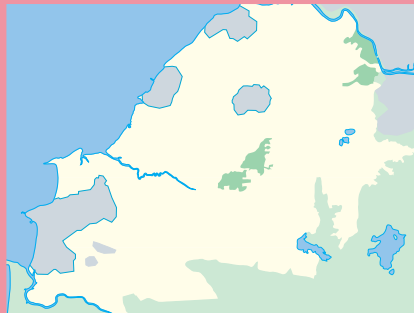


Health

in North Somerset



**The Annual Report
of the Director of
Public Health 2002/3**

North Somerset
Primary Care Trust



Contents

	Page
Foreword	iii
1. General Background	1
2. The Population of North Somerset	3
3. Key causes of early death	9
a) Cancer	10
b) Circulatory Disease	11
c) Accidental death	12
d) Suicides	13
4. Health Inequalities	15
a) The influence of deprivation on health	15
b) Improving health through regeneration	20
5. Sexual Health	23
a) Sexually transmitted infections	23
b) Teenage Pregnancy	27
6. Other health issues	29
a) Smoking and Health	29
b) Falls	33
c) Diabetes	36
d) Young People's Health-report of a local survey	38
7. Communicable diseases	39
a) Immunisation	39
b) Key Infectious Diseases	41
8. Concluding remarks	43
9. Acknowledgements	44
10. Feedback Form	45

Foreword

It is with great pleasure that I present this, the first ever annual report focussing exclusively on the health of people living in North Somerset.

North Somerset Primary Care Trust (PCT) is geographically co-terminous with the district of North Somerset and this allows concentrated attention to be paid to the specific health issues and challenges facing local people. We are fortunate in having a solid foundation of work carried out by our predecessor organisations to build on, but our local base means that we will be able to be much more responsive to the different and specific problems in our area.

One of the key functions of our PCT is to improve the health of the community and reduce inequalities in the health of the population we serve. This task is much broader than just the provision of health services for ill people, important though that is. Many influences on our health are related to facets of every day life, and tackling them depends on action at many levels – from government down to the individual. Many organisations and groups of people from within and outside the NHS are striving in different ways to make North Somerset a healthy place, and we need to work closely together to get the maximum benefit from all our efforts.

This report is intended to inform everyone who is working to improve the health of local people. It attempts to make an independent assessment of the health of local people and to recommend ways this can be improved. Where actions are already in hand, these are outlined along with any suggestions for their future development or enhancement.

I hope that some of the key messages and recommendations will be reflected in future plans by a variety of different organisations – such as the health service Local Delivery Plans and the North Somerset Community Plan.

Not every area of ill-health can be covered in one report, and I would welcome suggestions for what other topics should be included in future reports, as well as general feedback on the content and presentation of this report.

A form for your comments is included with this report. Further copies of this report and the feedback form are available from the North Somerset PCT website where there are also links to more detailed information on local health issues – <http://www.northsomerset.nhs.uk/>



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1. General Background

North Somerset Primary Care Trust (PCT) was established in April 2002 to ensure the provision of appropriate healthcare services to the residents of North Somerset. The PCT shares its geographical boundaries with North Somerset Council, although it has responsibilities for all patients registered with North Somerset GPs even if they live slightly outside the area.

The Trust was set up with the following objectives:

- ◆ To improve the health of the community and reduce health inequalities in the population of North Somerset;
- ◆ To develop primary and community health services;
- ◆ To commission secondary care services for the population of North Somerset.

North Somerset covers 144 square miles of diverse rural and urban environments. The population is concentrated on 4 main towns: Weston-super-Mare (40%), Clevedon, Nailsea and Portishead (30% combined).

There is a spread of community health services across the area. There is a district general hospital located in Weston-super-Mare, a community hospital in Clevedon and General Practice surgeries located in most wards. North Somerset residents also make significant use of Bristol hospitals in addition to local hospital services in the area (see Figure 1.1).

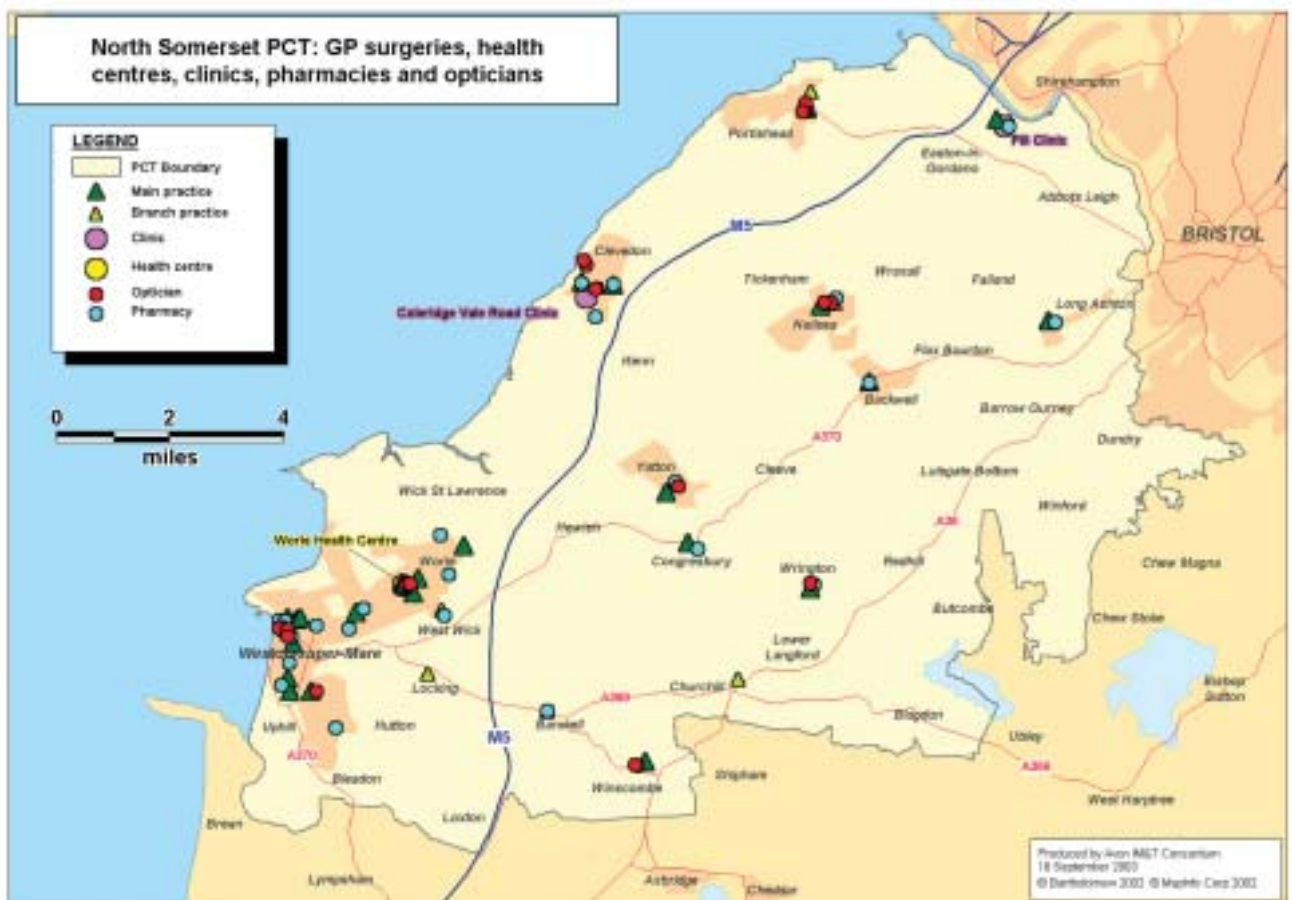


Figure 1.1 Shows where our GP practices, health centres and clinics are based.

There are numerous nursing and residential homes spread across the area. The majority of these homes are clustered around Weston-super-Mare and Clevedon (see Table 1.1).

Table 1.1 *Nursing and residential home places in North Somerset by area.*

Area	No. of places
Banwell and Winscombe	61
Blagdon and Churchill	19
Clevedon	606
Congresbury	37
Easton-in-Gordano	51
Gordano	7
Nailsea and Backwell	144
Portishead and Pill	192
Weston-super-Mare	1877
Wraxall and Long Ashton	30
Yatton	118
Total	3159

Source: North Somerset Council

2. The Population of North Somerset

KEY POINTS

- ◆ the population of North Somerset has doubled over the past 50 years, and is set to increase by around 9% over the next decade
- ◆ North Somerset has a population which is relatively elderly and relatively low in people aged 20–34
- ◆ up to 2011, most population growth will be in the 40–50 age group and amongst the younger elderly (60–69)
- ◆ the child population will increase by around 6%
- ◆ the largest percentage increase in population will be in the Portishead area
- ◆ there are around 3.3 million day trippers and 375,000 staying visitors in North Somerset each year
- ◆ ethnic minorities represent around 1.4% of the local population, there are few asylum seekers and an unknown number of gypsy and traveller families
- ◆ 9% of the people in North Somerset live in areas which are amongst the most deprived in the country

RECOMMENDATIONS

- ◆ population forecasts and measures of deprivation need to be updated in the light of the 2001 census

Population estimates

The 2001 census reported a population for North Somerset of 188,000, which has doubled since 1950. The population profile is shown in Figure 2.1, comparing the North Somerset population distribution to the national picture. There are relatively low numbers in the younger age groups, particularly 15–34. This may be explained by the outward migration of young people to larger urban areas for further and higher education. Overall the population is older than the national picture and this is most marked for people in late middle age and the younger elderly.

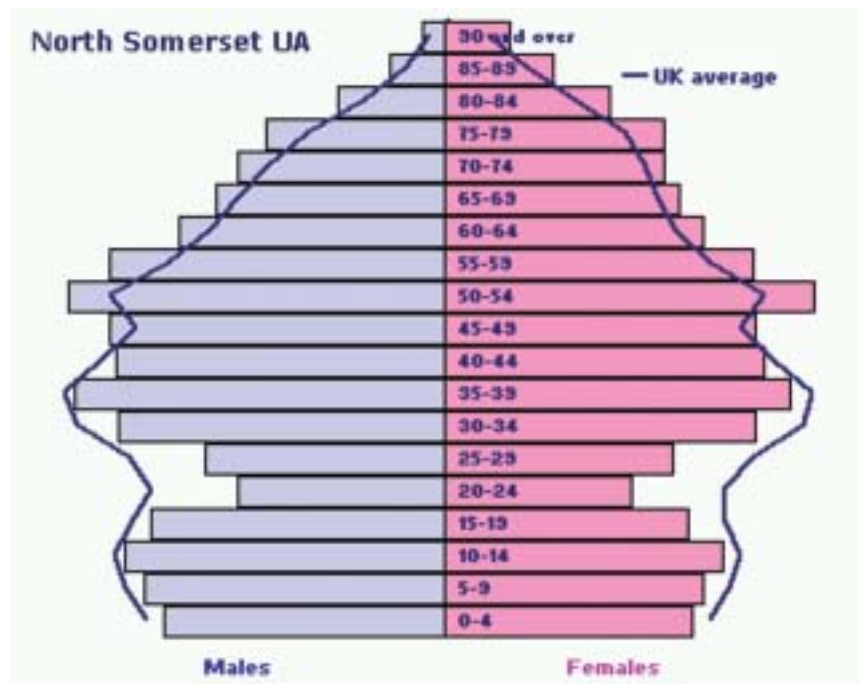


Figure 2.1 North Somerset population profile census 2001

Ward based estimates

There is considerable variation in the population distribution in smaller areas as shown in Table 2.1.

Table 2.1

Area	Population	% under 5	% over 75
Weston	71700	6	11
Clevedon	22000	6	11
Nailsea	16500	5	8
Portishead	1700	6	9

Source: 2002 census

The wards with the highest proportion of the population aged over 75 years are: Clevedon North, Clevedon Walton, Weston-super-Mare Central, Weston-super-Mare Clarence and Uphill, Weston-super-Mare Central and Portishead Coast. The wards with the highest proportion of under 5s are North Worle, Weston-super-Mare South, Weston-super-Mare East, South Worle, Portishead East, Portishead Central, Clevedon Yeo, and Clevedon South.

Population projections

Detailed work commissioned by North Somerset Council has explored likely population increases over the next decade taking into account the new housing developments identified in their published Structure Plans. The Plans indicate that between 1996 and 2011 there will be around 13,800 new dwellings in the area, which represents an increase of around 17.2%.

Overall, the population is expected to increase to around 210,000 by 2011 (an increase of around 9%).

The population increase is not spread equally across age groups, as shown in Figure 2.2. The biggest increases are amongst people aged 40–50, and in those aged 60–70. The increase in the latter group suggests that the area is likely to see a similar increase in the very elderly after 2011, as these people themselves age.

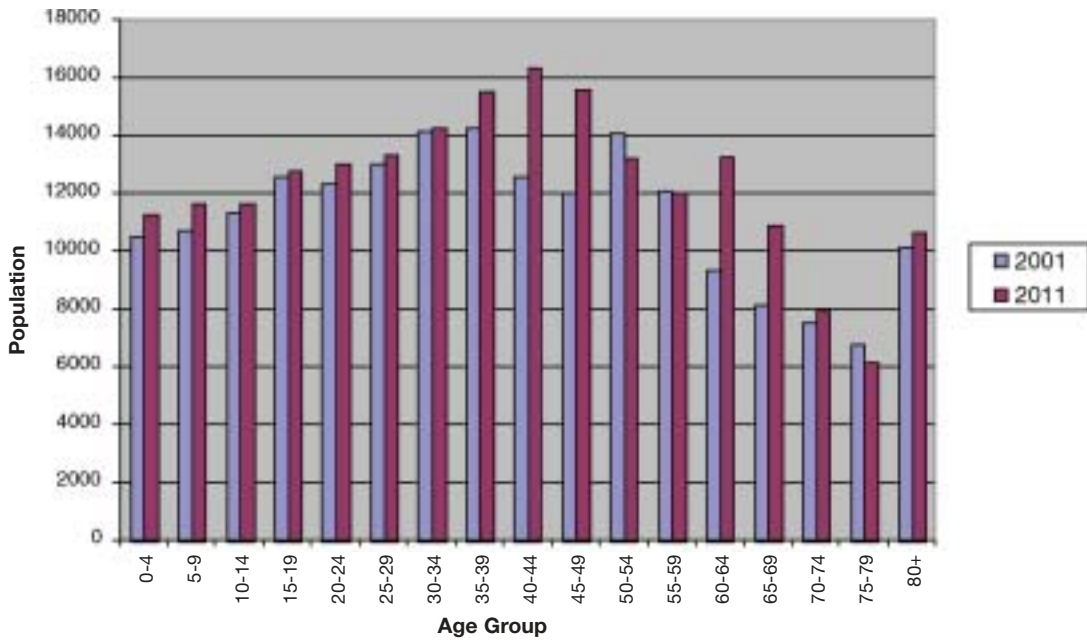


Figure 2.2 Changes in population by age band: North Somerset 2001–2011

(NB This work was based on ward data from the 1991 census, and then updated by North Somerset Council. These estimates gave overall figures for 2002 within 2% of the latest census, and so are likely to give a realistic picture despite the age of the original baseline).

