



The health of Bristol 2003

Report of the integrated
public health directorate

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

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Introduction by Director of Public Health

This is the first report from the Integrated Public Health Directorate for the two Primary Care Trusts covering Bristol: Bristol North, and Bristol South and West. Bristol has a wide range of health indicators from the very good to the very bad. A unified approach across the health sector, and increasingly joint working with Bristol City Council with its adoption of health as a corporate priority, means a new city wide approach to health. It is time for health to improve for all people in the city.

The 2001 Census provides the opportunity for this report to highlight those factors – largely outwith the NHS – that have an impact on health such as housing, education and family composition. It also looks at strategies to tackle risks of ill health across the community:

- Improving physical activity and nutrition
- Reducing smoking
- Strengthening communities through improving social contacts and social cohesion, empowering communities and reducing fragmentation.

Future reports will further build on this approach.

The health and well being of the population is the product of decisions and actions – by organisations and individuals - some in and some outside of the NHS. Increasingly intense use of the road traffic system creates hazards for cyclists and pedestrians as well as increasing risk of respiratory problems in children and vulnerable people. Mental health is exacerbated by unemployment. Poor housing is a key determinant of ill health in children. Likewise developments in primary and secondary health care underpin support for communities through health promotion, disease prevention, effective treatment of illness, care of people with disabilities or disease and reduce reliance on supported housing and social services. Health is key to economic prosperity both directly and indirectly. Over £200 million is spent on health services in Bristol annually and these resources also provide employment.

Partnerships between agencies acting together have great potential for realising health benefit particularly in more deprived areas and communities. Acting singly there is much risk of fragmentation and lost opportunity - especially for a city as complex as Bristol with its rich legacy of social and political history, responsible for the health of older residents and new, and with emerging risks to health facing young people and families. Quick fix organisational solutions to problems will be of little benefit - what is needed is deeply rooted collaborative work across the city and with many interest groups, including work through public participation and community involvement.

Our analysis suggests that there are already many examples of excellent work across organisational boundaries. New policy on statutory duties of partnership, for example for Crime and Disorder and Local Strategic Partnerships, is welcome particularly with the emphasis on pooling budgets for health improvement and preparing plans for prevention. There is evidence however that many decisions do not fully embrace the health consequences

and there is a need for renewed emphasis on health impact assessment across the public and private sectors.

This report demonstrates clearly that the distribution of disease is not uniform throughout the population of Bristol and, apart from key health factors of age and gender, some diseases are more common in low income groups and among Black and Minority Ethnic communities. The extent of poverty, deprivation and social exclusion is a key characteristic affecting the state of health across the community. People living in poverty and particularly marginalised people have considerably worse health than the most affluent. Poverty and social exclusion exist across the city: even in the more affluent areas there are people living in deprivation. Moreover there is an excess of premature death from some common causes, particularly cancer, with mortality rates not improving across the City of Bristol in line with more encouraging trends seen elsewhere in England and Wales.

There are no simple answers and many organisations involved are undergoing rapid change. Moving towards a better balance of health services linked to health need is complicated by a number of factors:

- The need to develop a better infrastructure for health services and other public services such as public transport against a background of competing demands on resources
- The recurring health problems of people suffering multiple deprivation augmented by the arrival of new groups with high health needs who are undercounted in population estimates
- The problem associated with old hospital stock, local consultation on change, and the speed at which alternatives providing better access for local communities can be afforded and established
- Policy imperatives to reinterpret national targets in a local context and to avoid distortion of long term aims for short term expedience
- Changing social structures and unemployment contributing to increased drug and alcohol misuse and crime including violence.

Directors of Public Health are required to publish annual reports on the health of the population every year and next year it is hoped that considerable progress will be reported in taking forward a Healthy City Programme in Bristol alongside Bristol City Council and other key partners. Commitment to building on existing partnership working is already in place. Health promotion is becoming a distinct component of health services development and is embedded in much of the work of the city council. Work is underway to develop primary care and health services within the community and to secure increased levels of public participation in designing health services. Most important is the support for a **Smoke Free City**, sponsored by the Bristol Partnership. Work has begun with policies for developing smoke free workplaces, set to be the single most important factor in improving health and reducing inequalities.

Population

The City of Bristol is divided into several administrative and geographical areas that are used to plan and deliver public health. These include:

- 2 Primary Care Trusts (PCTs): Bristol North PCT and Bristol South and West PCT
- 35 electoral wards: 19 in Bristol North PCT and 16 in Bristol South and West PCT and
- 32 GP practices in Bristol North PCT and 29 GP practices in Bristol South and West PCT.

Numbers

There has been some debate on the number of people living in Bristol and trends in population growth. Before the 2001 Census, the Office of National Statistics (ONS) had estimated that the Bristol population was 407,100 in 2001, and that the population had grown over the past 10 years.

After the Census, ONS estimated that the Bristol population was 380,753 in 2001, and that the population was declining. Due to the large discrepancy in estimates before and after the Census, Bristol City Council appealed to ONS to recalculate the population and take into account additional research particularly concerning migrant populations.

The research found that there was significant undercounting in the Census in three wards, Lawrence Hill, Ashley and Easton. ONS then revised their estimates, and new figures released in September 2004 showed that the Bristol population on Census day was 390,000, an additional 9,250 people from the original estimate.

PCT Populations

The population of the Bristol PCTs can be calculated as either the *registered* population, which is the total number of people registered with GP practices within the PCT boundaries, or the *resident* population which is the total number of people living within the geographical boundaries of the PCT.

Revised ONS populations for the Bristol PCTs are not currently available. In 2003 the registered population for the whole of Bristol was 12% higher than the ONS estimated resident population. This is partially explained by people living outside of Bristol registering with practices in Bristol. (see Table 0.1 overleaf)

Table 0.1: Population of Bristol

	2001	2002	2003	2004
Bristol Unitary Authority				
ONS estimate	390,000	389,700	391,500	-
GP Registered	430,610	434,623	436,656	438,958
Bristol North PCT				
GP Registered	228,200	229,831	230,153	229,346
Bristol South and West PCT				
GP Registered	202,410	204,792	206,503	209,612

Source: ONS and Exeter System

Details of the research for this can be found on the ONS and Bristol City Council websites.

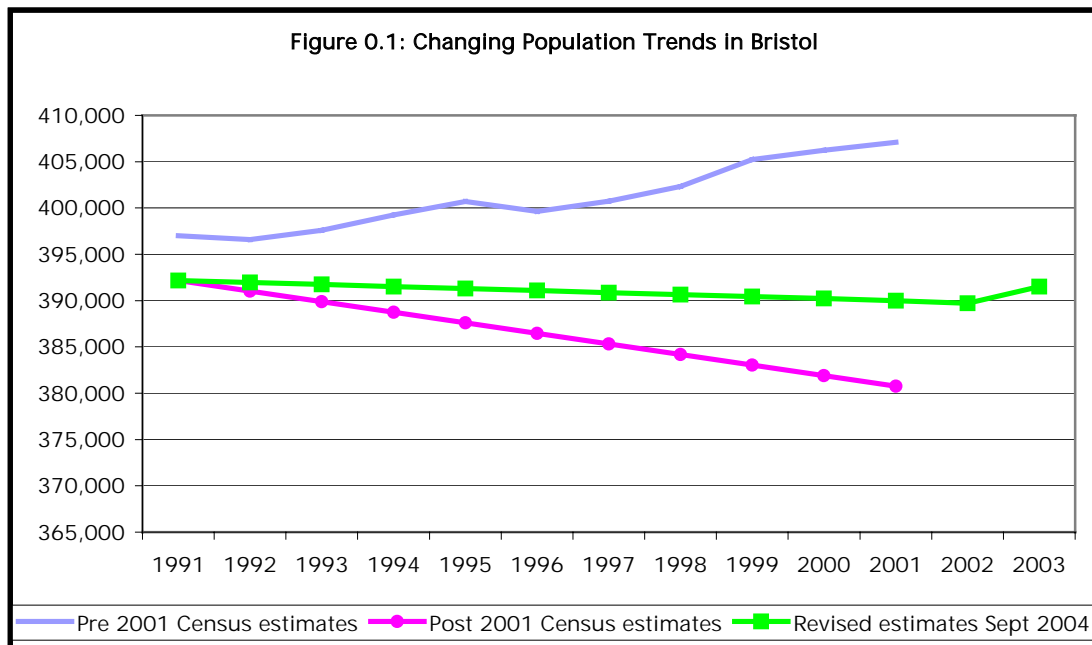
ONS: <http://www.statistics.gov.uk>

Bristol City Council: www.bristol-city.gov.uk/statistics

Trends & Projections

ONS estimate that the population fell until 2002, but has risen again in 2003 (see Figure 0.1). The Bristol GP registered population has increased steadily over the last four years (see Table 0.1 below). There are currently no population projections available that take account of the population estimates.

Figure 0.1: Changing Population Trends in Bristol

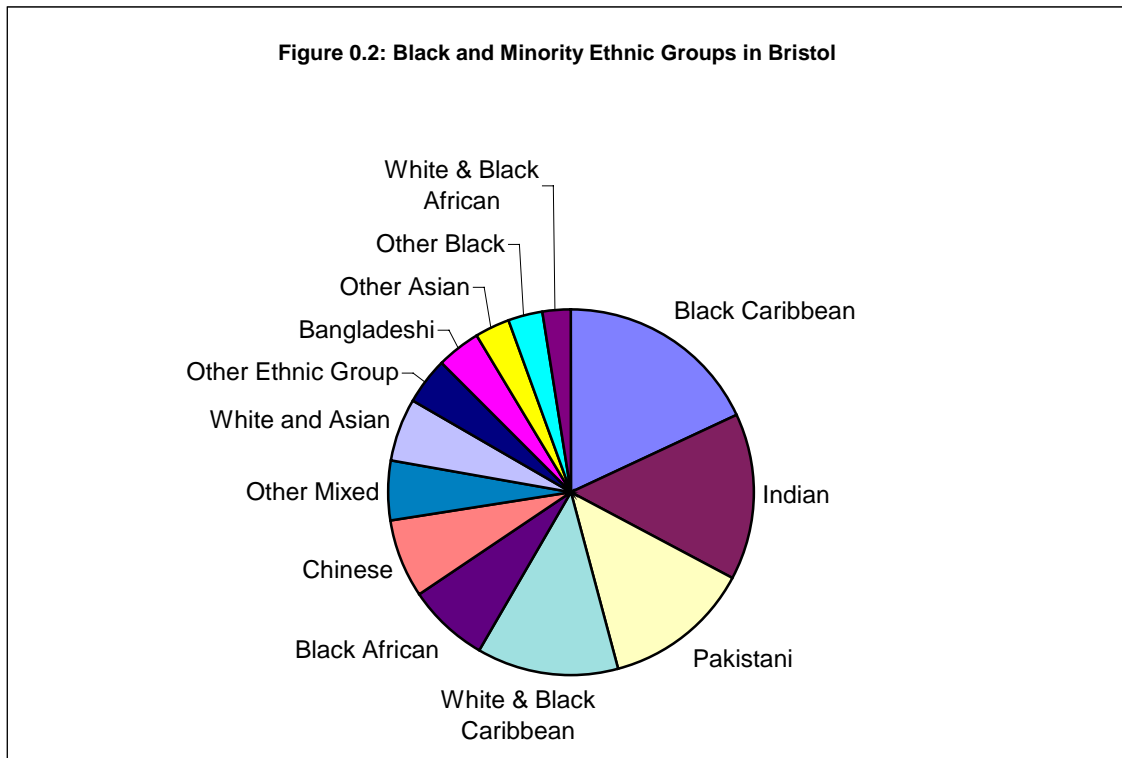


Source: Bristol City Council www.bristol-city.gov.uk/statistics

Black and Minority Ethnic Populations

The 2001 Census showed that 8.2% of the Bristol population were from Black and Minority Ethnic groups, 10.6% in Bristol North PCT and 5.2% in Bristol South and West PCT. This is slightly less than England, which has a non-white population of 9.1%. Black Caribbean, Indian and Pakistani groups constitute almost half of these ethnic groups (see Figure 0.2 below).

Figure 0.2: Black and Minority Ethnic groups in Bristol

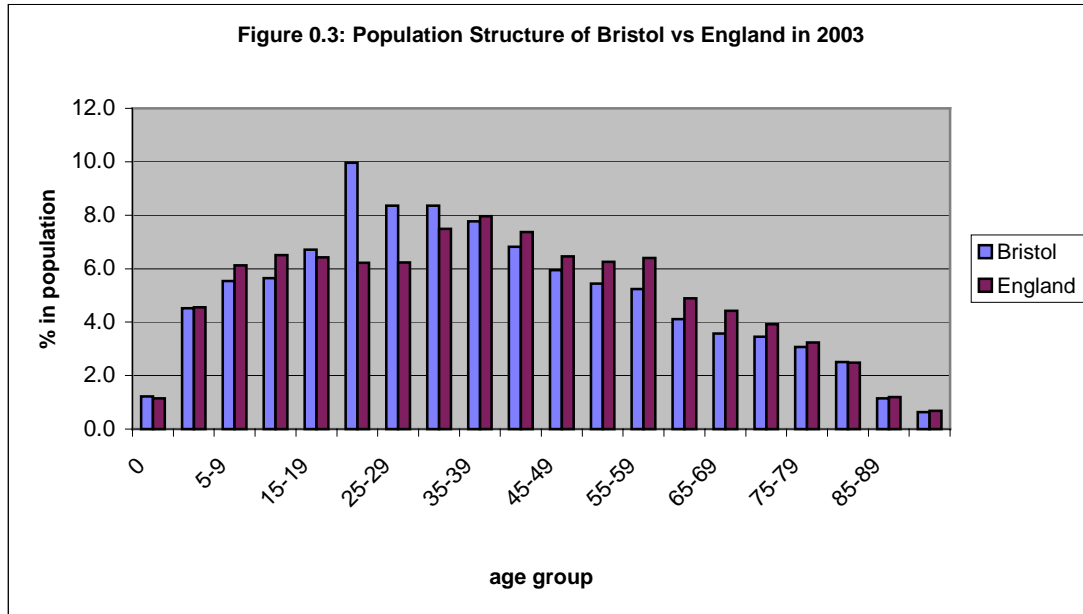


Source: 2001 Census

Age Profile

The population structure of Bristol is similar to that of England, with the exception of the high number of young adults aged 20-30, resulting largely from the student population of the two universities (see Figure 0.3 below).

Figure 0.3: Population Structure of Bristol vs England

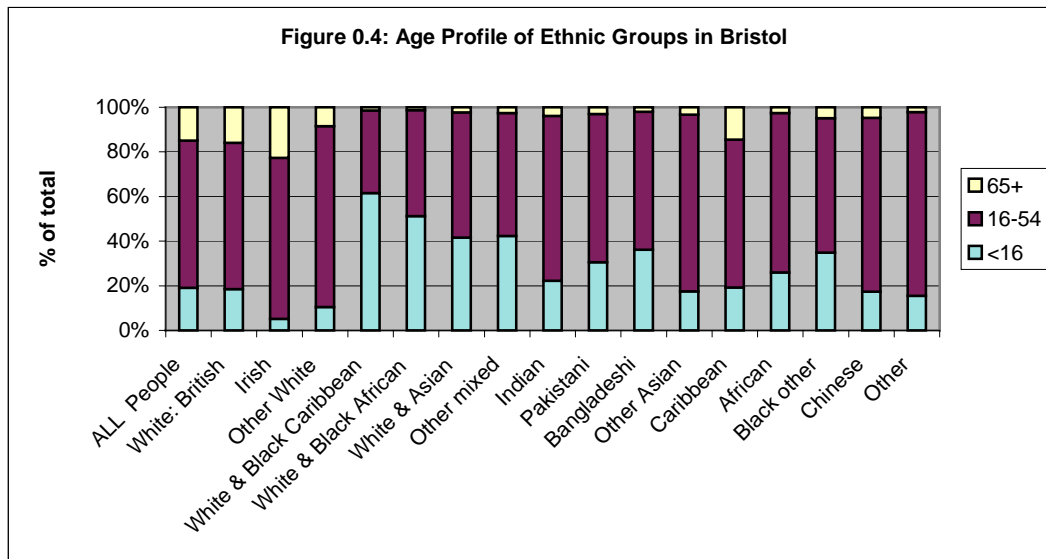


Source: ONS 2003 Mid-Year Estimates

The age profile of the Black and Minority ethnic population is affected by a combination of migration, birth and death rates, and social trends so therefore varies between different ethnic groups. The 2001 Census showed that all the mixed ethnicity groups have a very young age profile reflecting some relatively recent migration of young people and families, with the under 16s making up 56% of mixed ethnic groups in Bristol North PCT and 47% in Bristol South and West PCT.

Conversely the White British, White Irish and Black Caribbean populations have higher proportions of older people, with over 14% of their population aged over 65. This compares to 8% and under for all other groups (see Figure 0.4 below).

Figure 0.4: Age profile of Ethnic Groups in Bristol



Source: 2001 Census

Determinants of Health

Deprivation

There have been great improvements in health over recent decades, with increasing life expectancy and improvements in quality of life. However, there continue to be great inequalities in health in Britain. Differences in socio-economic deprivation have resulted in many cases in the inequalities gap widening, with some populations experiencing the same levels of early death as the national average occurring in the 1950s¹.

The Index of Deprivation 2004 is a new national measure of deprivation containing seven individual deprivation indices. These include income, education, crime and health, barriers to housing and services as well as the living environment. These were combined and a weighted average formed as an overall multiple deprivation score. Two additional multiple deprivation indices, one for older people and one for children, were also produced.

This deprivation measure provides an opportunity to look at small pockets of deprivation using a new geographical area, the 'Super Output Area' (SOA). This is an area containing about 1,500 people with similar characteristics, and is smaller than a ward. There are 252 SOAs in Bristol and about 32,000 nationally.

The results show that:

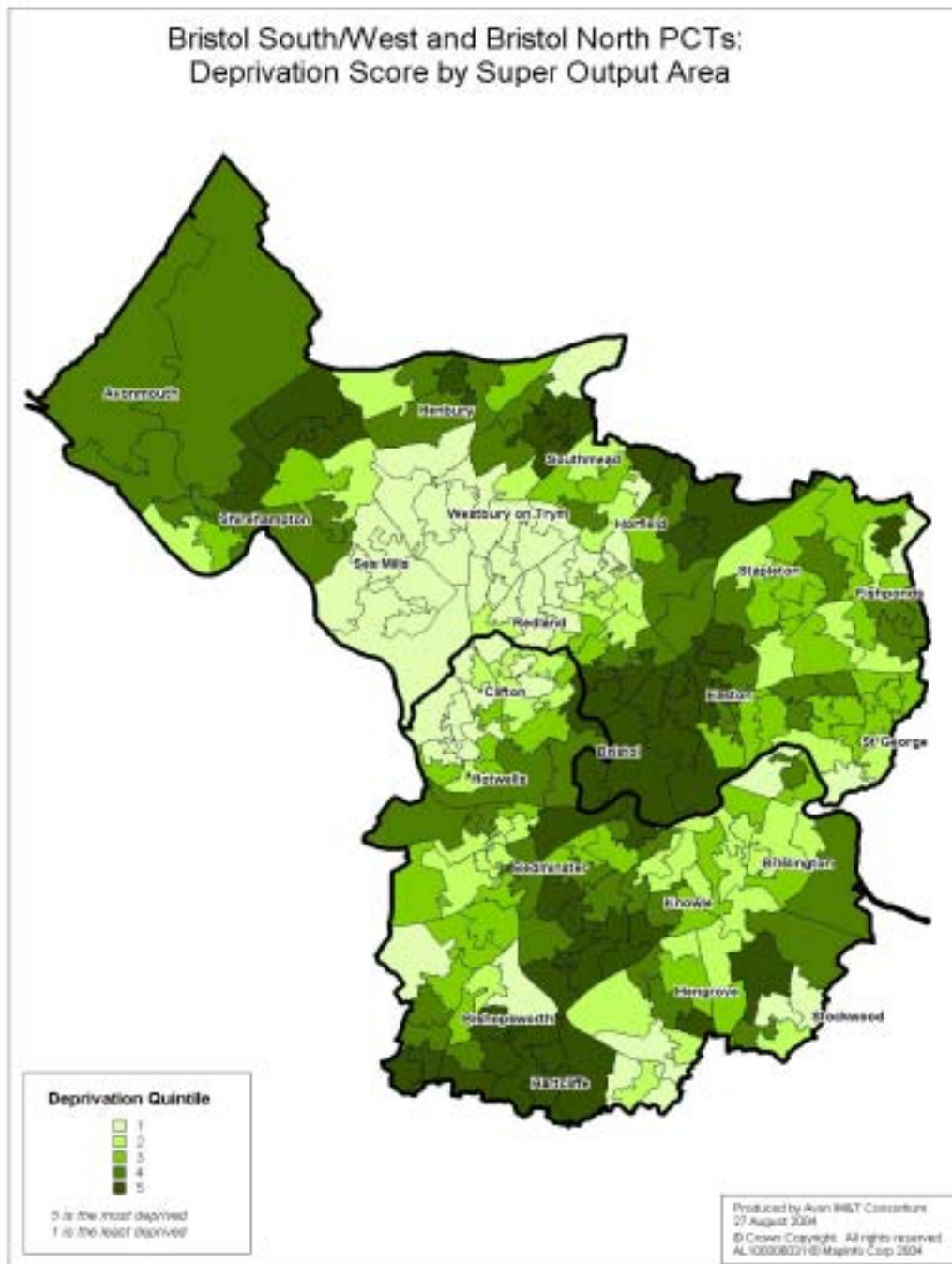
- 35 (14%) of Bristol SOAs rank within the most deprived 10% of SOAs nationally
- 2 SOAs, both within Lawrence Hill ward, are in the top 100 most deprived SOAs nationally
- 3 SOAs within Lawrence Hill and Ashley are in the top 100 most income and education deprived SOAs nationally

Introduction by Director of Public Health

- 3 SOAs within Southville and Filwood are in the top 100 most deprived SOAs for crime and disorder nationally.

Figure 0.5 (overleaf) shows the distribution of deprivation across the city. The most deprived wards in Bristol North PCT are Lawrence Hill, Ashley and Southmead. The most deprived wards in Bristol South and West PCT are Filwood, and Whitchurch Park.

Figure 0.5: Distribution of Deprivation Across Bristol by SOA



Source: Indices of Deprivation 2004, Office of Deputy Prime Minister.

Details on many of the determinants of health such as income, transport, housing and education are contained in the Census 2001. As data was collected on everyone in England, this provides a unique opportunity to compare Bristol with other areas, and to identify particular problems within Bristol.

Housing

The condition of housing, amenities and overcrowding contribute to poor physical and mental health. This includes lack of heating (contributing to excess winter deaths), over crowding and dampness (increasing levels of respiratory diseases), and poor design (leading to increased accidents and social isolation).

Compared with England and Wales, Bristol has a lower proportion of people owning their home and a higher proportion renting, partly reflecting the large student population (see Table 0.2 below). There are high numbers of renting households in Lawrence Hill (73.8%), Cabot (66.8%), and Clifton East (55.6%). (see Table 0.2 below).

Table 0.2: Households by Tenure

	England & Wales	BN PCT	BS&W PCT
Number of households	21,66,0475	87,948	74,142
% Owner occupied: Owns outright	29.46	26.92	24.71
% Owns with a mortgage or loan	38.76	36.94	36.00
% Shared ownership	0.64	0.49	0.64
Total Owned	68.86	64.35	61.35
% Rented -Council (local authority)	13.24	17.74	16.01
% Rented - Housing Association / Registered Social Landlord	5.95	3.91	4.38
% Rented - Private landlord or letting agency & Rented - Other	8.72	10.28	14.36
	3.22	3.72	3.89
Total Rented	31.13	35.65	38.64

Source: 2001 Census

Bristol has a lower proportion of detached houses, and a higher proportion of terraced and converted houses than England and Wales (see Table 0.3 below).

