The Health of Bristol 2002

Joint annual report from the Directors of Public Health

Prepared by:

David Evans
Director of Community Development and Public Health
Bristol North PCT
Telephone: 0117 900 2612
Fax: 0117 900 3409
Email: David.Evans@bristolnorth-pct.nhs.uk
www.bristolnorth-pct.nhs.uk

Dr Christine Hine
Director of Public Health
Bristol South and West PCT
Telephone: 0117 900 2636
Fax: 0117 900 2571
Email: Chris.Hine@bristolswpct.nhs.uk
www.bristolswpct.nhs.uk

King Square House
King Square
Bristol
BS2 8EE

If you would like further copies of this report, it can be downloaded from either PCT website.

For more information on the health of Bristol visit the Public Health Network website, www.avon.nhs.uk/phnet

Acknowledgements

This report could not have been produced without the very valuable public health analysis provided by Susan Hamilton. Our thanks to Karen Blowers and Mike Shepherd for their contribution to the section on tackling smoking, Joyshri Sarangi for the section on health protection, Paul Pilkington for the heart health needs assessment, Tanya Cross for her section on lymphoedema, Susan Laverty for her work visual health, Una Fallon for the section on abortion services and last but not least, Carl Muldoon and Suaad Walker for their essential administrative support.

Contents

		Page
1.	Introduction	4
2.	The population of Bristol	5
3.	Health in Bristol North PCT	11
4.	Health in Bristol South & West PCT	24
5.	Avon Health Protection Unit	37
6.	Tackling smoking	39
7.	Heart health needs assessment in Filwood / Knowle West	50
8.	Health care needs assessment for lymphoedema services in Bristol and the surrounding area	52
9.	Visual health needs assessment	53
10.	Assessment of the effectiveness and efficiency of abortion services in Bristol	56
11.	Public health partnership in Bristol	57
12.	Joint priorities for action	59
13.	Developing the Director of Public Health Annual Report	60
	Glossary	61
	Feedback Form	65

1. Introduction

This is the first joint annual report of the Directors of Public Health (DsPH) of Bristol North and Bristol South and West Primary Care Trusts (PCTs). Following the establishment of the PCTs on 1st April 2002, the Bristol North DPH was appointed in May and the Bristol South & West DPH on 1st September 2002. We have decided to produce a joint annual report as so many of the public health issues we face are common across Bristol. Section 2 provides an overview of Bristol's population, and the PCTs, which serve the city. We have however, provided more local information in specific sections on health in Bristol North (section 3) and Bristol South & West (section 4).

2002 has been a year of substantial change and reorganisation. During 2002, priorities for public health included the development of the public health function to meet the needs of the PCTs and their partnerships, planning for changes in health protection services as the new national Health Protection Agency was established on 1st April 2003, maintaining services for health promotion and improvement, health protection and provision of advice on services. This has proved challenging given the financial position of the PCTs and local health community, which has meant that the PCTs (including their public health function), have not had the resources to develop as fully as planned. Section 12 describes our joint priorities for public health action in Bristol.

Against this background, this report on the state of health of the PCTs' population provides a baseline of epidemiological data. Much of this looks at trends in death rates – one measure of the health status of the population, but a very limited one given broader definitions of health. Nevertheless, data on deaths and specific diseases, and related inequalities, indicate clear needs for improving health in the Bristol population, which need to be taken into account in key plans for health in Bristol - the Bristol Partnership Community Strategy and the PCTs' Local Delivery Plans.

This report also provides information on recent public health work in Bristol and public health partnerships. In section 13 we discuss development of future DPH reports and ask for your views on the report as a source of information and recommendations for improving health.

David Evans
Director of Community Development and Public Health
Bristol North PCT

Dr Christine Hine
Director of Public Health
Bristol South and West PCT

2. The Population of Bristol

Bristol: its population and primary care trusts

Bristol North and Bristol South & West PCTs serve diverse populations across the city of Bristol (figure 2.1). In Bristol South & West, Filwood and Hartcliffe & Withywood wards are amongst the most deprived wards and are priorities for neighbourhood renewal; by contrast, Clifton and Cotham are amongst the least deprived of Bristol wards. Similarly, in Bristol North, Lawrence Hill, Ashley and Southmead have high levels of deprivation whilst Redland, Helnleaze and Westbury-on-Tryme are the least deprived areas. 15% of the Bristol population live in wards that are amongst the 10% most deprived in England (as measured by the Index of Multiple Deprivation 2000).

The results of the 2001 census revealed that there was a discrepancy between the population determined by the census and the population as determined by the Exeter System. (table 2.1). The Exeter system contains details of all people registered with a GP. The resident population in table 2.1 refers to all people registered with a GP in Avon and living in Bristol.

Table 2.1: City and PCT populations: discrepancy between Census and GP Resident populations

Measure	Source	Population	Trend
City of Bristol	ONS 2001census count	380,615	3% decline since 1991
Bristol North PCT	ONS 2001 mid-year estimate	210,325	
Bristol South & West PCT	ONS 2001 mid-year estimate	170,888	
Bristol North PCT resident population	Exeter System	230,200	Increasing since 1996
Bristol South & West PCT resident population	Exeter System	187,125	Increasing since 1996
Combined Bristol PCTs population	Exeter System	417,325	Increasing
Discrepancy between combined PCT population, and City of Bristol Census count		36,710 (9.6%)	

We also see differences between PCT registered populations and resident populations (table 2.2). The registered population is the total number of people who are registered with GPs that make up the PCT regardless of where they live.

A discrepancy between the number of residents of Bristol's electoral wards, and the number of people registered with PCT practices is to be expected, as local people are not required to register only with practices within their PCT area. Given the size of the discrepancy and differing trends in population growth, care is needed in using population estimates for epidemiological and health planning purposes.

Figure 2.1: Location of Bristol Primary Care Trusts

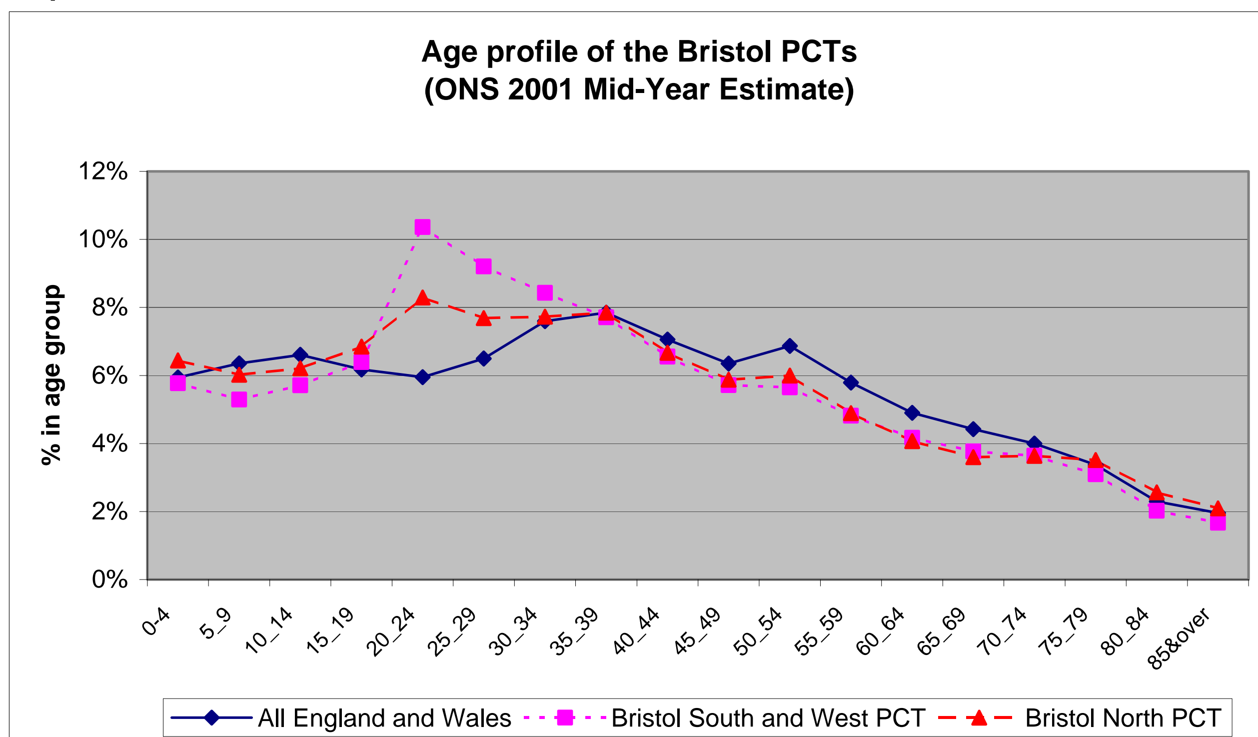
Table 2.2: GP Registered Populations

Area	Population
Bristol North PCT	228,200
Bristol South and West PCT	202,410
Bristol Total	430,610
Discrepancy between GP registered and resident populations	13,285 (3.1%)

Source: Exeter System

The structure of the Bristol population differs from the national in that it has a lower proportion of children, a higher proportion of young adults, and a lower proportion of middle age people (graph 2.1). The large proportion of young adults, particularly in Bristol South & West PCT, is mainly due to the student population of the two universities in the city.

Graph 2.1



Source: ONS

At the time of writing, the first results from the 2001 census were available only for local authorities. This revealed that 8.2% of the Bristol population are from Black or minority ethnic groups, higher than the 1991 census figure of 5.1%. However these figures are not directly comparable as the Census question included in the 2001 Census was extended to include people describing themselves as of mixed race (table 2.3). The 1991 Census indicated that 2.5% of the Bristol South and West population and 7.3% of the Bristol North population described themselves as being from Black and minority ethnic groups.

Table 2.3: 2001 Census data on ethnicity. Percentage of population identifying themselves within each ethnic group.

Ethnic Group	England	City of Bristol	Total Bristol Population
All people	100.0%	100.0%	380,615
White: British	87.0%	88.0%	335,085
White: Irish	1.3%	1.1%	4,321
White: Other White	2.7%	2.7%	10,124
Total White	**90.9%**	**91.8%**	**349,530**
Mixed: White and Black Caribbean	0.5%	1.0%	3,871
Mixed: White and Black African	0.2%	0.2%	755
Mixed: White and Asian	0.4%	0.4%	1,652
Mixed: Other Mixed	0.3%	0.4%	1,656
Total Mixed	**1.3%**	**2.1%**	**7,934**
Asian or Asian British: Indian	2.1%	1.2%	4,595
Asian or Asian British: Pakistani	1.4%	1.1%	4,050
Asian or Asian British: Bangladeshi	0.6%	0.3%	1,230
Asian or Asian British: Other Asian	0.5%	0.3%	984
Total Asian or Asian British	**4.6%**	**2.9%**	**10,859**
Black or Black British: Caribbean	1.1%	1.5%	5,585
Black or Black British: African	1.0%	0.6%	2,310
Black or Black British: Other Black	0.2%	0.2%	936
Total Black or Black British	**2.3%**	**2.3%**	**8,831**
Chinese or other ethnic group: Chinese	0.4%	0.6%	2,149
Chinese or other ethnic group: Other Ethnic Group	0.4%	0.3%	1,312
Total Chinese or Other Ethnic Group	**0.9%**	**0.9%**	**3,461**

Source: 2001 Census, Office of National Statistics

Indicators of quality of life in Bristol

Bristol City Council publish an assessment of over 100 indicators relating to the wider determinants of health in an annual report 'Indicators of the Quality of Life in Bristol'. It describes trends relevant to whether Bristol is becoming a better or worse place to live, and highlights relevant strategies for change.

Trends for an index of 25 indicators are reproduced in table 2.4. These represent an average view for Bristol overall – at a more local level the situation can differ. Air pollution is an important example; where overall trends are favorable but more local levels of pollution are unacceptable e.g. an Air Quality Management Programme has been proposed to tackle pollution in the City center.

The report is relevant to wider public health, relating to a very broad range of topics and strategies for the City. Key points based on data in the 2002 report include:

- Favorable trends in unemployment rates
- Affordability of housing is a problem in Bristol, and level of demand for council housing remains high
- Trends in truancy, and educational attainment in secondary schools are static
- Indicators for community safety are mostly unfavorable, 2002 having seen substantial increases in reported crimes
- Trends for traffic flow and road traffic accidents are static.

The report includes a section on health and well-being noting most indicators as static or improving. The infant mortality rate in 2001 was higher than the previous year, but at a level consistent with 1997-1999.

Table 2.4: Bristol's Quality of Life indicators

Quality of Life Index	1996/ 1997	1997/ 1998	1998/ 1999	1999/ 2000	2000/ 2001	2001/ 2002
Energy efficiency in council housing	amber	green	green	green	green	green
Total domestic waste	amber	red	red	red	red	red
Recycling of domestic waste	amber	green	green	green	green	green
Traffic flow	amber	red	amber	amber	amber	amber
Road traffic accidents	amber	amber	red	red	amber	amber
Air quality	amber	green	green	green	green	green
Surface water quality	amber	green	green	green	green	green
Noise complaints	amber	green	green	green	amber	amber
Dog fouling complaints	amber	amber	red	red	amber	amber
Water use / conservation	amber	green	green	green	green	green
Foodborne and waterborne diseases	amber	red	amber	amber	amber	green
Rats (requests for treatment)	amber	amber	amber	red	red	red
Premature death (15 - 64 years)	amber	amber	amber	green	green	green
Infant death (less than 1 year)	amber	red	red	red	amber	red
Homeless households	amber	amber	amber	red	amber	green
% Housing development on brownfield sites	amber	amber	amber	amber	amber	green
Unemployment	amber	green	green	green	green	amber
Benefit claimants	amber	green	green	green	green	green
New business registrations	amber	green	green	amber	amber	red
Secondary school achievement	amber	red	amber	amber	amber	amber
Primary school achievement	amber	amber	green	green	green	green
Truancy from school	amber	amber	amber	red	red	amber
Total crime incidents	amber	green	green	green	amber	red
Children on the child protection register	amber	amber	amber	green	green	green
Access to information in museums and libraries	amber	amber	green	green	green	green
TOTAL	**50**	**55**	**58**	**56**	**58**	**59**

Source: Bristol City Council. Indicators of Quality of Life in Bristol 2002.
Copies of this report are available from env_qual@bristol-city.gov.uk

Please see www.bristol-city.gov.uk for a full list of indicators.

3. Health in Bristol North PCT

Indicators of health

This section provides an overview of indicators of the health of the Bristol North PCT population. Whilst the indicators are not comprehensive – for example mental health problems are not well addressed by this approach – they do highlight important local issues and trends.

Tackling inequalities in health

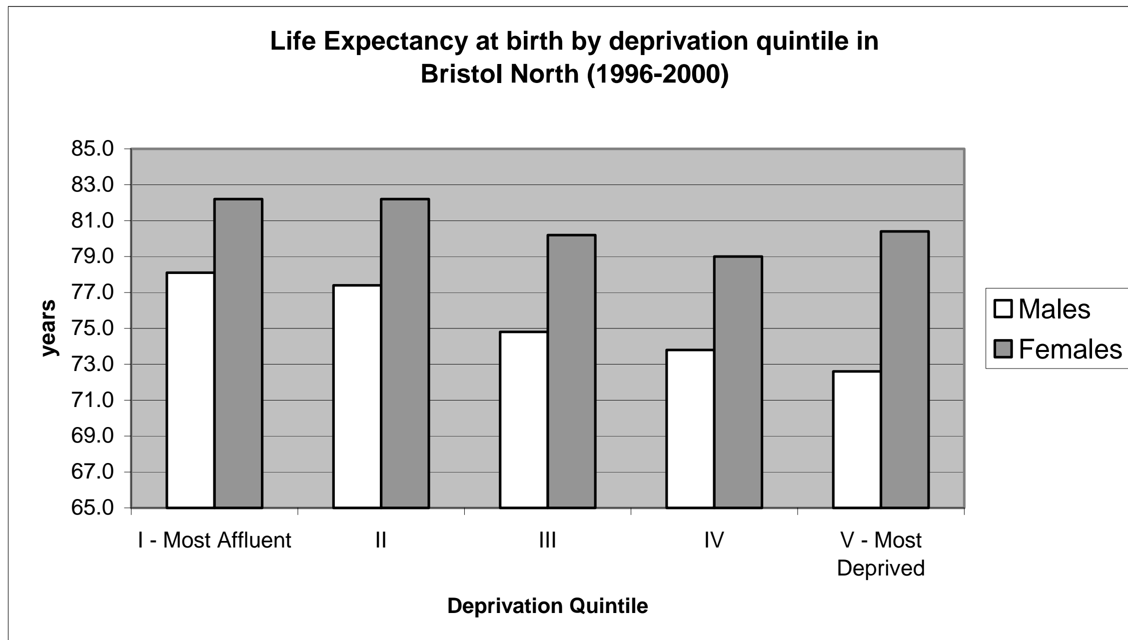
Two national targets have been set, addressing life expectancy and infant mortality.

Life expectancy - "Starting with Health Authorities, by 2010 to reduce by at least 10% the gap between the quintile of areas with the lowest life expectancy at birth and the population as a whole."

Within the PCT area, data from 1996-2000 reveals that men in the fifth most deprived areas in Bristol North live on average 5.5 fewer years than those in the fifth least deprived areas. Women in the fifth most deprived areas live on average 2.1 fewer years than those in the fifth least deprived areas (graph 3.1).

Poorer survival is related to social and economic circumstances in both early and adult life. For adults currently at high risk of relatively common conditions like heart disease and lung cancer, childhood factors clearly cannot be reversed – but managing current risk factors such as smoking and physical activity can help to reduce their risk of heart disease and some cancers. Wider strategies are needed to help improve social and economic factors influencing health. Tackling poverty (particularly affecting children) and promoting higher levels of educational attainment in disadvantaged populations are priorities if we are to achieve more equal opportunities for health.

Graph 3.1



Source: ONS birth and mortality files & 1991 census for Townsend Score of deprivation.

Infant mortality - "Starting with children under one year, by 2010 to reduce by at least 10% the gap in mortality between manual groups and the population as a whole".

Birth registration statistics for local areas are not coded by occupational group, and there are too few births to look at the relationship between infant mortality and deprivation each year locally, so data for several years are grouped together.