This work also allows a look at population growth within the towns in North Somerset. Figure 2.3 demonstrates the very major growth in Portishead, with smaller increases in Weston and Nailsea. Over most of the next decade the over 75s (who have the greatest impact on health services) in Weston and Clevedon are likely to reduce in number.

Seasonal population changes

Visitors to the North Somerset area have a significant impact upon the population, especially during the summer months. Approximately 16 million visitors travel through the district along the M5 motorway each year. Staying visitors and day-trippers account for around four

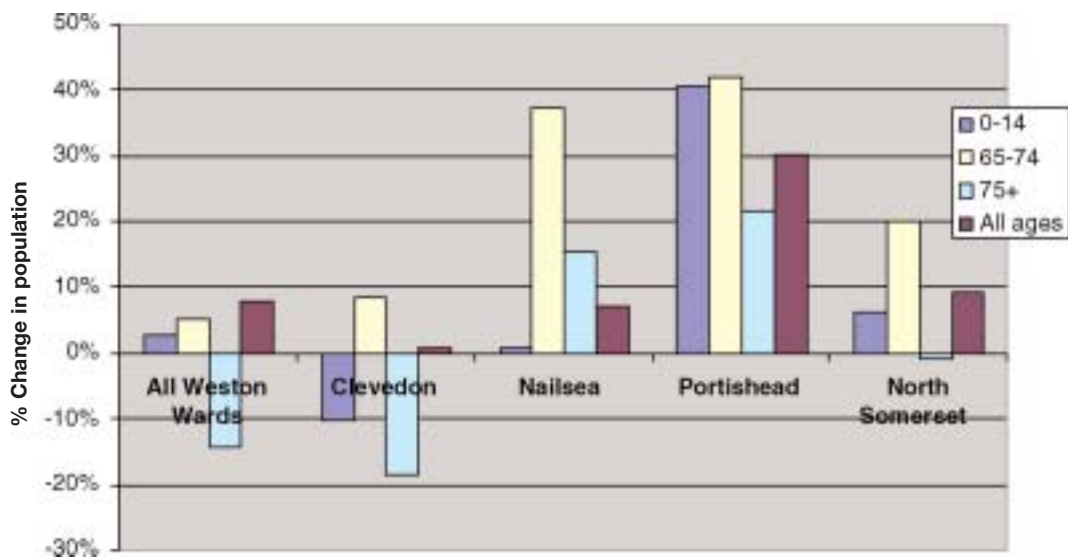


Figure 2.3 Population change in different parts of North Somerset 2001–2011

NB Some caution must be used in interpreting these figures, as they need to be updated in light of the results of the 2001 census. Updated information will be available on the NSPCT website as soon as possible.

million visitors per year, although the number of staying visitors is declining. Bristol International Airport, which lies within the district, opened a new terminal in the spring of 2000 and expects to cater for around 3.5 million passengers a year.

A breakdown of the most recent figures suggests that there are around 3.3m day visitors and 375,000 staying visitors each year in North Somerset.

Registered population

The population of North Somerset PCT based on GP registrations is very similar to the Census and North Somerset Council estimates. As it reflects the population registered with North Somerset GPs, it does not cover exactly the same population. It includes some people in neighbouring districts who register with, for example, GPs in Weston, and excludes some people who register with GPs outside the area. However it is very much more up to date, as it changes to reflect population movements on a daily basis. The registered population had increased to 193,000 by March 2003.

Ethnic minorities

The only comprehensive data source of ethnicity is the Census. This showed the non-white population of North Somerset to be 1.4% of the total population. Another source of data is the Avon wide Child Health Surveillance system which contains ethnicity data on all babies born in Avon. In the financial year 00/01 in North Somerset, 1.8% of new babies were from Black and Other Minority Ethnic Groups (African, West Indian, Far East/Indo-Asian, Indian Subcontinent, Polish, Irish, White Other and Other).

One area where we know people from ethnic minorities often have significant unmet health needs is in the case of refugees and asylum seekers. In the Avon area, based on 2000/2001 data most asylum seekers were male and young and under half were registered with a local general practitioner. The country of origin of local asylum seekers was diverse,

ranging from Somalia to China. The majority of asylum seekers were from Somalia, Kosovo, Iraq, Iran, Turkey and Afghanistan. However, only very small numbers of asylum seekers were identified as living in North Somerset.

However, we know from contacts made by our community staff that some have asylum seeker families on their caseload, and there seem to be small numbers of asylum seekers moving to Weston.

There are a number of Gypsy and Traveller families in North Somerset. Some are settled in social or private housing, some in mobile homes or chalet bungalows on private sites, some in council owned sites and some come into North Somerset and settle in temporary camps and then move on or are moved on. The largest site is a privately owned site at Moorland Park that has more than 20 plots. The council owned site at Willowmead has 4 plots and there is another single plot site at Puxton.

We have no realistic estimate of the total number of Gypsy and Travellers that are resident in North Somerset for all or part of each year.

It would be very easy to overlook the specific needs of the small number of people from ethnic minority backgrounds, but North Somerset PCT is committed to the delivery of services which are responsive and accessible to local people from different racial backgrounds. We have a Race Equality Scheme, and are working towards a much more locally based process of needs assessment, allowing us to understand better the specific needs of small groups.

Deprivation

A number of ways of measuring deprivation have been developed, each to meet different objectives. These include the Jarman Underprivileged Area Score, the Townsend Material Deprivation Score and the Index of Multiple Deprivation (IMD) 2000. Although they are calculated differently, and designed for different purposes, the three measures give broadly similar pictures, and are closely related to

each other. Typically each index shows North Somerset as having lower levels of deprivation compared to the national picture, or to other unitary authorities within Avon. However there are small pockets of deprivation, which are masked by the average figures. Indeed, on a ward level most indices highlight certain wards, particularly the urban wards around Weston-super-Mare, as having high levels of deprivation. Currently the local scores have been calculated using the baseline from the 1991 census. We will be working to update these using the latest census data in the near future.

The Index of Multiple Deprivation (IMD) 2000 is a ward level index which takes into account income, housing, employment, education, health and access to services. Figure 2.4 shows the national range of IMD scores across wards, with North Somerset highlighted. The most deprived wards in North Somerset are found around Weston-super-Mare. Indeed, Weston-super-Mare South and Weston-super-Mare Ellenborough wards fall within the most deprived national 10% of the IMD. Around 9% of our population live within these areas. Figure 2.5 shows the IMD for wards across North Somerset, the higher the index the more deprived the ward.

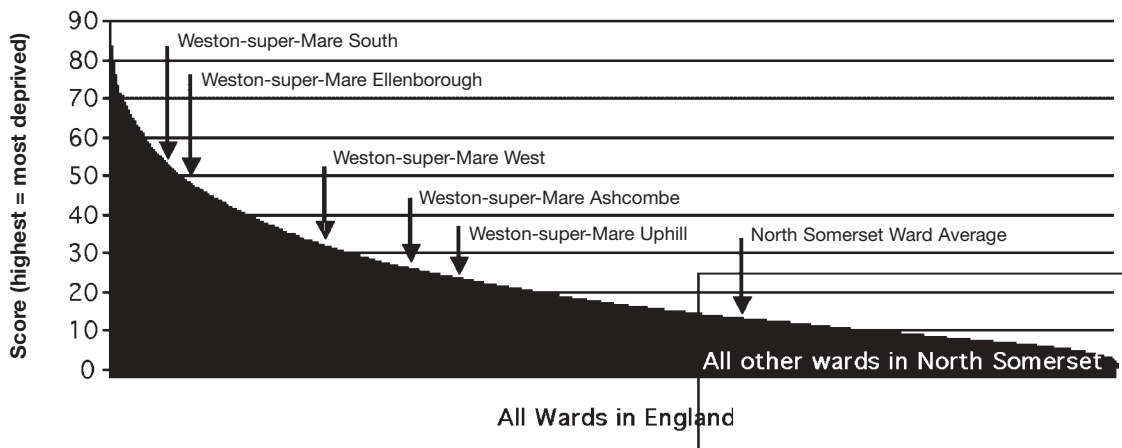


Figure 2.4 Index of multiple deprivation wards score across England 2000

Source: DETR

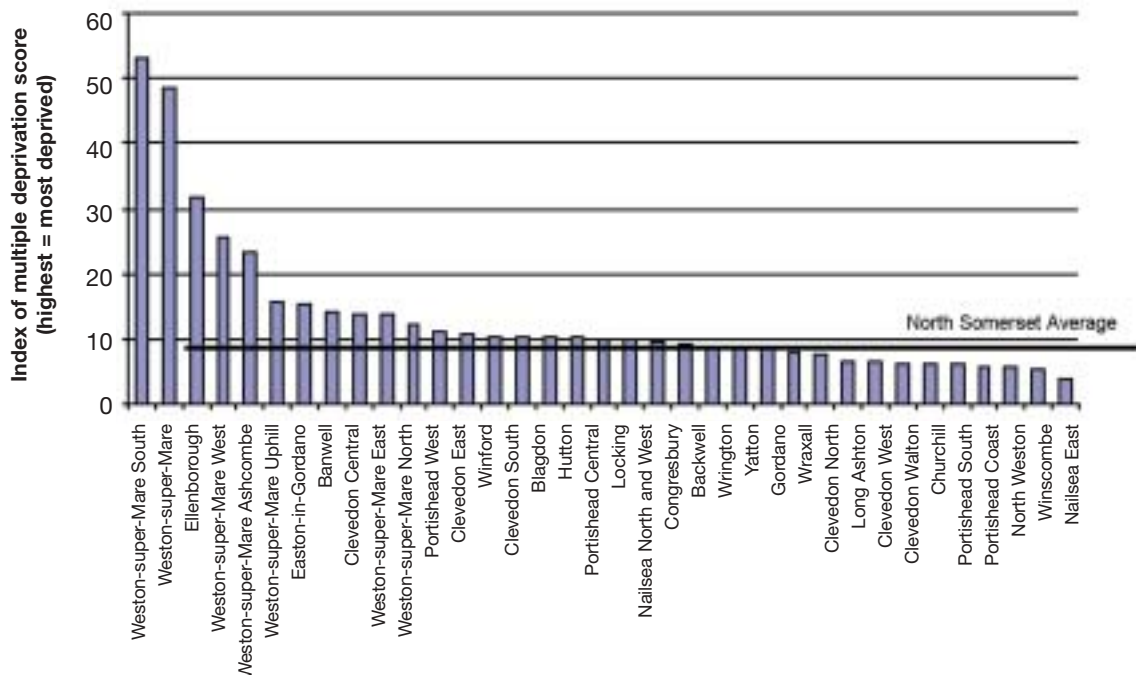


Figure 2.5 Index of multiple deprivation score across wards in North Somerset in 2000

Source: DETR

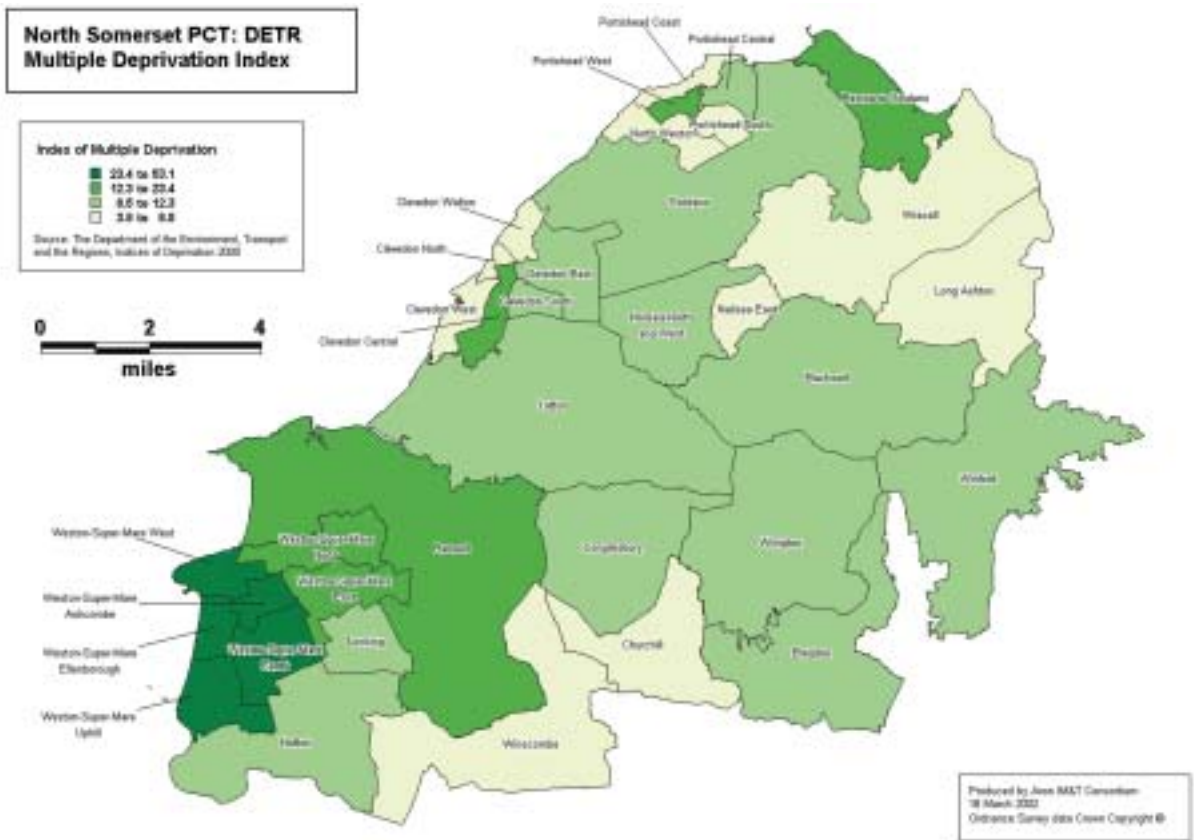


Figure 2.6 Map displaying DETR multiple deprivation indexes for wards across North Somerset PCT. Deprivation index divided into four equal groups, based on national data

Source: DETR

3. Key Causes of Early Death

KEY POINTS

- ◆ death rates from the two commonest causes of early death – cancer and circulatory disease – are reducing in North Somerset in line with national trends. We are likely to meet the national targets for reducing deaths in these areas
- ◆ there are much smaller numbers of deaths from suicides and accidents, and it is much harder to spot long term trends
- ◆ accidents are the largest cause of death in young people and cause a significant amount of illness and disability
- ◆ falls are the major cause of death from accident in older people and road traffic crashes kill more young people than any other sort of accident

RECOMMENDATIONS

- ◆ we must continue to implement the national strategies for cancer and heart disease
- ◆ we must ensure good quality care for people at high risk of suicide and support the development of initiatives to promote good mental health
- ◆ we must focus on action to reduce falls and increase the emphasis on reducing road traffic accidents

Introduction

The importance of working to prevent premature death was highlighted in Saving Lives – Our Healthier Nation (DoH 1999) which set national targets to reduce the death rate from accident and suicides in all ages, cancer in the under 75s by at least a fifth by 2010, and circulatory diseases in the under 75s by at least two fifths by 2010. The importance of these targets to the work of the NHS has been demonstrated by the inclusion of reducing suicides in the Mental Health NSF, and targets to reducing premature deaths from cancer and heart disease in our Local Delivery Plan for 2003–2006.