Table 0.3: Types of Houses in Bristol (as percentages)

	England & Wales	Bristol North	Bristol South and West
Detached	22.77	8.08	4.36
Semi-detached	31.58	30.07	27.73
Terraced (including end-terrace)	26.04	37.49	35.52
Flat maisonette or apartment	13.62	14.81	14.42
Part of a converted or shared house (including bed-sits)	4.43	7.85	16.1
In a commercial building	1.15	1.56	1.75
Caravan or other mobile or temporary structure	0.42	0.13	0.12

Source: 2001 Census

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The Land Registry figures for August 2004 show that the average house price in Bristol was £166,747. This is lower than the South West average of £187,495. House prices impact on the ability of the City to recruit and retain key workers such as police, nurses and teachers.

Unemployment

Unemployment leads to lack of income and social contacts, which in turn can affect physical and mental health, and the health of the children¹.

In 2001, Bristol had a lower unemployment rate than England and Wales. The Census showed that 3.2% of 16-64 year olds in Bristol North PCT and 3.0% in Bristol South and West PCT were economically inactive and unemployed. This compares to a national figure of 3.4%. There were however big differences within Bristol, from 7.2% in Lawrence Hill to 1.3% in Stoke Bishop.

A quarter of those who are unemployed are long term unemployed, and 8.6% in Bristol North PCT and 7.8% in Bristol South and West PCT of unemployed people have never held paid employment.

Qualifications

Qualifications improve life chances, increasing the opportunity of employment and thereby reducing the risk of poverty and social exclusion. Of people aged 16 – 74, 25% in Bristol North PCT and 27% in Bristol South and West have no qualifications. This is lower than the England and Wales figure of 29%. However the range within Bristol is very large, from 52% in Filwood to 4% in Clifton East. (see Table 0.4 below)

Table 0.4: People aged 16 – 74 with No Qualifications in Bristol

% No qualifications	Ward Name	
50-59%	Filwood	
40-49%	Hartcliffe	Whitchurch Park Bishopsworth
30-39%	Southmead Lockleaze Avonmouth Lawrence Hill Kingsweston Henbury Hengrove	Stockwood Hillfields Bedminster St George West Knowle Brislington East St George East
20-29%	Brislington West Frome Vale Easton Southville	Windmill Hill Eastville Horfield
10-19%	Ashley Westbury-on-Trym	Bishopston Henleaze
0-9%	Cabot Stoke Bishop Redland	Clifton Cotham Clifton East

Source: Census 2001

References

1. *HM Treasury and Department of Health. Tackling Health Inequalities. Summary of the 2002 Cross Cutting Review. 2002, London.*

Information on Health

There are four main sources of information on the health of the population:

- Death registrations
- Disease registers e.g. the cancer registries
- Population Census or surveys
- Service use data, e.g. hospital admissions.

In describing health these sources all have limitations. Deaths registers are complete, but death is a rare event and does not reflect the true burden of disease. Other than cancer, there are very few diseases with complete registers although this is changing with more data being collected in GP practices on diseases in childhood and chronic diseases such as diabetes.

The Census in the UK is only undertaken every 10 years, and asks very few direct questions on health. Surveys need to have a large sample to give reliable local data, and are therefore very expensive. Bristol City Council has for several years been undertaking a 'Quality of Life Survey' that contains valuable information on factors influencing health and wellbeing at local level. (See: www.bristol-city.gov.uk/qualityoflife)

Health Service activity data only provides information on people attending services. Often those most in need are the least likely to attend. The most complete information is on in-patient admissions to hospital. There is also very limited, routinely collected or aggregated information about those attending GP practices – yet this is where most healthcare takes place.

Poor information limits the picture of the health and illness in the population. It is particularly difficult to look at health in small areas. Certain illnesses, such as mental health and neurological conditions, are particularly poorly documented. Increasingly information collected through primary and community services and continued findings from the Bristol Quality of Life Survey will help our understanding of disease patterns, determinants of health and wellbeing.

General Health

The Census provides the only source of information on the health status of everyone in Bristol. Two questions were asked in the 2001 Census, one on long term limiting illness and the other on general health. Bristol had similar proportions of people reporting long term limiting illness and describing their health as 'not good' as England and Wales (see Table 1.1 overleaf). It should be noted that these figures have not been adjusted to take account of the age structure of the population.

There are great variations in health status within Bristol. The percentage of people of working age reporting a long term limiting illness is highest in Lawrence Hill (24.36%), Filwood (22.22%), Lockleaze (20.9%), Hartcliffe (16.5%), Kingsweston (20.5%) and Southmead (16.32%). This compares with

an average of 13.0% for Bristol North PCT and 12.2% for Bristol South and West PCT. The high levels of deprivation experienced by these wards are likely to be a major determinant of long term limiting illness.

Table 1.1: General Health and Long term Limiting Illness

	England & Wales	BN PCT	BS& W PCT
Long Term Limiting Illness			
% of people with limiting long-term illness	18.23	18.30	17.19
General Health			
% of people whose health was not good	9.22	9.44	8.99

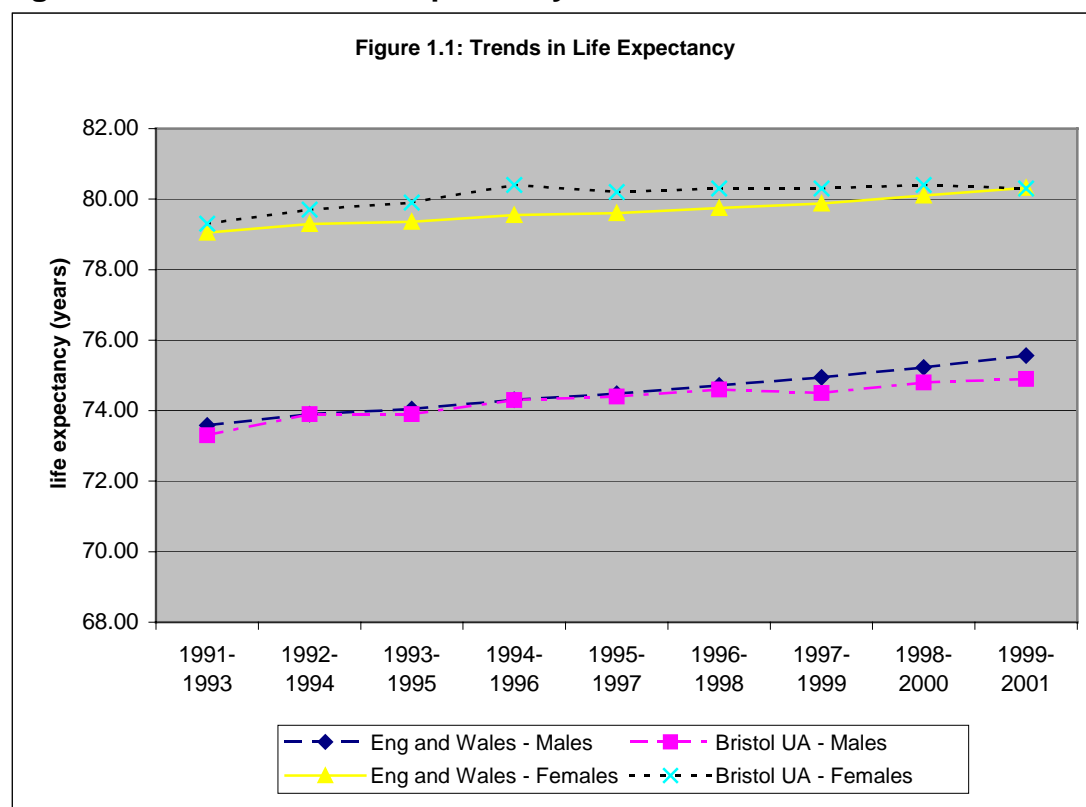
Source: 2001 Census

Life Expectancy

Life expectancy is used as an indicator of overall health of the population, and is used nationally to monitor inequalities in health. Between 1999 and 2001, average life expectancy for men in Bristol was 74.9 years and for women 80.3 years. This is very similar to the national and South West averages, and to comparable cities such as Plymouth and Leeds.

Over the last 10 years, average life expectancy in men increased by 1.6 years, lower than the England and Wales and South West average increase of 2.0 years. Similarly the improvement of 1 year for Bristol women is less than the national average of 1.3 years and the South West average of 1.2 years (see Figure 1.1 below).

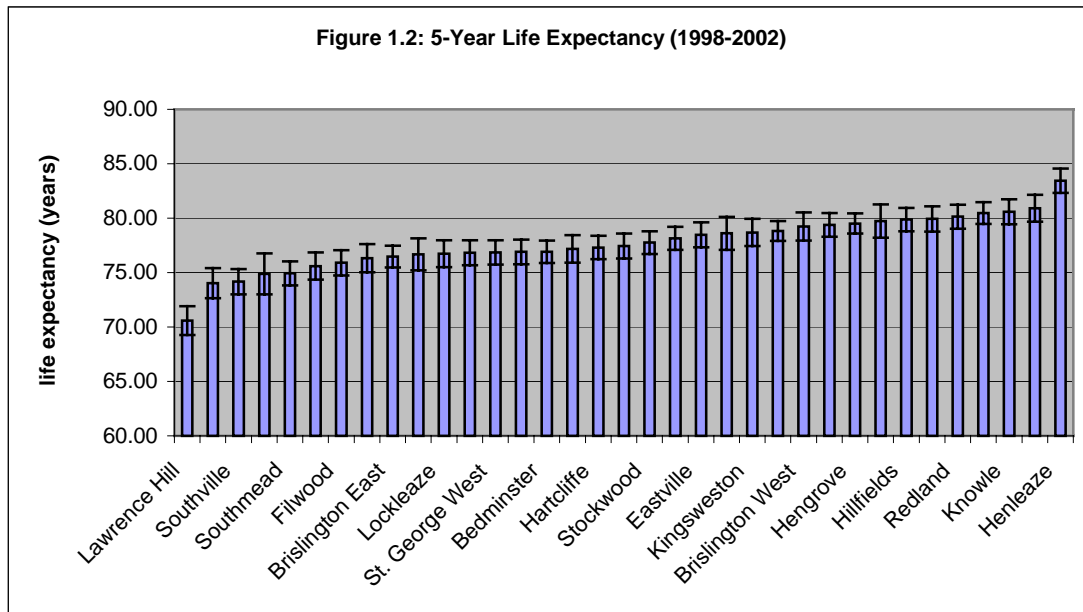
Figure 1.1: Trends in Life Expectancy



Source: Compendium of Clinical Indicators, 2003.

There are major differences in life expectancy within wards in Bristol, with a difference of 12.9 years between the highest and the lowest life expectancy. In Henleaze, life expectancy is 83.4 years, whereas for Lawrence Hill it is 70.6 years. While deprivation plays a large part in this variation, some of the differences may be the result of the underestimate of ward populations. As the undercounting is in 3 deprived wards, this will have the apparent effect of reducing life expectancy. (see Figure 1.2 below)

Figure 1.2: 5 year Life Expectancy

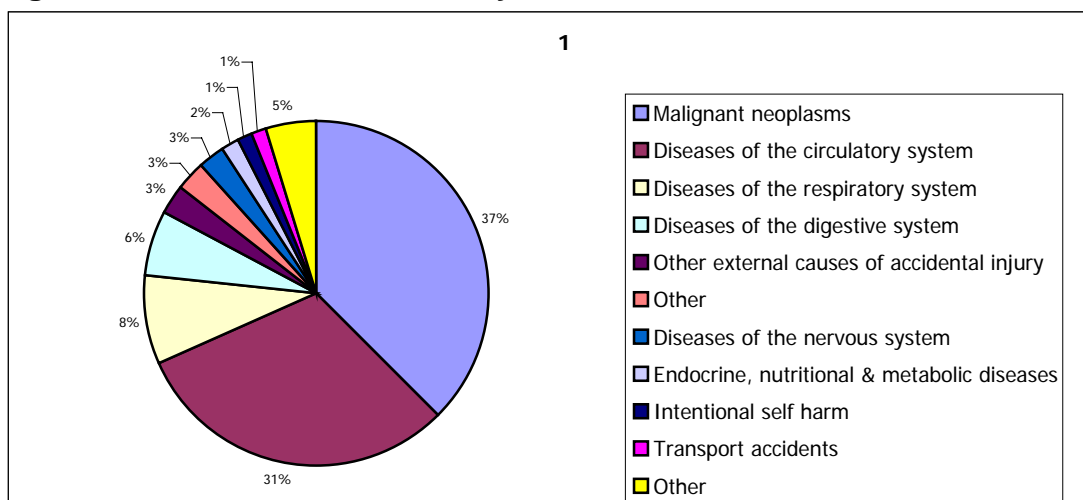


Source: South West Public Health Observatory

Main Causes of Death

Improvements in life expectancy are affected by trends in mortality, in particular from the major killers, cancer and circulatory diseases including coronary heart disease and stroke. These account for two thirds of all premature deaths (under age 75 years) in Bristol. (see Figure 1.3 below)

Figure 1.3: All Causes of Mortality in Bristol



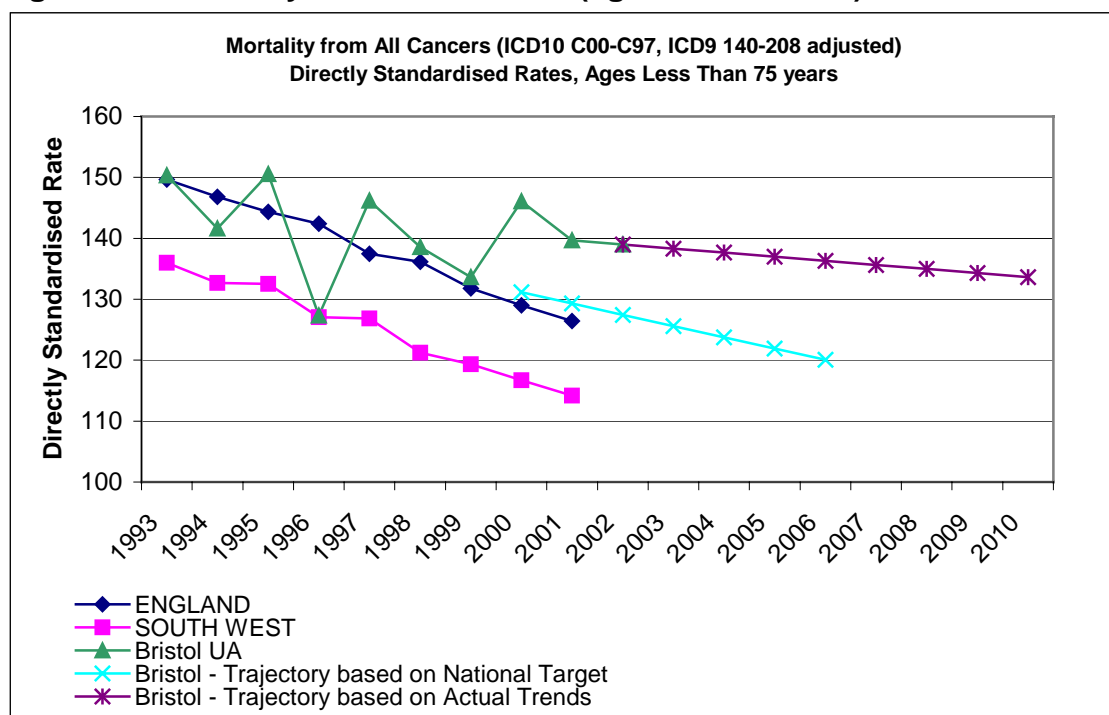
Source: ONS mortality file

Cancer

Cancer is the biggest cause of premature mortality in Bristol and a major cause of ill health. In 2002, 1010 people in Bristol died of cancer, 542 in Bristol North PCT and 468 in Bristol South and West PCT.

While the national mortality rate from cancer in those aged under 75 has fallen steadily over the last 10 years, the Bristol rate remains at or around levels seen in 1993 and 1994. Indeed in 1993, the Bristol rate was the same as that for England and Wales but by 2001, was substantially higher (see Figure 1.4 below). It is difficult to know the exact reasons for the lack of improvement, although possible explanations include differences in risk factors, in particular levels of smoking. The trend in mortality shown in Figure 1.4 looks unlikely to achieve the target set for 12% reduction in mortality by 2010.

Figure 1.4: Mortality from All Cancers (ages less than 75)



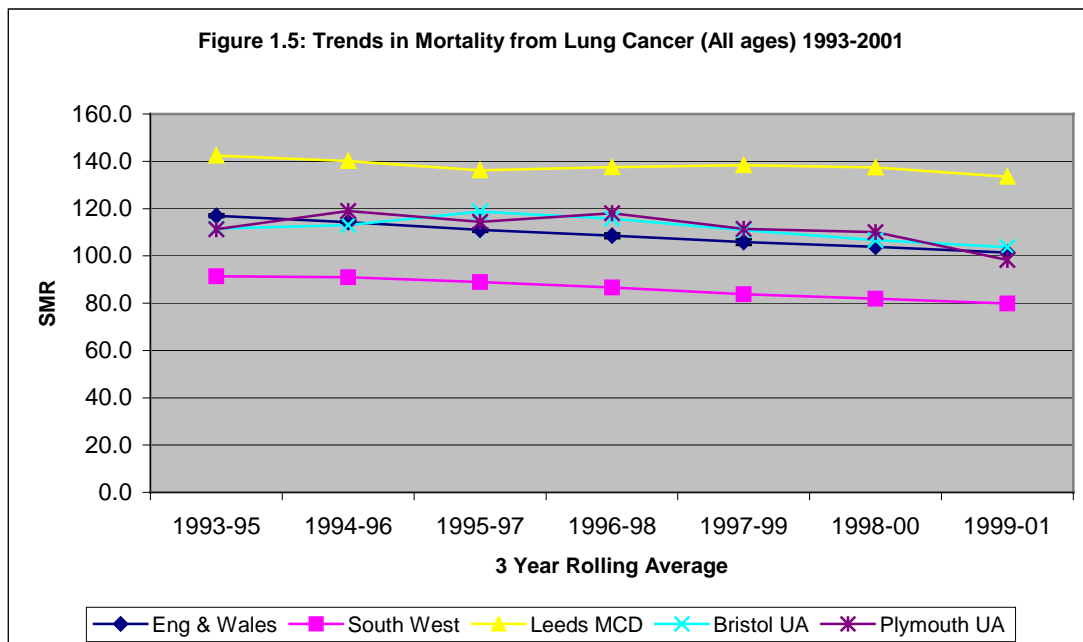
Source: Compendium of Clinical Indicators, 2003

Lung Cancer

Lung cancer is the second most common cancer after prostate cancer in men and breast cancer in women. Of every 10 cancer deaths, 9 are directly attributable to active or passive smoking. This association explains higher rates in more deprived communities where smoking rates are higher than those in the least deprived². The risk of lung cancer also increases with age, with exposure to certain chemicals such as asbestos and is higher in men than women.

There has been a decline in mortality from lung cancer in Bristol in line with that experienced by the South West Region and England and Wales as a whole. Nationally, there has been a steady decline in smoking prevalence among men over the past few decades, although there has been a rise in smoking among women which may reverse the downward trend in lung cancer mortality in the future. Figure 1.5 below illustrates the trends in mortality from lung cancer for all ages between 1993 and 2001.

Figure 1.5: Trends in Mortality from Lung Cancer (all ages)



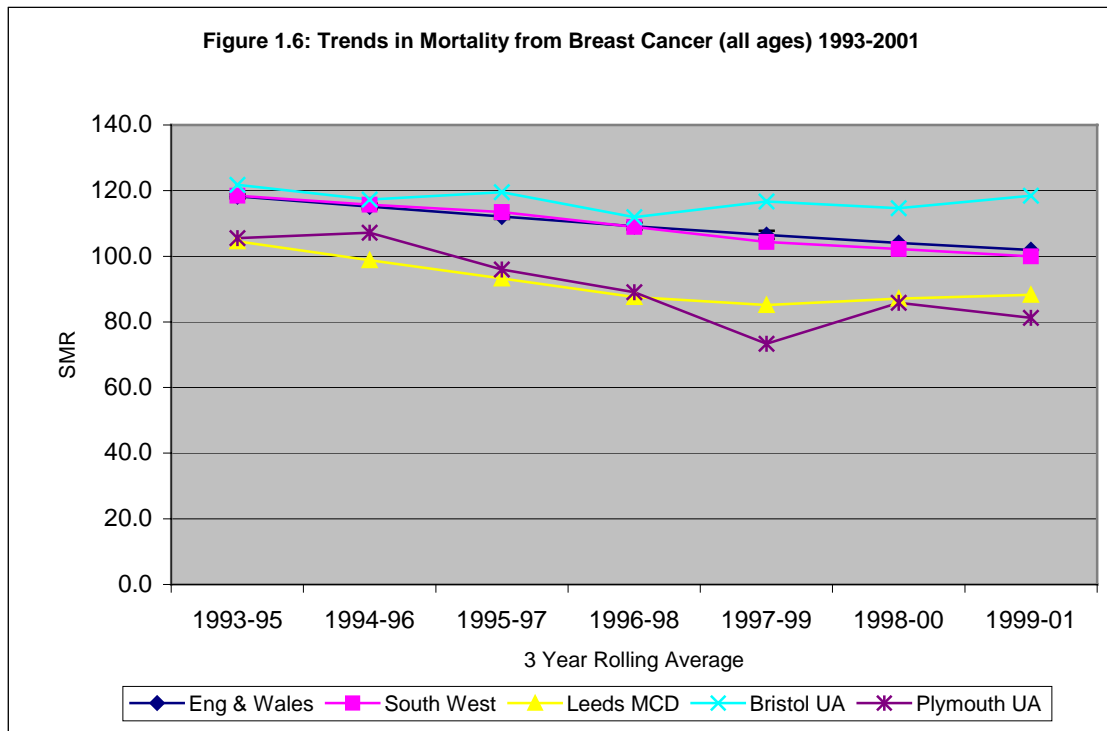
Source: Compendium of Clinical Indicators, 2003

Breast Cancer

Breast cancer is the most common cancer in women nationally. A number of different risk factors have been identified for breast cancer, including early age at menarche (starting periods), having fewer children later in life, a family history of breast cancer, obesity, and alcohol consumption². Breastfeeding is thought to be protective, reducing breast cancer risk.

Breast cancer rates in Bristol have changed little over recent years, while declines have been experienced in other similar cities, nationally and in the South West (see Figure 1.6 below).

