

Changing Southampton

Southampton

Working together to understand the needs of
Southampton people and to improve health
and well-being



Report of the Public Health Director 2007 to inform the Joint Strategic Needs Assessment consultation

Figure 1 Southampton City depicting priority neighbourhoods



- | | |
|--|---|
| 1. Bevois and Bargate
(includes West Itchen Community Trust Area) | 6. Lordshill |
| 2. Portswood and St Denys | 7. Flower Roads, Hampton Park and Mansbridge |
| 3. Thornhill
(Thornhill Plus You) | 8. Freemantle and Polygon |
| 4. Outer Shirley
(Single Regeneration Budget 6) | 9. Townhill Park |
| 5. Weston
(Action plan area, includes Weston Shore Single Regeneration Budget 6) | 10. Harefield |
| | 11. Shirley Estate |

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Southampton today

Changing Southampton

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Southampton

Changing Southampton

preface

changing Southampton

Southampton is a great City with a proud past and a promising future. Its people value their health and well-being, and may have never been healthier. But not everyone shares in this good fortune, and there are some stark health and social inequalities across our City.

Many organisations, not just health and social services, are working to improve health and well-being. Local communities and individuals themselves have important roles to play. But times are changing - expectations are higher, needs are increasing and resources are stretched.

Against this background we need to gain a better understanding of the needs of the City, whilst getting ideas about how we can change Southampton for the better.

As Public Health Director, I report each year on the health of Southampton people and make recommendations on how this can be improved. These reports cover 2004 to 2006 and can be accessed at:
<http://www.southamptonhealth.nhs.uk/publichealth/p/har>

This year I am summarising where we have got to - what the key needs are - and asking some important questions such as, have we got the picture right, or are there some important issues we need to give more attention? Have we got the right plans and, if not, what more should we be doing to make life better for local people? I am doing this together with the City Council's Directors responsible for Children's Services and Adult Social Services.

We need the views and comments of local people, service users and provider organisations as we re-focus and re-shape the services we provide. We want to meet local aspirations whenever that is possible, and we need an honest and open debate about the things that will take time to change. But most importantly Southampton people can make a difference themselves - by getting more involved in health, and in the things that all of us can do to stay well and avoid preventable ill health, to enjoy our independence for as long as possible and to give the next generation the very best possible start in life.

Although we have drawn on many strategic and operational needs assessments, documents and reports, we know we currently have gaps in our understanding. To remain as concise as possible service delivery targets have generally not been included in this report.

We look forward to hearing from you, as we complete this Joint Strategic Needs Assessment and work towards minimising gaps in our knowledge, and to make our plans for improving health and well-being in Southampton robust and engaging.

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Director for Communities, Health and Care

November 2007

jargon buster

AAA	Abdominal Aortic Aneurysm	MH	Mental Health
AGE	Accident & Emergency	MINI	Mental Health Needs Index
AIDS	Acquired Immune Deficiency Syndrome	MRSA	Methicillin Resistant Staphylococcus Aureus
anti-VEGF	anti Vascular Endothelial Growth Factor	NCHOD	National Centre for Health Outcomes Development
BLF	British Lung Foundation	NCN	National Cycle Network
BME	Black and Minority Ethnic	NHS	National Health Service
CAMHS	Child & Adolescent Mental Health Service	NICE	National Institute for Clinical Excellence
CDAD	Clostridium Difficile Associated Disease	NIMHE	National Institute for Mental Health in England
CHD	Coronary Heart Disease	NSF	National Service Framework
COPD	Chronic Obstructive Pulmonary Disease	ONS	Office of National Statistics
DAT	Drug Action Team	PALS	Patient Advice & Liaison Service
DDA	Disability Discrimination Act	PCT	Primary Care Trust
DGH	District General Hospital	PHO	Public Health Observatory
DfT	Department for Transport	PSHE	Personal Social and Health Education
DH	Department of Health	QMAS	Quality Management and Analysis System
EPP	Expert Patient's Programme	QOF	Quality Outcomes Framework
EU	European Union	SE	South East
GAD	Government Actuary Department	SEAL	Social and Emotional Aspects of Learning
GMS	General Medical Service	SEPHO	South East Public Health Observatory
GO	Government Office	SCC	Southampton City Council
GOSE	Government Office of the South East	SCPCT	Southampton City Primary Care Trust
GP	General Practitioner	SHA	Strategic Health Authority
HCAI	Health Care Associated Infection	SRE	Sex and Relationship Education
HIV	Human Immunodeficiency Virus	STI	Sexually Transmitted Infections
HPV	Human Papilloma Virus	SW	South West
HSE	Health Survey for England	SWAP	Southampton Warmth for All Partnership
IMD	Index of Multiple Deprivation	TB	Tuberculosis
JSNA	Joint Strategic Needs Assessment	YISP	Youth Inclusion Support Panel
LAA	Local Area Agreement		
LGBT	Lesbian Gay Bisexual Transgender		
LSP	Local Strategic Partnership		
LTP	Local Transport Plan		

Southampton

1 - changing times

Changing Southampton

Introduction and background to Southampton's Joint Strategic Needs Assessment

The Director of Public Health's annual report for 2007 is being used this year to engage local stakeholders in the development of Southampton's Joint Strategic Needs Assessment for health and well-being. This document is a full professional assessment; engagement with the wider public will be managed through a full media campaign based on a focused shorter text.

Production of a local Joint Strategic Needs Assessment (JSNA) will become a legal requirement for those organisations with a formal responsibility for planning and arranging publicly-funded provision of health and social care services. This is known as 'commissioning'. In Southampton the responsibility for health and social care commissioning lies jointly with the City Council and Southampton City Primary Care Trust (PCT). This includes arrangements for jointly commissioning services for children and young people through the new Children's Trust.

Locally the Southampton Health and Well-being Strategy and the Children and Young People's Plan drive developments and initiatives including social services, children's services, housing, voluntary organisations, the independent sector and neighbourhood groups to examine health, social care and well-being needs. We know that there has been a lot of good work done by partner organisations, including primary and secondary care providers, and realise that we cannot capture it all within this consultative document. We are, therefore, seeking your ideas and views on our future direction.

Southampton's JSNA will help inform and drive the commissioning and future investment priorities of both the City Council and the PCT. It will also be important in shaping some of the wider social, environmental and economic factors that determine people's health, for example, through influencing the

City's long term strategies and Local Area Agreement (LAA).

What is a needs assessment?

A needs assessment is a systematic method of gathering information about the current and future health, care and well-being needs of a defined population, in order to agree priorities and inform planning and resource allocation to address health inequalities.

Assessing the needs of the population in order to provide appropriate services is a key role for PCTs and local authorities.

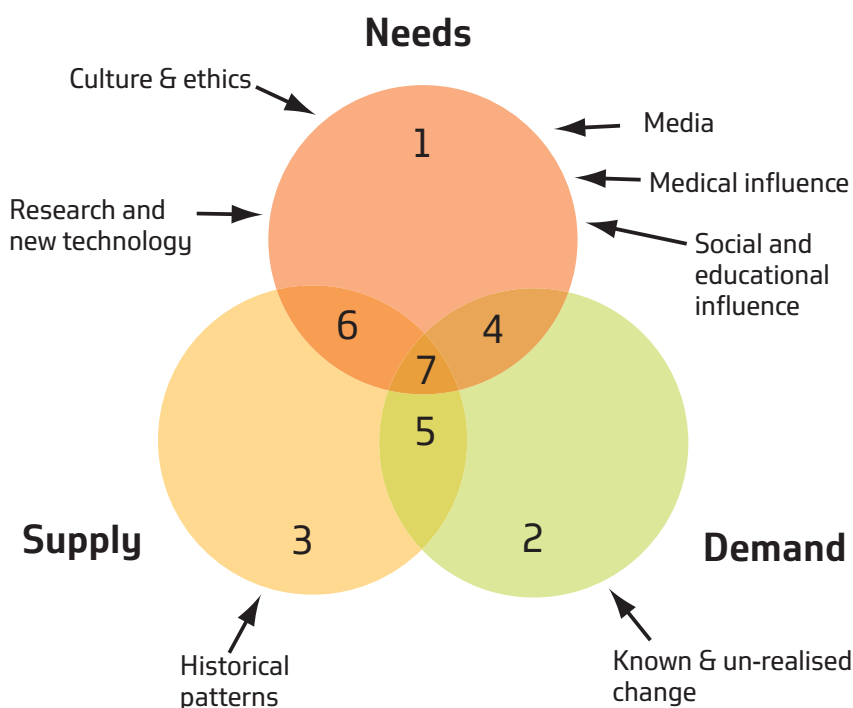
Need is the ability to benefit from an intervention. Need is classified into:

- felt need - anything people consciously lack and desire
- expressed need - a felt need that is made known-people's expectations of services
- unmet need - recognised needs that are not being met by existing services
- normative need - perceptions of commissioners and service providers of the needs of the population
- comparative needs - needs of the target population as assessed by comparing to another similar population

Need is different from supply and demand, but there are overlaps.

- demand is what people would be willing to pay for in a market or wish to use in a free health care system
- supply is what is actually provided

Figure 1.1 Need, supply and demand (conceptual diagram)



Key:

1. Need but no demand or supply - unrecognised and unmet need
2. Demand but no need or supply - inappropriate demand - may be no effective intervention
3. Supply but no need or demand - inappropriate service
4. Need and demand but no supply - unmet need
5. Demand and supply but no need - inappropriate service
6. Need and supply but no demand - service not accessed - need to increase demand
7. Met needs

A thorough needs assessment should be the starting point for the development of any strategy to tackle health and social care issues and is at the heart of the effective commissioning of a comprehensive and equitable range of high quality services within allocated resources.

The key components of a needs assessment are:

- assessing the incidence and prevalence (how many people need the service/intervention)
- reviewing the effectiveness and cost-effectiveness of services (do they confer any benefit, and if so at what cost i.e. what is the relative benefit)
- mapping the baseline services (changing provision for the better necessitates knowledge of the existing services, both to know which services ought to change and to identify opportunities for the release of resources to enable the change to happen)
- comparing services to what is provided elsewhere to similar populations
- gaining an excellent understanding of the population's expectations and wishes
- seeking and listening to the views of interested parties, including those who provide services

- deciding local priorities for developing and transforming services.

What is a Joint Strategic Needs Assessment?

A JSNA is the means by which Southampton City PCT and the City Council will describe the current and future health, care and well-being needs of our population and the strategic direction of service delivery to meet these.

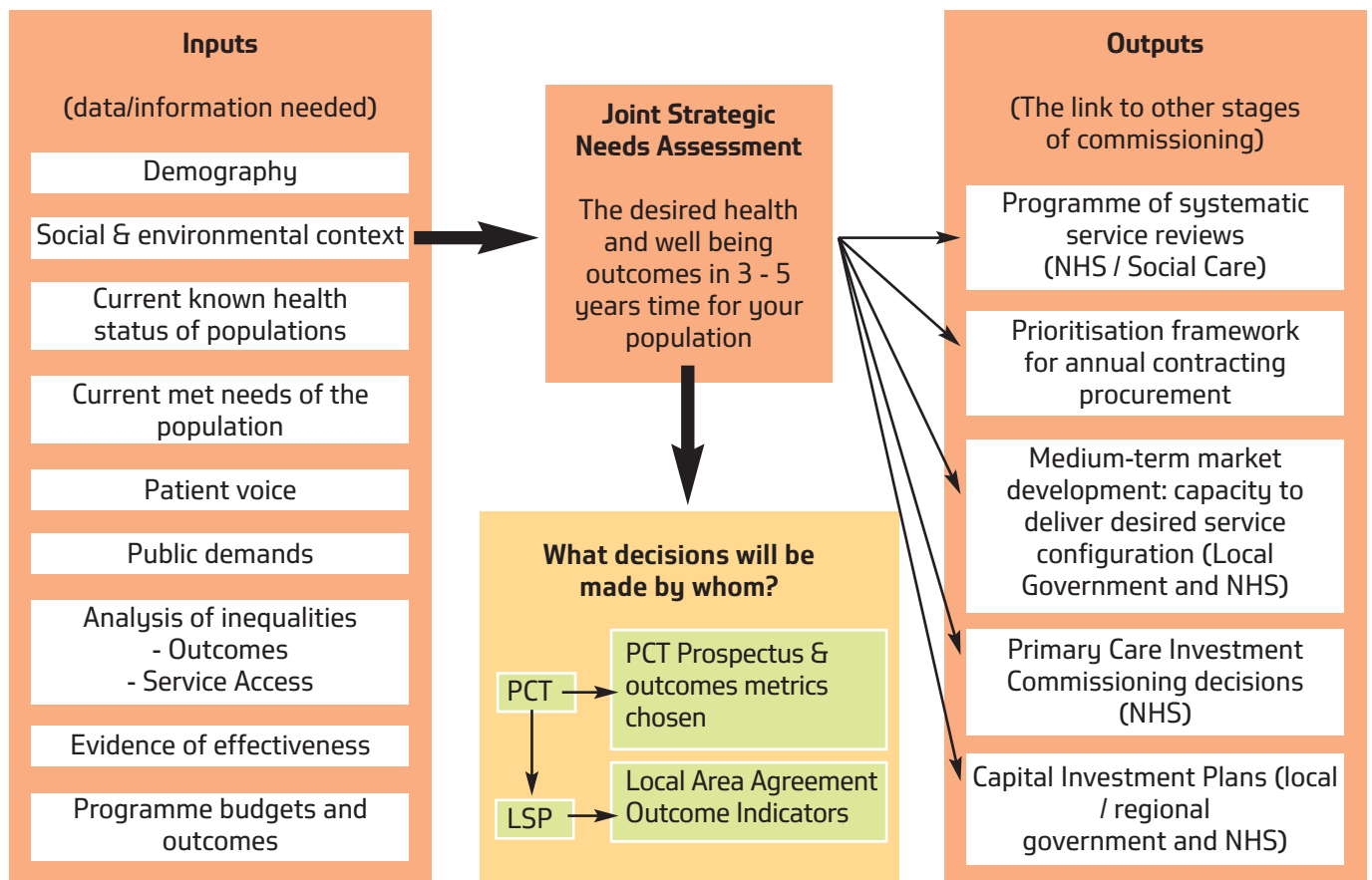
Importantly the JSNA will take account of what Southampton people want from their local services. Our JSNA includes data and information on inequalities between the differing and overlapping communities across Southampton. It will also support the meeting of statutory requirements in relation to equity audits. Production of a JSNA forms the basis of a new duty to co-operate for PCTs and local authorities as contained in the Local Government and Public Involvement in Health Bill (2006-07) awaiting Royal Assent at the time of writing.

Another reason for doing a JSNA, and doing it well, is to develop the whole health and social care response so it will more closely meet the wants and needs of local people. It will provide an opportunity to look three to five years ahead and support and direct the change that may need to happen in local service systems. This means that the quality of services is shaped by local communities, inequalities are reduced, social inclusion is

increased and these outcomes are maximised at minimum cost.

Much of the PCT and City Council's recent work has been along these lines. We realise that through the JSNA we have an opportunity to better integrate our health and social care responsibilities whilst meeting the needs of our community and Figure 1.2 below illustrates this.

Figure 1.2 Joint Strategic Needs Assessment and the Commissioning Cycle



George Leahy, Renu Bindra Department of Health 9 May 2007 presentation

For the purpose of this document commissioning is defined as:

- understanding and shaping the supply and demand factors within local health, social care and housing economies to meet the present and future needs of service users
- co-ordinating the strategies and implementation plans of partner agencies to ensure these needs are met
- reviewing and evaluating the services provided at regular intervals to ensure services are adapted and re-focused to meet ever changing population needs

Programme budgeting information will help the PCT and City Council with the wider Local Strategic Partnerships to understand where they are spending their resources and to identify the potential for

shifting resources between activities to produce better outcomes. However, we cannot expect the new duty of JSNA to define precisely what commissioners should 'buy' each year.

We aim to build on our current work to provide analyses of data to show the health and well-being status of Southampton communities, define where inequities exist, and use local community views and evidence of effectiveness of interventions to shape the future investment and disinvestment in services. Our JSNA will:

- support the delivery of better health and well-being outcomes for the local community
- define achievable improvements in health and well-being outcomes for the local community
- aid better decision-making and inform the next

- stages of the commissioning cycle
- send signals to existing and potential providers of services about potential service change
- underpin the LAA and the choice of refreshed local outcomes and targets
- inform the PCT's 'Your Guide to Local Health Services' patient prospectus and other plans

Our approach

The approach being adopted locally seeks to:

- **Review** the current work being done in a number of areas in relation to assessing the health, care and well-being needs of the local population
- **Refresh** existing strategies and plans for action where necessary
- **Represent** our plans to those people with responsibility for making key decisions on expenditure priorities
- **Re-engage** local communities and stakeholders to ensure that our priorities are the right ones and people are taking responsibility for their health improvement
- **Re-prioritise** our programmes of action in light of the evidence of need and of the effectiveness of interventions available to address this, and the aspirations of local people

Through the JSNA we will address these key questions

Information on illness, what people are dying of, and what stops people living the best life they can, is available, but not necessarily in one place. It can be used, alongside cost information, to make the best judgements possible regarding service provision. We want to ask:

- what needs are already known about in our local population? Many services and providers have information, but there is often a time lag gaining data due to the way it is collected and managed and this information it is not always cohesively shared.
 - For example, is the city ready to meet the challenges of a rising birth rate and longer life?
- What do local people consider to be the major health and social care issues?
 - What are people living with that makes their lives difficult?
- Are local people getting a fair share of the available resources for health and social care?
 - Which groups living in Southampton need better support?
 - How many older, vulnerable people are living in relative poverty?
 - What help do the groups who need support want?
 - Where do the groups needing support live?

The City of Southampton - a 20 year vision

The Southampton Partnership (<http://www.southampton-partnership.com>) has adopted a long term vision where:

“...Southampton will be known as a city that is good to grow up in and good to grow old in where people are proud to live...”

The City of Southampton Strategy includes a number of key aspirations for Southampton's future health and well-being:

- Southampton will be a place which promotes health and well-being and continuously improves the quality of life of all its people
- lengthen the average life-expectancy of people we serve by an extra year by 2012

It will achieve these aspirations by:

- implementing health improvement programmes across the City
- increasing access to preventive services
- continuing to reform and improve the local health care system

The health and well-being of Southampton's citizens is a central theme and partners are committed to promoting:

- healthier lifestyles and taking action on smoking, exercise and diet
- wider citizen ownership and control over factors that influence their health and access to services
- developing a secure and supportive City for people to grow up in and grow old in

The City of Southampton Strategy makes a clear link between health and well-being and wider sustainability. It is recognised that a degraded environment, poverty, unemployment and social exclusion impact directly upon the health and well-being of all communities. Health issues are strongly interlinked with social, environmental and economic factors, particularly for people experiencing poverty.

Southampton's Local Area Agreement

What is a local area agreement?

A local area agreement (LAA) is a three-year agreement between a local area and central government. The LAA describes how local priorities including health and social care will be met by delivering local solutions. It also contributes to national priorities set out by the Government. The LAA is negotiated between the local strategic partnership (LSP) and the regional Government Office (GO). The LSP is made up of key players in a local area who deliver services. The local authority is

the lead partner in the LSP. The local authority negotiates the LAA on behalf of its LSP and is the only body accountable to government. Other key players in a LSP include the police and the PCT.

The current LAA has set challenging local targets relating to children's dental health, the number of smoking quitters in priority neighbourhoods and the uptake of Warm Front grants and Pension Credits. Details of these and other relevant targets in the LAA can be found at: http://www.southampton-partnership.com/performance_pages_/local_agreement.htm

Building on our strengths

The Southampton Health and Social Well-being Partnership are implementing a health and well-being strategy based on three programme areas:

- **Choosing health** (prioritising action on: mental health promotion, sexual health/ teenage pregnancy; obesity; a smoke-free City; dental health inequalities and tackling alcohol harm)
- **Promoting independence** (prioritising action on meeting long term health and social care needs and improving access to services)
- **Tackling health inequalities** (prioritising action in the City's 11 most deprived neighbourhoods and amongst black and minority ethnic communities).

Engaging everyone in their health

Achieving a 'fully engaged' scenario, where there is better population commitment to health, will improve the cost-effectiveness of the NHS (Wanless, 2004). Across health and social care a wide range of data are collected on health status, for example, the prevalence of important behavioural factors, such as smoking, drinking, diet and exercise and the use of services and outcomes. However, gaps exist and the data we have requires better profiling and more complete analysis.

We want to make more and better data available to everyone who are interested in, and working to, improve health and well-being. A dedicated public website has been set up, to provide easier access.

Southampton's JSNA portal:
<http://www.southamptonhealth.nhs.uk/jsna>

Fit for the future

Southampton City PCT is trying to establish a world class commissioning system by consulting on its health commissioning priorities, which build on the health and well-being strategy. Six key programme areas have been identified, which will have the biggest

impact on improving overall health outcomes:

- cancer
- mental health
- vascular diseases (including heart disease, stroke and diabetes)
- respiratory diseases (including asthma and obstructive airways disease)
- infectious diseases (including hospital acquired infections such as MRSA, sexually transmitted infections and meningitis)
- alcohol harm, accidents and falls

These topics are also included in relevant sections of this report.

Complementing this work is a national review, not yet complete, of existing NHS priorities undertaken by Lord Darzi (2007) *Our NHS - our future*. The vision set out in *Our NHS - our future* is to provide fair, personalised, effective and safe services so that patients and the public have confidence in the care they receive. The findings will further support the JSNA (visit <http://www.nhs.uk/ournhs>).

A key challenge for local partners is to ensure that the commissioning priorities of the NHS in the City compliment those being led by the City Council (e.g. in respect of the local implementation of national strategies such as: Every Child Matters, Tackling Teenage Pregnancy, a number of key National Service Frameworks, Supporting People, and Drug Action Team and the Choosing Health (2004) and Our Health, Our Care, Our Say (2006) White Papers).