Table 3.1 Progress towards mortality targets in North Somerset

Topic	Target	Baseline (1995–1997)	Current (1998–2000)	2010 Target
Cancer (age under 75)	Reduce death rate by one fifth by 2010	117.6	109.7	94.0
Circulatory Diseases (age under 75)	Reduce death rate by two fifths by 2010	109.2	94.9	65.5
Accidents (all ages)	Reduce death rate by one fifth by 2010	5.8	14.6	12.
Suicides & injury undetermined (all ages)	Reduce death rate by one fifth by 2010	5.7	7.5	4.6

Rates used are directly standardised rate per, 100,000.

As shown in Table 3.1, death rates from cancer and circulatory disease are falling. If the reduction in mortality continues at the rate that has occurred since the 1995–1997 baseline, these targets will be met in North Somerset. Monitoring of trends towards the targets of mortality from accidents and suicides at a PCT level is difficult due to the relatively small number of events.

Cancer

Numbers and rates of death from cancer

Cancer is the most common cause of premature death in adults in North Somerset, accounting for 41% of all deaths in people aged 15–64 in 2000. Just over 500 deaths each year are related to cancer and roughly half of these deaths occur before age 75. Over the last 10 years (1990–2000), the age standardised mortality rate for all cancers in the under 75s in North Somerset has been lower than the England and Wales rate and has fallen in line with the national average (Figure 3.1). Lung cancer is the most common cause of death from cancer in men causing an average of 56 deaths each year. Breast cancer is the most common cause of death from cancer in women, with an average of 49 deaths each year.

Reducing cancer deaths

The National Cancer Plan, published in 2000, outlined a comprehensive programme for reducing cancer deaths. Key areas where we are working are:

1 Helping prevent cancer

The single most important preventive measure for cancer is reducing cigarette smoking and this is discussed in more detail in section 6. On average a premature death will be prevented for every 2 smokers who quit long term. We also know that eating a diet with plenty of fresh fruit and vegetables, being of normal weight and taking exercise are all related to a lower risk of developing cancer. Other important prevention measures include reduction of harmful levels of exposure to ultraviolet radiation in sunbeds and sunlight and reduction in industrial exposures to cancer causing chemicals. Work on all these approaches is taking place in North Somerset.

2 Screening for cancer

Women in North Somerset are offered three yearly screening by mammography as part of the national NHS Breast Screening Programme. The service is provided by the Avon Breast Screening Unit, whose performance meets or exceeds all the national standards for breast screening.

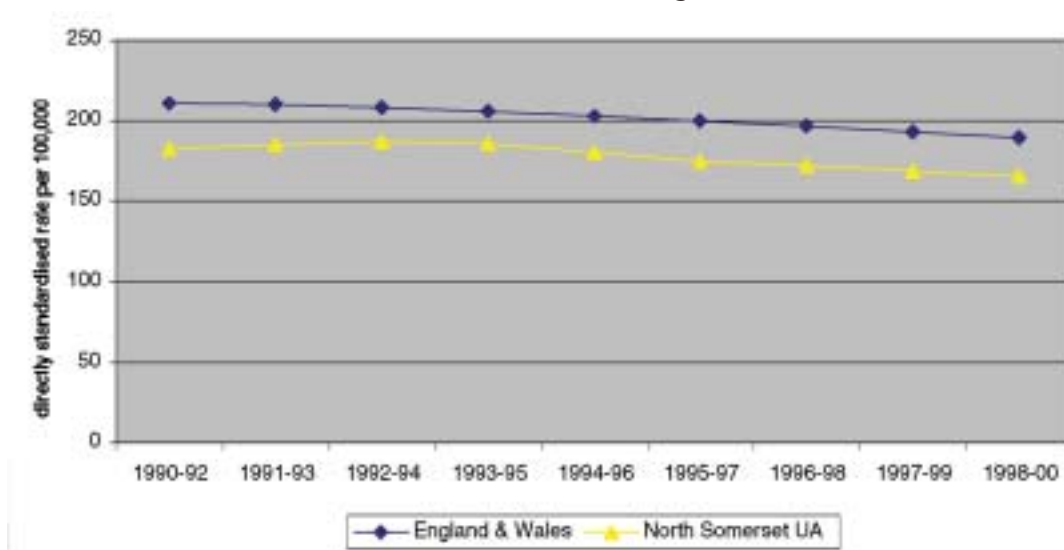


Figure 3.1 Trends in mortality from all malignant neoplasms in the under 75s in North Somerset (1990–2000)

Source: Compendium of Clinical Indicators 2001

We offer screening to all women between the ages of 50 and 65, and about 75% take up the offer. We have plans to increase the upper age range for invitation to 70 years of age, in line with national policy, in the near future.

The Office for National Statistics estimates that one third of the recent 21% fall in breast cancer deaths in women aged 55 to 69 in England and Wales is directly attributable to routine breast screening. This equates to one woman per year in North Somerset having death prevented as a direct result of the breast screening programme.

Women in North Somerset are also offered five yearly screening by cervical cytology as part of the national NHS Cervical Screening Programme. The local Programme meets all key national quality standards and around 85% of eligible women have had a recent cervical smear.

The number of additional cervical cancer deaths that would be occurring in England and Wales were it not for the screening programme, has been estimated by the Office for National Statistics. Their findings suggest that an average of 5 women each year in North Somerset have their lives prolonged as a result of cytology screening. The numbers with screen detected abnormality and needing investigation and treatment are far higher than this because the changes picked up on screening are non-specific and most will return to normal on their own.

We follow the advice of the National Screening Committee (NSC) on screening programmes. Although there is growing demand for prostate specific antigen (PSA) testing to screen for prostate cancer, the NSC has reported that there is no good evidence of benefit from such a screening programme, and it is not part of our future plans.

3 Treatment services

There have been major improvements in cancer treatments over the past decades and, more recently, there has been a

concerted effort to make sure that scientific knowledge is being implemented efficiently for cancer patients. A cancer network covering the areas of Avon, Wiltshire and Somerset has been established, and clear guidelines for the management of the major cancers are now in place. People with suspected cancer are being seen within two weeks, which is major improvement on the situation a few years ago. We have been able to support Weston Hospital in establishing a unit to allow some day treatments to take place locally, rather than patients having to travel to Bristol.

Circulatory Diseases

Numbers and death rates from circulatory disease

Circulatory diseases, which include coronary heart disease and stroke, are the second main cause of premature death in adults in North Somerset. There are 214 deaths a year from circulatory disease in the under 75s in North Somerset (1998–2000). The rate has been falling steadily over the last 10 years in line with the national trend, and has remained below the national rate during this period (see Figure 3.2).

Reducing deaths from circulatory disease

A major national plan to reduce deaths from heart disease – which is the biggest contributor to this category of deaths – was published in 2001. We are working to implement its recommendations.

1. Preventing heart disease

We know that we can reduce the risk of getting heart disease by:

- a) reducing smoking;
- b) promoting healthy eating;
- c) increasing physical activity; and
- d) reducing overweight and obesity.

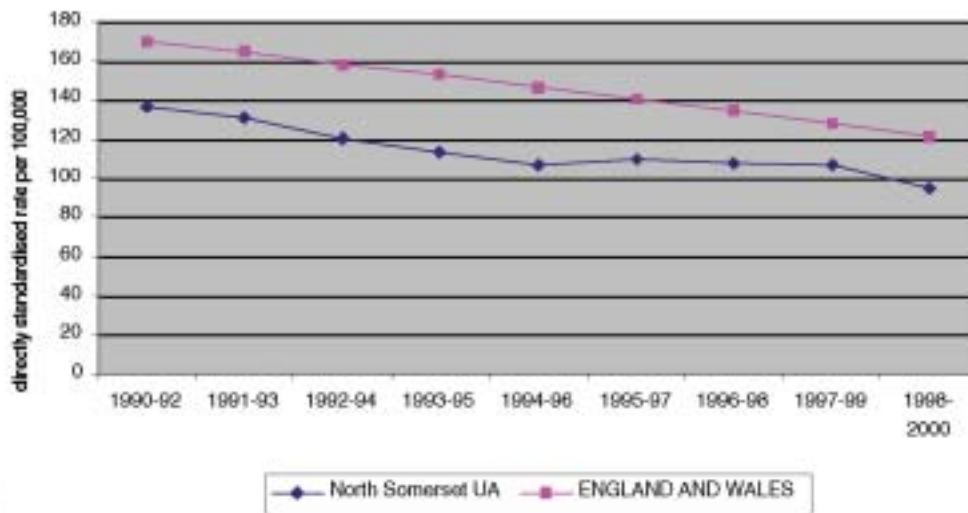


Figure 3.2 Trends in mortality from all circulatory diseases in the under 75s (1990–2000)

Source: Compendium of Clinical Indicators 2001

There is much debate at present about the benefits of treating people without any evidence of heart disease with drugs to reduce cholesterol which lowers the risk of developing heart disease.

2. Treatment of heart disease

Once someone has heart disease, we know that we can help prevent further problems by encouraging regular review, treatment with certain key medications and helping people to live a healthy lifestyle.

For people with serious problems, we know that we should provide fast and efficient hospital treatment and access to specialist investigations and treatment, alongside support to return to a normal life after discharge.

For people with long term heart damage better managed treatment can significantly improve the quality of their lives, as well as preventing the need for hospital care.

Accidental death

Numbers and rates of deaths from accidents

Accidents are the single largest cause of death in young people in the UK. Between 1998 and 2000, there were 33 deaths a year from accidents in North Somerset, approximately two thirds of whom were men.

Figure 3.3 shows the changes in mortality rates compared with the England and Wales mortality rate in 1993. While there has been little change in the national rate over the last 10 years (1990–2000), the mortality rate in North Somerset has fluctuated but remained below that of England and Wales.

Causes of death

The top 3 causes of accidental death in North Somerset are transport crashes (37%), falls (23%), and poisoning (19%). Falls are the largest cause of mortality in the elderly and transport crashes result in the most deaths in the under 24s. Overall, men are twice as likely to die from an accident as women (Figure 3.4).

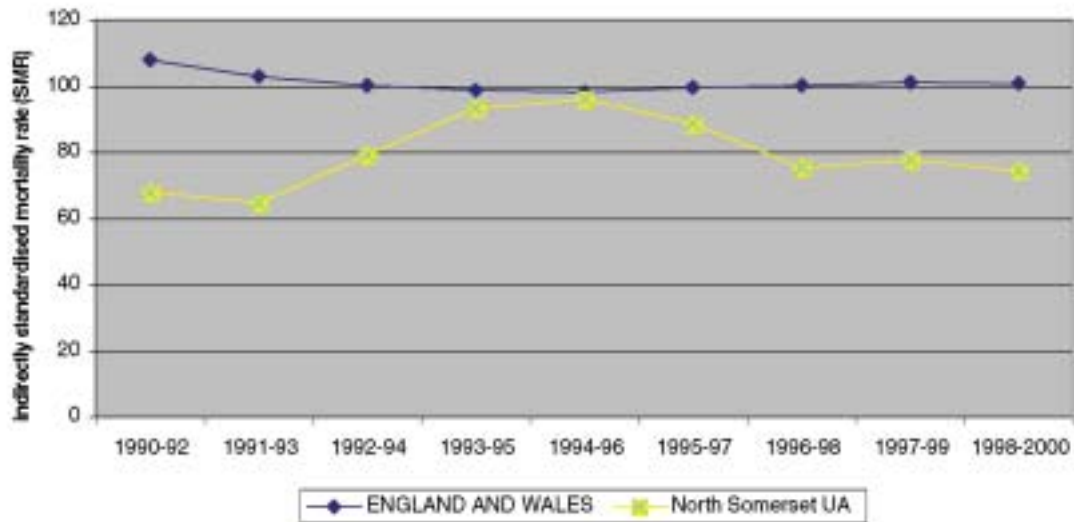


Figure 3.3 Trends in mortality from accidents in North Somerset (1990-2000)

Source: Compendium of Clinical Indicators 2001

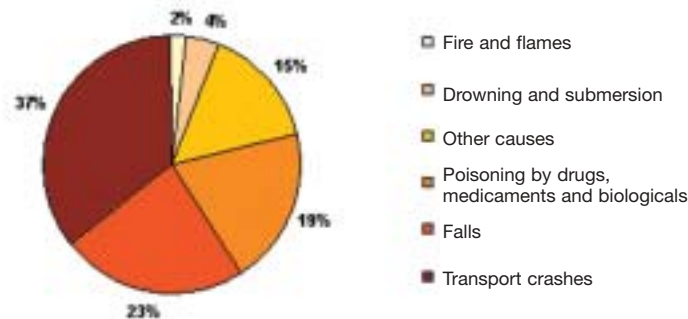


Figure 3.4 Causes of death from unintentional injury in North Somerset (1997-1999)

Source: ONS

Reducing deaths from accidents

Much work on accident prevention is taking place in a co-ordinated fashion across the former Avon area through the established multi-agency injury prevention partnership AVONSAFE. Our Community Nurses play a lead role in the prevention of childhood accidents through their health education work and support for the two low-cost safety equipment schemes. The Bristol based LIFESKILLS Centre offers an exciting way of learning about safety to local people with learning difficulties and to school children in their last year at primary school. In the past year 1,559 North Somerset children from 32 schools have visited the centre. Younger children have also had the opportunity to learn more about safety by visiting the Safety Zone which is a North Somerset charity.