Figure 1.6: Trends in Mortality from Breast Cancer (all ages)



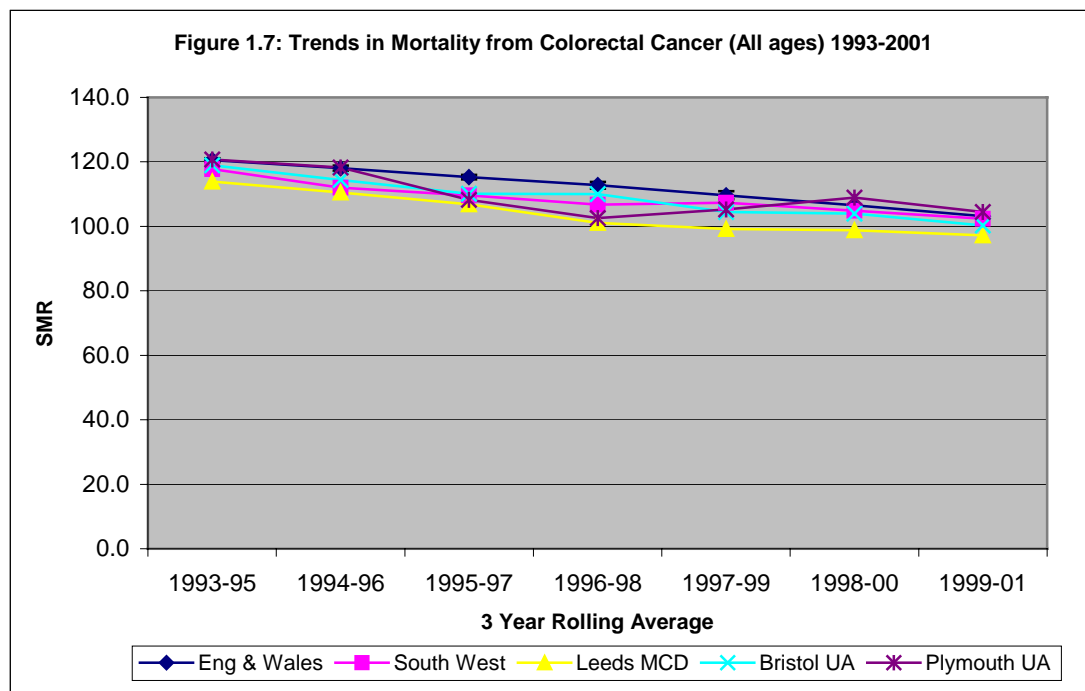
Source: Compendium of Clinical Indicators, 2003

Colorectal Cancer

Colorectal cancer is the third most common cancer in men, and the second most common cancer in women in the UK. Risk factors for colorectal cancer include a diet low in fruit and vegetables, alcohol intake, obesity and lack of physical activity².

Mortality from colorectal cancer in Bristol has fallen steadily over recent years in line with the decrease nationally. With the increase in obesity nationally and declining physical activity, there is a risk that in the long term this trend could be reversed. (see Figure 1.7 below)

Figure 1.7: Trends in Mortality from Colorectal Cancer (all ages)



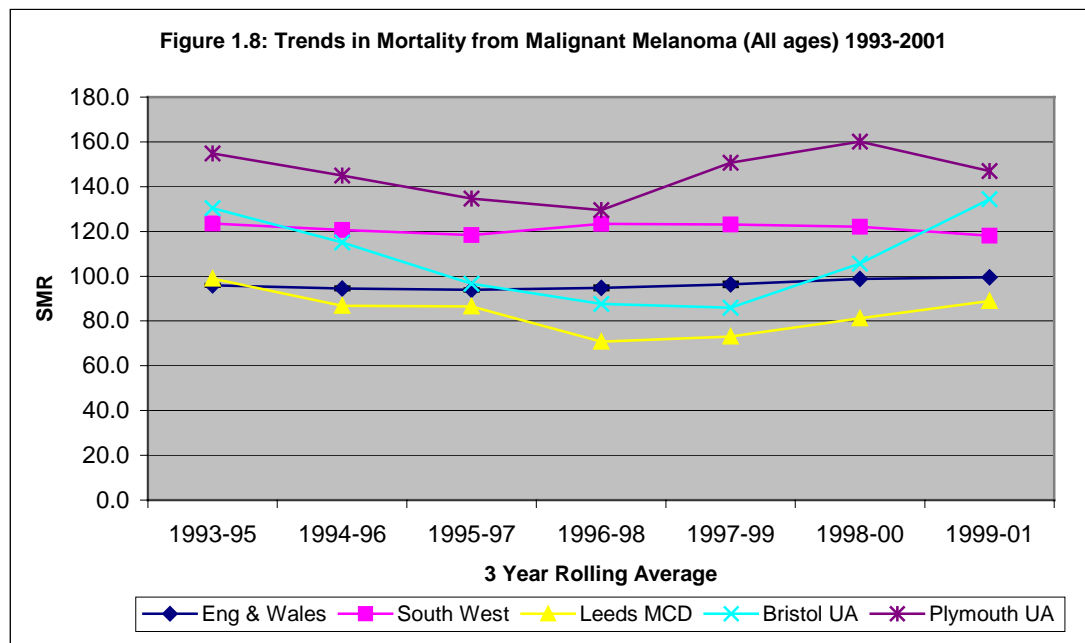
Source: Compendium of Clinical Indicators, 2003

Skin Cancer

Although skin cancer is a relatively rare cancer, incidence is increasing. It is an important cancer in younger people, is the third most common cancer in women and the fifth most common cancer in men under the age of 35². The single biggest risk factor is excess exposure to ultra violet light from the sun. This risk is increasing as the ozone layer that provides a protective layer is thinned. Avoiding going out in the sun in the middle of the day, putting on a hat and high factor sun cream reduces the risk.

Nationally there has been a gradual increase in the levels of skin cancer over the last eight years. While the mortality in Bristol fell before the late 90s, it has subsequently risen to be much higher than for England and Wales (see Figure 1.8 below). As the numbers of people dying from skin cancer are small, there can be considerable variation in rates which makes it difficult to interpret the overall trend.

Figure 1.8: Trends in Mortality from Malignant Melanoma (all ages)



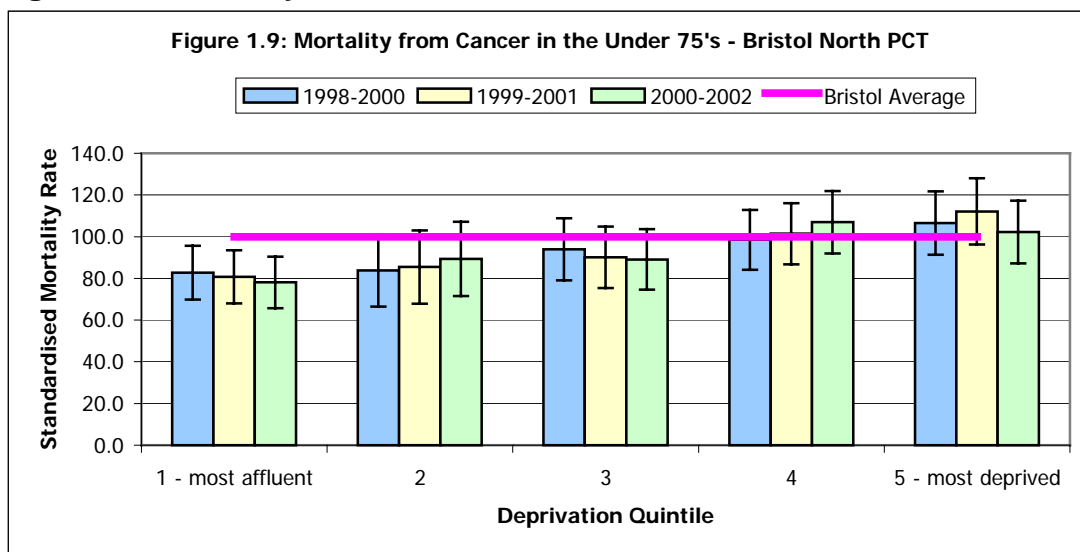
Source: Compendium of Clinical Indicators, 2003

Inequalities and Cancer

During the period 2000-2002, mortality rates from cancer in the fifth most deprived areas were significantly higher than those in the fifth least deprived. Figures 1.9 and 1.10 below illustrate mortality from cancer in the under 75s for Bristol North Primary Care Trust and Bristol South and West Primary Care Trust respectively.

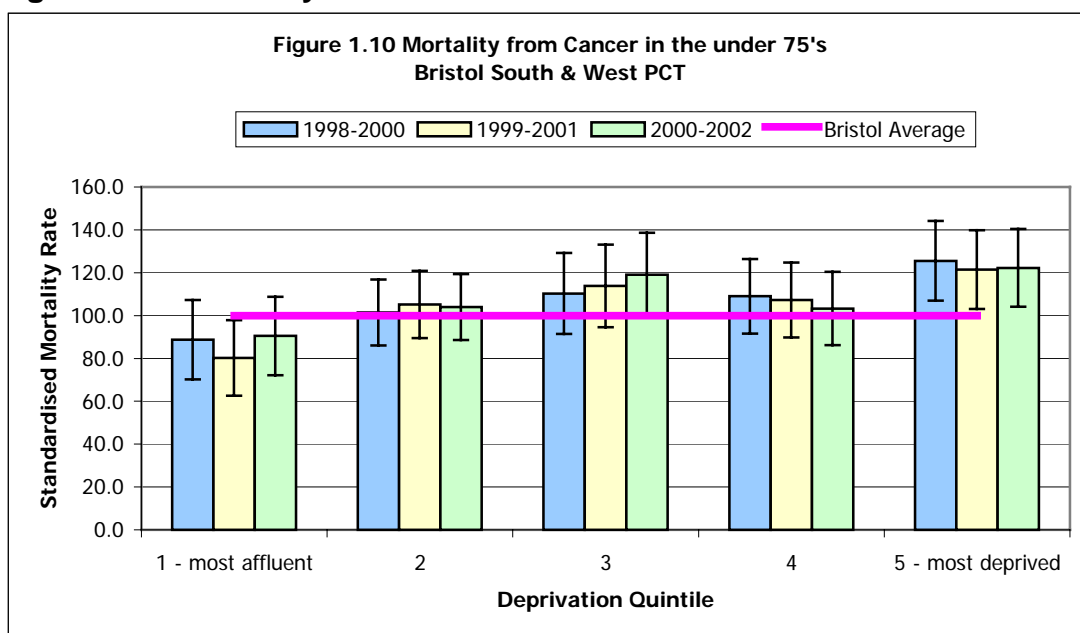
Over the last few years, mortality rates in the most deprived and the most affluent areas of both PCTs have changed little. None of the changes in any group over these years are statistically significant. Data from more years is needed to determine any clear trends.

Figure 1.9: Mortality from Cancer in the under 75s BN PCT



Source: ONS mortality file & IMD 2000 deprivation score

Figure 1.10: Mortality from Cancer in the under 75s BS & W PCT



Source: ONS mortality file & IMD 2000 deprivation score

Accidents

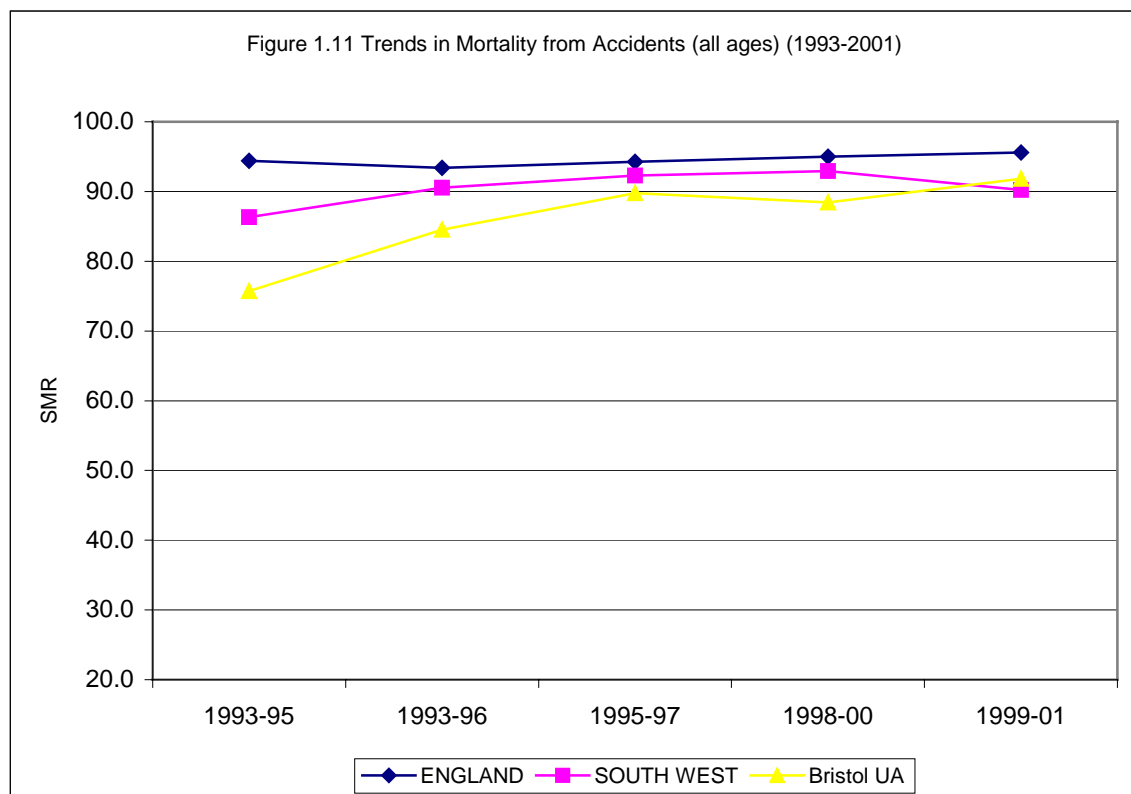
Accidents are the main cause of death in children over the age of one, and a serious cause of mortality and morbidity among all age groups. Accidents are more common in deprived areas, with children in social class V, those experiencing the most deprivation, five times as likely to suffer accidental death than those in social class 1¹.

Accidents in children are linked to poor housing, lack of safe play areas and supervision, and proximity to busy streets. In young people, alcohol consumption is a major contributory factor. In the elderly, falls account for a large proportion of accidents.

Accidental Deaths

In Bristol, accidental deaths have risen since 1993 although recently they have levelled out and now remain below the national average (see Figure 1.11 below). There are few deaths from accidents therefore it is difficult to interpret the trend.

Figure 1.11: Trends in Mortality from Accidents (all ages)



Source: Compendium of Clinical Indicators, 2003

Hospital Admissions

In 2002/03, there were 1682 discharges from hospital in Bristol North PCT from people following accidents and 1307 in Bristol South and West PCT. Half of these were discharges from hospital in people who had experienced falls.

In Bristol North PCT:

- 130 discharges from hospital were people who had been involved in a road traffic accident.
- Of these 130 people, 45% were motorcycle or pedal cyclists, 25% were pedestrians, and 22% were car drivers or passengers.

In Bristol South and West PCT:

- 80 discharges from hospital were people who had been involved in a road traffic accident.
- Of these 80 people, 39% were motorcycle or pedal cyclists, 29% were pedestrians, and 29% were car drivers or passengers.

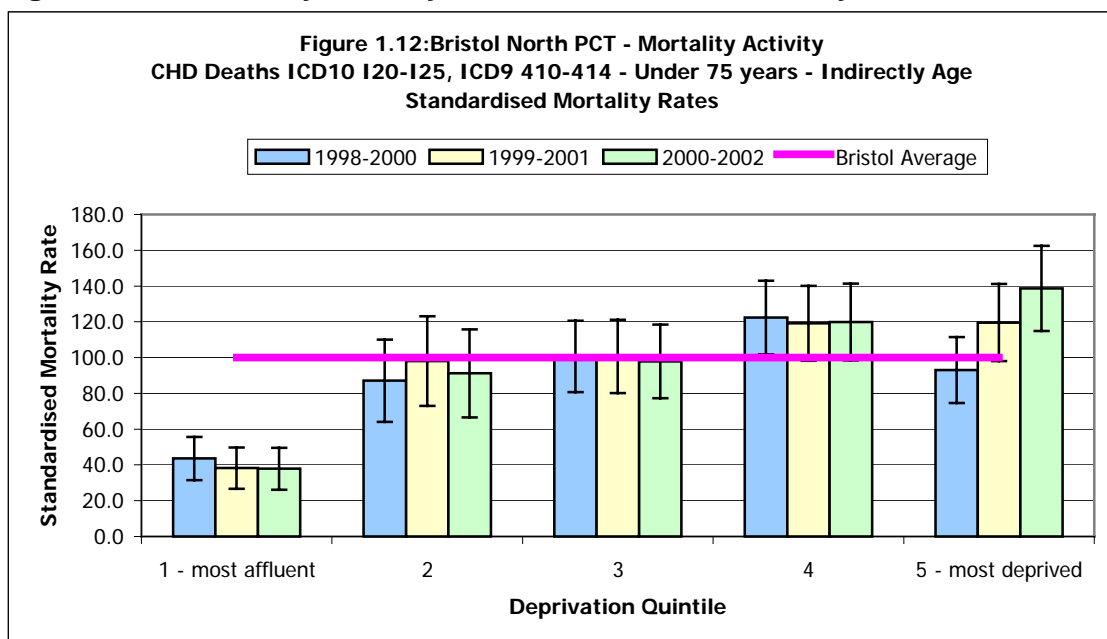
A more accurate picture of the type and number of accidents and how to prevent them will be gained through working in partnership with other agencies such as the Fire Brigade, Police, and Ambulance service.

Avoidable Mortality from Major Diseases

Death rates from CHD, for all ages and for under 75 year olds in Bristol have declined overall between 1993 and 2001, though this has not been consistent year on year. In particular the trend of falling premature mortality (under 75) appears to have slowed in recent years.

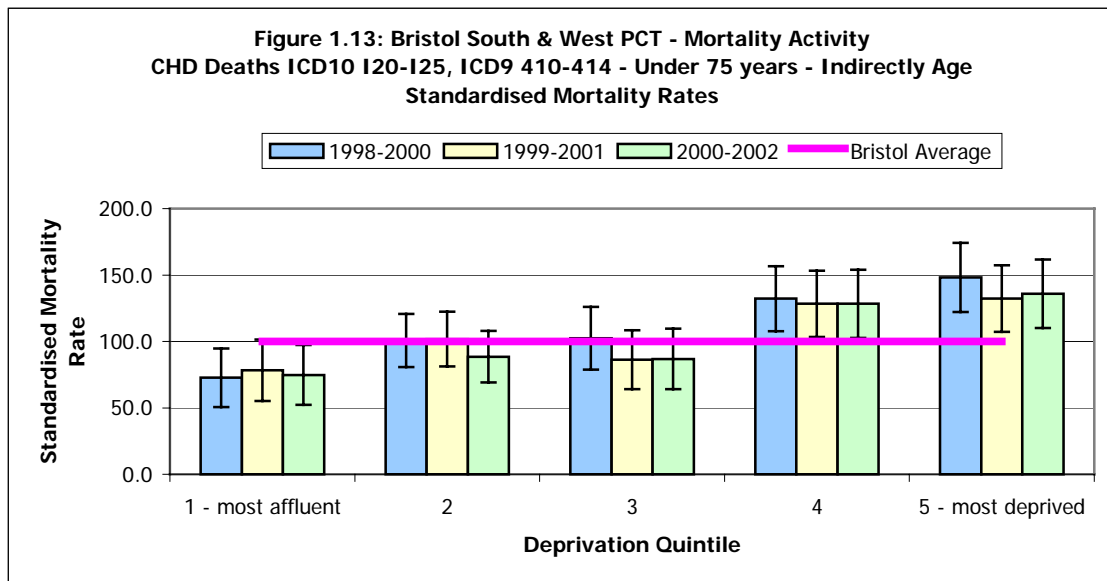
Against this background, the inequality in premature death rates from CHD between higher and lower socio-economic groups is stark. Figures 1.12 (below) and 1.13 (overleaf) show indirectly standardised mortality from CHD by deprivation quintile within each PCT.

Figure 1.12: Mortality Activity CHD Bristol North Primary Care Trust



Source: ONS mortality file & IMD 2000 deprivation score

Figure 1.13: Mortality Activity CHD Bristol South and West Primary Care Trust



Source: ONS mortality file & IMD 2000 deprivation score

For this analysis the population of Bristol as a whole has been divided in five deprivation quintiles using the income measure on the Index of Multiple Deprivation. Population data are taken from the Exeter system (patients registered with a GP). It should be noted that these rates are based on calculations for deprived areas; this does not imply all people in those areas experience the same level of deprivation.

Data published by the British Heart Foundation show that nationally the death rate has been falling faster in higher socio-economic groups, thus increasing the inequality between groups. In Bristol South and West, the populations of the two most deprived quintiles have premature CHD death rates above the average for Bristol. Death rates within each quintile have not changed significantly over this period, and the rates in the two most deprived quintiles remain significantly higher than in the least deprived quintile.

In Bristol North the death rates in the most affluent quintile are less than half the Bristol average. In the most deprived quintile the death rate from CHD has increased significantly, and there is over a three fold difference across deprivation quintiles.

We need to monitor this trend closely, but the data available so far emphasises the continuing need to focus work on CHD prevention, and to target more deprived areas.

Reducing inequalities is a major challenge. Locally initiatives such as the Health Improvement (HImp) Performance Scheme has supported the Bristol PCTs in implementing the National Service Framework for CHD with additional funding being provided for both secondary and primary prevention of CHD. Improvements in aspirin and statin prescribing are effective in reducing risk of death from CHD in people with established disease

(secondary prevention) having been demonstrated through audit in general practice.

Sexual Health

Over recent years, there have been huge rises in the levels of sexually transmitted diseases in the UK, and Britain continues to have the highest level of teenage pregnancy in Europe. This trend is partly due to people becoming sexually active earlier and having more partners in life.

The consequences of poor sexual health include:

- Sexually transmitted diseases and ill health
- Unwanted conceptions
- Fertility problems
- Psychosexual problems
- Death in the case of HIV
- Psychological distress.

A recent Parliamentary Select Committee Report on sexual health drew attention to the poor state of sexual health in Britain, inadequate and under funded services and a failure of NHS organisations to tackle the issues⁷. This report focuses on three sexually transmitted infections – chlamydia, gonorrhoea and HIV and teenage pregnancy. It is difficult to assess rates of change since information on the population at risk is rarely available.

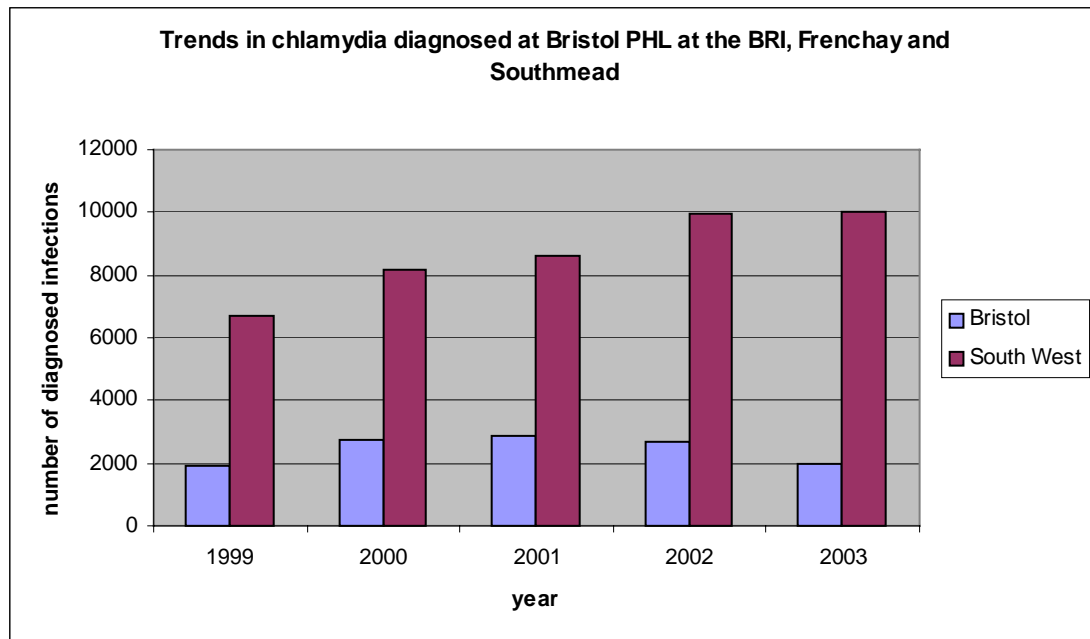
Chlamydia

Chlamydia is the most commonly diagnosed sexually transmitted bacterial infection. Infection is asymptomatic in 70% of women and 50% of men, and can cause pelvic inflammatory disease and infertility in women. Risk of chlamydia rises with having two or more sexual partners in one year⁴ and single people are at greatest risk.

