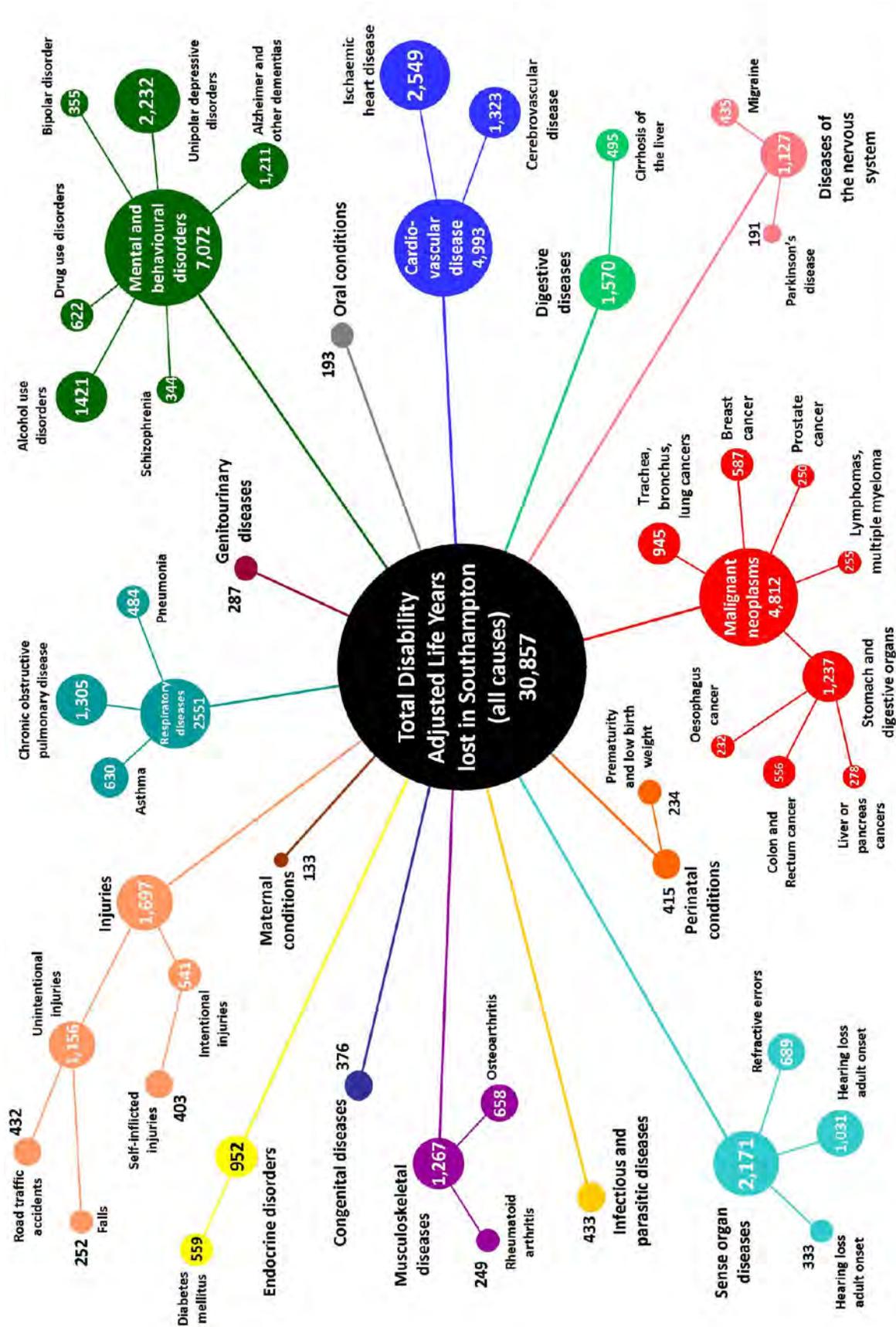
Figure 4: Total deaths to Southampton residents (2010)



Source: Office for National Statistics 2010 annual mortality file

Note: This diagram shows the number of deaths by category (derived from ICD 10 coding on cause of death).

Figure 5: Total disability-adjusted life years (2010)



LUNG HEALTH

What is the issue?

Keeping our lungs fit and healthy is not something we consciously think about unless, perhaps, we are in a dusty or polluted environment.

Lung disease, or Chronic Obstructive Pulmonary Disease (COPD), is an illness of the lungs that is characterised by airflow obstruction. COPD is an umbrella term for a group of lung diseases that include chronic bronchitis, emphysema and small airways disease.

Lung damage over a long time impairs the passage of air in and out of the lungs and causes breathlessness. It can be caused by occupational exposure to dust and/or gases, indoor pollution such as smoke from wood and coal fires, or, in a small number of cases, can be inherited. However, its primary cause is smoking.

Lung disease affects a massive number of people – an estimated 3.5 million nationally – but perhaps more staggering is that an estimated 2.7 million of these are undiagnosed. In total lung disease accounts for 30,000 deaths a year in England with 15% of people admitted to hospital with lung disease dying within three months. Premature deaths from COPD in the UK in 2008 were nearly twice as high as the rest of Europe⁶.

People with lung disease have a poor quality of life; the British Lung Foundation (BLF) estimates that 90% of people with severe COPD are unable to participate in certain socially important activities, 66% are unable to take a holiday and 33% have disabling breathlessness.

The societal cost of poor lung health is also very high; lung disease costs businesses 24 million working days in sick leave and £3.8 billion in direct costs from lost productivity. The direct cost of lung disease to the UK healthcare system is estimated to be between £810m and £930m a year.

COPD is the fifth biggest killer in the UK⁷ and worldwide. Every hour COPD is estimated to kill over 250 people worldwide.⁸ COPD is the only major cause of death whose incidence is on the increase⁹ and is expected to be the third leading cause of death worldwide by 2020 (exceeded only by heart disease and stroke)¹⁰.

⁶ Department of Health *An outcomes strategy for people with chronic obstructive pulmonary disease (COPD) and asthma in England*. London DH, 2011.

⁷ National Statistics (2006) Health Statistics Quarterly 30
http://www.statistics.gov.uk/downloads/theme_health/HSQ30.pdf

⁸ WHO. The World Health Report 2002. Reducing risks, promoting healthy life. MDI.WHR.202.A, The World Health Organization,

⁹ Murray CJL, Lopez AD. Alternative projections of mortality and disability by cause 1990-2020: Global Burden of Disease Study. *Lancet* 1997; 349 1498-504

¹⁰ <http://www.lunguk.org/media-and-campaigning/media-centre/lung-stats-and-facts/chronicobstructivepulmonarydisease>

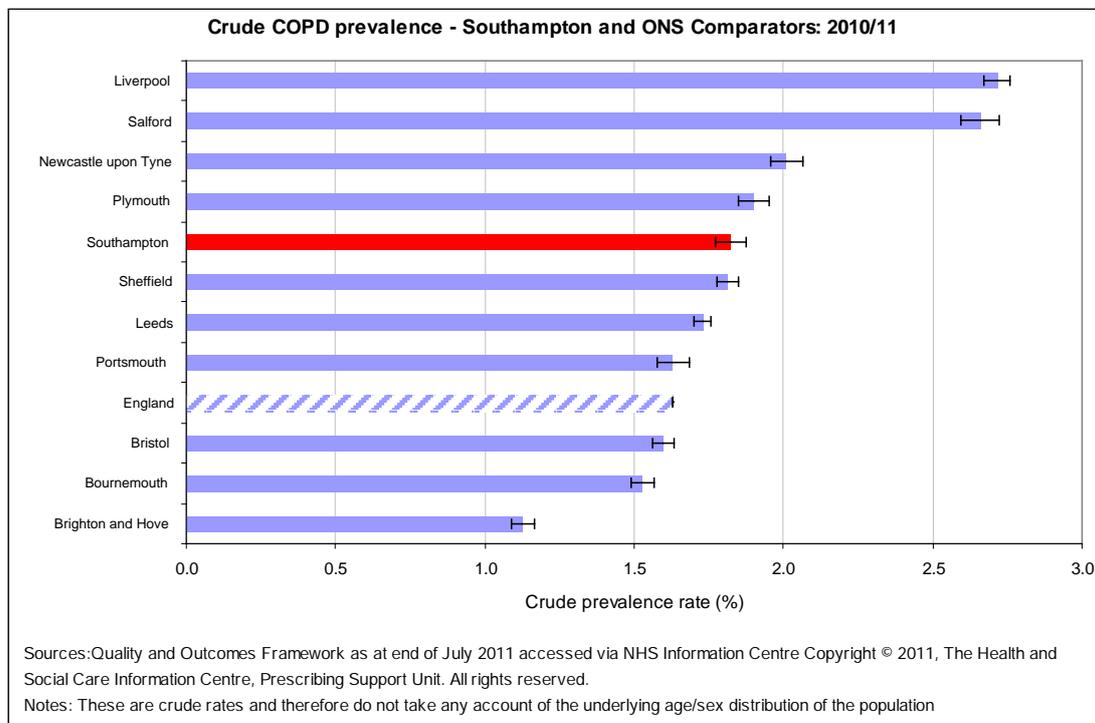
Despite all this, awareness of lung health is low amongst the general population. A survey by the BLF in May 2007 found that 89% of people in the UK have never heard of COPD. Even 85% of smokers have never heard of the disease. These findings reflect results from previous surveys carried out by the BLF.¹¹

The Southampton context

Prevalence

In 2010/11 there were 4,834 people on GP COPD registers in the city giving a crude prevalence rate of 1.8%. The chart shows that in Southampton the COPD crude prevalence rate is higher than the national average but not the highest amongst ONS peers. The crude prevalence of COPD, as recorded in GP registers, has been rising over time both nationally and locally. It is impossible to know the contribution that changing recording practices have made to this increase.

Figure 6: Crude COPD prevalence – Southampton and ONS comparators 2010/11



In response to the disparity between recorded and estimated prevalence, the Eastern Region Public Health Observatory (ERPHO)¹² has developed a model to estimate underlying COPD prevalence down to GP practice level. For Southampton as a whole this model estimates there are 7,868 people with COPD which is a crude prevalence of 3.0%. If these figures are correct there may be over 3,000 undiagnosed COPD sufferers in Southampton. It is important to note that the model is supplied with various caveats about the assumptions that have gone into it; in particular, for practices with a population that significantly differs

¹¹ British Lung Foundation (2007) *Invisible Lives Chronic Obstructive Pulmonary Disease (COPD) - finding the missing millions* www.lunguk.org

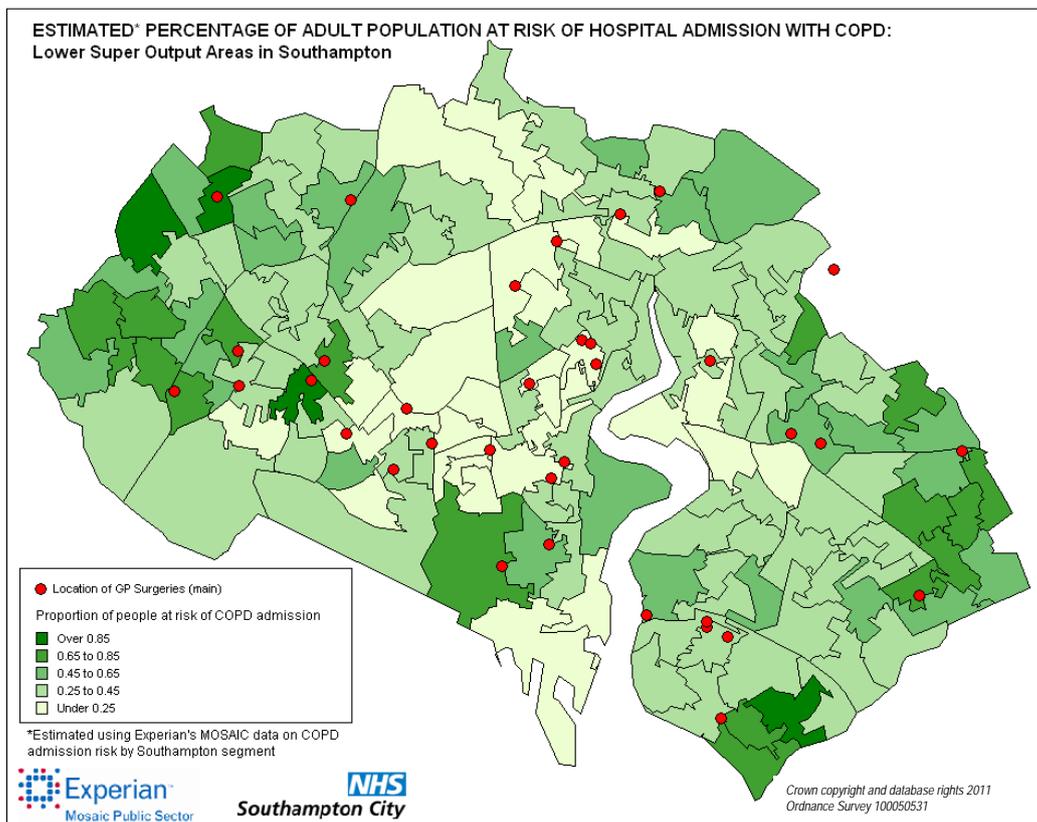
¹² <http://www.apho.org.uk/resource/view.aspx?RID=48308>

from a ‘typical’ population the assumptions of the model may not apply and discrepancies may occur.

The British Lung Foundation used MOSAIC¹³ population segmentation data to predict which lifestyle types are most at risk of future hospital admission with COPD. They then used this information to pinpoint which primary care trusts have the highest proportions of predicted COPD admissions. Through this work Southampton was identified as one of the COPD ‘hot spots’.

We have been able to replicate this work locally using our own Southampton-specific MOSAIC data; the map below shows which areas of Southampton are estimated to have the highest proportions of people at risk of hospital admission due to COPD. The areas of the city estimated to be most at risk (darkest shading on the map) are Weston, Lords Hill, parts of Shirley and Redbridge.

Figure 7: Estimated percentage of adult population at risk of hospital admission with COPD

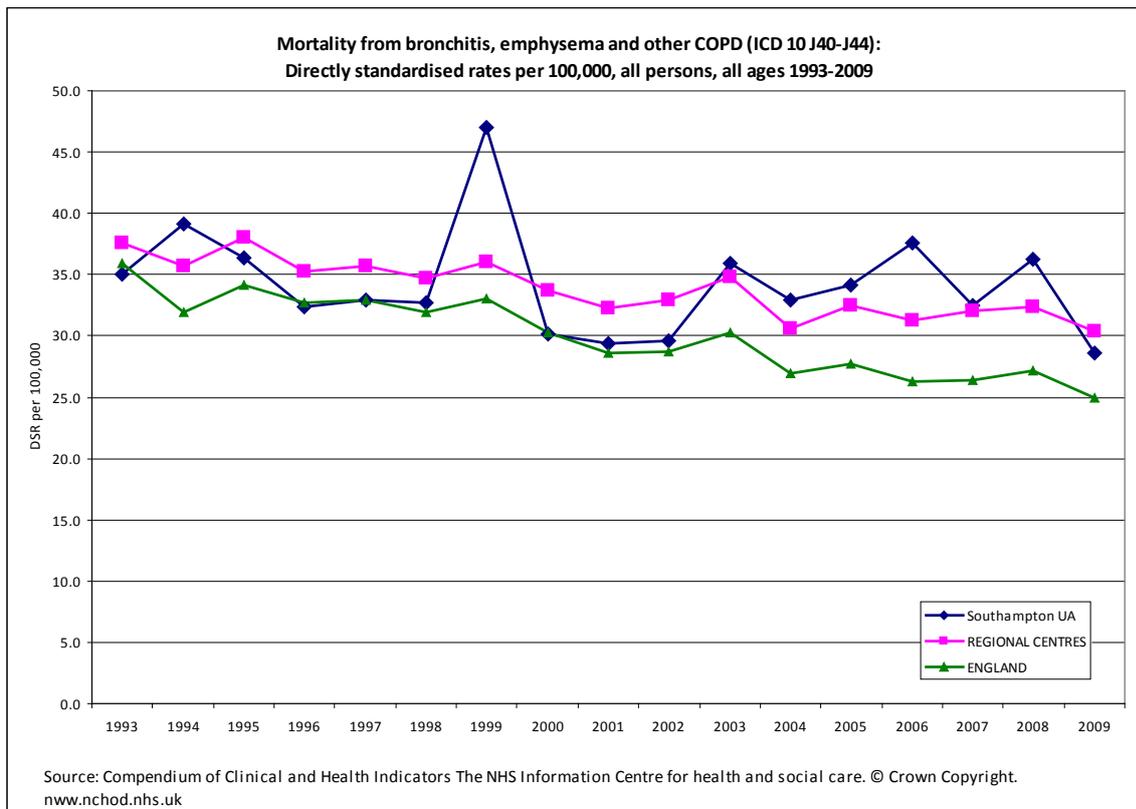


Mortality

On average 105 Southampton residents die each year from COPD. The following chart shows how age standardised mortality rates from COPD have changed over the past decade and beyond. Whereas the national rates appear to be gradually falling there is no evidence that this is the case in Southampton. Note the year-on-year variability in Southampton due to the relatively small numbers involved when looking at annual data.