We need to continue to support these activities in the future. We should also investigate why some schools have not yet visited LIFESKILLS and try to ensure that those schools in areas with the highest levels of childhood accidents are able to take their children to the centre.

We need to develop our work on road traffic accident prevention.

Suicides

Numbers and death rates from suicide

The mortality rate from suicides and undetermined injury in North Somerset declined in the early 1990s, and then remained steady until 1998-2000 when the rate rose (see Figure 3.5). The rate has

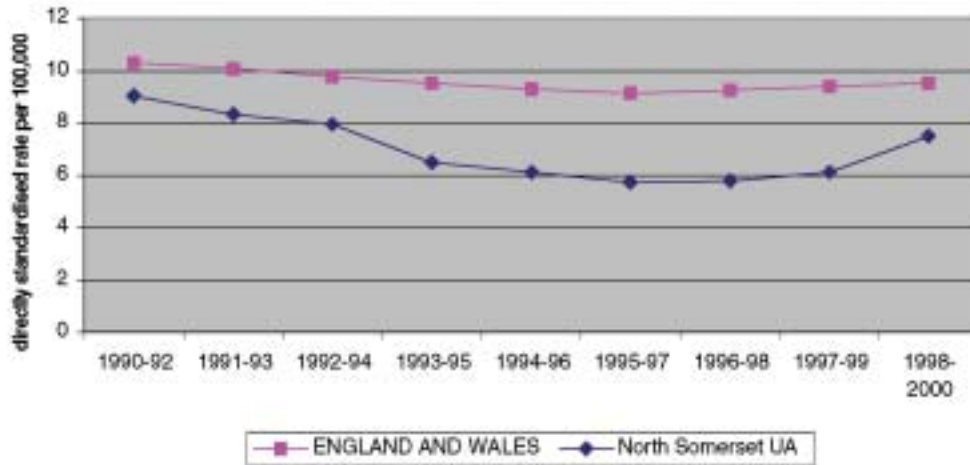


Figure 3.5 Trends in mortality from suicides and injury undetermined in North Somerset (1990–2000)

Source: Compendium of Clinical Indicators 2001

remained below that of England and Wales during the last 10 years. Between 1998 and 2000, there were 14 deaths a year in North Somerset from suicides and injury undetermined, 63% of whom were men.

Reducing deaths from suicide

Our core aim must be to ensure both high quality services for people with mental health problems at risk of suicide, and to work to prevent people actively considering suicide as an option through the positive promotion of good mental health.

4. Health Inequalities

4a The influence of deprivation on health

KEY POINTS

- ◆ men in the most deprived areas live 7 years less than men in the more affluent areas
- ◆ a pattern of increasing death rates in more deprived areas can be seen for the most common causes of premature death – cancers and circulatory diseases, accidents and suicides
- ◆ mothers living in deprived areas are much more likely to give birth to a low birth weight baby, have a child who is born dead or who dies within the first week of life and are much less likely to be breastfeeding at 8 weeks
- ◆ people living in deprived areas appear less likely to get cardiac surgery when their relative need is taken into account

Introduction

RECOMMENDATIONS

- ◆ a multi-agency health inequalities strategy is needed, to ensure we deliver the interventions which have been shown to be effective

In the report, 'Independent Inquiry into the Health Inequalities' produced in 1998 by Sir Donald Acheson (Dept. of Health 1998), the widening gap in health between the richer and poorer sections of society was documented. In response, the government have recognised the impact on the health of the nation and have developed a wide range of strategies that cut across the responsibilities of many different government departments to tackle these inequalities.

There is a national health inequalities target:

By 2010 reduce inequalities in health outcomes by 10% as measured by infant mortality and life expectancy at birth

This next section shows the effects of deprivation on health in North Somerset.

Deprivation and Health in North Somerset

Measuring Deprivation

The Avon Public Health network has used the Townsend Material Deprivation scores, as a measure of deprivation. The Townsend score has been found to be reasonably well related to the need for health care services. It is based on four census variables:

1. Unemployment
2. Car ownership
3. Home ownership
4. Overcrowding

They ranked the wards according to their Townsend score from the most to the least deprived, and then divided them into five equal groups – so called quintiles.

The data was based on the 1991 census and will need to be repeated using the results of the 2001 census, as soon as the relevant information is published.

Life expectancy

The current life expectancy for women in England and Wales is estimated to be 80.1 years and for men 75.2 years. Across the South West life expectancy is slightly

higher than the national average, at 81.2 years for women and 76.5 years for men. In North Somerset life expectancy for both men and women is higher than the national and regional average. However there is marked variation in life expectancy by deprivation quintile, which is more marked in women than men (Figure 4.1). Men in our deprived areas have a life expectancy 7 years less than men living in the least deprived areas.

Premature mortality

Mortality for the main causes of premature death is also linked to deprivation. People living in the more deprived areas of North Somerset have significantly higher mortality rates from

heart disease, cancer, suicide and accidents than those in the fifth most affluent areas (Figures 4.2 and 4.3).

Low birthweight births and infant mortality

Between 1996 and 2000 there were an average of 10 deaths per year in children under 1 year of age, giving an infant mortality rate of 5.1 deaths per 1,000 live births (Avon figure = 5.2 deaths per 1,000 live births). These numbers are fortunately very small, but are at such a low level that it is not possible to look at the effect of deprivation on infant mortality directly. However, babies who are born with a low birthweight are more likely to have developmental problems and poor health

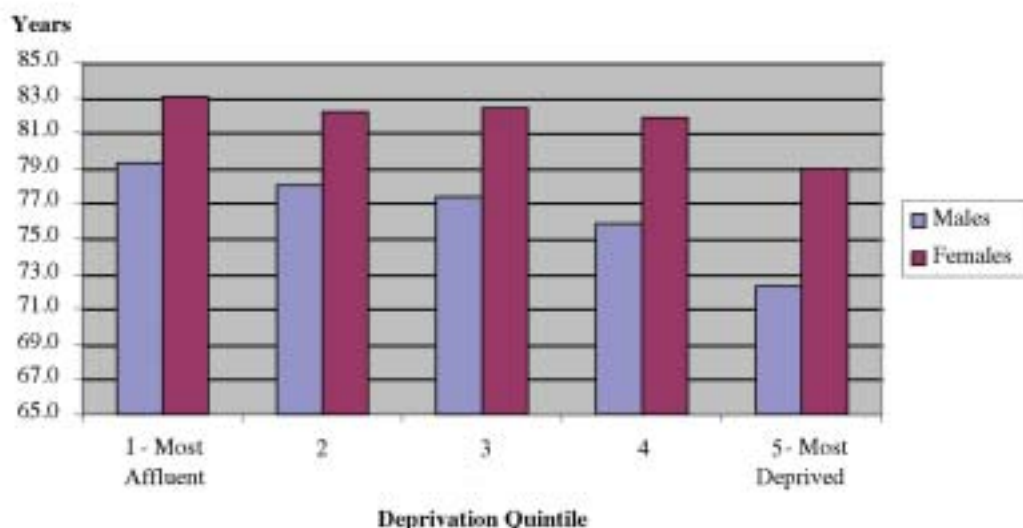


Figure 4.1 Life Expectancy at birth by deprivation quintile in North Somerset (1996–2000)

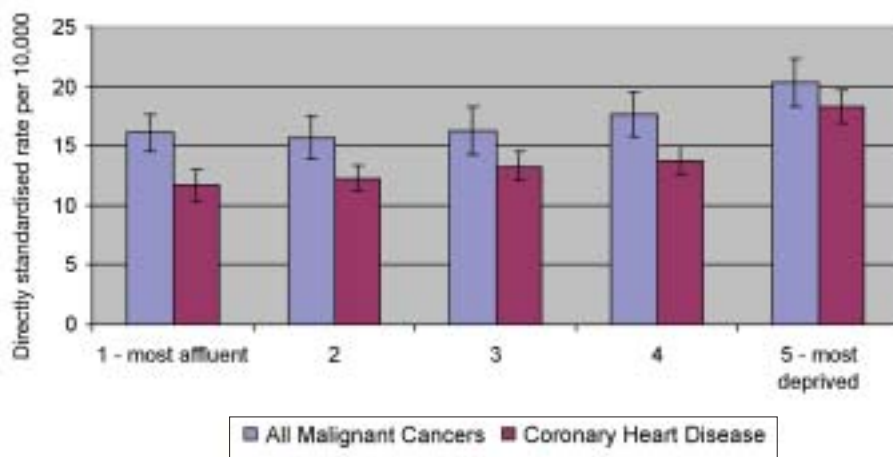


Figure 4.2 Coronary Heart Disease and cancer mortality rates in North Somerset by deprivation quintile (1995–1999)

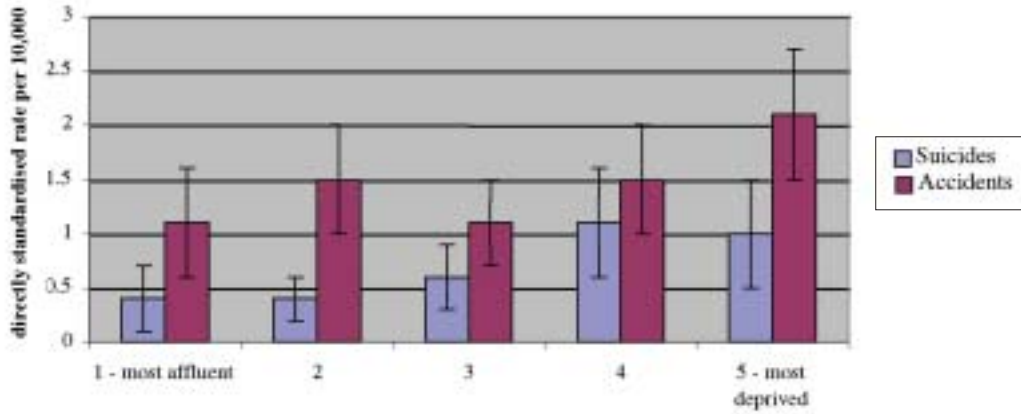


Figure 4.3 Suicide and accident mortality rates in North Somerset by deprivation quintile (1995–1999)

Source: ONS for death data; 1991 census for Townsend score of deprivation

later in life. Low birth weight and infant mortality are linked and both are associated with deprivation. Low birthweight is also associated with multiple pregnancies, maternal nutrition, teenage pregnancy and smoking in pregnancy.

We have therefore focussed on this much larger group to look at the disadvantages associated with deprivation.

Over the same period there were an average of 115 low birthweight (under 2500g) births per year, representing 6.1% of all live births (Avon figure = 6.8%).

Figure 4.4 shows the variation in incidence of low birthweight births by Townsend Score deprivation quintile.

As can be seen there is a general increase in the proportion of low birthweight births as the level of deprivation within the population increases, the rate in the most deprived areas being nearly 70% higher than in the most affluent areas. Detailed investigation of the relationship between low birthweight births and infant mortality across Avon has taken place, and if applied to North Somerset would suggest that this variation in low birthweight births is associated with a

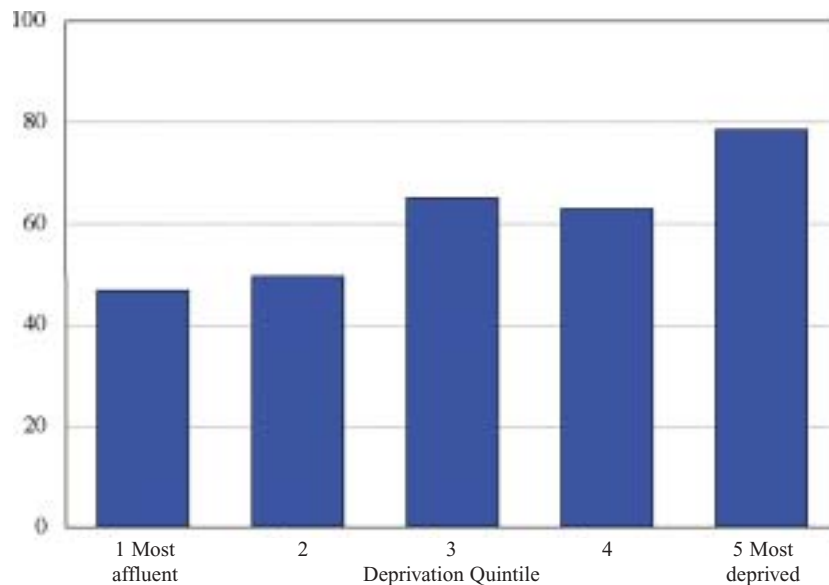


Figure 4.4 Low birthweight births per 1000 live births

doubling of infant mortality rates between the most affluent and the most deprived populations in the area.

Perinatal mortality

Perinatal mortality includes stillbirths and deaths of infants up to 7 days old. The most important risk factor for perinatal death is low birthweight. The perinatal mortality rate increased with deprivation, with the most deprived quintile in North Somerset PCT having a significantly higher rate than the most affluent quintile between 1995–1999 (see Figure 4.5).

Breastfeeding

Breastfeeding improves a child’s long term health. In North Somerset less than a quarter of women in deprived areas are

still breastfeeding their babies at 8 weeks, compared to nearly 60% in the least deprived areas (Figure 4.6).

Access to services

A specific local study was carried out to look at whether people in deprived areas get equal access to services. Because of the importance of heart disease as a cause of death, it looked at how likely people with heart disease were to get specialised treatment such as heart surgery or angioplasty (a newer technique which is replacing heart surgery in some cases).

The study looked at deaths and admissions to hospital with a heart attack as markers of need.