The number of chlamydia infections diagnosed at Bristol laboratories rose rapidly from 1999 until 2001, when the number started to fall (see Figure 1.14 overleaf). Between 2001 and 2002, there was a 6.2% decrease of diagnosed infections. The decline continued in 2002 and 2003, with a 26.5% decrease. It is not clear yet whether the decline is the start of a reverse in the epidemic or a temporary halt in the overall rise. (see Figure 1.14) By contrast in the South West as a whole, numbers have continued to rise, although between 2002 and 2003 the rise was only 0.4%.

The overall increase in chlamydia could be a reflection of increasing levels of infection in the population or raised awareness among sexually active people of the need to be tested. Improved sensitivity in tests may also create an apparent increase. Eradication of Chlamydia is unlikely in the absence of a national screening and treatment policy.

Figure 1.14: Trends in Chlamydia diagnosed at Bristol Public Health Laboratory, Bristol Royal Infirmary, Frenchay and Southmead

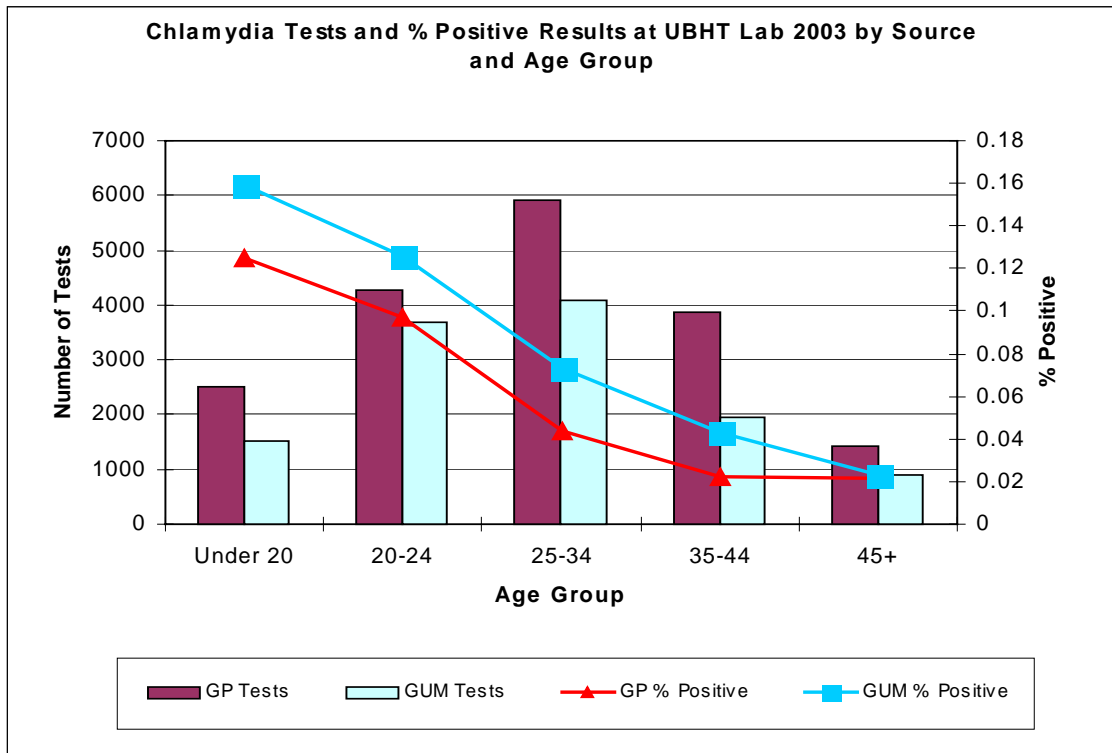


Source: Assist database, Avon Health Protection Agency, South West

In 2003, two thirds of chlamydia infections were diagnosed in women. This reflects the low numbers of men presenting for testing. Both partners need to receive treatment to avoid an untreated partner re-infecting their treated partner.

More tests in both GP surgeries and the sexual health clinic were carried out for people over the age of 25. Yet the majority of infections occurred in those less than 25 (see Figure 1.15 overleaf). This highlights the need to target testing in younger age groups.

Figure 1.15: Chlamydia Tests and % Positive Results at UBHT Lab by Source and Age Group



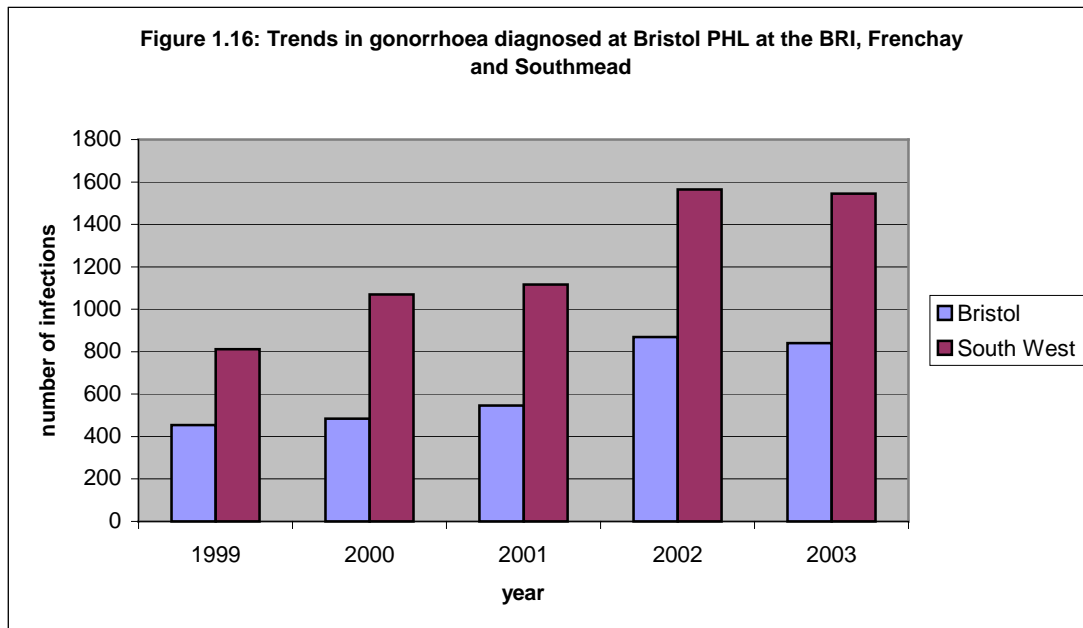
Source: Assist database, Health Protection Agency

Gonorrhoea

Gonorrhoea is the second most common bacterial sexually transmitted infection. Groups most at risk of gonorrhoea are young people, particularly homosexual or bisexual men, and Black & Minority ethnic groups.

The number of gonorrhoea infections in Bristol and the South West rose every year until 2002, when the number fell slightly. Infections were most common in the younger age groups, with 60% of infections in men and 83% in women under the age of 30 (see Figure 1.16 below).

Figure 1.16: Trends in Gonorrhoea Diagnosed at Bristol PHL, at BRI, Frenchay and Southmead



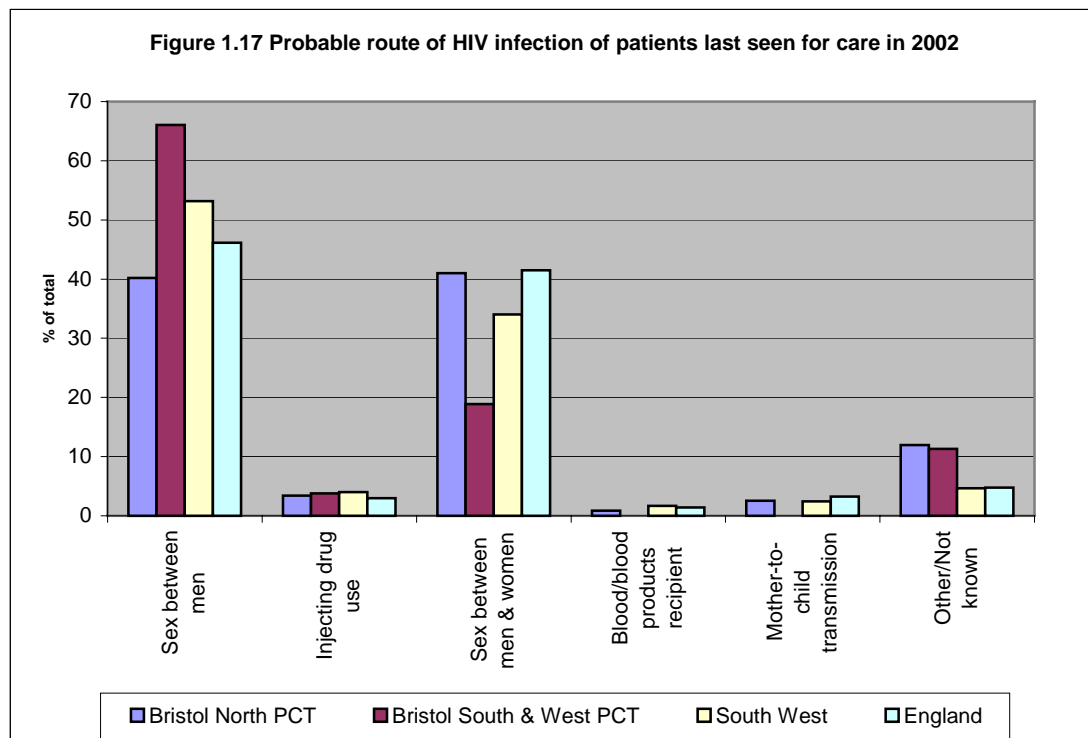
Source: Health Protection Agency, South West

HIV and AIDS

HIV is the virus that causes AIDS, an infection affecting the immune system for which there is no cure. The patterns of infection of HIV are changing nationally. For the first time in 1999 the number of infections acquired heterosexually exceeded those acquired homosexually. An increasing number of infections are in people from Black African groups. With fewer deaths resulting from improved treatment and an increasing number of new infections, the number of people living with HIV (prevalence) is rising⁵.

The patterns in Bristol are similar to those nationally, with the number of people living with HIV increasing and more infections transmitted heterosexually (see Figure 1.17 below). While the most common route of infection in Britain is men having sex with men, the proportion acquiring the disease heterosexually is likely to increase.

Figure 1.17: Probable Route of HIV Infection of Patients Last Seen for Care in 2002



Source: SOPHID 2002

While we will continue to focus preventive interventions on the homosexual community, it is increasingly important to assess needs within the heterosexual community, particularly those in the Black African and Black Caribbean groups.

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What is Ethnicity?

Ethnicity refers to social groups who share a cultural heritage with a common language, values, religion, customs and attitudes¹. It is distinct from race, which is based on biological differences, such as skin colour.

Over time, definitions for different ethnic groups have changed as understanding of the dimensions of ethnicity have evolved along with societal values and attitudes. The 2001 Census introduced new categories of mixed ethnicity to reflect the changing nature of the British population.

Classifications are limited since they fail to take into account the cultural diversity within ethnic groups that makes them distinct. This means that some ethnic groupings including travellers, Eastern Europeans, and those from the Middle East are often hidden, and assumptions are made about a range of groups based on averages that may not be a fair representation.

Despite this, useful health information is available from the Census though needs to be complemented by input from local communities to truly understand the diversity of experience. See Table 3.1 overleaf for summary of the population breakdown for ethnicity, comparing England, Bristol Unitary Authority and each of the Bristol PCTs.

Table 3.1 Population by Ethnicity

	England	Bristol UA	BS & W PCT	BN PCT
ALL PEOPLE	100.0	100.0	100.0	100.0
White: British	87.0	88.0	91.1	85.5
White: Irish	1.3	1.1	1.0	1.2
White: Other White	2.7	2.7	2.6	2.7
Total White	90.9	91.8	94.8	89.4
Mixed: White and Black Caribbean	0.5	1.0	0.7	1.3
Mixed: White and Black African	0.2	0.2	0.2	0.2
Mixed: White and Asian	0.4	0.4	0.4	0.5
Mixed: Other Mixed	0.3	0.4	0.3	0.5
Total Mixed	1.3	2.1	1.6	2.5
Asian or Asian British: Indian	2.1	1.2	0.8	1.5
Asian or Asian British: Pakistani	1.4	1.1	0.6	1.4
Asian or Asian British: Bangladeshi	0.6	0.3	0.1	0.5
Asian or Asian British: Other Asian	0.5	0.3	0.2	0.3
Total Asian or Asian British	4.6	2.9	1.7	3.8
Black or Black British: Black Caribbean	1.1	1.5	0.5	2.3
Black or Black British: Black African	1.0	0.6	0.4	0.8
Black or Black British: Other Black	0.2	0.2	0.1	0.4
Total Black or Black British	2.3	2.3	1.0	3.4
Chinese	0.4	0.6	0.6	0.6
Other Ethnic Group	0.4	0.3	0.3	0.4
Chinese or Other Ethnic Group	0.9	0.9	0.9	0.9

Source: 2001 Census

Ethnicity and Health

Research into differences in health between Black and Minority Ethnic groups, has repeatedly shown certain groups to be at considerable disadvantage.

Many factors contribute to differences in health status including:

- Access to services
- Lifestyle
- Genetics
- Socio-economic status
- Factors associated with displacement and discrimination or racism.

A recent review of research into ethnicity and health concluded that the most important contributors to poor health are probably socio-economic factors and experience of racism². Tackling health inequalities and planning health services requires an understanding of the contributions these factors make to the health of the Black and Minority Ethnic (BME) population.

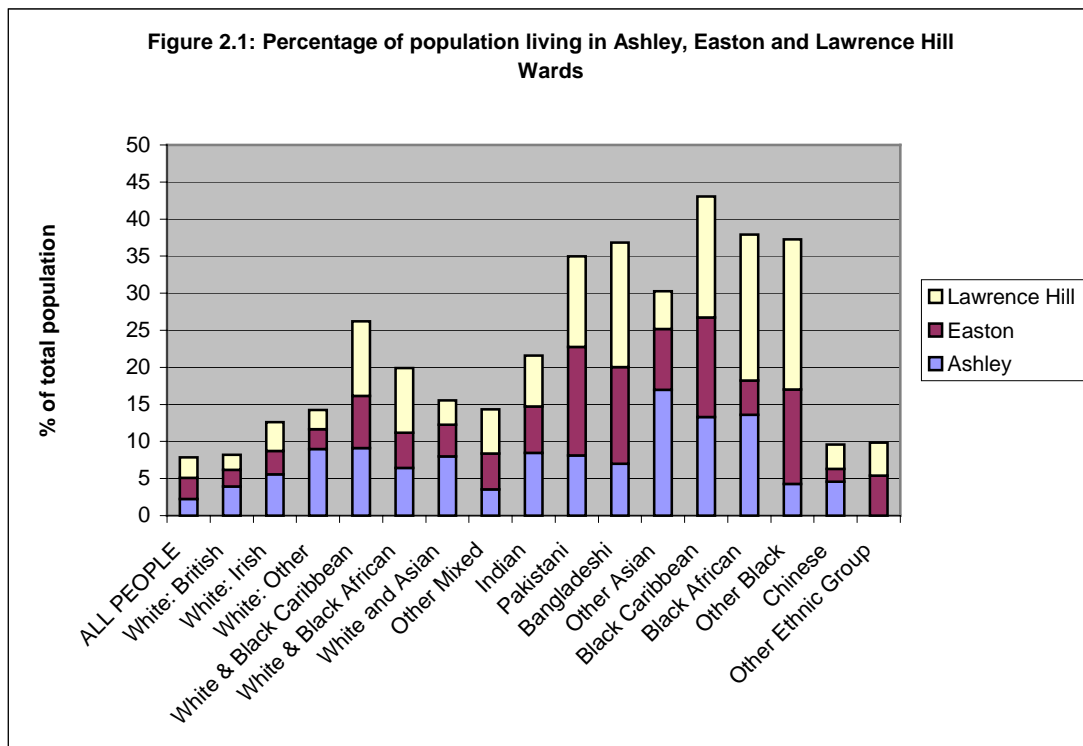
Socio-Economic Factors

The Census provides information about some of the major determinants of health, such as housing, education, employment and place of residence broken down by ethnic grouping.

Deprivation

As with other cities, certain Black and Minority Ethnic groups in Bristol are concentrated in a few areas. Over a third of Pakistani, Bangladeshi, Black Caribbean, Black African and Black Other groups live in Lawrence Hill, Ashley and Easton. These three wards are in the top five most deprived wards in Bristol (see Figure 2.1 below).

Figure 2.1: Percentage of Population Living in Ashley, Easton and Lawrence Hill Wards



Source: 2001 Census

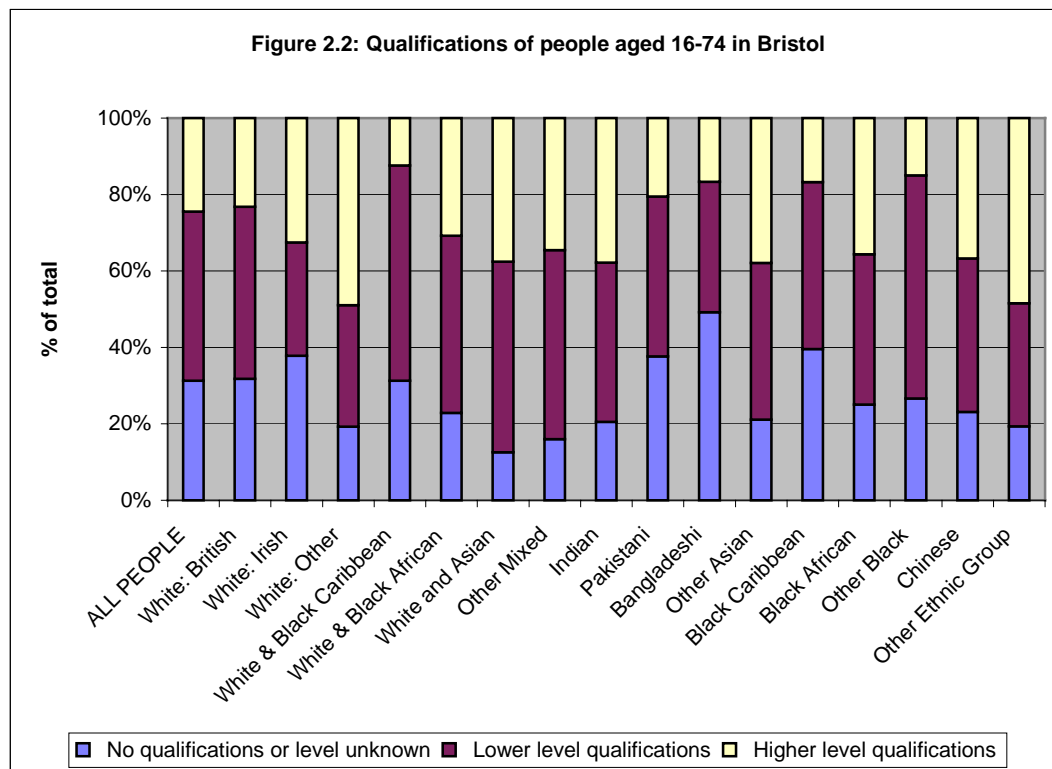
Conversely, certain ethnic groups have higher proportions of their population in affluent wards. Eight percent of the Bristol population live in the three most affluent wards of Henleaze, Stoke Bishop and Westbury-on-Trym. However 14.1% of all Chinese in Bristol live in these wards. Other groups which have a higher proportion of their population in these affluent wards are:

- Mixed White and Asian (12.8%)
- White Other (11.5%)
- Other Asian (11.0%)
- Other Mixed (8.5%)
- Indian (8.4%).

Education

There are wide variations in the education levels between the Black and Minority Ethnic groups. Groups with the highest proportion of people with no qualifications are Bangladeshis (49%), Black Caribbean (40%), and (38%) Pakistani and White Irish.

Figure 2.2: Qualifications of People Aged 16 – 74 in Bristol



Source: 2001 Census

Employment

A new method of measuring socio-economic status was introduced into the 2001 Census. The National Statistics Socio-economic Classification (NS-SeC) is based on occupation, but has rules to provide coverage of the whole adult population. It is divided into eight categories. The results for categories 1 (higher managerial and professional occupations) and 8 (never worked or long term unemployed) are shown Table 2.2 overleaf. In Bristol:

- Indian males and Mixed White and Asian females have the highest proportion of their populations assigned to NS-SeC1, 'higher managerial and professional occupations'.
- Black African men and Pakistani women have the highest proportions in NS-SeC 8, 'Never worked and long term unemployed'.

Table 2.2 National Statistics Socio-economic Classification of Ethnic Groups shown as percentages

	NS-SeC Higher managerial & professional occupations		Never worked and long-term unemployed	
	Males	Females	Males	Females
ALL PEOPLE	17.1	8.8	3.3	5.5
White: British	16.7	8.4	2.9	4.3
White: Irish	21.6	13.9	4.9	5.6
White: Other White	29.5	17.3	3.4	5.2
Mixed: White and Black Caribbean	6.7	3.2	9.9	12.7
Mixed: White and Black African	11.8	9.8	9.2	8.2
Mixed: White and Asian	26.2	17.7	3.7	6.5
Mixed: Other Mixed	18.9	14.5	7.0	8.3
Indian	32.4	13.6	4.6	14.7
Pakistani	13.3	5.1	7.1	49.9
Bangladeshi	7.1	3.6	7.8	44.5
Other Asian	21.2	10.5	7.6	23.0
Black Caribbean	8.4	5.6	9.5	8.0
Black African	15.2	4.7	22.8	29.4
Other Black	4.5	5.5	14.4	12.6
Chinese	23.0	14.7	3.3	12.2
Other Ethnic Group	27.6	9.9	6.6	13.0

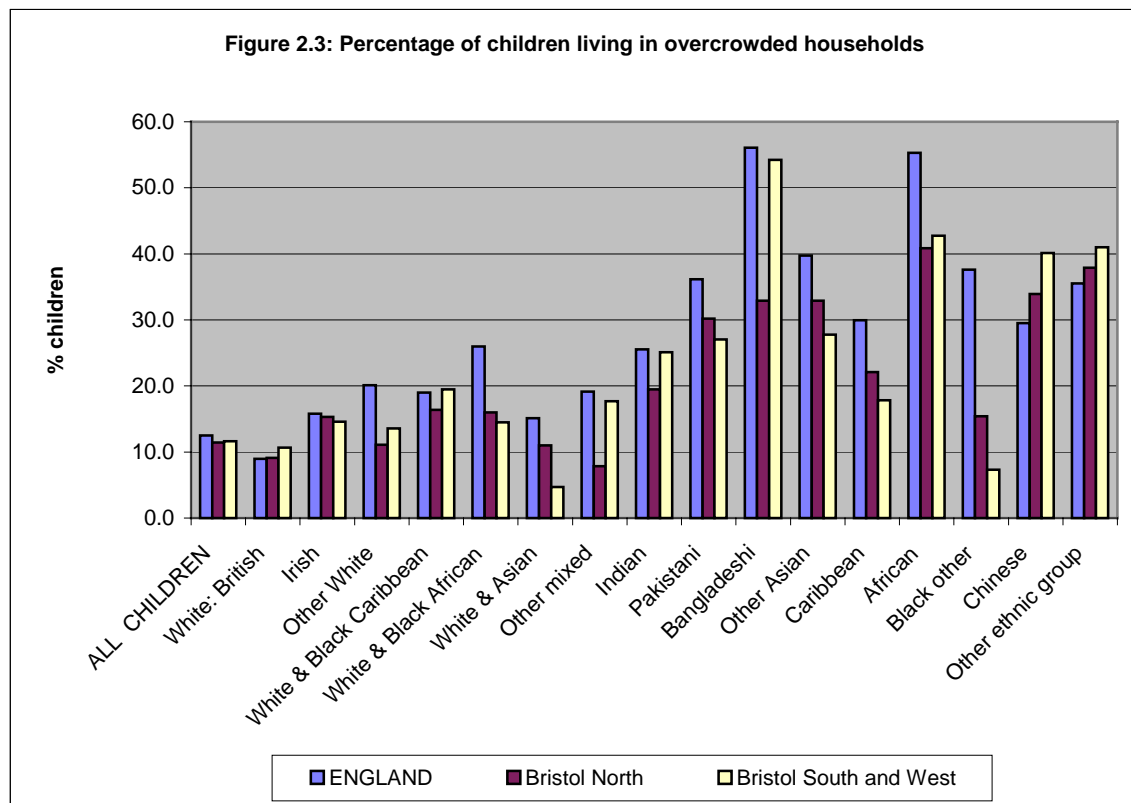
Source: 2001 Census

Housing

Overcrowding is thought to increase the risk of respiratory diseases and infections such as tuberculosis, gastrointestinal disease such as diarrhoea, and mental illness such as depression³.