¹³ Experian MOSAIC <http://www.experian.co.uk/business-strategies/mosaic-uk-2009.html>

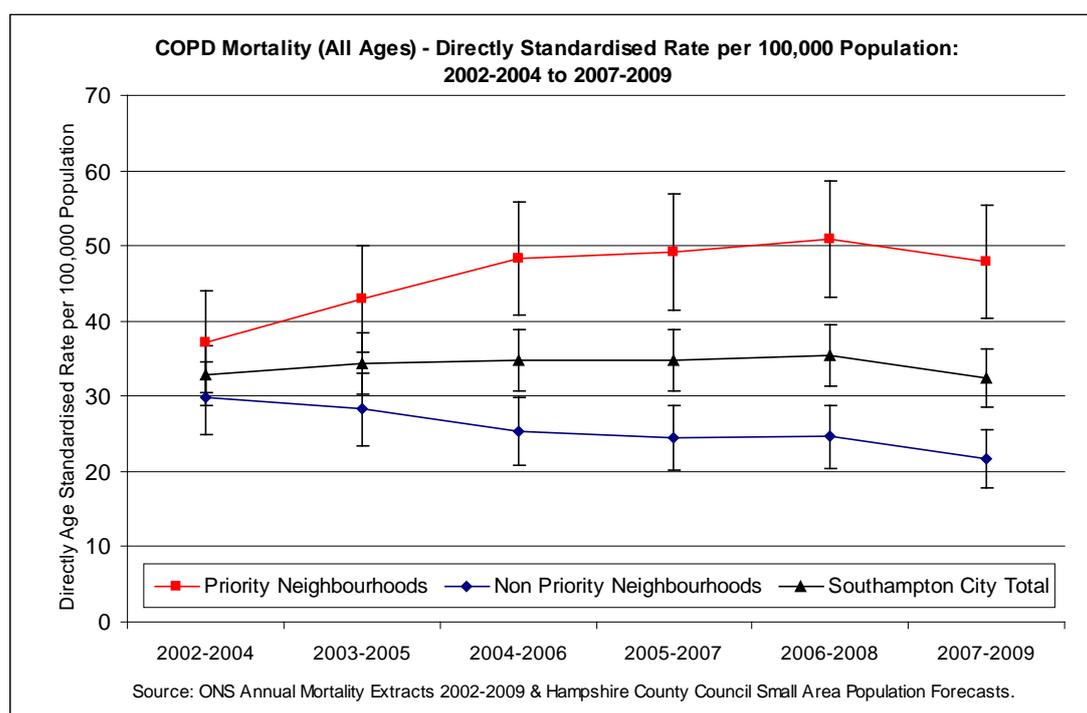
Figure 8: Mortality from Bronchitis, Emphysema and other COPD (ICD 1-J40-J44): Directly standardised rates per 100,000, all persons, all ages 1993 – 2009



Mortality from COPD has been consistently higher amongst residents from the ‘priority areas’¹⁴ of the city as the chart below shows. In 2002-04 mortality rates from COPD were 25.3% higher in priority areas compared to non-priority areas. There is evidence of a widening inequalities gap as in 2007-09 mortality rates from COPD were 120.7% higher in the priority areas.

¹⁴ Areas identified as a ‘priority for action’ because of their high needs in Southampton City Council’s Local Neighbourhood Renewal Strategy 2006- 2010
<http://www.southamptonhealth.nhs.uk/aboutus/publichealth/improvement/healthstrategies/lnrs/>

Figure 9: COPD mortality (all ages) – Directly standardised rate per 100,000 population: 2002-04 to 2007-09



Smoking

The main cause of COPD is smoking. The likelihood of developing COPD increases the more you smoke and the longer you have been smoking¹⁵. Once you give up smoking, you gradually reduce the chances of getting COPD – and you slow down its progress if you already have it. Occupational factors, such as coal dust, and some inherited problems can also cause COPD. Whether pollution is a factor is under investigation.¹⁶

It is difficult to get an accurate figure for smoking prevalence at a local level without a robust local survey. Using the national Integrated Household Survey the latest estimate for Southampton is that 22.3% of adults smoke, which is not significantly different from the England average of 21.2%. However, smoking prevalence in the city amongst people classified in the ‘routine and manual’ socio-economic group is estimated to be 35.6%, which is significantly higher than the national average of 29.7%.

It is largely because of this disparity in smoking rates by socio-economic group that men between 20 and 64 in unskilled manual occupations are 14 times more likely to die of COPD than men employed in professional roles¹⁷.

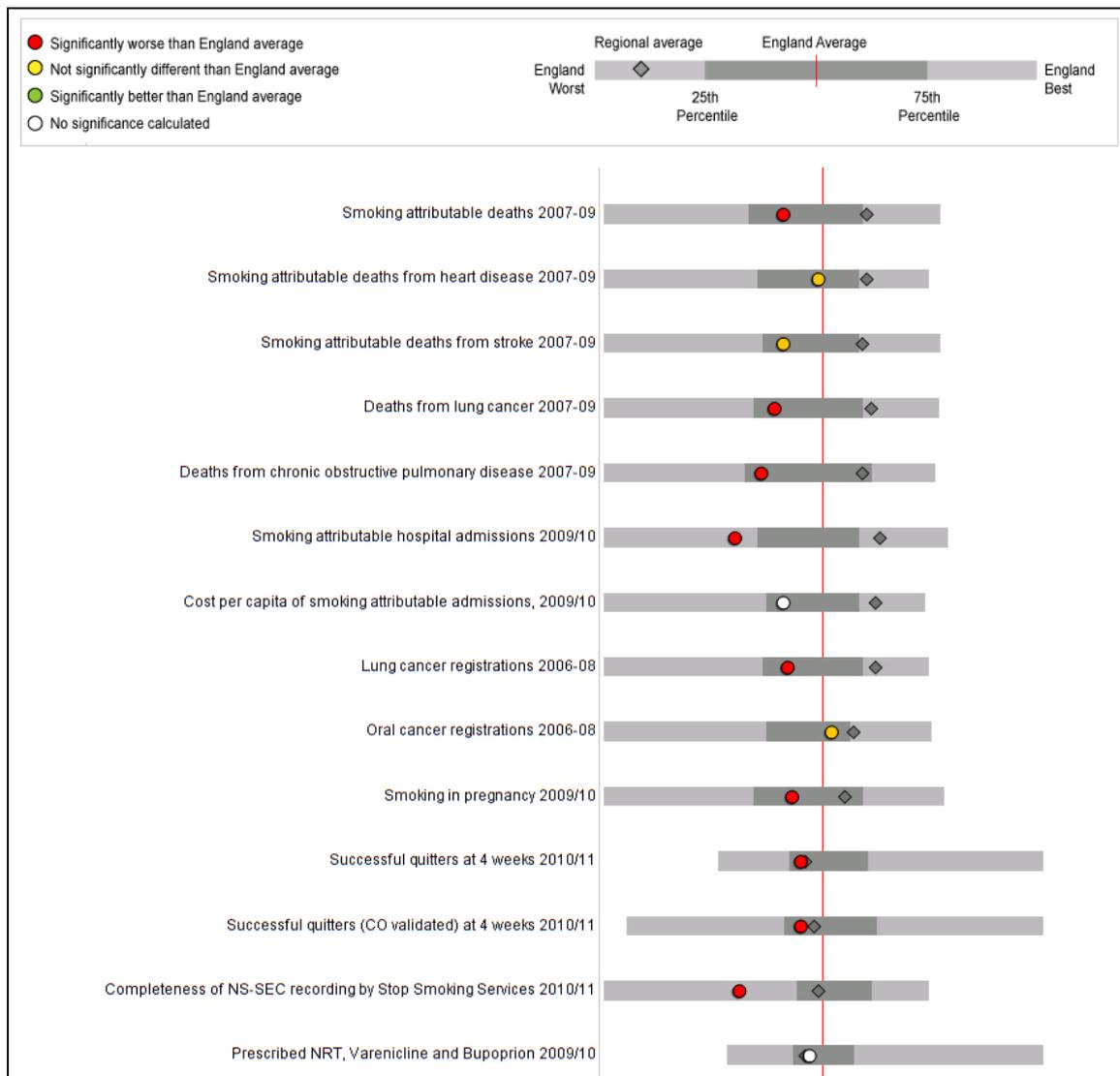
¹⁵ <http://www.nhs.uk/conditions/chronic-obstructive-pulmonary-disease/Pages/Introduction.aspx> accessed 02/08/2011

¹⁶ British Lung Foundations <http://www.lunguk.org/you-and-your-lungs/conditions-and-diseases/copd.htm> access 02/08/2011

¹⁷ Health Inequalities National Support Team (2011) Systematic Approach to Delivering Management of COPD to have a Population Level Impact.

The London Health Observatory regularly produces Local Tobacco Control Profiles¹⁸ to support the NHS and other local agencies in monitoring the impact of tobacco on local communities and assessing the services and initiatives that have been put in place to tackle tobacco-related problems. The latest Tobacco Control profile for Southampton is presented below and clearly shows that the city scores significantly worse than the national average for the majority of the indicators. For instance, Southampton had the highest rate of smoking-related hospital admissions in the South East region in 2009/10.

Figure 10: Tobacco control profile for Southampton (January 2012)



Spend and outcomes

In 2009/10 Southampton City PCT spent £3 million (0.7% of total expenditure) on Obstructive Airways Disease. This equates to a rate of £1.2 million per 100,000 population which is similar to the ONS cluster¹⁹ average of £1.3 million per 100,000. The three 'bubble diagrams' presented at the start of this report show how respiratory disease causes a high

¹⁸ http://www.lho.org.uk/LHO_Topics/Analytic_Tools/Tobaccocontrolprofiles/

¹⁹ ONS 2001 Classification of Areas www.statistics.gov.uk

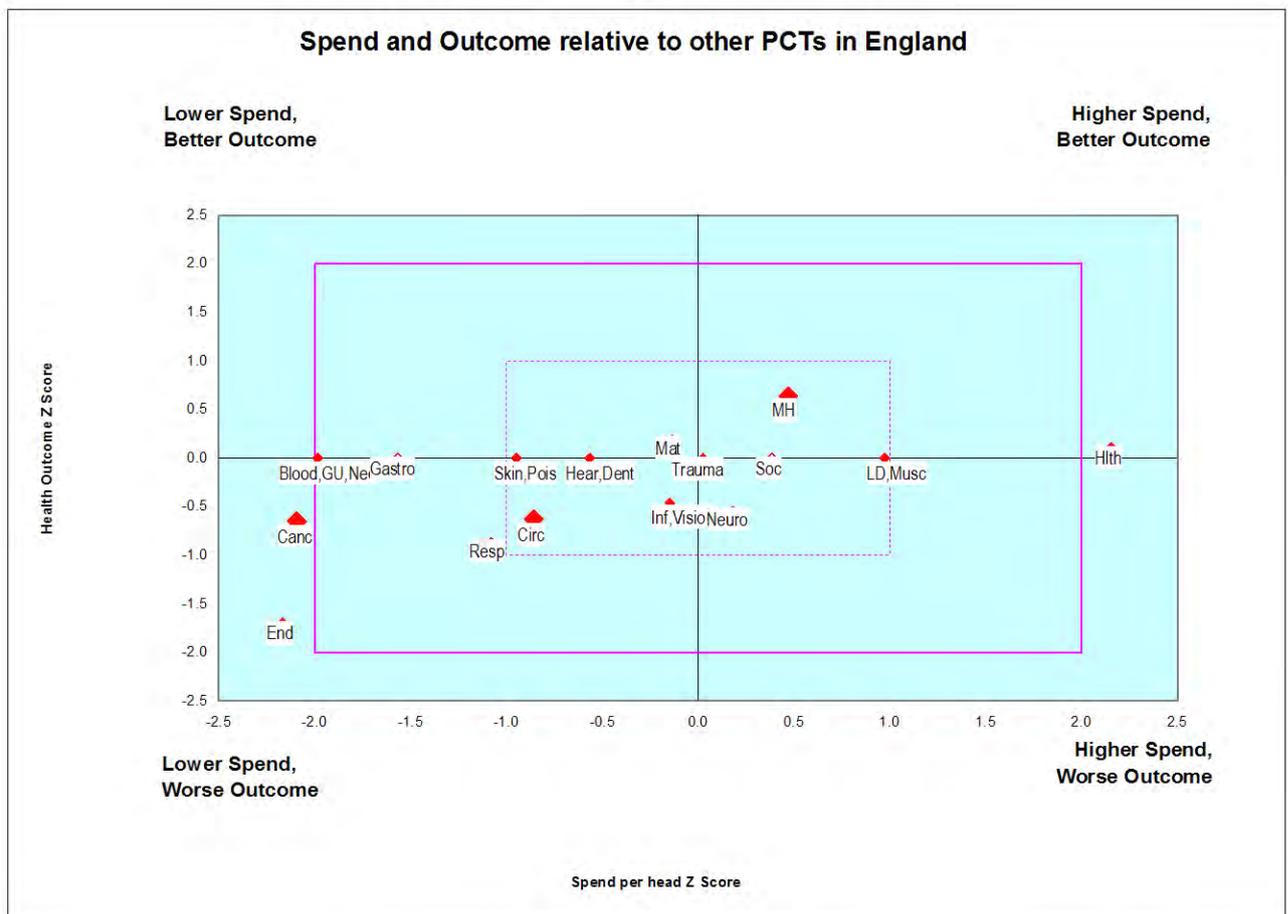
proportion of ill health and disability in the city but uses relatively lower proportions of the healthcare budget.

We have used the Association of Public Health Observatories Spend and Outcome tool²⁰ to look at spend on respiratory disease in Southampton and the outcomes, in terms of mortality, compared to other PCTs. The chart below shows that relative to all PCTs in England the city is in the 'lower spend, worse outcome' quadrant for respiratory disease. In 2009/10 Southampton spent £72 per weighted head of population on respiratory disease compared with £84 nationally and £87 on average across its ONS peers.