Between 1996 and 2000, Bristol North PCT had 18 infant deaths per year, (6.2 deaths per 1,000 live births). In the City of Bristol, there were 27 infant deaths (5.8 deaths per 1,000 live births) during the year 2000, close to the England Wales infant mortality rate, and lower than comparable areas in England

Table 3.1: Birth data, Bristol North PCT

	2001 data	Trend	Definitions
Total births	2652	Falling, 9.6% lower than 1996	Number of births
General fertility rate	53 / 1000 (2000 data)	Falling, 11.8% lower than 1996	Number of live births per 1000 women aged 15-44yrs
Stillbirths (rate)	14 (5.3/1000)	No clear trend	Number of stillbirths (rate per 1000 total births)
Numbers (%) low birthweight	200 (7.5%)	Little change since 1996	Live and stillborn infants with birthweight <2,500g (as % of all births)

Source: ONS birth registrations file
Breastfeeding rates - Child Health Surveillance, Avon IM&T Consortium

Low Birth Weight

Low birth weight (birthweight <2,500g) can be used a proxy for infant mortality & deprivation. (table 3.1) A baby born weighing less than 2500g is at higher risk of dying as an infant, and of developing coronary heart disease and diabetes in later life. Low birthweight is commoner in areas of deprivation.

Locklease and Kingsweston had a significantly higher percentage of low birth weight babies than the Bristol North PCT average. In 2000, 7.7% of registered births in Bristol were <2500g, not significantly different from than the England and Wales average of 7.9%.

Breastfeeding

In 2000 & 2001, 2537 (53%) of 4760 mothers in Bristol North PCT were breastfeeding at 8 weeks. There was variation between wards, from 88.8% in Redland to 21.7% in Southmead. Breastfeeding is associated with lower risks of asthma, eczema and gastrointestinal problems.

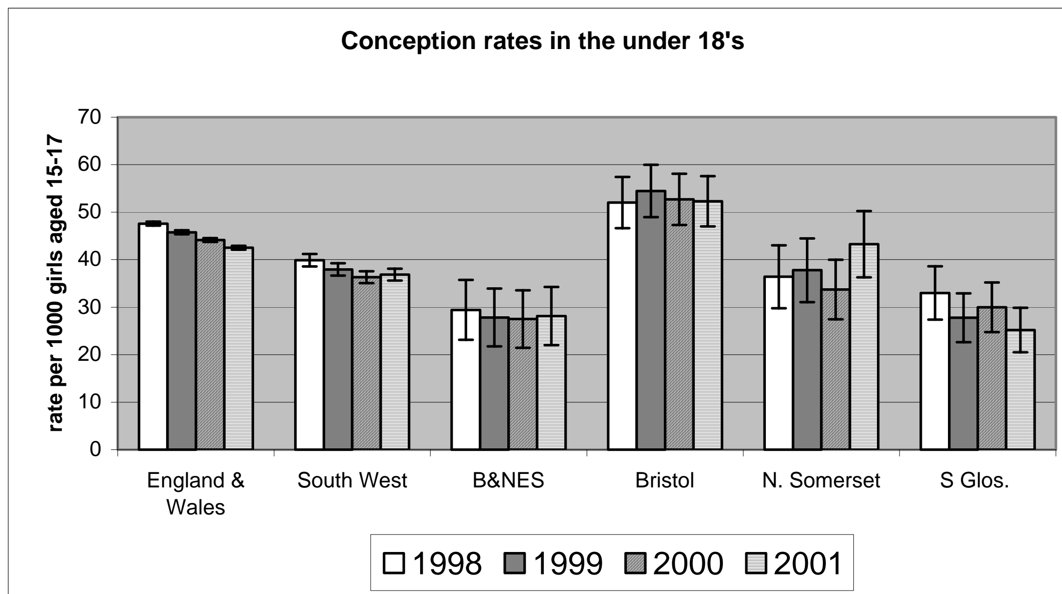
Teenage pregnancy

Teenage pregnancy can be associated with poor educational achievement, poorer health, social isolation and poverty. Socio-economic disadvantage can be both a cause and consequence of teen parenthood. Babies are more likely to be low birthweight, they are less likely to be breastfed and infant mortality is higher than in babies of older mothers.

During 2001, there were 354 conceptions amongst under 18's in Bristol, of which approximately 20% were under the age of 16. The Bristol under 18 and under 16 conception rates have changed little over the last few years (graphs 3.2 and 3.3). 40% of conceptions in under 18's ended in termination during 2000.

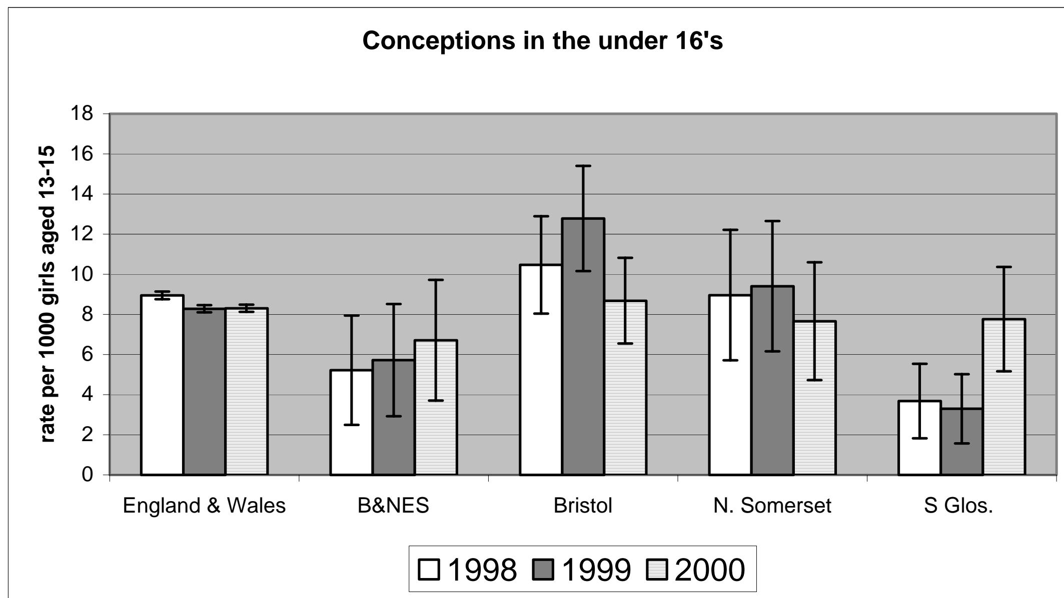
The conception rate for the under 18's is significantly higher than the England and Wales rate. The number of conceptions in Bristol North PCT are highest in Lawrence Hill, Kingsweston, and Easton wards.

Graph 3.2



Source: ONS

Graph 3.3

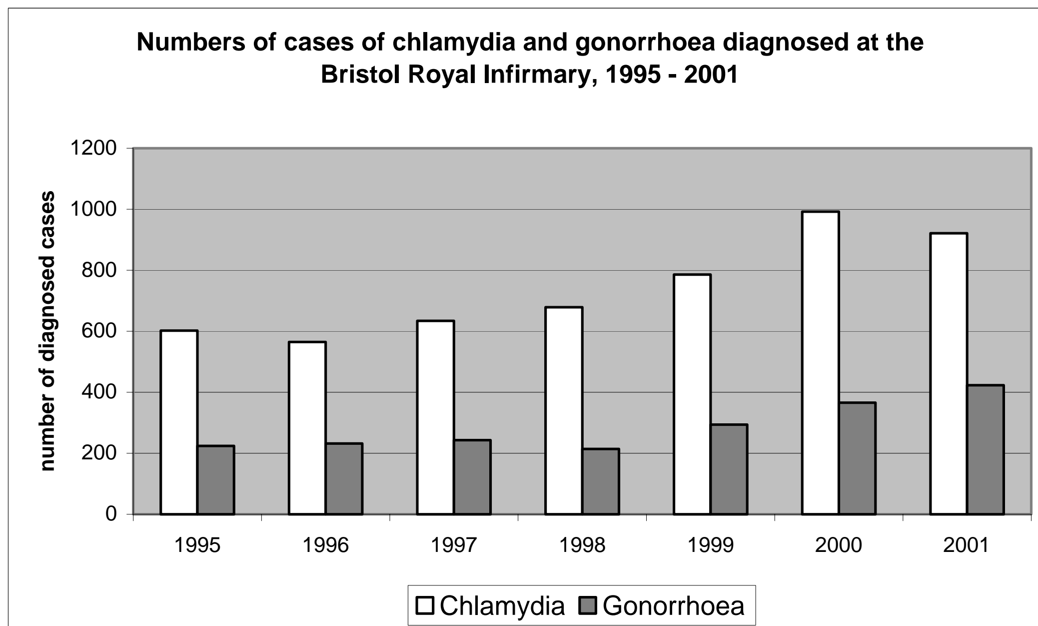


Source: ONS

Sexually transmitted diseases

There have been large rises nationally and locally in the number of cases of chlamydia and gonorrhoea. We cannot calculate prevalence rates for Bristol North alone, as for confidentiality reasons our local clinics do not report on the PCT of residence for their patients. Graph 3.4 shows the growing numbers of cases diagnosed by the specialist sexual health clinic for the Bristol area.

Graph 3.4



Source: KC60 returns from GUM clinics

Genital chlamydia infection does not cause symptoms in as many as half of the men and women affected, but it is an important cause of fertility problems. Untreated it can cause pelvic inflammatory disease in <40% of women. It is also a cause of epididymitis in men, and is thought to facilitate transmission of HIV. Nationally, an estimated 3-5% of women attending their general practice have chlamydia. Gonorrhoea can similarly be asymptomatic but lead to complications including pelvic inflammatory disease.

Growth in problems of intravenous drug use

The number of people involved in drug misuse is not known. The South West Public Health Observatory has published 'The Impact of drug misuse on health in the South West, 1996-2001'. This provides estimates of prevalence of drug misuse based on surveys elsewhere, and notifications to the Regional Drug Misuse Database (RDMD) of people presenting with drug misuse problems to various statutory and voluntary agencies. The report estimates that 20-24/1000 15 – 44 yr olds in the South West region are involved in drug misuse, representing 40,000 to 48,000 people.

There are fewer notifications to the RDMD of people with *problem* drug misuse. Approximately half of all notifications in the South West arise from the former Avon area. Within Avon, Bristol accounts for the largest proportion of these (9257 Bristol residents notified during 1996-2001).

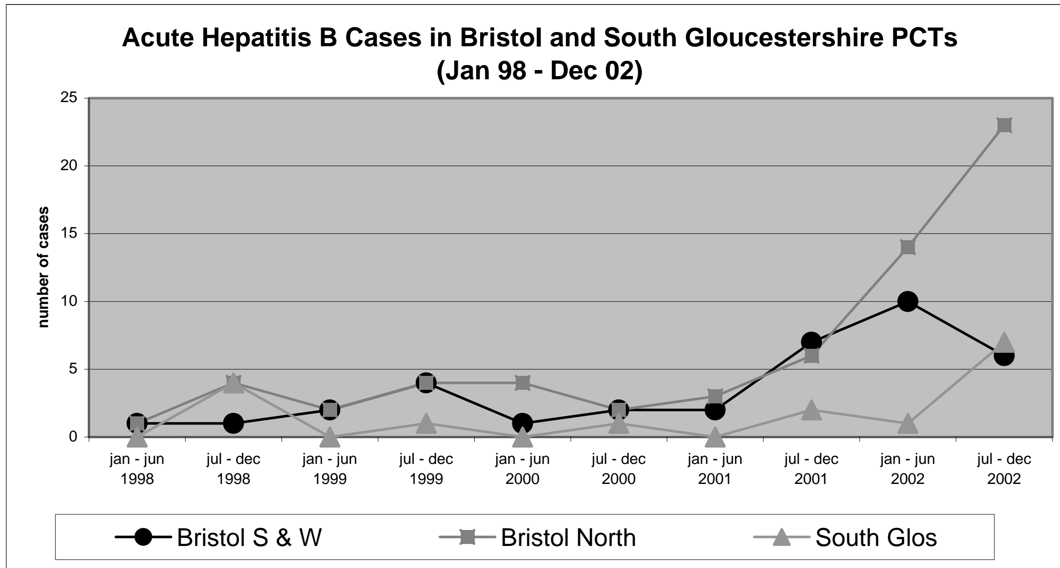
Trends in notifications and relevant problems e.g. drug related deaths, are consistent with an underlying rise in the number of people involved in drug misuse, but we lack data to confirm this. Notification practices have changed with the possibility that a greater proportion of problem drug misuse is being notified, but there is also evidence of under-notification in some parts of the region.

The report notes dramatic growth in the number of cases of hepatitis C, whilst regionally numbers of cases of hepatitis A and B were stable. In Bristol however, there were outbreaks of hepatitis A and of syphilis during this period, both linked with intravenous (IV) drug misuse. Two new problems were identified in Bristol in 2002, and are currently under investigation:

- Cases of hepatitis B in Bristol have risen to outbreak levels during 2002 (graph 3.5). The outbreak has been linked with unprotected sexual intercourse and IV drug use. The action plan aims to increase immunisation amongst those at risk, particularly commercial sex workers and IV drug users. There is also an information campaign on preventing hepatitis B.

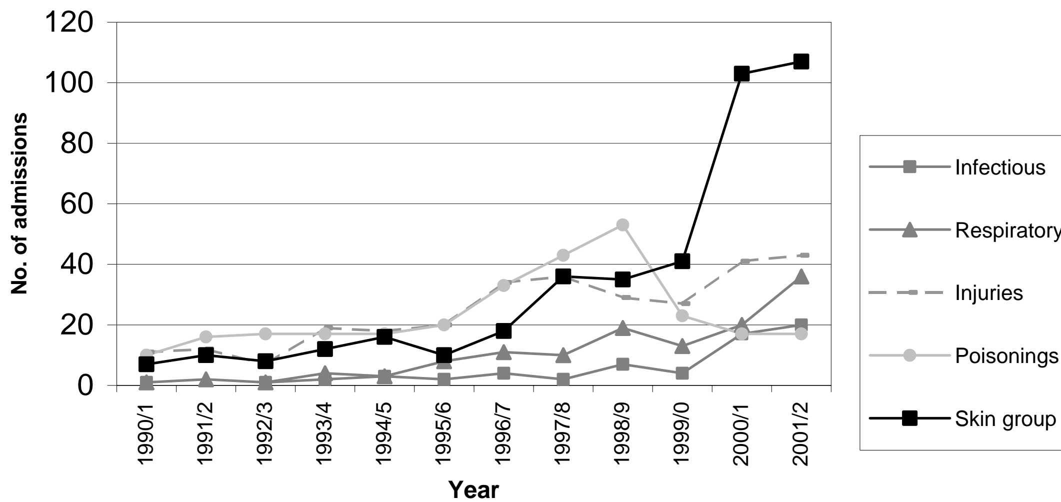
- Clinicians have observed more medical emergency admissions of people with complications of IV drug misuse e.g. skin infections. Graph 3.6 shows the rise in these admissions over the past decade. Improved data recording may account for some of the increase, but clinician observations suggest that a real increase in numbers of admissions has occurred. The possible causes of this rise are being investigated, to inform plans for prevention and treatment

Graph 3.5



Source: Avon Health Protection Unit

Graph 3.6



Source: Avon IM&T Consortium in-patient files

Commonest causes of death in Bristol North PCT

Coronary heart disease (CHD) is the commonest cause of death in Bristol North PCT for 'all ages' and amongst people aged under 75 yrs. (table 3.2) The commonest causes of death reflect relatively high local levels of smoking and smoking related diseases, particularly when looking at premature deaths in people under 75yrs. This pattern is stronger than in neighbouring PCTs, where lung cancer and Chronic Obstructive Pulmonary Disease (COPD) are ranked lower. COPD is caused by an abnormal reaction to the chronic inhalation of particles e.g. in smoke, leading to problems with breathing.

Table 3.2: Top Five commonest causes of death in Bristol North PCT 1998-2000

All ages	Total number of deaths all ages	% Total deaths all ages	<75's	Total deaths number <75	% Total deaths <75
CHD	1481	22.0	CHD	439	19.5
Pneumonia	685	10.2	Lung cancer	184	8.2
Stroke	648	9.6	Stroke	112	5.0
Lung cancer	345	5.1	COPD	111	4.9
COPD	314	4.7	Pneumonia	98	4.3

Source: ONS mortality file

Circulatory diseases

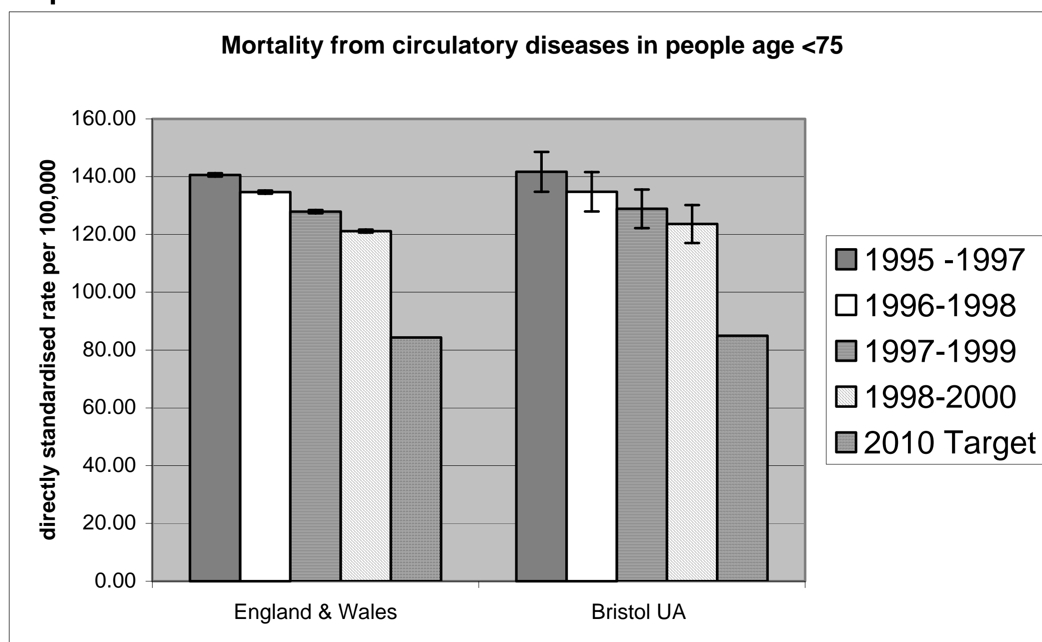
Coronary heart disease, stroke and all other circulatory diseases together accounted for 913 Bristol North deaths on average each year during 1998-00, a quarter being in people under 75yrs. National targets require a fall in the death rate of two fifths (by 2010 compared with 1997). Death rates for the under 75's for Bristol have been falling since the target was set (graph 3.6). However Bristol North PCT death rates were higher than for England and neighbouring PCTs (table 3.3).