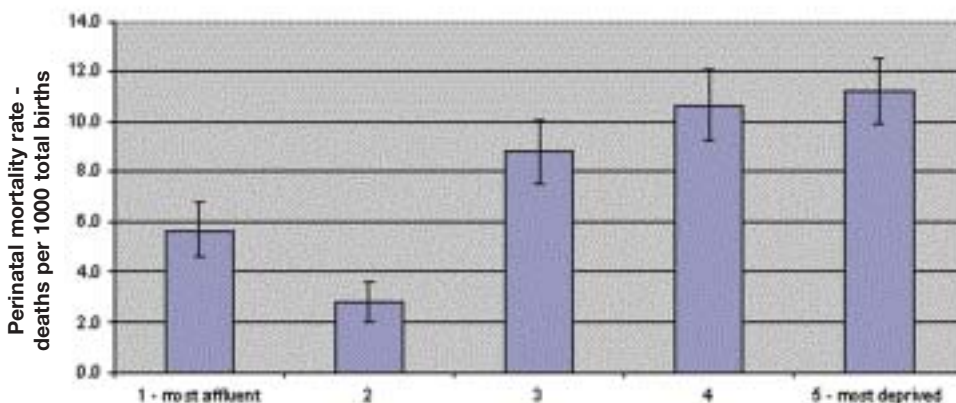


Figure 4.5 Perinatal Mortality Rates in North Somerset by deprivation quintile (1995–1999)

Source: ONS birth & death registrations; Townsend score (1991 census)

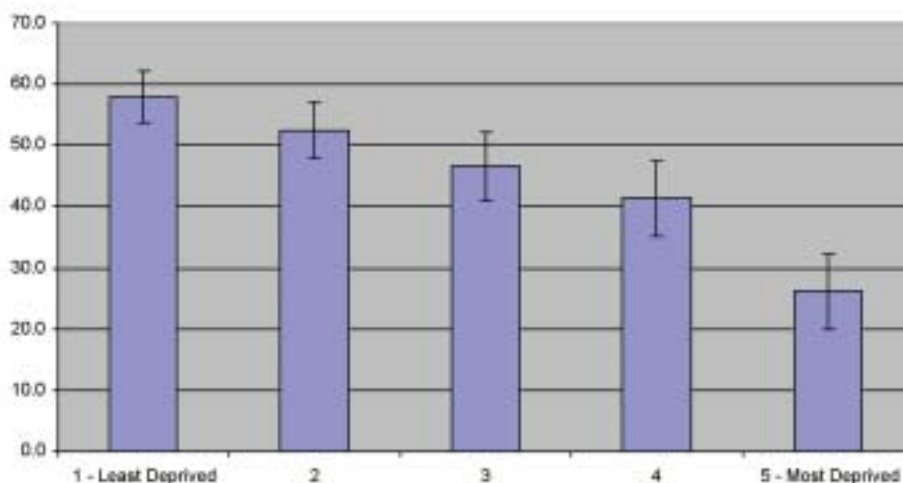


Figure 4.6 Percentage of mothers breastfeeding at 8 weeks by Deprivation Quintile in North Somerset (2000)

Table 4.1 Age standardised rates per 100,000 population

Event	Most affluent areas	Most deprived areas
Death from heart disease (1996–2000)	104.3	180.6
Admission with a heart attack (1999/00 to 2001/02)	92.4	129.4
Heart surgery or angioplasty (1999/00 to 2001/02)	41.5	44.0

Although deaths from heart disease were nearly twice as common in deprived areas, and heart attacks 40% commoner, specialised treatment was offered at very similar rates. This suggests a significant inequality in access to these services in relation to underlying need.

Population Groups

Some groups within the population suffer worse health than the population as a whole and these differences can also be measured. For example young people who have been in local authority care are more likely to misuse drugs, become teenage parents and end up in the criminal justice system. As a consequence they will certainly suffer poorer health than their peers. Other vulnerable groups include lone parents, people with Learning Difficulties, people who have used the mental health services, those with physical disabilities and older people.

Reducing inequalities in health

There has been much work at a national level looking at the kind of interventions that are likely to have the most impact on the socio-economic inequalities we have examined in this section.

Interventions likely to make the major impact on achievement of life expectancy targets are:

- ◆ reducing smoking in manual social groups through extended smoking cessation services
- ◆ prevention and management of other risk factors in primary care (e.g. through early identification and intervention on poor diet, physical inactivity, obesity and hypertension)
- ◆ environmental improvements to improve housing quality, tackle cold and dampness and increase safety at home
- ◆ targeting over-50s where the greatest short-term impact on life expectancy will be made – especially in regard to the major killers – cancer and heart disease

Interventions likely to make the major impact on the infant mortality targets are:

- ◆ building on Sure-Start to improve early years support in disadvantaged areas
- ◆ reducing smoking in pregnancy
- ◆ reducing teenage pregnancy and tackling its causes and effects
- ◆ improvements in housing conditions for children in disadvantaged areas
- ◆ other forms of early intervention for NHS for example to increase immunisation rates and breastfeeding, improve diet, family support and education about infant sleeping position

To deliver work across these areas we need to work closely with a range of partner agencies, both within the statutory sector and outside, to develop a cross cutting Inequalities Action Plan.

4b Improving health through regeneration

KEY POINTS

- ◆ regenerating deprived areas is a major plank of any attempt to reduce health inequalities
- ◆ Weston-super-Mare South Ward, Pill village and central Weston-super-Mare have all received grants from the Government's Single Regeneration Budget (SRB)
- ◆ two of the SRB schemes are now completed but there is ongoing work in these areas including the Healthy Living Project in South Ward and the Community Resource Centre in Pill
- ◆ the SRB scheme for central Weston-super-Mare continues until March 2006 and a rapid appraisal in January 2003 identified 35 ways that health could be improved. These include tackling drug and alcohol misuse, addressing crime and the fear of crime, reducing poverty, expanding health services for disadvantaged groups and providing more places to go and things to do

RECOMMENDATIONS

- ◆ that we continue to support the Weston Regeneration Partnership to bring real improvements to people living in the most deprived areas of North Somerset

Introduction

We have shown in the previous section how people living in deprived areas have worse health. One way of tackling deprivation is through multi-agency work to regenerate a local area. The government has supported this work through a Single Regeneration Budget (SRB), targeted at providing resources for geographical areas with measurably high levels of social and material deprivation. The Weston Regeneration Partnership was successful in obtaining funds from round 3 of the budget allocation for work in Weston-super-Mare South (1996–2002), and from round 6 for work in central Weston-super-Mare (2000–2006). The Pill Regeneration Partnership gained funding from round 5 for work in Pill Village (1999–2002).

SRB3 in Weston-super-Mare South

The regeneration scheme for Weston-super-Mare South ward received £2.173 million SRB grant over the 5 years ending in July 2002 and attracted a further £18 million in match funding. During the life of the scheme 36 projects were funded built around three key themes:

- ◆ employment, education and training
- ◆ quality of life, community and environment
- ◆ reducing crime and fear of crime

As the SRB scheme ended the need for continued sustained effort and support for the area was recognised. The PCT has been an active partner in supporting the work of the Healthy Living Project, based on the Bournville estate. Through major efforts by many local people with support from the Church and the statutory agencies, funding has been secured to build a healthy living centre in the area and a Healthy Living Company has been established to oversee the building and running of the centre.

SRB5 in Pill

The North Somerset village of Pill is four miles from the city of Bristol and is part of the prosperous parish of Easton-in-Gordano. However, a small area in the village was identified as having specific problems, with a high number of young lone parents (16 – 24 years), a low uptake of further education and a high number of young unemployed people when compared to the North Somerset average. Research and consultation with the residents highlighted two main issues for the Pill community:

- ◆ social exclusion of the community, particularly young people
- ◆ fragmented availability of information due to the absence of a central information point

When the scheme ended in 2002, a Pill Resource Centre was up and running, there was an additional Community Beat Officer in post, 2 Residents and Tenants associations had been established, 2 new Neighbourhood Watch areas created and a ten year Community Action Plan agreed. In the year 2000 the Resource Centre received the “Investors in Community Award” for a successful legal surgery.

The work is now being carried forward by the Pill Community Foundation, which is almost exclusively made up of local people.

SRB6 in Central Weston-super-Mare

The SRB6 area includes Weston-super-Mare (WsM) town centre, seafront and the residential areas immediately to the north

and south of the town centre and is home to almost 9,500 people. A breakdown of the population shows there are fewer dependent children, slightly more young adults and more people over 65 years than the North Somerset average.

The area covers most of the 2nd and part of the 3rd most deprived electoral wards in North Somerset. One of the wards (WsM Ellenborough) is in the 10% most deprived wards in England.

Health in the area is poor when compared to North Somerset as a whole with higher early death rates from cancer, coronary heart disease and accidents. A high percentage of the population claim incapacity benefit, severe disablement allowance, attendance allowance, and disability living allowance when compared to North Somerset as a whole, as shown in Table 4.2.

The area has attracted £2.36 million of SRB grant against planned match funding of £9.2 million. The scheme is spread over 6 years and is due to end in March 2006.

A Healthy Living Task group has been established as part of the programme, and has, so far, supported two projects. The Health Matters project is managed by the Citizen’s Advice Bureau and provides money and welfare advice sessions in a range of community locations. The Carlton Centre provides vocational rehabilitation for people with mental health conditions and alcohol and drug service users.

In January 2003 a rapid appraisal of the health needs of people living in Central

Table 4.2 Percentage of benefit claimants in WsM Ellenborough ward and North Somerset

Benefit	% of population receiving benefit WSM Ellenborough	% of population receiving benefit North Somerset
Incapacity benefit	10.98%	3.06%
Severe disablement allowance	2.41%	0.59%
Attendance allowance	8.02%	2.67%
Disability living allowance	7.24%	2.59%

Source: Avon Information Management and Technology Consortium based on data from Neighbourhood Statistics government website and Exeter systems for populations.

Weston-super-Mare identified 35 ways in which their health could be improved (Myaya, 2003). The ideas are based on suggestions given by professionals working in the area and by local people themselves. The key issues raised include tackling alcohol and drug problems, addressing crime and the fear of crime, reducing poverty, expanding primary health care services and providing more places to go and things to do at a price everyone can afford. The review shows that people do not think about health just in terms of not being ill but have a much broader view. It seems that to most people health is about quality of life and a sense of physical and mental well-being.

The way forward

The Healthy Living Task Group will work with partners in the Council, Primary Care Trust and the voluntary sector to see how some of the recommendations from the rapid appraisal can be implemented and the quality of life in the area improved.

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5. Sexual Health

5a Sexually Transmitted Infections

KEY POINTS

- ◆ Weston-super-Mare has the characteristics of a community likely to have high rates of sexually transmitted infections
- ◆ gonorrhoea is on the increase. Chlamydia rates are also increasing. This may be due to better detection, as only a minority of actual cases are found and treated
- ◆ there is a hepatitis B outbreak in Bristol, which does not seem to be spreading to North Somerset

RECOMMENDATIONS

- ◆ we must put in place robust structures and processes to enable the PCT and its providers to work together to improve sexual health services for the population of North Somerset
- ◆ North Somerset should join the national programme of screening for detection and treatment of Chlamydia as soon as practicable
- ◆ we must keep a close eye on the spread of hepatitis in North Somerset, and be prepared to move to a targeted programme of immunisation if the outbreak is confirmed to be spreading

Introduction

People in North Somerset should be able to enjoy sexual activity of their choice without mental or physical harm, or to abstain without stigma, and be able to access a range of advice and services from prevention to treatment.

Sexually transmitted infections (STIs) can have a long lasting impact on people's lives. Genital wart infection is associated with cervical cancer, Chlamydia, if untreated, can result in pelvic inflammatory disease, and consequently,

ectopic pregnancy and infertility and some such as HIV, can be life threatening.

Weston-super-Mare, in particular, has the characteristics of a high-risk community for STIs. The population is increased substantially in the summer months by an influx of visitors, including commercial sex workers. An active club scene throughout the year attracts young people from surrounding areas. Increasing alcohol and intravenous drug use adds to the likelihood of individuals engaging in risky sexual activity.

Information about the numbers of people with STIs comes from specialist services at the BRI or at Weston Hospital, or from laboratory reports from specimens sent by other organizations providing sexual health services including GPs, hospitals, and clinics. As much of this information is anonymous, it cannot be applied directly at PCT level.

We do not have information on people who have an infection but have not contacted any health services. This is especially a problem in infections that do not usually cause symptoms. Despite the problems, we can derive a useful estimate of the number of new and existing conditions in the community, and of the number of people accessing sexual health services.

Chlamydia and Gonorrhoea

Chlamydia is a bacterial infection and the most common STI in England and Wales. Highest rates are among 16–19 year old females and 20–24 year old males, and recent studies have estimated that between 9.8 and 11.2% of women are infected although most will have no symptoms. It is estimated that diagnosis at GUM clinics represents only 10% of cases. Chlamydia can lead to pelvic inflammatory disease which can lead to chronic pelvic pain, infertility and ectopic pregnancy.

Gonorrhoea is the second most common bacterial infection, again highest among the same age groups, but tends to be concentrated in certain groups such as men who have sex with men and some black & ethnic minorities.

The national and regional rise in Chlamydia and gonorrhoea is reflected in significant increases locally although there was a reduction in both in 2000–2001 (see Figure 5.1).

The rise in gonorrhoea is thought to be reflective of changes in sexual behaviour, particularly in young people and men who have sex with men. It is thought that a

reduction in risky behaviour in response to the epidemic in 1985–1988 has not been sustained. The rise in chlamydia may be due to increased awareness of the disease leading to more people getting tested.

Laboratory results indicate a higher rate of both infections in Avon compared to the rest of the south west region. This maybe due to a larger number of people being tested rather than a higher prevalence in the community, although further work is underway to get a more accurate picture directly relevant to North Somerset.

Hepatitis B

Hepatitis B is a viral infection, transmitted through sexual intercourse or by infected blood. Every year, there are about 20 cases in Avon. However in 2001, there was a rapid increase in the number of new infections resulting in an outbreak in 2002 which was still present in mid 2003. Although the outbreak is focused in the Bristol area, it could spread to North Somerset, and the local picture is under close surveillance (see Table 5.1). We may need to actively encourage targeted immunisation in high risk groups if the numbers in future suggest a sustained rise in cases.

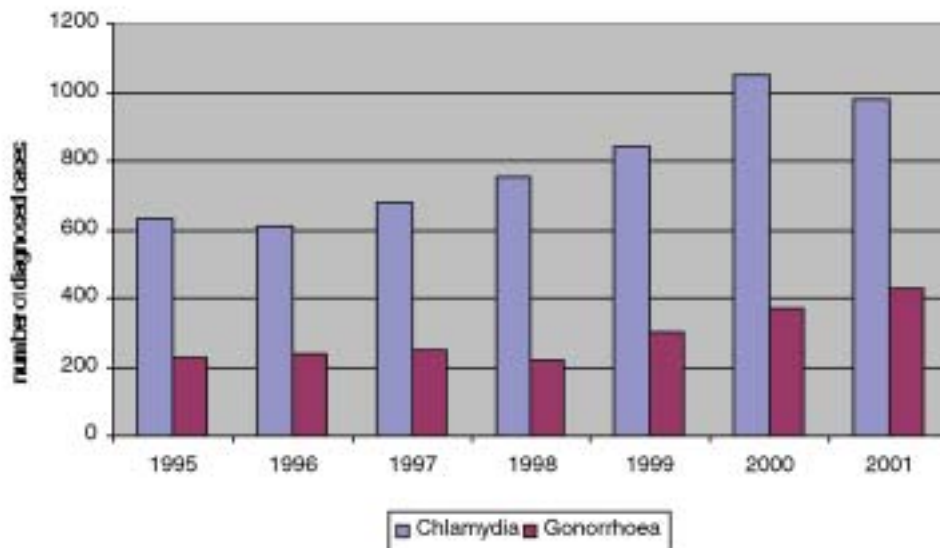


Figure 5.1 Total number of diagnosed chlamydia and gonorrhoea (Bristol Royal Infirmary & Weston)

Source: KC60 data.