Figure 11: Southampton spend and outcome relative to other PCTs in England 2009/10



Southampton City PCT 2009/10



◇ No outcome indicators readily available
 ◆ Outcome indicators available

Programme Area Abbreviations

Infectious Diseases	Inf	Hearing	Hear	Disorders of Blood	Blood
Cancers & Tumours	Canc	Circulation	Circ	Maternity	Mat
Respiratory System	Resp	Mental Health	MH	Neonates	Neo
Endocrine, Nutritional & Metabolic	End	Dental	Dent	Neurological	Neuro
Genito Urinary System	GU	GI System	Gastro	Healthy Individuals	Hlth
Learning Disabilities	LD	Musculoskeletal	Musc	Social Care Needs	Soc
Adverse effects & poisoning	Pois	Trauma & Injuries	Trauma		

²⁰ <http://www.yhpho.org.uk/resource/view.aspx?RID=49488>

Source: Association of Public Health Observatories Spend and Outcomes Tool

Experian have used their MOSAIC data to develop models to predict how a change in future smoking behaviour will impact hospital admissions for COPD²¹. They produced forecasts of the cost of COPD by PCT area for 2015 given the Department of Health's national ambition to reduce the English smoking population to 18.5%. According to this work, in 2015 Southampton PCT is forecast to have the highest cost of COPD admissions per thousand head of population at £10,643. This is followed by Knowsley (£9,175) and Liverpool (£8,901).

Nationally 20% of hospital admissions are due to respiratory disease with readmission rates within 28 days as high as 33%²². Mortality is particularly high in those who are hospitalised; one in six will die during an emergency admission, and one in 12 will die within three months²³. The recently published NHS Atlas of Variation shows that hospital admission rates for COPD in Southampton are amongst the highest in the country http://www.rightcare.nhs.uk/atlas/downloads/Respiratory_AoV_2011.pdf

The Department of Health has done some work looking at the true prevalence of COPD by severity category and then relating this to the cost to the NHS²⁴. The table below shows the estimated breakdowns:-

Table 1: Prevalence of COPD by severity and annual cost to NHS per lung disease patient

Global Initiative for Chronic Obstructive Lung Disease (GOLD) Severity	% of lung disease cases	% undiagnosed	Average annual Cost to NHS per lung disease patient (£)
Mild	31.75	100	98
Moderate	39.82	79.34	1021
Severe	23.37	59.9	3944
Very severe	5.06	7.34	6475
Total	100	77.7	

This work assumes an underlying prevalence of COPD amongst the 16+ age group of 8.2% which for Southampton would mean 16,515 people (of which 32% would be mild and undiagnosed).

What can be done about it?

The Department of Health is in the process of finalising a strategy for COPD services in England. Key aims of this strategy include recommendations on achieving enhanced early

²¹ Sparks, E. (2011) Local Forecast: predicting healthcare demand and targeting interventions. *Health Services Journal* August 2011 <http://www.hsj.co.uk/resource-centre/best-practice/public-health-resources/local-forecast-predicting-healthcare-demand-and-targeting-interventions/5033127.article>

²² Health Inequalities National Support Team (2011) Systematic Approach to Delivering Management of COPD to have a Population Level Impact.

²³ Right Care Atlas of Variation 2011 <http://www.rightcare.nhs.uk/index.php/atlas/atlas-of-variation-2011/>

²⁴ NHS Improvement –Lung Health Action Plan <http://www.improvement.nhs.uk/lung/PreventionandEarlyIdentification/tabid/154/Default.aspx>

warning and interventionist approaches designed to either stop people getting COPD, or on improving outcomes for those already diagnosed with the condition. Locally we need to develop programmes and initiatives to incorporate these national strategy objectives.

A clear message is that although smoking cessation will make the biggest impact at a population level this cannot be the only strategy employed. The benefits of smoking cessation are long term and so other actions are needed to realise more immediate benefits to society and cost-savings to the NHS. These include better medicine adherence and inhalation technique, risk mitigation in the workplace, enhanced physical activity programmes and building personal motivation. There needs to be good equitable provision of pulmonary 'lung' rehabilitation services including psychosocial aspects.

Southampton needs to adopt the two pronged strategy being developed by central government – prevention and early identification. Table 1 demonstrates the clinical and cost effectiveness of treating COPD at the mild and moderate stages compared to the more severe stages.

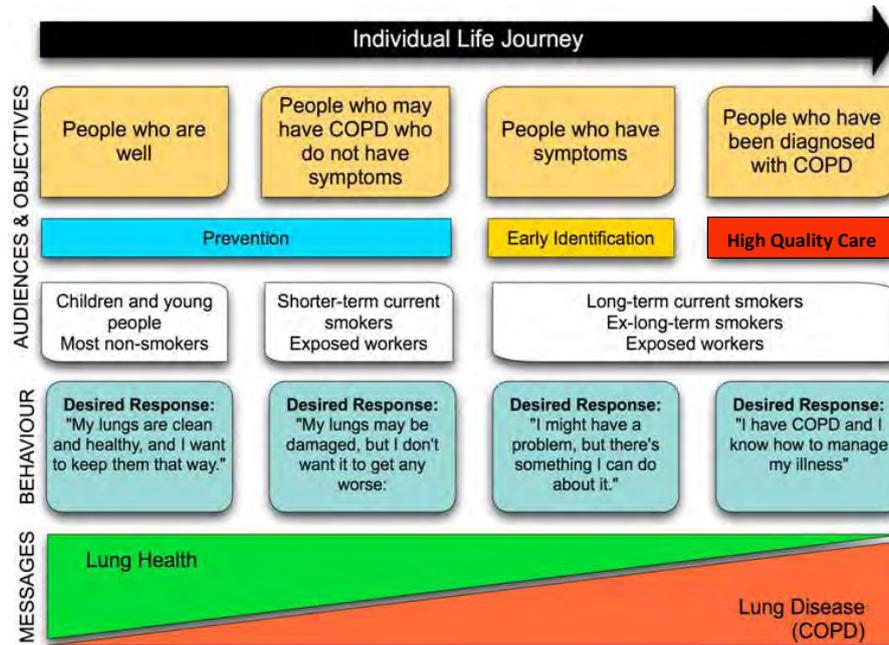
In order to find those people in the city who are undiagnosed we need to improve understanding of lung health and develop a local 'listen to your lungs' campaign. This should be putting the message across that there are audible symptoms (persistent cough or wheeze) that can tell us when something is wrong with our lungs – none of these should be accepted as part of everyday life.

Of course lung disease affects different communities disproportionately so we need to make good use of the segmentation and social marketing tools that we have available in order to target messages most appropriately.

The diagram below from the Department of Health²⁵ shows how approaches need to be tailored to at risk audiences:-

²⁵ Department of Health (2010) COPD Prevention and Early Identification Strategy
<http://www.improvement.nhs.uk/lung/PreventionandEarlyIdentification/tabid/154/Default.aspx>

Figure 12: Approaches for at risk audiences



Letting people know their 'lung age' can have a very powerful impact on behaviour change. A study by Parkes (2008)²⁶ found that, used as part of a smoking cessation intervention, 13.6% of people who had their lung function measured (spirometry) and this converted to the equivalent 'lung age' were still not smoking at 12 months compared with 6.4% of those who had not.

A key message to get across is that diagnosis of lung disease is not bad news, as the longer you leave a cough the worse it gets and once diagnosed you can start treating it. For those people with mild lung disease the immediate response should be to encourage quitting smoking and increasing physical activity. Lungs, like our skeletal muscles, need exercise to stay fit.

We need to ensure our healthcare workforce has the information and equipment they need to raise awareness and increase diagnosis. For instance, the spirometry equipment should be linked to computers, staff must be fully trained on how to use it and it should be regularly tested.

Recommendations

- Promote greater understanding of lung health, lung disease and symptom recognition across both primary and secondary care
- Unite and engage critical partners providing them with the right tools to deliver the 13 NICE quality standards for COPD²⁷

²⁶ Parkes G. (2008) Telling smokers their "lung age" promoted successful smoking cessation. *Evid Based Med* 2008;13:104

²⁷ NICE COPD Quality Standard

www.nice.org.uk/guidance/qualitystandards/chronicobstructivepulmonarydisease/copdqualitystandard.jsp

- Target those specifically at risk with education and self-management and help to deliver 'behaviour change' through use of insightful triggers and motivation
- Establish appropriate interventions such as lung function testing to help detect lung problems earlier
- Build an activation programme to engage 'catalyst' partners particularly the Clinical Commissioning Groups (CCG), GP practices and secondary care
- Use the REACT approach to coordinate efforts of the NHS, patients, social care and the voluntary sector to help people avoid lung disease, particularly COPD and asthma, and to lead healthier, longer lives:
 - Respiratory health and good lung health
 - Early accurate diagnosis
 - Active partnership (as above)
 - Chronic disease management (good symptom control, education, self management and care plans)
 - Targeted evidence-based treatment for the individual including pulmonary rehabilitation
- Audit new care pathways to ensure there is a reduction in inappropriate hospital admissions, better prevention, reduction in premature deaths, improved quality of life, safe and effective care, reduced inequalities and access to quality services
- Early discharge schemes and hospital-at-home services should be commissioned to support evidence-based admission avoidance
- There needs to be prompt support for patients when they develop new or worsening symptoms, with early access to specialist-led multidisciplinary team care in the community when appropriate
- A structured approach to admissions is needed with timely assessment and treatment, comprehensive management of COPD and co-morbid conditions, regular review by specialist respiratory team and early discharge planning
- Previous initiatives should be further developed; for example, the health checks held in the city in collaboration with Diabetes UK which should be modified and held in collaboration with the British Lung Foundation.
- Better use must be made of intelligence around COPD such as using dashboards (as described by the Health Inequalities National Support Team²⁸), using local resources such as practice profiles or national resources such as www.inhale.nhs.uk. This type of intelligence should be used to support practices where maximum QOF points are not being achieved, looking at prescribing costs data alongside outcomes data to ensure cost-effective as well as effective practice.

²⁸ Health Inequalities National Support Team How to develop an ongoing programme of GP chronic disease management audits using a z-score-based 'dashboard'
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_115096.pdf

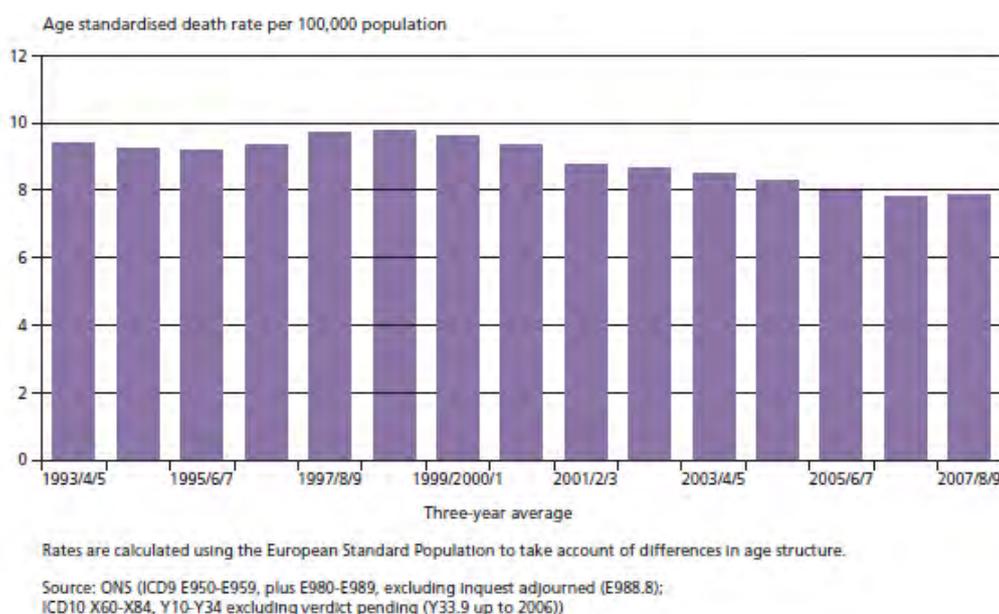
SUICIDE

What is the issue?

The burden of suicide is a tragedy. Its impact can be devastating psychologically and spiritually as well as economically for all those affected. There were 4,390 suicides in England in 2009 which translates to one death by suicide every two hours. Every suicide affects a number of people around the individual, directly and indirectly.

Encouragingly, national statistics suggest that rates of death from suicide are reducing. However, we cannot be complacent in our action. We are living in a time of economic recession; suicide rates have tended to rise during periods of high unemployment or economic uncertainty. Furthermore, suicides tend to happen younger in life so the number of life years lost is high. In 2007-09, suicide had a higher rate of years of life lost than diseases such as stroke, skin cancer and stomach cancer.

Figure 13: Death rates from intentional self-harm and injury of undetermined intent: England 1993-2009



The government recognises the importance of this issue and has highlighted areas for action. Most recently, it has proposed that suicide prevention public health activities should be the responsibility of local authorities working with local health and wellbeing boards.

In 2011, a new government suicide prevention strategy for England was launched. Its aim is to reduce the suicide rate further and improve support for those bereaved or affected by suicide. The consultation period for this strategy closed in October 2011 and the final strategy should be published Spring/Summer 2012.

Earlier in 2011 the government published 'No Health Without Mental Health' which sets out a programme of local and national action to improve not only the care of people with mental health problems but also the mental health and wellbeing of the population. They

state that improving the wellbeing of the population is fundamental to preventing suicide. The fear of stigma attached to mental health problems can in turn lead to a greater sense of isolation and despair which could lead people to take their own lives. The national campaign 'Time to Change'²⁹ aims to end discrimination faced by people suffering mental illness.

There are a number of risk factors associated with suicide. Mental illness has the largest impact. Repeated self-harm is one of the strongest predictors. Around 10% of those who present to hospital following an act of self-harm commit suicide within 10 years. Furthermore, the risk of suicide is increased threefold in those who self-harm regularly³⁰. Other key risk factors are unemployment, drug and alcohol abuse.

Suicide prevention strategies can be population- or intervention-based strategies in high risk groups. Effective population-based strategies include: restriction of access to means of suicide (e.g. alcohol and toxic 'over-the-counter' medicines), media guidelines on reporting suicides, and training primary care workers in screening and detection of patients with a high risk of suicide. Intervention based strategies appear to be less successful but psychological interventions such as cognitive behaviour therapy have some impact³¹.

Southampton context

A note about the data:

All deaths suspected as suicide must be certified by a coroner's inquest. A coroner records a verdict of suicide when they have decided that there is evidence beyond reasonable doubt that the injury was self-inflicted and the deceased intended to take their own life. Open verdicts include cases where the evidence available to coroners is not sufficient to conclude that the death was a suicide (beyond reasonable doubt) or an accident (on balance of probability). They include those where there may be doubt about the deceased's intentions. Open verdicts are generally coded by the Office for National Statistics (ONS) as deaths from injury or poisoning of undetermined intent. When we use the ONS data we combine suicides and undetermined deaths because research has shown that most open verdicts are likely to be suicides.

Our local data on suicide deaths comes from two sources: firstly, an audit conducted in early 2011 using coroner's records for suicide deaths 2007-09 and secondly, the ONS death registrations. These two data sources will be slightly different because the Coroner's data only covers suicides amongst Southampton residents that occurred within the city whereas the ONS data includes data on suicides amongst Southampton residents wherever they occurred.

The number of deaths from suicide in Southampton is relatively small and because of this there is likely to be much year-on-year variability and the confidence intervals around suicides rates are large. This makes it difficult to draw conclusions about trends and differences between population groups. To try and increase the statistical validity of our analysis we often aggregate the data over three or five years.