How can you contribute to and influence the JSNA?

The production of a JSNA will soon be a statutory responsibility with a clear role for Directors of Public Health, Children's Services and Adult Social Services to ensure that it happens. However many others have an important role to play in getting the JSNA right so we can deliver better outcomes. Local people and service providers, who are close to their communities, can play a vital role in supplying information to shape the future. Service providers will not only want to shape the JSNA, but also deliver the outcomes on a day-to-day basis in the way they work with their customers (patients and clients) and in how they make referrals to other services.

What you can do

At the end of chapters 3 to 6 we have posed some questions - these are also available at the end of this consultation report with space for you to feedback to us using a free post form. The postal address can be found on page 2 of this report and feedback can also be given on line at <http://www.southamptonhealth.nhs.uk/jsna>

The deadline date for feedback is **29 February 2008**.

Regional agencies will use local JSNAs as they look to the future to ensure the availability of a long-term infrastructure capable of delivering high quality performance including: a fit-for-purpose workforce; a more responsive primary care capital base and the long-term acute care needs of large populations, as services are brought closer to communities and patients.

What happens next?

JSNAs will become an integral part of the planning cycle for local authorities and the NHS, and we expect they will need to be carried out in line with the three-year LAA cycle. Our vision for the JSNA is a continuous programme of work that will enable us to better understand the City's changing needs.

References

Department of Health, (2004) Choosing Health, making healthy choices easier
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/Browsable/DH_4924964

Department of Health, (2006) Our Health, Our Care, Our Say: A new direction for community services. London: Department of Health. Available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4127453 accessed 15 October 2007

Professor Lord Darzi, (2007) NHS Next Stage Review Interim Report. London: Department of Health, 2007. Available at http://www.ournhs.nhs.uk/files/283411_OurNHS_v3acc.pdf
Accessed 15 October 2007

The House of Commons, (2006) Local Government and Public Involvement in Health Bill [Bill 16]. London: The Stationery Office 12 December 2006. Available at <http://www.publications.parliament.uk/pa/cm200607/cm200607/cmbills/016/en/2007016en.pdf>
Accessed 15 October 2007

Strategy references

Health in Southampton, (2004) Annual Public Health Director Report Southampton City Primary Care Trust
<http://www.southamptonhealth.nhs.uk/publichealth/p/har>

Health in Southampton, (2005) Annual Public Health Director Report Southampton City Primary Care Trust
<http://www.southamptonhealth.nhs.uk/publichealth/p/har>

Health in Southampton, (2006) Annual Public Health Director Report Southampton City Primary Care Trust
<http://www.southamptonhealth.nhs.uk/publichealth/p/har>

Southampton City Council, (2007) Southampton's Local Area Agreement 2007-2010, final version 11 [On line]. Available at <http://www.southampton-partnership.com/strategies/LAA%20final.pdf>
Accessed 15 October 2007

Southampton City PCT, (2007) Fit for the Future Delivering a First Class City Health System – Consultation draft [On line]. Available at <http://www.southamptonhealth.nhs.uk/wcc>
Accessed 15 October 2007

Supporting People (2005) Strategy 2005-2008. Southampton City Council
<http://www.southampton.gov.uk/thecouncil/thecouncil/strategy/city-plans-initiatives/people-strategy>

Southampton

2 - changing people

This chapter provides a brief overview of the population changes, known health and well-being inequalities and some needs that have not been met.

The City is the 21st most densely populated area in England and Wales, with 43.6 people per hectare: nationally, there are strong links between density of population and deprivation.

Demography

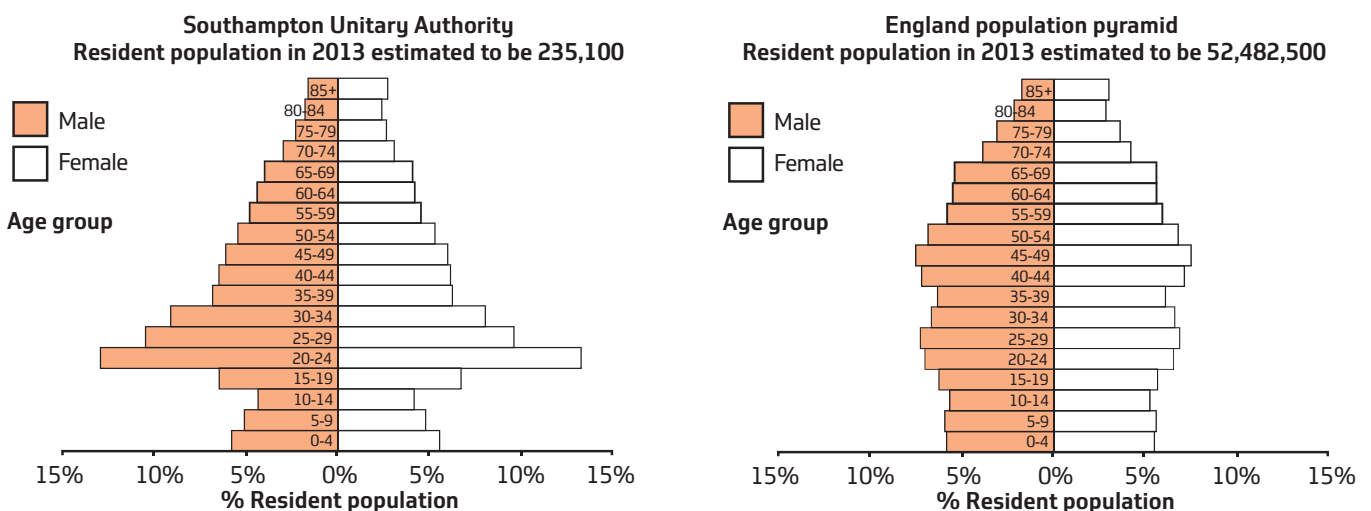
In 2006 the resident population of Southampton was estimated to be 228,600 people; by contrast the number of people registered with GPs in the City is over 253,000 because some practices serve people outside the City.

The age profile of Southampton's resident population differs from the national average because of the large numbers of students living in the City. The students are mainly located in Southampton's Central and North localities. Of the resident population, 16% are under 16 years of age, 70% are between the ages of 16 to 64 and 13% are aged over 65. Nearly 8% of

the population are from ethnic minorities, which is lower than the national average, but higher than the South East Region as a whole. The proportion of children and young people from black, minority and ethnic (BME) communities is significantly higher than the City average, and rises among younger children. There are twice as many BME children in reception classes (year R) as in year 11.

The BME communities in the City are very diverse. For example, gypsies and travellers, although not counted in the 2001 National Census, have a permanent site in the City, which is home for around 60 people. Between April and October 2007 20 unauthorised encampments were reported.

Figures 2.1 and 2.2 Population projection pyramids for Southampton and England 2013



ONS 2004-based (Revised) long term subnational population projections published Sept'07. Notes: Long term subnational population projections are an indication of the future trends in population by age and sex over the next 25 years. They are trend based projections, which means assumptions for future levels of births, deaths and migration are based on observed levels over the previous five years. They show what the population will be if recent trends in these continue. The projections do not take into account any future policy changes that have not yet occurred. They are constrained at a national level by the national projections produced by GAD on 20 October 2005. These projections, for areas in England, published on 27 September 2007 are based on the revised 2004 mid year population estimates (published 22 August 2007).

As well as the national population projections that are trend based, Hampshire County Council has produced population forecasts for Southampton based on planned residential developments. Between 2006 and 2013 Southampton is expected to see a 7% increase in the number of residential dwellings which equates to 7,174 new homes across the City. Over the same period the population will grow by just 2% (about 4,200 people) due to the impact of falling household sizes and changing family patterns (a trend which is being experienced nationally not just locally as a result of later marriage, separation/divorce and increased numbers of people choosing to live alone).

Much of the new development is planned for the Bargate ward (around 2,800 new homes) and the population here is forecast to increase by 27% between 2006 and 2013. However, in some parts of the City, particularly in the East, we are forecasting a decline in the population as falling household sizes mean that the same number of people can no longer be accommodated within the existing dwelling stock.

An ageing population is perhaps the most startling demographic change that we are likely to see in the future. Improved life expectancy will radically change the shape of the population pyramid both nationally and locally. The high ratio of older people relative to younger people will increase even more as the post-war and 1960s baby boomers move into, and through, their retirement years.

Long term population projections for Southampton produced by Hampshire County Council, predict that the over 65 population will increase by 30% between 2006 to 2026, whereas there will be a decrease of 5% in the number of people aged under 30.

The Hampshire County Council population forecasts and projections cannot take full account of the likely impact of Eastern Europe migrants to the City because these are not well recorded in official statistics. A recent report from Southampton City Council: East European Nationals Living in Southampton (2007) estimated that there may already be between 10,000 and 14,000 Eastern European nationals living in the City. However, it is not known how many will stay on a long term basis. These new communities might have significant impact on the City's demography, particularly with respect to birth rates and the numbers of dependent children of all ages. Work is being done, both nationally and locally, to try and get a better understanding of these new migration patterns.

Analysis of current inequalities

In Southampton eleven areas have been identified, through the Local Neighbourhood Renewal Strategy

(LNRS) as priority neighbourhoods areas for action (see Figure 1 on the inside cover). Health and other well-being inequalities exist between these priority areas and the rest of the City, and are summarised in Table 2.1

Table 2.1 Priority areas versus the rest of the City

- Life expectancy is lower – 3.4 years for men, 2.7 years for women
- Overall mortality rate is 28% higher
- Premature (under 75) deaths are 58% higher
- The death rate from circulatory disease in people under 75 is 56% higher
- Severe mental illness is more common
- Teenage pregnancy rates are higher
- Low birth-weight is 32% more frequent
- Smoking in pregnancy is over twice as common
- Breast feeding is less common - 21% v 39%

Life expectancy across the City is increasing, but this is not happening as fast in the priority areas as it is elsewhere, so the gap is widening. Between 2003 and 2005 the life expectancy of men in the City's priority areas was 74.8 years compared with 78.2 years for men living elsewhere in Southampton.

In 2006/07 over 29% of pregnant women from the priority areas said they were smoking at the time when they made their midwifery booking compared with just 14% of women from the rest of the City.

The 2006 local health and lifestyle survey found that people in the priority areas and some BME communities eat less fruit and vegetables. The survey discovered that respondents from BME groups had lower levels of social support and were less likely to have visited a dentist. Results from the Health Status of Gypsies and Travellers in England (2004) revealed that they have a significantly poorer health status than other UK residents, English speaking ethnic minorities and economically disadvantaged white residents.

Children and young people living in priority neighbourhood areas consistently do worse at school than those in the rest of the City, and are more likely to be living in poverty, in poor housing, have poor access to safe play and poorer outcomes across a range of health indicators.

Progress in reducing health inequalities has been assessed recently (briefing note, Wilkinson R, 2007). A mixed picture has emerged, in which most indicators improved for people living in priority areas, but in most cases the gap has not yet narrowed. See Table 2.2.

Table 2.2 Priority areas versus the rest of Southampton- progress

■ Life expectancy	X
■ Overall mortality rates	✓
■ Premature (under 75) deaths	X
■ Under 75 deaths from circulatory disease	✓
■ Severe mental illness	incomplete data
■ Teenage pregnancy rates	✓
■ Low birth-weight	X
■ Smoking in pregnancy	X
■ Breast feeding	✓
■ Dental health - 5 year-olds	X

Social and environmental context

In 2006 nearly a quarter of children in Southampton were living in families dependent on workless benefits; this is compared to 22% nationally, and just 14% across the South East region as a whole.

According to the Index of Multiple Deprivation (IMD) 2004, Southampton City ranks as the 96th most deprived City out of the 354 local authorities across the Country. The IMD also reveals that within the City there are some areas that are greatly disadvantaged; for instance in one area of the Bargate ward 75% of children are living in income deprivation, and the City has the three most deprived areas in the South East for income deprivation affecting older people. Across the City well over 50% of children live in priority neighbourhood areas.

In 2007 more than 4% of the working age population in Bevois and Bitterne wards were claiming jobseekers allowance, compared to the national average of just 2.4%.

Current known health status

In the 2001 Census, 17% of Southampton residents reported suffering a long term illness or disability which limited their daily activities or the work they could do. This is very similar to the national average. In our local survey over a third reported some pain or discomfort on the day that they completed the questionnaire.

It is estimated that around 32% of adults in Southampton smoke which is significantly higher than the England average of 26%. According to the national Tellus survey, smoking amongst children and young people is also higher than the national average. Tellus is an on-line survey that gathers the views of children and young people as part of the schools Ofsted process. The Tellus survey is used by the City Council to judge how much of an impact their services are having on improving outcomes for

children and young people.

In our local adult health and lifestyle survey (2006) less than half of the respondents said they were eating the recommended five portions of fruit and vegetables a day and 70% reported that they did not do enough exercise.

Data from GP disease registers can tell us how many people in the City have been diagnosed with a particular illness. In June 2006 there were 7,540 people on coronary heart disease (CHD) registers, 7,951 people on diabetes registers, 15,587 on asthma registers and 2,021 on severe mental illness registers.

Teenage conception rates in Southampton have been consistently higher than the national average since records began. In 2005 the conception rate for under 18s was 58.8 per 1,000 females aged 15-17, compared to the national rate of 41.1.

Current met and unmet needs of the population

Using national morbidity rates by age, sex, disability, ethnicity and other factors we can model the number of people we expect to be suffering with certain illnesses from the known characteristics of Southampton's population. This allows us to identify the likely levels of unmet need.

Maternity services

We know that over the last year between 200 and 250 babies were born each month to Southampton residents. The numbers of births appear to be increasing and a maternity strategy is being developed to ensure demand is catered for. Southampton has a low infant mortality rate of 3.2% compared with the national rate of 5.1% (2007).

Neonatal care

Low birth weight presents big challenges to maternity services due to the increased needs of the mother during pregnancy and the babies when they are delivered. Prematurity is a particular problem, with babies often requiring ventilation and intensive care for periods ranging from a few hours to several weeks.

A range of risk factors increase the burden of neonatal disease, including maternal smoking, alcoholism and illicit drug taking and dependency. Prevention programmes are vitally important in all these areas, but many infants still suffer from the negative impacts of these avoidable risks during pregnancy.

Specialist obstetric services (foetal medicine

services), neonatal intensive care, and special care all provide expert management for low birth-weight babies. Local access is excellent geographically with the neonatal network centre in Southampton, but services are overstretched, in common with the national picture, and it is a struggle to fully staff the facility. In general, nursing provision falls 20-40% below the national recommended level and the occupancy of cots can be very high, necessitating higher levels of transfer than we need to achieve the best results. The neonatal network, working across the health authority area, has been instrumental in improving staffing levels, and developing specialist neonatal transport systems.

Investments in both maternity and neonatal services are necessary, but the prevention and avoidance of many of these affected pregnancies must also remain a high priority for the future.

Transient populations - Students

As an established University City we have around 30,000 students in the City. These students are in the main vibrant and healthy, but some do require the services of health and social care systems. These focus particularly around sexual health, mental health and musculo-skeletal injuries. This population by its nature changes and can cause high service demands during term time. Students are encouraged to register with a local GP and we know some choose not to do so. This impacts on health and social care budgets because we are not funded for our un-registered population.

Cancers

There are inequalities in cancer incidence, mortality and survival within the City. A number of factors influence a person's risk of developing cancer and the outcome of the disease. Some of these factors such as age, genetic make up and sex are fixed, but others are lifestyle factors which can be modified.

Deprivation is strongly linked to lung cancer, with the highest rates in the most deprived populations, whilst breast cancer is inversely linked, with the highest rates in the most affluent groups. There are inequalities in survival, with poorer relative survival rates in the most deprived groups for cancers of the lung, colon and breast.

Smoking is the most important avoidable cause of cancer, followed by being overweight or obese. In the South East around 27% of cancer deaths are due to smoking.

Screening for cancer

Screening is a public health service in which members

of a defined population, who do not necessarily think they are at risk of or already have a disease, are asked a question or offered a test. This helps us identify those people who are more likely to be helped than harmed by further tests or treatment to reduce the risk of the disease or its complications (National Screening Committee).

Ensuring there is a good uptake of screening programmes for cancer in Southampton is a challenge.

Breast cancer is the commonest cancer, and the commonest cause of death from cancer in women. The incidence of breast cancer in Southampton is 119 per 100,000, below the regional average of 121 per 100,000, which is what we would expect from the socio economic make up of the population.

The national breast screening programme is estimated to reduce mortality from breast cancer by 35% in women who participate. Screening is offered to all women between the ages of 50 and 70 years.

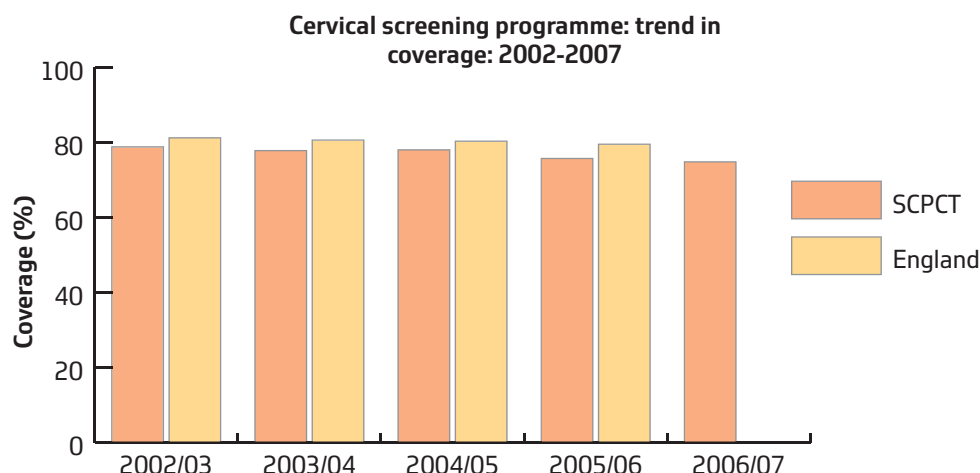
Uptake in Southampton is just below the national average of 74% but varies between localities, being particularly poor in the City centre at 66%. We know that uptake is lower in socio-economically deprived groups and in some minority ethnic groups. Screening is offered to all women between 25 and 65 years of age.

The national cervical cancer screening programme is estimated to have saved 8,000 lives between 1988 and 1997, and incidence rates have fallen by about 40% in that time. Rates of cervical cancer in Southampton are the same as national rates, 8.1 per 100,000 women. The actual number of women developing invasive cervical cancer is small.

If an overall screening coverage of 80% can be achieved, the evidence suggests that a reduction in death rates from cervical cancer of around 95% is possible in the long term. In line with the national picture coverage rates for cervical screening are falling in Southampton. The uptake of cervical screening in the PCT in 2006/07 was 74.8%. This is much lower than we would like, and well below the national target of 80%. The lowest rates are in the City centre and the North of the City. Rates have fallen, particularly in young women, which is worrying. National work for the National Screening Committee found that the commonest reasons given for not attending for smears were embarrassment and not having enough time. Figure 2.3 indicates the reduction in coverage.

It is a priority to increase the number of women participating in the screening programmes in Southampton. A quarter of the women who would benefit from breast and cervical cancer screening are

Figure 2.3 Cervical screening programme trend coverage 2002-2007



Southampton City PCT (2007)

not doing so. We know something about the characteristics of these women, but the reasons why they do not attend are poorly understood and we need to identify and remove the barriers to screening.

In September 2008 we are planning to implement the Human Papilloma Virus Vaccination program for girls 12-13 years which will reduce, but not eliminate, cervical cancer, screening will still be required.

As part of the national roll-out programme the PCT is planning the introduction of bowel cancer screening for men and women aged 60 to 69 early in 2008. This programme will help identify potential cancers before symptoms appear enabling earlier diagnosis and treatment.

Sexual health

The number of people living with HIV-infection and accessing services in Southampton increased to 209 in 2006 (a rise of nearly 80% since 2002). Evidence suggests that around 30% of HIV is undiagnosed and nationally the burden of disease is high in migrants from Africa and India.

Dental and oral health

Dental health amongst children is a major issue in Southampton. Over 50% of children living in the priority areas have some decayed, missing or filled teeth compared to 32% elsewhere in the City.

Towards a healthier Southampton

The NHS, both nationally and locally, is moving away from its concentration on being a sickness treatment service to becoming a health and well-being service.

This change of emphasis has been reinforced nationally by the public health white paper Choosing Health which focuses on:

- promoting healthy living lifestyles
- encouraging and empowering individuals to take greater responsibility for their personal well-being in factors such as smoking, eating and exercise benefits
- recognising the many social and environmental factors that contribute to health and well-being such as housing, education, crime, home safety, employment and earnings

Summary

This chapter on changing people has provided an overview of the City's demography and population forecast. It has briefly explored the inequalities and social aspects of health and raised the issue of needs that have both been met and unmet. The next chapter explores our changing needs and provides more detail on the issues already identified.

As you read through the following chapters we will pose some questions to you. When answering them please consider Southampton's population and their changing needs, have we got the balance between prevention, treatment and social care right? Where are the gaps?

Profiling data showing a range of indicators of people's health in Southampton can be seen in Appendix 1. It shows the local value for each indicator compared to the England worst, England best, England average and Regional average.

Further, more detailed information can be found via the JSNA portal.