Note: Includes complicated & uncomplicated infections diagnosed at the Bristol Royal Infirmary and Weston General

Table 5.1 Number of Hepatitis B cases in North Somerset

Year	Number of cases
1998	3
1999	5
2000	3
2001	3
2002	6

HIV

HIV is the virus that leads to AIDS. There are approximately 20 newly diagnosed cases of HIV every year in the Avon area. The number of newly diagnosed cases has remained approximately the same over the past five years. The number of people living with HIV has increased due to improved treatments and more people with the virus moving into the area (Table 5.2).

Table 5.2 Number of newly diagnosed HIV infections in Avon

Sex	1996	1997	1998	1999	2000	2001
Male	26	17	19	23	13	21
Female	2	9	4	4	7	7
Total	28	26	23	27	20	28

Source: SOPHID

Syphilis

Syphilis is caused by the bacterium *Treponema pallidum* and is a relatively uncommon disease. However the rate of diagnosed infections has been increasing nationally. This is partly because of several outbreaks in high risk groups, one of which occurred in Bristol in 1997. This was associated with heterosexually acquired infection, commercial sex work and 'crack' cocaine use (see Figure 5.2).

The Way Forward

A North Somerset Sexual Health Partnership has been set up to deliver the local Sexual Health Strategy which will involve developing all aspects of sexual health services, including reducing STIs, from improved data collection, better prevention to good quality treatment and care.

A national chlamydia screening programme is being developed and we will participate in this as soon as practicable.

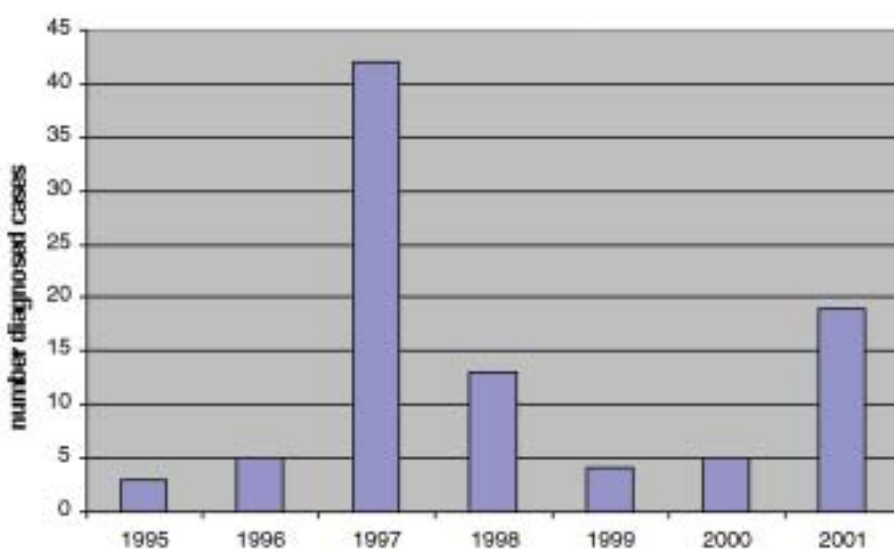


Figure 5.2 Numbers of new cases of syphilis (Bristol Royal Infirmary & Weston)

Source: KC60 data.

Note: Includes early latent syphilis and primary and secondary infectious syphilis infections diagnosed at the Bristol Royal Infirmary and Weston General.

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Milne Clinic; Bristol; Provision of sexual health services in North Somerset: 2003

5b Teenage Pregnancy

KEY POINTS

- ◆ the UK has the highest rate of teenage pregnancy in Western Europe – three times those in France and six times those in the Netherlands
- ◆ the North Somerset teenage pregnancy rate for 2001 was 43.2 conceptions per 1000 girls aged 15–17 years, which is 0.9% higher than the national average for England. This is a disappointing increase, as we were lower than the national rate in previous years
- ◆ parts of Weston-super-Mare have particularly high rates of teenage pregnancy

RECOMMENDATIONS

- ◆ continued support for the long term multi-agency strategy currently in place in North Somerset
- ◆ we must continue to ensure that schools, colleges, parents, health professionals, community groups, work together to educate young people about relationships, sex and the risks of teenage pregnancy and sexually transmitted infections, and improve access to contraceptive services for young people

The two main aims highlighted in the report are:

1. reduce under 18 conceptions by 50% by 2010
2. get more teenage parents into education, training or employment, to reduce their risk of long term social exclusion

Local authorities were required to produce a ten year Teenage Pregnancy Strategy to address these aims. North Somerset's Teenage Pregnancy Strategy was produced in 2001. It is monitored and reviewed by a multi agency partnership board which includes members from education, social services, health, youth and community service, Connexions, Weston College, housing, voluntary and community groups.

Introduction

The United Kingdom had the highest rate of live births to teenage women in the European Union – in 1995 it was over twice the EU average (see Figure 5.3). The UK conception rate fell from a peak in 1996 when there was a dramatic rise in conceptions in all ages, probably as the result of the 1995 pill scare.

Teenage Pregnancy Strategy

In June 1999, the Social Exclusion Unit report on Teenage Pregnancy set a target of halving the rate of conception amongst under 18 year olds in England by 2010.

Teenage pregnancy rates in North Somerset

While teenage pregnancy rates in North Somerset were relatively low compared with England and Wales, they are very high in some local 'hot-spots', which tend to be in the Weston-super-Mare area. Social and environmental conditions such as high levels of unemployment, low educational achievement and poor housing are strongly associated with high teenage pregnancy rates, so these need to be tackled alongside provision of accessible services.

In North Somerset our current conception rate is 43.2 per 1000 girls aged 15–17 (ONS Data 2001) this equates to 141 conceptions. This is a dramatic increase on the previous years' figures as the bar chart demonstrates below (Figure 5.4).

We are disappointed with these figures, as rates in previous years were significantly lower than those for England and Wales, and low in comparison to Bristol. Nevertheless, we are optimistic that the initiatives that have been implemented since the North Somerset Teenage Pregnancy Strategy was launched in 2001 will have a positive impact on future years' figures.

Key components of our strategy are:

◆ a comprehensive media and communications strategy for North Somerset

- ◆ a comprehensive review and programme of training and support for sex and relationships education
- ◆ service developments in primary care, young people's clinics, emergency contraception and special targeting of services to priority groups
- ◆ support for teenage parents covering education, child care, housing and advice

- ◆ a comprehensive review and programme of training and support for sex and relationships education
- ◆ service developments in primary care, young people's clinics, emergency contraception and special targeting of services to priority groups
- ◆ support for teenage parents covering education, child care, housing and advice

The Way Forward

We have set out our strategic vision and plans for the North Somerset Teenage Pregnancy Strategy. These are reviewed and updated each year in our annual report, which can be downloaded from www.northsomerset.nhs.uk/teenadvice

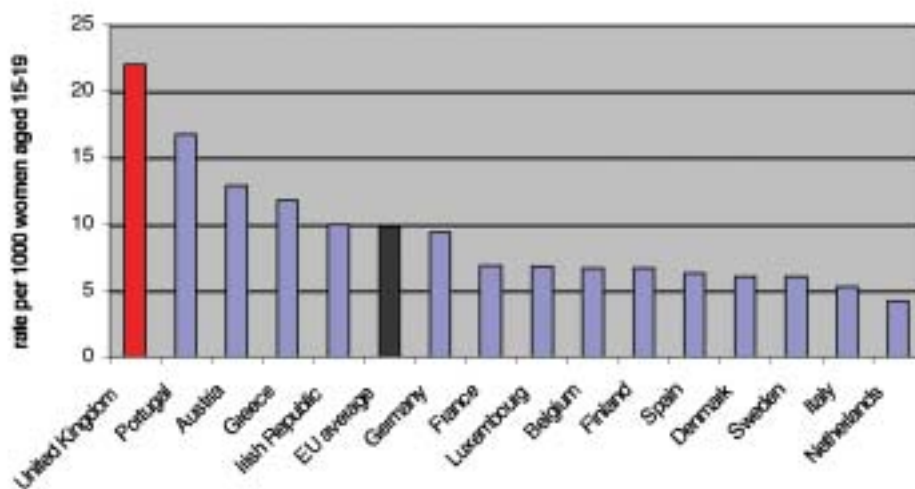


Figure 5.3 Live births to teenage women: European Union comparison (1995)

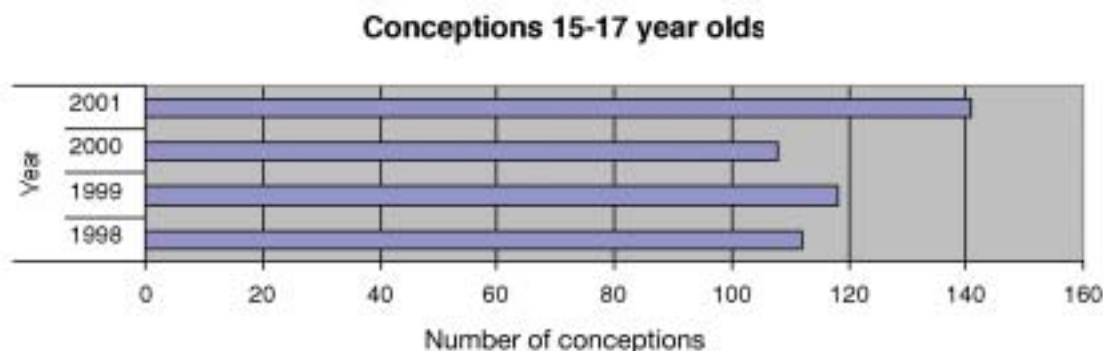


Figure 5.4

6. Other health issues

6a Smoking and Health

KEY POINTS

- ◆ Support to Stop, the smoking cessation service for people who want to stop smoking, has reached over a thousand people in North Somerset over the last year. Of these, 577 stopped smoking for at least four weeks. A survey of people who quit a year ago showed 25% of them remained off cigarettes for one year
- ◆ smoking cessation services reach more people in deprived areas, where smoking is more common, and, in North Somerset, the percentage of people who succeeded in quitting in the deprived areas was similar to that in the more affluent areas
- ◆ young people made limited use of the smoking cessation services
- ◆ there were very high rates of smoking among pregnant teenagers, far higher than Health Survey for England estimate and this was persistent across all social groups

RECOMMENDATIONS

- ◆ there is a pressing need nationally to develop effective interventions targeted at young people; both in terms of smoking cessation services in general and very specifically, to help them to quit during and after pregnancy
- ◆ in North Somerset smoking cessation and tobacco control work should be continued and expanded to contribute to a decrease in the detrimental effect of smoking on our population, particularly targeting pregnant women, young people and those living in areas of deprivation

Second hand smoke may lead to ill health in children and others who are exposed, (Ferrence & Ashley 2000) while smoking during pregnancy has been associated with low birth weight, and other complications for both mother and baby (Conter et al. 1995; Owen, McNeill, & Callum 1998). Effects start before birth, resulting in increased perinatal mortality and morbidity and the sudden infant death syndrome. There is also evidence of health problems later in life for people born to mothers who smoked during pregnancy (Montgomery & Ekobom 2002; Rantakallio, Laara, & Koironen 1995).

According to the General Household Survey (2001), an average of 27% of the adult population smoke and 10% of young people aged 11–15. Smoking rates vary according to age. Smoking prevalence is highest in the 20–24 age group for both men and women (40% and 35% respectively). There is a strong link between cigarette smoking and socio-economic group. In 2001 33% of men and 30% of women in manual occupations smoked compared to 22% of men and 20% of women in non-manual occupations.

Introduction

Smoking is recognised as the major threat to the long term health of the public and the single biggest preventable cause of illness and death. It is the leading cause of cancer, heart and lung disease in adults.

In this section we look at local information about smoking using data collected from 1998 to 2001 by maternity services in Avon, data collected from October 1999 to June 2002 for the smoking cessation services in the Avon area and up to March 2003 for services in North Somerset.

Smoking Cessation

The Support to Stop smoking cessation service provides support for people who wish to stop smoking, including prescriptions for nicotine replacement therapy (NRT) or smoking cessation drugs (Zyban) where appropriate from GPs. Participants set "quit dates" and are supported to achieve their desire to stop smoking. Four weeks after their quit date, they are asked if they have smoked during that period.

Older people were more likely to participate in Support to Stop, despite the higher proportion of smokers in younger age groups. Men were less likely to participate than women, again despite higher overall rates of smoking amongst men.

While more people in deprived areas participate and succeed in quitting at the four week stage, people living in these areas generally find quitting more difficult. The percentage that succeed in quitting is generally lower in deprived areas. However, this is not the case in North Somerset, where the intensive

support provided in the more deprived areas has resulted in quit rates which are similar to elsewhere. Figure 6.1 shows rates of participation and success rates across Avon, by deprivation group.

In North Somerset, in 2002/3, 1128 smokers set a quit date, and 577 remained stopped at four weeks.

Of course, stopping at four weeks is only a small step in remaining off cigarettes permanently. We have made significant efforts to contact people who went through the Support to Stop programme one year later, and between Oct and Dec 2001 255 people attempted to stop smoking, 142 people quit smoking for 4 weeks and 63 of these remained quit for one year which is 25% of the number who made a quit attempt.

Smoking and Pregnancy

Women are advised by health professionals of the risks of smoking during pregnancy. Their smoking status and their level of smoking, if any, are recorded on the pregnancy record at the time of booking.

29.1% of women in North Somerset who become pregnant smoke prior to their pregnancy, and 74% of these women continue to smoke during pregnancy.