Table 3.3: Mortality from circulatory diseases, 1998-2000

	All Ages			Age <75		
PCT name	**DS rate**	**Number**	**95% CI**	**DS rate**	**Number**	**95% CI**
Bath and North East Somerset	217.4	2118	9.3	86.9	497	7.6
Bristol North	255.5	2740	9.6	116.1	711	8.5
North Somerset	240.8	2805	8.9	95.8	647	7.4
Bristol South & West	275.8	2072	11.9	133.3	678	10.0
South Gloucestershire	242.2	2439	9.6	98.2	748	7.0

Source: ONS mortality files, population local estimates
DS rate: directly standardised rate, taking account of age and sex of the population

Graph 3.7



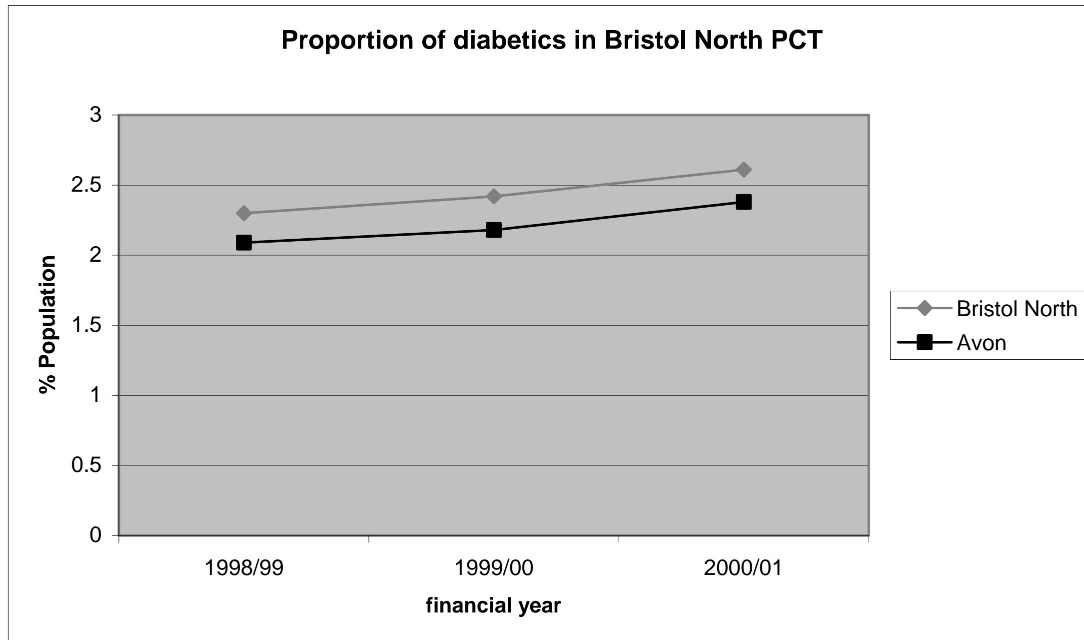
Source: Compendium of Clinical Indicators 2001

Approximately 500 Bristol North residents die of CHD each year, 30% before the age of 75yrs. Premature death rates are highest in Lawrence Hill, Hillfields, and St George West. Mortality rates in the most deprived fifth of enumeration districts are significantly higher than the fifth that are least deprived. Help to stop smoking, increase physical activity and reduce levels of blood pressure and lipids can reduce CHD and premature mortality.

Diabetes

Diabetes can lead to loss of limbs, vision and renal failure and is an important risk factor for heart disease. The number of people recorded as having diabetes by GPs is rising (graph 3.8). This is so for both type 1 diabetes, which starts in childhood and early adulthood, and for type 2 diabetes which mainly affects adults and older people. Type 2 diabetes is associated with obesity. Higher levels of physical activity can help to prevent cases and improve health in those already diagnosed. People from certain ethnic minority backgrounds e.g. South Asian are at higher risk of diabetes.

Graph 3.8



Source: General practitioners (Chronic Disease Management reports)

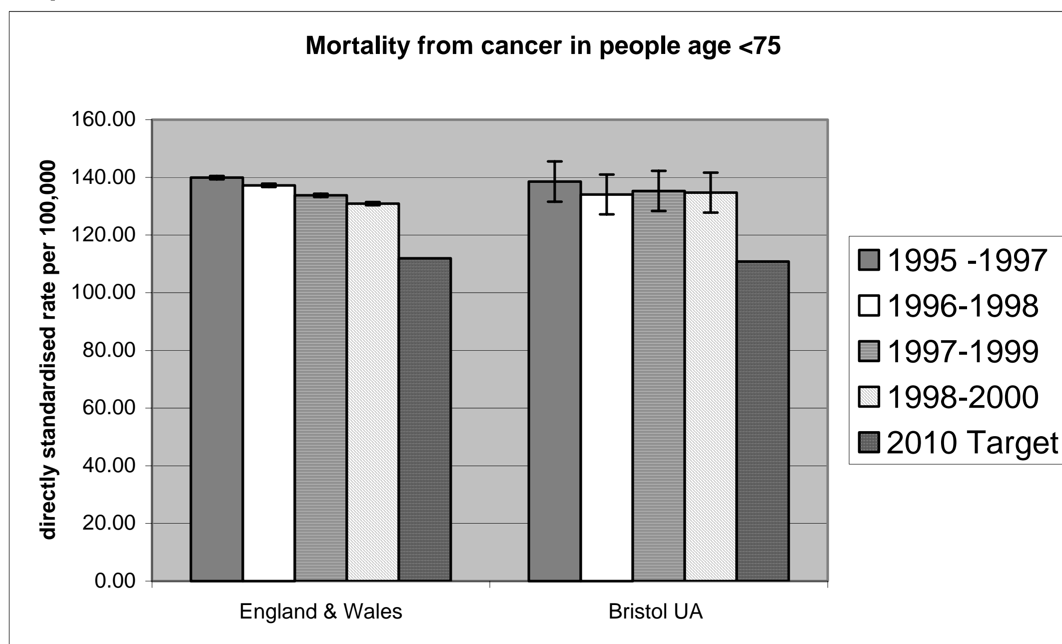
A more comprehensive analysis of local diabetes information is available from the Avon PH Network, at www.avon.nhs.uk/phnet/publications/diabetes_spotlight2.doc.

Cancers

Saving Lives - Our Healthier Nation set a national target to reduce the death rate from cancer in the <75's by at least a fifth by 2010. Although there has been an overall reduction in the last 10 years, the mortality rate in Bristol UA has declined only slightly since the target was set (graph 3.9).

Bristol North has significantly higher cancer death rates than England and Wales, and the South West region. Cancers are the commonest cause of premature death (under 75) in Bristol North. On average there were 525 deaths annually (1998 –2000), 59% before the age of 75yrs.

Graph 3.9



Source: Compendium of Clinical Indicators 2001

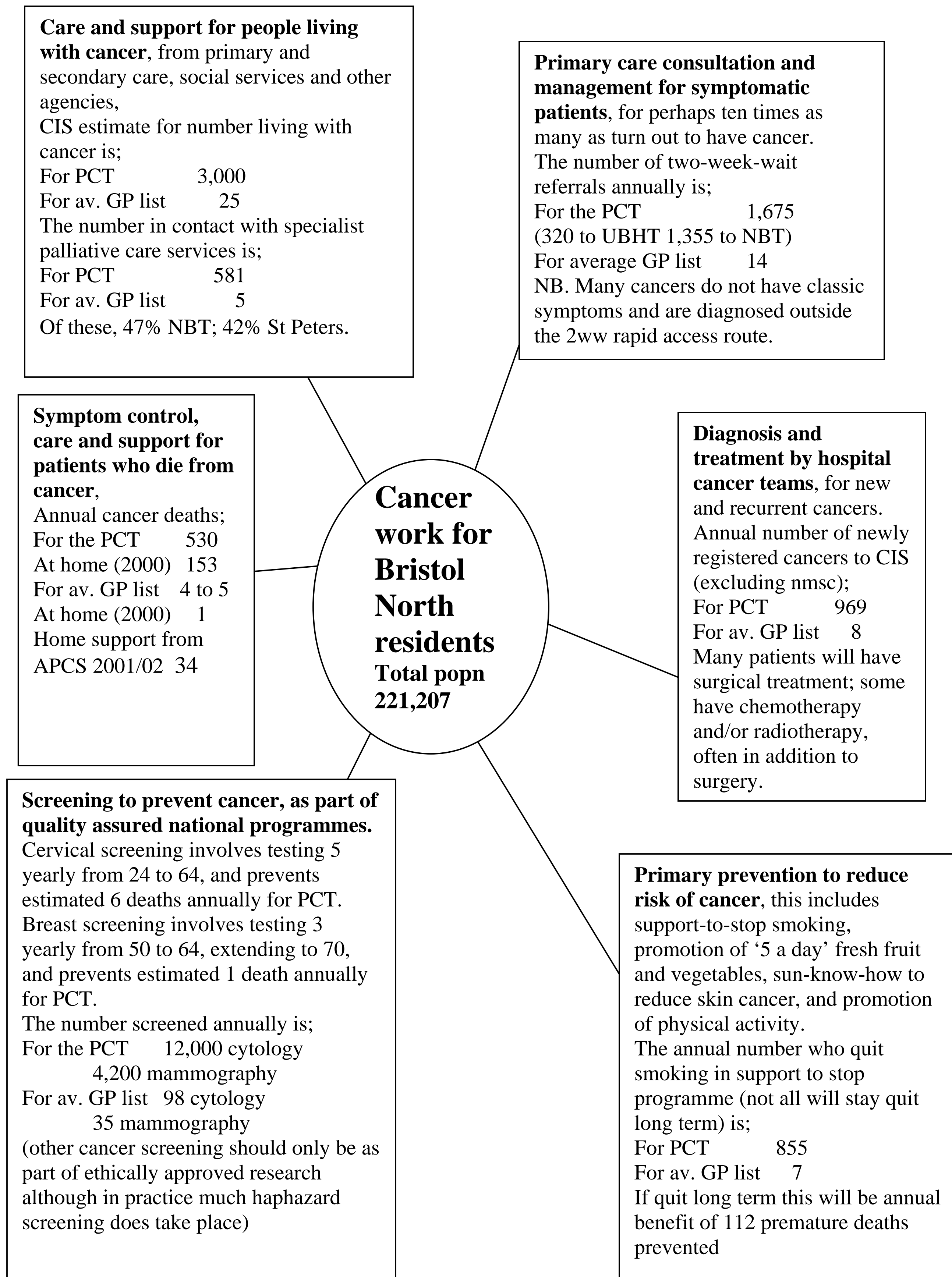
About one third of cancer deaths amongst Bristol North PCT men are due to lung cancer, about 115 deaths each year during 1998-2000. Lung cancer deaths are significantly higher in more deprived areas where smoking is commoner. Lung cancer is the commonest cancer in men and is predicted to overtake breast cancer as the commonest cause of cancer deaths in women. About 80% of lung cancers are attributed to smoking, the remainder being accounted for by passive smoking, occupational diseases and exposure to radon.

Amongst women, breast cancer is becoming more common and is the single commonest cause of female cancer deaths, accounting for an average of 44 out of 207 cancer deaths annually during 1998-2000. The standardised death rate is higher than would be expected compared to the South West region. This is being investigated jointly with the South West Public Health Observatory. Lung cancer accounted for an average of 34 deaths amongst women annually during the same period.

Smoking is the single most important preventable risk factor for cancer in Bristol North. Exposure to the sun, higher alcohol intakes, low intake of fruit and vegetable and physical inactivity are also associated with increased risk of some cancers.

A report on cancer statistics for the PCT is available from the South West Cancer Intelligence Service.

Figure 3.1: Overview of cancer work in Bristol North PCT

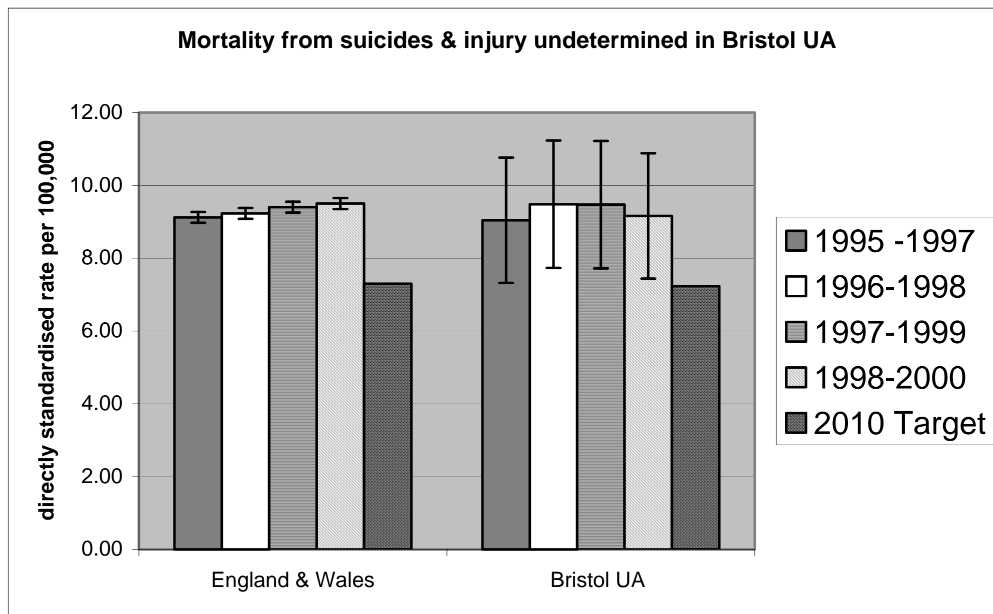


Key; CIS = Cancer Intelligence Service, nmsc,= non-melanoma skin cancer, Average GP list = 1,800,
APCS = Avon Palliative Care Intensive Home Support Service (New Opps Funded).

Suicide

On average 20 people died through suicide each year during 1998 – 2000. The Bristol North rate is not significantly different to England and Wales. The Bristol rate has declined slightly, but like the national trend has shown little progress towards the national target for 2010 (graph 3.10).

Graph 3.10



Source: Compendium of Clinical Indicators 2001

There is a strong relationship between suicide and deprivation in Bristol North (graph 3.11).

Graph 3.11

Source: ONS mortality files & 1991 Census for Townsend scores of deprivation

Suicide mortality rates in the most deprived areas of Bristol North (those contained in number 5 quintile) are significantly higher than rates in the least deprived quintile (graph 3.11). However mortality differences between other quintiles are not statistically significant.

Injuries

Between 1998 – 2000 there were on average 39 deaths from accidents in Bristol North PCT. Injuries are the commonest cause of deaths in young people. For Bristol, there has been no significant progress towards the national mortality target for all ages for 2010. The Bristol North rate is not significantly higher than England and Wales or the South West. Mortality rates are higher amongst relatively deprived populations.

On average there were 181 hospital admissions following assault each year from 99/00 – 01/02. Approximately 85% were for men, with 15-24 yr olds being more affected than other age groups. In-patient admission rates were highest for Lawrence Hill, Avonmouth and Locklease wards.

Falls are the main cause of accidental death in older people. On average 6 people aged over 65 died following a fall, each year from 1998 – 2000 in Bristol North. During 2001/02 there were 520 hospital admissions in the over 65's; three quarters being women, and one half of those aged over 85 years.

Avonsafe (Action for Safety) is a local multi-agency alliance that aims to prevent injuries across the area. Work focuses mainly on injury prevention in older people and children and young people. It has developed a strategy with priority areas for action between 2001-2006. A main aim of the strategy is to seek to address inequalities in health and promote access to accident prevention for all sectors of the community. See www.avon.nhs.uk/avonsafe/about_us.htm

PCT Performance indicators for vaccination and immunisation

Immunisation levels were close to the national average for childhood immunisations, and above average for flu immunisation in 2001/02 (table 3.4).

Table 3.4: Vaccination and Immunisation activity in Bristol North PCT 2001/02

Health Improvement Indicator	National Figure	BN PCT	Indicator definitions
Childhood immunisations	91.3%	87.5%	Percentage average of children immunised against MMR (measles, mumps and rubella) and diphtheria by age 2
Flu vaccinations	67.2%	69.2%	Persons vaccinated against flu as a percentage of number of people aged 65 and over

Source: Department of Health national performance indicators at http://www.doh.gov.uk/performanceratings/2002/4vp62wvm8p.html

4. Health in Bristol South & West PCT

Indicators of health

This section provides an overview of indicators of the health of the Bristol South & West PCT population. Whilst the indicators are not comprehensive – for example mental health problems are not well addressed by this approach – they do highlight important local issues and trends.

Tackling inequalities in health

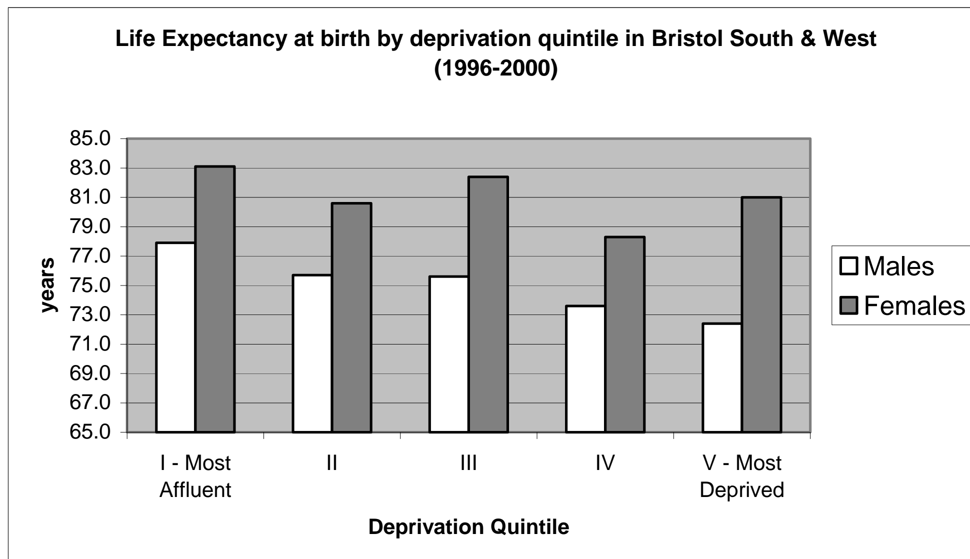
Two national targets have been set, addressing life expectancy and infant mortality.

Life expectancy - "Starting with Health Authorities, by 2010 to reduce by at least 10% the gap between the quintile of areas with the lowest life expectancy at birth and the population as a whole."

Within the PCT area, data from 1996-2000 reveals that men in the fifth most deprived areas in Bristol South & West live on average 5.5 fewer years than those in the fifth least deprived areas. Women in the fifth most deprived areas live on average 2.1 fewer years than those in the fifth least deprived areas (graph 4.1).

Poorer survival is related to social and economic circumstances in both early and adult life. For adults currently at high risk of relatively common conditions like heart disease and lung cancer, childhood factors clearly cannot be reversed – but managing current risk factors such as smoking and physical activity can help to reduce their risk of heart disease and some cancers. Wider strategies are needed to help improve social and economic factors influencing health. Tackling poverty (particularly affecting children) and promoting higher levels of educational attainment in disadvantaged populations are priorities if we are to achieve more equal opportunities for health.