References

- Association of Public Health Observatories and the Department of Health (2007). Southampton Health Profile 2007. [On-line] (updated 28 July 2007) Available at <http://www.communityhealthprofiles.info> Accessed 15 October 2007
- Department of Health, (2004) Choosing Health, making healthy choices easier http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/Browsable/DH_4924964
- Hampshire County Council. Small Area Population and Dwelling statistics. [On-line] (updated 12 September 2007). Available at <http://www3.hants.gov.uk/planning/factsandfigures/population-statistics/small-area-pop-stats.htm> Accessed 15 October 2007
- Hampshire County Council Small Area Population Forecasts plus explanatory notes can be accessed at <http://www3.hants.gov.uk/planning/environment-statistics/population.htm>
- Oxford Cancer Intelligence Unit, (2007) Cancer Inequalities in the South Central Strategic Health Authority [On-line] Oxford Cancer Intelligence Unit. Available at <http://www.ociu.nhs.uk/data/South%20Central%20inequalities%20factsheet%20FINAL.pdf> Accessed 15 October 2007
- Synthetic estimates of adults age 16+ who currently smoke modelled using Health Survey for England data 2000 to 2002, Census 2001 and other administrative sources via PHO Health Profiles.
- Strategy references**
- Health and Lifestyle Survey (2007) Southampton City Council and Southampton City Primary Care Trust 2006 King D, Wilkinson R. Local Health Comparisons 2006. Southampton City PCT 2006. Available at <http://www.southamptonhealth.nhs.uk/publichealth/lhc/lhc2006>
- Oral Health Needs Assessment and Oral Health Improvement Strategy Draft documents October 2007. Southampton City PCT
- Pearce, H. (2002) Southampton Local Neighbourhood Renewal Strategy Part 1: The neighbourhood renewal vision for Southampton. Available at <http://www.southamptonhealth.nhs.uk/publichealth/plans/lhrs>
- Southampton Partnership (March 2006). Closing the Gap-Local Neighbourhood Renewal Strategy (2006-2010). [On-line] Southampton Partnership. Available at <http://www.southampton-partnership.com/strategies/LNRS.pdf> Accessed 15 October 2007
- Southampton Partnership (June 2006). The Southampton Children and Young Peoples Plan 2006-9 [On-line] Southampton Partnership. Available at <http://www.southampton-partnership.com/strategies/Children%20&%20Young%20Peoples%20Plan.pdf> Accessed 15 October 2007
- Tellus Ofsted Report: Ofsted (2006).
- Wilkinson, R. (2007) Health Inequalities in Southampton City: An analysis of trends. Southampton City Primary Care Trust <http://www.southamptonhealth.nhs.uk/publichealth/briefings>
- Winkworth, S., Kalinowska, J. & Mead, V. (February 2007) East European Nationals Living in Southampton. [On-line] Southampton City Council. Available at http://www.southampton.gov.uk/Images/East%20European%20immigration%20report_tcm46-180191.pdf Accessed 15 October 2007

Southampton

3 - changing needs - staying healthy

Changing Southampton

This chapter examines the populations changing needs from the perspective of staying healthy and improving health. Whilst we know a huge amount of work goes into maintaining health and well-being across a host of settings, there are still gaps in our knowledge around some areas of need.

Children Young People

Educational attainment

Although overall Key Stage results have improved in the last few years, at all Key Stages Southampton children continue to perform below the national average, significantly so for Key Stage 3. At the important Key Stage 4 (GCSE) the percentage of 16 year olds gaining five or more A* to C GCSE grades was 50.0% in 2007, significantly below the national average of 59%.

Educational attainment and skills are positively related to employability and the reduction of poverty. Improving children's health and well-being improves children's self-esteem and ambition. Educational attainment and health are strongly correlated. If we cannot improve educational attainment we will have difficulty in improving health and vice versa.

The role that Healthy Schools can play in educational attainment is such an important local priority, enabling children to achieve their potential, and yet only two thirds of Southampton schools have Healthy Schools accreditation.

Exclusions

Although children and young people are less likely to be permanently excluded from school in Southampton than nationally, levels of children and young people who are excluded who are receiving alternative provision are lower than average. The percentage of pupils receiving alternative provision who were reintegrated into school is well below the national average (2.7% compared with 17.8% nationally in 2005).

School attendance

In Southampton's primary schools, the level of

authorised absence is above the national average and that of our statistical neighbours. In secondary schools, the level of authorised absences is in line with our statistical neighbours, but is also above the national average.

What has the Children and Young Peoples Plan needs assessment told us?

The Southampton Children and Young People's Plan encompasses the national Every Child Matters outcomes and outlines these with underlying plans and actions. It provides an overarching plan for all children's services within Southampton.

In relation to health and well-being outcomes for Southampton children and young people, the needs assessment indicated the following:

Low birth weights

In 2004, 8.4% of babies born to Southampton residents weighed less than 2.5kg, compared to 7.0% for the South East region and 7.9% for the country as a whole. Significantly higher rates were recorded for the wards of Bevois (13%), Bitterne (10%) and Bassett (10%). Information collected by Sure Start Children's Centres suggests that recent gains are being made, but it is too early to detect sustainable trends.

Breast feeding

There is significant research evidence to demonstrate the benefits of breastfeeding to both infants and young children and mothers. Although in some areas, the average number of mothers breast feeding is higher than average (80% in the north of the City, compared to the national average of 73%), it is significantly lower in other parts of the City, most noticeably in the east (60%).

Midwives, health visitors and Sure Start projects within the City have been working to increase breast

feeding rates especially in Priority Neighbourhoods to bring these in line with rates for the City. Targets to improve breastfeeding commencement and continuation rates are in the Health and Well-being Strategy and the LAA.

Oral health in our children

Good oral health is an integral part of general health and well-being, and a key marker of the health of a community. Poor oral health leads to pain, discomfort, sleepless nights and difficulties with eating, which leads to poor nutrition and time away from school.

The oral health of children in Southampton is poor. For example, five-year-old children have more missing or filled teeth than the average for England. Significant inequalities in child oral health exist: 42% of children who have experienced dental decay have an average of over four decayed, missing or filled teeth. These children are often from areas of social and material deprivation.

The causes of poor oral health are well known and include:

- an unhealthy diet with large amounts of sugar increases the risk of tooth decay. Dietary habits are established from a very young age and a diet of sugary and unhealthy foods will encourage a young child to continue eating these foods later in life

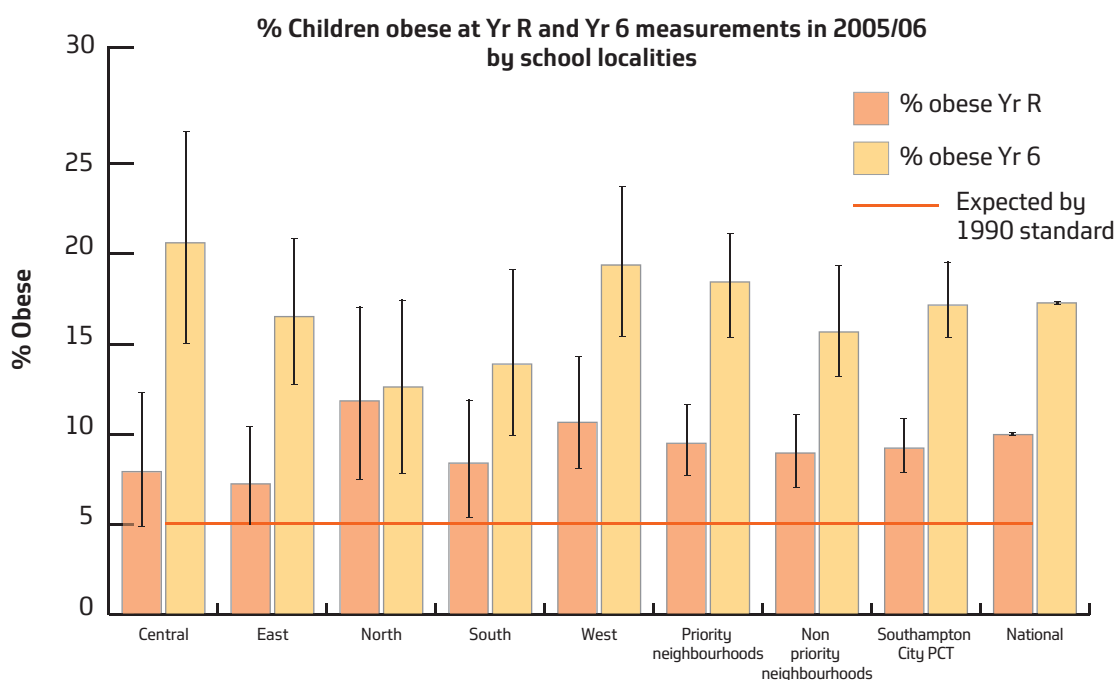
- poor oral hygiene - not brushing teeth regularly with a fluoride toothpaste increases the risk of tooth decay and periodontal disease
- lack of exposure to fluoride can increase the risk of tooth decay occurring every time sugary foods and drinks are consumed
- the health of teeth can be affected by a traumatic injury, which is a particular risk for those who play contact sports

Obesity

The rate of obesity is rising alarmingly in children. Nationally it is estimated that rates increased from 10% in 1995 to 17% in 2005 in children aged between two and ten years. This is of concern as evidence suggests that overweight or obese children go on to be overweight or obese adults. Local data from 2005/06 school year, collected as part of the DoH Height and Weights measurements programme, suggests that Southampton PCT has significantly higher proportions of overweight, obese and severely obese children in both Year R and Year 6 than would be expected from the 1990 UK reference data*. However, the overall proportion of obese children in Southampton is not significantly different from the national averages for both Year R and Year 6 (see Figure 3.1 below). We need to work to stop the year-on-year increase in obesity in children under 11 against the 2006 baseline.

* Footnote: This is the national benchmark used by the Department of Health.

Figure 3.1 Obese Children Year R (4-5 years) and Year 6 (10-11 year olds)



NCHOD database Note: Data based on school postcode and not child residence.

Numerator: Number of children obese

Denominator: number of children with valid measurement

King, D & Lovegrove, P. (2007) Childhood Obesity, summary report for Southampton City PCT

Activity in childhood

Activity in childhood helps healthy physical and mental growth and development. Children and young people should achieve a total of at least an hour a day of moderate intensity physical activity.

We do not have detailed local data of the health related beliefs and lifestyles of children and young people about physical activity but we know that in the South East:

- three out of ten boys and four out of ten girls are not meeting the recommended amount of physical activity
- more children travel to school by car than in England as a whole
- children spend a lot of time in inactive leisure e.g. watching TV, computer gaming, which detracts from physical activity

In Southampton, 45% of all schools have two hours or more a week of timetabled physical education.

Children and young peoples mental health

The UK ranks bottom for children's well-being in a recent UNICEF (2007) study compared with North America and 18 European Countries. Nationally, it is estimated that about one in 10 children and young people by the age of 15 will have a mental health, emotional or behavioural problem.

The 2006 population forecast for children and young people aged 0-17 years in Southampton is 44,809, and therefore we can anticipate that approximately 4,480 children and young people are likely to require mental

health support at some time.

As mental health problems affect so many children and young people in the City, it is important that everyone working with children and young people is aware of mental health issues and has the skills to identify and intervene early to support children and families.

The total number of referrals to Child and Adolescent Mental Health Services (CAMHS) between April 2004 and April 2005 was 701 (15 per 1,000 children and young people). There are more referrals from Woolston and Portswood wards and fewer from Coxford, Shirley and Freemantle wards.

Bullying and fear of crime

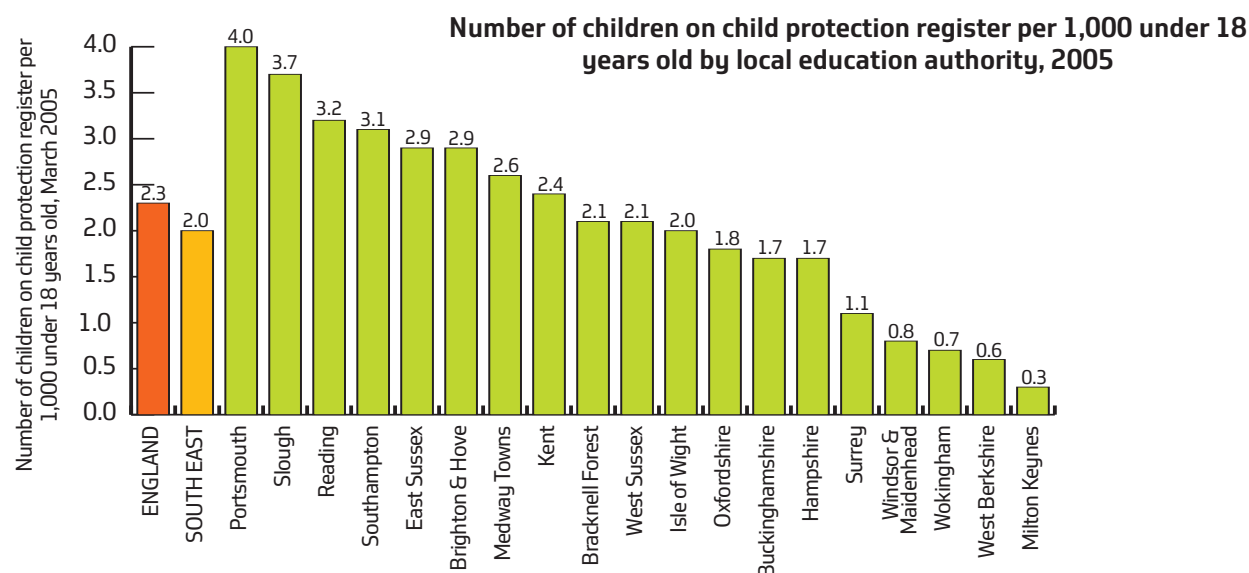
The Fear of Crime Survey (2004) results showed that 89% of children and young people said that they felt safe in their area; those from Thornhill, Harefield and Freemantle felt safest. One third of the survey respondents said they had been victimised; significantly more of these children and young people were from Priority Neighbourhoods.

Vulnerable young people

Child protection and children in care

Children on the Child Protection Register and Children in Care are a particularly vulnerable population. They have higher rates of adverse childhood experiences, including physical, sexual and emotional abuse or neglect compared to children in the general population. Figure 3.2 below, shows variations in rates of children on child protection registers, with higher rates in Portsmouth, Brighton and Hove, Medway and Southampton compared to England and the South East.

Figure 3.2 Number of Children on Child Protection Registers



Children in Care are six to eight times more likely to have a conduct disorder than children in the general population, (36.5% vs 4.6% of 5-10 year olds, and 40.5% vs 6.2% of 11-15 year olds). They are also two to three times more likely to have an emotional disorder, and 5-7 times more likely to have a hyperkinetic disorder, compared to children in the general population. Girls are also more likely to suffer with an emotional disorder as they get older.

Poor mental health is associated with low educational performance and absenteeism; additionally, conduct and hyperkinetic disorders disrupt the educational environment for other children.

Conduct disorders in particular are associated with anti-social and offending behaviour, which impacts on the safety and well-being of the wider community. The average cost to society of an individual with untreated conduct disorder is £70,000. (GOSE, 2007).

We need to ensure that appropriate and accessible services are targeted at the following high risk groups:

- children in care / child protection register
- children experiencing physical, sexual, emotional abuse or neglect
- children with a physical health problem
- young disabled, LGBT or BME people
- children excluded from school, teen parents, young offenders
- children with family members who have mental health or substance misuse problems
- children with family members who are offenders or ex-offenders
- children in families with parental violence
- homeless or disadvantaged families
- Traveller or Asylum Seeker families

What works?

In early childhood the most protective aspect promoting mental well-being and reducing the risk of abuse for children is good parenting skills. Additionally, long term follow-up of health visitor programmes to develop parent skills found reductions in adolescent anti-social and offending behaviour as well as improved educational and employment outcomes.

Social and Emotional Aspects of Learning (SEAL), is a primary school programme interwoven and integrated into the main curriculum. It is voluntary for schools to adopt the SEAL curriculum, with approximately 30% of primary schools nationally signed up to it. SEAL programmes bring about an immediate reduction in self-reported depression, reduction in drug and cigarette use and improved educational outcomes. Details can be found at: <http://tinyurl.com/ho24l>

What are we doing?

- increasing access to parenting support through Family Points and Sure Start Children's Centres
- we have developed a community based early intervention programme which combines Child and Adolescent Mental Health Services with Youth Inclusion Support Panel (YISP) functions (Saucepans)
- we are improving service provision for children and young people with complex mental health needs including twenty-four hour cover
- we have reduced waiting times for Specialist CAMHS
- we are supporting more children within the City so that out of area placements are avoided
- developing CAMHS services for children with learning disabilities
- developing a fully comprehensive service for sixteen- and seventeen year olds

We currently lack information regarding therapy for abused children and the population need for this.

Delayed speech and language skills

A significant proportion of children and young people with complex needs have delayed speech and language. If these were assessed effectively first, then we would be able to better assess their other needs. The introduction of newborn hearing screening means that babies with hearing difficulties are detected within weeks of birth so that appropriate support can be put in place early for them and their family to improve communication.

We know that we need to reduce waiting times for speech and language therapy for initial assessment from 10 weeks (2005/06) down to four weeks (2008/9). The extension of joint care plans to cover more children and young people with complex needs would support the earlier identification and assessment of their related needs.

Adults and older people

The Southampton adult lifestyle survey in 2006 provided us with a snapshot of health behaviour and the risks taken.

Diet and health

Over the last four decades there has been a significant change in the UK diet with a move away from home cooked traditional meals towards more convenience foods. This has been accompanied by a reduction in physical activity due in part to a more automated lifestyle, having more inactive occupations and engaging in less physical activity.

Just under half of respondents (45%) in the 2006 lifestyle survey reported that they were eating the recommended five or more portions of fruit and vegetables (including tinned or frozen fruit or vegetables) per day.

The importance of good oral health

Good oral health can improve a person's self esteem and quality of life. There is no local data on how common tooth decay is in adults, but data from a 1998 national survey indicated that more adults are keeping their own teeth and that the condition of their teeth has also improved. The proportion of people with no teeth at all is expected to drop from 13% in 1998, to 8% in 2008, and then down to 5% in 2018.

It is important that people retain enough of their own teeth to enable them to eat what they want. This is called 'functional dentition'. More people are retaining more of their own teeth without the need for dentures until later in life, if not for their entire lifetime. We predict that for the next couple of decades many people will need a combination of natural teeth and dentures, but the management of patients may become more complex.

Data from the adult oral health survey also indicated that people are reluctant to lose the last of their teeth. A total of 79% of adults would rather have an aching tooth filled, than have it removed. Although 61% of adults with no experience of dentures said that they would be very upset at the thought of wearing full dentures, only 27% said that they would be upset at the thought of wearing partial dentures. This highlights the need for more preventive interventions to help people keep their own healthy teeth for longer.

Although oral health in the adult population is improving, there are still significant inequalities. Besides age, educational attainment has a significant impact on tooth decay and loss. Those with no qualifications were almost nine times more likely to have no teeth than those with degree level qualifications. Those with qualifications below degree level were four times more likely to have no teeth than those with degree level qualifications. People who said they attended a dentist only when they had trouble were five times more likely to have un-restorable decay than those who said that they had regular check-ups. Adults who attend check-ups were also almost three times more likely to have 12 or more sound and restored teeth than those who said they only attended when they had dental problems. This shows us that there is still a continuing need to provide access to dental care, particularly for those from lower socio-economic backgrounds as well as a need to encourage more people to visit a dentist more regularly.

As well as the causes of poor oral health already mentioned in children, smoking increases the severity of periodontal disease and is one of the main risk factors for oral cancer. Smoking combined with excessive alcohol consumption can increase the risk of oral cancer by 30 times.

What we are aiming to achieve

- a population with good oral health with minimal risks of dental disease
- good access to primary dental care for everyone in the general population
- good access to dental care for vulnerable groups and populations who may in the past have faced barriers accessing appropriate dental care and advice
- good access to specialist care including ensuring that everyone is treated at the most suitable location and by the most appropriate professional
- a highly-skilled workforce who will be able to deliver high-quality care to the local population

What are we doing?

- reviewing our oral health promotion programme and ensuring that it is targeting those who are at increased risk of dental disease, such as people living in areas of social and material deprivation
- reviewing the cost-effectiveness and feasibility of water fluoridation to improve the oral health of the local population, particularly young children
- there has been a lot of investment in the centre of the City to improve access to NHS primary dental care. Special effort is being made to develop dental services in areas where there are high needs for access to oral health care and advice
- the Salaried Dental Service is providing care for the people in our population with special needs; these services are constantly reviewed to ensure that they are appropriate
- specialist dental services are being reviewed to ensure that waiting times are not excessive and that referral to these services is clear and straightforward

Obesity

Is obesity an issue for adults and older people in Southampton?

Obesity is considered to be a global epidemic. In Southampton, as in other parts of the UK, the number of adults becoming overweight or obese is increasing.

It is estimated that over half of women and two thirds of men in England are now overweight or obese, which has major costs in the form of ill health and premature death.

Obesity has serious long-term health consequences and increases the risk of:

- type 2 diabetes
- coronary heart disease
- stroke
- certain cancers

Obesity is also associated with low self-esteem, a negative self image, stigma and isolation amongst many other social and psychological consequences which have an impact on how well people feel from day to day.

For the vast majority of people, obesity is caused by an energy imbalance - we eat or drink more energy than we need or use and so we store the excess as fat.

What are we doing?

The causes of obesity are many and complex and so the solution is far from simple.

Tackling obesity is a priority for the City and we already have a Fit 4 Life Strategy (tackling obesity), including a Fit 4 Life Children and Young People's Strategy which has been jointly developed between Southampton City PCT and Southampton City Council. We are ensuring that members of the public and other stakeholders are involved in developing and shaping services, activities or initiatives so that they meet the needs and issues faced by local communities.

The aim of the strategy is

To improve the health of the people of Southampton by identifying and implementing effective strategies to prevent obesity and help overweight people to lose weight.

A large number of activities and initiatives have been developed and continue to run in community settings that focus on food and/or physical activity to encourage long term sustainable change in behaviour.