²⁹ <http://www.time-to-change.org.uk/home/>

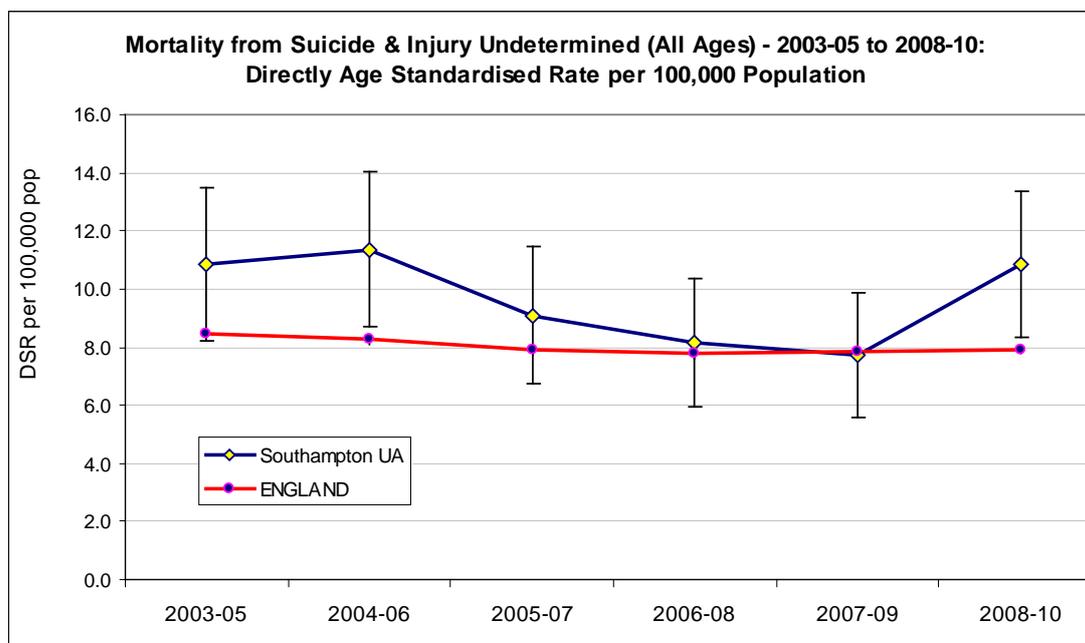
³⁰ Butler J.& Longhitano, C. Self Harm .*Psychiatric aspects of general medicine* 2008, 36:9, p455-458.

³¹ Ougrin D., Taylor K., Banarsee R., Dunn-Toroosian V. & Majeed A. Suicide survey in a London borough: primary care and public health perspectives *Journal of Public Health* 2010, 10.1093

Trends

Over the period 2008-10 there were an average of 26 suicides every year amongst Southampton residents. The chart below shows how suicide rates in Southampton have changed over the past few years (compared with the national average). In the latest period (2008-10) suicide rates in the city were significantly higher than the national average.

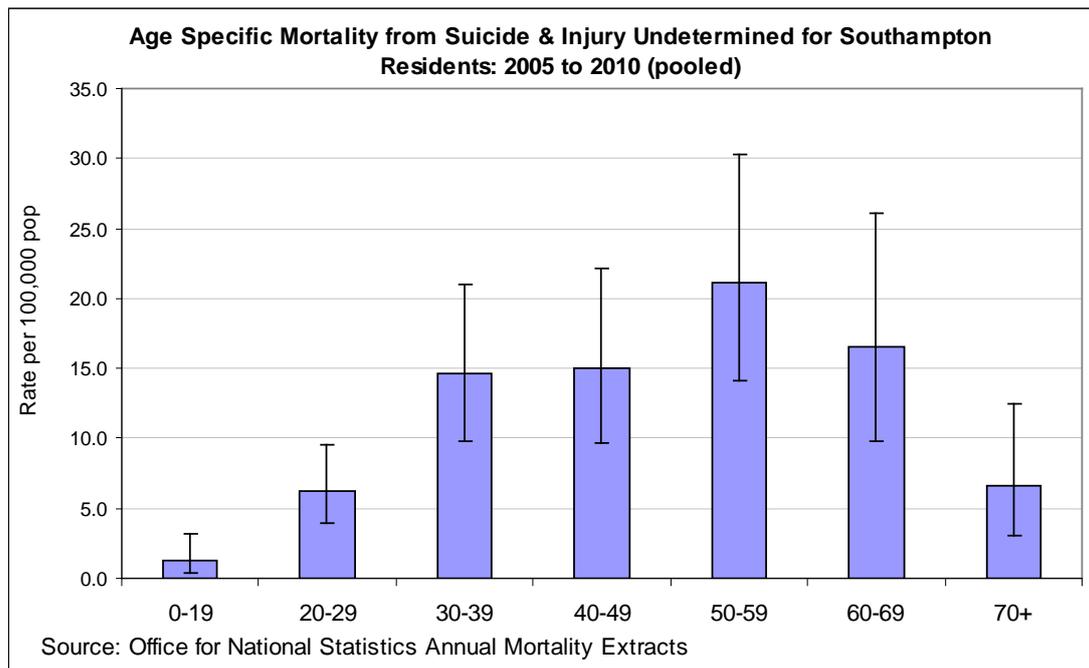
Figure 14: Suicide Rates: Southampton and England 2003-05 to 2008-10



Suicide risk is not equal across all population groups. Nationally men are three times more likely than women to take their own lives and in Southampton this is also the case with 103 males compared to 32 females committing suicide over the 2005-10 period (this equates to age standardised rates of 14.7 per 100,000 for males compared to 4.6 per 100,000 for females).

Across England people aged 40-49 years now have the highest suicide rate. The situation in Southampton follows a similar pattern as the chart below shows. Although rates were slightly higher in the 50-59 group over the period studied the confidence intervals are very large and the only definite conclusion we can draw is that rates of suicide are significantly lower amongst people aged less than 30 or over 70 years.

Figure 15: Suicide mortality rates by age: Southampton 2005-10 (pooled)



Risk factors

As described, a history of mental illness is clearly a major risk factor for suicide. The coroner’s audit in Southampton revealed that 36% of cases had a history of mental health disorders or depression, 45% had attempted suicide in the past and 48% had contact with mental health services in the past 12 months.

There is also evidence nationally that other groups are at higher risk of suicide. For instance, sexual orientation has been found to be a risk factor³² and there are known differences in suicide risk amongst black and minority ethnic groups in the UK, with a particularly high risk of suicide in young Asian women³³. However, because information on these characteristics is not well recorded there is no local intelligence on suicide amongst these population groups.

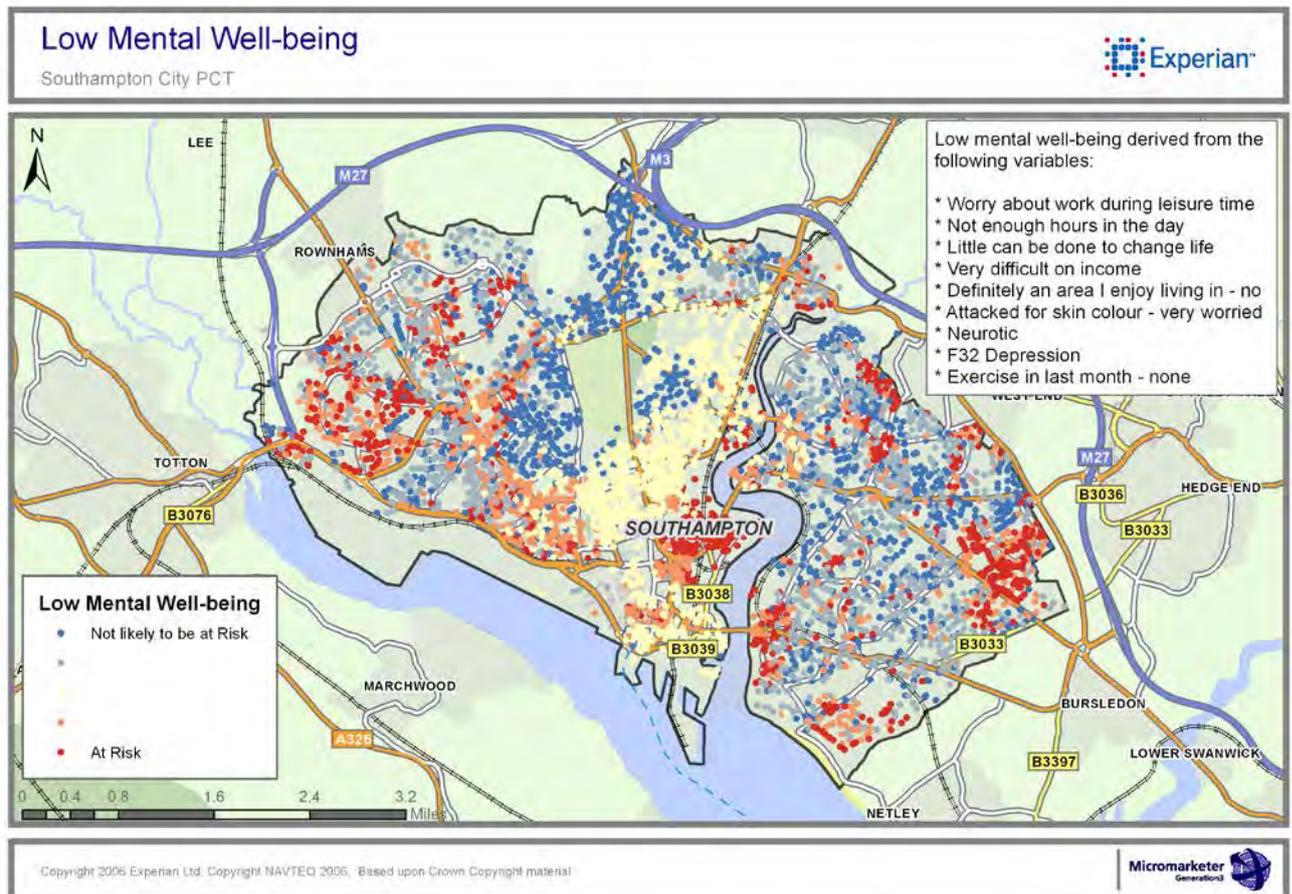
NHS Southampton has worked with a company called Experian to profile or ‘segment’ the population of Southampton in order to better understand people’s lifestyles and the methods of communication they may respond to. Through this work we have developed a ‘mental wellbeing score’ at postcode level and the following map shows where in the city populations most at risk of low mental wellbeing may live (red on the map indicates most likely to be at risk of low mental wellbeing whereas blue indicates least likely). It is important to bear in mind that this type of exercise can only make generalisations about the

³² National Institute for Mental Health in England (2007) Mental disorders, suicide, and deliberate self-harm in lesbian, gay and bisexual people a systematic review <http://www.nmhd.org.uk/silo/files/mental-disorders-suicide-and-deliberate-selfharm-in-lesbian-gay-and-bisexual-people.pdf>

³³ Centre for Health Improvement and Minority Ethnic Services (2007) Suicide Prevention for BME groups in England <http://www.nmhd.org.uk/silo/files/executive-summary-suicide-prevention-for-bme-groups-in-england.doc>

populations of the different parts of the city and individual households will only 'approximate' to a category rather than match exactly.

Figure 16: Map showing mental risk of low mental wellbeing in Southampton

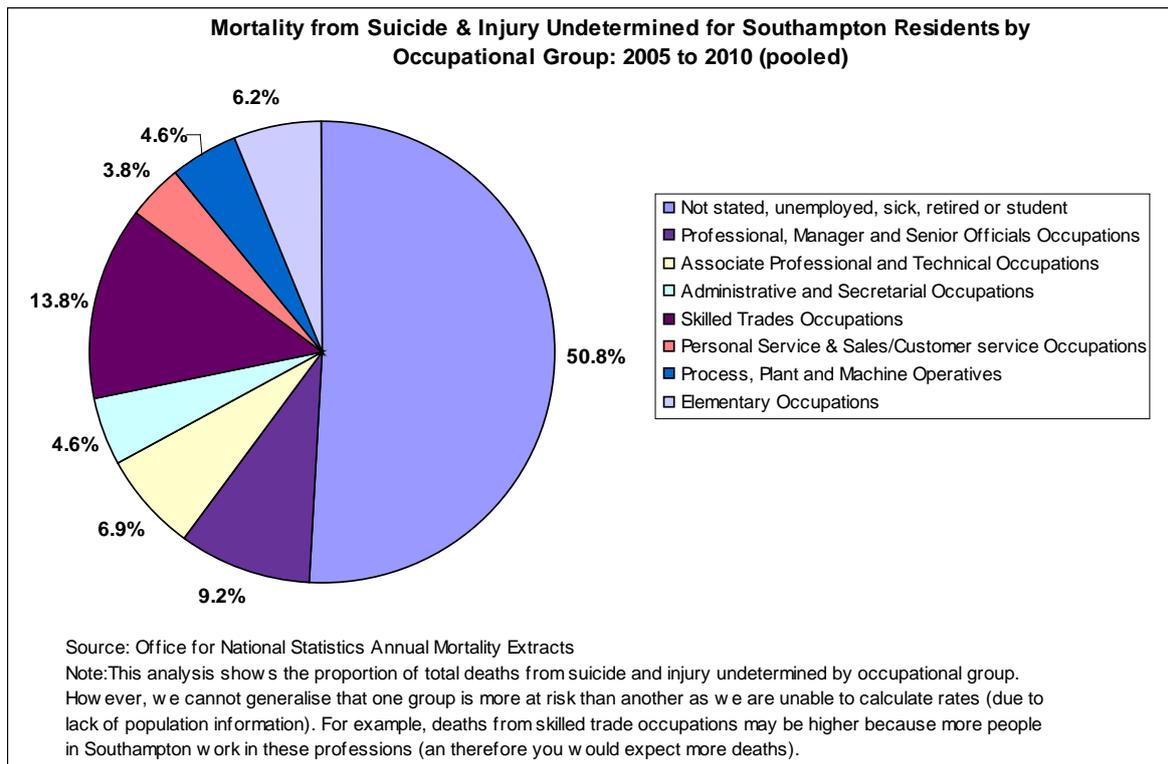


Those people bereaved by suicide are at increased risk of suicide themselves³⁴ and other stressful life events can also be risk factors – for instance loss of a job, imprisonment, debt, living alone and family breakdown. The local audit found that 59% of suicide victims in Southampton were single or separated.

The occupational group of the suicide victim is recorded in the death registration for those aged under 75 years. It is not possible to calculate suicide rates by occupational group because of the lack of a population denominator for each category. The chart below shows suicides in Southampton by occupational group; it can be seen that just over half were not stated, unemployed, sick, retired or students. Because of the large number in this category and the difficulty in calculating rates it is very difficult to draw conclusions locally about the link between suicide and socio-economic group.

³⁴ Ubido J. & Scott-Samuel A. Merseyside Mental Health Needs Assessment Liverpool Public Health Observatory, Observatory report series no. 86 August 2011

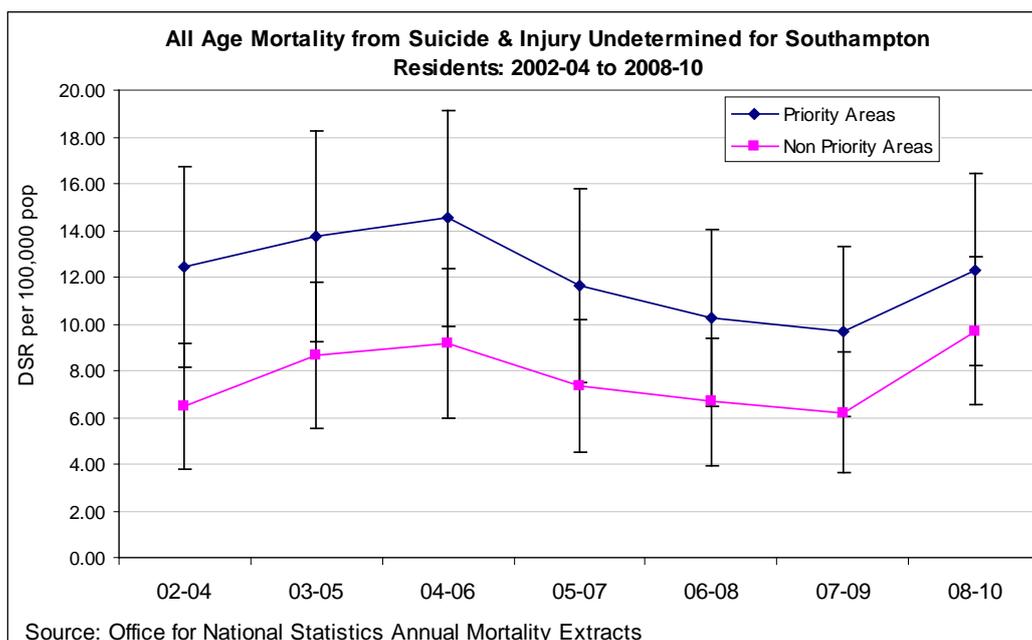
Figure 17: Number of suicides in Southampton by occupational group: 2005-10 (pooled)



One way to explore the link between socio-economic group and suicide rate is to calculate rates within the 11 priority neighbourhoods³⁵ compared to the rest of the city. The following chart shows how suicide rates in the priority areas of the city have been consistently higher than elsewhere although the large confidence intervals mean that this is not a statistically significant finding.