In Bristol households with children, who are particularly vulnerable to respiratory and gastrointestinal diseases, levels of overcrowding are higher in almost all Black and Minority Ethnic groups than the experience across the population as a whole. Compared to the national levels, the situation for Bangladeshi children is particularly poor, with over half of Bangladeshi children living in overcrowded households compared to about a third nationally (see Figure 2.3 overleaf).

Figure 2.3: Percentage of Children living in Overcrowded Households



Source: 2001 Census

Measuring Ethnicity and Health

Information about the health of the population and use of services has not been routinely available according to ethnicity. Data from registrations of births and deaths, from which mortality, low birth weight and life expectancy is calculated, cannot be broken down by ethnic group. GP surgeries collect a lot of information about diseases that disproportionately affect some ethnic groups such as diabetes and coronary heart disease. Yet only three GP practices in Bristol have started routinely collecting information on the ethnicity of their practice population.

National and International studies have found that mortality rates of migrants tends to be lower than in their country of origin, but higher rates of mortality are experienced by many migrants to the UK in comparison to the general UK population. These higher rates of mortality persist into the second generation¹.

Recording Information

Health services, including hospital services and Walk-in Centres are beginning to collect information on ethnicity, using the 2001 Census categories. Other health service datasets use outdated ethnic categories such as the 1991 Census categories. For example: the Child Health Surveillance System, which holds details of all babies born in Bristol including weight, breastfeeding status and immunisation. Changes in categories also make it difficult to assess trends over time.

Incomplete Collection of Data on Ethnicity

Even when appropriate categories are used, ethnicity is often not recorded. One example of this is admissions to hospital. While there has been sustained improvement in recording of ethnicity over recent years in 2003/04, ethnic origin was not given in 28% of admissions to United Bristol Healthcare Trust (UBHT) (Bristol Royal Infirmary) and 13% of admissions to North Bristol Trust (NBT) (Southmead and Frenchay)

Public Health Intervention**Health Improvement and Modernisation Programme (HIMP)**

Rapid improvements in health can be gained where good information is combined with well organised services focused on high risk groups. The South Asian Living with Heart Disease Project, supported and monitored the implementation of the National Service Framework on Coronary Heart Disease in Primary Care¹⁰. Following this effective intervention, a 2002/03 repeat audit showed improved management and care across the 17 GP practices selected for having high proportions of patients of South Asian origin. Scope for further improvement in health status and life style monitoring is being pursued.

A report has been produced summarising the findings of the repeat clinical audit as well as the baseline-repeat audit comparison. This is available online: http://www.avon.nhs.uk/phnet/Publications/ischaemic_august2004.pdf

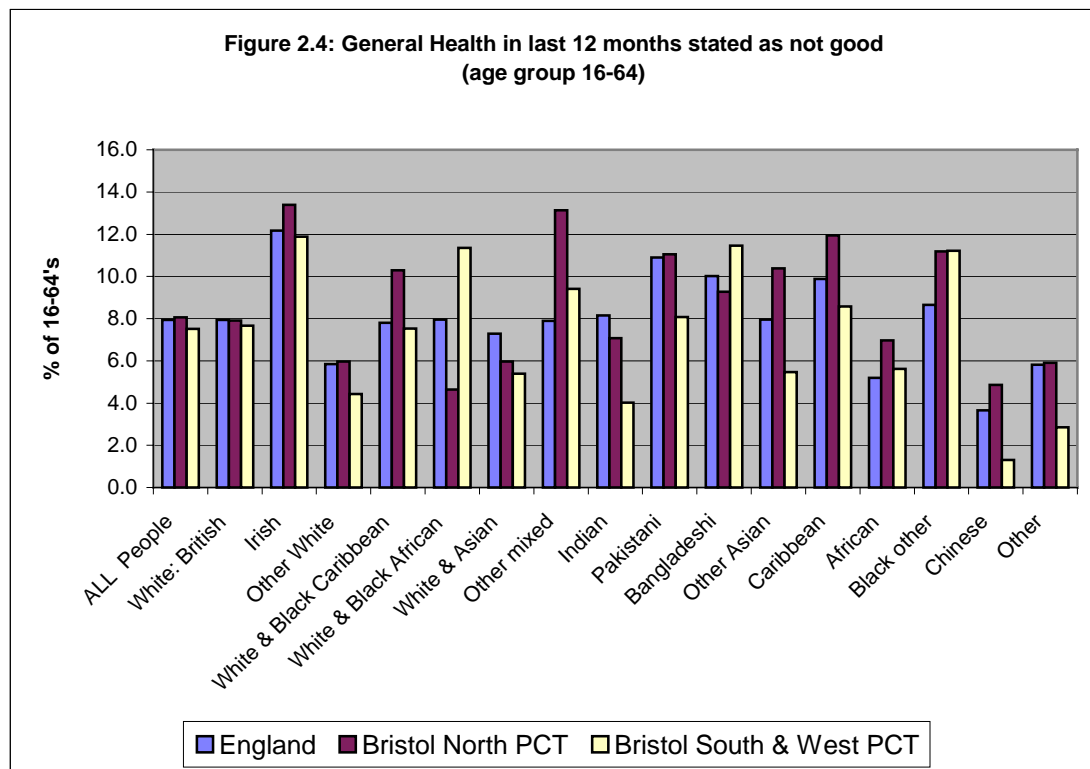
Health Status

The 2001 Census reported people's self assessment of general health in the last 12 months. Comparing the proportion stating that their health was 'not good' with the Bristol average:

- In Bristol North PCT the three groups with the highest levels of poor health were Bangladeshi, Irish and Pakistani.
- In Bristol South and West PCT, the three groups with highest levels of poor health were Irish, Bangladeshi and Mixed 'White and Black Caribbeann'.

Certain groups, in particular the Chinese, reported relatively good health. This is consistent with national patterns.

Figure 2.4: General Health in Last 12 Months Stated as 'not good'



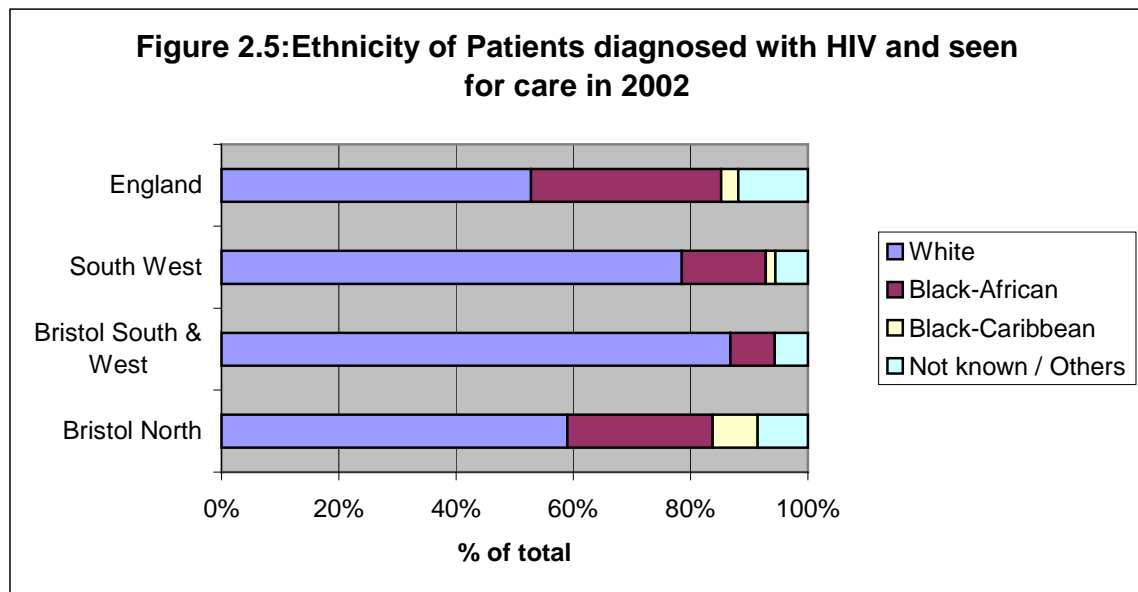
Source: 2001 Census

Communicable Diseases

People from Black and Minority Ethnic groups in Bristol have disproportionately more serious communicable disease, including TB and sexually transmitted diseases, such as HIV and gonorrhoea^{4, 5} than the average level in the population.

Although only 0.8% of the Bristol North PCT population are from Black African groups, they constitute a quarter of those diagnosed with HIV. A similar situation is seen in Bristol South and West PCT and nationally (see Figure 2.5 overleaf).

Figure 2.5 Ethnicity of Patients Diagnosed with HIV



Source: 2002 SOPHID

A similar pattern is found with gonorrhoea. In Bristol, 2.3% of the population were from Black and Minority Ethnic groups according to the Census. However in 2003, 24% of diagnosed gonorrhoea cases in the Genitourinary Medicine (GUM) Clinic at the Milne Centre were in Black Caribbean and Black (Other) groups⁶ The ethnicity of 25% of Milne attenders was unknown.

In 2002, 70% of the 83 tuberculosis cases in Bristol were amongst people born outside of the UK and 65% were in Black and Minority Ethnic groups⁷ The total number of cases of tuberculosis in Avon rose by 41% between 1999 and 2002.

Non Communicable Disease

Because of the lack of data or incomplete data collection, knowledge about certain diseases must come from national surveys or reviews. A recent review of the information found that²

- **Coronary Heart Disease:** South Asian people, in particular the poorest groups of Pakistani and Bangladeshi origin, have the highest rates.
- **Lung Cancer:** Rates in England are higher in men and women from Scotland and Ireland, but lower in other migrant groups.
- **Breast Cancer:** Mortality rates are lower in women from migrant communities.
- **Diabetes:** A higher prevalence of diagnosed non-insulin dependent diabetes occurs in South Asians and Caribbeans. Compared to the general population, mortality is three and a half times higher in South Asian migrants and Caribbean men, and six times higher in Carribean women.
- **Mental Health:** The reported rate of schizophrenia is higher in Black Caribbean men than other groups

A similar information gap exists in understanding lifestyle factors. The same review found that:

- **Tobacco:** Bangladeshi men have higher than average rates of smoking, and Bangladeshi women high rates of chewing tobacco although significant differences exist between surveys.
- **Alcohol:** White and Caribbean men have higher levels of alcohol consumption than average, while Pakistani men have lower levels.
- **Exercise:** Compared to other groups, Bangladeshi men and Pakistani men and women are much less likely to participate in vigorous physical activity.

Genetics

Certain genetic disorders are only found in particular ethnic groups. For example:

- 3-17% of people with Mediterranean and Asian origins are carriers of thalassaemia, an inherited blood disorder
- 8-25% of people of African or African-Caribbean origins are carriers of another blood disorder, sickle cell disease
- 4% of white Europeans are carriers of cystic fibrosis⁸.

Carriers do not experience ill health, but there is a one in four chance that a baby will have the disease if both parents are carriers. In Avon it has been estimated that:

- 0.3 babies per year will be born with thalassaemia disease
- 1.5 babies per year will be born with sickle cell diseases⁹.

The majority of these babies will be born in Bristol as over three quarters of Avon's Black and Asian population live in Bristol.

Use of Services

Attitudes towards and use of health services vary by ethnic group. Services need to be sensitive to the needs of communities for example by:

- Providing translation services and material in different languages
- Recognising and responding to cultural and religious differences
- Ensuring staff have been trained in cultural diversity
- Targeting services to Black and Minority Ethnic groups especially where there is a higher risk of disease
- Involving Black and Minority Ethnic groups in service planning.

Inconsistent use of ethnicity categories, incomplete and inaccurate data collection causes problems in assessing use of health services in relation to need.

Summary

The Census revealed that many Black and Minority Ethnic groups are living at considerable socio-economic disadvantage, in the most deprived areas of the city with low education and employment levels.

Black and Minority Ethnic groups disproportionately experience many of the major causes of mortality and morbidity such as CHD and diabetes. Within Bristol, there is also evidence of higher risks of infectious disease. It is important that PCTs work to develop preventive treatment and strategies that are acceptable to the communities involved.

Efforts should be made within the NHS to ensure that data on ethnicity is recorded consistently and used to monitor uptake of services in relation to need. Until reliable data becomes available, it is difficult to target services in appropriately.

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Health of Children and Young People

The Government's agenda for children, young people and families is now high profile and compelling. The Kennedy¹ report on paediatric cardiac surgery and the Laming report on Victoria Climbié² have triggered new policy initiatives to improve the health of children: the National Service Framework (NSF) for Children, Young People and Maternity Services³ and the recent Children Bill following the Every Child Matters Green Paper⁴.

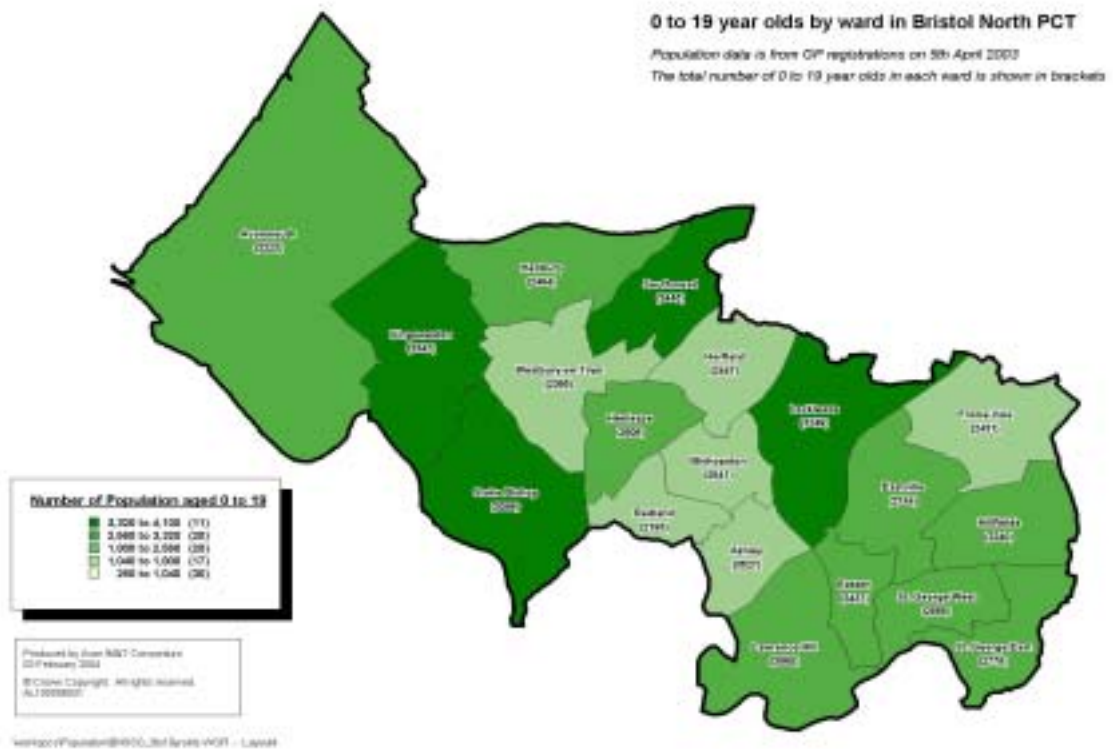
These initiatives herald a new focus on health, wellbeing and health promotion, as well as on service provision. They advocate child-centred services addressing the needs of the whole child. The NSF is a ten-year plan requiring health, social and educational services to work together to meet eleven key standards.

Every Child Matters⁴ required the creation of a Children's Commissioner for England and for all Local Authorities to appoint a Director of Children's Services and a lead council member for children. These steps aim to raise the needs of children and to ensure a multiagency and fully integrated response.

Demography

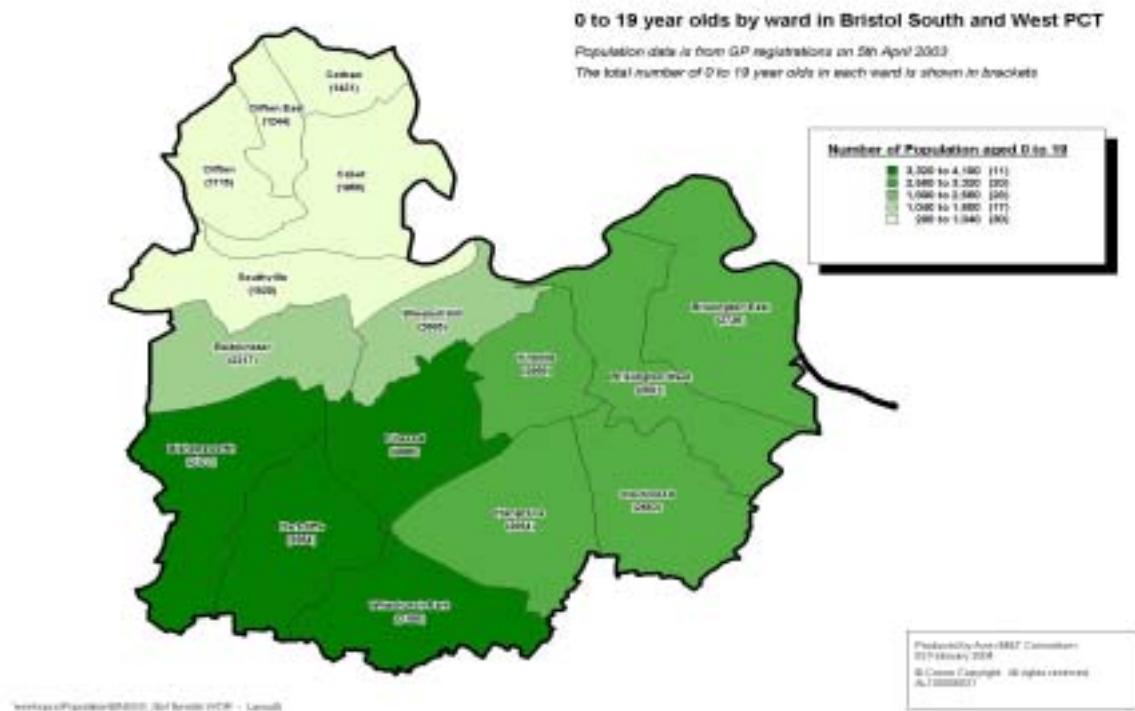
Estimated resident population mid 2003 figures for Bristol from the Office of National Statistics (ONS) show that Bristol has a population of some 66,300 children under the age of 15 years and 26,3300 aged 15 - 19. There are slightly more males than females (51.3% male, 48.6% female). Bristol has a slightly lower proportion of under 15 year olds (16.9%) compared to England (19.7%). Figures 3.1 and 3.2 show the relative proportion of 0-19 year olds by wards for Bristol North PCT and Bristol South and West PCT respectively.

Figure 3.1: 0–19 Year Olds by Ward Bristol North Primary Care Trust



Source: Exeter system

Figure 3.2: 0 – 19 Year Olds by Ward in Bristol South and West Primary Care Trust



Source: Exeter system

Fertility

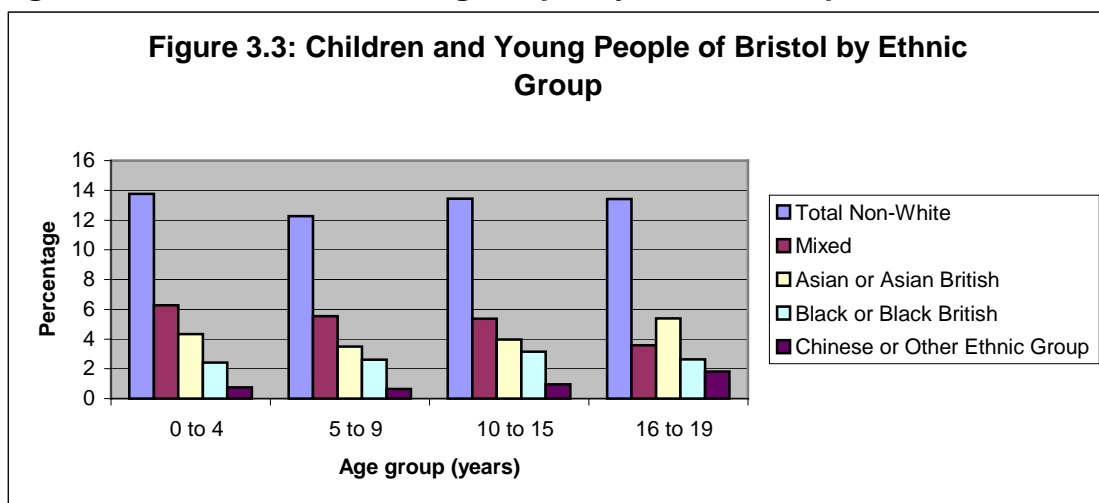
The fertility rate is the number of births per 1000 women aged 15 - 44. When compared with the standard England population the “standardised fertility” ratio describes the relative fertility of the population. In the most recent data (2002) the standardised fertility ratio for Bristol North PCT was 97 and for Bristol South and West PCT was 85 reflecting lower fertility than England as a whole (fertility ratio = 100). This is an interesting finding given the high proportion of people in the city within the fertile age range and may reflect the mobile student population delaying child bearing or moving away from the City to start families.

Crude birth rates in Bristol North PCT in 2002 were higher than those for England and Wales, with 57.7 live births per 1,000 women aged 15 – 44 compared to 55.7 for England and Wales⁵. The birth rate in 2002 for Bristol South and West PCT was 46.8 live births per 1,000 women aged 15 – 44.

Age Structure and Ethnicity

At the time of the 2001 Census⁶ of 116,749 children and young people (aged 0 to 19) living in Bristol, 101,161 (86.6%) were white, and 15,588 (13.4%) were from Black and Minority Ethnic groups. For 5 year age bands Figure 3.3 below shows the percentage of children and young people in each Black and Minority ethnic group in Bristol.

Figure 3.3: Children and Young People by Ethnic Group



Source: 2001 Census Key Statistics

Health Inequalities

Social and environmental circumstances during childhood have lasting effects on health and life expectancy. Strengthening communities, improving housing and the environment, tackling poverty and raising standards of education are key to improving the lives and health of children.

Babies of mothers living in poverty are more likely to be born prematurely or have a low birth weight. Children living in poverty are more likely to experience passive smoking, poor diets and have a higher rate of childhood infections⁷.

Infant Mortality Rates

Infant mortality (death in the first year of life) is a key indicator sensitive to inequalities in health. Comparisons are difficult, however because of the small numbers involved. The infant mortality rate in Bristol is comparable to the national average. In 2002 rates were: 5.3 per 1,000 live births for England and Wales compared with 5.5 per 1,000 live births for Bristol.

Low birth weight (birth weight < 2,500g) is a risk factor for childhood disability and poor health in later life and is associated with poverty. In 2002 the percentage of low birth weight babies in Bristol was 1.5% under 1500 grams (compared to 1.5% for England and Wales) and 7.6% under 2500 grams (compared to 7.9% for England and Wales)⁵.