We have identified the following priority areas for action:

- raising awareness of the health consequences of obesity for both children and adults
- developing and providing effective weight management and treatment services and support services in the community for adults and children
- developing and supporting targeted prevention strategies and actions aimed at children, and involving the wider community

- providing training and support for staff and the wider workforce in order to help address the issues of obesity

Why is physical activity important for adults and older people?

Being physically active has great benefits for overall health. Regular physical activity can cut the risk of major chronic diseases such as coronary heart disease, stroke, diabetes and some forms of cancer, especially of the breast and colon, by a half (WHO, 2004). Physical inactivity costs the NHS in England an estimated £8.2 billion each year in the treatment of chronic disease.

For general health benefit, adults should try and do a total of at least 30 minutes a day of moderate intensity physical activity on five or more days a week.

Over the last 25 years the distance people walk or cycle has fallen by a quarter. Generally we are less active at work and tend to spend more time watching television and using computers. Six out of ten men and seven out of ten women in England and Wales are not active enough to benefit their health.

The Southampton Lifestyle survey (2006) showed that levels of physical activity were similar to those for the South East region as a whole:

- seven out of ten people surveyed did not take enough exercise
- three out of ten people surveyed had not taken any exercise in the last week
- men were more likely to take sufficient exercise than women

Lack of time and the cost were the most common reasons people gave in the survey for not taking more exercise.

Physical activity is important for older people. Regular activity helps maintain mobility and independent living and reduces the risk of osteoporosis, back pain and osteoarthritis as well as helping to prevent falls.

Physical activity decreases with age and seven out of ten men and eight out of ten women aged 75 years and above are inactive. The lifestyle survey showed that as people get older medical reasons were more likely to prevent them from being physically active.

What are we doing?

A variety of initiatives have been developed – for example Active Options, the upcoming cycling on referral project, exercise classes and healthy walks. The Council's Leisure Services offer discounted prices

on occasion to increase activity levels. However, these are isolated and do not offer a comprehensive approach.

The City of Southampton Local Transport Plan 2006 – 2011 (LTP2) includes an 'Active Travel Plan' which was produced jointly (and endorsed) by the PCT and Sport England (South East). It is Council policy to provide new and improved physical infrastructure, targeted promotional literature and public events that encourage people to undertake Active Travel. The advantage of incorporating physical activity into everyday life as a travel choice is twofold. Firstly, it can replace a car journey and has a specific purpose and, secondly, it can contribute to tackling the alarming rise in obesity.

The City Council continues to work closely with Sustrans on completing the National Cycle Network (NCN). The Council is also part of the Connect 2 Consortium which is seeking funding from the National Lottery in order to install a boardwalk along the banks of the River Itchen, linking Northam to St. Denys via Horseshoe Bridge and filling in the 'missing gap.'

The Stressbusters exercise on prescription scheme for adults with common mental health problems is running successfully in the East of the City and we hope to expand this programme.

The PCT's Physical Activity Strategy will also have a longer term impact, but the key issue is investment, and the shift of resources from acute provision to investment in preventive measures.

Whilst a lot of good work is going on to habitualise physical activity back into peoples everyday lives, we can see from what we are doing lacks coherence and evaluation to see if these schemes meet peoples needs.

Mental health

Population and mental ill health prevalence

Mental health problems are complex and associated with both social and biological/genetic predisposing factors, and difficult/traumatic events in people's lives. Factors such as low self-esteem, social exclusion or stress, can also put people at risk of developing mental health problems.

These variables are more likely to become important against a backdrop of poor housing and transport, high crime rate, discrimination, abuse and violence, inequality and poverty.

Mental health problems are the largest single cause

of disability and illness in England accounting for:

- 40% of all disability (physical and mental)
- nearly 40% of people on Incapacity Benefit (and a secondary factor for 10% more of them)
- a third of all GPs' time

About one in six adults in the UK have a common mental health condition (i.e. depression or anxiety disorders) and an estimated 91 million working days a year are lost due to mental illness. The Government aspires to raise the number of working age adults in employment from 75-80% of the working age population, and has a target to reduce the number of people on Incapacity Benefit.

The Mental Health Needs Index (MINI) in 2001 showed mental health needs are highest in the areas covered by West and Central Community Mental Health Teams and the PCT has the highest incidence in the Strategic Health Authority area.

The PCT has completed an audit of people with schizophrenia and psychosis on GP caseloads. The results show more cases in inner City practices, although all surgeries have people with these complex needs on their caseloads.

We know that many people with mental health problems are not getting the treatment they need to bring them out of the misery these conditions cause. Only one in four people are diagnosed and in treatment. Many people who are receiving treatment are taking drugs prescribed by their GP, although they would prefer the more-recently developed cognitive behavioural therapy.

The Council and the PCT are working in partnership to jointly commission Adult Mental Health Services. The strategy covers services for adults aged 18 – 64 and addresses the targets laid out in the National Service Framework for Mental Health.

Suicide

Suicide accounts for 1% of deaths in the City. The reasons behind these deaths have been difficult to assess but could include the high prevalence of mental illness, places of opportunity (e.g. the Itchen Bridge), and high unemployment. The recent National Suicide Strategy for England aims to support the reduction in suicide rates, and the National Institute for Mental Health England (NIMHE) issued guidance in 2003 to assist Mental Health Services in reducing and preventing suicides.

There are clear differences in the background causes and manifestations of mental illness between the sexes. Men suffer more often with substance misuse and personality disorders, whilst women suffer more often with anxiety, depression and eating disorders.

Unexplained deaths involving substance misuse now outnumber suicides and are discussed in the next chapter. Most studies suggest that depression and anxiety are at least one and half to two times more common in women. In contrast, mental illnesses, such as schizophrenia and bipolar affective disorder, do not show such clear gender differences in incidence and prevalence.

Employment and mental health

Southampton has one of the highest unemployment rates in the Hampshire and Isle of Wight area; see Table 3.1:

Table 3.1 Economically-active (seeking work) unemployed people as % of the workforce.

	Southampton %	South East %	GB %
Mar 01 – Feb 02	3.9	3.4	5.1
Mar 02 – Feb 03	5.0	4.1	5.2
Mar 03 – Feb 04	3.9	3.9	5.0
Jan 04 – Dec 04	4.8	3.8	4.8
Apr 04 – Mar 05	4.6	3.7	4.8
Oct 04 – Sep 05	5.5	3.8	4.8
Jan 05 – Dec 05	4.9	3.8	5.0

NOMIS 2006

Unemployment is a significant risk factor for a number of health indicators; the effects can be linked with poverty and low income amongst the unemployed. There are significant psychological consequences of being out of work, especially for the long-term unemployed. In addition, work can play an important role in our social networks and the ways in which we participate in society. Policies that increase levels of employment are, therefore, likely to have significant benefits for mental, physical and social health.

Unemployed people have been found to have:

- lower levels of psychological well-being which range from symptoms of depression and anxiety through to self harm and suicide
- higher rates of morbidity – such as limiting long term illness
- higher rates of premature mortality, in particular for coronary heart disease, injuries and poisoning including suicide

Employment deprivation is defined as people who want to work but are unable to do so through unemployment, sickness or disability. Five Southampton wards are within the most employment

deprived 10% wards within the South East Government Region. Bargate, St.Luke’s and Redbridge wards are the most employment deprived wards in Southampton. In Bargate 19% of people are living in employment deprivation.

A review of the policies needed to improve mental health, with a particular focus on supporting people to gain employment and stay in employment was announced in the 2006 Budget. The review recommended improving the way that people with a mental health condition are supported and treated, with a holistic approach engaging individuals, employers and GPs, as well as Jobcentre Plus and the wider NHS.

Black and minority ethnicity (BME) mental health

Neurotic disorders are more common, affecting 15% of the population at any time. There is a lack of data on how these disorders affect different ethnic groups although Pakistani women appear to report the highest rates of depressive episodes and anxiety disorders.

African Caribbean people in Britain have higher admission rates to psychiatric hospitals and are three to six times more likely to be diagnosed with schizophrenia. The incidence amongst British Caribbeans is also much higher than that recorded in Jamaica and rates for second-generation British-born black people are higher than those for the first generation. Black people are over-represented among patients compulsorily detained in psychiatric hospitals under the Mental Health Act, or via Police admissions and under-represented in less intrusive treatments.

Gypsies and travellers

The Council’s gypsy and traveller strategy noted levels of depression as being very high in the gypsy and traveller population.

These inequalities are reflected in Southampton by referrals to the Assertive Outreach Team, a tertiary service, and by compulsory admissions under the Mental Health Act.

Asylum seekers and refugees

Over recent years Southampton has become home to a range of asylum seekers, the majority being single adults. There are estimated to be:

- 1,500-2,000 Somalis of whom 40% are families
- 1,000-1,500 Afghani people where only 5% are families
- 500-700 Kurdish and Iranian people where 5% are

- families
- 1,500 refugees from 40 other ethnic backgrounds

Whilst refugees have the same general health needs as those of all people from ethnic minority groups, they are likely to have additional needs related to their experiences in their home countries. These may include the mental, physical and social effects of violence, trauma, torture and rape.

These traumatic experiences with the shattering of values and beliefs regarding self, the world and the future can lead to severe psychological and psychiatric problems, particularly post-traumatic stress disorder.

Substance misusers

The relationship between mental health and substance misuse problems is complex:

- a primary psychiatric illness can precipitate or lead to substance misuse
- substance misuse can worsen or alter the course of a psychiatric illness
- intoxication and/or substance dependence can lead to psychological symptoms
- substance misuse and/or withdrawal can lead to psychiatric symptoms or illness

Substance misuse amongst people with psychiatric disorders has been associated with significantly poorer outcomes and people who misuse alcohol have a high risk of suicide, with 65% of all suicides attributed to alcohol.

Our Community Mental Health Teams have reported that a significant proportion of their clients have dual diagnosis problems (alcohol/substance misuse with a mental illness). A local needs assessment undertaken for the Dual Diagnosis Strategy identified a prevalence of between 15-40%, with some teams such as the Supportive Outreach Team reporting that the majority of their caseload had a dual diagnosis.

Lesbian and gay communities

In Spring 2001 a survey by the Southampton Gay Community Network of 279 gay, lesbian, bisexual and trans-gendered people in the City showed:

- significant mental health and psychological problems
- high levels of homophobic incidents, 40% of people having experienced an incident in the previous year

National studies have found:

- gay men, lesbians and bisexuals appear to have higher rates of some mental disorders

- discrimination is thought to fuel these higher rates
- higher rates of major depression, generalised anxiety disorder and substance misuse or dependence are found in young lesbians and gays
- higher use of mental health services in men and women reporting same sex partners

Offenders

Offenders and ex-offenders generally have poorer physical and mental health than the wider population. Around 90% of all prisoners have a diagnosable mental health problem (including personality disorder), substance misuse problem or both. The rate of suicide in prisons is higher than in the community. The City has no prison within its boundary but has close links with Winchester Prison where people from Southampton are often detained. We know that offenders are in need of a more targeted approach by health and social care on discharge to support their future needs.

The Government has made it a priority to ensure that all prisons have strategies or systems in place to identify those prisoners with mental health needs who are due for release and to link them to local services which are operated consistently and effectively.

Rough sleepers

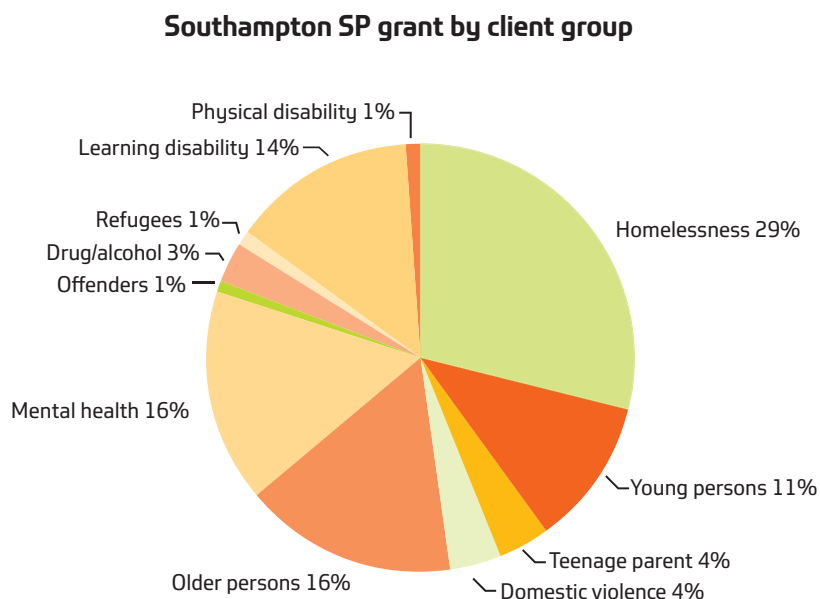
The Government's Social Exclusion Unit estimates that 30% to 50% of people sleeping rough suffer from mental health problems. For the vast majority (88%) their mental health problems were present before they went on the street. About half of people sleeping rough have alcohol problems and about one in seven has drug problems.

In Southampton the Street Homeless Prevention Team reported a high prevalence of both common and serious mental health problems amongst the City's homeless population.

Supported housing needs

'Supporting People' is the new framework for supported and sheltered housing services. Supporting People brings together the existing funding streams for support services into a single budget to be applied at the local level based upon the strategic priorities of the Council's Housing Community and Regeneration and Health and Social Care Directorates, the PCT and Probation services. There is a wide range and diversity of supported housing provision across the City and Southampton has a varied and vibrant supported housing sector that will now be funded directly through Supporting People Grant.

Figure 3.3 Supported Housing - where the money is spent in Southampton



Supporting People 2005 Southampton City Council

Presently, there is high level data available which gives a general indication of unmet need in the City. The recent Housing Needs and Markets Survey (2006) provides a good overview of the needs of people in all general needs housing in the city. This allows us to identify those areas in which there may be relatively high unmet demand for additional services. The survey provides very useful information at a high-level; however it is not a specialist Mental Health survey, and as such falls foul of definition issues.

The Housing Needs Survey found that 891 people required primary mental health support, with 90% receiving sufficient support.

Single homeless people

Needs identified for this vulnerable group include an increase in the amount of self contained accommodation (as opposed to shared houses) and a need for clustered independent accommodation for some who no longer need support but do not want to live on their own. This could include the use of any current excess sheltered housing.

In summary the findings were:

- we identified a large number of people who needed mental health support, who do not currently use Supporting People-funded services, but who do not require additional support
- we identified a low number of people with a Mental Health support need and no additional needs who require additional support. The

suggestion is that at the time of survey, an additional 52 people would have benefit from housing-related support

- the indication is that there are no people with more complex needs (i.e. needs additional to a mental health need) whose needs (housing-related support or care) are unmet in the City
- none of those who require additional support are housed in inadequate accommodation

Additional information is becoming available from the mental health accommodation panel which targets people with serious mental health problems who meet the criteria for specialist services. Issues emerging from the first six months are:

- the need to consider gender specific services
- supported accommodation projects that can manage people with a dual diagnosis (mental health and substance misuse)
- increasing numbers of people who are unable or unsuitable for shared accommodation, due to impact on other residents or specific diagnosis
- the need for intensive community resources to support people with high care needs in independent accommodation

Consultation with service users and carers

Service user and carer involvement in planning the design and future direction of mental health services is an established practice in Southampton. The City Council has a number of initiatives to further improve service user and carer involvement, including community participation, and these forums are used as appropriate for consultation and networking

opportunities. These include:

- city user involvement officer
- citizen involvement panel
- neighbourhood partnership groups
- community action forums
- federation of tenants and residents associations
- council tenants groups
- racial harassment groups
- regeneration partnerships

In addition, the City funds Southampton Voluntary Services to run a number of user forums including a mental health forum, a counselling forum, a domestic violence forum and supported housing forum.

The health of black and minority ethnic (BME) communities

People from BME groups make up 7.6% of the Southampton population, similar to the UK as a whole. Southampton has the largest concentration of BME groups in Hampshire; one third of the county's BME population live in the City, although these communities are not evenly distributed across the City. For example, people from black and ethnic minorities account for approximately twenty percent of the population in the Bargate ward and eighteen percent in St Luke's. The age profile of the BME population is similar to that of the UK.

New communities

We have recently seen a growth in new communities in Southampton. New communities include asylum seekers and refugees and economic migrants, including those from the EU accession states.

Communities from the EU accession states

By far the largest new community, with an estimated 10,000 to 14,000 people is from Eastern Europe, with over 80% coming from Poland. The highest concentration of new communities, particularly refugees, is in the City centre.

Why is ethnicity important for health?

Ethnicity is linked to health in a number of ways:

- the determinants of health differ between ethnic groups, for example people from ethnic minority groups are more likely to live in socio-economically deprived areas
- the rates of many diseases, for example CHD and diabetes, vary by ethnic group
- health-related behaviours differ between ethnic groups

National surveys tell us that the Afro-Caribbean population has higher rates of hypertension and stroke than in the general population while South Asians experience higher rates of CHD. Rates of renal disease are higher in Africans and Indo-Asians.

All ethnic minority groups have higher rates of diabetes; the Health Survey for England (HSE, 2004) reported a rate of 44% in Pakistani women. These higher rates of chronic disease have significant implications for the future provision of health and social care services.

There is a variation in the distribution of lifestyle factors with, for example very high smoking rates in Bangladeshi men and low rates in Indian, Pakistani, Bangladeshi and Chinese women. Very high rates of overweight and obesity are seen in Black Caribbean and African women, reaching over 90% in the over 55 age group compared to 68% in the general population.

Levels of physical activity are particularly low amongst Indian, Pakistani and Bangladeshi men and women and in Chinese women. Men and women from BME communities eat more portions of fruit and vegetables than the general population.

These variations are important when considering the best way to target services and preventive programmes.

What are we doing?

In common with many parts of the UK there is a lack of robust local data about who is using which health and social care services. This hinders our understanding of the health needs of ethnic communities and our ability to improve access to services.

The local needs assessment identified five key priorities to improve the health of Southampton's ethnic minority communities:

- improve data collection of ethnicity in primary care
- primary prevention of cardiovascular disease - focusing on physical activity
- secondary prevention of cardiovascular disease and the complications of diabetes
- improve mental well-being
- improve access to services, particularly through the use of the interpretation and translation service

We still need to do more work to get a better understanding of the local patterns of disease in BME groups and to find out how new communities can best access our health and social care services.

Summary and questions

This chapter changing needs – being and staying healthy covered the following areas regarding children and young people:

- educational attainment
- birth weights
- breast feeding
- oral health
- obesity
- activity in childhood
- mental health
- vulnerable young people
- delayed speech and language skills

Questions about children

Do you agree that these are the right priorities to maintain and improve children's health in Southampton?

What are your key priorities and why?

What key actions would you recommend to achieve these to improve children's health and social care needs in Southampton?

The section on adults and older people examined:

- diet
- oral health
- obesity
- physical activity
- mental health – under this broad heading
 - suicide
 - unemployment
 - BME specific needs
 - gypsies and travellers
 - asylum seekers
 - substance misuse
 - lesbian gay and bisexual
 - offenders
 - rough sleepers and homelessness
- ethnicity and health

Questions about adults and older people:

Do you agree that these are the right priorities to maintain and improve adults' health in Southampton?

What are your key priorities and why?

What key actions would you recommend to achieve these to improve adult health and social care needs in Southampton?

The next chapter examines the needs for support in health and social care to enable people to stay safe.

References

Choosing Health in the South East, (2006): Physical Activity. SEPHO

Department of Health (1999) National service framework for mental health: modern standards and service models. London.
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009598

GOSE (2007), Children and Young People Promoting Emotional Health, and Well-Being; Information Series Draft March 2007.

Health Survey for England, (2005) Health of Ethnic Minorities 2004 Department of Health
<http://www.ic.nhs.uk/pubs/healthsurvey2004ethnicfull>
Index of Multiple Deprivation (2004)

Mental Health Act (2007)
http://www.opsi.gov.uk/acts/acts2007/ukpga_20070012_en_1

Mental Health Index MINI (2001)

National Statistics (2004) Crime and Fear of Crime Survey
<http://www.statistics.gov.uk/about/data/harmonisation/downloads/S9.pdf>

NOMIS National Statistics office (2006)
www.nomisweb.co.uk/

UNICEF, (2007) An overview of child well-being in rich countries: A comprehensive assessment of the lives and well-being of children and adolescents in the economically advanced nations. UNICEF Innocenti Research Centre Report Card 7.