³⁵ The 11 neighbourhoods identified as a 'priority' for action in Pearce, H. (2002) Southampton Local Neighbourhood Renewal Strategy Part 1: The neighbourhood renewal vision for Southampton. See <http://www.southamptonhealth.nhs.uk/aboutus/publichealth/improvement/healthstrategies/lnrs/>

Figure 18: Suicide rates in priority vs non-priority areas of Southampton: 2002-04 to 2008-10



Suicide in the context of serious physical illness has become a major issue recently as growing numbers of people with chronic or terminal illness travel abroad for assistance with suicide. Demos has conducted research into this through a series of Freedom of Information requests to primary care trusts in England³⁶. Their findings provide a strong argument that people with chronic and terminal illnesses should be considered a ‘high risk group’ for suicide within national policy. The local audit was unable to link the coroner’s data to health records so we cannot estimate the number of suicide victims in the city who were suffering from long term or terminal illness. This has recently been undertaken in a London Borough where, of 38 cases with traceable primary care records, 45% had a chronic illness and 26% were in chronic pain³⁷.

Method

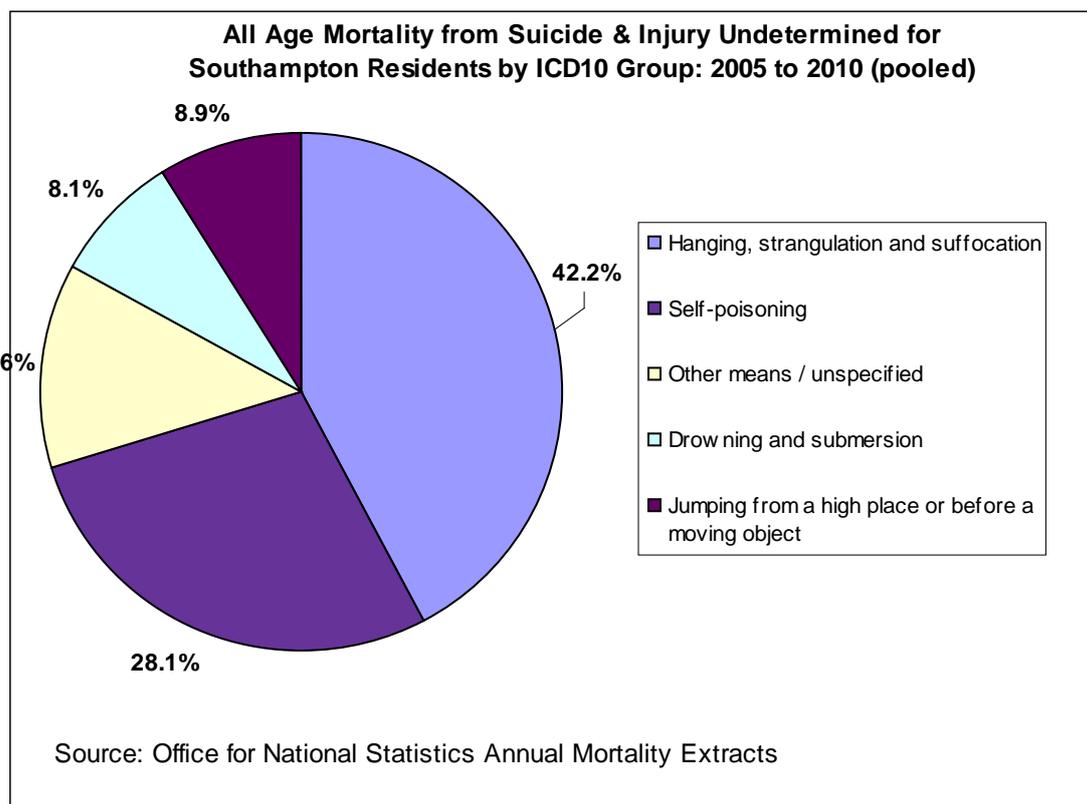
Nationally, the category ‘hanging, strangulation and suffocation’ is the most common method of suicide for men, accounting for more than half of all male suicide deaths. For women hanging, strangulation and suffocation is also now the most common method, with drug-related poisoning a close second.

In Southampton, analysis of method has not been split by gender because of the small numbers involved. As the chart below shows, over the 2005-10 period 42% of suicides in the city were through hanging, strangulation and suffocation, with 28% due to self-poisoning. Data from the coroner’s audit showed that in Southampton 49% of suicide deaths occurred at home.

³⁶ Bazalgette L., Bradley W. & Ousbey J. Truth about Suicide Demos 2011

³⁷ Ougrin D., Taylor K., Banarsee R., Dunn-Toroosian V. & Majeed A. Suicide survey in a London borough: primary care and public health perspectives *Journal of Public Health* 2010, 10.1093

Figure 19: All age mortality from Suicide and Injury Undetermined for Southampton Residents 2005-10



Self-harm and attempted suicide

The Adult Psychiatric Morbidity Survey (APMS) for England³⁸ found in 2007 that overall 16.7% of people reported in the self-completion part of the survey had thought about committing suicide at some point in their life; 5.6% said that they had attempted suicide, and 4.9% said that they had engaged in self-harm. The prevalence of each broadly declined with age.

It is obviously very important to think about the people in the city who have attempted suicide although this is rather more difficult to get data on because of the many different diagnoses that these people may be given on presenting in a healthcare setting.

The APMS 2007 describes how official statistics on recorded suicides (official suicides and undetermined deaths) provide a profile of people who have committed suicide, but cannot provide detail about their lifetime experiences or precise socio-demographic circumstances. Research with people who have attempted suicide can provide more in-depth data, but excludes those people, mostly male, who commit suicide at the first attempt. There is therefore a need to look at suicidal thoughts, as well as attempts.

Locally we have looked at data on hospital admissions for self-harm. The Oxford Centre for Suicide Research³⁹ defines deliberate self-harm (DSH) as “intentional self-injury or self-

³⁸Adult Psychiatric Morbidity in England, 2007: results of a household survey

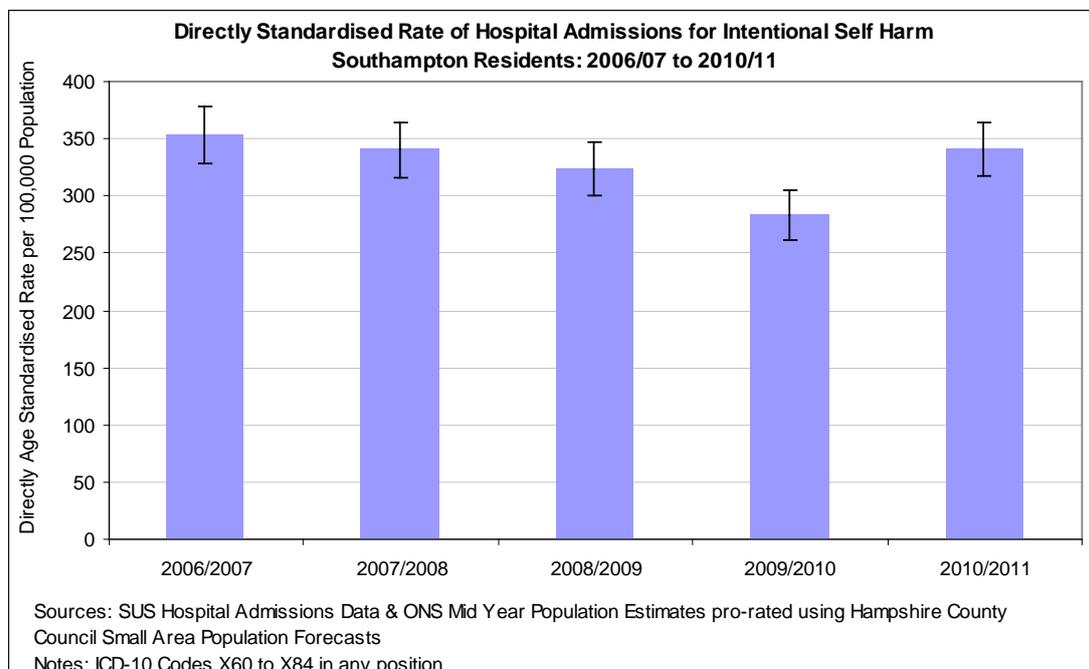
<http://www.ic.nhs.uk/pubs/psychiatricmorbidity07>

³⁹ University of Oxford, Centre for Suicide Research <http://cebmh.warne.ox.ac.uk/csr/>

poisoning, irrespective of type of motivation or degree of suicidal intent”, thus this definition encompasses both suicide attempts and acts with other motives or intentions. The charity MIND⁴⁰ explains that self-harm can be about trying to stay alive – a coping mechanism for survival, and to escape from emotional pain. The majority of people who self-harm are not suicidal, but a small minority will intentionally attempt suicide. Some suicides resulting from self-harming behaviour may be accidental, occurring when someone has hurt themselves more than they intended to.

Self-harm is one of the most frequent reasons for admission to hospital and accounts for around 170,000 attendances at UK Emergency Departments each year⁴¹. The chart below shows the rate of hospital admissions for self-harm amongst Southampton residents over the past few years. On average there were 820 admissions for self-harm a year over the 2006/07 to 2010/11 period and this equates to an average of 624 people being admitted because some individuals have repeated admissions for self-harm.

Figure 20: Directly Standardised Rate of Hospital Admissions for Intentional Self Harm



Individuals admitted to hospital for self-harm tend to have a very young age profile – over the 2006/07 to 2010/11 period nearly 50% of the individuals were aged between 15 and 29 years.

Support services

In getting a full picture of the suicide risk amongst Southampton’s population it is also very important to include information from the voluntary sector organisations in the city who offer help and services to people with mental health needs. For instance, the Southampton

⁴⁰ MIND website <http://www.mind.org.uk/>

⁴¹ Kapur N, House A, Creed F, Feldman E, Friedman T, Guthrie E. Management of deliberate self poisoning in adults in four teaching hospitals: descriptive study. *BMJ* 1998; **316**: 831–32.

Samaritans answered 33,419 calls (from the Southampton area which is slightly wider than the city boundaries) during the 12 month period ending 30th June 2011. Of these 14,302 were silent and 19,117 were dialogue calls. Nationally, the Samaritans record that 20% of all dialogue calls express suicidal thoughts – this would equate to 3,823 calls with suicidal thoughts in the Southampton area over the year.

Nationally, over the period 2006-2010, the Samaritans report that the proportion of callers feeling suicidal but having made no plan increased from 14.0% to 15.9%, callers feeling suicidal and having made a plan increased from 3.2% to 3.8% and the proportion of callers where suicide was in progress remained stable at around 0.6%. Suicidal feelings are expressed in a higher proportion of contacts made by email (42.9%) and text message (52.2%) than over the phone.

APMS for England found that in 2007 63% of men and 58% of women who reported having attempted suicide said that they had sought help following the last attempt. The most common sources of help sought were a GP or family doctor, hospital or other specialist medical or psychiatric service, and family, friends or neighbours. This highlights the importance to engaging all parts of the health and social care system in action against suicide as well as communicating key messages to the wider population.

What can be done about it?

Action Against Suicide

National and local data suggest that prevention efforts should be at the level of society and the NHS. Societal measures include better employment, education and housing. Access to means of suicide can be reduced by safety adaptations of the physical environment. However, as we found from the local audit, many individuals take their lives within their homes.

A key finding both locally and nationally is the need for stronger engagement between agencies to support high risk individuals, their carers and survivors, and share data in the event of a death. Through stronger partnership, better support mechanisms can be developed to prevent and delay future suicide cases.

Six areas of action have been proposed by the government to achieve a reduction in suicide rates and provide better support for those bereaved or affected by suicide:

1. Reduce the risk of suicide in key high-risk groups
2. Tailor approaches to improve mental health in specific groups
3. Reduce access to the means of suicide
4. Provide better information and support to those bereaved or affected by a suicide
5. Support the media in delivering sensible and sensitive approaches to suicide and suicidal behaviour
6. Support research, data collection and monitoring.

The Demos report concluded that in order to better understand the interaction between suicide, physical illness and other characteristics such as mental health or level of social

support, better monitoring of suicides is essential. The report made the following key recommendations:

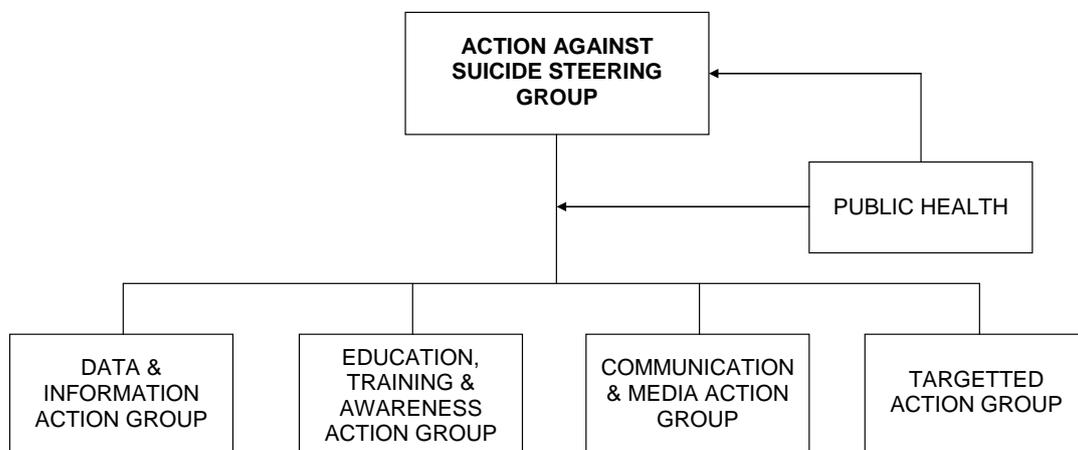
- Make local suicide audits a requirement (via Health and Wellbeing Boards)
- Improve guidance on suicide audits for health commissioners
- Clarify coroners’ duty to share information
- Computerise inquest records
- Legislate to improve quality of inquest records
- ONS to provide detailed reporting of suicide trends.

The data on suicide method and location reveals a high proportion through hanging and strangulation and a high proportion at home. This means that preventative intervention at the time of the event is highly unlikely for many cases.

Southampton’s public health response will be in line with these proposals. A workshop was held in July 2011 to present the findings of the local coroner’s audit and to map out a way forward for suicide prevention. Attendees at the workshop included NHS mental health provider services, voluntary sector organisations, primary care professionals and counselling services. The output from the day was a plan for ‘Action Against Suicide’ (AAS) in the city which is presented diagrammatically below. It consists of a strategic group facilitated by the public health team at NHS Southampton City and supported by a number of action groups:

Figure 21

ACTION AGAINST SUICIDE STEERING GROUP AND SUB GROUP INFORMATION



The AAS group has the following goals:

1. Reduce risk in key high risk groups and communities
2. Promote mental wellbeing in wider population
3. Reduce availability of suicide methods
4. Improve reporting of suicidal behaviour in media (link with stigma work-streams)
5. Learn from adverse incidents/investigations/cases
6. Focus on prevention
7. Support survivors/families/bereaved families.