Education

Pupils leaving secondary education in Bristol have shown lower levels of achievement than in England as a whole, though the situation is improving. In 2003, 11.4% of pupils left school in Bristol with no qualifications, (no passes at GCSE / GNVQ), in 2003, compared to 5.2% for England. The schools with lowest levels of attainment are concentrated in the areas of Filwood, Windmill Hill, St George West, Southmead, Lawrence Hill, Brislington East, Hartcliffe and Whitchurch East with 26% of children not achieving five A* to C grades at GCSE. The percentage of school days lost due to fixed term exclusion also tend to be higher in the schools with lower attainment levels.

The Healthy Schools Programme has continued to work in partnership with the LEA to raise pupil achievement, promote social inclusion and reduce health inequalities, particularly focusing on schools with more than 20% free school meal eligibility. A new multi agency partnership, including the Healthy Schools Programme, has recently been developed to support the planning and delivery of an Emotional Literacy Strategy for schools across Bristol. The Healthy Schools Programme is also responsible for promoting the Healthy Living Blueprint⁸ distributed to all schools in September 2004.

Housing

In 2001, 11.5% of dependent children in Bristol were living in overcrowded households, compared to a 12.5% national average. This rate was higher in the more deprived wards of Windmill Hill, Lawrence Hill, Lockleaze, Filwood, Southmead, Easton, Cabot and Ashley.

Evidence shows that lone parent families, and large families where adult members are either unemployed or earn low wages, along with older people and people with disabilities, are at risk of fuel poverty - a household that needs to spend more than 10% of its income on heating its home to an adequate standard of warmth⁹.

5.3% of dependent children in Bristol live in a home with no central heating similar to the national average of 5.9% although the percentage of children living in housing with no central heating was higher in deprived wards, in particular in Knowle and Bishopsworth.

Mental Health

Mental health problems in the young are strongly predictive of poor mental health and social outcomes in later life and are associated with educational failure, family disruption, physical disability, offending and antisocial behaviour. Nationally it has been estimated that 10% of 5-15 year olds have a mental disorder; 5% have a clinically significant conduct disorder; 4% an emotional disorder and 1% are hyperactive.

The Priorities and Planning Framework and the Children's National Service Framework state that a comprehensive Child and Adolescent Mental Health Service (CAMHS), including mental health promotion and early intervention should be achieved by 2006.

Accidents

After the first year of life accidents are an important cause of preventable death. In young children these occur mainly in the home but from the age of five they are increasingly traffic related. The mortality rates for all ages for accidents in the Bristol area have shown a steady decline throughout the last decade but local data for children is not available. National surveys suggest that the rates of non-fatal major accidents in children are falling and that the incidence of serious accidents peaks at the age of three and again among young men in their teens and early twenties¹⁰.

Vulnerable Groups

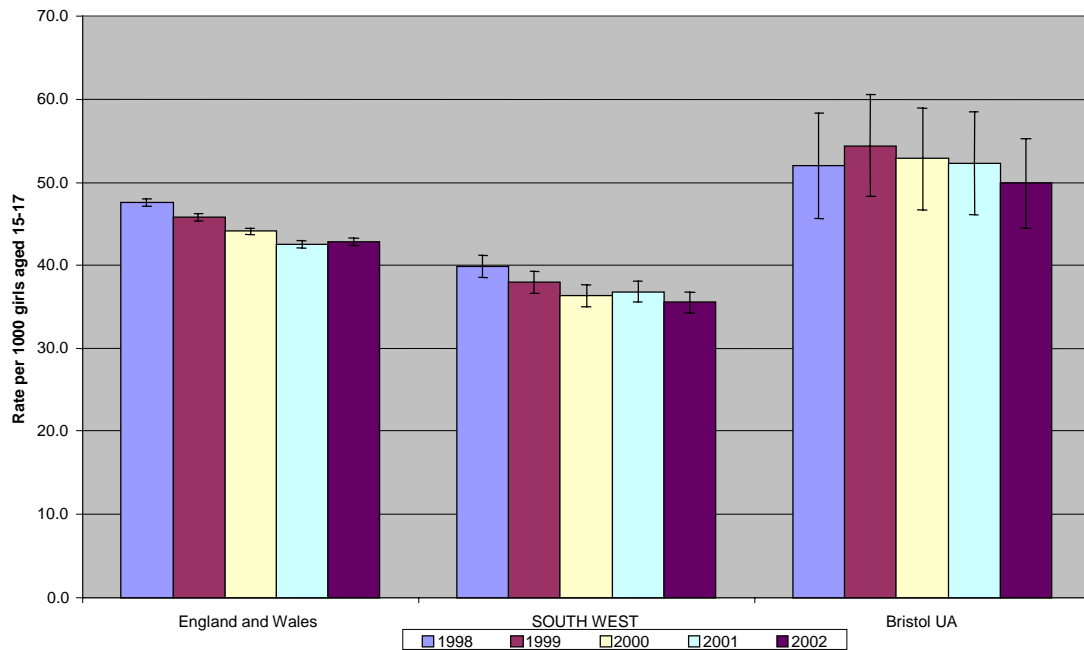
Families

Teenage parenthood is both a cause and a consequence of social exclusion, with teenage parents being more likely than their peers to live in poverty. Giving birth at a young age is associated with poor educational, social, economic and health outcomes for both mother and child.

The under 18 conception rate for Bristol has for some time been the highest rate among the local authorities in Avon: Bath, North Somerset and South Gloucestershire and is higher than the South West as a whole. The figures for 1998–2002 may however begin to show a downward trend from 52 to 49.9 conceptions per 1000 (females aged 15 – 17), see Figure 3.5 overleaf.

Figure 3.5: Conception Rates in Under 18s

Figure 3.5: Conception Rates in under 18s

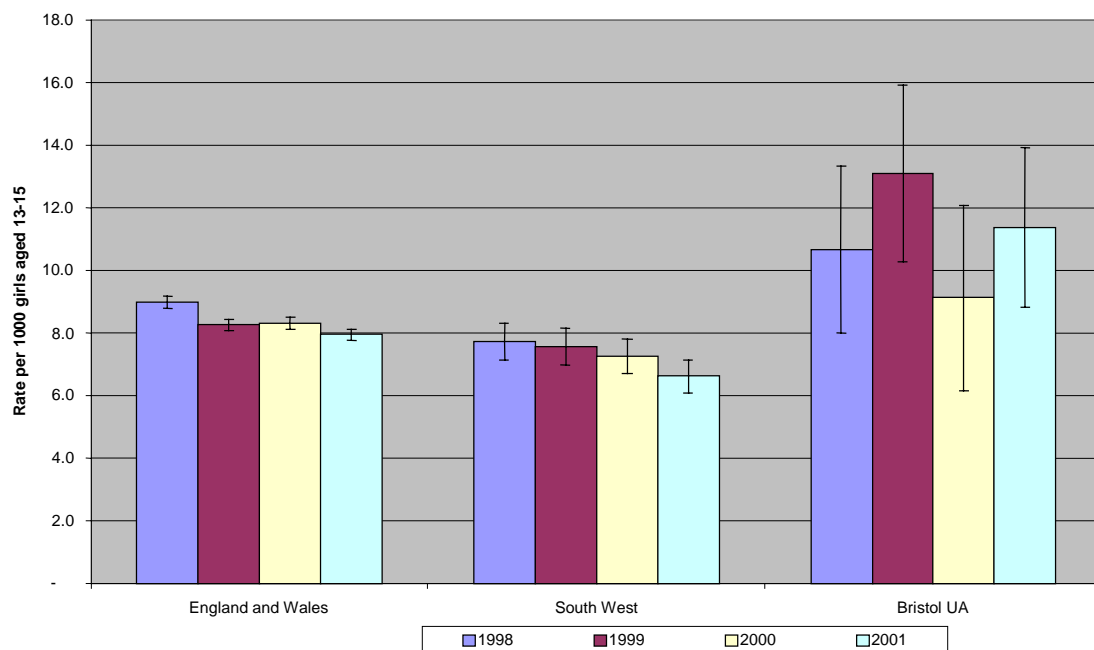


Source: ONS

Figure 3.6 below looking at under 16 conceptions, also shows a higher rate in Bristol than in the South West of England as a whole. Variation in the data is caused by small numbers and a downward trend is by no means established.

Figure 3.6: Conception in the Under 16s

Figure 3.6: Conceptions in the under 16s



Source: ONS

Nationally 40% of teenage mothers experience postnatal depression, this is three times higher than other mothers. Infant mortality is more than 50% higher than the average and birth weights are likely to be lower. Children born to teenage mothers are twice as likely to be admitted to hospital as a result of accidents or gastroenteritis than other children of the same age⁷.

A new joint target has been set with the Department of Health and the Department of Education and Skills to reduce the under-18 conception rate¹¹:

“Reducing the under-18 conception rate by 50% by 2010 (from the 1998 baseline), as part of a broader strategy to improve sexual health”.

Local Initiatives

Implementation of the Teenage Pregnancy Strategy in Bristol

Teenage pregnancy and parenthood are important public health issues and collaboration with a broad range of partners is required to reduce conceptions and improve the health of teenage parents and their children. The work across the PCTs, Bristol City Council and other voluntary sector organisations is a good example of local partnership working. The strategy encompasses sex and relationship education, contraceptive and sexual health services and the provision of a range of other services to give young parents education, training and employment opportunities. Examples of the many initiatives includes work within the Meriton School which provides tailored educational facilities for school aged mothers. Teen Confidential Henbury is a partnership between primary care and young people’s services where young people needing to talk to a nurse or youth worker in confidence about a health related issue can drop-in to the Brentry Youth Centre. Services include emergency contraception, free condoms, chlamydia tests as well as an opportunity to talk about safer sex, drugs, exercise and diet, relationships, stress or anything else of concern.

Looked After Children

Looked after children are those cared for by the local authority. Most are placed with foster carers but some are placed in residential homes. There is clear evidence of higher than average health needs and increased risk of disability. Many have experienced families affected by drug or alcohol misuse or domestic violence, or have come from a highly mobile family. Uptake of health services among Looked After Children such as dental services, immunisations, health surveillance and health promotion is frequently low.

Over 7,200 children in Bristol were referred to Social Services in 2002/03 by a range of agencies: 525 were recorded as being Looked After by the local authority on the 31st March 2004.

Both Bristol PCTs are devising a joint action plan with Bristol Social Services to undertake health assessments for all Looked After Children. The PCTs have allocated resources to provide designated nurse support for Looked After Children from within the school nursing team.

Child Protection

Children on Local Authority Child Protection Registers are separate though often overlapping from Looked After Children. The Child Protection Register (CPR) indicates children at risk of abuse in the family. In Bristol in recent years there has been a decline in the rate of children (aged under 18 years) being placed on the register from 51 per 10,000 in March 2000 to 30 per 10,000 in March 2003. The length of time children are on the register is also decreasing. The figure below shows the numbers of children by ward in Bristol North PCT and Bristol South and West PCT.

Figure 3.7: Children on Child Protection Register Bristol North PCT

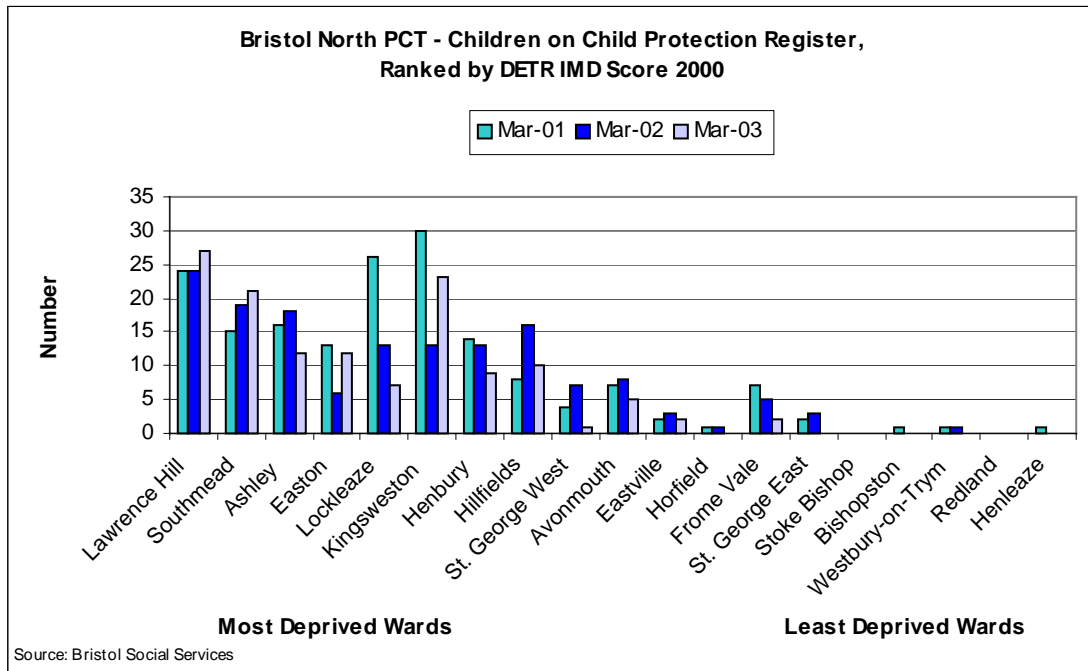
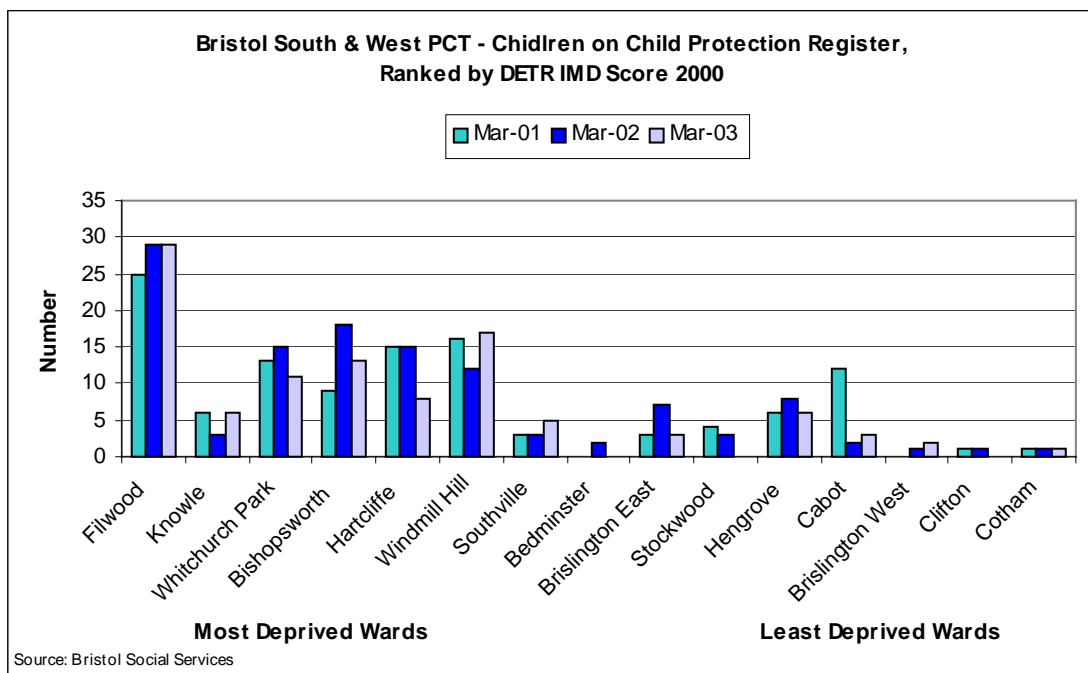


Figure 3.8: Children on Child Protection Register Bristol South and West PCT



Family Lifestyle and Risk Taking Behaviour by Children and Young People

Breastfeeding and Infant Feeding

There are proven health benefits of breastfeeding for both mother and child. Breast fed babies have a lower risk of gastro-enteritis, respiratory, urinary tract and ear infections, eczema and wheezing than children who are bottle-fed. Mothers who breast-feed reduce their risk of pre-menopausal breast cancer, ovarian cancer and hip fractures. The National Infant Feeding Survey, carried out every five years, has shown a significant difference in the numbers of mothers breastfeeding in different social classes. The last survey in 2000¹⁴ found that 91% of mothers in social class 1 initiated breast-feeding compared to just 57% in social class 5¹⁴. The proportion of babies who are initially breastfed has been increasing in England and Wales (69% in 2000) but the numbers fall to 52%, 28% and 21% at two weeks, four months and six months respectively. Current Department of Health recommendations are that babies are solely breast fed until the age of six months.

The NHS Priorities and Planning Framework (PPF) target¹⁵ for breastfeeding is to:

“Deliver an increase of 2% per year in breastfeeding initiation rate, focusing especially on women from disadvantaged groups”.

In 2002, 55% of mothers in Bristol North PCT were breastfeeding at six to eight weeks. Avonmouth, Henbury, Kingsweston and Southmead have significantly lower rates of breastfeeding compared to the Bristol average.

In 2002, 43% of mothers in Bristol South and West PCT were breastfeeding at six to eight weeks. Bishopsworth, Filwood, Hartcliffe, Stockwood and Whitchurch Park have significantly lower rates of breastfeeding compared to the Bristol average.

Local Initiatives on Breastfeeding

Both Bristol PCTs have developed a multi agency breastfeeding strategy which was adopted in January 2004.

The Effect of Smoke and Smoking on Children and Young People

See Chapter 5

Alcohol and Drug Use

There is increasing concern about alcohol drinking among young people, the association with crime and the potential damage to health. As many as 94% of young people have tried alcohol by the age of sixteen. Alcohol consumption among the young is significantly higher (average 9.9 units a week in 1998) than it was in 1990 (5.3 units)¹⁷. School surveys have shown that 14-15 year old girls are now consuming more spirits than boys at this age¹⁸. The prevalence of reported alcohol consumption in 8 to 15 year olds

has increased with rising household income and social class. Young adults aged 16-24 years are the heaviest drinking section of the population with 12% of males and 7% of females aged 16-19 showing signs of alcohol dependence.

In young people common severe effects of alcohol misuse are:

- Severe intoxication
- Road and water accidents
- Facial injuries caused by violence and accidents.

There is also a strong association between alcohol misuse and unsafe sexual practice and male suicide. These compelling findings underpin the determination of government to develop policies to reduce the overall alcohol consumption nationally¹⁹ as detailed in the National Alcohol Strategy. Alcohol related problems in young people are often under-reported or managed inappropriately by service providers; further training for frontline staff would support earlier detection and treatment of this growing problem.

Factors leading to smoking, drinking and drug misuse are also highly interrelated. A survey of 11-15 years olds in England in 2001 suggested that the increase in drug taking reported in the late 90s was continuing; 20% of those surveyed had taken drugs in the last year and 12% in the last month¹⁹. A number of factors have been identified that increase susceptibility to drug use amongst young people:

- Smoking
- Early use of alcohol
- Bullying
- Peer pressure
- Abuse and stress
- Mental illness
- Deprivation
- Parental drug and alcohol abuse

Local Initiatives on Alcohol and Drugs

The Bristol Drug Strategy Team, part of the Safer Bristol Partnership, is responsible for local implementation of the national drugs strategy. This includes commissioning services for young people, ranging from prevention to treatment.

The outcome of a consultation in Bristol with vulnerable young people and workers in February 2004 has been to develop training for agencies working with vulnerable young people and identification of particular new resources to support this work. Of concern is the need to identify housing, employment and training opportunities to prevent recourse into drug misuse.

Nutrition, Obesity and Physical Activity

Over half the UK population is either overweight or obese. In 2002, 70% of men and 63% of women were classified as being either overweight or obese.

Obesity in 2 to 4 year old children almost doubled from 5% to 9% from 1989-1998, and in 6 to 15 year olds trebled from 5% to 16% between 1990 and 2001²⁰. The long-term consequences are significant. Heart disease, stroke, joint problems and Type 2 diabetes are direct effects of overweight and obesity.

The cause of overweight and obesity is multi factorial. In general it seems that calorie intake has not reduced significantly to offset the dramatic decline in physical activity in the population seen at the latter end of the twentieth century²¹.

Type 2 diabetes, previously only seen in adults, is now being diagnosed in children. The Health Survey for England found that levels of physical activity were generally lower in girls than boys and that for both sexes declined from the age of 8 years. At 15 years, 7% of boys, but only 36% of girls were engaging in 30 minutes of physical activity per day. The Department of Health (2004) recommends that children participate in an hour of moderate intensity physical activity at least five days per week²². The eating habits of children are related to social class and household income, with the frequency of fruit and vegetable consumption decreasing in line with socio-economic groups, while proportions of sweet foods, soft drinks and crisps increase.

Lifestyle patterns and behaviours are established in childhood and so initiatives aimed at children and families that promote healthy eating habits and increase levels of physical activity throughout life are vital. This requires a partnership approach to provide easy access to facilities such as safe pedestrian and cycle routes to schools, easy access to good affordable food and affordable leisure activities to all sections of the community, particularly disadvantaged and marginalised groups.

A new joint target set by the Department of Health, the Department of Education and Skills and the Department of Culture, Media and Sport aims to reduce the rise in childhood obesity in children¹¹:

“Halting the year-on-year rise in obesity among children under 11 by 2010 (from the 2002-04 baseline) in the context of a broader strategy to tackle obesity in the population as a whole.”

The development of Bristol wide strategies on physical activity, food and health and overweight and obesity, in conjunction with partner agencies, particularly Bristol City Council will be key in delivering this target.

Oral Health

The Community Dental Service carries out dental surveys on school children each year, though PCT based information is not currently available.

In Bristol as a whole average dental health is good. Approximately 33% of five year-olds have experienced dental decay (total number of decayed, missing or filled teeth per children = 0.78) compared to 40% (and 1.52 respectively) for England. 35% of 12 year old children had experienced dental decay only half of which had been treated at the time of the survey. Children living in deprived areas are more likely to suffer from dental decay and less likely to get treatment. Surestart schemes locally ensure that children receive free fluoride toothpaste to help reduce dental decay.

Access to Treatment in the General Dental Service (GDS)

About 53% of 0-9 year old children and 63% of all children under 18 are registered with a dentist in Bristol North²³. This is slightly less than the national average. Comparable registration figures for Bristol South and West are 71% of 0 – 9 year olds and 81% of all children under 18²³. Registration (which currently lasts for 15 months) has fallen by about 3% over the past ten years. Some practices are unwilling to take on new patients and some may not welcome children unless their parents are registered under private contract.

In addition to treating children and adults with disabilities, the Community Dental Service sees Looked After Children especially if they are unable to get treatment in the GDS. In some areas without GDS, such as Hartcliffe or Filwood the Community Dental Service offers routine treatment to children.

Health Promotion and Young People Initiatives

- As part of the National Healthy Schools Programme, schools in Bristol are introducing healthy eating and physical activity initiatives.
- The Bristol Breakfast Club Forum was established to support and promote the establishment of breakfast clubs in schools and childcare organisations. A database of breakfast clubs has been developed to encourage sharing good practice and networking. The Forum also provides in-service support and training for staff working for breakfast clubs.
- Children's Gardening Course. An eight week gardening course was developed for children aged 3 years to 12 years in Avonmouth. A range of indoor and out door activities were carried out, with encouragement to work in the Community Garden and knock on effects for parents and grandparents.
- Young people with disabilities often receive less sex and relationships education than young people in general and face greater difficulties in forming friendships and relationships. A multi agency group was established to share knowledge and experience of working on sexual health issues with disabled young people. Members include young people themselves, Brook Accsex Project, Bread Youth Project, West of England Coalition of Disabled People, Bristol Social Services and Young People's Services, Community Learning Difficulties Team, School Nurse Team and Health Promotion.