Graph 4.1



Source: ONS birth and mortality files & 1991 census for Townsend Score of deprivation.

Infant mortality - "Starting with children under one year, by 2010 to reduce by at least 10% the gap in mortality between manual groups and the population as a whole".

Birth registration statistics for local areas are not coded by occupational group, and there are too few births to look at the relationship between infant mortality and deprivation each year locally, so data for several years are grouped together.
Between 1996 and 2000, Bristol South and West PCT had 12 infant deaths per year, (5.6 deaths per 1,000 live births). In the City of Bristol, there were 27 infant deaths (5.8 deaths per 1,000 live births) during the year 2000, close to the England Wales infant mortality rate, and lower than comparable areas in England

Table 4.1: Birth data, Bristol South and West PCT

	2001 data	**Trend**	**Definitions**
Total births	2062	Falling, 6.8% lower than 1996	Number of births
General fertility rate	48.5 / 1000 (2000 data)	Falling, 12% lower than 1996	Number of live births per 1000 women aged 15-44yrs
Stillbirths (rate)	5 (2.4/1000)	No clear trend	Number of stillbirths (rate per 1000 total births)
Numbers (%) low birthweight	157 (7.6%)	Little change since 1996	Live and stillborn infants with birthweight <2,500g (as % of all births)

Source: ONS birth registrations file
Breastfeeding rates - Child Health Surveillance, Avon IM&T Consortium

Low Birth Weight

Low birth weight (birthweight <2,500g) can be used a proxy for infant mortality & deprivation. A baby born weighing less than 2500g is at higher risk of dying as an infant, and of developing coronary heart disease and diabetes in later life. Low birthweight is commoner in areas of deprivation.

Whitchurch Park had a significantly higher percentage (12.5%) of low birth weight babies than the Bristol South and West PCT average. In 2000, 7.7% of registered births in Bristol were <2500g, not significantly different from than the England and Wales average of 7.9%.

Breastfeeding

In 2000 & 2001, 1612 (44.8%) of 3600 mothers in Bristol South & West PCG were breastfeeding at 8 weeks. There was variation between wards, from 89.7% in Clifton to 18.8% in Filwood. Breastfeeding is associated with lower risks of asthma, eczema and gastrointestinal problems.

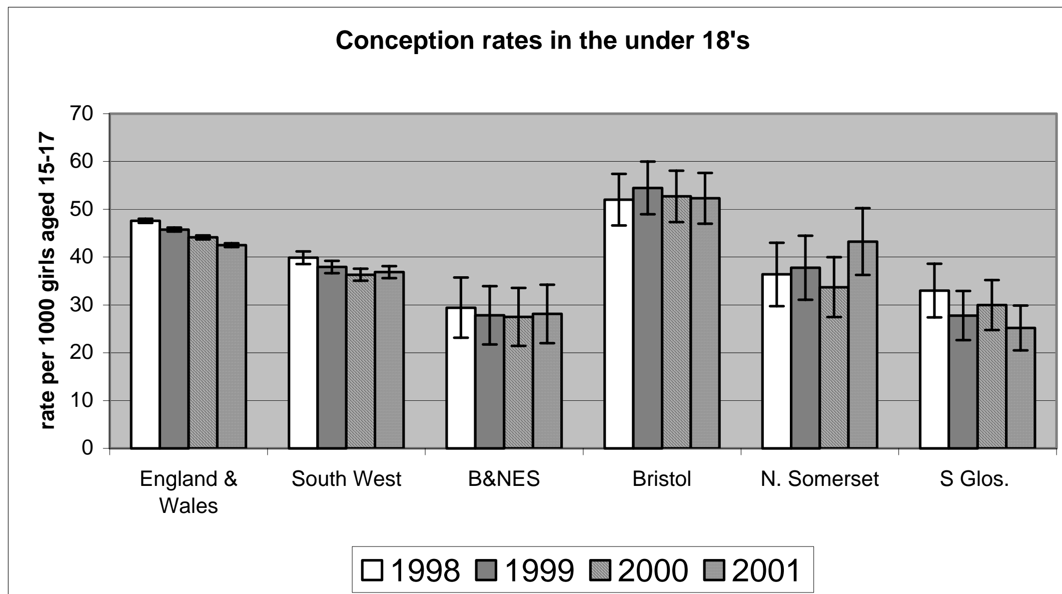
Teenage pregnancy

Teenage pregnancy can be associated with poor educational achievement, poorer health, social isolation and poverty. Socio-economic disadvantage can be both a cause and consequence of teen parenthood. Babies are more likely to be low birthweight, they are less likely to be breastfed and infant mortality is higher than in babies of older mothers.

During 2001, there were 354 conceptions amongst under 18's in Bristol, of which approximately 20% were under the age of 16. The Bristol under 18 and under 16 conception rates have changed little over the last few years (graphs 4.2 and 4.3). 40% of conceptions in under 18's ended in termination during 2000.

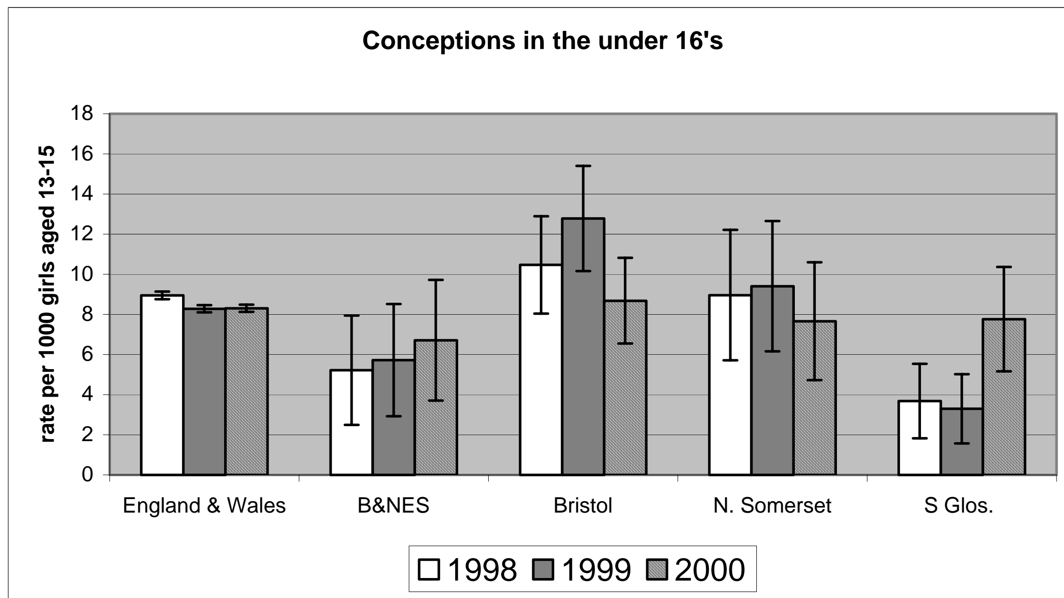
The conception rate for the under 18's is significantly higher than the England and Wales rate. The number of conceptions are highest in Bristol South & West PCT are highest in Filwood, Whitchurch Park, and Windmill Hill wards.

Graph 4.2



Source: ONS

Graph 4.3

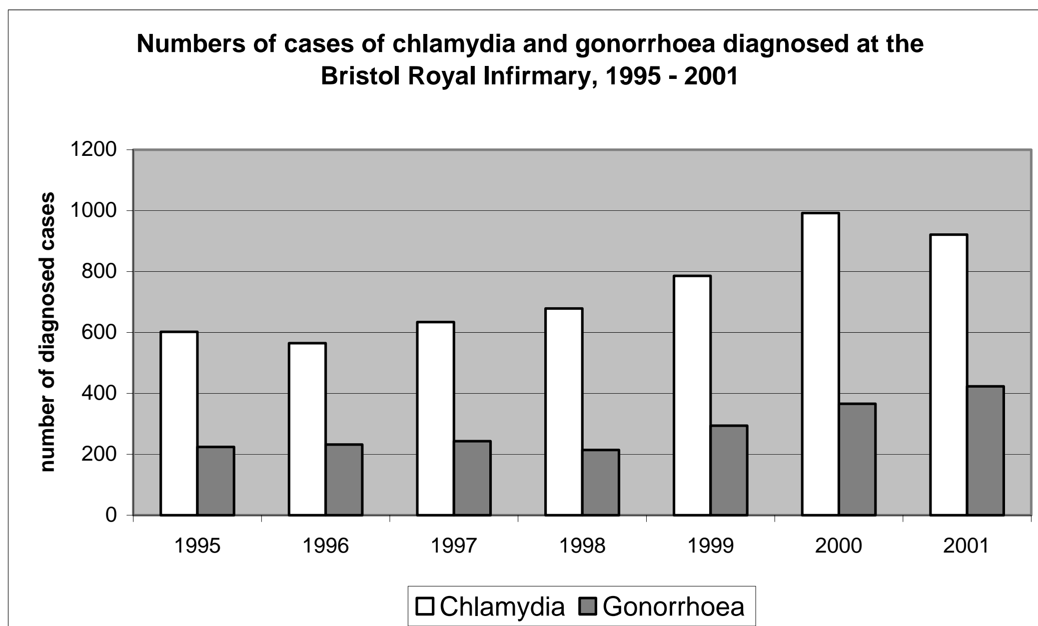


Source: ONS

Sexually transmitted diseases

There have been large rises nationally and locally in the number of cases of chlamydia and gonorrhoea. We cannot calculate prevalence rates for BSW alone, as for confidentiality reasons our local clinics do not report on the PCT of residence for their patients. Graph 4.4 shows the growing numbers of cases diagnosed by the specialist sexual health clinic for the Bristol area.

Graph 4.4



Source: KC60 returns from GUM clinics

Genital chlamydia infection does not cause symptoms in as many as half of the men and women affected, but it is an important cause of fertility problems. Untreated it can cause pelvic inflammatory disease in <40% of women. It is also a cause of epididymitis in men, and is thought to facilitate transmission of HIV. Nationally, an estimated 3-5% of women attending their general practice have chlamydia. Gonorrhoea can similarly be asymptomatic but lead to complications including pelvic inflammatory disease.

Growth in problems of intravenous drug use

The number of people involved in drug misuse is not known. The South West Public Health Observatory has published 'The Impact of drug misuse on health in the South West, 1996-2001'. This provides estimates of prevalence of drug misuse based on surveys elsewhere, and notifications to the Regional Drug Misuse Database (RDMD) of people presenting with drug misuse problems to various statutory and voluntary agencies. The report estimates that 20-24/1000 15 – 44 yr olds in the South West region are involved in drug misuse, representing 40,000 to 48,000 people.

There are fewer notifications to the RDMD of people with *problem* drug misuse. Approximately half of all notifications in the South West arise from the former Avon area. Within Avon, Bristol accounts for the largest proportion of these (9257 Bristol residents notified during 1996-2001).

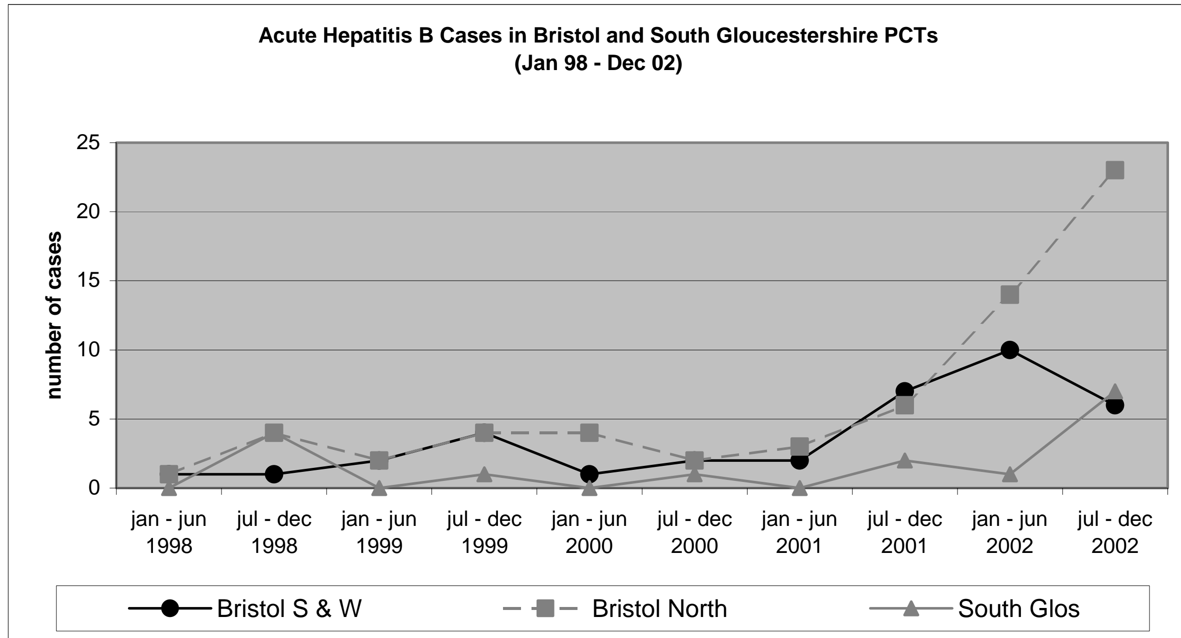
Trends in notifications and relevant problems e.g. drug related deaths, are consistent with an underlying rise in the number of people involved in drug misuse, but we lack data to confirm this. Notification practices have changed with the possibility that a greater proportion of problem drug misuse is being notified, but there is also evidence of under-notification in some parts of the region.

The report notes dramatic growth in the number of cases of hepatitis C, whilst regionally numbers of cases of hepatitis A and B were stable. In Bristol however, there were outbreaks of hepatitis A and of syphilis during this period, both linked with intravenous (IV) drug misuse. Two new problems were identified in Bristol in 2002, and are currently under investigation:

- Cases of hepatitis B in Bristol have risen to outbreak levels during 2002 (graph 4.5). The outbreak has been linked with unprotected sexual intercourse and IV drug use. The action plan aims to increase immunisation amongst those at risk, particularly commercial sex workers and IV drug users. There is also an information campaign on preventing hepatitis B.

- Clinicians have observed more medical emergency admissions of people with complications of IV drug misuse e.g. skin infections. Graph 4.6 shows the rise in these admissions over the past decade. Improved data recording may account for some of the increase, but clinician observations suggest that a real increase in numbers of admissions has occurred. The possible causes of this rise are being investigated, to inform plans for prevention and treatment

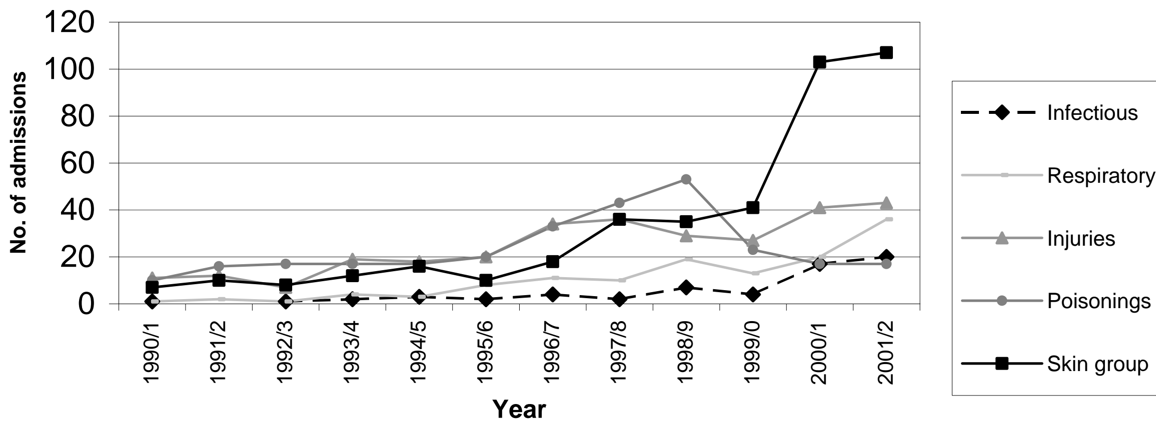
Graph 4.5



Source: Avon Health Protection Unit

Graph 4.6

Emergency admissions of drug misusers to UBHT from Bristol, S. Glos, N. Somerset Local Authorities or NFA (most frequent diagnoses shown)



Source: Avon IM&T Consortium in-patient files

Commonest causes of death in BSW PCT

Coronary heart disease (CHD) is the commonest cause of death in BSW PCT for 'all ages' and amongst people aged under 75 yrs. The commonest causes of death reflect relatively high local levels of smoking and smoking related diseases, particularly when looking at premature deaths in people under 75yrs. This pattern is stronger than in neighbouring PCTs, where lung cancer and Chronic Obstructive Pulmonary Disease (COPD) are ranked lower. COPD is caused by an abnormal reaction to the chronic inhalation of particles e.g. in smoke, leading to problems with breathing.

Table 4.2: Top Five commonest causes of death in BSW PCT 1998-2000

All ages	Total number of deaths all ages	% Total deaths all ages	<75's	Total number of deaths <75	% Total deaths <75
CHD	1178	22.8	CHD	453	22.8
Stroke	461	8.9	Lung cancer	172	8.7
Pneumonia	460	8.9	COPD	105	5.3
Lung cancer	293	5.7	Stroke	101	5.1
COPD	281	5.4	Pneumonia	80	4.0

Source: ONS mortality file

Circulatory diseases

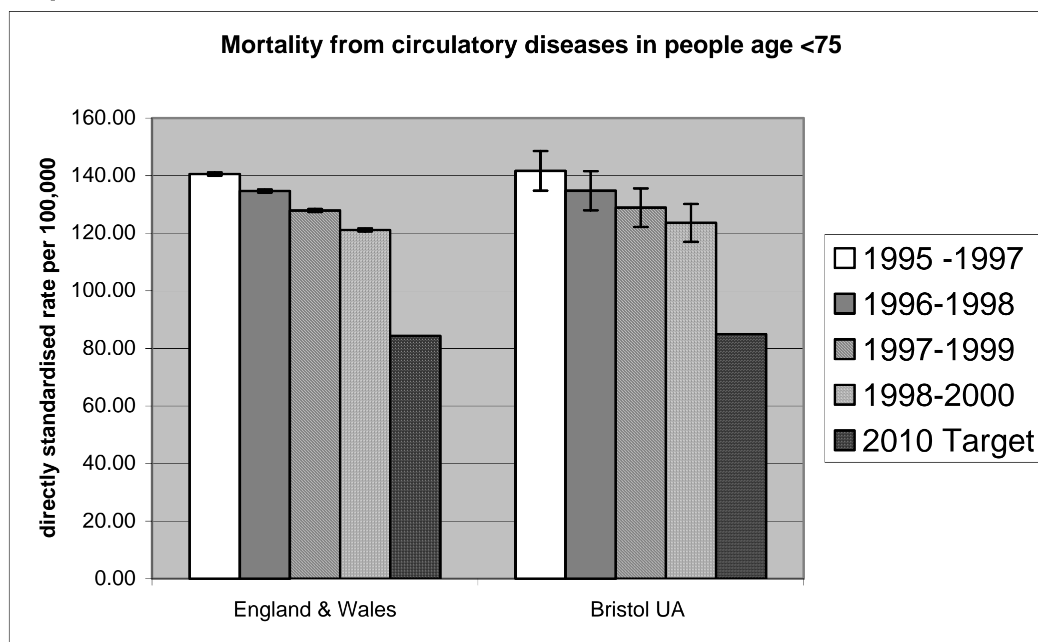
Coronary heart disease stroke and all other circulatory diseases together accounted for 691 BSW deaths on average each year during 1998-00, a third being in people under 75yrs. National targets require a fall in the death rate of two fifths (by 2010 compared with 1997). Death rates for the under 75's for Bristol have been falling since the target was set (graph 4.7). However BSW PCT death rates were higher than for England and neighbouring PCTs (table 4.3).