The latest NICE guidance⁴² suggests that psychological interventions should be offered to people who self-harm to help them overcome their behavioural issues. It states that healthcare professionals should offer three to 12 sessions of a psychological intervention that is specifically structured for people who self-harm.

Recommendations

- Awareness should be promoted that suicide is a preventable public health problem
- More should be done to reduce the stigma associated with accessing mental health, self-harm and suicide prevention services
- More training on suicide prevention and awareness should be provided for staff in a range of front line services
- Regular audits of suicide should be carried out but only if coroner's records are made more consistent and accessible as recommended by the Demos report
- Further improvements are needed to the way services link with each other and work in a joined-up way
- To facilitate joined-up working, the issues of confidentiality and data sharing between services need to be clarified. This could be done through adoption of a data sharing protocol across the city.

⁴²<http://www.nice.org.uk/newsroom/news/OfferPsychologicalInterventionsToPeopleWhoSelfharm.jsp>

THE HEALTH IMPACTS OF COLD HOMES AND FUEL POVERTY IN SOUTHAMPTON

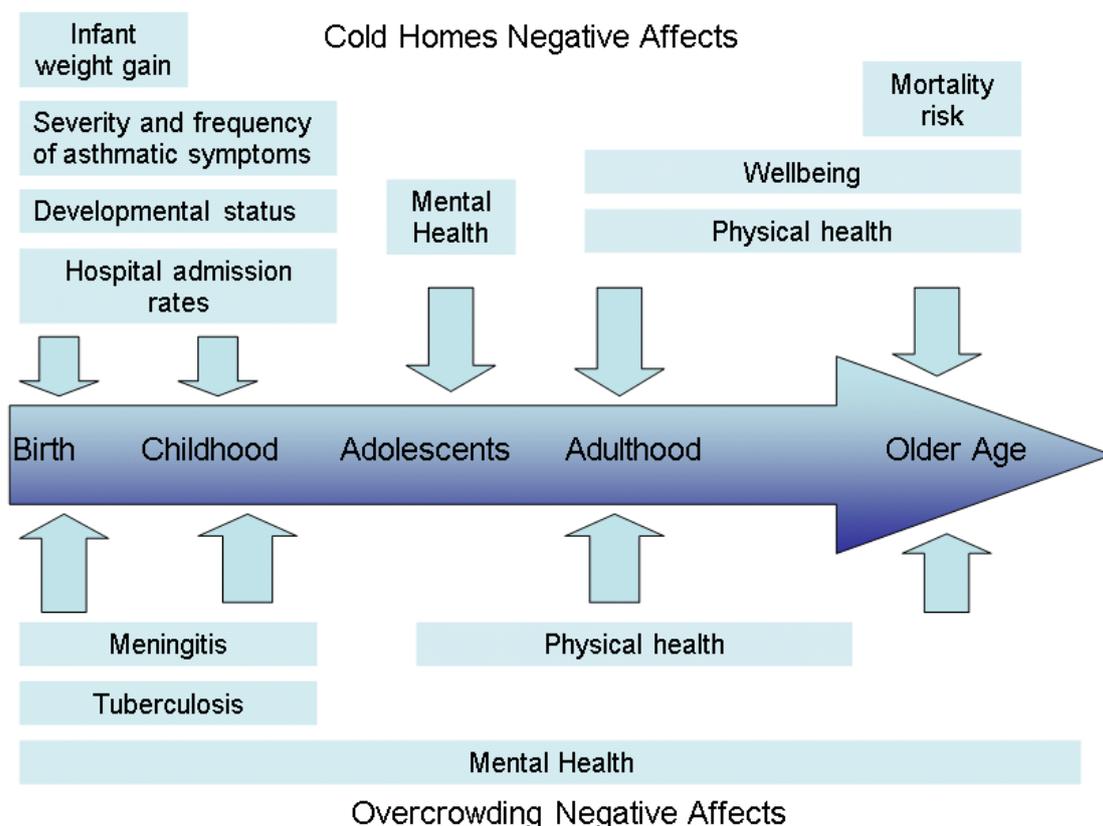
What is the issue?

The condition of our housing has a significant impact on our health. Throughout the whole life course people are affected by poor housing conditions reducing life chances and threatening survival, as demonstrated in Figure 22.

Indeed the risk of poor housing to health is not small; multiple housing deprivation appears to pose a risk comparable to smoking and greater than excessive alcohol consumption⁴³.

To compound the effect, poor housing is often situated in areas with poor amenities such as access to good transport links, safe outside space and healthy food supplies. This can contribute to the increased likelihood of making vulnerable people housebound which in turn prolongs their exposure to indoor hazards⁴⁴. This is one of the ways that health inequalities are intrinsically linked with housing conditions.

Figure 22: Housing affects on health⁴⁵



⁴³ Marsh A, Gordon D and Pantazis C et al (1999) Home sweet home? The impact of poor housing on health. Bristol: The Policy Press

⁴⁴ British Medical Association (2003) Housing and health: building for the future. London: BMA Publications Unit.

⁴⁵ Developed by Duffield, N. (2011)

As at 1 April 2010, there were approximately 99,600 homes in Southampton. The city has twice the national average of privately rented accommodation (including over 7,000 Houses in Multiple Occupation); below the average number of owner occupied homes; and a higher proportion of council homes, equating to one in six homes, or 17%, compared to 10% nationally. Southampton City Council is the largest landlord in the south of England;⁴⁶ many councils have divested themselves of housing stock over the last 30 years since the introduction of the *Right to Buy* legislation.

Of the council stock, 99% met the government's Decent Homes Standard as at 1st April 2011. The Decent Homes Standard was set out by the previous government and expected 95% of housing controlled by councils and registered social landlords (such as housing associations) to be compliant by 2010; see Box 1 for details.

One of the main features set out in the decent homes criteria is to provide homes which have effective insulation and efficient heating.

Box 1: Decent Homes Standards

A decent home meets the following four criteria:

- 1) It meets the current statutory minimum standard for housing
Dwellings which fail to meet this criterion are those containing one or more hazards assessed as serious ('Category 1') under the Housing Health and Safety Rating System (HHSRS).
- 2) It is in a reasonable state of repair
Dwellings which fail to meet this criterion are those where either:
 - one or more of the key building components are old and, because of their condition, need replacing or major repair; or
 - two or more of the other building components are old and, because of their condition, need replacing or major repair.
- 3) It has reasonably modern facilities and services
Dwellings which fail to meet this criterion are those which lack three or more of the following:
 - a reasonably modern kitchen (20 years old or less);
 - a kitchen with adequate space and layout;
 - a reasonably modern bathroom (30 years old or less);
 - an appropriately located bathroom and WC;
 - adequate insulation against external noise (where external noise is a problem); and
 - adequate size and layout of common areas for blocks of flats.

A home lacking two or fewer of the above is still classed as decent, therefore it is not necessary to modernise kitchens and bathrooms if a home meets the remaining criteria.
- 4) It provides a reasonable degree of thermal comfort
This criterion requires dwellings to have both effective insulation and efficient heating.

It should be noted that, whilst dwellings meeting criteria 2, 3 and 4 are likely also to meet criterion 1, some Category 1 hazards may remain to be addressed. For example, a dwelling meeting criterion 4 may still contain a Category 1 damp or cold hazard.

⁴⁶ Southampton City Council (2011) Housing Strategy 2011-15.

The effect of cold homes

Cold homes negatively affect people across the age spectrum with differing severity (see figure 22). Conditions such as circulatory diseases, mental illness and respiratory conditions are directly associated with cold housing. Additionally, other conditions are exacerbated by cold housing such as arthritis, rheumatism, colds and influenza. There is also a marked impact on the mental health of children, adolescents and adults. Living in a cold home also increases the level of minor illnesses such as colds and flu and exacerbates existing conditions such as arthritis and rheumatism. Cold negatively affects dexterity and increases the risk of accidents and injuries in the home.⁶

Hills (2011)⁷ shows that, for the vulnerable, temperatures below 12 degrees Centigrade (°C) can stimulate cardiovascular problems and below 16°C can impact on respiratory function. In addition lower temperatures are associated with compromised resistance to infections and the occurrence of damp and associated mould in the home.

Older people and children are more readily affected by cold housing; this was investigated by Liddell and Morris⁴⁷ in their study measuring the impacts of improvements in energy efficiency and reduced fuel poverty. In children they found that there were significant effects upon infant weight gain, hospital admission rates and caregiver-rated developmental status, and a reduction in the severity and frequency of asthmatic symptoms⁴⁸.

Unfortunately the effect of cold homes on vulnerable older people can lead to an increase risk of death; 50% of excess winter deaths can be attributed to low indoor temperatures⁴⁹. These are usually increases in respiratory disease, cardiovascular disease and influenza. Forty percent of excess winter deaths are attributable to cardiovascular disease, 33% to respiratory disease and a very small proportion to influenza and hypothermia.

The Hills Review (2011)⁷ shows that there is clear evidence of an increased risk of cardiovascular-related death following days when the maximum outdoor temperature falls below 20 degrees. Therefore, low indoor temperatures appear to be only part of the explanation and expert opinion suggests that around half of excess winter deaths may be attributable to outdoor temperatures.

The UK has a higher rate of 'excess winter deaths' (i.e. additional deaths each winter than would be expected from the rate of deaths in the non-winter months) than other countries with colder climates (see Table 1 below). Indeed higher rates are found in countries with less severe winters such as Spain and Greece. Colder countries have higher building standards and therefore lower rates of excess winter deaths (Marmot 2011).

⁴⁷ Liddell C and Morris C (2010) Fuel poverty and human health: A review of recent evidence. *Energy Policy*, 38 (6), pp2987-2997.

⁴⁸ Marmot Review Team (2011) *The Health Impacts of Cold Homes and Fuel Poverty*.

⁴⁹ Hills J (2011) *Fuel Poverty: the problem and its measurement*. London: Department for Energy and Climate Change

Table 2: European comparison of excess winter deaths and energy efficient housing (mean 1988-1997)

Country	Coefficient of seasonal variation in mortality	Cavity wall insulation (% houses)	Roof insulation (% houses)	Floor insulation (% houses)	Double glazing (% houses)
Finland	0.10	100	100	100	100
Germany	0.11	24	42	15	88
Netherlands	0.11	47	53	27	78
Sweden	0.12	100	100	100	100
Norway	0.12	85	77	88	98
Denmark	0.12	65	76	63	91
Belgium	0.13	42	43	12	62
France	0.13	68	71	24	52
Austria	0.14	26	37	11	53
Greece	0.18	12	16	6	8
UK	0.18	25	90	4	61
Ireland	0.21	42	72	22	33
Portugal	0.28	6	6	2	3

Source: Marmot Review Team <http://www.sochealth.co.uk/confs/HousingMarmot.pdf>

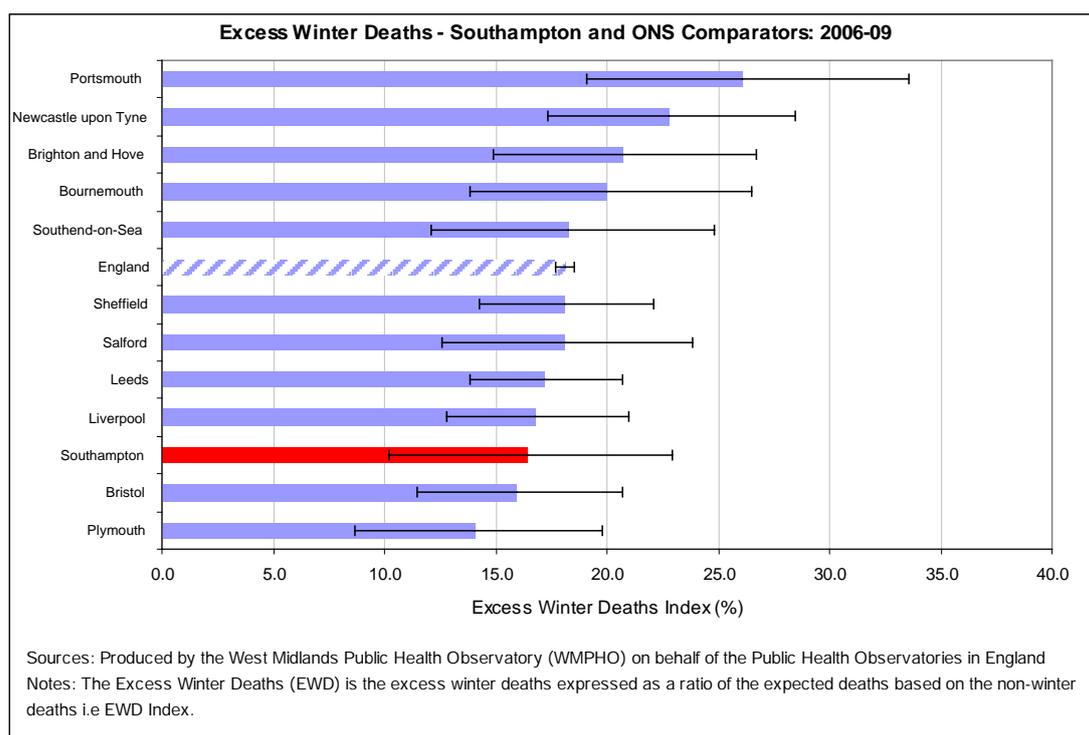
Southampton

In the 2006-09 period the Excess Winter Deaths (EWD) Index for Southampton was 16.4% with an average of 95.3 excess winter deaths. This means that Southampton had an average of 95 additional deaths each winter than would be expected from the rate of death in the non-winter months. The EWD Index for the city was not significantly different from the England average of 18.1% and, as the chart below shows, was lower than most of its ONS comparator authorities.

The annual cost to the NHS of treating winter related disease due to cold private housing is £859 million; for Southampton the estimated cost is £4 million each year. This does not include additional spending by social services, or economic losses through missed work.⁵⁰

⁵⁰ Department of Health (2010) On the state of public health: Annual report of the Chief Medical Officer 2009
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/AnnualReports/DH_113912

Figure 23: Excess Winter Deaths 2006-09



The EWD Index is very variable year on year because of the relatively small number of deaths involved in the calculation as well as the determining factors, such as weather conditions, which also vary each year.

Excess winter deaths affect all ages; however the EWDI is known to increase with age, with the elderly the most susceptible group to higher death rates in winter. In addition, as excess winter deaths and the EWDI are not age standardised, given the age profile of excess winter deaths, it is reasonable to assume that areas with a greater older population will have higher excess winter deaths. Looking at the EWDI by age group provides a solution to this problem. Over the 2006-09 period the EWDI for the over 85s was 26.3 in Southampton which is higher, although not significantly so, than the national average of 24.4.