- **Banishing Hillfield Blues - Health Development Agency Aug/Sept 2004**

Hillfields is one of ten neighbourhood renewal areas in Bristol. It is among the 20% of most deprived wards in England. Educational achievement is poor: in 2002/03 33.7% of children had no qualification compared to the Bristol 11.4% average. Hillfields has a higher percentage of people with limiting or long-term illness (20%) compared to Bristol 17.8% and a high proportion of young people under 16 (22% compared to 19% in Bristol as a whole).

Health visitors in Hillfields are working with public health specialists and the Neighbourhood Renewal Health Theme Group to consult members of the local community on how best to meet their needs. A baby clinic at the centre's nursery (for pre-school baby advice) has started and a Peers Early Education Partnership course is planned with nursery staff addressing issues relating to infant health and behaviour. The Health Visiting team are also running a group for over 70s that is about keeping fit, safe, making friends and having a laugh.

A postnatal depression group is part of the community programme running with health visitors developing their 'family centred public health role'²⁴. The focus is on well being rather than specific issues such as weaning – a positive rather than problem centred programme is thought to underpin its success.

Recommendations

The Bristol PCTs and Bristol City Council should continue to work to strengthen existing partnerships and develop alliances with local communities in order to raise awareness of the health needs of children and young people and promote their health by:-

- Targeting local initiatives aimed at improving measurable health outcomes for children and young people in geographical areas identified as having higher levels of child poverty.
- Assessment of equity of access to services, for children's and maternity services.
- Developing initiatives to enable children to grow up in a smoke-free environment.
- Implementing the standards in the National Service Framework for Children.
- Continuing to strengthen joint working between the LEA and PCTs on the Healthy Schools Programme.
- Involving young people in the development of local action plans and services.
- Developing a dedicated service for young drug misusers and pregnant women who misuse drugs.

- Developing initiatives aimed at children and families to promote healthy eating habits and increase levels of physical activity.
- Developing initiatives to address mental health and psychological issues amongst children and young people, in line with the National Service Framework for Children.
- Sexual health promotion work among young people should continue to be a high priority, including raising awareness of sexually transmitted infections, their prevention and the importance of prompt treatment. Work should continue to implement the Teenage Pregnancy Action Plans for Bristol and increasing the provision of accessible contraceptive and sexual health services for young people.
- Implementing the recommendations of the Lord Laming Inquiry Report into the death of Victoria Climbié (2003) ¹.
- Continuing to promote and support a multiagency education and training programme in child protection, now well attended by most groups of health professionals, particularly aiming in 2005/6 to increase uptake and awareness among general practitioners.

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Chapter 3: Health of Children, Families and Young People

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Health of Older People

Across the UK, since the 1930s the number of people aged over 65 has more than doubled: today one in five of the population is over 60. Chronological age is not always predictive of how fit and healthy an individual may be, though in general older people tend to have a much greater need for health and social care. Recent evidence suggest that for a large proportion of older people good health is retained into later years and that nearness to death is far more important in determining the need for health and social care than age.

Local Demography

According to the 2001 Census, 15% of the population in Bristol was over 65 years old, compared with the national proportion of 16%. There is however considerable local variation, with Ashley and Cotham wards having the lowest recorded proportion at just 6% of people aged over 65 years. In Westbury-on-Trym almost a quarter of the ward population (24%) is aged 65 or over.

People aged 75 and over, according to the 2004 NHS Exeter system for GP registrations in the Bristol North PCT area make up 7.5% of the population and 6.3% in Bristol South & West PCT. These figures fall considerably for people over 85 to less than 2% of the population across the city. (see Table 4.1)

Table 4.1: Older Age Groups in Numbers and as a % of the Population

	75+	% of Bristol population	85+	% of Bristol population
Bristol North PCT	17,521	7.5%	4,605	2.0%
Bristol South & West PCT	11,956	6.3%	2,884	1.5%
Bristol	29,477	6.9%	7,489	1.8%

Source: Exeter System, 2004

The wards with the largest proportion of people over 75 within Bristol North PCT, include Westbury-on-Trym (18.4%), Frome Vale (15.2%) Henbury (12.7%), Henleaze (12.6%) and St George West (12.5%). Within Bristol South and West PCT, the highest proportions are in Bishopsworth (11%), Stockwood (11%), Bedminster (10.4%) and Hengrove (10.3%). (see Figure 5.1)

Population Dependency

Demographic projections suggest that trends in ageing will continue such that by 2011 the number of people over 65 will be greater than the number under 16. It is important to consider the implications of this in the context of the total population.

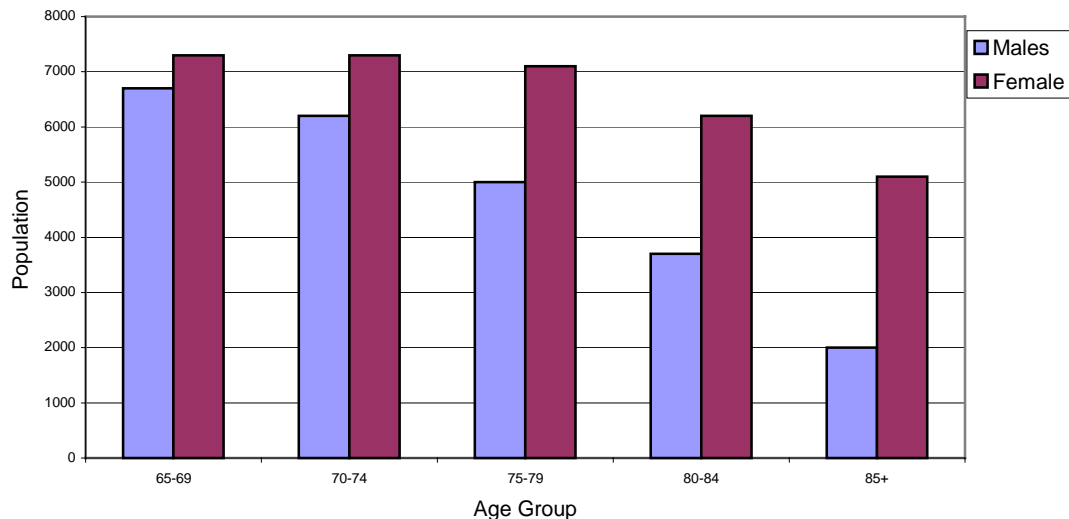
The dependency ratio measures the proportion of the population under 16 and over 65 in comparison with the population of working age. For Bristol the ratio is low at 45.6 in comparison with 58.1 for England as a whole,

suggesting that ageing has a relatively smaller economic impact locally than across the country in general.

Figure 4.1 shows the number of older people in 5 year age bands. Women begin to outnumber men from the age of 50 and by age 85+ there are about three women to every man.

Figure 4.1: Bristol Population for Over 65s

Figure 5.1: Bristol Population for over 65's in 2003



Source: Population estimates unit ONS

Hospital Admissions for Older People

During 2003/04 there were 10,154 admissions to hospital of residents aged 75 and over from the Bristol North PCT area, and 8,013 admissions in the Bristol South and West PCT area. This accounts for just over 18% (1 in 5) of all inpatient (elective and non-elective) hospital admissions for the total PCT population. People over 75 account for 7% of the total population meaning that rate of use of hospital services is over twice the size of this population.

Health Care Needs of Older People

Given this finding it is important to note that there are two competing perspectives put forward to explain the future health care needs of older people: the “*increasing burden*” versus “*continuing independence*”¹¹.

The former perceives older people as higher users of costly health and services than younger people and is evident in many policy discussions about the problems of funding future health and social care. The alternative view, although acknowledging cost associated with ageing and the increased need for care, argues that the highest costs actually occur only in the last 2 – 4 years of life regardless of age. The rise in medical cost associated with the ageing population is much slower than the rise in the total number of older people. In fact acute care costs decrease as older people age. It is possible that if people become healthier due to changing health behaviour in earlier

life, they may need less care than previous generations maintaining independence well into old age. Clearly both views have validity but it is important to note that services being used mostly at older ages are in the Social Care Sector with relatively low levels of medical and nursing input. More importantly the vast majority of older people live in their own homes and need regular both informal and formal social support to stay healthy - maintaining social contacts, retaining mobility and good nutrition - rather than direct medical care.

Staying healthy longer

- **Prevention** and health promoting activities in middle years increase healthy life expectancy: Regular physical activity, eating a balanced diet, engaging in social activities, early detection and treatment for hypertension to reduce stroke and heart disease, falls prevention and screening for some cancers.
- **Treatment**, such as hip or knee replacement are highly effective in improving mobility, good rehabilitation following stroke improves survival and cataract removal restores failing vision, contributing to future independence.
- **Care and support**, such as the provision of walking aids, assistance to bathe and dress and intensive home support, including care and repair in the home help retain independence.

National Policy in **Tackling Health Inequalities: A Programme for Action**⁷ sets out specific actions for the Department of Health to reduce health inequalities in older people:

- *Preventing illness and providing effective treatment and care*
- *Implementing the National Service Framework for Older People:*
 - *Supporting action to identify and eliminate age discrimination in access to health and social care*
 - *Developing a local Single Assessment Process with shared information and assessment mechanisms across health and social care covering stroke care, falls services and mental health.*

Inequality and Life Expectancy

A national study showed that the mortality rates of people aged between 60 and 74 years living in local authority rented accommodation were 16% higher than the national average, whereas the rates for those who owned their own homes were 13-14% lower than the national average. Life expectancy at 65 is 2.6 years greater in men and 2 years greater in women from social classes I and II compared to men and women from social classes IV and V. Older people experiencing disadvantage have higher rates of long standing illness, poorer respiratory function, higher blood pressure and higher rates of tooth loss than those from higher socio-economic groups.

- **Poverty and Benefits.** Older people, particularly women, are more likely to be living in poverty. Disabled pensioners are more likely to rely on state benefits than non-disabled pensioners. Since the link between increases in earnings and annual rises in pensions was broken in the 1980s the poorest pensioners have experienced a relative deterioration in their income. Many pensioners do not take up means-tested benefits to which they are entitled and locally Citizens Advice Bureaus and other advice agencies have launched projects to address this.
- **Housing and health.** Older people occupy a disproportionate amount of houses that are in poor condition, particularly those that are older and privately rented⁸. Poor housing design contributes to major accidents amongst older people and unmodernised homes may be poorly insulated. The Bristol Indicators in the Quality of Life report for 2004⁸ suggests that most older people in Bristol had poorer access to social housing than is available to younger age groups. For those living in private rented housing however the survey found that dwellings are nearly twice as likely to be 'unfit' as housing in other tenures. Older people are more likely to occupy homes in this sector.

The voluntary sector can play an important role in addressing this issue and Bristol Care and Repair work with the council to provide help to vulnerable people, many of them older people, by offering practical support including a handy person scheme, support to deliver grants and advice on building work.

- **Lack of access to transport** can limit access to goods, services and social contacts, particularly for older women and older people with

disabilities. Concessionary fare schemes are available in Bristol, but that does not always mean that transport is available when and where people want it. Free concessionary fares are available for the over 65s in London and some other cities. In Bristol older people are eligible for half price fares.

- **Community Safety.** Significantly fewer people over 75 feel safe either during the day or after dark, compared with younger people. Four out of five of people under 54 said they feel safe in the day and over two in five feel safe after dark, the figures for those over 75 are 72% feel safe in the day and only 28% feel safe after dark. Fear of crime is more common amongst older people, who may consequently limit their activities outside the home, especially at night⁸.
- **Access to Services.** Older people from lower socio-economic groups have higher rates of ill-health and disability than those from more affluent groups yet equity of access to care is not always achieved. Severe visual problems, for example, are more likely to remain unrecognised and untreated in older people from lower socio-economic groups than for people in higher socio-economic groups².

Specific Health Issues for Older People

Stroke

Stroke is the biggest cause of severe disability and the third most common cause of death in the UK. For Bristol in 2003/04 there were 823 admissions of people aged over 75 to hospital following a stroke (512 in Bristol North and 311 in Bristol South & West). For 2003/04 a rate of 45 per 1000 people aged 75 and over.

Subgroups in the population having a higher relative risk of stroke, include African-Caribbean and South Asian men, and unskilled manual workers.

Strong evidence suggests that improvements in early detection and management of hypertension (high blood pressure) will reduce death and disability from strokes. Well organised acute or community based rehabilitation has also been shown to reduce severe disability and increase the number of people able to live at home. Stopping smoking, improved nutrition, reducing alcohol intake and increasing physical activity taken can also significantly reduce the risk of stroke.

Falls

Older people fall frequently. This is a serious public health problem with a substantial impact on the health and quality of life of older people and on health care costs. A broken hip (fractured neck of femur) is the most common, serious injury related to falls in older people resulting in an annual cost to the NHS in England of around £1.7 billion. In Bristol in 2003/4 there were 423 admissions of people over 75 to hospital following a fall, which resulted in a fractured neck of femur (fractured hip) an admission rate of 2.3%; 87 per 1000 people aged 75 and over.

Osteoporosis, a condition in which bones become more fragile increases the risk of sustaining a fracture after falling. One in three women and one in twelve men over 50 are affected by osteoporosis. Stopping smoking, taking weight-bearing physical exercise and healthy eating throughout life and particularly in middle age help to reduce the risk of osteoporosis.

Following fracture of neck of femur around half of older people can no longer live independently and fear of falling leads to a loss of confidence, poor mobility and limits daily activities.

The risk of falling and the impact of falls can be reduced by:

- The prevention and treatment of osteoporosis;
- Addressing risk factors such as multiple medications, poor eyesight, balance and mobility problems;
- Improving the environment such as poor lighting, slippery floors and providing safety equipment such as grab rails.

People who have already fallen are at increased risk of a subsequent fall. Assessment and treatment by a multi disciplinary falls service can reduce the risk of further falls.

Local initiatives are tackling the potential for reducing harm caused by falls:

- Community based activities to promote health and independence
- Additional investment in intermediate care.
- Joint work to reduce delayed discharges from hospital and an increase in the number of people receiving a timely package of care after a stay in hospital.
- The introduction of in-reach services for older people with mental health problems to deliver better services in Care Homes and intermediate care locations.
- The Bristol Evercare programme involving community-based nurses with advanced training to provide high quality care to vulnerable people.
- The Lifeskills Centre provides and evaluates safety training courses for older people and people with learning difficulties in addition to its focus on child safety. See www.lifeskills-bristol.org.uk for further information.

Diabetes

Diabetes is a common, chronic condition that impairs the body's ability to control blood sugar levels. Around 11,500 people in Bristol have diabetes. In 2002/03 there were 6535 registered diabetics in Bristol North PCT of which 48% were over 65. In Bristol South and West PCT of 5159 registered diabetics 52% were over 65. Diabetes is more common in some Black and Minority ethnic populations, particularly South Asian and African-Caribbean people, in less affluent communities and with increasing age.

Type I diabetes is less common, tends to occur at a younger age and requires insulin treatment and dietary modification. Type II diabetes is more common, its prevalence increases with age, and it can be treated by a mixture of diet

and oral medication although in some areas insulin is required. Obesity is a major risk factor for type II diabetes⁴.

Diabetes can lead to a range of complications. It is the main cause of blindness in people of working age, can lead to kidney failure, lower limb amputation and increases the risk of heart disease.

There is a good systematic evidence that the onset of Type II diabetes can be delayed and possibly prevented entirely through lifestyle modification and with appropriate medication. The two main modifiable lifestyle risk factors are obesity and physical activity, which account for 47% and 13% of Type II diabetes respectively.⁵

Detection and effective monitoring and treatment of diabetes reduces the incidence and impact of complications. The drive towards patient education and self-management strategies is logically compelling, though not as yet evidence-based.

Cancer

The incidence of most cancers increases with age.

Based on an increasing body of evidence the NHS Cancer Plan⁶ seeks to reduce mortality and morbidity from cancer through; early diagnosis and treatment; supportive and palliative care for people with cancer and prevention. Effective prevention starts in early life, but can have an impact at all ages: stopping smoking, increasing fruit and vegetable consumption and increasing physical activity will reduce risk of most cancers.

Improving equity of access for care and prevention of cancer requires that people with common cancers can be treated locally, and that those with more rare cancers have equal access to specialist centres.

Local Initiatives for Older People

Evercare

The Bristol and South Gloucestershire PCT's Evercare project aims to reduce the impact of disease and manage chronic conditions for high risk or chronically ill older people, to maintain health and to minimise avoidable or long-term hospital stays⁹.

A Bristol pilot started in April 2003 with the recruitment of 12 community-based nurses with advanced training. The project works with 600 older people and plans with patients and relatives to achieve the desired level of care. Positive results from the first 10 months of this 17 month pilot include;

- shortening hospital stays
- medication changes to avoid adverse reactions
- improving patient functional status and quality of life
- averting preventable hospital admissions
- responding to patient preferences
- coordinating care to reduce fragmentation among different services.

More in depth evaluation of the pilot will consider the cost of the intervention in relation to target outcomes.

Recommendations

Much of the published guidance on what is effective in maximising the opportunities for older people to stay as healthy as possible suggests that Bristol PCTs and key partners work together through local strategic and community partnerships to:

- Ensure that older people have fair and appropriate access to health promotion and disease prevention in line with the CHD and Diabetes NSFs and the National Cancer Plan. These should take account of the impact of cultural and religious beliefs and lifestyles.
- Continue to develop a local community based falls service, to minimise the likelihood of vulnerable older people experiencing frequent and recurrent falls.
- Continue to develop and build on existing local work to prevent and treat stroke through early detection and treatment of hypertension, rapid and effective dedicated stroke services and flexible rehabilitation programmes in hospital and community settings.
- Work with residential and nursing homes to assess health needs and improve access for residents to a healthy diet, appropriate physical activity, social contact and disease prevention programmes, such as regular dental check ups and the provision of hip protectors.
- Help older people to maintain their independence by:
 - Work to prevent accidents, target interventions to enhance mobility and independence.
 - Improving access to social and leisure activities to decrease isolation, promote mental health and increase physical activity for example by promoting healthy walks.
 - Improved housing and environmental design, reduce risk of fuel poverty, target care and repair of homes and strengthen communities.
 - Reduce poverty, and increase access to high quality goods and services by promoting uptake of benefits.

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Introduction

Smoking is the single biggest preventable cause of illness and death in the developed world, killing over 114,000 people nationally per year (BHF 2004). Treating smoking related illnesses costs the NHS £1.7 million annually. Smoking kills around five times more people in the UK than road traffic accidents, other accidents, poisoning and overdose, murder and manslaughter, suicide, and HIV infection all put together. Smoking causes about thirty per cent of all cancer deaths (including around 84% of lung cancer deaths), 17% of all heart disease deaths and at least 80% of deaths from bronchitis and emphysema. About half of all regular cigarette smokers will eventually be killed by their habit.

Smoking prevalence in the UK has been slowly declining over the last decade, and in 2002, the General Household Survey found that 26% of people aged 16 years or over in England were smokers. (27% men, 25% women)

Cost Effectiveness of Stopping Smoking

The Government currently spends around £30m a year on anti-smoking education campaigns. A further £41m is spent on measures to help people stop smoking.

Smoking cessation interventions are extremely cost effective, both in financial savings to the NHS and in health gain. In 1998, West et al estimated a range of cost per life year saved of a comprehensive smoking cessation treatment service between £212 to £873. The approved National Institute for Clinical Excellence⁸ threshold for cost effectiveness of medical treatments is £30,000. Smoking cessation interventions are at least 34 times more cost effective.

Smoking Prevalence in Bristol

The Health Survey for England indicates that 27% of people in Bristol smoke, although local debate suggests that this may be higher and up to 57% of people smoke in some parts of the city. Estimates of smoking prevalence by ward have been compiled by the Children of the Nineties study¹⁰. The wards with the highest rates of smoking correlate closely with highest levels of deprivation in Bristol. (see Figure 6.1 overleaf)

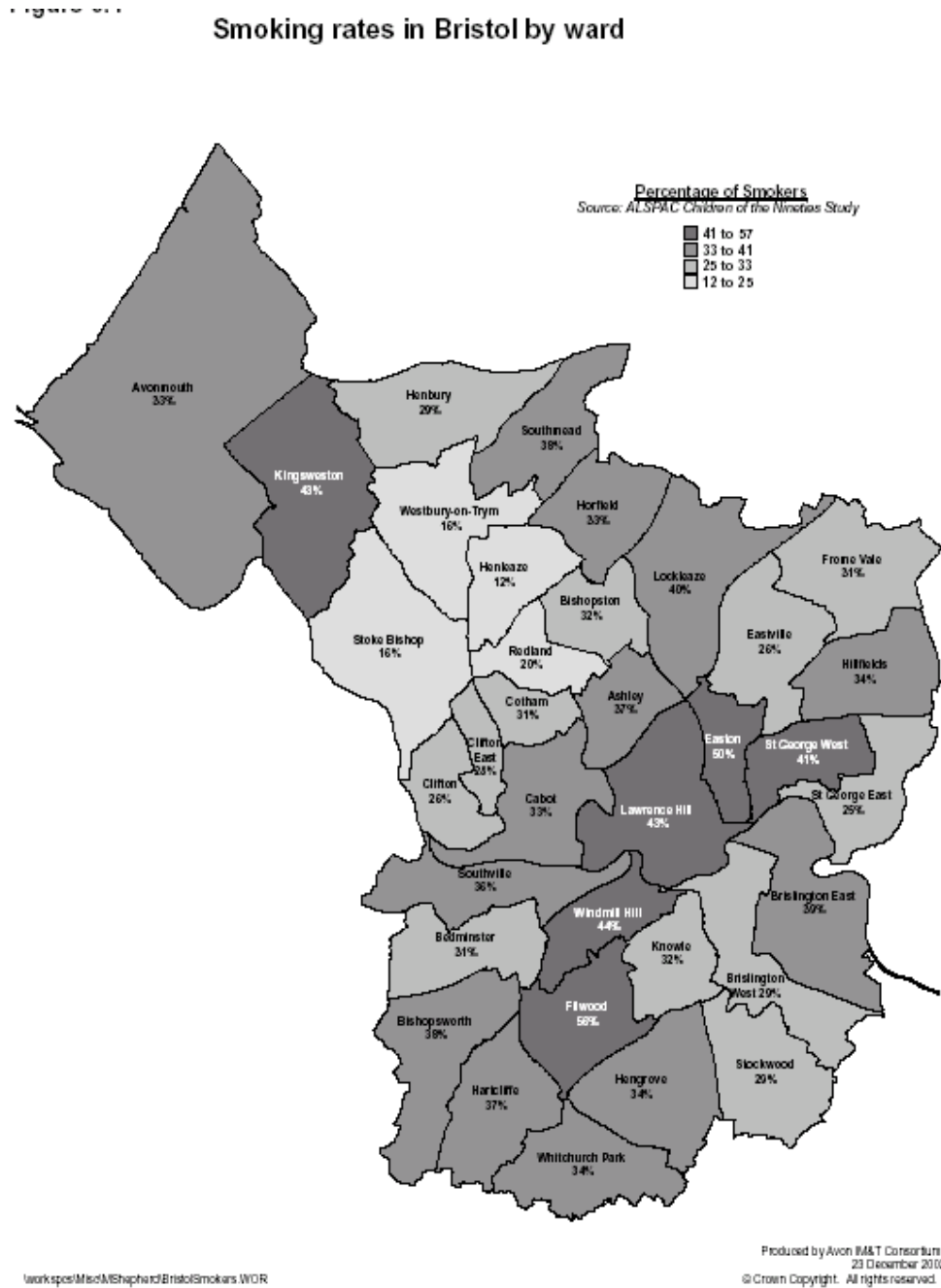
Bristol has the highest rate in the South West for deaths from lung cancer, and vascular disease due to smoking¹ (see Table 5.1)

Table 5.1: Deaths from Lung Cancer and Vascular Disease

Primary Care Trust	Percentage of deaths from lung cancer due to tobacco (%)	Percentage of deaths from vascular disease due to tobacco (%)
Bristol South and West	91	24.8
Bristol North	90	22.9

Source: Health and Lifestyle Bulletin 2003, South West Public Health Observatory

Figure 5.1: Smoking Rates by Ward



Source: ALSPAC Children of the Nineties Study

Stop Smoking Services

Local smoking cessation services in Bristol (**Support to Stop**) have been funded by the government since April 2000 after the publication of the White Paper ‘Smoking Kills’⁴. Further funding for three years was allocated following the large increase in targets for numbers quitting published in the NHS ‘Priorities and Planning Framework 2003-2006’.