Table 4.3: Mortality from circulatory diseases, 1998-2000

	All Ages			Age <75		
PCT name	**DS rate**	**Number**	**95% CI**	**DS rate**	**Number**	**95% CI**
Bath and North East Somerset	217.4	2118	9.3	86.9	497	7.6
Bristol North	255.5	2740	9.6	116.1	711	8.5
North Somerset	240.8	2805	8.9	95.8	647	7.4
Bristol South & West	275.8	2072	11.9	133.3	678	10.0
South Gloucestershire	242.2	2439	9.6	98.2	748	7.0

Source: ONS mortality files, population local estimates
DS rate: directly standardised rate, taking account of age and sex of the population

Graph 4.7



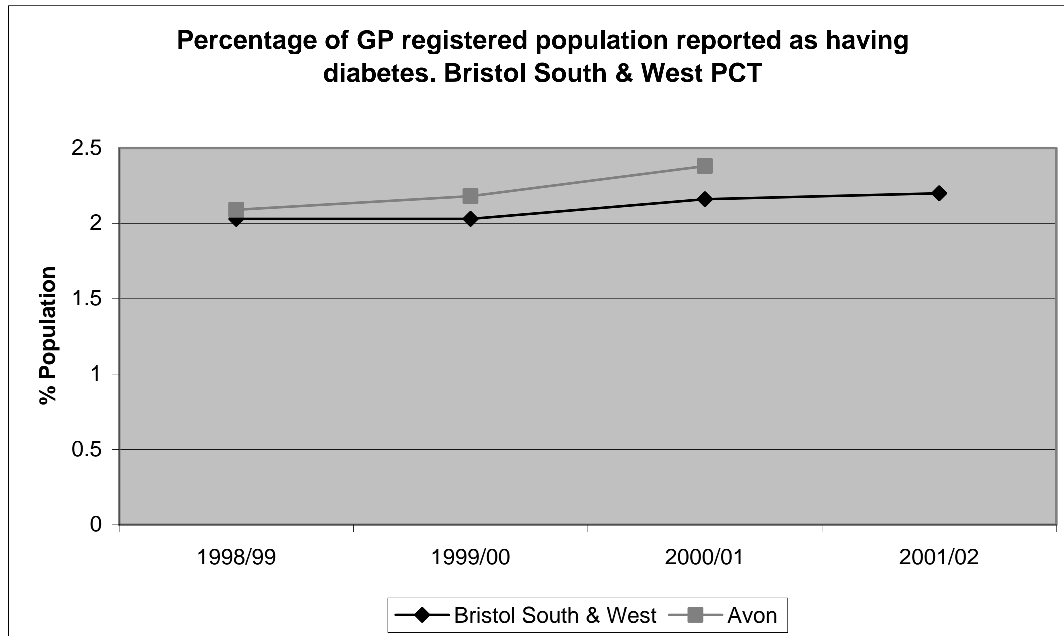
Source: Compendium of Clinical Indicators 2001

Approximately 400 BSW residents die of CHD each year, 40% before the age of 75yrs. Premature death rates are highest in Bishopsworth, Brislington East, Filwood, Hartcliffe, Southville and Windmill Hill. Mortality rates in the most deprived fifth of enumeration districts are significantly higher than the fifth that are least deprived. Help to stop smoking, increase physical activity and reduce levels of blood pressure and lipids can reduce CHD and premature mortality.

Diabetes

Diabetes can lead to loss of limbs, vision and renal failure and is an important risk factor for heart disease. The number of people recorded as having diabetes by GPs is rising (graph 4.8). This is so for both type 1 diabetes, which starts in childhood and early adulthood, and for type 2 diabetes that mainly affects adults and older people. Type 2 diabetes is associated with obesity. Higher levels of physical activity can help to prevent cases and improve health in those already diagnosed. People from certain ethnic minority backgrounds e.g. South Asian are at higher risk of diabetes.

Graph 4.8



Source: General practitioners (Chronic Disease Management reports)

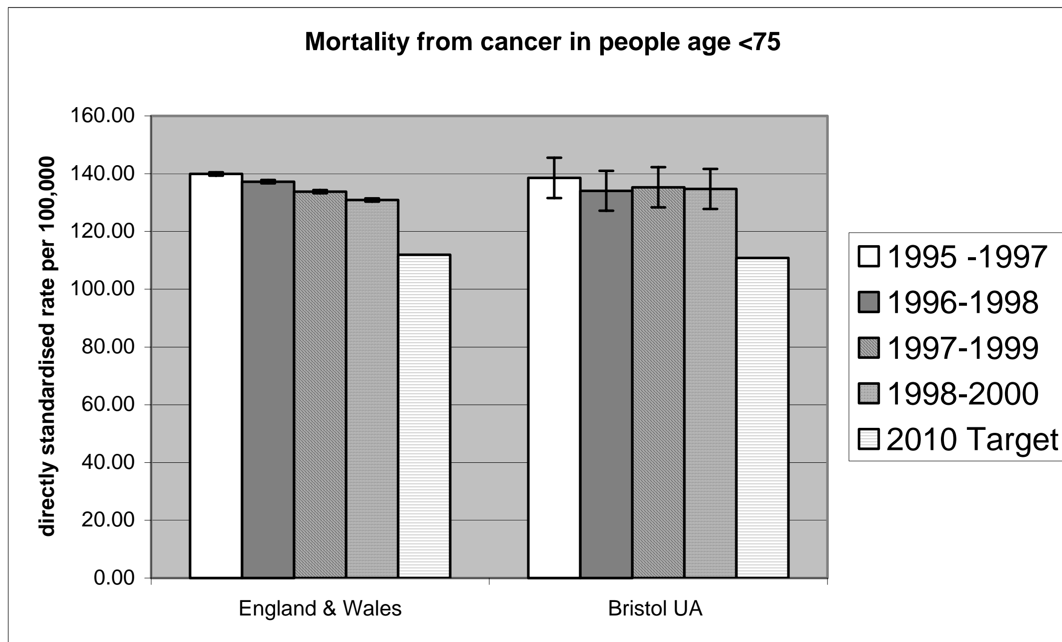
A more comprehensive analysis of local diabetes information is available from the Avon PH Network, at www.avon.nhs.uk/phnet/publications/diabetes_spotlight2.doc.

Cancers

Saving Lives - Our Healthier Nation set a national target to reduce the death rate from cancer in the <75's by at least a fifth by 2010. Although there has been an overall reduction in the last 10 years, the mortality rate in Bristol UA has declined only slightly since the target was set (graph 4.9).

BSW has significantly higher cancer death rates than England and Wales, and the South West region. Cancers are the commonest cause of premature death (under 75) in BSW. On average there were 437 deaths annually (1998 –2000), 54% before the age of 75yrs.

Graph 4.9



Source: Compendium of Clinical Indicators 2001

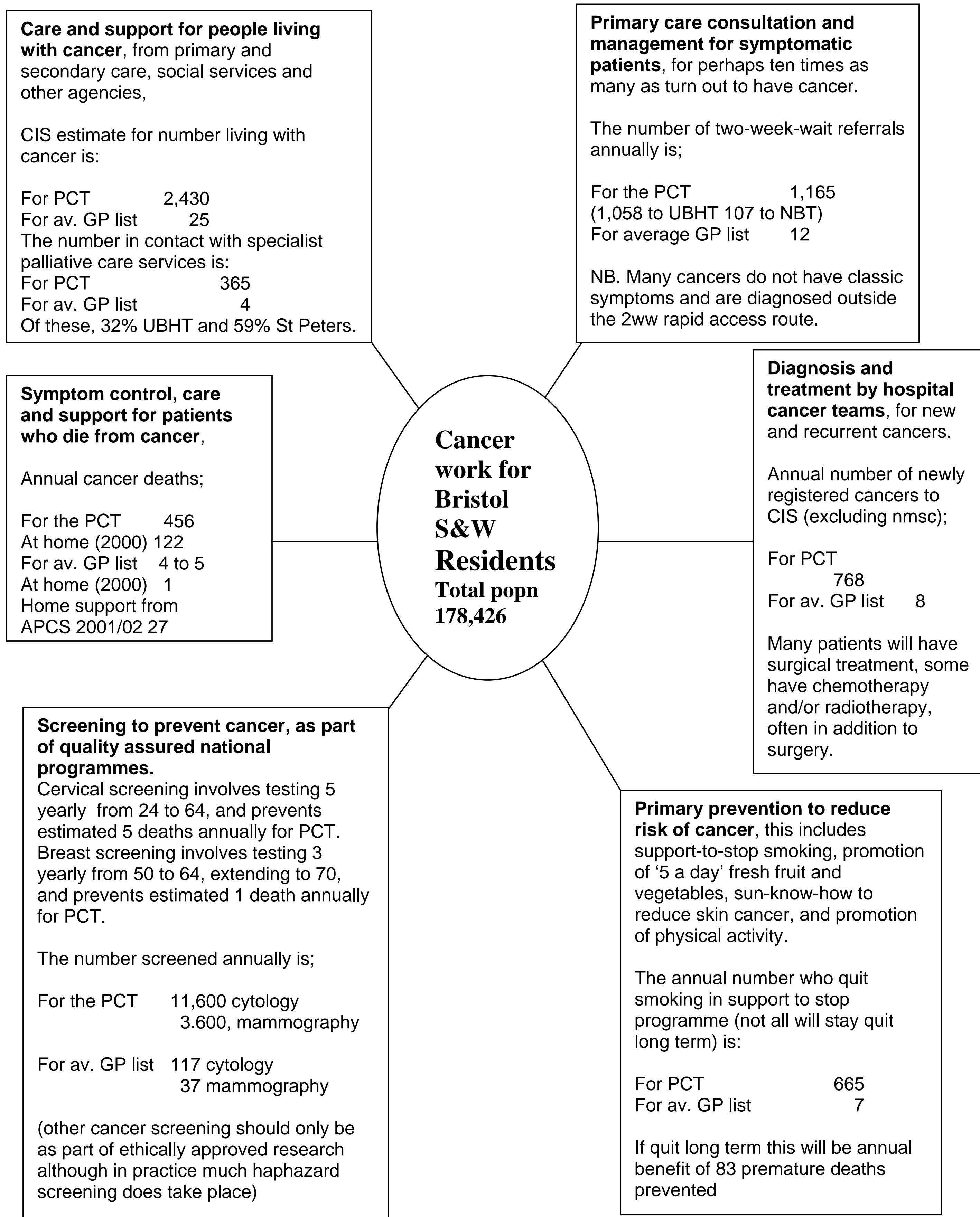
About one third of cancer deaths amongst BSW PCT men are due to lung cancer, about 60 deaths each year during 1998-2000. During this period BSW PCT had the highest incidence rate of lung cancer in men and women out of 32 PCTs in the South West region. Lung cancer deaths are significantly higher in more deprived areas where smoking is commoner. Lung cancer is the commonest cancer in men and is predicted to overtake breast cancer as the commonest cause of cancer deaths in women. About 80% of lung cancers are attributed to smoking, the remainder being accounted for by passive smoking, occupational diseases and exposure to radon.

Amongst women, breast cancer is becoming more common and is the single commonest cause of female cancer deaths, accounting for an average of 44 out of 207 cancer deaths annually during 1998-2000. The standardised death rate is higher than would be expected compared to the South West region. This is being investigated jointly with the South West Public Health Observatory. Initial findings suggest that the high result could be due to underestimation of the BSW population in the 2001 Census. Lung cancer accounted for an average of 34 deaths amongst women annually during the same period.

Smoking is the single most important preventable risk factor for cancer in Bristol South and West. Exposure to the sun, higher alcohol intakes, low intake of fruit and vegetable and physical inactivity are also associated with increased risk of some cancers.

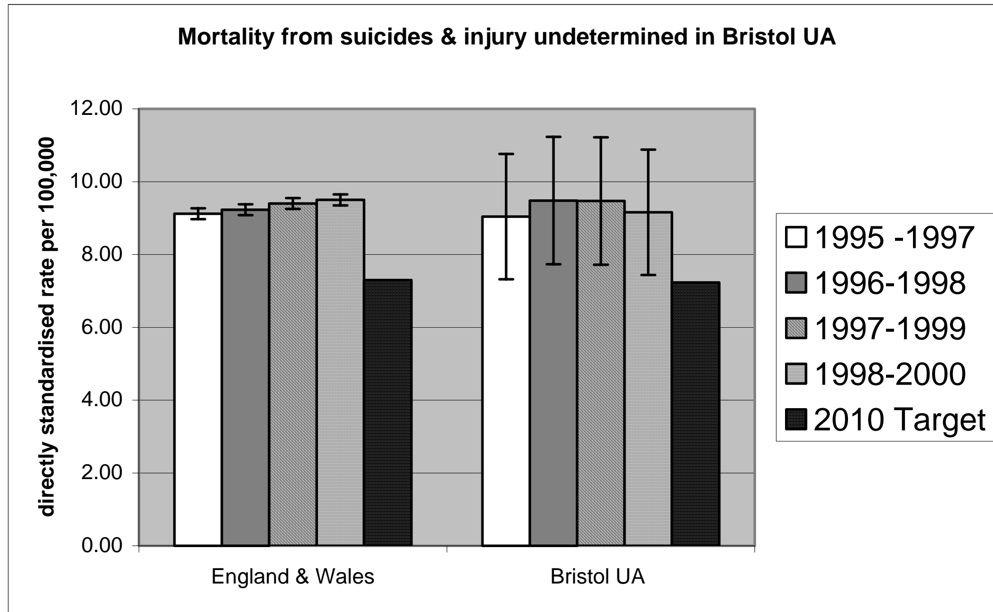
A report on cancer statistics for the PCT is available from the South West Cancer Intelligence Service.

Figure 4.1
Overview of cancer work in Bristol South and West PCT



Key; CIS = Cancer Intelligence Service, nmsc,= non-melanoma skin cancer, Average GP list = 1,800,
APCS = Avon Palliative Care Intensive Home Support Service (New Opps Funded).

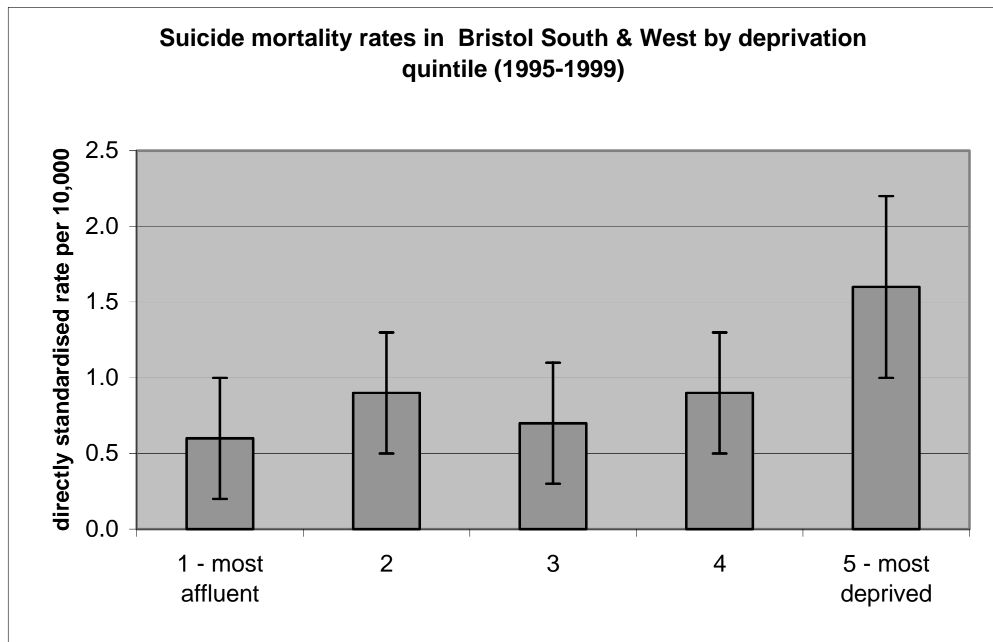
Graph 4.10



Source: Compendium of Clinical Indicators 2001

There is a strong relationship between suicide and deprivation in BSW (graph 4.10).

Graph 4.11



Source: ONS mortality files & 1991 Census for Townsend scores of deprivation

Suicide mortality rates in the most deprived areas of BSW (those contained in number 5 quintile) are significantly higher than rates in the least deprived quintile (graph 4.11). However mortality differences between other quintiles are not statistically significant.

Injuries

Between 1998 – 2000 there were on average 32 deaths a year from accidents in Bristol South & West. Injuries are the commonest cause of deaths in young people. For Bristol, there has been no significant progress towards the national mortality target for all ages for 2010. The BSW rate is not significantly higher than England and Wales or the South West. Mortality rates are higher amongst relatively deprived populations.

On average there were 119 hospital admissions following assault each year from 99/00 – 01/02. Approximately 85% were for men, with 15-24 yr olds being more affected than other age groups. In-patient admission rates were highest for Knowle and Filwood wards.

Falls are the main cause of accidental death in older people. On average 7 people aged over 65 died following a fall, each year from 1998 – 2000. During 2001/02 there were 381 hospital admissions in the over 65's; three quarters being women, and one half of those aged over 85 years.

Avonsafe (Action for Safety) is a local multi-agency alliance that aims to prevent injuries across the area. Work focuses mainly on injury prevention in older people and children and young people. It has developed a strategy with priority areas for action between 2001-2006. A main aim of the strategy is to seek to address inequalities in health and promote access to accident prevention for all sectors of the community. See www.avon.nhs.uk/avonsafe/about_us.htm

PCT Performance indicators for vaccination and immunisation

Immunisation levels were close to the national average for childhood immunisations, and above average for flu immunisation in 2001/02 (table 4.3).