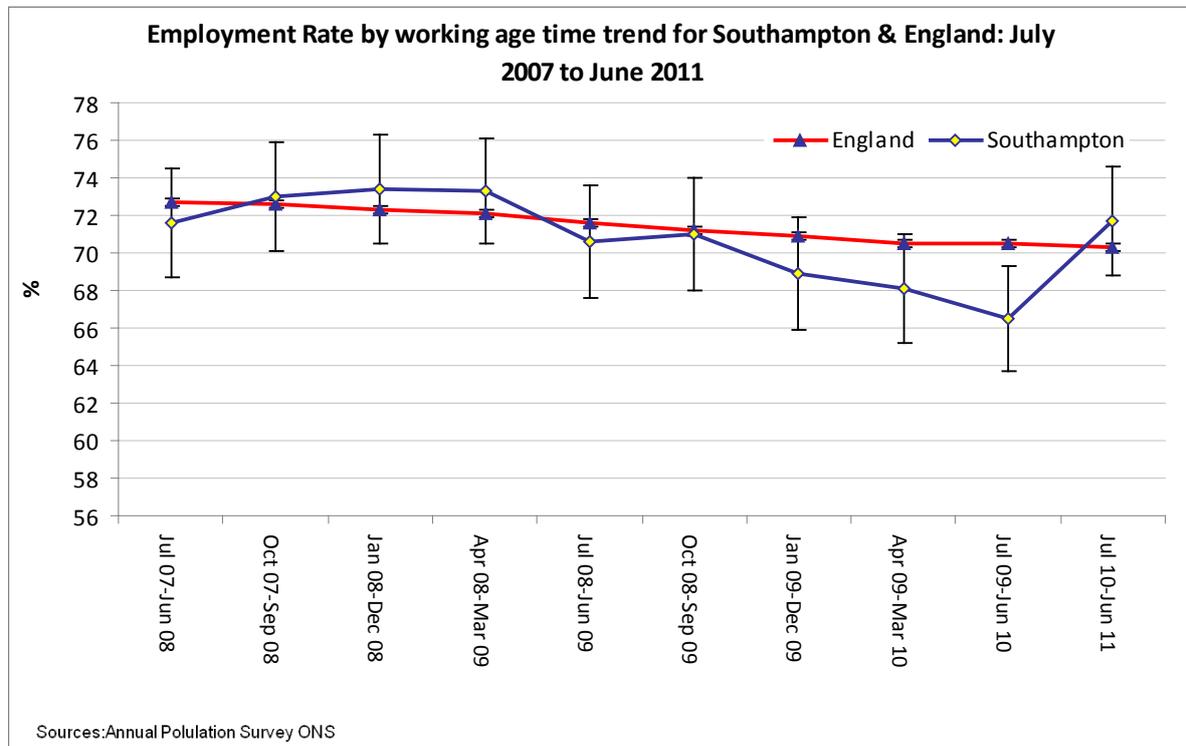
Cold winter temperatures are an important determinant of excess winter mortality but other variables such as humidity and air pollution are important. However it is likely that the main determinants of winter mortality are those that moderate an individual's exposure to cold temperatures. Effective protection to outdoor exposure can virtually eliminate winter variations in respiratory mortality.

The economic recession

Southampton has experienced a significant fall-out from the economic recession over the last four years. Unemployment has risen, inflation is high and wage rises are few and far between. In 2010 the average weekly gross earnings for a full-time employee in Southampton were estimated at £452.20. This compares poorly to Portsmouth and

Hampshire, where the average earnings are £480.20, and £540.70 respectively⁵¹. Figure 24 shows that employment rates in Southampton are generally not significantly different from the national average. However, a major issue for the city is poverty amongst people in employment.

Figure 24: Employment Rates



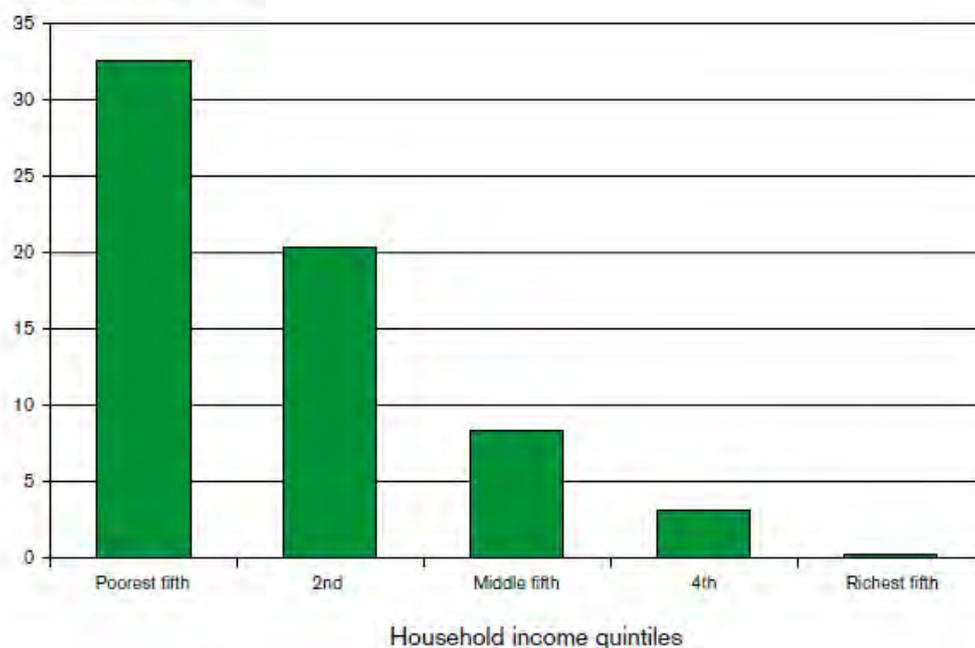
Fuel poverty

Fuel poverty is defined as having to spend 10% or more of a household’s net income to heat their home to an adequate standard of warmth. The World Health Organization recommends that living areas should be maintained at 21°C and sleeping areas at 16°C.

Fuel poverty is not necessarily related to income deprivation, and occurs across the whole population (see figure 25 below). It relates to certain housing characteristics, including age of property, tenure and thermal efficiency.

⁵¹ Nomis – Annual Survey of hours and earnings 2010 www.nomisweb.co.uk

Figure 25: Percent of households in fuel poverty



Note: Percent in fuel poverty relates to households in fuel poverty after deducting housing costs

Source: The Health Impacts of Cold Home and Fuel Poverty, Marmot Review Team 2011

Fuel costs as part of the poverty premium

The poverty premium is a notional extra cost that people on lower incomes can pay for goods and services, compared with the cost that is paid for the same goods and services by higher-income families.⁵²

The table below gives an illustration of the additional costs that low-income families may pay for some basic goods and services.

Table 3: Poverty Premium: examples from 2010

	<i>Typical costs</i>	<i>Costs to low-income families</i>	Difference
Basic household item: cooker	£239.00	£669.24	£430.24
Loan for £500	£500.00	£750.00	£250.00
Cost to cash 3 x £200 cheques	£0	£36.00	£36.00
Annual electricity & gas bill combined	£881.06	£1,134.23	£253.17
Home contents insurance	£66.72	£98.64	£31.92
Car insurance	£309.82	£597.96	£288.14

Costs sources between September and November 2010

⁵² Save the Children (2010) The UK Poverty Rip Off. The Poverty Premium 2010. www.savethechildren.org.uk

As the table above demonstrates annual fuel costs can be over £200 more expensive for a low income family with children. This is because of a number of factors:

- Higher tariffs for pre-paid meters
- Those without bank accounts cannot make use of the lowest tariffs which require direct debit
- Social tariffs (which offer lower tariffs for those most vulnerable) exclude households with children.

This phenomenon clearly has an impact on fuel poverty. In the UK, 7% of lone-parent households and 9.9% of couples with children live in fuel poverty.⁵³ Figures for the UK showed that 5% of children were living in accommodation with inadequate heating (where a parent has stated that they are unable to keep the house warm in winter).⁵⁴ In Southampton that would equate to approximately 2,000 children living in accommodation with inadequate heating.

Southampton

Fuel poverty has been rising over the last eight years. Figures for England show that in 2004 6% of households were deemed to be in fuel poverty and by 2009 (the latest figures) over 18% were in fuel poverty. Although Southampton figures are not so high and do not go back so far, we can see from Figure 26 below that fuel poverty is rising. In 2006 10% of households in Southampton were in fuel poverty whereas by 2009 the figure had risen to over 12%.

Nationally the reason for this rise is two-fold and the Annual Report on Fuel Poverty Statistics⁵⁵ gives reasons for the rise between 2008 and 2009:

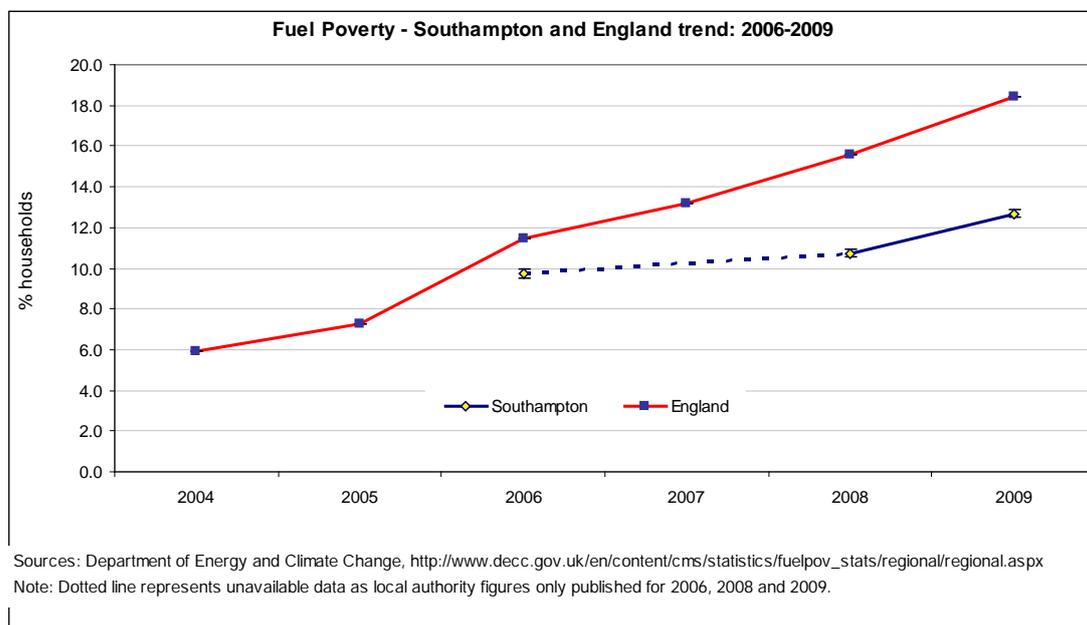
“The largest contribution to the change in fuel poverty between 2008 and 2009 came from rising prices. Without the counter effects of rising incomes and falling energy consumption, prices alone may have shifted a little under one million households into fuel poverty. Rising incomes helped to keep just under 0.2 million of those out of fuel poverty. Using the methodology employed here, an estimated reduction in fuel poverty of around 130,000 households can be attributed to lower energy consumption, largely representing energy efficiency improvements.”

⁵³ Department of Energy and Climate Change (2010) Fuel Poverty 2008 Detailed Tables: Annex to Annual Report on Fuel Poverty Statistics 2010, Office for National Statistics.

⁵⁴ Barnes, M, Butt, S, and Tomaszewski, W (2008) The Dynamics of Bad Housing: The impact of bad housing on the living standards of children. NatCen

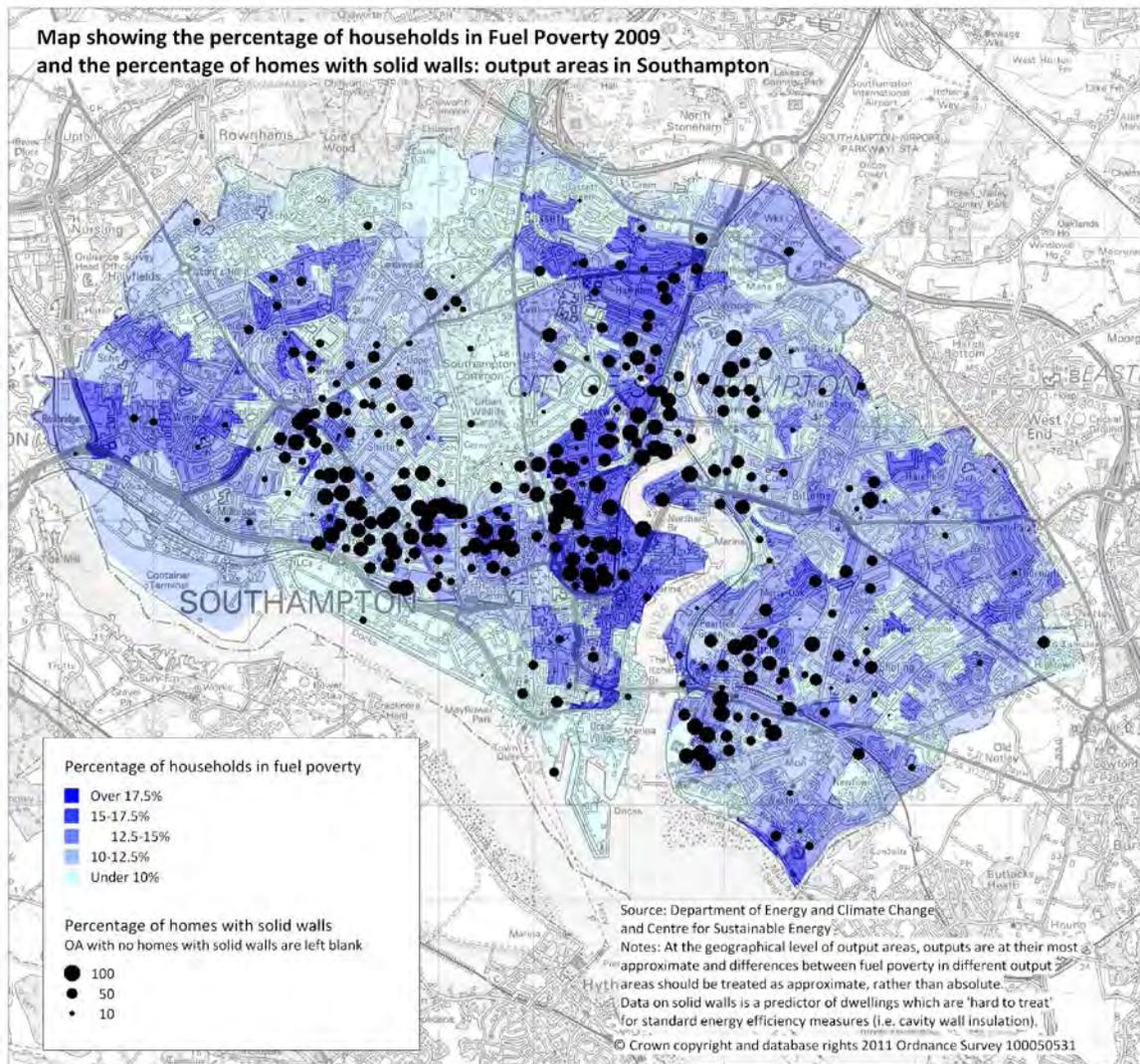
⁵⁵ Department of Energy and Climate Change (2011) Annual Report on Fuel Poverty Statistics 2011

Figure 26: Fuel Poverty – Southampton and England trend 2006 – 2009



The map in Figure 27 shows the percentage of households in fuel poverty in Southampton at very small geographical areas called 'Output Areas' (OAs). The Centre for Sustainable Energy, an independent national charity, has assessed the proportion of homes that are 'hard to treat' for standard energy efficiency measures. In the map below we have plotted the proportion of homes in each OA that have solid walls as this is a predictor of hard to treat housing as these homes could not be fitted with cavity wall insulation.