When analysed by the deprivation score of where smokers lived, smoking was highest

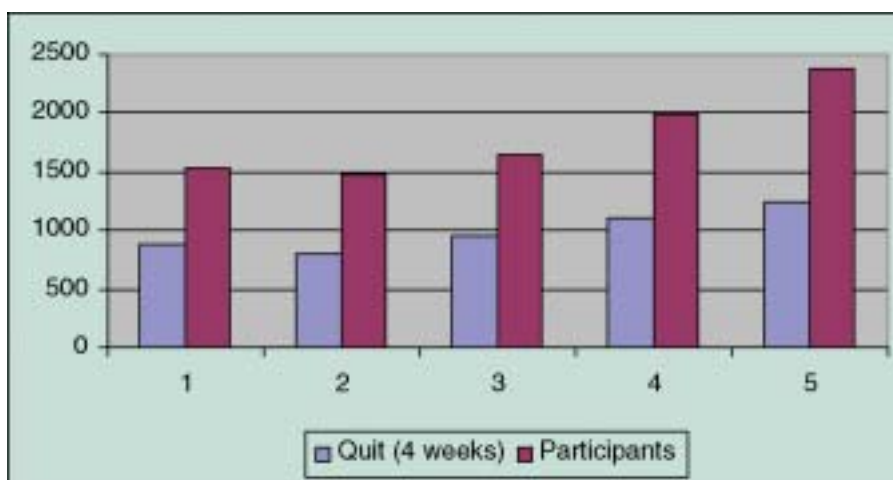


Figure 6.1 Support to Stop participants and quitters at four weeks by deprivation area (where 1 is the most affluent area and 5 is the most deprived area)

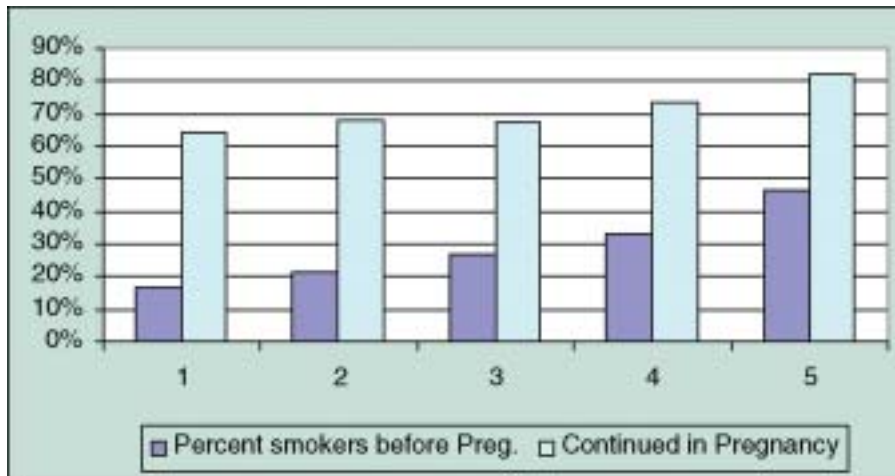


Figure 6.2 Smoking before and during pregnancy by deprivation area (where 1 is the most affluent area and 5 is the most deprived area)

among women from the most deprived areas. Figure 6.2 shows that both pre-pregnancy smoking rates and those for continued smoking increased as the area became more deprived. Pre pregnancy rates among women in the most deprived areas (46.6%) were close to three times those in the most affluent areas (16.5%).

Younger women who become pregnant are 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 over 30s. Overall, over three quarters of teenagers who smoked at the start of pregnancy continued to do so while pregnant. This figure was lower in the least disadvantaged area at 64% and highest in the most deprived area at 82%.

Any attempt to tackle smoking in pregnancy will need to make special efforts to tackle teenage mothers, with a real focus on the more deprived areas of North Somerset.

Recommendations for Action

- ◆ the poor take up of Support to Stop among young people is a cause for concern that should be addressed by the programme
- ◆ Support to Stop has achieved impressive quit rates across the board, but new strategies to recruit smokers to the service and more intensive support will be needed in neighbourhoods with high levels of deprivation

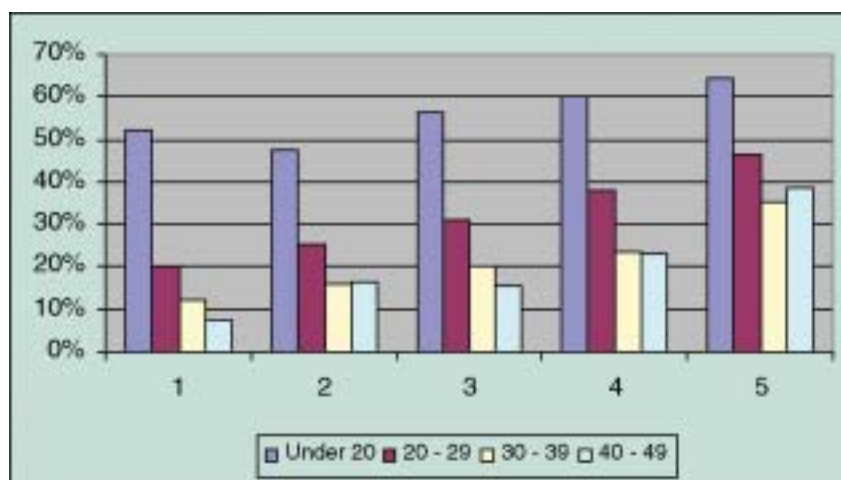


Figure 6.3 Smoking Rates prior to pregnancy by age group and deprivation area (where 1 is the most affluent area and 5 is the most deprived area)

- ◆ ways of helping pregnant teenagers to stop smoking need to be considered
- ◆ tobacco control work needs to be increased in order to help all people in North Somerset to see no smoking as the norm. This should include work to promote smoking policies in the work place and smoke free public places and homes

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6b Falls in Older People in North Somerset

KEY POINTS

- ◆ falls are the major cause of death from accidents in older people in North Somerset
- ◆ three-quarters of older people who end up in hospital after a fall are women and almost half are over 85 years
- ◆ reducing falls would improve both the quality and quantity of life for older people

RECOMMENDATIONS

- ◆ that we reduce the number of older people who fall through improving prevention and providing an integrated service for those who do fall

Introduction

Falls are an important cause of disability and the main cause of death from accidents in older people (see Figure 6.4). Between 1998 and 2000, 18 people in North Somerset aged over 65 died as the result of a fall.

In 2001/02 in North Somerset, there were 551 discharges from hospital in people over 65 who had a fall. The majority (75%) were women, almost half of whom were over the age of 85. 85% were in hospital for more than three days, although other factors not related to the fall may be responsible for a long stay in hospital.

The rate of falls increases with age, and is higher in women than in men (see Figure 6.5).

These figures do not represent the full picture as not everyone who falls ends up being admitted to hospital. A survey of care homes in North Somerset in 2002 collated information from 61 homes. This showed that 965 falls had been recorded

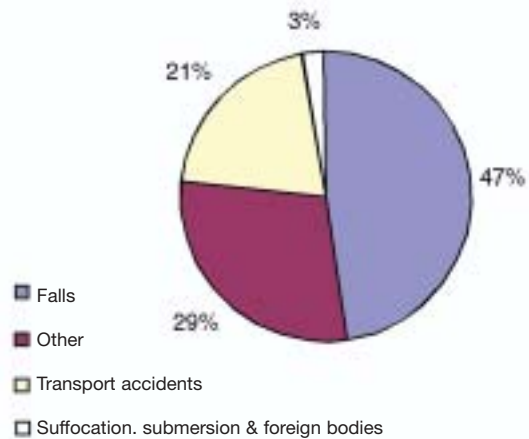


Figure 6.4 Deaths from accidents in the over 65s in North Somerset (1998–2000)

Source: ONS

in a six months period, 90 of the fallers were seen by a GP, 26 were admitted to hospital and three deaths were recorded that were judged to be indirectly caused by the fall.

The consequences of falling

The seriousness of the injuries that result from falls in the over 65s and the contributing factors are reflected in the main diagnosis of those hospitalized with falls (see Table 6.1). As well as the physical consequences, falls also impact on the psychological well-being of older people, and can lead to a loss of confidence, social isolation and depression.

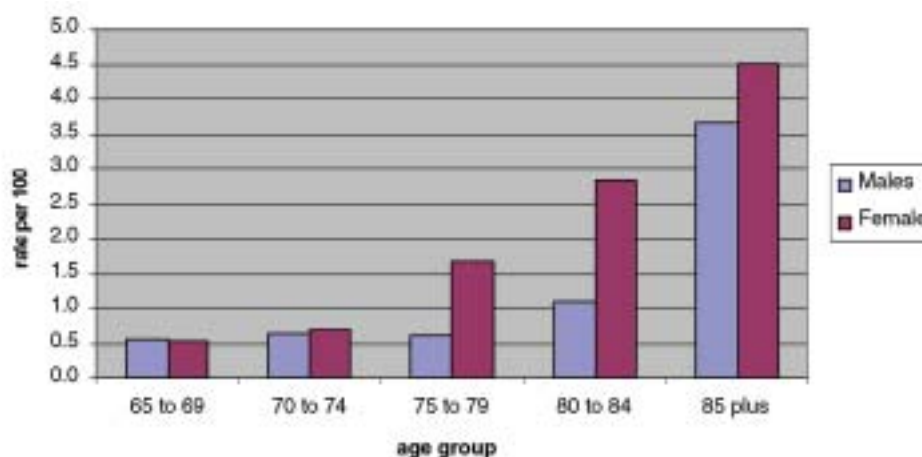


Figure 6.5 Discharges from hospital with a diagnosis of falls in North Somerset (2001/02)

Source: IM&T Consortium. Based on resident PCT population.

Table 6.1 Main diagnosis of those discharged from hospital with a falls diagnosis aged over 65 (2001/02).

Main Diagnosis	Number	% of total
Fracture of neck of femur	111	20.1
Pertrochanteric fracture	88	16.0
Senility	32	5.8
Unspecified injury of head	20	3.6
Fracture of pubis	19	3.4
Fracture of lower end of radius	17	3.1
Fractures of other parts of lower leg	13	2.4
Fracture of upper end of humerus	10	1.8
Urinary tract infection, site not specified	9	1.6
Fracture of shaft of femur	8	1.5
Total Top 10	327	59.3

Source: IM&T Consortium. Based on resident PCT population.

The causes of falls

The majority of falls result from multiple contributing and interrelating factors, which include:

- ◆ side effects of medication
- ◆ remedial physical and mental conditions, in particular depression
- ◆ cognitive impairment
- ◆ history of arthritis
- ◆ Parkinson’s Disease
- ◆ stroke in women

- ◆ fall in the previous 2 years
- ◆ episode of serious illness

The Way Forward

There is a multi-agency Falls Task Group in North Somerset which is mapping and coordinating the work on falls. They have found that:

- ◆ services are patchy and partly depend on where the faller lives
- ◆ falls assessment is duplicated with different agencies visiting the same individual
- ◆ there is no agreed system in place for referral of potential fallers

Actions which are likely to be helpful in preventing injury from falls include:

- ◆ gentle exercise
- ◆ home assessment and surveillance
- ◆ multi-faceted intervention – including tackling low blood pressure (which can make people dizzy on standing up), number of medications, balance, walking and specific risk areas, such as moving from, say, bed to chair
- ◆ encouraging the use of hip protectors in high risk populations
- ◆ treatment of osteoporosis
- ◆ calcium and vitamin D supplements

A Full Action Plan is currently being developed.

References

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<http://www.doh.gov.uk/nsf/olderpeoplemain.doc.htm>

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<http://193.32.28.83/public/summary1.htm>

Prevention and reduction of accidental injury in children and older people – An Evidence Briefing Note from the Health Development Agency

6c Diabetes

KEY POINTS

- ◆ Diabetes is a common condition that may affect children and adults; the number of people with diabetes is increasing
- ◆ the Diabetes National Service Framework has set standards for high quality diabetic care. The PCT has put in place a Network of people who are finding ways to meet the standards locally

RECOMMENDATIONS

- ◆ develop the Implementation Plan for North Somerset to deliver Diabetes NSF Standards for primary and secondary care

Introduction

Diabetes is a common disease in which raised blood sugar levels lead to a diverse range of problems. It can have a considerable effect on the physical, psychological and material well-being of individuals and their families and can lead to complications such as heart disease, stroke, renal failure, amputation and blindness.

Socially disadvantaged groups in affluent societies and people from black and minority ethnic communities are particularly vulnerable.

Type 1 diabetes develops mostly in children, young people and young adults. It is less common than Type 2 diabetes and is more immediately evident. Type 2 diabetes is most commonly diagnosed in adults over the age of 40; the symptoms appear more gradually and may not be diagnosed for some years.

Diabetes in North Somerset

Diabetes is becoming more common (see Figure 6.6). There are several possible reasons for this including ageing population, migration, better diagnosis or

recording of information, a real increase. More information on diabetes is contained in the Spotlight on Diabetes (<http://www.avon.nhs.uk/phnet/publications.htm#Diabetes>)

There is evidence to show that

- ◆ onset of type 2 diabetes can be delayed or even prevented
- ◆ effective management of the condition increases life expectancy and reduces risk of complications
- ◆ self management is the cornerstone of effective diabetes care

There are estimated to be between 5,000 and 6,000 people with diabetes in North Somerset. Detailed work with a small number of local practices has suggested that 6,000 is closer to the real number. There are also likely to be small areas where the incidence is even higher. A practice, in a deprived area made a concerted effort to detect as many diabetics as possible, and found an incidence of 4% for the practice population.

The number of new cases of diabetes diagnosed each year is around 350.

The Diabetes National Service Framework sets out 12 standards for prevention, diagnosis, initial care and continuing care of people with diabetes, their families and carers. These cover the health complications arising from diabetes, major life events, major treatment changes, pregnancy, hospital admission and residential care.

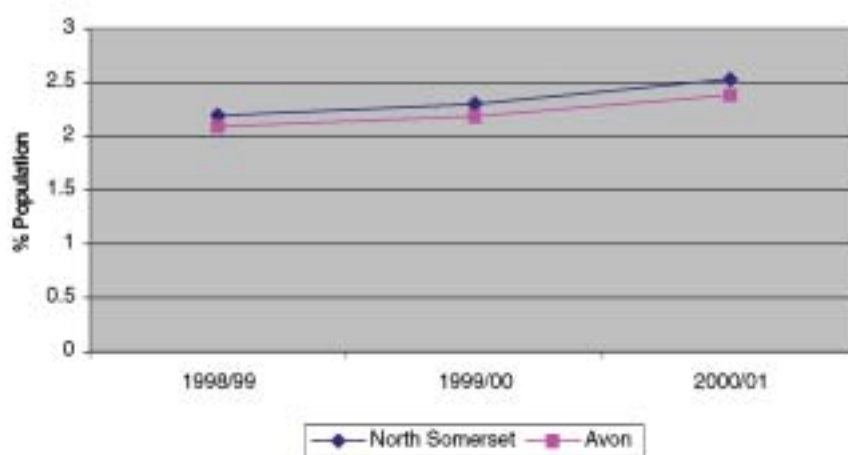


Figure 6.6 Proportion of diabetics in North Somerset PCT

Source: Chronic Disease Management Scheme. Note – % relate to those practices that returned the data.