WHO, (2004) Towards a European strategy on non-communicable diseases Fifty-fourth session Copenhagen, 6–9 September. World Health Organization Regional Office for Europe

Strategy references

Active Options, (2006) Stress Busters Report. April

Allan, K. Allan, S. Davis, T. Ramsey, S. Sitaram, S, Tong, R. and Webster, C. (2003). Children and Young People's Plan Southampton City Council and Southampton City PCT
Bagshaw, K. Gardner, J. and Wilkinson R. Health and Lifestyle Survey, (2006) Southampton City Council and Southampton City Primary Care Trust
CAMHS, (2002) Learning Disability, Needs

- Assessment, Strategy Development, Service Planning
http://www.hascas.org.uk/pdf_files/CAMHS%20LD.pdf
 Accessed 1 October 2007
- Fear of Crime Survey (2004) Southampton City Council
<http://www.southampton.gov.uk/thecouncil/thecity/research/marketresearchresults/fearofcrime.asp>
- Getting Southampton Active (2003)
<http://www.southamptonhealth.nhs.uk/publichealth/plans/physicalactivity>
- Health in Southampton, (2004) Annual Public Health Director Report Southampton City Primary Care Trust
<http://www.southamptonhealth.nhs.uk/publichealth/p/har>
- Health in Southampton, (2005) Annual Public Health Director Report Southampton City Primary Care Trust
<http://www.southamptonhealth.nhs.uk/publichealth/p/har>
- Health in Southampton, (2006) Annual Public Health Director Report Southampton City Primary Care Trust
<http://www.southamptonhealth.nhs.uk/publichealth/p/har>
- Health and Lifestyle Survey, (2007) Southampton City Council and Southampton City Primary Care Trust 2006
- Hird, S. (2006) Needs assessment of black and ethnic minorities in Southampton, Southampton City Primary Care Trust
- Housing Needs and Markets Survey (2006)
<http://www.southampton.gov.uk/thecouncil/thecity/research/marketresearchresults/housingneeds2006.asp>
- King D, Lovegrove P. (2007) Childhood Obesity Southampton City PCT 2001/02 to 2005/06
<http://www.southamptonhealth.nhs.uk/publichealth/briefings>
- Gay Community Health Service (2001) A comparative assessment of the health needs of Gay and Bisexual men in Bournemouth and Southampton. Southampton City PCT
- Obesity Strategy for Southampton 2003 to 2008
<http://www.southamptonhealth.nhs.uk/publichealth/plans/obesity>
- Oral Health Needs Assessment and Oral Health Improvement Strategy Draft documents October 2007. Southampton City PCT
- Pavey, L. (2003) Active Options Exercise Recommendation Scheme, Southampton City PCT
- Southampton Health profile (2007) SEPHO
http://www.communityhealthprofiles.info/profiles/hp2007/hi_res/00MS-HP2007.pdf
- Southampton's Local Area Agreement 2007-2010, Southampton City Council
- Supporting People (2005) Strategy 2005-2008. Southampton City Council
<http://www.southampton.gov.uk/thecouncil/thecouncil/strategy/city-plans-initiatives/people-strategy>
- Tellus Ofsted Report: Ofsted
- The Health Status of Gypsies and Travellers in England (2004) Department of Health. University of Sheffield
- The Southampton Children and Young People's Plan 2006-09. CYPP Southampton City Council
- Southampton City Council Homelessness Strategy (2003)
<http://www.southampton.gov.uk/housing/housingneeds/default.asp#0>

Southampton

4 - staying safe - supporting health and care needs

This chapter focuses on protecting the vulnerable in society from transient and permanent harm and neglect. We know that people want to be able to develop and grow into the adult and older person they choose to be whilst contributing to the richness of society. While we know an enormous amount about aspects of these needs in primary, secondary and tertiary health and social care, there still remain gaps in our knowledge.

Long-term conditions (LTC)

Around 17.5 million people in the UK are living with a LTC and 26,000 of these live in Southampton. Of these around half report that their condition limits their daily activities or work and around 2,000 will require case management to coordinate their complex needs.

Most long term conditions (LTC) increase as people get older. As our ageing population increases, LTCs will make an increasing contribution to the overall burden of disease. These conditions are hugely costly, both to the NHS and to society, yet they, and their complications, are also largely preventable. The prevalence of some risk factors is increasing and urgent action is needed now to prevent a steady rise in the prevalence of risk factors and the incidence of disease. The changes recommended in this document aim for people in Southampton to live long and to live well.

Self-management and education for LTC

Condition-specific training when a patient is diagnosed increases their understanding of the clinical aspects of their condition, and can shape beliefs about their role in managing the condition, its progression, the significance of medication in its treatment and the potential for self-management.

The Expert Patients Programme (EPP) is a self-management skills programme for any adult with a long-term health condition. Entirely lay-led and working from a social model of health, EPP achieves significant changes in people's confidence to manage their long-term health.

Monitoring data published by the Department of Health in February 2005 reported the improvements in health state and use of health services among people attending EPP courses. These include:

- decrease in GP consultations of 7%
- decrease in A&E attendances of 16%
- outpatients appointments decreased by 10%
- decrease in hospital admissions of 13%
- increase in visits to pharmacy of 18%
- 33% of participants felt better prepared for consultations with care professionals after the course

The PCT plans to put more investment into the EPP and is currently examining the potential demand.

Children

Children with a long term condition - focus on disability

Data from the 2001 national census indicated that 5% of children and young people in Southampton had a limiting long-term illness, which is around 2,175 children and young people. This is average for our population compared to similar UK cities. During the week of the 2005 Children in Need Census, 245 (12%) of the children and young people known to children's social care were disabled. This was slightly lower than the England average. Compared to the number of children with limiting long-term illness, 6.4% of children and young people received a service from children's social care services – slightly higher than the England and comparator averages.

Consultation from the disabled children and young people stakeholder day identified a number of unmet needs:

- equitable access to user-friendly transport across the City
- better access to occupational therapy
- improved access to equipment and services within

- mainstream schools
- enhanced support to access leisure facilities, particularly for older children without parents and there is a need for more facilities in certain areas such as Thornhill
- more provision of respite care for parents who are finding it difficult to cope
- access to adult-based services for young disabled people as they enter adulthood, particularly 16 to 19 year olds

Adults

Adults with long term conditions – focus on General Practitioner data

Data on prevalence of common long term conditions obtained through the Quality Management and Analysis System (QMAS) that analyses data collected through the new GMS contract's Quality and Outcomes Framework (QOF) is presented below in Table 4.1.

Table 4.1 Common long term conditions

Condition	Southampton	
	Percentage of population	Number
Hypertension	9.4%	23,469
Asthma	6.2%	15,589
Diabetes	3.0%	7,563
Coronary Heart Disease	3.0%	7,490
Hypothyroid	2.1%	5,208
COPD	1.4%	3,570
Stroke and TIAs	1.2%	3,065
Severe mental illness	0.8%	1,958
Epilepsy	0.6%	1,492
Total		69,404

Data extracted relates to March 2005

Work is ongoing in primary care to review and refresh practice registers particularly regarding the prevalence of diabetes and COPD, which national modelling suggests are under diagnosed.

People with long term neurological conditions

We are proud of our services in Southampton. We provide a range of specialist neurological rehabilitation services, from inpatient rehabilitation following an acute event such as traumatic brain injury, through to long term involvement with patients diagnosed with multiple sclerosis, to helping those with rapidly progressive diseases such as motor neurone disease.

People with long term physical disability

Assessments for people with a long term disability (lasting longer than 6 month in people over the age of 30 months) are carried out by a specialist team of therapists and rehabilitation engineers. Clients may be assessed in clinics held at the Wheelchair Service Headquarters, or in their own home, school, work-place, day centre or hospital. In addition to the client's clinical needs, the assessment also considers environmental and lifestyle issues and the needs of the carer.

The Wheelchair Service provides wheelchairs, special seating and pressure relieving cushions to clients with a GP in the City. In complex cases, special adaptive or supportive seating may be supplied to prevent or contain skeletal deformity. Consultant-led clinics are held twice monthly for clients with severe postural problems.

We seek to empower people to manage their own health care, whilst recognising that people will need regular support. Increasingly complex disabilities are managed at home, and within current resources it is difficult to maintain waiting lists at reasonable proportions. We are looking at ways of managing the growth in demand of these highly specialised services to meet the complexity of needs, especially of young people who in the past would not have survived into adulthood.

Tele-care / tele-health

Helping people to monitor their own symptoms may affect the quality of care that they receive. The effects of home monitoring devices, telephone monitoring and written care plans on systems and health service use are unclear. There is some evidence that self-monitoring may improve clinical outcomes for people with some types of long term conditions, but there is insufficient evidence about the impacts of self monitoring on healthcare costs or resource use. We have evidence that using computers and telecommunications systems to monitor patients may improve care processes and could be associated with improved clinical outcomes especially for people with diabetes. However, there is insufficient evidence to draw conclusions about the impact of computer systems and tele-monitoring on healthcare costs and patient satisfaction. The PCT is currently carrying out some pilot studies with diabetic and chronic obstructive respiratory disease patients using tele-care monitoring in their own homes. Early results are encouraging and we are already seeing a reduction in hospital admissions.

Disease management

Disease management is an approach to patient care that seeks to limit preventable events by maximizing patient adherence to prescribed treatments and to health promoting behaviours.

Case management

Case management has been defined as the process of planning, coordinating, managing and reviewing the care of the individual. The broad aim is to develop cost-effective and efficient ways of co-ordinating and providing services in order to improve quality of life.

Older people

Older people with long term conditions - focus on depression and dementia

In 2005 a higher number of older people in the City

suffered from depression than had dementia. By 2012 we estimate there will be an additional 357 people with dementia and 385 with depression in the older population (see Tables 4.2 and 4.3 below). Some people may fall into both categories. This has implications for services such as day care, and the need for residential care. Depressed older people will tend to neglect their health and therefore are candidates for targeted monitoring.

Women are shown as having higher levels of depression than men, but it is nationally recognised that there is a major under-diagnosis of depression in men which may be reflected in the higher suicide rate in men compared to that for women.

Table 4.2 National prevalence of dementia - 2005-2012

Age group	National dementia prevalence	SCC estimates 2005	SCC estimates 2009	SCC estimates 2012	SCC dementia change % 05-12
65 - 69	1.4%	114	127	143	+25%
70-74	2.8%	209	222	230	+10%
75-79	5.6%	380	395	386	+1.5%
80-84	11.1%	624	642	646	+4%
85+	23.6%	1038	1231	1317	+27%
65 + yrs totals		2365	2617	2722	+15%

National estimates of prevalence of dementia from the Alzheimer's Society. Population data from 2001 census applied to City population.

Table 4.3 National prevalence of depression - 2005-2012

Age Group	Depression prevalence		SCC estimates 2005		SCC estimates 2009		SCC estimates 2012		Change 05-12	
	M	F	M	F	M	F	M	F	M	F
65-74	4%	9.9%	298	807	330	865	359	935	+20%	+15.9%
75-84	5%	10.5%	251	776	272	777	278	752	+10%	-3.1%
85+	5.7%	9.7%	74	301	93	348	104	364	+40%	+21%
65yrs+ total			623	1884	695	1990	741	2051	+9%	+17%

National depression prevalence from 'Key Health Statistics from General Practice 1998 applied to City census population data 2001.

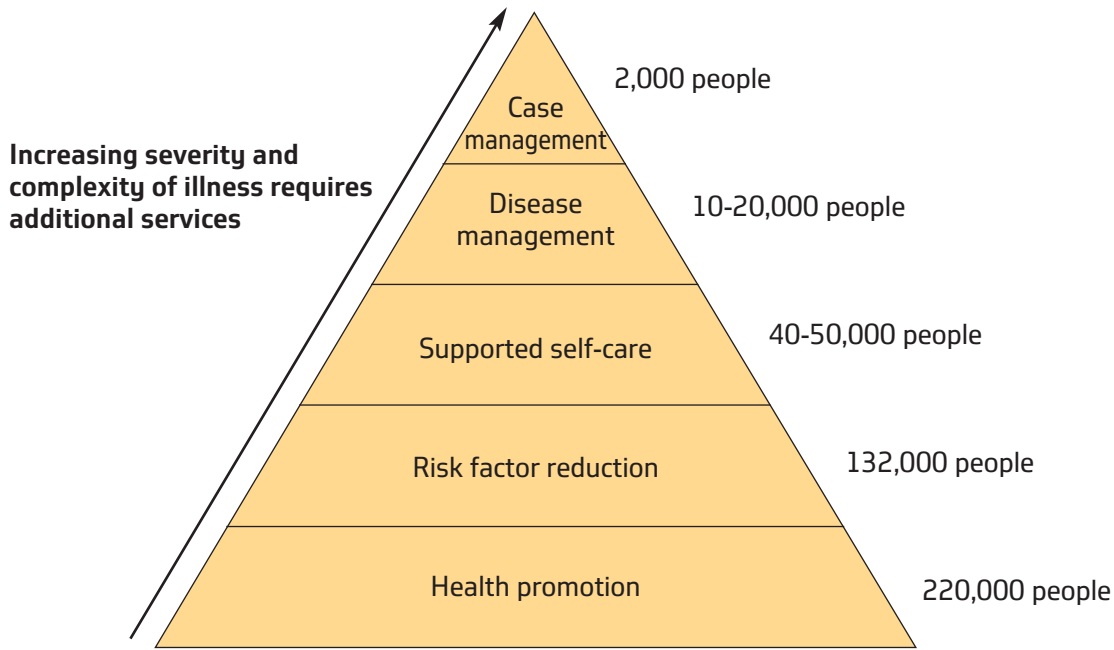
Framework for long term conditions

The NHS health and social care model has been used as a framework around which the recommendations have been built (see Figure 4.1 below). The model identifies the components of chronic care that need to be addressed to provide a service for people with long term conditions. The key infrastructure components are community resources, decision

support tools and clinical information systems and the health/social care system environment. The key delivery system components are public health, supported self-care; disease management and case management.

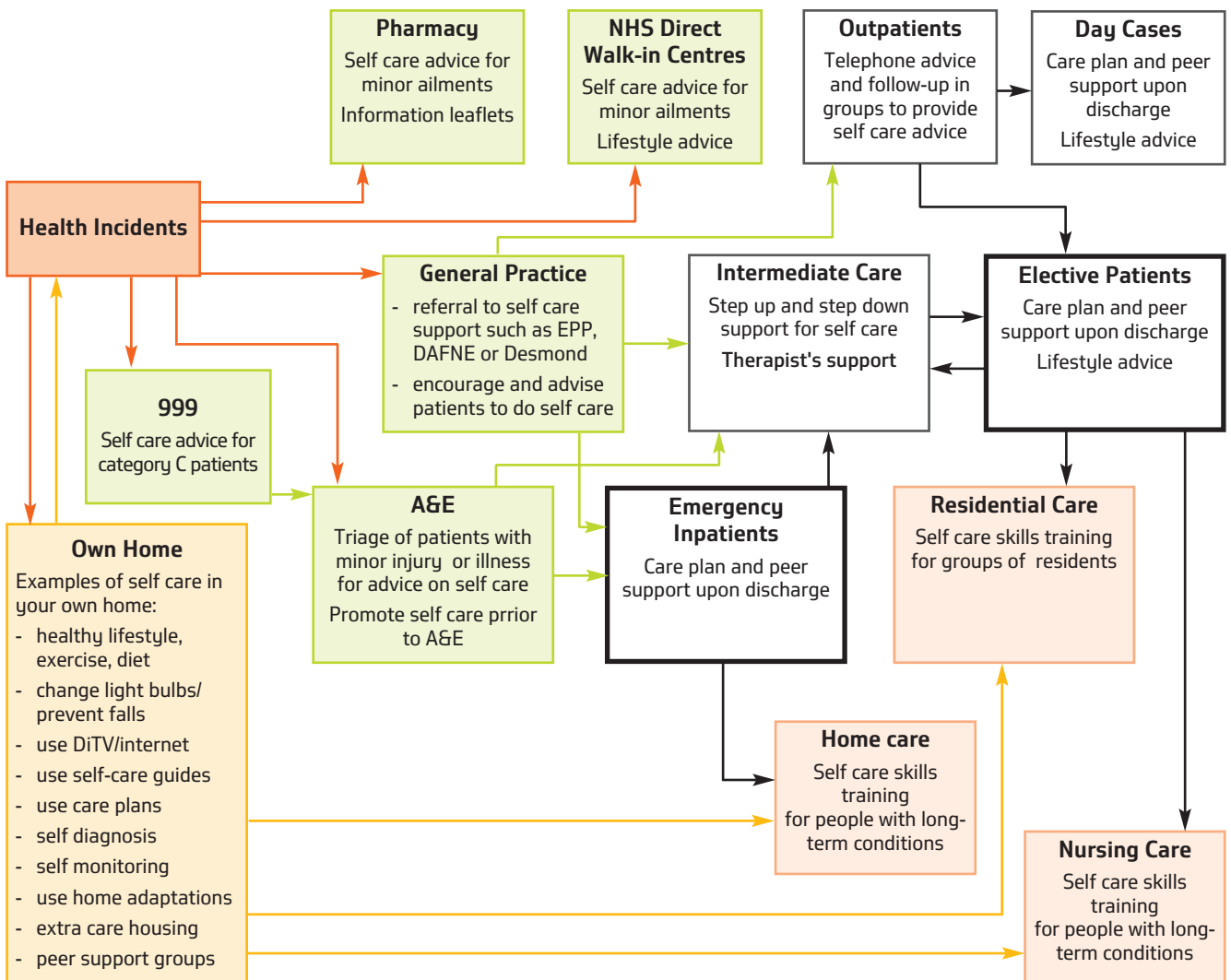
Figure 4.2 below outlines the public involvement in staying healthy, home care, community care to specialist care in a snapshot.

Figure 4.1 Long term conditions hierarchy of need



Adapted from Kaiser Permanente triangle

Figure 4.2 Self care involves a whole system approach



Department of Health: www.dh.gov.uk/SelfCare

Social Care Services

Why are social care needs important?

Southampton's Adult Social Care Services are responding to the needs and demands of a typical urban area with substantial levels of local deprivation, resulting in a high level of need.

The need for social care is rising due to the increasing age of the population, particularly the year on year rise in the number of people over 85 who are major users of social care services. People in this age group, as highlighted above, are more likely to have dementia and a high level of need for care services. Also, younger disabled people are living longer due to advances in social and medical care.

In Southampton as in the rest of England, service growth and funding have not kept pace with growing needs. The Council has a relatively low budget per head of population for social care provision compared with other similar authorities and works hard to keep overall service costs low to help meet rising demands. The Council has also focused more of its services on older people with mental health problems than other comparable concerns.

Local services have been modified to help people live independently in the community rather than in residential care. There are 24% fewer admissions to residential and nursing care homes in Southampton compared to other similar authorities but this leads to a greater dependence on family and carers. In response the Council carries out almost twice as many carer assessments per capita than other authorities, but can provide only slightly more carer related services.

Compared to similar areas in England, referral rates for adult health and community care are approximately 20% higher, indicating that services are well publicised in the community and in referral agencies.

Southampton City Council, in common with many authorities, is putting increasing efforts into providing information and advice to assist people prior to formal referral which helps keep referral rates steady despite the increases in age-related demand. We also have a much higher proportion of new referrals coming from primary/community health services and fewer from secondary health care agencies, supporting a local focus on preventive approaches to care management.

Domestic violence

What is domestic violence?

Domestic violence is:

A pattern of behaviour, which is characterised by the exercise of control and the misuse of power by one person over another, usually a current or former partner. This includes, but is not restricted to, physical, sexual, emotional and financial abuse and the imposition of social isolation. It is most commonly a combination of all these.

Why is domestic violence important?

Domestic violence affects thousands of people in Southampton every year, regardless of their ethnicity, age, faith, gender, socio economic background and ability. It affects us in our homes, workplaces and communities and impacts on all aspects of well-being. We all have a responsibility to address this serious crime and to commit to making Southampton a safer City.

Whilst domestic violence has a disproportionate effect on women, we know that it affects the lesbian, gay, bisexual and transgender community as well as men.

Domestic violence:

- accounts for nearly a quarter (23%) of all violent crime in England and Wales
- one in four women and one in six men will experience domestic violence during their lifetime
- of those who suffer sustained domestic abuse, 89% are female
- one incident of domestic violence is reported to the Police every minute
- on average, a woman is assaulted 35 times before her first call to the Police
- two women every week are killed by their current or former partner
- a third of all murders are 'domestic'
- domestic violence costs approximately £23 billion a year in the UK, £3 billion of which falls to public services

In Southampton

Data from Hampshire Constabulary indicate that they received 3,372 reports of domestic violence in 2006, of which 1,296 were recorded as violent crimes. This is an average of 65 domestic violence reports every week in Southampton. Approximately five families per month submit homeless applications to Southampton City Council because of domestic violence.

Domestic violence accounts for approximately 11.5% of all reported violent crime in the City, which is not only lower than the national average (23%), but is a

reduction from three years ago when the figure was between 13-15%. We do not fully understand the reasons behind this but it may be due to the hidden nature of domestic violence as a crime.

Repeat victimisation rates stand at 38%, which is above the national average.

Children and young people

There is growing recognition of the damaging effect of domestic violence on the lives of children.

- in 90% of domestic violence incidents children are in the same or the next room
- in over half of known domestic violence cases, children were also directly abused
- around half of child protection cases involve domestic violence

Children and young people who have witnessed domestic abuse are 14 times more likely to experience physical mistreatment than those who have not.

Southampton has four key strategic priorities on domestic violence:

Advocacy and risk: Increasing safety, reducing risk and providing an advocacy service to victims most at risk whilst continuing to provide outreach support and advice to those experiencing domestic abuse.

Children and young people's work: Providing accessible support, help and advice to children and young people who have been exposed to domestic violence, increasing safety and helping them to learn the skills to develop healthy future relationships.

Mainstreaming, education and prevention: Increased public awareness and understanding, preventative measures (including training) around domestic violence and related issues; targeted at all communities, including children, survivors, perpetrators and professionals.

Diversity: Diversity underpins all aspects of domestic violence work in the City, and is of key importance in providing inclusive and effective services to those in need no matter what their background, ethnicity or sexual orientation.

Children and young people living with learning disabilities

Why is learning disability important?

National research suggests that just under 3% of the population has a learning disability of whom 1% are

known to specialist services.

People with learning disabilities (and their families) have poorer health than the general population. In particular they:

- are more likely to suffer from mental illness and have higher rates of dementia, with greater chance of early onset especially for individuals with Downs Syndrome
- have higher rates of respiratory disease
- have increased rates of obesity
- have an increased rate of abuse
- are likely to die younger

Improvements in antenatal, postnatal and neonatal care have led to improvements in the life expectancy of children with severe disabilities, including learning disabilities. These children have highly complex needs and are high users of health and social care services.

Children with learning disabilities are at greater risk of abuse and of developing a mental illness and their siblings are at risk too. We know that children, their parents and families benefit from early intervention and increased support.

We need to ensure that we have good information about inequalities in health and health and social care for people with learning disabilities and that we develop action plans to improve care pathways so that individuals with learning disabilities have better outcomes.