Table 4.3: Vaccination and Immunisation activity in BSW PCT 2001/02

Health Improvement Indicator	National Figure	BSW PCT	Indicator definitions
Childhood immunisations	91.3%	91.2%	Percentage average of children immunised against MMR (measles, mumps and rubella) and diphtheria by age 2
Flu vaccinations	67.2%	69.4%	Persons vaccinated against flu as a percentage of number of people aged 65 and over

Source: Department of Health national performance indicators at http://www.doh.gov.uk/performanceratings/2002/4hf25sbfpy.html

5. Avon Health Protection Unit

As a result of the Chief Medical Officer's strategy, *Getting ahead of the Curve - a strategy for combating infectious diseases (including other aspects of health protection).* London: Department of Health 2002, available on www.doh.gov.uk/cmo/publications.htm a new Health Protection Agency has come into existence from April 2003. This Special Health Authority incorporates the following agency functions:

- **Communicable Disease Control Consultants and their teams in Health Protection Units**
- **Regional Health Emergency Planning Advisors**
- **Public Health Laboratory Service (PHLS)**
- **Centre for Applied Microbiological Research (CAMR)**
- **National Focus for Chemical Incidents (NFCI) and regional toxicological units**

The Health Protection Agency will be working closely and may, in future, incorporate the National Radiological Protection Board.

The Avon Health Protection Unit (AHPU) was set up on the 1st April 2002 to consolidate local Health Protection Service delivery to the former Avon Health Authority area covering the following Primary Care Trusts:

Bath and North East PCT
Bristol South and West PCT
North Somerset PCT
South Gloucestershire PCT
Bristol North PCT

In practical terms AHPU encompasses the following:

- **Infectious disease incident/outbreak investigation and management**
- **Immunisation advice**
- **Co-ordination of mass immunisation**
- **Toxicological Incident Response**
- **Community Infection Control**
- **Contact tracing for cases of infectious diseases**
- **Gastroenteritis surveillance and outbreak monitoring**
- **Nursing Homes and Care Homes**
- **Chief Medical Officer cascades**
- **Infectious disease advice**
- **Chemical Incident Response advice**
- **GP Notification of Infectious diseases**
- **Liaison with neighboring Health Protection Units**
- **Liaison with local Authorities**

The Avon Health Protection Unit staff are as follows:

Name	Contact Details
Dr Joyshri Sarangi Consultant in Communicable Disease Control	Tel: 0117 900 2618 Mobile: 07740465220 Pager 07625 228609
Dr Charles Irish Consultant in Communicable Disease Control	Tel: 0117 900 2626 Mobile: 079326756059
Chris Judge Community Infection Control Sister	Tel: 0117 900 2574
Kalsang Childs Infectious Diseases Sister	Tel: 0117 900 2689
Mrs Carol Momber Health Protection Unit Manager	Tel: 0117 900 2621
Mrs Jo Watson PA/Administrator to the Health Protection Unit	Tel: 0117 900 2620
Health Protection Unit Fax	0117 900 2385

The Health Protection Unit operates on a 24 hour basis therefore out of office hours contact can be made through the Avon Ambulance Control on 01454 455433 or fax 01454 455448 who will contact the Consultant on call.

6. Tackling Smoking

Background
Smoking is the single biggest preventable cause of illness and death in our communities, killing over 120,000 people in the UK every year (Department of Health, 1998). Most die from one of the three main diseases associated with cigarette smoking: cancer, chronic obstructive lung disease (bronchitis and emphysema) and coronary heart disease (CHD). Smoking causes 84% of deaths from lung cancer, 83% of deaths from chronic obstructive lung disease and 14% of deaths from coronary heart disease, stroke and circulatory diseases. Passive smoking may also lead to ill health in children and others who are exposed (Ferrence & Ashley, 2000). In Bristol, at least 760 deaths each year can be directly attributed to smoking.

Smoking, more than any other identifiable factor, contributes to the gap in life expectancy between those most in need and those most advantaged. Despite a reduction in the overall prevalence of smoking over the last 30 years, there has been little change in smoking rates among those living on low incomes and who are least advantaged. In social class I around 15% of men and 14% of women smoke cigarettes. In social class V smoking prevalence reaches 45% for men and 33% for women. However, in the most deprived groups smoking prevalence reaches over 70%, and is about 90% in homeless people sleeping rough (Richardson & Croosier, 2002).

Other countries have had significant success in reducing rates of smoking through the introduction and implementation of comprehensive tobacco control strategies. High quality international research evidence demonstrates that smoking cessation services are effective in helping people give up smoking. In the UK, the government published *Smoking Kills: a White Paper on Tobacco* (Department of Health, 1998), which set out national targets and a comprehensive plan of action including the development of smoking cessation services and wider tobacco control. Further targets and plans were detailed in the *National Service Framework for Coronary Heart Disease* (Department of Health, 2000a), *The NHS Plan* (Department of Health, 2000b) and *The Cancer Plan* (Department of Health, 2001). A new Support to Stop cessation service was established in the Bristol area in 2000 as well as four Sure Start projects each of which also targets smoking in their local area.

National targets
The recent *Priorities and Planning Framework 2003 - 2006* (Department of Health, 2002) sets out the key targets the Department of Health expects the NHS to address within local delivery plans. In respect of smoking these are to:

- Reduce the rate of smoking, contributing to the national target of: reducing the rate in manual groups from 32% in 1998 to 26% by 2010; 800,000 smokers from all groups successfully quitting at the 4 week stage by 2006.

- Deliver a one percentage point reduction in the proportion of women continuing to smoke throughout pregnancy, focusing especially on smokers from disadvantaged groups as a contribution to the national target to reduce by at least 10% the gap in mortality between “routine and manual” groups and the population as a whole by 2010, starting with children under one year.

- In primary care, update practice-based-registers so that patients with CHD and diabetes continue to receive appropriate advice and treatment in line with NSF standards and by

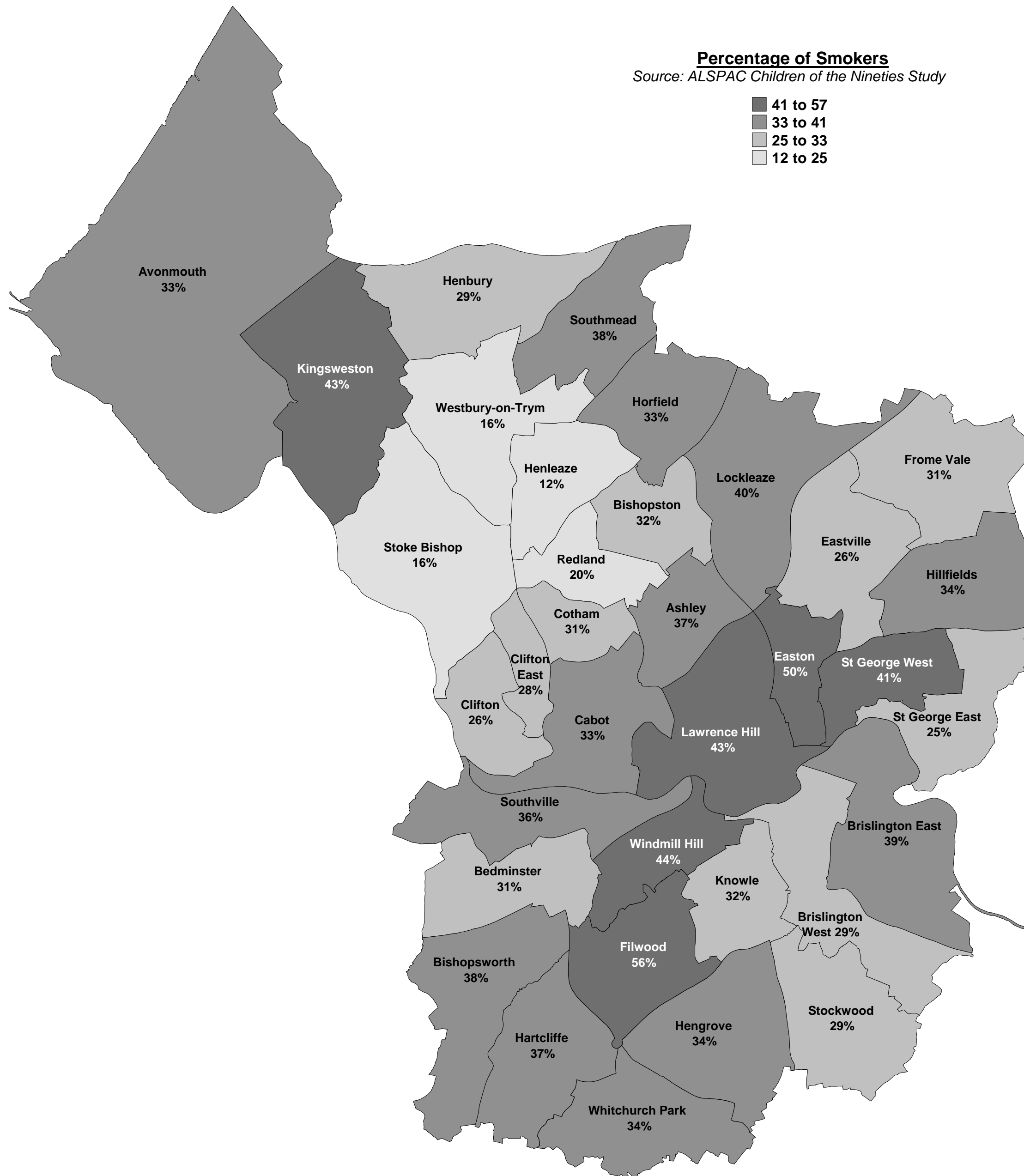
March 2006, ensure practice-based-registers and systematic treatment regimes, including appropriate advice on diet, physical activity and smoking, also cover the majority of patients at high risk of CHD, particularly those with hypertension, diabetes and a BMI greater than 30.

Prevalence of smoking in Bristol

The Health Survey for England indicates that 27.2% (82,561 / 303,68) of people over 16 in Bristol smoke (http://www.doh.gov.uk/public/summary.htm). We have limited local data on the overall prevalence of smoking. Data from the *Children of the Nineties* (ALSPAC) study (http://www.alspac.bris.ac.uk/alspacext/Default.shtm) provides estimates of local rates of smoking using national data from the Health Survey for England, local data on smoking in pregnancy and information on levels of deprivation from the census. Figure 6.1 shows the estimated smoking prevalence by ward for Bristol.

Figure 6.1

Smoking rates in Bristol by ward



Support to Stop

A new Support to Stop smoking cessation service was established during 2000. The service model follows evidence-based guidelines published in *Thorax* (West, McNeill & Raw, 2000) and can be accessed on three levels. The first tier provides brief opportunistic advice from the primary health care team or other professionals. A second tier involves referral to trained Support to Stop advisors at general practice level for one-to-one or group help and support. The third tier, for those who are unable to quit with tier 2 support, involves referral to trained specialist advisors. Buproprion (Zyban) and Nicotine Replacement Therapy (NRT) are available on prescription to support smoking cessation.

During 2001/02 smoking cessation services nationally and locally significantly overachieved against their targets. Table 6.1 shows how the Bristol Support to Stop scheme compares with results across Avon, the South West and nationally.

Table 6.1: Smoking cessation targets and activity in 2001/02

	Target setting a quit date	Target successful at 4 weeks	Target success rate at 4 weeks	Actual number setting a quit date	Actual number successful at 4 weeks	Actual success rate at 4 weeks
Bristol North	584	175	30%	1724	855	50%
Bristol South and West	496	149	30%	1279	665	52%
Bristol	1080	324	30%	3003	1520	51%
Avon	2,500	750	30%	6,449	3,328	52%
South West	12,780	4,263	33%	23,927	12,889	54%
England	159,106	54,287	34%	227,308	119,813	53%

Source: Smoking Cessation Services

Older people were more likely to participate, despite the higher proportion of smokers in younger age groups. According to the Health Survey for England, 41% of young men aged 16-24 and 38% of young women smoke, but these were the people least likely to participate in Support to Stop. Men were less likely to participate than women, again despite higher overall rates of smoking.

A recent audit of a sample of those in Bristol who had quit at 4 weeks suggests that around 15% of all those who set a quit date will remain quit at 52 weeks, and are therefore likely to have given up smoking for good. This is consistent with the average of 13% of those who set a quit date found to be still successful at 52 week follow up in a national assessment of Health Action Zones. Thus the smoking cessation service in Bristol is likely to have resulted in 390 smokers (13% x 3003 setting a quit date) having given up smoking for good during the year 2001/02. As half of all smokers are likely to die early of smoking related diseases, Support to Stop will have significantly reduced the likelihood of 195 premature deaths in Bristol.

Smoking in Pregnancy
Smoking is pregnancy harms both the mother and the unborn child. Smoking in pregnancy is associated with higher rates of infant mortality, sudden infant death, low birth weight and other complications for mother and baby (Conter et al., 1995; Owen, McNeill Callum, 1998).

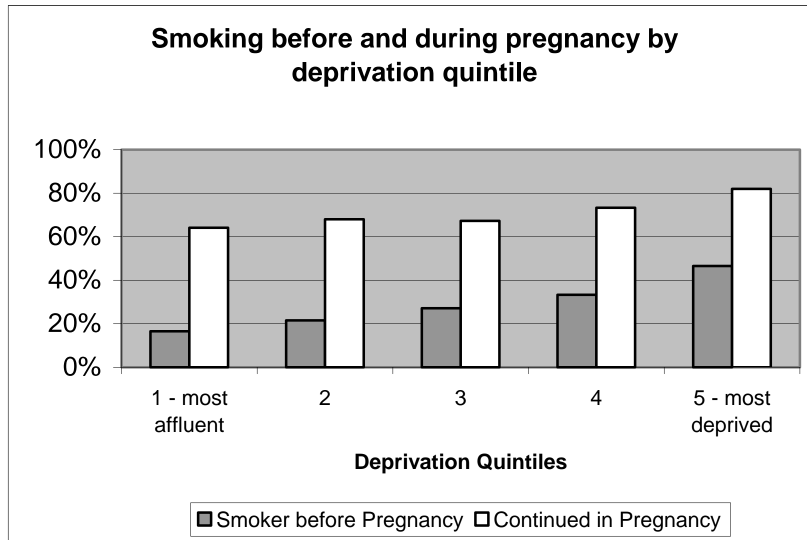
The ill effects start in utero and may continue to cause health problems in latter life (Montgomery & Ekbom, 2002; Rantakallio, Laara & Koiinanen, 1995).

Data on smoking in pregnancy are collected by maternity services and by the smoking cessation service. Women are asked about smoking at the time they ‘book’ with their midwife, usually at around 12-15 weeks gestation. In October 2001, maternity services in Bristol also began asking women on discharge from delivery whether they smoked in the latter part of their pregnancy. Age and sex are coded for in both the maternity and Support to Stop databases, but social class data were not available from either. As an alternative, census data identifying deprivation quintiles was used to identify those areas that have the highest levels of health need. The most disadvantaged areas are in deprivation quintile 5.

Nationally, the Infant feeding survey (http://www.doh.gov.uk/public/infantfeedingreport.htm) indicates that just over a third of mothers (34%) in the United Kingdom smoked before or during pregnancy, whilst a fifth of all mothers (20%) continue smoking during their pregnancy. Among women who were smoking before their pregnancy, rates of stopping average 10% immediately before pregnancy and 18% during pregnancy (Owen, McNeill & Callum, 1998). Rates are higher in Bristol than the national average, with 35% of women smoking prior to pregnancy and 23% of all pregnant women (or 68% of pre-pregnancy smokers) continuing throughout their pregnancy.

When analysed by deprivation quintile, smoking rates were highest among women from the areas of highest health need. Graph 6.1 shows that both pre-pregnancy rates and those for continued smoking show a marked deprivation quintile gradient. Pre-pregnancy rates among women in the poorest quintile 5 (46.6%) were close to three times those in the most affluent quintile 1 (16.55).

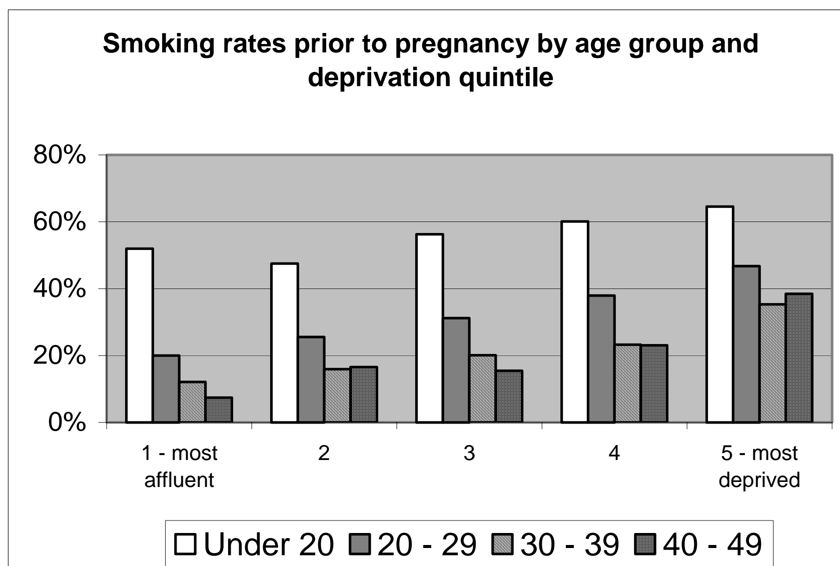
Graph 6.1



Source: Trust Maternity Services

Younger women were more likely to be smokers before pregnancy. More than 60% of women who became pregnant before the age of 20 were smokers, compared to fewer than 20% of the over 30s. High rates of smoking among young women were evident in all deprivation quintiles. Graph 6.2 shows pre-pregnancy rates of smoking for four age groups in each of the five deprivation quintiles.