Recommendations for Action

The North Somerset Diabetes Network has been established by the PCT to lead and support progress towards meeting the NSF standards, building on the excellent work done in the south of the district by the former Weston Local Diabetes Service Advisory Group. The Diabetes Network is made up of people with diabetes and carers of people with diabetes. The team is developing an Implementation Plan to deliver the NSF standards in the area. This will include progress to:

- ◆ develop ways of raising awareness of the condition, preventing onset as far as possible and encouraging earlier detection giving priority to the communities most at risk
- ◆ encourage self management of the condition by people with diabetes supported by primary care professionals and specialist diabetes teams
- ◆ deliver better quality care provided by specialist diabetes teams and during admission to hospital and in pregnancy

6d Young People's Health – results of a local survey

KEY POINTS

- ◆ a survey was carried out of health related behaviour of children aged 12–15
- ◆ children in this area are more likely than children elsewhere in the country to have a paid job during term time, drink "alco-pops", or to be worried about their looks. They are less likely to go for walks, or to know about local young people's contraception and advice services

A survey of the health related behaviour of young people was undertaken in North Somerset in 2002/3. A total of 2300 pupils from 9 secondary schools took part by completing anonymous questionnaires. The results were analysed by the Schools Health Education Unit in Exeter.

2300 young people were involved in the survey

Age	12–13	14–15	Total
Boys	668	481	1149
Girls	655	496	1151
Total	1323	977	2300

The Schools Health Education Unit has been surveying young people in this age range for a number of years and has compiled a database of responses from almost 19,000 pupils from all over England. The next section describes some of the significant differences between the answers of the North Somerset pupils who completed the questionnaire, compared with the national sample.

All comparisons are with the wider national sample.

Home & Family

49% of pupils live in a home with four or more bedrooms compared with 44% nationally

Money & Work

A greater proportion of pupils had a regular paid job outside school during term time. 37% in North Somerset compared with 30% nationally

Hygiene, Medication & Dental

A greater proportion of pupils felt at ease on their last visit to the doctor. 45% in North Somerset compared with 36% nationally

Drugs, Alcohol & Tobacco

15% of the North Somerset pupils drank 'alco-pops' compared with 6% nationally

Sex & Relationships

67% of the North Somerset pupils didn't know if there was a special contraception and advice service for young people available locally, compared with 59% nationally

Healthy Eating

Fewer North Somerset pupils said they had a cafeteria lunch, 23% compared with 29% and a greater proportion ate a packed lunch, 55% compared with 44% nationally

Safety

A greater proportion of pupils rated the safety of their area as 'very good' during the day, 54% compared with 49% nationally

Emotional Health & Wellbeing

36% of the North Somerset sample said they worried about their looks compared with 30% nationally

Physical Activity

Fewer pupils reported going for walks in the North Somerset sample, 19% compared with 30%

7. Communicable diseases

7a Immunisation in North Somerset

KEY POINTS

- ◆ immunisation rates are generally high in North Somerset
- ◆ there has been a drop in uptake of MMR vaccination, associated with national publicity. However, detailed reviews have shown no evidence of a link between MMR and autism or bowel disorder
- ◆ a recent fall in uptake of several vaccines needs to be closely monitored

RECOMMENDATIONS

- ◆ we need to actively encourage the uptake of vaccination, and support parents who are anxious

Uptake of booster immunisations

However, we have recently noticed that the uptake of pre-school boosters for most vaccinations have also dropped – with the exception of meningococcal C vaccine. (See Figure 7.2).

Immunisation rates

Immunisation rates in North Somerset PCT for children before the age of 2 are high, with uptake rates of over 97% for most vaccines. The exception to this is Measles, Mumps and Rubella vaccine (MMR), the uptake of which is significantly lower than the other vaccines and has fallen further recently (see Figure 7.1).

MMR vaccination

There has been no link proven between the MMR vaccine and autism or bowel disease, although this has been suggested by a very small number of researchers. There has been much work looking again at all the evidence for the safety of the vaccine, and this has consistently shown the absence of any relationship. However,

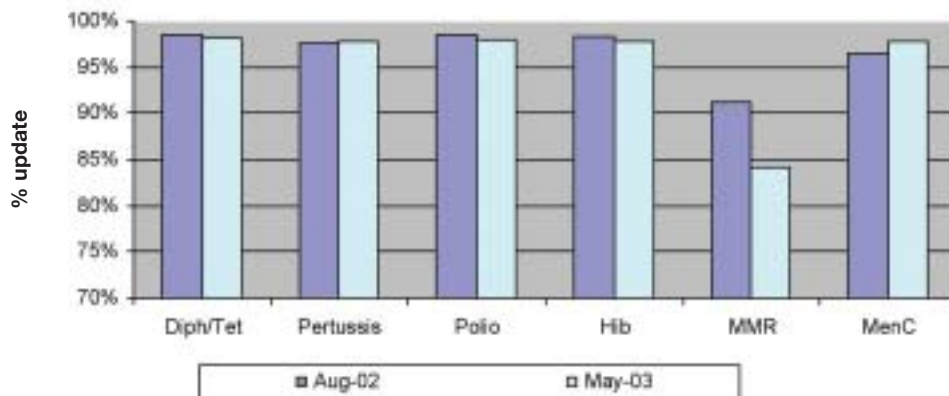


Figure 7.1 Immunisation Uptake before 2nd Birthday in North Somerset, August 2002 – May 2003

Source: Child Health Surveillance
 DTP = diphtheria, tetanus, pertussis
 MMR = measles, mumps and rubella

there has been considerable parental anxiety leading to disturbing fall in MMR rates.

In North Somerset, uptake rates for the MMR1 in children aged two years was 91% in 2001/02 and fell to around 84% by spring 2003 – the same as the national rate. However the uptake rate for the second MMR vaccine (MMR2) given just before school was 85% of children vaccinated in 2001/2, dropping to 82% by May 2003. This remains higher than the national rate – which was 74% in 2001/02.

In order to prevent outbreaks of a disease, the levels of immunisation in the community need to be high, and there is concern that the low levels of vaccination against MMR could allow outbreaks of these conditions to occur again. Although generally mild, they can have serious complications, leading to disability and death. Rubella is a particular risk for pregnant women, particularly early in pregnancy when it can lead to the birth of a disabled child.

The fall in the rate of children receiving their booster vaccines pre-school may possibly reflect a general spread of concern about MMR vaccination to other vaccines and we need to monitor this situation closely.

The fact that the fall in MMR vaccination rates is smaller in North Somerset than elsewhere is a credit to the sensible approach of local parents and the hard work of our primary care and community staff.

References & Further Information

MMR The Facts:

<http://www.mmrthefacts.nhs.uk/>

Public Health Laboratory Service

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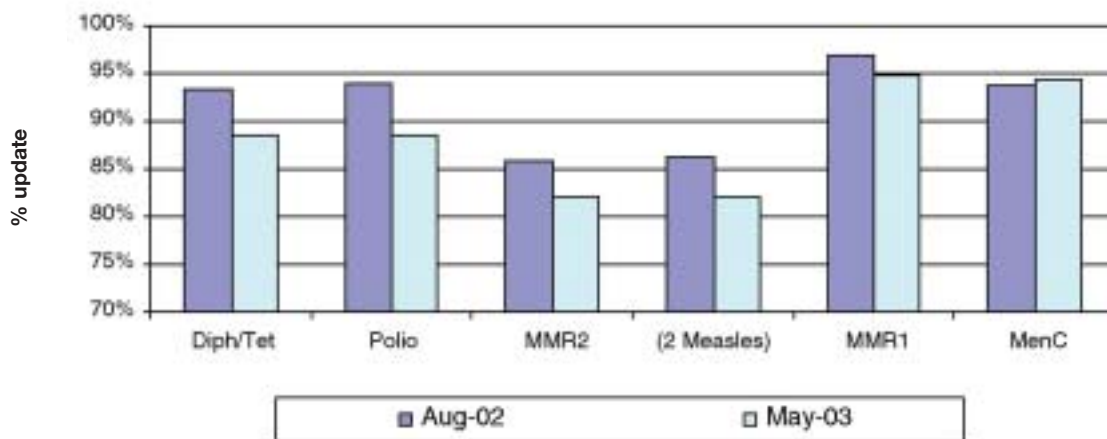


Figure 7.2 Immunisation Uptake before 5th Birthday in North Somerset, August 2002 – May 2003

Source: Child Health Surveillance

7b Key Infectious diseases – Tuberculosis and Meningitis

KEY POINTS

- ◆ Tuberculosis is a significant problem in Bristol, but, currently, is at low rates in North Somerset
- ◆ vaccination against meningitis is a powerful tool, but there remains no vaccine against some important strains of meningococcus

Tuberculosis

With the exception of the two world wars, tuberculosis has been declining over the last century in England and Wales. However, since the early 1990s, there has been a small increase in the number of tuberculosis notifications.

In the South West region in 1998–99, a high proportion of cases (32%) occurred in those over 70s. Although most occur in the white ethnic group (73%), rates are highest in the Black African and Indian Sub Continent ethnic groups, and an increasing proportion are born outside the UK. Two thirds of foreign born cases originated from the Indian sub-continent and Somalia, and more than half (57%) have entered the UK since 1990.

Between 1999 and 2001, there was, on average, one death a year from Tuberculosis in North Somerset. There were 3 notifications of TB in North Somerset, an incidence rate significantly

lower than England and Wales and the rest of the South West region. However, in Bristol, rates are far higher, and are similar to the national rate.

Meningitis

Meningitis is the inflammation of the lining of the brain and is caused by several bacteria and viruses. It is a serious cause of illness and death in children, with the highest numbers occurring in the under 5s. Teenagers between the age of 15 and 19 are the second highest risk group.

Meningitis is caused by several bacteria and viruses, and although bacterial infections are less common than viral, they are more serious. Over half the cases of bacterial meningitis are caused by *Neisseria meningitidis*. There are two main types of *Neisseria meningitidis*, type C and type B. In November 1999, a vaccine was introduced which is effective against type C, and recommended for everyone up to

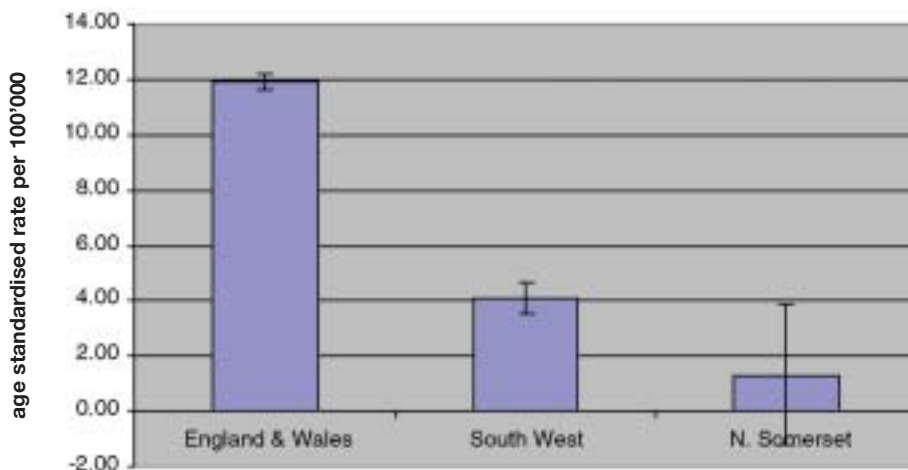


Figure 7.3 Incidence of Tuberculosis (2000)

Source: Compendium of Clinical Indicators, 2001

the age of 18. There is still no vaccine for type B which is currently responsible for the majority of meningococcal infections in the UK.

In 2000, there were 4 notifications of meningococcal meningitis in North Somerset. Because of the small numbers, looking at trends is best across the former Avon area. The number of laboratory confirmed cases of *Neisseria meningitidis* has remained fairly constant, and the rate has been below that of the South West region (see Table 7.1).

References & further information:

Public Health Laboratory Service Communicable Disease Surveillance Centre. Tuberculosis Update September 2001.
http://www.phls.co.uk/topics_az/tb/pdf/newsletter_september_2001.pdf

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<http://www.swpho.org.uk/idreport.htm>

Table 7.1 *Number of laboratory reports of* *Neisseria meningitidis*

Organism	Year	Number		Rate per 100,000	
		Avon	South West	Avon	South West
<i>Neisseria meningitidis</i>	1999	19	164	1.5	3.3
	2000	22	179	1.7	3.5
	2001	15	165	1.1	3.3

8. Concluding remarks

In this report, I have tried to give a brief overview of the health issues facing people in North Somerset. Our population is generally older than elsewhere, and will grow significantly over the next ten years. This growth will be mainly in middle aged people and those aged 65–74. We can expect significant growth in the elderly (over 75) after that.

The main causes of death are cancer and circulatory disease (particularly heart disease). Premature deaths from these diseases are falling and we are implementing national programmes of prevention and treatment to ensure continued improvements. Helping people stop smoking, or to never to take it up, is the single most important thing we can do.

Diabetes is another common and serious illness for which we are now working to a national programme of standards. This should lead to much better care and better health for people with this condition.

Although fewer people die from accidents, they are nevertheless very important causes of potentially avoidable death and disability. We have a series of local actions to address this, but we have highlighted the need to increase our work on preventing road accidents and on helping older people avoid falling.

There is good evidence locally that people's health is worse if they live in

deprived circumstances in poor areas. Much good work has taken place in regenerating some of the most deprived parts of the district, but I have emphasised how tackling such health inequalities needs us all to work together across traditional organisational boundaries, and in partnership with local people.

Sexual health is a particular matter of local concern. There are local areas with very high rates of teenage pregnancy, and we have in place a co-ordinated multi-agency strategy to work towards reducing this. There is evidence of increasing rates of sexually transmitted illnesses, and we are beginning to work together to find ways of tackling this situation.

The recent concern over the measles, mumps and rubella (MMR) vaccine has led to fewer parents having their children vaccinated. There is a chance that immunisation levels will fall and allow future outbreaks of these diseases, with the risk of death and disability, and damage to babies before birth. The evidence for MMR has been examined in detail, and no link between the vaccination and other problems, such as autism and bowel cancer, has been found.

I believe we have a solid foundation in North Somerset for working together to improve the health of the people we serve, and I hope this report will be seen as a contribution to that task.

9. Acknowledgements

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Dr Max Kammerling
August 2003

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