We do not currently have accurate information on the number of children or the precise nature of their disabilities.

What are we doing?

- modernising children's services
- improving transition services for young people moving into adult services
- modernising specialist behavioural and mental health assessment and treatment services
- raising awareness in Primary Care, training and setting up primary care learning disability registers
- GP practices developing action plans to address health inequalities
- acute care-awareness raising, training and development of care pathways for people with a learning disability
- ensuring the needs of people with learning disabilities who have long term conditions are recognised and met
- healthy lifestyle support should be part of each care package
- undertaking a needs analysis identifying the service requirements for people with complex

health needs, including people who present challenges and those requiring intrusive health interventions

The Disability Rights Commission is demanding action (Disability Discrimination Act) from providers and commissioners to measure health inequalities and develop action plans for improvement. This will be for all services to focus on.

Alcohol and children

Children and young people drinking alcohol is a particular problem in the UK with levels of drunkenness and binge drinking among the highest in Europe. Binge drinking is particularly harmful and can lead to:

- risky sexual behaviour
- teenage pregnancy
- sexual assault
- accidents, violence and criminal behaviour
- alcohol poisoning

In Southampton as many as 2,564 (6%) of dependent children may be affected by chronic adult alcohol use. These children are at increased risk of delinquency and aggressive behaviour and are four times more likely to develop a mental illness by the age of 15. Alcohol misuse is a major factor in domestic violence; one in three incidents is alcohol related. There are also strong links between alcohol use and teenage pregnancy.

In Southampton

The Drug Action Team (DAT) recently reported that an estimated 22% of 11 to 16 year olds interviewed across the City reported having drunk alcohol in the previous week.

- four alcohol-related domestic violence reported incidents every day
- each month between five to nine children and young people aged nine to sixteen years are admitted to hospital due to alcohol poisoning, sometimes with a combination of other substances

Substance misuse, children and young people

Hidden Harm, the report by the Advisory Council on the Misuse of Drugs, estimated that between 200,000 and 300,000 children and young people in England and Wales have one or both parents with serious drug problems. Children are badly affected by their parent's problematic drug and alcohol use. These children are identified in Southampton's Children and Young People's Plan as a key vulnerable group in the City.

We know that there are higher rates of drug misuse amongst truants and those children and young people who have been excluded. Nationally, over 50% of young offenders in custody reported Class A drug use in the past year, among the highest for any at risk group.

Our Lifestyle Survey (2006) revealed that the use of illicit drugs in the past 12 months in Southampton is significantly higher amongst younger respondents (a quarter of 16-24 year olds have used drugs in the past 12 months). Cannabis is the substance most likely to be used, with one fifth (20%) of 16-24 year olds using it in the last 12 months.

Drug and substance misuse is a significant factor in poor health, safety and education outcomes for many of the young people it affects. It radically increases young people's vulnerability to becoming involved in crime and anti-social behaviour, and affects longer-term prospects of having a fulfilling work and family life. Outcomes for children of those misusing drugs and other substances are also generally poorer. Southampton is fully committed to playing its part in the local delivery of the National Drugs Strategy. One of the aims within this strategy is to reduce the use of Class A drugs and the frequent use of any illicit drug among all young people under the age of 25, especially by the most vulnerable young people.

What is the most effective way to keep children off and away from drugs?

Before solutions can be addressed, there needs to be a much wider understanding about the nature of risk taking behaviour generally, the sheer extent of hidden harm locally and the role that opportunity, availability and accessibility plays in misusing drugs and alcohol.

Local consultation among stakeholders highlighted key areas for action in relation to "keeping young people off drugs". These include:

- valuing young people as opposed to the continual demonisation of young people in the media
- highlight links between alcohol, drugs and sex for young people
- early year education around these issues, to look at self esteem
- consultation with young people around 'what they want'
- alternatives to substance misuse as a cheap pastime
- programme for all parents (carers) around talking to children about substances and strategies to cope with peer pressure
- getting parents to control own substance use, including use of alcohol in front of children
- getting parents to be positive role models and

promote aspirations for their children

Young people spend a great deal more time at home than they do at school and so any advice or information which young people take in at school must be reinforced in the home and the community. Southampton's Personal Social and Health Education Action Research project aims to provide evidence of the benefits of involving families and the wider community in the teaching of PSHE.

What are we doing?

A major priority for the City is reducing the harm caused to children and young people by parental drug or alcohol use. Southampton is a high focus area for young people's substance misuse services and as such has chosen a "hidden harm" theme. A consultant is working with the City's Hidden Harm Working Group on an action plan to reduce the harm caused to children by parental or familial substance use.

During 2007 the DAT will have delivered a range of public campaigns or events aimed at young people with drug and alcohol themes. These will include joint displays with emergency services on drink and drug driving, FRANK street marketing teams (staffed by young people from local further education colleges and local youth groups) and DRINKSAFE media work.

The DAT commissions high quality and easily accessible treatment services for young people with drugs and alcohol issues. These are a mix of fixed site drop-in, outreach and targeted support work, a further twelve young people agencies have staff trained to Tier 2 specialism in substance misuse, and regularly clinically supervised by the Tier 3 service.

The Young People's Drug and Alcohol Reference Group is a regular and well-attended meeting of young people across the City. They focus on young people's drug and alcohol use and providing peer support and information sharing for practitioners.

Who is being missed out?

- those who don't have access to our normal marketing media, e.g. homeless, those who cannot read or understand, those who are marginalised and isolated
- whoever has not been identified as a target audience or group
- those who don't think drugs are anything to do with them
- young people and adults already using drugs 'niche audiences', who don't want to change because they are still having a good time

Sexual health

Why is sexual health important?

Across the UK the increase in sexual promiscuity has resulted in an epidemic rise in sexual transmitted infections (STI). Southampton has high levels of sexual ill-health and sexual risk-taking.

There are:

- high numbers of people living with HIV
- high rates of other sexually transmitted infections
- high rates of teenage pregnancies
- high rates of unprotected sex

Southampton has a good range of sexual health services, but many young people report inconsistent use of protection during sex. Around 10% of young people have undiagnosed chlamydia infection.

There are also inequalities in sexual health with many infections disproportionately affecting minority communities, notably African and Caribbean young people, and gay and bisexual men. Young people in the most deprived areas and the most vulnerable have the poorest sexual health.

Services are generally rated highly, but many young people have low levels of awareness of what sexual health services are available, what they provide and where they are located.

There are varying levels of sex education provided in Southampton schools and many young people report little or no sex education, or rate it as poor.

Sexually transmitted infections

The most prevalent infections locally are:

- chlamydia
- genital warts
- gonorrhoea
- herpes
- HIV

Syphilis has once again become a local infection having been virtually eradicated in the 1980s. Numbers of STIs recorded at the Royal South Hants Hospital in 2005 were:

- 630 cases of chlamydia, of which 458 were in the 16-24 age group
- 81 cases of gonorrhoea, 44% in men having sex with men
- 177 cases of herpes
- 20 cases of syphilis, 63% in men having sex with men
- 643 cases of genital warts, 380 of which were in the 16-24 age group

There were 209 people receiving care for HIV in 2006, of which 101 were African and 75 infected through sex between men.

Young people and sexual health

Rates of sexually transmitted infections are high particularly among young people aged 16-24. A survey of young people in 2002 showed that:

- 45% were sexually active
- 40% of young women who were sexually active had accessed emergency contraception
- over 70% had sex under the influence of alcohol and over 20% under the influence of other drugs
- friends were the main source of information about sex
- most wanted more information at school, particularly on sexually transmitted infections and safer sex
- there was a lack of knowledge of what sexual health services were available

The economic cost of sexually transmitted infections

The infection most costly to treat is HIV, with an annual treatment cost of around £15,000 per person. About two-thirds of those infected with HIV in Southampton are receiving triple combination therapy with anti-retroviral drugs – a cost of around £1.5million. Many also access mental health services. Most other infections are easy to treat if diagnosed early. However complications, such as infertility and pelvic inflammatory disease, are costly to treat if infections are not diagnosed early enough.

What are we doing?

Sexual health is a priority area for action in the City. We have both a Sexual Health and HIV strategy for Southampton City (2004, revised in 2007) and a Teenage Pregnancy Strategy (revised 2007). There is currently an action plan to improve sexual health and improve sexual health services and there is a task group to oversee this action plan as part of the Health and Well Being Strategy.

Teenage pregnancy:

Teenage pregnancy is a complex issue, affected by a wide range of personal, social, economic and environmental factors. Research evidence has identified key risk factors known to increase the likelihood of teenage pregnancy. These can be broadly grouped into:

- education related factors
- risky behaviours
- family and social circumstances

Southampton historically has some of the highest

rates of teenage pregnancy in the South East. There is significant evidence of generally poor outcomes for teenage parents in relation to economic prosperity, skills and poverty. The children of teenage parents are also vulnerable to poorer outcomes in a number of areas.

What works?

Emerging evidence highlights the need for local authorities and PCTs to address the wider underlying causes of teenage pregnancy such as raising aspirations, educational attainment levels, school attendance, progression into college or higher education after 16 and reducing poverty. It also highlights the need for policies and programmes that change the culture of risk-taking behaviour that leads to unplanned pregnancies and teenage parenthood.

Priorities for action

- better prevention to reduce unplanned pregnancies and STIs through strong delivery of SRE and PSHE in schools
- the provision of free, confidential, friendly advice, information, contraception and sexual health services in primary care, health and community settings
- targeted work with young people at risk in particular young people in care, care leavers, young people with disabilities and ethnic minority young people
- media and publicity campaigns that promote messages about the benefits of delaying sex and the combined use of contraception and condoms known as the 'Double Dutch' approach
- work with parenting programmes to support parents and carers to speak to their children about relationships, the benefits of delaying sex, sexual health and parenthood

The aim of the above is to reduce numbers of conceptions in line with Southampton's Teenage Pregnancy Strategy.

Teenage parents

A focus group on Supporting Teenage Parents in Education and Parenting (STEP) provides a forum where practitioners working with young parents share information and skills to strengthen joint working. There is a direct correlation between the number of teenage parents and the number of units of supported housing needed.

The needs analysis suggests that up to:

- 79% of teenage parents may not be accessing appropriate supporting people services
- 39% needed more support than the service can provide
- 11% were seen as not having the potential to ever move to independent accommodation

- 5% were ready to move to services with lower levels of support
- 24% are ready for independent accommodation with no support

This has raised concerns that the accommodation needs of teenage parents in the City are not always being met.

Reducing problem alcohol use in adults

Alcohol is a serious problem for Southampton. Earlier we discussed the importance of adult behaviour with alcohol and the potential negative affects on children and young people.

Southampton has:

- higher rates of binge drinking
- a rate of alcohol-related violent crime twice that for the South East region
- higher rates of alcohol-related hospital admissions

Drinking too much (more than the recognised 'sensible' levels) can have far reaching effects on individuals, families and communities, and it can lead to a wide range of health problems and may result in early death. These include:

- liver damage
- heart disease
- stroke
- cancer of the mouth, larynx, oesophagus, liver and breast
- mental ill health
- brain damage
- injury, for example from falls and road accidents

Sensible drinking levels for adults:

- men drink up to three to four units per day, but not every day and not exceeding a total of 21 units per week
- women drink two to three units per day but not every day and not exceeding a total of 14 units per week
- people allow two alcohol free days per week.

Figure 4.3 An illustration of typical units of alcohol



Pint of ordinary strength lager or beer
2 units



Small glass of wine
1 unit



Single measure of spirit
1 unit



Bottle of Alcopop
1.5 units



Single measure of aperitif
1 unit

Binge drinking

Binge drinking has recently been defined as:

“drinking too much alcohol over a short period of time, eg. over the course of an evening, and it is typically drinking that leads to drunkenness. It has immediate and short term risks to the drinker and to those around them ... trends in binge drinking are usually identified in surveys by measuring those drinking over 6 units a day for women or over 8 units a day for men. In practice, many binge drinkers are drinking substantially more than this level, or drink this amount rapidly, which leads to the harm linked to drunkenness.” (Home Office, 2007).

Crime and public disorder

About half of all violent crimes are alcohol-related and alcohol contributes to fear of crime and the social fragmentation of communities.

In Southampton

- over four in 10 respondents in the Lifestyle Survey had drunk more than the recommended weekly amount in the last week
- 10,000 people are drinking dangerously
- an estimated 70,000 working days are lost due to alcohol
- over 1,000 people are developing cirrhosis
- 750 people may die from other alcohol related causes
- seven out of every ten people in the Southampton's General Hospital's Emergency

Department on Friday and Saturday nights are there because of alcohol - putting huge pressures on the emergency services

- alcohol misuse costs the local NHS £8.1 million a year including 1,800 hospital admissions
- alcohol-related crime and anti-social behaviour costs £29.2 million a year
- seven out of ten violent crimes occur in the commercial centre on weekend nights
- around 580 drink-driving offences are reported each year

What are we doing?

Alcohol is a priority area for action in the City. We are working to reduce the harm from alcohol in Southampton through the Alcohol Harm Reduction Strategy and the Health and Well Being Strategy.

We have identified the following priority areas for action and these cover children as well as adults:

- raising awareness of the dangers of alcohol misuse and supporting sensible drinking choices
- providing effective treatment services and support services in the community
- reducing alcohol related crime, disorder and anti-social behaviour
- reducing violent crime in the City centre with a specific focus on alcohol related crime
- promoting the community safety aspects of licensing proposals and decisions
- raising awareness of the responsibilities of the drinks industry

We know we need to particularly target young people (under 18) who drink alcohol in particular, as well as 18-24 binge drinkers and harmful drinkers, many of whom do not realise that their drinking patterns are damaging their physical and mental health.

Smoking

Nationally around 17,000 children under five years old are admitted to hospital each year because they are exposed to tobacco smoke. Whilst smoking directly and indirectly affects pregnancy and children and young people's health, there are gaps in our local data. It would be naive to believe that now that it is illegal to purchase tobacco under the age of 18 years fewer young people will take up the habit.

In Southampton

Southampton has very high smoking rates, the highest in the South East. Cigarette smoking is the leading cause of preventable death in Southampton today. The harm caused by cigarette smoking is

well established. But thankfully, smoke free legislation is already making an impact on environmental tobacco smoke.

Our 2006 Lifestyle Survey showed that 30% of respondents are daily smokers and a further 9% currently smoke occasionally, 47% are ex-smokers and one in ten (11%) are non-smokers. Our survey reflected national trends showing that manual workers are significantly more likely to smoke than non-manual workers (45% compared with 34%). However, the survey found no significant difference in smoking prevalence between those respondents living in the priority areas and those living in the rest of the City.

Respondents from BME groups are significantly more likely to smoke (46% compared with 38% of respondents from a white-British background) but BME respondents who were smokers were more likely to be classified as light smokers and to say that they would find it very/fairly easy to give up for a day.

Eight in ten smokers (80%) have tried to stop smoking at some point, and currently two thirds of smokers say they would like to give up smoking altogether. Older people (aged 50+ years) are significantly less likely to smoke than younger people; of those that do continue to smoke a significantly higher proportion are likely to be classified as a medium or heavy smoker.

In the year ending 31 March 2007, 1,583 people have successfully quit smoking using our City Quitters service.

Substance misuse and drug-related deaths

The children and young peoples section above has covered substance misuse. We know that there are approximately 1,400 problematic drug users; many more use drugs recreationally, particularly cannabis (usually the skunk variant) and powder cocaine. Traces of powder cocaine have been found in every pub and club in the City. Shortages of cannabis have led to an increase in the market for powder cocaine. However for adults, substance misuse has become an ever increasing cause of death, causing a significant loss of life years.

In Southampton

An investigation into drug-related deaths in Southampton City was published in September 2007. The aim of this investigation was to increase the knowledge and understanding of deaths due to illicit drug use in the City in order to inform future harm-prevention policy.

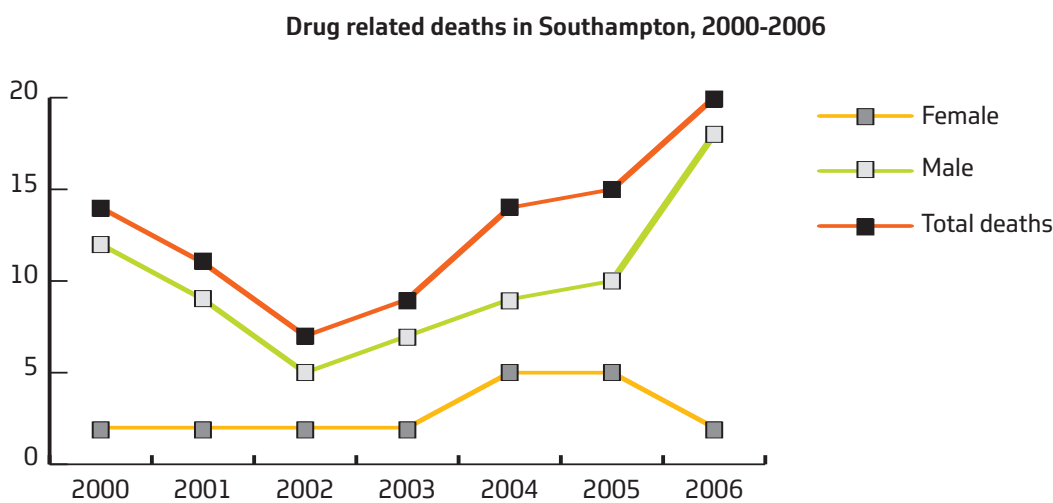
The key findings of this investigation are:

- the numbers of drug-related deaths in Southampton has been increasing over the last five years to 20 deaths in 2006 (majority classified as accidental by coroner's inquest) and is higher than we would expect in comparison with national figures
- more men than women die from drug-related death in the city, and the commonest age group is between 30 and 50 years, which reflects national trends (median age 35, mean age 37.5)
- less than half of those who died were known to drug treatment services
- the commonest drugs implicated are opiates

(morphine, heroin, methadone, dihydrocodeine), but cocaine-related deaths appear to have been increasing in the last four years

- multiple drug use was identified as an important risk factor and associated use of alcohol was extremely common in these deaths (13/20)
- other important factors included a history of mental illness and unaccustomed drug use (such as after release from prison)
- interviews with relatives, friends and drug users revealed that in the majority of cases, those who knew the individuals were surprised at their death, and that drug users tend to think more about obtaining the next dose of drugs than about risk

Figure 4.4 Drug-related deaths in Southampton 2000-2006

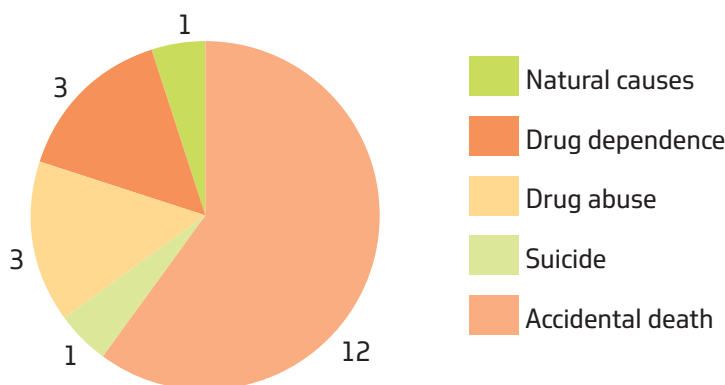


Fraser S and Coates R. (2007)

In cases of suspected drug-related death a coroner's inquest is held. This is a legal process similar to a court of law. The verdict reached by the inquest therefore depends on the individual circumstances of

the case, but is also limited by the information available. The verdicts from the coroner's inquests for the Southampton drug-related deaths in 2006 are shown in Figure 4.5 below.

Figure 4.5 Drug-related deaths in Southampton 2006, Coroner's Verdicts



Fraser S and Coates R. (2007)

The results of this report also showed a predominance of opiates as the main drug causing death.

What are we doing?

The report recommends that the DAT and substance misuse services:

- target men in the 30-50 age group with harm prevention messages (such as the cardio-pulmonary resuscitation training that has been funded locally for drug users)
- communicate with GPs, particularly over prescribing issues
- liaise with mental health services over shared clients and regularly reviewing shared-care arrangements
- educate particularly opiate users with regard to risk management e.g. combination of alcohol and drugs, using multiple drugs at one time
- liaise with prison services, particularly at release
- make efforts to access new communities in the city and provide translated information about access to services
- monitor methadone related deaths in view of apparent increase (which is in contrast to national trend)

Adults and learning disabilities

We predict that the numbers of people with learning disabilities will rise in the 10 years between 2001 and 2011 by 6.3% overall with a disproportionate 20% increase in the 60+ age group. The health needs of people with learning disabilities are often unmet due to under-diagnosis of disease. For example, stroke, and heart disease are reported to be lower in people with learning disabilities than in the general population but this is highly likely to be due to under-reporting rather than a true lower incidence.

People with learning disabilities have increased social care needs which may include:

- housing support
- supported employment
- help with personal care and activities of daily living
- getting away for a break

Carers and parents

We know that there are parents who have a learning disability that get a very poor deal from existing services which has been highlighted nationally.

Carers of adults with a learning disability also have specific needs. We need more robust ways to quantify these. There are a significant number of carers who are over the age of 70 who are still caring

for a relative. Carers also have very poor health and have difficulty accessing services due to their caring role.

Health Care Associated Infection (HCAI)

These are infections that are acquired (by patients or staff) following admission to hospital or as a result of healthcare interventions in other healthcare facilities. Being in hospital or receiving treatment has always carried a risk of infection. Risk factors that contribute to infections include:

- underlying illnesses e.g. cancer, diabetes, heart disease
- invasive procedures such as surgery, renal dialysis, intravenous therapy,
- the use of antibiotics to treat one infection can enable other micro-organisms to cause harm e.g. *Clostridium difficile*
- the widespread use of antibiotics to treat infection, particularly in hospitalised patients, encourages antibiotic-resistant micro-organisms to emerge
- caring for many patients together in hospitals provides opportunities for micro-organisms to spread between patients

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

Two infections that are a problem in hospitals treating patients with complex medical problems are Methicillin Resistant *Staphylococcus Aureus* (MRSA) and *Clostridium Difficile* Associated Disease (CDAD).