Graph 6.2



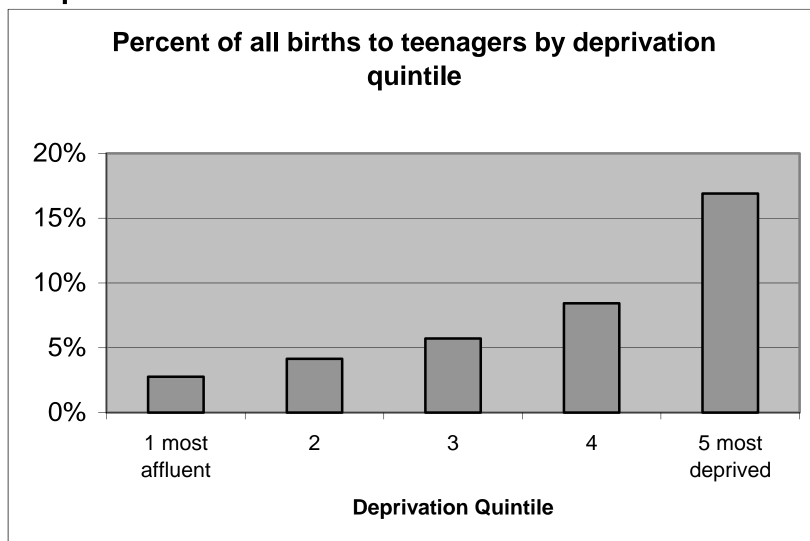
Source: Trust Maternity Services

Smoking rates among teenagers who become pregnant are dramatically higher than for other age groups regardless of deprivation quintile. Overall, the rate is 60% with this rate crucially influenced by the high numbers of teenagers in quintiles 4 and 5 (the most deprived areas) where rates are in excess of 60%. 77% of teenagers who smoked at the start of pregnancy

continued to do so while pregnant. This figure was lower in quintile 1 at 64% and highest in quintile 5 (82%).

More than half of all teenagers (51.2%) who became pregnant live in areas in deprivation quintile 5. This represents 16.8% of all pregnancies in that quintile, more than five times the average for quintile 1 (graph 6.3)

Graph 6.3



Source: Trust Maternity Services

Smoking cessation in pregnancy
All pregnant women should be advised by their health professionals (including GP and midwife) of the risks of smoking during pregnancy and offered support to stop including referral to the primary care based smoking cessation service. In addition, specialist smoking cessation support by a 'midwifery champion' was established at both Bristol maternity units in 2001. Buproprion (Zyban) and most forms of NRT are not licensed to support smoking cessation with pregnant women, which may be one factor in the relatively small number of pregnant smokers seen by the general Support to Stop service. Table 6.2 shows that although the number of pregnant women accessing this service is relatively low, success rates of those who do use the service are similar to that achieved with the wider population.

Table 6.2: Smoking cessation and pregnant women in 2001/02

	Number of pregnant women setting a quit date	Number of pregnant women successful quitters at 4 weeks	Actual success rate at 4 weeks
Bristol	66	29	44%
Avon	99	49	49%
South West	331	168	51%
England	4,037	1,941	48%

Source: Trust Maternity Services

Inequalities in Health

In setting up the smoking cessation service there was a risk that uptake would be higher in more affluent communities and thus that inequalities in health would be increased. To avoid this impact we took several steps to ensure good uptake in high health needs areas including rolling the service out in these areas first and offering subsidized NRT until it was made available on prescription. Specific targeted work includes the recruitment and training of smoking cessation advisors from minority ethnic communities and cessation work in HMP Bristol. In addition, there is additional cessation support offered to pregnant smokers by midwives in the four Bristol Sure Start areas.

There are a higher percentage of smokers among people living in the (more deprived) quintile 5 areas. The Support to Stop database includes more people from deprivation quintile 5 areas than other areas. The total number of people who participated and succeeded in quitting at the four-week point was largest in quintile 5, although the overall quit rate was lower as shown in Table 6.3.

Table 6.3 Estimated prevalence, quit dates and rates by deprivation quintiles

Data for 2001/02 – 2002/03	Population	Estimated Percentage of adults who smoke#	Estimated percentage of smokers setting a quit date*	Four week quit rate	Number of smokers who have quit at 4 weeks
Quintile 1 (most affluent)	67,413	15.5%	5.2%	56.8%	179
Quintile 2	58,341	20.2%	4.5%	54.1%	191
Quintile 3	56,239	24.5%	4.6%	56.4%	443
Quintile 4	57,751	31.4%	4.4%	56.3%	582
Quintile 5 (least affluent)	63,357	46.0 %	3.8%	52.9%	955

- Based on smoking in pregnancy data
* - Based on smoking in pregnancy data and smoking cessation service records

Wider tobacco control work
The Bristol Tobacco Action Network brings together partners from the PCTs, Bristol City Council and other agencies to co-ordinate wider action on tobacco control. Recent initiatives include the Easy Breathing Pub project, Clean Air for Kids (a neighbourhood renewal initiative focusing on reducing children's exposure to environmental tobacco smoke), support to the development of workplace smoking policies (particularly in more deprived neighbourhoods), targeted work for young people and work to reduce the availability of cigarettes to children.

Cost effectiveness
Smoking cessation is one of the most cost effective interventions to improve the health of the people of Bristol. In 2001/02 the number of Bristol residents who had quit smoking for at least four weeks was 1520, while the total cost was £130,000 for the service and around £260,000 prescribing costs for Zyban and NRT, giving a total cost of £390,000. This gives an average of £257 per four week quitter. For every two people who quit long term, one (on average) will have their life prolonged as a result. If 13% of those setting a quit date do remain quit long term (as the Bristol 52 week follow up data indicate they will) then 390 lives each year are prolonged, at a cost of £1000 each. Stopping smoking in pregnancy is also an effective intervention to reduce infant mortality, low birth weight and other negative consequences for mothers and babies.

In comparison, table 6.4 shows that the two national screening programmes produce a benefit among Bristol residents of ten women each year having their lives prolonged as a result of cervical screening and two women a year having their lives prolonged as a result of breast screening. The cost of providing screening is at least £720,000 for cervical screening (24,000 Bristol women screened each year at an average cost of £30 per test) and £294,000 each year for breast screening (8,400 Bristol women screened each year at an average cost of £35 per woman). Thus the costs per premature death prevented of breast and cervical screening are much higher than that of smoking cessation

As an additional comparison, NICE recommended (March 2002) the use of Trastuzamab in combination with Paclitaxel for breast cancer. The additional cost for one patient is £15,500, and the benefit is a few additional months to disease progression, but no definite improval in survival.

Table 6.4 Comparison of different elements of cancer programmes in Bristol

	Annual cost	Numbers involved	Premature deaths prevented
Support to stop smoking	£130,000 service costs + NRT/Zyban £260,000 = £390,000 total costs	1520 four week quitters 390 long term quitters	195 future premature deaths prevented amongst this year's quitters
Cervical screening	£720,000	24,000 screened annually	Currently 10 fewer premature deaths each year as a result of screening
Breast screening	£294,000	8,400 screened annually	Currently 2 fewer premature deaths each year as a result of screening
Trastuzamab for breast cancer (recommended by NICE)	£15,500 per patient	N/A but could be significant	No definite survival improvement

Recommendations

- The Support to Stop smoking cessation service should be continued and expanded to address the continuing threat of smoking to the health of the people of Bristol, especially to pregnant women and those living in areas of deprivation.

- The relatively poor uptake of smoking cessation among young people, and particularly young men, should be reviewed and addressed by the service.

- In particular, the extremely high rates of smoking among pregnant teenagers should be considered in partnership with the Teenage Pregnancy Strategy Group and a plan of action agreed.

- The wider tobacco control work of the Bristol Tobacco Action Network should be continued and expanded.

References

Conter, V, Cortinovis, I, Rogari, P & Riva, L. (1995) Weight growth in infants born to mothers who smoked during pregnancy. *BMJ* 310: 768-771.

Department of Health (1998) *Smoking Kills: A White Paper on Tobacco* London: Department of Health.

Department of Health (2000a) *National Service Framework for Coronary Heart Disease* London: Department of Health.

Department of Health (2000b) *The NHS Plan* London: Department of Health.

Department of Health (2001) *The Cancer Plan* London: Department of Health.

Department of Health (2002) *Improvement, Expansion and Reform: The Next Three Years. Priorities and Planning Framework 2003 - 2006* London: Department of Health.

Ferrence, R & Ashley, M.J (2000) Protecting children from passive smoking. *BMJ* 321: 310-311.

Montgomery, S M & Ekbom, A. (2002) Smoking during pregnancy and diabetes mellitus in a British longitudinal birth cohort. *BMJ* 324: 26-27.

Owen, L, McNeill, A, & Callum, C. (1998) Trends in smoking during pregnancy in England, 1992-7: quota sampling surveys. *BMJ* 317: 728-730.

Rantakallio, P, Laara, E, & Koiranen, M. (1995) A 28 year follow up of mortality among women who smoked during pregnancy. *BMJ* 311: 477-480.

Richardson, K, Crooosier, A (2002) *Smoking and Health Inequalities* London: ASH/Health Development Agency.

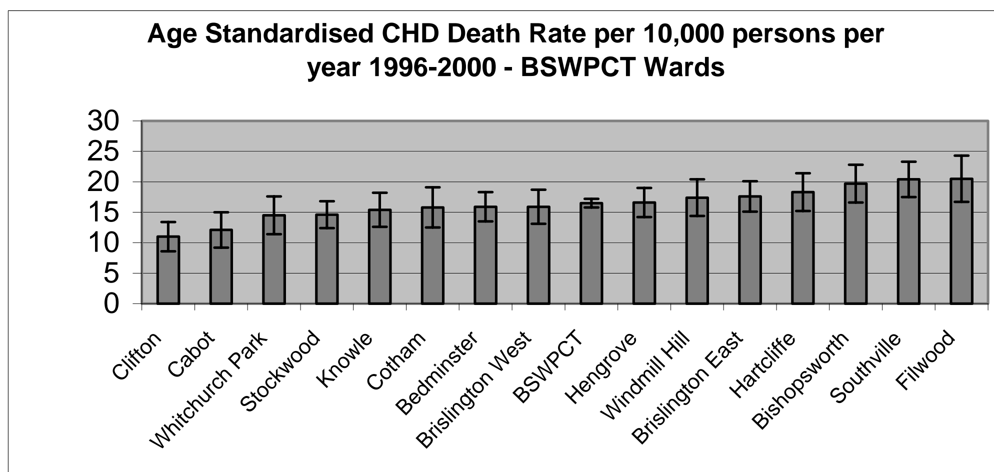
West, R, McNeill, A, Raw, M. (2000) Smoking cessation guidelines for health professionals: an update. *Thorax* 55: 987-99.

7. Heart Health Needs Assessment in Filwood/Knowle West

During 2002, a heart health needs assessment was conducted in Filwood (often referred to as Knowle West). Filwood ward is one of ten priority wards in Bristol receiving Neighbourhood Renewal funding. The needs assessment involved investigating health data, current service provision and the views of local residents and workers on a range of local heart health issues.

Filwood has the highest standardised rate of deaths at all ages from coronary heart disease amongst BSW PCT wards (graph 7.1). It has the third highest rate amongst people under 75 years. It has higher than average levels of smoking and obesity, and low levels of breastfeeding.

Graph 7.1



Source: LAPIS system

The main issues identified from the needs assessment were:

- Smoking cessation and tobacco control
- Healthy eating and access to food
- Physical activity
- Overweight and obesity
- Management of risk in primary care

The needs assessment identified sixteen priorities for change, based on data gathered in the needs assessment and evidence of effectiveness for interventions aimed at improving heart health. Planning is underway to tackle the issues identified. These include:

- The proposed development of a community gym and fitness room at the Healthy Living Centre.
- Proposals to bring forward the creation of cycle paths/lanes, to provide access between key facilities in Knowle West, including the Healthy Living Centre.
- Training of local people to work as smoking cessation advisors.
- The creation of a fruit and vegetable box scheme, which will provide fresh fruit and vegetables to the local community.

As well as providing a basis to bid for neighbourhood renewal money, the proposals also suggest how mainstream services can be delivered in different ways to better respond to local needs. A copy of the report is available on-line at the Public Health Network website: www.avon.nhs.uk/phnet/publications.htm.

8. Health Care Needs Assessment for Lymphoedema Services in Bristol and the Surrounding Area

Background

Lymphoedema is a chronic swelling affecting one or more parts of the body. It is an incurable condition, which can cause pain, limited mobility and altered appearance. It can have major effects on a person's quality of life. Lymphoedema can be caused by cancer and its treatment, congenital problems of the lymphatic system, chronic venous disease and conditions, which lead to chronic immobility, such as stroke or spina bifida.

The Needs Assessment

This work involved the following steps:

- Investigating how many people are affected by lymphoedema in the area;
- Summarising the treatments that are available for lymphoedema, and the evidence for how effective these treatments are;
- Investigating what lymphoedema services are currently provided;
- Getting the views of people currently working in the area about what needs to change.

All of this information was analysed and used to make recommendations to local Primary Care Trusts about the most appropriate way to strengthen and develop local lymphoedema services.

Involving Users of Lymphoedema Services

One of the recommendations from the needs assessment report was to find out from people with lymphoedema what matters most to them about the services they receive. This was done by using qualitative research techniques to gather detailed information from people with lymphoedema about their experiences, and what they most wanted to see change.

The people who took part in the research wanted to see improvements in 5 key areas of services:

- Increased knowledge about lymphoedema amongst health care professionals;
- The provision of accurate information about lymphoedema on diagnosis;
- The provision of appropriate treatment for lymphoedema;
- Greater access to staff with specialist knowledge and skills in managing lymphoedema;
- The establishment of a patient support group.

How is this work being taken forward?

A group of people from local Primary Care Trusts, Acute Hospital Trusts and Hospices are working together to develop plans to strengthen and develop lymphoedema services in the area.

A copy of the report is available at the Public Health Network website:
http://nww.avon.nhs.uk/phnet/palliative/documents.htm.

9. Visual Health Needs Assessment

In January 2002 a visual health needs assessment for older people in Bristol South and West PCG found that:

- Visual health services are weighted towards secondary prevention, i.e. amelioration of visual impairment, rather than primary prevention and rehabilitation.
- The population of Bristol South and West do not currently have access to a quality assured diabetic retinopathy screening programme. Diabetic retinopathy is a leading cause of preventable blindness.
- Current service provision for people with glaucoma and those who are blind or partially sighted fails to meet estimated need.
- Mapping of community optometry services across the PCT suggests relative lack of optometry services in South Bristol.
- The visual health needs of special groups, including people from different ethnic backgrounds, people with learning difficulties and people in care or housebound need further investigation.
- Escalating prescribing costs, particularly for the new glaucoma drugs, place cost-pressures upon primary care.

Research data for estimating the size of the population needing these services is incomplete, making planning difficult. With this caveat, the following expectations were identified:

- As the population ages the prevalence of visual impairment will increase.
- There is some evidence to suggest that the incidence of low vision caused by age-related macular degeneration (AMD) is increasing. Diabetes is becoming more common; raising concern that associated visual problems will also increase unless effective prevention (including screening) is fully implemented.
- Current unmet need for visual health services will increase if service provision and resource allocation remain the same.
- The development of new treatments and drugs for eye disease continue to place cost pressures on the service. If primary care prescribing for glaucoma drugs increases at the current rate, prescribing costs for the PCT are likely to have doubled by 2005 (to approximately £500,000). The National Institute for Clinical Excellence (NICE) is expected to recommend photodynamic therapy, a new treatment for selected patients with 'wet' AMD, for implementation in the NHS shortly. Implementation of diabetic retinopathy screening by 2005 is an NHS Plan target.

Several policy drivers are relevant to the development of the service over the next 5 – 10 years. These drivers are summarised in figure 9.1. The PCT has established a Visual Health Steering Group to act on the findings of the needs assessment.

The full report of the visual health needs assessment is available at http://nww.avon.nhs.uk/phnet/publications.htm

Figure 9.1: Policy drivers affecting development of visual health and social care.