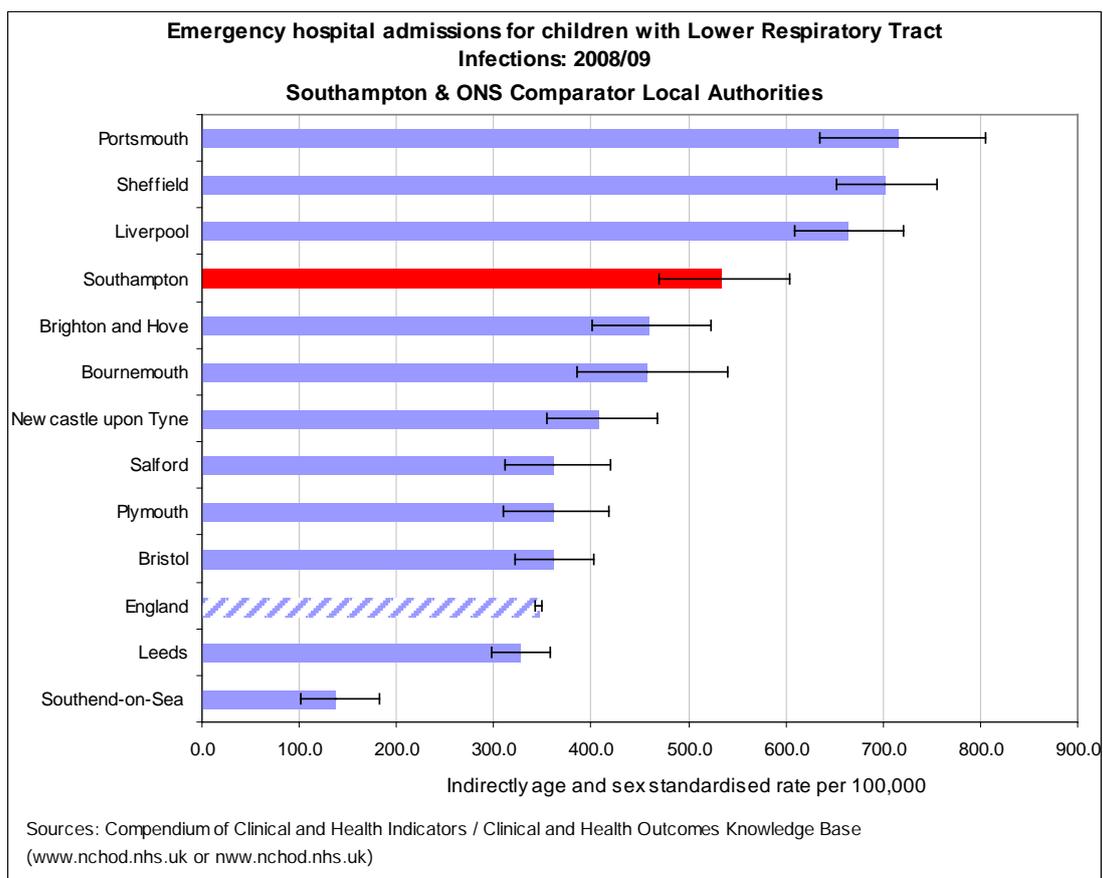
Figure 27: Fuel Poverty and homes with solid walls in Southampton OAs



Children and Young People

Figure 28 shows how emergency admissions rates for children with lower respiratory tract infections were significantly higher in Southampton than the national average in 2008/09.

Figure 28: Emergency admissions for children with respiratory infections



Past trends show that the number of paediatric respiratory A&E attendances and non-elective admissions increases within the colder winter months. From December 2009 to November 2010 there were 727 paediatric respiratory related non-elective admissions at a cost of £732k. The majority of these admissions are aged under five (77%).

The Community Paediatric Asthma Nurse Service has helped to reduce asthma/wheezing related admissions. The service provides a rapid, same day response to children who were acutely wheezy and provides advice about safe parameters for home management. In September 2009, an Out of Hours nurse was appointed to target the peak admission period from 18:00 – 21:00 hours. The number of asthma/wheezing admissions has declined since September 2009.

In October 2011, a community nursing admission avoidance pilot started with the aim of reducing the number of short stay paediatric non-elective admissions within five high volume conditions by providing assessment, review, advice and support to children and their families to manage common paediatric minor illnesses at home, thereby preventing an acute admission. The conditions include viral infections, acute upper respiratory tract infections and common cold, acute bronchiolitis without complications and lower respiratory tract infections.

What can be done about it?

In Southampton the Decent Homes scheme has seen investment of nearly £7 million in 2011/12 and just over £5.7 million will be invested in 2012/13. In addition to this the Decent Homes Plus scheme saw an investment of £7 million in 2011/12 and £10 million will be invested in 2012/13.

The Southampton Warmth for All Partnership was created in 2005 to increase the number of people in Southampton claiming Warm Front grants. The Warm Front scheme provides heating and insulation improvements to households on certain income-related benefits living in properties that are poorly insulated and/or do not have a working central heating system.

Qualifying households can get improvements worth up to £3,500 (£6,000 where oil central heating and other alternative technologies are recommended)⁵⁶.

Grants are available for improvements such as:

- loft insulation
- draught proofing
- cavity wall insulation
- hot water tank insulation
- gas, electric, liquid petroleum gas or oil heating
- glass-fronted fire - the Warm Front scheme can convert a solid-fuel open fire to a glass-fronted fire

Since its inception in 2003 the Southampton Warmth for All Partnership has enabled more than £5.5 million of grants to improve heating and energy efficiency of private and rented homes in the city.

The Environment Centre in Southampton is currently working within specific communities. Volunteer Energy Champions are being recruited and trained in Thornhill, St Mary's and Shirley Warren to help their friends and neighbours to use energy more efficiently and save money on fuel bills. In addition to this The Environment Centre's qualified energy advisors will visit individual homes to provide tailored advice on saving energy.

Green Deal

The Green Deal is a government initiative, launching in October 2012, that intends to reduce carbon emissions cost effectively by improving the energy efficiency of British properties. Every British home and business will be able to install packages of energy saving

⁵⁶ Direct Gov website

http://www.direct.gov.uk/en/Environmentandgreenerliving/Energyandwatersaving/Energygrants/DG_10018661

technologies such as insulation at no upfront cost making their property warmer, with repayments made over time out of the energy savings.⁵⁷

Healthy Outlook

Healthy Outlook is run by the Met Office and helps people with chronic obstructive pulmonary disease (COPD) stay well throughout the year by taking control of their own health. The Met Office monitors environmental conditions and warns people when their health is likely to be affected, giving them the opportunity to take action to stay well. Initial research shows 20% fewer exacerbations, 32% fewer hospital admissions and 10% fewer GP visits than the control group.⁵⁸

Recommendations

- Investment in the Met Office Healthy Outlook service (heat and cold alerts for people with COPD) needs to be considered by the Clinical Commissioning Group as part of improved self-management for these individuals
- Implementation of Green Deal will happen in the autumn of 2012. As part of the government's communication strategy the City Council will need to ensure that information is available to homeowners and business
- Ensure that the Stop the Cold and Keep Warm campaign, which provides free help for over 50s in Southampton, offering advice and practical solutions to help people stay warm, is evaluated in 2012 and, if successful, continued. (Visit www.environmentcentre.com or phone 0800 804 8601 for further details)

⁵⁷ Department of Energy and Climate Change 2011

http://www.decc.gov.uk/en/content/cms/tackling/green_deal/green_deal.aspx

⁵⁸ The Met Office Healthy Outlook results.

<http://www.metoffice.gov.uk/health/professionals/healthyoutlook/results>

Appendix 1: Progress of recommendations from Public Health Annual Reports 2003-2010

Since the appointment of a Director of Public Health for Southampton in 2002 there has been a requirement to produce an annual report on the most important health problems in the city. From the first report in 2003 through to last year's report recommendations have been made to improve the health of Southampton. Each chapter of each report has included a number of recommendations, which vary from specific targets to whole policy areas of work. This appendix reviews these recommendations to see what has been achieved. A more detailed audit is available on our website at <http://www.southampton.nhs.uk/aboutus/publichealth/hi/phar/>

Overall there has been significant progress on many of the Director of Public Health's recommendations. For instance, in the area of tobacco control, Southampton Quitters continues to deliver comprehensive smoking cessation services in a variety of settings across the city. Additionally, the Fitness for Surgery pathway, to support elective care/secondary care patients to give up, was agreed by the Clinical Commissioning Group in July 2011. Additional investment was agreed to support increased smoking cessation advisor support in the hospital setting and to enhance activity in the community.

The obesity chapter of the 2010 annual report included a series of recommendations, many of which have now been actioned. For example, the use of the city's green spaces for physical activity has been encouraged through a range of activities including the development of directories for signposting use of green spaces, cycle challenge events, the Sustrans Street tread project and the Sky Ride. Also, the Children and Young People's and the Adult Weight Management Care Pathways are being implemented with a range of services on offer at the different tiers (e.g. a new tier 3 specialist weight management support service has been commissioned for adults).

In last year's annual report we flagged progress on the recommendations around alcohol and inequalities as areas of concern.

There is now much work going on around the alcohol agenda. Initiatives with partner organisations and through the NHS QIPP⁵⁹ programme include young people's social awareness campaign 'Buzz without Booze', brief interventions and Safe City work especially on the night time economy. More information about these initiatives is available in our January Public Health Information Newsletter at: <http://www.southamptonhealth.nhs.uk/aboutus/publichealth/hi/inews/>

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

Despite the recommendations made in 2003 and significant investment over the years there has been little improvement in narrowing the gap for men's life expectancy and premature mortality. This is a theme that was re-visited in the 2009 Annual Report and in the 2010

⁵⁹ QIPP is the Quality, Innovation, Productivity and Prevention transformation programme for the NHS see <http://www.dh.gov.uk/en/Healthcare/Qualityandproductivity/QIPP/index.htm>

report we reported on the progress made (see <http://www.southamptonhealth.nhs.uk/aboutus/publichealth/hi/phar/>).

Our latest Briefing Note on Health Inequalities <http://www.southamptonhealth.nhs.uk/aboutus/publichealth/hi/briefings/> shows Southampton has significant health inequalities when we look at health in our priority neighbourhoods (our most deprived areas) compared to the rest of the city. This is particularly the case for men in the city.

In 2010 the Director of Public Health in Southampton included a section on disability in his annual report. A key recommendation from the report was around the collection of data on disability.

The Southampton Joint Strategic Needs Assessment (JNSA) presented a variety of data sources to give the best indication possible of the significance of this issue to the city. However, there remains a need for better recording of data regarding disability in primary and secondary care to ensure that commissioners can better understand and quantify people's needs and plan services to meet these.

The NHS Equality Delivery System (EDS)⁶⁰ will help NHS organisations to ensure that the "Protected Characteristics" in the Equality Act 2010 are covered in the business of the organisation. Disability is one of the nine protected characteristics and, therefore, by complying with the EDS data recording plus equity of services and outcomes for people with disabilities should be improved.

In the 2010 report there were other recommendations regarding disability which have not been achieved; these are summarised in the table below:

Recommendation	Status
Ensure that eye health is a public health priority and the importance of regular eye tests are promoted to reduce sight impairment	This has only been partially met
Improve the quality, effectiveness and efficiency of services to mitigate hearing loss	There needs to be a strengthening of the specialist education service for deaf children
As increasing numbers of people live into older age with complex needs, there is a need for the whole health and social care system to plan to more effectively use resources for patient-centred planning	Work on this is ongoing

⁶⁰ The EDS has been designed to help NHS organisations meet the requirements of the public sector Equality Duty, for further information see <http://www.eastmidlands.nhs.uk/about-us/inclusion/eds/>

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RESIDENT POPULATION, 2010

Population resident in Southampton City PCT

Age band	Male	Female	Persons	%
0-4	7,968	7,541	15,509	6.6
5-14	11,886	11,199	23,085	9.9
15-24	24,671	23,127	47,798	20.4
25-49	41,088	37,655	78,743	33.6
50-64	17,902	17,323	35,225	15.0
65-74	8,172	8,542	16,714	7.1
75-84	5,110	6,847	11,957	5.1
85+	1,686	3,640	5,326	2.3
Total	118,483	115,874	234,357	100

Source: Hampshire County Environment Department's 2010 Based Small Area Population Forecasts (Figures may not sum due to rounding)

REGISTERED POPULATION, 2010

Population registered with Southampton City GPs

Age band	Male	Female	Persons	%
0-4	7,953	7,569	15,522	5.9
5-14	12,960	12,356	25,316	9.6
15-24	24,286	24,490	48,776	18.6
25-49	54,593	45,014	99,607	37.9
50-64	20,623	18,991	39,614	15.1
65-74	8,429	8,657	17,086	6.5
75-84	4,973	6,723	11,696	4.5
85+	1,619	3,367	4,986	1.9
Total	135,436	127,167	262,603	100

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

BIRTHS

General Fertility Rate and Number of Births

	2007	2008	2009	2010
Live births per 1,000 women aged 15-44				
Southampton	54.5	56.3	54.1	57.0
South East	60.8	62.5	62.6	64.4
England	62.1	63.9	63.8	65.5
Number of live births				
Southampton	3078	3279	3230	3448

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

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TEENAGE CONCEPTIONS

	2006	2007	2008	2009
No. of conceptions to girls aged under 18				
Southampton	227	185	198	188
Rate of under 18 conceptions per 1000 girls aged 15-17				
Southampton	60.7	49	51.4	49.2
South East	32.9	32.9	32.9	30.1
England	40.4	41.7	40.4	38.2

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

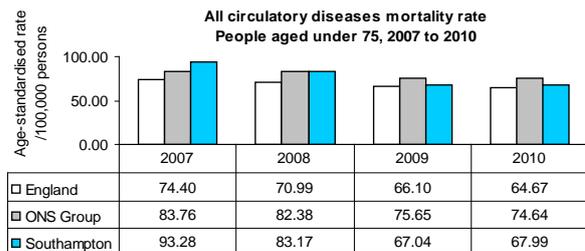
INFANT MORTALITY*

	2006-08	2007-09	2008-10
Number of deaths (in 3 year period)			
Southampton	44	43	49
South East	1220	1214	1204
England	9503	9421	9260
Mortality per 1000 live births			
Southampton	4.7	4.5	4.9
South East	4.0	3.9	3.8
England	4.8	4.7	4.6

*includes deaths of infants aged less than 1 year

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

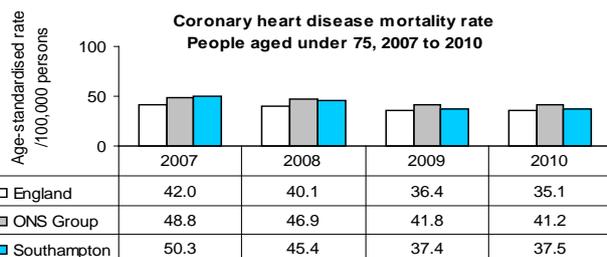
CIRCULATORY DISEASE



Number of deaths per year
Southampton 180 164 133 136

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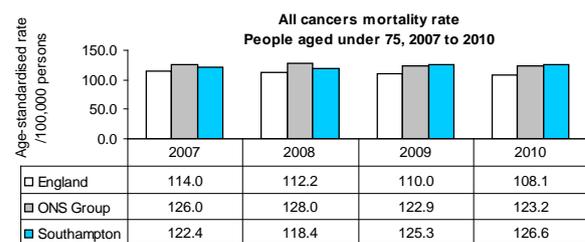
CORONARY HEART DISEASE



Number of deaths per year
Southampton 98 90 74 74

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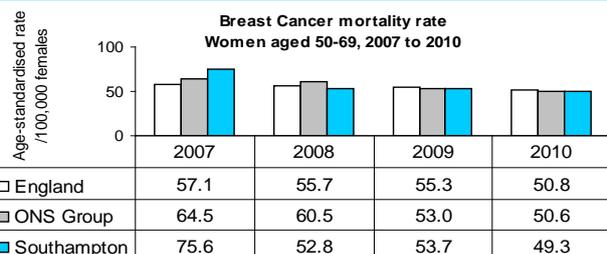
CANCER



Number of deaths per year
Southampton 233 230 247 256

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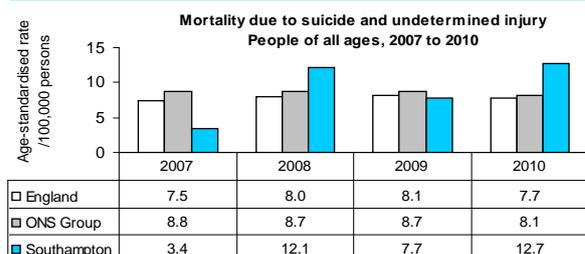
BREAST CANCER



Number of deaths per year
Southampton 15 11 11 11

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SUICIDE



Number of deaths per year
Southampton 7 27 18 32

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