Outcomes for 2003/04

GP Practices

52 week quit rates

The 52 week quit rate has been calculated from July 2003 to March 2004. All those who had quit at four weeks and consented to follow up were contacted by post one year after their quit date. 18.5% for Bristol North and 16.5% for Bristol South and West stated that they had not smoked at all since their quit date. When measured against all smokers setting a quit date within the service over the same period, 9.5% of those in Bristol North and 8.8% in Bristol South and West remain quit one year later.

Inequalities

Reducing smoking prevalence will make a substantial impact on inequalities in life expectancy. The Wanless¹³ report published in 2004 looks at males dying under the age of 70 years. (see Table 5.2)

Table 5.2: Males Dying Under the Age of 70

	Social Class I	Social Class V	Difference
Actual Proportion (%)	22	48	26
Actual proportion predicted if all population were non smokers (%)	15	27	12
Estimate of proportion attributed to smoking (%)	7	22	15

Source: Wanless Report ,2004

Support to Stop targets more deprived areas and populations in Bristol with concentrated high rates of smoking, and uses eligibility for free prescriptions as an indicator of high risk. In 2003/04, 53% for Bristol North PCT and 57% in Bristol South and West PCT using the smoking cessation services were eligible for free prescriptions.

Manual Groups

Premature death from lung cancer is five times higher among men in unskilled manual work compared to those in professional classes in the UK. Smoking rates in social class I are around 15% for men and women, but in social class V this climbs to 45% for men and 33% for women. In the most deprived groups it can be as high as 70% and is around 90% in the homeless.

Support to Stop is embedded in all GP practices in low-income areas in Bristol using staff trained as advisors from within the practice. Specialist Advisors give priority for additional support in these practices as required. Additional clinics for smokers wanting to access support to quit smoking are available at the Knowle West Walk In Centre and Citygate Walk In Centre.

Pregnant Women

Stopping smoking during pregnancy will have significant positive effects on the health of the foetus, reducing the risk of low birth weight, premature birth and sudden infant death syndrome.¹⁴

Three specialist pregnancy advisors are employed by the two midwifery services in Bristol. Referrals are received from the community midwives of pregnant smokers who are motivated to quit. In 2003/04 147 women used the service with 45 quitting at four weeks (quit rate – 31% at four weeks).

Smoking amongst Children and Young People

Smoking among young people shows no sign of decreasing and has remained at around the same level for the past 20 years. More girls smoke than boys. Data for 2001 shows that 10% of 11-15 year olds are smoking regularly; 8% of boys and 11% of girls. By the age of 15 this rate rises to 22% with 19% of boys and 25% of girls smoking regularly. There is very little difference in smoking by social groups among children until the age of 16.

Young people are particularly susceptible to nicotine and quickly become dependent, after as few as 4-6 cigarettes. The younger a person is when they start to smoke the more likely they are to develop long term nicotine addiction. As with adults, the majority of young people want to stop smoking and locally children are asking for help to quit. Interventions aimed at preventing and delaying the onset of smoking, and smoking cessation services that meet the specific needs of young people are essential in order to reduce smoking rates among young people. In June 2002, a change in legislation permitted the prescribing of nicotine replacement therapy to those aged 12-18 years. A small number of young people accessed the adult Support to Stop service across Bristol with 18 using the service over the year and 3 (17%) quit at four weeks. Cessation support has been piloted at Monks Park Drop-In Clinic for teenagers from February 2004.

Raising awareness of the effects and costs of smoking with students about to start university has been shown to have a positive effect on preventing or continuing the use of tobacco. A stall in Freshers' week in October 2003 at Bristol University and brief intervention training with stop smoking information provided during the summer term in 2003 for the wardens of the Halls of Residence has resulted in an increase in the provision of smoke free accommodation and support for students who smoke and want to quit.

Impact of Parental Smoking on Children and Young People

Children are particularly susceptible to the effects of passive smoking. The risks of bronchitis, pneumonia, coughing and wheezing, asthma attacks, middle ear infection and cot death are significantly increased when children live in the households of smokers¹⁶. Children of parents who smoke are three times more likely to become smokers than those of non-smokers. Parents and the public need to be aware of the health risks to children of passive smoking.

Clean Air for Kids: a local initiative

This Neighbourhood Renewal funded project in Southmead aims to reduce second-hand smoke in the home. Parents pledge smoke free areas in the home in a three staged approach starting where children play, eat and sleep progressing to a totally smoke free home and smoke free car journeys.

Ethnic Minorities

Smoking rates in the UK amongst the Black and Minority Ethnic groups are less than the national rate as a whole, but there are specific groups with significantly high rates of tobacco use. 44% of Bangladeshi men smoke, rising to 54% in men aged over 55 years. This same group has a high rate of chewing tobacco products.

Two Asian Advisors are trained to give support to smokers in Bristol wanting help to quit in their own language. This has resulted in a steady increase in the number of people from Black and Minority ethnic populations quitting at four weeks. 107 Asian people used the service in 2003/04 with a quit rate around 40% at four weeks. Overall 5% of all those accessing **Support to Stop** in 2003/04 were from Black or Minority ethnic groups.

Bristol Prison

Two stop smoking groups have been run during 2003/04 resulting in 7 out of 20 prisoners quitting at four weeks (35%). A stop smoking group has also been run for prison staff with 6 out of 8 people quit at four weeks (75%).

Reducing Secondhand Smoke

A comprehensive approach to tobacco control is recognised as the way forward for creating a social environment that would normalise non-smoking. This is reinforced in the Wanless Review published in 2004, calling for national measures to be implemented for protection from secondhand smoke. There are several projects that have been initiated or developed in Bristol during 2003/04 to raise awareness of the effects of this.

BATT

Partnership working with Bristol City Council has slowly developed into the Bristol Alliance Targeting Tobacco (BATT). This network has representation from Trading Standards, Environmental Health and includes the Principal Policy Officer for Health from the Cabinet Office. This Alliance gives an opportunity to monitor the wider work in tobacco control, such as under age tobacco sales, checks on the labelling of Asian tobacco products, and promoting second-hand smoke issues alongside environmental health issues.

Workplaces

Reducing smoking in the workplace is known to have positive benefits on staff sickness, increases productivity due to less time lost from cigarette breaks, and the risk of fire damage from careless disposal of burning cigarette ends. A workplace advisor was recruited during 2003/04 and has targeted businesses that employ less than 50 people in the areas of Avonmouth, St Phillips, Bedminster, Bishopsworth, Easton, Knowle West, Fishponds and Eastville. Over 200 businesses have been visited including engineering,

packaging, welding and scaffolding. Around 50% of these have a no smoking policy in place. As a result 29 new policies have been implemented, with 16 more making progress on further health improvement policies.

Easy Breathing Pubs

Workers in the hotel and catering industry have the highest incidence of lung cancer among occupational groups. Yet over 70% of people prefer to eat in a smoke free environment². There are 77 pubs in Bristol on the Avon-wide Easy Breathing Pubs database offering a variety of times for smoke free drinking. The Easy Breathing Pubs initiative was developed during 2003/04 to identify those pubs that are child friendly and have facilities for disabled people alongside smoke free areas. It is planned to expand this project further to include restaurants and cafés that are smoke free with a new directory for Easy Breathing Eateries for 2004/05.

Fitness and Well-being Exhibition

This pilot project has been funded by the Government Office for the South West region (GOSW). An exhibition displays the effects of smoking on fitness performance and general well being, including harm from second-hand smoke in the home. Whitchurch and Easton Leisure Centres are pilot sites for this project.

Brief Intervention training has been carried out with key fitness staff in the leisure centres in order to maximise the help and support that can be given to people wanting to quit smoking. There has also been an opportunity to review and improve smoke free policies within the council leisure centres. If successful, this project will be extended to all Bristol Community Sport leisure centres and swimming pools.

Areas for Development during 2004/05

Provision for smokers in primary care is gearing up to meet an increase in local delivery plan targets for 2004/05.

- Three new bank staff have been recruited to the service to increase provision within the Knowle West Walk In Centre and to provide greater support to practices within Bristol South and West. There will be an additional part time Advisor recruited to work within the North West locality of Bristol North.
- UBHT's hospital board approved the provision of a hospital cessation post based at the Bristol Royal Infirmary in January 2004. A steering group has been set up to support and advise on this post with recruitment taking place in July 2004.
- Work is to be carried out during 2004/05 to look at the provision of trained advisors within the community pharmacy setting to give greater access to support for smokers when GP practices are not open.
- Plans are being developed to expand the provision of appropriate cessation support available in Young Peoples Drop in Clinics in Bristol.
- Working towards Smoke Free Bristol in partnership with Bristol City Council and partner agencies in the Local Strategic Partnership.

- Expanding and developing the workplace smoking policy support for businesses in Bristol.
- Expanding and developing the Easy Breathing Eateries and Pubs initiatives in restaurants, cafes and pubs in Bristol.

Recommendations

- Further efforts are needed to support groups in the community with high rates of smoking: teenage mothers, homeless people and people with mental health problems.
- Long term monitoring of sustained smoking cessation is needed to properly assess the success of the programme.
- Increased investment in smoke free workplaces as part of the Smoke Free Bristol programme will have considerable benefit in reducing premature death and tackling inequalities in life expectancy.

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Health Protection

Delivering local Health Protection to the people of Bristol involves controlling communicable disease, dealing with the health implications of local Environmental Hazards and Health Emergency Planning.

In 2003, a new national Health Protection Agency (HPA) was set up, dedicated to protecting people's health and reducing the impact of infectious diseases and chemical and radiation hazards. The HPA has brought together several organisations including the Public Health Laboratory Service, the Chemical Incident Response Service and the National Radiological Protection Board. The health protection service has a major role in emergency planning, particularly arrangements for responding to major incidents caused by infection, chemicals or radiation. The local Avon Health Protection Team (AHPT) is also responsible for providing clinical advice on immunisation, co-ordinating national immunisation programmes locally and advising PCTs in terms of their infection control responsibilities as part of the HPA.

The Avon Health Protection Team covers the PCT Areas of Bristol North PCT, Bristol South and West PCT, Bath & North East Somerset PCT, North Somerset PCT and South Gloucestershire PCT areas¹.

Incidents & Outbreaks

Hepatitis B: A significant outbreak of Hepatitis B, which was first identified in 2002, continued throughout 2003. Injecting drug users and homeless people in the centre of Bristol are particularly at risk. Active steps have been taken by the local PCT to provide Hepatitis B vaccination to this vulnerable group, based on the pattern of infection which emerged. This outbreak is now being brought under control through the local partnership working between the Health Protection Agency, Primary Care Trusts, Bristol Drugs Project, The Milne Centre, Bristol Prison, Community Action Against Drugs & Safer Bristol Partnership.

Mumps: The national increase of Mumps, as a result of the fall of MMR uptake rates has been reflected locally. Table 6.1 indicates the fall in MMR vaccine uptake rates in Bristol North PCT and Bristol South and West PCT in comparison with other PCTs in Avon:-

Table 6.1: MMR uptake rates for children completing primary course before their 2nd birthday

MMR UPTAKE RATES FOR CHILDREN COMPLETING PRIMARY COURSE BEFORE THEIR SECOND BIRTHDAY																
Statistics collected	DOB range	South Gloucestershire PCT			Bristol North PCT			Bristol South & West PCT			North Somerset PCT			Totals Avon		
		Pop.	MMR	Uptake	Pop.	MMR	Uptake	Pop.	MMR	Uptake	Pop.	MMR	Uptake	Pop.	MMR	Uptake
Feb 2003	1.10.00 31.12.00	669	605	90.4%	632	495	78.3%	453	369	81.5%	461	383	83.1%	2215	1852	83.6%
May 2003	1.1.01 31.3.01	625	522	83.5%	591	452	76.5%	506	412	81.4%	501	422	84.2%	2223	1808	81.3%
June 2003	1.4.00 31.3.01	2771	2460	88.8%	2499	1989	79.6%	1986	1647	82.9%	1989	1719	86.4%	9245	7815	84.5%
Aug 2003	1.4.01 30.6.01	669	567	84.8%	617	473	76.7%	555	446	80.4%	484	411	84.9%	2325	1897	81.6%
Nov 2003	1.7.01 30.9.01	714	595	83.3%	676	528	78.1%	518	416	80.3%	490	408	83.3%	2398	1947	81.2%

(Lines in bold are taken from the annual Cover/Korner statistics)

Cryptosporidium: There were 87 clusters of Cryptosporidium in the Bristol area during the summer of 2003. These were related to travellers returning from holiday abroad and outbreaks in local swimming pools. APT has worked closely with the local Environmental Health Officers in order to control the spread of this infection, which causes diarrhoea and vomiting. Temporarily closing the pool to ensure thorough cleaning is an adequate control measure.

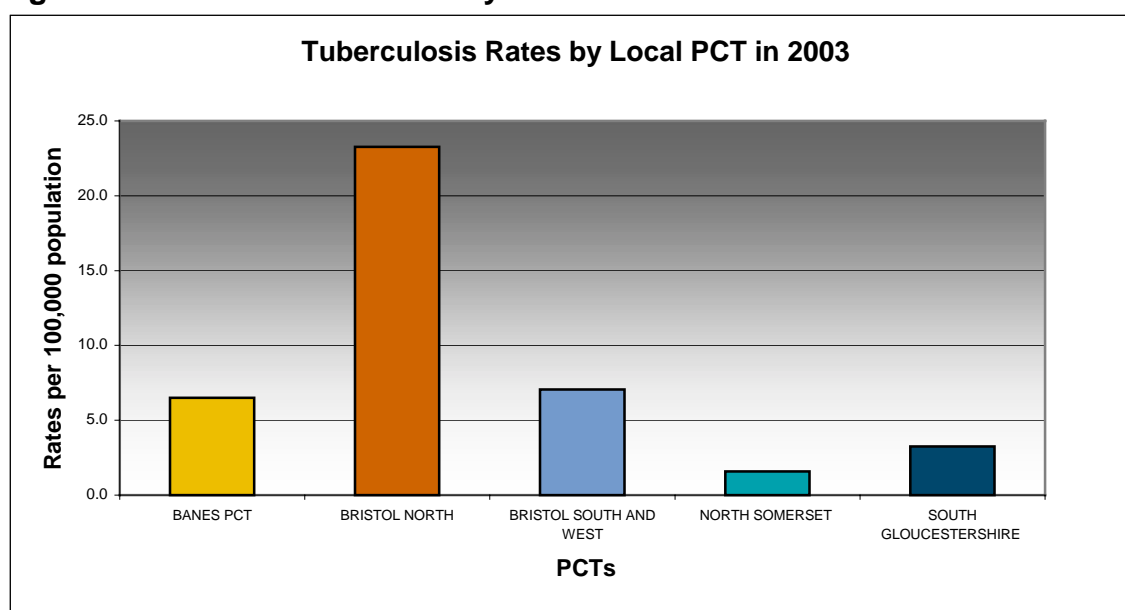
Meningitis: In October 2003, there were four confirmed cases of Meningococcal Meningitis amongst first year students at Bristol University. All first year students in halls of residence were given antibiotics as a prophylactic (preventive) measure. As a result of this major outbreak, antibiotics were also issued, as a precautionary measure, to all other residents of university student accommodation.

Tuberculosis: The Table (6.2) and graph (Figure 6.1) overleaf indicate Bristol North PCT area has rates of Tuberculosis which are raised in comparison with the surrounding PCT areas. This reflects the increase in numbers of Tuberculosis cases that are occurring amongst newly arriving in the country.

Table 6.2: 2003 Tuberculosis Rates Per 100,000 Head Of Population

HPU	PCT	Cases (n)	%	Population	Rates per 100,000 population
Avon	BANES PCT	11	13.3	1.69	6.5
	BRISTOL NORTH	49	59.0	2.11	23.3
	BRISTOL SOUTH AND WEST	12	14.5	1.70	7.1
	NORTH SOMERSET	3	3.6	1.89	1.6
	SOUTH GLOUCESTERSHIRE	8	9.6	2.46	3.3
TOTALS		83		9.85	8.4

Figure 6.1 Tuberculosis Rates by Local PCT 2003



Surveillance of Infectious Diseases in the Bristol Population During 2003

Table 6.3 overleaf is a description of 2003 data on local communicable diseases for the Bristol Primary Care Trusts' area in comparison with data from the areas covered by the neighbouring PCTs of Bath & North East Somerset, South Gloucestershire and North Somerset.

Table 6.3: Notified Diseases For 2003

DISEASE 2003	Bristol North PCT	Bristol S&W PCT	Bath & NE Somerset PCT	North Somerset PCT	South Glos PCT	TOTAL
Campylobacter	301	234	274	330	212	1451
Cholera	0	1	0	0	0	1
Cryptosporidium	62	25	9	82	81	259
Dysentery	9	6	0	6	8	29
E.Coli 0157	1	0	6	4	1	12
Food Poisoning	16	14	16	5	21	72
Giardia Lamblia	35	33	19	64	23	174
Hepatitis A	10	6	2	4	3	25
Hepatitis B	18	8	4	6	11	47
Hepatitis C	4	2	1	2	0	9
Leptospirosis	0	0	0	1	0	1
Malaria	3	1	0	0	0	4
Measles	9	5	3	3	22	42
Meningitis – H.Influenzae	2	1	0	1	1	5
Meningitis – Meningococcal & Septicaemial	11	8	5	4	5	33
Meningitis – Pneumococcal	1	1	0	1	3	6
Meningitis – Other	4	2	0	0	0	6
Meningitis – Viral	1	1	1	0	1	4
Mumps	10	7	8	6	7	38
O.Neonatorum	2	1	2	0	0	5
Paratyphoid A	0	1	0	0	0	1
Rubella	17	5	11	2	6	42
Salmonella	68	57	60	77	79	341
Scarlet Fever	5	4	4	10	12	36
Tetanus	1	0	0	0	0	1
Tuberculosis ** (Pulmonary) & (Non-Pulmonary)	49	12	11	3	8	83
Typhoid	0	0	0	0	0	0
Whooping Cough	2	0	0	0	2	4

The Avon Health Protection Team operates on a 24 hour basis. Office hours are: Mon - Fri 8:30am – 5:00pm on 0117 900 2620 or fax: 0117 900 2385. Out of office hours contact can be made via Avon Ambulance Control on 01454 455433 or fax 01454 45548. They will contact the consultant on call.

For further information: <http://www.hpa.org.uk>

Appendix 1: Glossary and abbreviations

AIDS	Acquired Immune Deficiency Syndrome
BCC	Bristol City Council
Birth rate	The number of live births in a population over a given time period, usually a year, expressed per 1000 population.
Bristol PHL	Bristol Public Health Laboratory
BN PCT	Bristol North Primary Care Trust
BRI	Bristol Royal Infirmary
Bristol UA	Bristol Unitary Authority
BSW PCT	Bristol South and West Primary Care Trust
Census	An enumeration of a population, conducted every ten years in England and Wales
CHD	Coronary Heart Disease
Clinical governance	A framework for continuous quality improvement
COPD	Chronic Obstructive Pulmonary Disorder
DAT	Drug Action Team
Demography	The basic characteristics of the population, such as age, sex, geographical distribution and mobility.
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. They can be varying size, e.g. Health Authority or enumeration districts.
Disability	Temporary or long term reduction of a person's capacity to function
DoH	Department of Health
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.
Evaluation	A process that attempts to determine as systematically and objectively as possible the relevance, effectiveness and impact of activities in the light of their objectives.
Evidence based health care	Systematic use of evidence derived from published research and other sources for practice and management.
Exeter System	Database holding details of all patients registered with a GP
GP	General Practitioner
Health Inequalities	The virtually universal variation in health indicators such as life expectancy, mortality rates and disease incidence rates especially used to refer to those associated with socio economic status and ethnicity.
Health Promotion	The process of enabling people to exert control over, and to improve, their health.
Health Protection Unit	The Health Protection Unit/Team is the local team of the Health Protection Agency (HPA) that exists to prevent and reduce the impact on human health of the consequences of infectious diseases, chemical and radiation hazards, and major emergencies.

Appendix 1: Glossary and abbreviations

HIMP	Health Improvement Modernisation Programme
HIV	Human Immunodeficiency Virus
IHD	Ischaemic heart disease
IMD	Index of multiple deprivation
Incidence	The number of new events eg new cases of a disease in a defined population within a specified period of time.
Infant mortality rate	A measure of the yearly rate of deaths in children less than one year old, expressed per 1000 live births in the same year.
Local Strategic Partnership	Draws together organisations from the public, private, business, community and voluntary sectors within the local authority, social and environmental well being of the community.
MMR	Measles Mumps Rubella vaccine
Morbidity	Any departure from a state of physiological or psychological well being, synonymous with sickness and illness.
Mortality	Death
Mortality rate	(death rate) an estimate of the portion of the population that dies during a specified time period.
Neighbourhood renewal	A national initiative under which areas with significant deprivation develop plans to tackle these problems. Local Strategic Partnerships are responsible for Neighbourhood Renewal Strategy and the funding that comes with it.
NHS	National Health Service
NSF	National Service Framework
ONS	Office of National Statistics
PCT	Primary Care Trust: PCTs were established in 2001 and their main functions are: to improve the health of their community and reduce inequalities; to secure the provision of high quality health services and to integrate health and social care locally.
Prevalence	The number of events eg instances of a given disease or condition in a given population at a designated time.
Primary Care	The first port of call for many people when they develop a health problem is their local doctor, also known as a general practitioner (GP). These doctors usually form a small practice or surgery to serve a particular neighbourhood. GPs are on the frontline of the NHS - the part officially called 'primary care'. Many other health professionals work as part of this frontline team - nurses, health visitors, dentists, opticians, pharmacists and a range of specialist therapists. Every UK citizen has a right to be registered with a local GP and visits to the surgery are free. NHS Direct and NHS walk-in centres are also part of primary care.
Public Health	The science and art of improving the population's health through the organised efforts of society.
Quintiles	Values that divide a distribution into equal fifths

Appendix 1: Glossary and abbreviations

Screening	The systematic application of a test or inquiry to identify individuals at sufficient risk of a specific disorder to benefit from further investigation or direct preventative action among persons who have not sought medical attention on account of symptoms of that disorder.
SHA	Strategic Health Authority: Established in 2002 following the amalgamation and reorganisation of health authorities described in 'Shifting the Balance of Power'. They cover about 1.5 million people, lead the strategic development of local health services and performance manage PCTs and Trusts on the basis of local accountability agreements.
SMR	Standardised Mortality Rate
SOAs	Social Output Areas
Social exclusion	Defines a wide range of people who are isolated in society such as children excluded from school, the unemployed, teenage mothers, the homeless, people with mental illness and some people from minority ethnic groups.
Stakeholders	Persons or organisations with an interest that may affect the outcome of an activity.
STD	Sexually transmitted disease
STI	Sexually transmitted infection
Substance misuse	The use of any substance (drugs, alcohol etc) in a way that is detrimental to the health of the person concerned.
Target	A specific change intended within a given time period.
TB	Tuberculosis
UBHT	United Bristol Healthcare Trust
Vs	versus
Ward	An area in which all the same single member of parliament represents the residents.
WHO	World Health Organisation

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The Health of Bristol 2003
Report of the Integrated Public Health Department for both Bristol PCTs

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