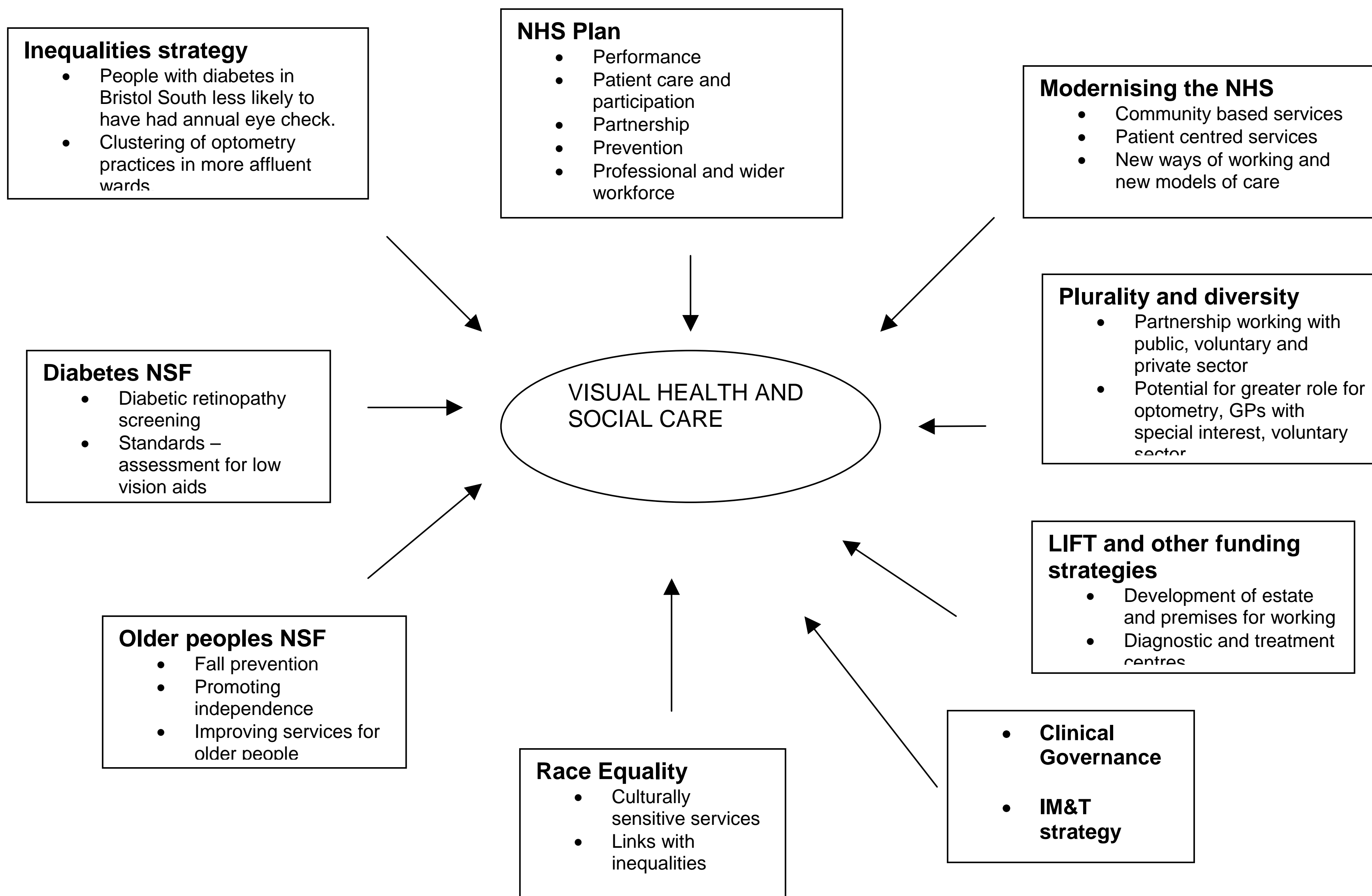
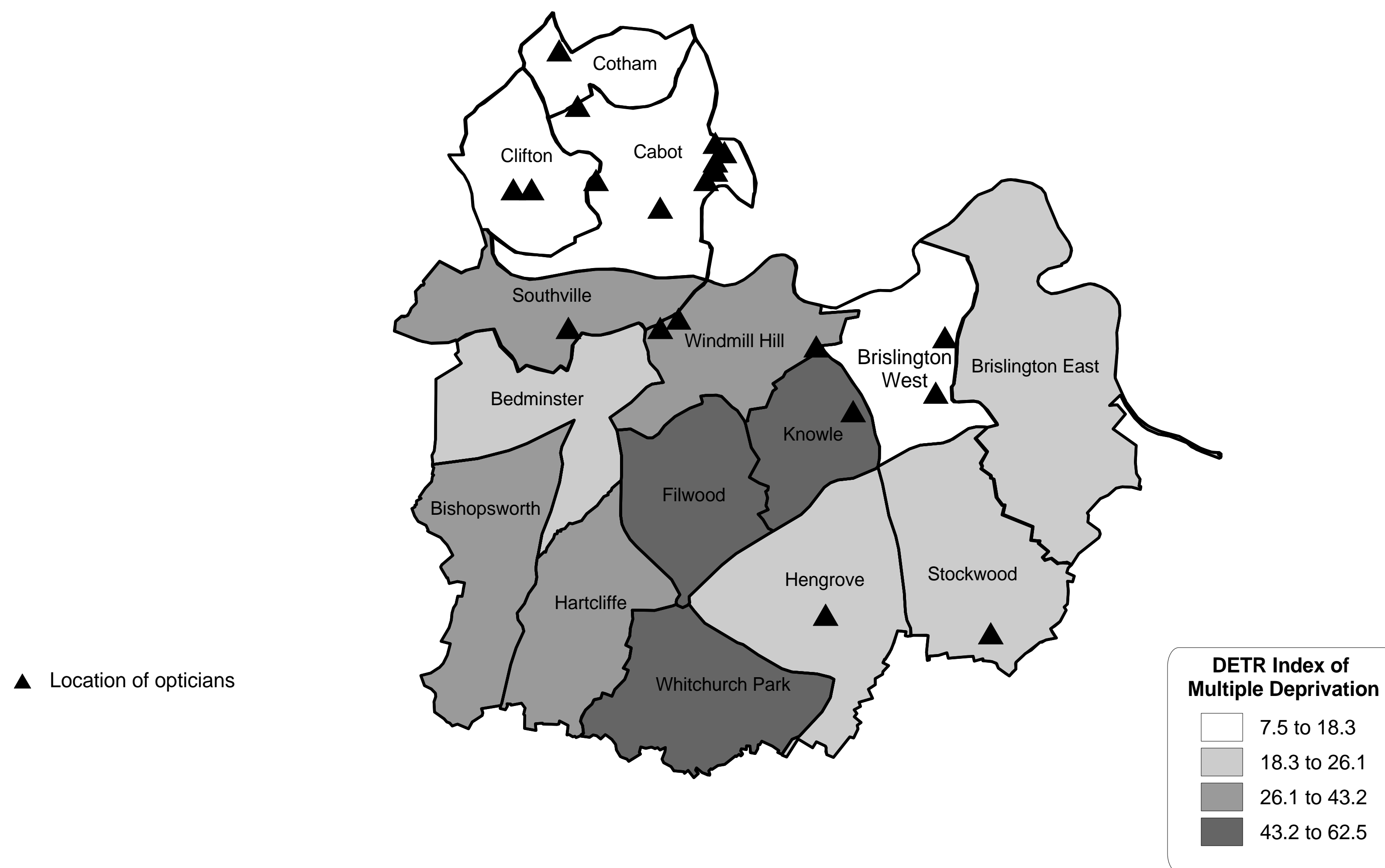


Figure 9.2: Location of optometrists in Bristol South and West, 2002.



10. Assessment of the Effectiveness and Efficiency of Abortion Services in Bristol

In 2002, a review of induced abortion services in Bristol was undertaken. This was in response to concern about the impact of long waiting times on women's health as well as increasing out of area expenditure. The finding were as follows:

- Bristol has the highest proportion of induced abortions at greater than 13 weeks pregnancy in comparison to almost all other healthy authority areas outside London. This is not explained by late presentation.
- The waiting time for assessment prior to abortion is between 3 and 5 weeks. This is considerably greater than the Royal College of Obstetricians and Gynaecologists (RCOG) guidelines, which recommend that it should be no longer than two weeks and ideally five days.
- Increasingly, women are leaving the service and self-funding a termination of pregnancy. In 1998, 21% of women in Bristol paid for abortion services. By 2001, this had increased to 28%, with almost no change in the abortion rate. Non-NHS funded abortions occur much earlier in pregnancy (68% < 9 weeks) than those funded by the NHS (24% < 9 weeks). There is unequal access to abortion services in Bristol, which potentially contributes to health inequalities.
- Because of long waiting times, reduced capacity and limited choice and availability of procedures, many Bristol women travel outside Bristol to obtain NHS funded abortions. This is un-necessarily traumatic and expensive and has a potentially negative impact of women's physical and psychological health.

The following proposals have been made:

- Develop the service to meet the RCOG quality standards, in particular waiting times and choice of procedure to reduce inequitable access and delays.
- Streamline and remove organisational barriers along the care-pathway, particularly within the Pregnancy Advisory Service (PAS), a direct access advisory and assessment service in Bristol. This includes electronic management of client data, efficient use of staff time and prioritizing clients at point of contact.
- Contract services from the non-NHS charity providers where necessary to increase capacity and reduce delays in access to termination of pregnancy.
- Maximize NHS potential by expanding the existing early medical abortion service from United Bristol Health Care Trust and set up a similar service in the North Bristol Trust and possibly in the other smaller Trusts.
- Consider funding a strong clinical lead such as a community gynaecologist, preferable within a sexual health directorate, to develop and oversee the care pathway.

A copy of the report is available at the Public Health Network website: http://nww.avon.nhs.uk/phnet/Publications/terminations.doc.

11. Public Health Partnership in Bristol

Introduction

Promoting and protecting the public health in Bristol is the shared responsibility of Bristol City Council, Bristol North and Bristol South & West Primary Care Trusts, partner agencies and communities. Each PCT has a Director of Public Health, health promotion specialists and other staff. Within the Council, there is a range of professional groups with a public health remit including those working in community development, environmental health, housing, leisure, neighbourhood renewal, planning and transport. There is no one overarching network or forum bringing together the key players in public health in Bristol. Rather, public health partnership works through a number of different mechanisms as illustrated below (but note this is can only be a partial list of the many types of partnership contributing to public health in Bristol).

Bristol Partnership

The overarching partnership for Bristol with responsibility for overseeing the Community Strategy. Professionals concerned with public health from the Council and the PCTs are involved in a range of ways including contributing to the Community Strategy section on 'Promoting Health and Wellbeing' and the Neighbourhood Renewal Strategy (www.bristol-city.gov.uk).

Within the overall Bristol Partnership there are a number of other partnerships concerned with health, in particular the Health and Social Care Board and the HIMP Co-ordinating Group, which produced the Bristol Health Improvement and Modernisation Programme 2002-2005. (www.bristolnorthpct.nhs.uk)

Avonsafe Injury Prevention Alliance

Avonsafe is the local multi-agency injury prevention alliance. More details at: http://nww.avon.nhs.uk/phnet/Avonsafe/about_us.htm.

Bristol Alliance Targeting Tobacco

Multi-agency partnership including the Council and the PCTs addressing the wider tobacco prevention and control agenda. For more information: http://www.supporttostop.avon.nhs.uk/.

Bristol Community Safety Partnership

A multi-agency partnership responsible for Bristol's Crime and Disorder Strategy, which aims to make the city, a safer place to live and work. More details at: http://www.crimebristol.org.uk/.

Bristol Health Scrutiny Commission

Public health issues and health inequalities have been a major focus of the Scrutiny Commission in its first year, and the Council and the PCTs have worked together on reviewing progress on tackling health inequalities.

Bristol Public Health Forum

A large quarterly forum for all those involved in promoting public health in Bristol. Jointly organized by the Council, the Care Forum and the two PCTs. Approximately 50 people from a range of agencies attend each one. Recent topics have included housing and health, obesity and physical activity, regeneration and Sure Start. Details available on the Public Health Network website: http://nww.avon.nhs.uk/phnet/forums.htm.

Bristol Research Network
A multi-agency network of information analysts including those concerned with public health. Good sharing of information exists between Council analysts producing the *Quality of Life Indicators* and other reports and the PCTs, e.g. DPH *Annual Reports*.

Health Protection
There is a close working relationship between the Council, PCTs and the new national Health Protection Agency in managing communicable disease control, major incident management and other public protection functions. For more details see section 5.

Neighbourhood Renewal Strategy
Professionals concerned with public health contribute at both the Bristol and neighbourhood levels, with strategic input into the Neighbourhood Renewal Working Group and local input into the Neighbourhood Renewal Partnerships and health working groups. Bristol South & West PCT covers two priority neighbourhoods (Hartcliffe and Withywood, Knowle West) while Bristol North PCT covers eight (Ashley, Barton Hill, Easton, Hillfields, Lawrence Hill, Lawrence Weston, Lockleaze and Southmead). More information on neighbourhood renewal in Bristol is available at: http://www.bristol-city.gov.uk/.

Public Health Network
A public health network covers the four local authority areas of B&NES, Bristol, North Somerset and South Gloucestershire. The network includes a web site and an open monthly meeting (www.avon.nhs.uk/phnet/).

Public Health Opportunities Group
A new and informal quarterly meeting of senior professionals concerned with public health from across all the Council directorates and the PCTs. It provides a forum to share information and identify issues of mutual concern. Contact either PCT DPH for more information.

Regional Public Health Group
The Regional Public Health team is now based in the Government Office of the South West. Other regional support includes the South West Public Health Observatory (www.swpho.org.uk), part of the wider Regional Observatory, and the Health Development Agency.

Safety Camera Partnership
A multi-agency partnership across Avon and Somerset which works to reduce road deaths and injuries by persuading drivers to travel at a safe speed – through enforcement and education. More details at: http://www.safecam.org.uk/index.asp.

Discussion
Recent government policy has strongly supported closer working on public health between local authorities and PCTs (*Saving Lives: Our Healthier Nation* (1999), *Shifting the Balance of Power* (2001)). It is well recognized in NHS public health that the major determinants of health and the best opportunities to promote health and tackle inequalities depend on partnership working. Tackling poverty, promoting physical activity and healthy eating, controlling tobacco and reducing the negative impacts of drugs and crime all require partnership working with the Council, the voluntary sector and communities.

The recent establishment of the Bristol Partnership provides a strategic framework for improved public health partnership. The Public Health Opportunities Group provides a new and more focused forum for supporting professionals concerned with public health in co-ordinating and enhancing their public health work.

12. Joint Priorities for Action

Sections 3 and 4 gave an overview of the epidemiological data on the health of the people of Bristol. These data complement other data published by Bristol City Council (in particular the Quality of Life Indicators). Overall, the data suggests that people's health is in important respects improving; in particular, there are welcome improvements in trends for deaths due to circulatory disease. But there are a number of specific areas of concern; adverse health trends reported here that require action include:

- Inequalities – continued increase in the health gap between more affluent and more deprived communities;
- Sexual health – notably the growth in chlamydia, gonorrhoea and hepatitis B;
- Complications of intravenous drug misuse;
- Smoking related disease – cancer, respiratory and heart disease;
- Teenage pregnancy;
- Diabetes.

In determining priorities for action, assessments of need based on epidemiological data need to be integrated with the views of local people, practitioners, partner agencies, partnership forums and national strategy. In Bristol, this prioritisation now takes place through the Bristol Partnership and its Community Strategy, local Neighbourhood Renewal Action Plans, other partnership action plans and the PCTs' Local Delivery Plans. Joint priorities for public health action include:

- Implement action to address the NHS *Priorities and Planning Framework 2003 – 2006* public health and inequalities targets; (www.doh.gov.uk/planning2003-2006)
- Implement the national *Sexual Health Strategy* in Bristol;
- Develop services to tackle drug misuse through the proposed merger of the Bristol Community Safety Partnership and Bristol Drug Action Team;
- Sustain and expand action to tackle smoking and reduce smoking related disease;
- Continued implementation of the Bristol *Teenage Pregnancy Strategy;*
- Tackle the growth in diabetes by increasing levels of physical activity, and planning for increased service provision to prevent complications of diabetes.

13. Developing the Director of Public Health Annual Report

This is the first joint Annual Report of the Directors of Public Health for Bristol North and Bristol South & West PCTs. It follows a series of annual health reports produced by the Director of Public Health of the former Avon Health Authority, and is part of a long history of public health reports which have both documented and contributed to improved health in the UK over the last century. Production of an annual report has recently been confirmed as a key task for DsPH by the Department of Health.

The purpose of the report is to 'contribute to improving the health and well-being of local populations, to reduce health inequalities, and to promoting action for better health, through measuring progress towards health targets, and planning and monitoring local programmes and services that impact on health over time' (FPHM, 2002). It is intended to be the DPH's independent and objective professional statement about the health of local communities.

This report has been produced for a year of substantial organizational change and severe resource constraints. The Faculty of Public Health Medicine has recently issued guidance on DPH annual reports, which provides a framework for developing future reports. The framework sets out expectations of good practices including the involvement of partnerships and community perspectives in producing the report. We are keen to hear views on how best to achieve this and on how we can complement other important health reports. The faculty of Public Health Medicine guidance is available at http://www.fphm.org.uk/#DPH.

Further information on health in Bristol is available on the Public Health Network website (http://www.avon.nhs.uk/phnet/) and in the annual Quality of Life Indicators report from Bristol City Council (www.bristol-city.gov.uk).

As the first joint report for Bristol, we would welcome feedback on the content and format of the report. In particular, we would appreciate comment on the approach of having one joint report but separate sections for the health data on the two PCTs. We have taken this approach as we work closely together and wanted to reflect the Bristol-wide nature of most public health issues, whilst recognising that people working within the NHS would need some PCT specific data.

Please comment by using the attached Feedback Form (also downloadable from http://www.avon.nhs.uk/phnet/.

Glossary

Age related macular degeneration (AMD)	Usually occurs in people over the age of 50 years. There are two forms of AMD: wet (neovascular) and dry (non-neovascular) AMD. Wet AMD is classified as choroidal neovascularisation (CNV), which may be classic or occult. CNV means growth of abnormal blood vessels beneath the retina. These may leak and bleed, leading to vision impairment and legal blindness.
BMI (Body Mass Index)	A person's weight in kilograms divided by the square of their height in metres (w/h2). In England, people with a BMI between 25 and 30 are categorised as overweight, and those with an index above 30 are categorised as obese.
Census data	This is collected every 10 years and provides a comprehensive population profile for small areas (wards and enumeration districts). It is also used to allocate funding from central government. The 2001 census results should be available in 2003.
Chronic Obstructive Pulmonary Disease (COPD)	COPD is a disease characterized by a progressive airflow limitations caused by an abnormal inflammatory reaction to the chronic inhalation of particles. COPD is one of the leading causes of morbidity and mortality worldwide and imparts substantial economic burden on individuals and society.
Confidence Intervals	Confidence intervals or limits are used to give a range of values within which there is a degree of certainly that the values are correct, and to assess if values are significantly difference from one another. This range is required as there is likely to be some variation that occurs by chance. The most common confidence interval that is used is the 95% confidence interval. This gives a range of values within which there is a 95% chance that

the values are correct.
Values are "significantly different" if the values in the range of confidence limits do not overlap with the range of confidence limits in another value. The narrower the confidence limits, the higher the chance of finding significant differences between values.

Coronary Heart Disease (CHD) — Heart disease caused by poor circulation of blood to the heart muscle because the blood vessels have become blocked. This may show up as a heart attack or chest pain (angina).

Deprivation Quintiles — Deprivation quintiles divide areas in fifths according to some measure of deprivation, and can be used to analyse variations in health between deprived and affluent sections of the population regardless of where they live. The can be of varying size, e.g. PCT or enumeration districts.

Diabetic retinopathy — Is a complication of diabetes that affects the blood vessels at the back of the eye. It is a cause of visual impairment, which can progress to blindness.

Directly Standardised Rate — Directly standardized rates give an indication of the number of events that would occur in a standard population, if the population had the same age-specific rates of the local area. The standard population that is most commonly used is the European Standard population, however other populations such as the Avon standard population can also be used. The rates are calculated per 100,000 and because rates are applied to the same population, rates across areas can be compared.

Epidemiology — The study of the distribution and determinants of health related states or events in specified populations, and the application of this study to control of health problems.

Glaucoma — Is a group of diseases that can lead to damage to the optic nerve (which

connects the back of the eye to the brain) and result in blindness.

Health inequalities	Differences in health status and access to health services across socio-economic groups, ages and geographical areas.
Infant mortality	A death occurring before the age of 1 year.
Life expectancy	How long, on average, a specified population can be expected to live, based on current mortality data.
Outbreak	Two or more linked cases of a disease occurring in a population.
Photodynamic therapy	For people with wet AMD aims to alter the progression of vision loss. A light sensitive dye is given by intravenous infusion and is taken up by new blood vessels at the back of the eye. A non-thermal laser is then applied to activate the dye in order to destroy the endothelial cells in the new blood vessels.
Primary Care Trusts (PCTs)	An NHS trust that provides all local GP, community and primary care serves and commissions hospital services from other NHS trusts.

Notes

We'd like your views

The Health of Bristol 2002
Joint Annual Report of the Directors of Public Health,
Bristol North Primary Care Trust & Bristol South & West Primary Care Trust

Please tell us what you think of this report. Your comments will help to ensure that future reports will be more useful to you.

Please cut out this page and send to:

Carl Muldoon
King Square House, King Square, Bristol, BS1 8EE.
Or send comments by fax: 0117 900 2612
Or e-mail, Carl.Muldoon@bristolnorth-pct.nhs.uk

Which Sections are most useful to you?

Which sections are least useful to you?

Do you have any suggestions for topics you would like included in future reports?

Do you have any other comments about the content of the report?

Do you have any comments about the length, layout and presentation?

Please put your name, job title and address here, or leave it blank if you prefer to remain anonymous.

Thank You!