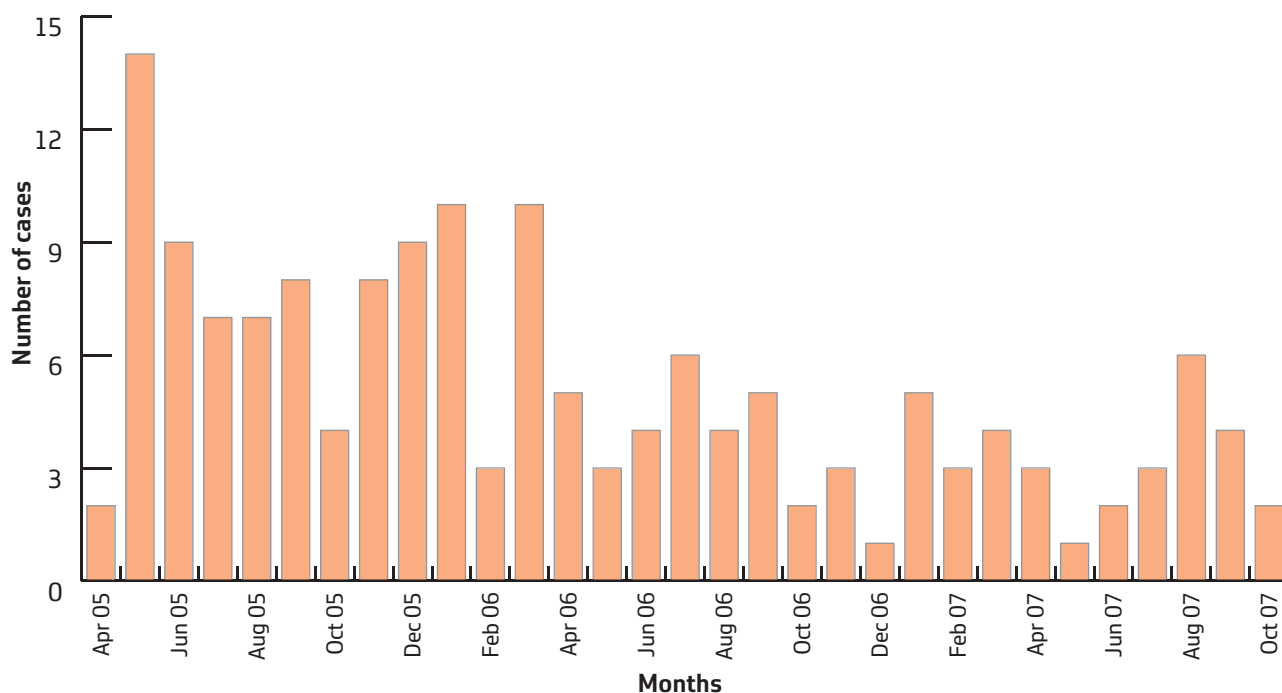
There is much that can be done to prevent many of these infections. The key is preventing the transmission of micro-organisms between patients and preventing their introduction during invasive procedures or other treatments. Transfer of micro-organism on the hands of healthcare workers is an important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

What are we doing?

Southampton University Hospitals NHS Trust (SUHT), Southampton City PCT and the Health Protection Agency are undertaking measures to improve performance in the control of HCAI. A Department of Health/Strategic Health Authority Improvement Team review was completed in December 2006 and an action plan agreed between SUHT, the Strategic Health Authority and the Department of Health.

Surveillance

Figure 4.6 Southampton University Hospitals Trust MRSA Bacteraemias: monthly trend 2005/06 to 2007/08



Southampton University Hospitals Trust (2007)

Action on MRSA and CDAD is being pursued vigorously, but there are several other more common pathogens that blight care pathways and cause significant morbidity and mortality. At the moment catheter-related urine infection is one of the most common acquired infections.

- the government have announced that deep cleaning of hospital wards is being planned and that extra funding will be made available
- pre-admission MRSA screening of patients needs to be assessed
- screening in the community will also require an assessment of need

Tuberculosis

Tuberculosis (TB) is one of the most important public health challenges facing the world today. Tuberculosis is a disease largely of deprivation. TB's recurrence and the emergence of multi-drug resistance are proving to be serious threats to health, particularly in a diverse and mobile population like Southampton's. The Chief Medical Officer has highlighted tuberculosis as an infection needing intensified action in a national action plan *Stopping Tuberculosis in England (2004)* which details ten major areas for action. These include increased awareness, improvement in surveillance and a first class service for the diagnosis and management of tuberculosis cases.

Potential numbers of TB contacts

For every case of TB that is confirmed, the average number of contacts examined is reported to be 6.5. Up to 10% of new cases are diagnosed through contact tracing. However, the potential numbers of contacts could be significantly larger depending on the specific circumstances surrounding the index case (i.e. cases identified in schools/nurseries, aircrafts, hospital in-patients and health care workers).

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

New entrants

New entrants to the UK are classified according to the incidence of TB from their country of origin. Low risk countries for TB are those with a TB rate of less than 40 cases per 100,000 population. High risk countries for TB are those with a TB rate of over 40 per 100,000 population and super high risk countries are those with a TB rate of over 500 cases per 100,000 population. Which group new entrants fall into can most easily be determined from the alphabetical list of countries on the Health Protection Agency website: www.hpa.org.uk/infections/topics_az/tb/epidemiology/who_table1.htm

NICE specifies that adults from high risk countries require a chest x-ray if no recent x-ray has been taken. Adults aged between 16 and 35 years from super high risk areas require referral to a TB service for Mantoux testing irrespective of their x-ray status and those over 35 require a chest x-ray. All adults from super high risk areas should also be offered HIV testing.

Children under 16 from high risk and super high risk areas require referral to a paediatric TB service where there is no record of previous BCG. Advice for pregnant women is provided locally in the TB clinic.

Southampton City PCT estimates the number of new entrants from outside the European Union last year was 1,290 people.

The priorities for the development of TB services are:

- to commission high quality treatment services for Southampton
- to ensure that a high quality testing and immunisation service is provided
- to raise awareness amongst GPs and other healthcare professionals to be alert for TB

What are we doing?

- early identification and treatment of cases, and prevention of unnecessary transmission
- reducing the incidence of TB infection through active case finding of new and latent infection in groups known, or thought to be, of high risk of TB within the population. This includes: tracing the contacts of newly diagnosed cases, screening new entrants to this country who come to live in Southampton, the identification and screening of high risk groups (e.g. homeless, drug and alcohol users, people with coexisting (HIV) morbidity, individuals in prison), and screening of healthcare workers
- implementing an elimination strategy aimed at reducing the prevalence of TB infection. This includes an active response to outbreak management, provision of prevention therapy and BCG vaccination in selected groups

Older People

Ageism

Ageism is direct and indirect discrimination or prejudice against people on the grounds of their age. This includes both negative attitudes towards seniors and making negative judgements about their abilities and their contribution to society. Ageism stereotypes individuals and labels them a burden to society, and it creates barriers. We see ageism throughout society, and particularly in employment, access to learning, care and medical services, and in the media.

Southampton Seniors Council statement on ageism adopted in February 2007

Older people and fuel poverty - what is fuel poverty?

A household that needs to spend more than 10% of its income to provide an adequate standard of warmth defined by the World Health Organisation to be 21°C in the living rooms and 18°C in other occupied rooms.

Why is fuel poverty important?

Fuel poverty contributes to the extra 28% of winter deaths that occur in South East England compared with other months of the year. Those most susceptible to higher death rates in winter are the over 85s. Despite the availability of Warm Front grants for owner occupiers and private tenants it has been difficult for services to reach those who are eligible and particularly those who need it most. Across the City in 2006 the Southampton Lifestyle Survey reported that 19% of adults felt that their homes were too cold.

Table 4.4 shows the types of Warm Front grants provided to private and rented households.

Table 4.4 Types of Warm Front grants provided

	Year 01/02	Year 02/03	Year 03/04	Year 04/05	Year 05/06	Year 06/07
Replacement boiler	34	46	46	107	134	138
Electric heating	71	70	55	115	76	32
Foam insulated hot water tank	9	2	3	0	3	2
Wall heating	80	45	12	3	3	0
Gas central heating	146	66	36	67	71	61
Heating repairs	63	95	58	131	121	152
New gas supply	0	2	5	11	4	2
Hot water tank jacket	59	22	32	86	41	14
Draught proofing	483	137	186	417	151	69
Loft insulation	333	157	255	502	217	93
Cavity wall insulation	359	171	215	462	224	111
CFL	787	626	560	1116	615	417
Households	939	518	540	1055	732	445
Spend	£526,371	£394,767	£378,865	£888,170	£812,341	£661,623

Southampton Warmth For All Partnership (2007) Annual Report

In Southampton

The Southampton Warmth for All Partnership (SWAP) aims to:

- specifically reduce health inequalities associated with fuel poverty and improve the quality of life of people living in fuel poverty
- target older people who live in private rented accommodation with no central heating and older people who live in owner occupied accommodation with no central heating
- target vulnerable families with young children
- eliminate fuel poverty in Southampton by 2010 - a target we are unlikely to meet

End of life care

End of life care is care that:

Helps all those with advanced, progressive, incurable illness to live as well as possible until they die. It enables the supportive and palliative care needs of both patient and family to be identified and met throughout the last phase of life and into bereavement. It includes management of pain and other symptoms and provision of psychological, social, spiritual and practical support.The phase 'end of life' ends in death.

What are we doing?

The PCT and City Council are currently doing an end

of life care review that will enable us to:

- assess the population need for end of life care services
- map current provision including its quality
- compare current provision with population need
- identify where service improvements are needed
- be prepared to respond to the national end of life care strategy when published

On completion of this joint review the PCT and City Council plan to share the data with local partners and any gap analysis and plans for development with the Strategic Health Authority.

Summary

This chapter on staying safe and support health and care needs covered the following areas:

- long-term conditions - self care
- self management and long term conditions
- Telecare/ telehealth
- disease management
- case management
- dementia and depression
- physical disability
- social care services support and needs

Specifically regarding children and young people

- domestic violence
- learning disabilities
- alcohol
- substance misuse
- sexual health
- teenage pregnancy

Questions about children

Do you agree that these are the right priorities to safeguard the health and care needs of vulnerable children in Southampton?

What are your key priorities and why?

What key actions would you recommend to improve the safety and well-being of children and young people in Southampton?

The section on adults examined

- alcohol
- smoking
- substance related deaths
- adults and learning disabilities
- carers and parents
- Health Care Associated Infection
- tuberculosis

Questions about adults

Do you agree that these are the right priorities to support health and care needs of adults in Southampton?

What are your key priorities and why?

What key actions would you recommend to achieve these to support the health and social care needs of adults in Southampton?

The section on older people added

- fuel poverty
- end of life care

Questions about older people

Do you agree that these are the right priorities to support health and social care needs of older people in Southampton?

What are your key priorities and why?

What key actions would you recommend to achieve these to improve older peoples health and social care needs in Southampton?

The next chapter explores the issues around unscheduled care and some of the difficult choices we face in these changing times.

References

Department of Health: www.dh.gov.uk/SelfCare

Department of Health, (2004) Stopping Tuberculosis

in England: An Action Plan from the Chief Medical Officer. London:

Department of Health, (2005) Saving Lives: The Delivery Programme to Reduce Healthcare Associated Infections (HCAI) including MRSA. London.

Department of Health, (2007) National Treatment Agency for Substance Misuse. Reducing Drug-related Harm: An Action Plan, London

Hidden Harm (2006) Issues for professionals working with parents who misuse alcohol. Alcohol Concern <http://www.alcoholandfamilies.org.uk/briefings/13.4.pdf>

National Council for Palliative Care (2007) End of Life Care A Commissioning Perspective enquiries@nccpc.org.uk

National Heart Forum, The Eaga Partnership Charitable Trust, the Faculty of Public Health, Help the Aged and the Met Office 'Fuel Poverty and Health Toolkit' (2003) <http://www.heartforum.org.uk/downloads/FPbook.pdf>

NICE, (2006) Tuberculosis: clinical diagnosis and management of tuberculosis, and measures for its prevention and control. London: <http://www.nice.org.uk/CG033>

NICE, (2007) Drug misuse: opioid detoxification. July 2007. <http://guidance.nice.org.uk/CG52>

Operating framework: (2007) PCT baseline review of services for end of life care April 2007/08 Gateway reference 8116

Safe. Sensible, Social, (2007) The next steps in the National Alcohol Strategy. Home Office. London

South East Public Health Observatory 'Technical report: Excess winter mortality in the South East' (2006) <http://www.sepho.org.uk/Download/Public/10098/1/excessWinterMortality.pdf>

Strategy references

Bagshaw, K. Gardner, J. and Wilkinson R. (2006) Health and Lifestyle Survey Southampton City Council and Southampton City Primary Care Trust

Drug Action Team (2007) Annual treatment plan draft .Crime Concern, C5 Consultancy, Solent University, Tier 4 people, GOSE, SCPCT Public Health Department

Fear of Crime Survey (2004) Southampton City Council <http://www.southampton.gov.uk/thecouncil/thecity/res>

[earch/marketresearchresults/fearofcrime.asp](#)

Fraser S, and Coates R. (2007) Investigation into drug-related deaths in Southampton City Public Health Southampton City CPCT

Health in Southampton (2004) Annual Public Health Director Report Southampton City Primary Care Trust
<http://www.southamptonhealth.nhs.uk/publichealth/p har>

Health in Southampton (2005) Annual Public Health Director Report Southampton City Primary Care Trust
<http://www.southamptonhealth.nhs.uk/publichealth/p har>

Health in Southampton (2006) Annual Public Health Director Report Southampton City Primary Care Trust
<http://www.southamptonhealth.nhs.uk/publichealth/p har>

Health and Lifestyle Survey (2007) Southampton City Council and Southampton City Primary Care Trust 2006

Health and Well-being Strategy – Stages 1 (needs assessment) and 2 (framework for action) stage 3 under way currently

Housing Strategy for Learning Disability
<http://www.southampton.gov.uk/thecouncil/thecouncil/strategy/city-plans-initiatives/h-strategy-learningdisability.asp>

Invest to save and gain, 2006-07
Long Term Conditions Strategy (2006): Towards consistent best practice for people with Long Term Conditions, 2006 – 2010 Southampton City Primary Care Trust

Mental Health Strategy currently being prepared

Sexual Health and HIV strategy for Southampton City (2004) and a Teenage Pregnancy Strategy (revised 2007)

Sharing the Caring (2006) A joint- commissioning strategy for older people and adults with long-term disabilities 2006 – 2009 Southampton City Council and Southampton City Primary Care Trust

Southampton Alcohol Harm Reduction Strategy –report of the Southampton Drug Action Team Alcohol Sub-Group (2004) and Tackling Alcohol Partnership Action Plan 2005-2008.

Southampton City Later Years Health and Well being Strategy: Health needs assessment & updated strategy, September 2004

Southampton Strategy Against Domestic Violence (2007)

Southampton Warmth for All Partnership (SWAP) Progress Report March 2007.

Southampton

5 - unscheduled healthcare difficult choices

This chapter examines the complexity of unscheduled care and some of the difficult choices that are made daily across the health and social care sectors. There are areas of unmet need that we understand and areas where our current knowledge is lacking.

What is unscheduled care?

An urgent and emergency care strategy, due for publication shortly, is currently being developed. This will continue the direction of encouraging health communities to deliver appropriate care closer to home, helping to ensure that patients receive appropriate, timely emergency and urgent care whatever, and whenever, they need to access the system.

Professor Sir George Alberti, National Director for Emergency Access, Emergency care ten years on: reforming emergency care 2007

The urgent and emergency care system provides services for a very large number of people with diverse needs around the clock every day of the year. Different public health problems can be described broadly as the need for “unscheduled care”. The spectrum of need can range from life threatening diseases (such as heart attacks or strokes), to multiple trauma (e.g. serious road traffic accidents), to less serious but sudden onset illnesses that can be dealt with by advice or simple treatments dispensed by a pharmacist or out of hours nurse or GP.

Sudden surges in demand for emergency care may result from a major incident, or an outbreak of disease, and the local health and social care system has planning systems in place to handle such an eventuality. Pandemic flu plans have been under sharp focus in recent years, given the perceived risk of another pandemic being due some time in the near future.

Local health services increasingly work in partnership with the national Health Protection Agency, established several years ago to deal with the rising

risk of chemical, biological or radiation threats linked to terrorism. Following the bombings in the London Underground and Glasgow airport, emergency services across the country have been stepping up their plans and capabilities to deal with future events.

Why is unscheduled care important?

Getting the right treatment at the right time can mean the difference between life and death, or a full recovery versus life long disability in a number of different emergency situations. To make sure we minimise the mortality and morbidity that can result, the emergency care system has to work in a responsive and integrated way across different services. Ambulance, fire, and police services are often the front line that has to deal with emergencies, and the interface between them and health services is really important when serious injuries occur.

The ability to triage (sort through) and resuscitate patients at the scene of an accident is a vital determinant of outcome and the speed of transfer to an A&E unit or major trauma centre can mean the difference between life or death. Paramedics and specialists in emergency medicine and A&E departments work to common protocols to ensure integrated care and the most effective approach to treating complex emergencies.

Major illnesses and emergencies only make up a small part of the demand for non-elective care however, and the majority of the urgent care system has to deal with demands made at multiple entry points to the health system. Urgent care services need to provide a high quality, safe, and responsive system of care that can provide a range of entry points for patients. Over the last decade there has been a steady expansion in the number and range of unscheduled care services.

The complexity of urgent and emergency care activity on a typical day in the National Health Service

(Department of Health 2007) has been summarised as follows:

- 17,000 999 calls
- 9,700 emergency ambulance call-outs
- 900,000 GP visits
- 1.8 million prescriptions
- 52,000 accident and emergency contacts

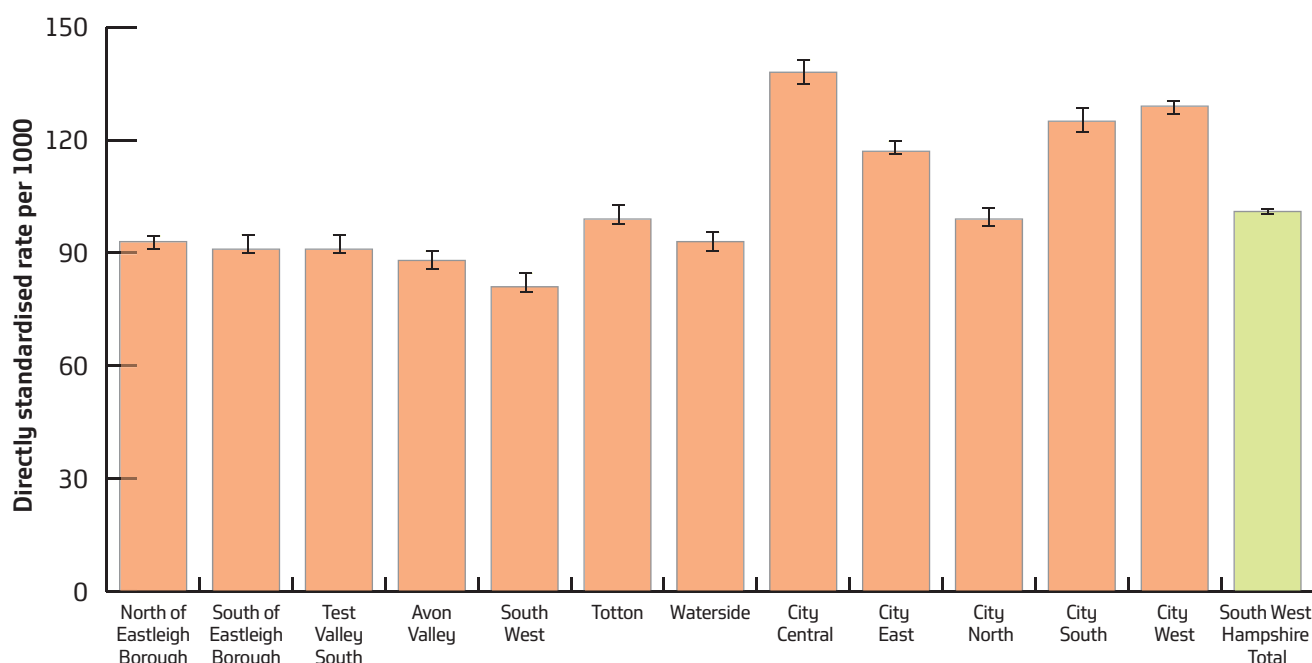
In Southampton

We have a well developed emergency care system, with a large A&E department in the city, three NHS Walk-in Centres, and 38 general practice and 41 pharmacy outlets across the City. NHS Direct is well established, and the local ambulance service ensures rapid transfer of emergencies into the A&E centre. The City PCT hosts the out of hours GP service for the

residents of the city and rural catchments in South West Hampshire. We have a higher volume of drop in centre contacts than most areas nationally. A&E attendances vary nationally, but tend to be higher in urban areas than rural, with London at the top with rates of 520 attendances per 1,000 population. In our area this is nearer 328/1,000. Admission rates following A&E attendance vary less widely, averaging 51 per 1000 population (age and need weighted) in South Central.

Local comparisons of emergency admission across Southampton and South West Hampshire localities are higher than the regional average, possibly reflecting the better access to the A&E department in the City and to some extent the different health seeking behaviours of more deprived communities and ethnic minority populations. See Figure 5.1 below.

Figure 5.1 Hospital emergency episodes 2005/06



Health Purchasing System, Hampshire and IOW Practitioner Services Agency (2007)

The rationale behind having greater capacity in our City NHS Walk-in Centres was to reduce the A&E attendance rates. There is an indication that the historic rising demand is just beginning to level off, but further monitoring will be necessary to confirm this trend in the longer term.

Given the national rising trend in attendances (+ 7.5%) and admissions (+ 4.6%) it will be a major challenge containing or reversing this trend locally. Two areas where real progress has been achieved has been in the reduction of waits in A&E below the 4 hour target, and an overall reduction in emergency bed days following non- elective or unplanned admissions due to shorter length of stay. A number of people use emergency departments inappropriately when they could have used their GP

practice or an NHS Walk-in Centre.

Local commissioners have been concerned about the rising number and cost of emergency admissions and are seeking to provide better chronic disease management systems and demand management programmes to reduce demand in the future.

Causes of emergency admission vary, and the “top ten” local causes are listed in Table 5.1 below. The table illustrates the most common causes of admission (adults and children), which are diverse, spanning cardiovascular diseases, falls and heart rhythm problems, undiagnosed abdominal pains, urine infection (often among the elderly and frail patients) chest infections, and self poisoning with drug overdoses.

Table 5.1 Emergency Admissions with Primary Diagnosis 2005-6

Emergency Admissions 2005-06

Primary Diagnostic Code	Primary diagnosis Description	Admissions
R074	chest pain, unspecified	1,782
R104	other and unspecified abdominal pain	1,550
N390	urinary tract infection, site not specified	1,079
R55X	syncope and collapse	921
R073	other chest pain	762
J22X	unspecified acute lower respiratory infection	670
R103	pain localized to other parts of lower abdomen	571
I48X	atrial fibrillation and flutter	569
Z038	observation for other suspected diseases and conditions	568
T391	poisoning by paracetamol derivatives (overdoses)	560

These conditions illustrate how medical conditions outweigh major accidents and other emergencies when it comes to the demand on emergency services. The overdose figures are a cause for serious concern, but fortunately very few result in suicide. Given the diversity of different conditions, any strategy to tackle the problems “upstream” will need to be broad based, linking with cardiovascular, mental health and other chronic diseases programmes that could potentially divert care away from the emergency setting.

Questions

Do you know how to contact emergency services at weekends and in the evenings, and have you been able to access services when you need them?

When you have contacted emergency services (NHS direct, ambulance, or GP services) did you get a quick response to your enquiry?

What would make life easier if you need to get in contact with emergency services when you have a query?

The next and final chapter looks at future trends in disease patterns and treatments and the challenges for all regarding this potential impact on resources.

References

Department of Health (2007) Emergency care Ten Years On: Reforming Emergency Care. Report by Professor Sir George Alberti National Director for Emergency Access

Department of Health, (2006) Our Health, Our Care, Our Say: A new direction for community services

Direction of Travel for Urgent care consultation (2006-2007)

McConnell et al, Mortality benefit of transfer to level 1 versus level 2 trauma centres for head injured patients, Health Services Research, 2005 Apr:40 (2):435-57

The Carson Review on OOH (2000), The national audit office report on OOH (2006)

Southampton

6 - new opportunities, new disease, new trends and treatments - will resources meet new expectations?

This chapter aims to provide a brief overview of the key issues that we currently forecast which may have a significant impact on health and social care delivery, as well as providing new opportunities to improve health and well-being.

Health needs

Living longer

The long battle against deaths from heart disease and cancer is steadily being won, with continued falls in mortality. Now we have more people living longer and surviving with chronic diseases. This demographic change requires a different approach to longer term care and better structure to programmes of chronic disease management. This is particularly true for older people, who can enjoy an unprecedented life expectancy these days, but unfortunately for some, the quality of life may be limited by one, or in many instances two, or more chronic diseases that restrict their lives. The rapid expansion of the retirement population is increasingly going to pose major challenges to health and social care, and innovative approaches will be needed to meet these changing needs and resource them.

Chronic Obstructive Pulmonary Disease (COPD)

COPD is the fifth biggest killer in the UK and is heavily related to smoking. The British Lung Foundation (BLF) estimates that around 3.7 million people have COPD in the UK but 2.8 million don't know it often because of its pernicious onset, for example, thinking a smokers cough or shortage of breath is normal.

More women die of COPD than of breast cancer and more men die of COPD than prostate cancer. Everyone over 35 who is at risk of COPD should be advised to have a simple lung test every three years particularly in the light of the forthcoming National Service Framework for COPD.

Because the City has the highest smoking rate in the South East, we believe that the 3,800 people we know that have COPD represent a fraction of the true number. Using the BLF estimate we could have as many as 15,416. Early diagnosis and treatment with smoking cessation can not only increase life expectancy, but importantly the quality of life lived. A health equity audit is currently underway to examine pulmonary rehabilitation provision to enable us to ensure an equitable, accessible service.

Dementia

During the later stages of ageing the problems of dementia increase rapidly. The future expansion of services for the sufferers of dementia and their carers will present special challenges to the health and social care system, particularly where a greater proportion of the population are choosing to live alone. Newer treatments for dementia are making an important and controversial contribution to care, but a cure remains elusive, and the social and emotional impacts of the condition remain as devastating as ever. Better support for carers is essential.

Liver diseases

Liver disease has been a growing concern in the UK, with diseases such as cirrhosis (chronic scarring and impairment of liver function) on the increase and presenting in an earlier age than previously recorded. The causes are mixed, ranging from alcohol related damage, viral infections like Hepatitis C and B, and a recently discovered type of cirrhosis linked to excess fat deposition in the abdomen. The experts in liver disease have predicted rising numbers of cases from all these causes over the next 20 to 30 years. This will be associated with an increase in primary cancer of the liver, a condition that is presently quite rare.

New treatments for viral hepatitis have been developed in recent years, and these are promising, but a large number of new and undiagnosed cases will inevitably increase the population burden of disease over future years. Hepatitis C has been the focus of recent efforts to improve diagnosis and management, but there are signs nationally that a new hepatitis B epidemic is about to emerge due to the higher level of infections among immigrants to the UK.

The liver damage associated with excess abdominal fat deposition is doubly worrying given the epidemic of obesity affecting the general population, and trends in alcohol consumption among all age groups, but especially teenagers and young adults, remain worryingly high, among the highest in Europe. The consequences of these trends are self-evident, and point to the need for effective population programmes that will prevent, or at least halt the rise in these conditions in future years, and expansion in the capacity and capability of liver services, including diagnostics, monitoring and where appropriate, liver transplantation. Needs assessment should explore the burden of disease that remains undiagnosed or “silent” in the general population.

Blindness through macular degeneration

The next condition of interest has been diagnosed for many years but with only limited treatment options. A breakthrough occurred in the management of macular degeneration – a disease of the retina that causes blindness or partial sight – when a new class of drug was developed a few years ago and licensed this year. The condition can start when someone is in their fifties, but is more common in retirement years, and is the single commonest cause of blindness in the retired population. The new drug therapy, called anti vascular endothelial growth factor treatment (anti-VEGF), has been found to restore or stabilise sight in this condition following a series of injections into the affected eye.

Previously laser and vitamin therapy was all we had, but this was not as effective as the newer drug treatments that can improve vision in a good proportion of patients. Research continues into some aspects of the anti VEGF treatments, but patients have already benefited from therapy and we are conducting local research and ensuring patients gain access to treatment locally. In the future many cases of macular degeneration will benefit from the treatment, enabling us to prevent blindness and partial sight and helping people to live more independent and fulfilling lives in future. NICE is due to publish guidance on this in November 2007, and a needs assessment should be done to help plan services for the future, as the numbers of patients will expand steadily for years to come.

HIV and AIDS

HIV and AIDS has received variable attention over the last 20 years, and we have observed important changes in the way the condition is spreading through the general population as well as subgroups. Having started as a disease affecting high risk groups, with outbreaks predominantly among gay men and intravenous drug users in the UK, the condition is now as common among heterosexuals and the general population as in the former high risk groups.

The success of antiviral therapy, and in particular combinations of treatments, has greatly improved the prognosis for many sufferers by reducing viral load. Where the high impact prevention programmes at the end of the last century resulted in safer sex and use of condoms to reduce sexually transmitted diseases and HIV, as we discussed earlier we are starting to see high risk behaviours in all parts of the population and a rise in the number of new HIV infections to a record level.

HIV services will need to expand to manage the rising demand from the disease in future, with further cases likely to emerge from within the UK in future alongside rising numbers of affected people migrating from former commonwealth countries, in particular sub-Saharan Africa. The need to promote safer sexual behaviours has never been greater.

Cardiovascular diseases

Major changes in the management of acute illness in adults will have a particularly affect on two important conditions over coming years; acute stroke and myocardial infarction (heart attacks). Strokes occur suddenly and can result in death or serious disability. The majority result from blockage of a cerebral artery, and treatment with a “clot busting” drug, given rapidly after onset of symptoms, can result in a complete recovery or reduced disability. At the moment patients arrive in hospital too late to have a brain scan and treatment in time to benefit from this therapy, so a new system is required to speed up referral and treatment, integrating ambulance and hospital protocols to manage cases more effectively.

Public education about stroke and how to recognise symptoms will be an important part of changing the approach to treatment and preventing disability from the condition. The whole system of care will have to change to achieve the best results from this new approach, including new ambulance transfer protocols, better access to urgent brain imaging, and rapid delivery of clot busting therapy.

Myocardial Infarction’s (heart attacks) have been dealt with rapidly for many years, and we have been using clot busting drugs to help re-perfuse the heart of patients who can get to hospital rapidly for over a

decade in the UK. A new form of treatment now replaces the clot busting with a procedure known as primary percutaneous angioplasty. This involves insertion of a catheter and balloon into the coronary artery to open up blood flow. The procedure needs to be done as quickly as possible and can achieve better results than the clot buster. We can only get the best results when the whole system works carefully to a triage (sorting) protocol and transfers patients efficiently to the specialist centre where this can be provided. Southampton cardiac centre has started to provide this service for daytime referrals, and plans to expand this to a 24 hour specialist service.

A new screening programme for abdominal aortic aneurysm (AAA) is on the horizon and should be introduced within the next few years. This is a vascular condition that can cause a rupture of the large blood vessel in the abdomen resulting in collapse and sudden death. Nationally and locally the trend in AAA mortality has been rising steadily for 20 years. A simple and very accurate ultrasound scan can identify aneurysms easily, enabling a repair to be made before rupture occurs. As the condition affects men more commonly than women, the screening programme will targeted men in their retirement years. It is likely to be the first male only screening programme in the UK.

Routine aneurysm repair is best done by a surgical team performing a large number of procedures each year, so a vascular network needs to oversee the screening programme and subsequent patient referrals. The national screening committee has developed all of the necessary policies and protocols to run the programmes, and recommends we start to introduce screening in a series of waves across the country. Southampton is considering applying to be one of the early adopters. Specialists in the area have gained experience in the screening and management of abdominal aneurysms by being part of the successful and ground breaking research trial into AAA screening (the MASS study) a decade ago, and are keen to implement the programme locally. If successful, this would systematically prevent ruptures (90% mortality) and enable us to repair aneurysms in a planned way and reduce mortality to under 5%.

The last example of change refers to kidney disease and the provision of kidney dialysis and transplant services. Kidney units have expanded steadily since the 1970s and increased the intake of patient's year on year. The eligibility criteria for dialysis have altered over the 30 years to include patients with diabetes and some cases of cancer that can be linked to kidney failure such as myeloma. The largest change in eligibility has been the rising age of patients, and now it is common for many patients to be in retirement age while on dialysis, whereas in the early years a strict age cut-off prevented patients over 45 from entering the dialysis programme.

Nowadays, kidney units provide a wide range of kidney support to their patients who are often frailer with more co-morbidities than ever before. This requires greater reliance on hospital and satellite haemodialysis facilities than the home based dialysis machines that require a greater degree of autonomy. The exception is the use of peritoneal dialysis that enables a wider range of patients to dialyse successfully at home, and kidney transplantation that can be offered to patients across a wide age range, including patients in retirement years.

Continued expansion of patient numbers is likely to continue for the foreseeable future and kidney units, like the rest of the hospital sector, will have to increase capacity and capability to cope with an increasingly complex and demanding case-mix of patients. Forward planning of kidney unit facilities is essential to meet the increasingly complex needs of patients. This is an area where specialist commissioning across large areas is needed to ensure that dialysis and transplant services can appropriately meet the needs of patients.

Summary

These diverse health and social care needs and changes in service provision are all important to the patients and families affected directly and to the health of population as a whole. Work continues to help planners and commissioners to predict future requirements and we know that some areas of this work are more developed than others.

In this chapter we have highlighted some key opportunities and trends around living longer, chronic respiratory disease, liver diseases, macular degeneration, HIV/AIDS cardiovascular diseases and social care.

Questions

Have we provided an accurate snapshot of new disease trends?

What else needs to be considered to support health and social care within the resource limitations of the NHS and City Council?

What do you see as the most important areas where health needs assessment should be targeted in the future?

Are there areas where disinvestment can be used to maximise health gain elsewhere?

If yes where?

Are there other health needs not described here you feel we should be investigating in the future?

Thank you for engaging with us to ensure together we meet the strategic health and social care needs of the people in Southampton.

Next Steps

This report from the Director of Public Health (2007) will inform the JSNA and is the first step to draw together work from a number of health and social care strategies to seek the views of stakeholders and the public.

The development of this JSNA will start in the autumn and continue throughout the winter to be published in the Spring 2008.

The deadline date for feedback is **29 February 2008**; please use the feedback form on page 87 or feedback online at www.southamptonhealth.nhs.uk/jsna

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Work stream	Timescale
Publication of Report of the Public Health Director (2007) to inform the Consultative Joint Strategic Needs Assessment	Nov 2007
■ technical version for stakeholders and public version	
Opportunity for stakeholders and the public to comment on the respective consultative drafts.	November - February 2008
Publication of the JSNA	April - May 2008

Southampton

Changing Southampton

appendix 1

SEPHO Profiling data showing a range of indicators of people's health in Southampton

Health summary for Southampton

The chart over the page shows a number of indicators of people's health in this local authority. It shows the local value for each indicator compared to the England worst, England best, England average and Regional average. The circle indicating the local value is shown as amber if it is significantly better or red if it is significantly worse than the England average. An amber circle may still indicate an important public health burden. A white circle is not significantly different from the England average. For technical information about each indicator, see www.communityhealthprofiles.info

Domain	Indicator	Local no per year	Local value	Eng avg	Eng worst	England Range Eng Best	Eng worst
Our communities	1 Income deprivation	30115	13.6	12.9	31.1		3.3
	2 Ecological footprint	n/a	5,885	5,470	6,430		4,904
	3 Homelessness	591	6.4	7.8	35.8		0.0
	4 Children in poverty	10900	27.4	21.3	58.8		5.2
	5 GCSE achievement*	1174	48.6	57.5	33.6		81.9
	6 Violent crime	7745	35.0	19.8	41.1		5.0
Giving children and young people a health start	7 Smoking in pregnancy						
	8 Breast feeding						
	9 Obese children						
	10 Physically active children*						
	11 Teenage pregnancy (under 18)*	219	60.6	42.1	95.3		12.8
The way we live	12 Adults who s,ple	n/a	32.4	26.0	37.3		15.5
	13 Binge drinking adults	n/a	21.8	18.2	29.2		8.8
	14 Healthy eating adults	n/a	23.9	23.8	11.4		38.1
	15 Physically active adults	n/a	10.4	11.6	7.5		17.2
	16 Obese adults	n/a	21.5	21.8	31.0		14.6
	How long we live and what we die of	17 Life expectancy – male*	n/a	76.5	76.9	72.5	
18 Life expectancy – female*		n/a	81.2	81.1	78.1		86.2
19 Deaths from smoking		374	263.5	2344	366.5		147.6
20 Early deaths: heart disease & stroke*		201	103.1	90.5	151.3		44.9
21 Early deaths: cancer*		246	127.8	119.0	168.0		81.6
22 Infant deaths*		8	3.2	5.1	9.9		1.2
23 Road injuries and deaths		106	47.8	59.9	214.1		20.2
Health and ill health in our community	24 Feeling 'in poor health'	18060	8.3	7.8	15.4		4.2
	25 Mental health	4440	29.8	27.4	720		8.5
	26 Hospital stays due to alcohol	623	291.2	247.7	652.4		85.6
	27 Drug misuse	1409	9.1	9.9	34.9		1.3
	28 People with diabetes	7575	3.4	3.7	5.9		2.1
	29 Children's tooth decay	n/a	1.8	1.5	3.2		0.4
	30 Sexually transmitted infections						
	31 Older people: hip fracture	264	593.2	565.3	936.8		259.7

- Significantly better than England average
- Significantly worse than England average
- Not significantly different from England average

*PSA target Measure 2005-2008



Note (numbers in bold refer to the above indicators)

1 % of residents dependent on means-tested benefits. 2003. 2 Land (hectares per capita) required to support an average resident's lifestyle: no significance calculated 2001. 3 % of households on local authority housing register who are statutorily homeless. 2004/05. 4 % in low-income households. 2001. 5 % achieving 5 A*-C. 2005/06. 6 Crude rate/1,000 pop 2005/06. 7 8 9 10 30 No comparable local data currently available. 11 Crude rate/1,000 female pop.aged 25-17. 2002-04. 12 13 14 16% Modelled estimates from the Health Survey for England. 12 13 16 2000-02. 14 2001-02. 15 % 2005/06. 17 18 Years. 203.05. 19 Directly age standardised rate/100,000 pop. aged 35 or over. 2003-05. 20 21 Directly age standardised rate/100,000 pop. under 75. 2003-05. 22 Crude rate/1,000 live births. 2003-05. 23 Crude rate/100,000 pop. 2003-05. 24 Directly age standardised %. 2001. 25 Crude rate claimants of benefits/allowances for mental or behavioural disorders/1,000 working age pop. 2005. 26 Directly age sex standardised rate/100,000 pop. 2005/06. 27 Crude rate/1,000 pop. aged 15-64: no significance calculated for lower tier authorities. 2004/05. 28 % 2005/06 29 Average no. of decayed, missing and filled teeth in children aged 5; data incomplete or missing for some areas. 2005/06. 31 Directly age standardised rate/100,000 pop. aged 65 and over 2005/06.

For more information from your regional PHO, visit www.apho.org.uk You may use this profile for non-commercial purposes provided the source is acknowledged. 'Source: APHO and Department of Health. © Crown copyright 2007'.

Your ideas feed back form on the JSNA consultation

Name

Contact details if you wish to receive feedback

Organisation

Feedback results will be published on our website and in the JSNA

Chapter 3 changing needs - being and staying healthy

Questions about children

1 Do you agree that we have the right priorities to maintain and improve children's health in Southampton?

Yes No

2 What are your key priorities and why?

3 What key actions would you recommend to achieve these to improve children's health and social care needs in Southampton?

Questions about adults and older people

4. Do you agree that these are the right priorities to maintain and improve adults' health in Southampton?

Yes No

5. What are your key priorities and why?

6 What key actions would you recommend to achieve these to improve adult health and social care needs in Southampton?

Chapter 4 Staying safe supporting health and care needs

Questions about children

7. Do you agree that we have the right priorities to safeguard the health and care needs of vulnerable children in Southampton?

Yes No

8. What are your key priorities and why?

9. What key actions would you recommend to improve the safety and well-being of children and young people in Southampton?

Questions about adults

10. Do you agree that these are the right priorities to support health and care needs of adults in Southampton?

Yes No

11. What are your key priorities and why?

12. What key actions would you recommend to achieve these to support the health and social care needs of adults in Southampton?

Questions about older people

13. Do you agree that these are the right priorities to support health and social care needs of older people in Southampton?

Yes No

14. What are your key priorities and why?

15. What key actions would you recommend to achieve these to support the health and social care needs of older people in Southampton?

Chapter 5 Unscheduled healthcare - difficult choices

16. Do you know how to contact emergency services at weekends and in the evenings?

NHS direct Yes No

Ambulance Yes No

GP services Yes No

17 Have you been able to access services when you need them?

18 When you have contacted emergency services did you get a quick response to your enquiry?

19 What would make life easier if you need to get in contact with emergency services when you have a query?

Chapter 6 New opportunities, new diseases, new trends and treatments

20 Have we provided an accurate snapshot of new disease trends?

Yes No

21 What else needs to be considered to support health and social care within the resource limitations of the NHS and City Council?

22. What do you see as the most important areas where health needs assessment should be targeted in the future?

23 Are there areas where disinvestment can be used to maximise health gain elsewhere?

If yes where?

24. Are there other health needs not described here you feel we should be investigating in the future?

Thank you. The deadline date for feedback is **29 February 2008**; please use this feedback form or feedback online at www.southamptonhealth.nhs.uk/jsna

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Southampton SO15 5NB

Sir Liam Donaldson, Chief Medical Officer for England, set out ten tips for better health at the beginning of 2007.

Sir Liam said:

People often make resolutions about how to improve their lives. Following any or all of the tips below will help you to improve your health.

The top tips are:

1. Don't smoke and don't breathe others' tobacco smoke
2. Eat at least 5 portions of fruit and veg each day and cut down on fat, salt and added sugar
3. Be physically active for at least 30 minutes, 5 days a week
4. Maintain, or aim for, a healthy weight (BMI 20 -25)
5. If you drink alcohol, have no more than 2-3 units a day (women) or 3-4 units a day (men)
6. Protect yourself from the sun. Cover up, keep in the shade, never burn and use factor 15 plus sunscreen. Take extra care to protect children
7. Practise safer sex - use a condom
8. Make the decision to go for cancer screening when invited
9. On the roads, THINK safety
- 10 Manage stress levels - talking things through, relaxation and physical activity can help

Further information can be found at:

www.southamptonhealth.nhs.uk/jsna