Health

our area our health

Annual Report of the Director of Public Health 2005 - 2006

Focus on the environment and healthy ageing

South Gloucestershire
Primary Care Trust

Contents

Contents i
List of figures iii
Introduction 1
Local Area Agreement 3
Section 1: New Challenges 5
- Climate change 5
- New communities 10
- Healthy ageing 14

Section 2: An Update on Health and Inequalities 21
- Major causes of ill health 21
- Health inequalities 24
- Black and minority ethnic communities (BME) and health 29

Section 3: Choosing Health 35
- Reducing the numbers of people who smoke 35
- Tackling obesity 39
- Improving sexual health 43

Section 4: Improving Community Health and Services 47
- New opportunities 47
- Assessing local need 48

Section 5: Communicable Diseases 53
- Mumps 53
- Immunisation 54
- Hepatitis B 55
- Hepatitis C 55
- Sexually transmitted infections 56
- Food poisoning 56
- Emerging threat of pandemic influenza 56

Recommendations 57
- Index of Director of Public Health annual reports 58
- Thanks to 59

List of figures

Figure 1: Health links to South Gloucestershire's Local Area Agreement........................3
Figure 2: Global temperature record from 1860 projected to 2100 according to the IPCC 5
Figure 3: The main pathways by which climate change affects health 7
Figure 4: Links between the built environment and health..........10
Figure 5: Projected number of older people in South Gloucestershire 2003-2028 14
Figure 6: Trends in the dependency ratio in South Gloucestershire 2003-2028..........15
Figure 7: Life expectancy, HLE and DFLE at 65 years 16
Figure 8: Additional years of life expectancy and healthy life expectancy 1981-2002 16
Figure 9: Falls in people 65 years and over in South Gloucestershire..........18
Figure 10: Trends in mortality from all cancers in under 75 year olds in South Gloucestershire UA 1993-2004..........21
Figure 11: Mortality from lung cancer in South Gloucestershire by deprivation quintile, all ages 2000-2004 22
Figure 12: Trends in mortality from all circulatory diseases in South Gloucestershire in under 75 year olds 1993-2004 22
Figure 13: Coronary heart disease in under 75 year olds 2000-2004 by deprivation quintile 23
Figure 14: Trends in mortality from accidents South Gloucestershire UA 1993-2004 23
Figure 15: Accidents, all ages, 2000-2004 by deprivation quintile 24
Figure 16: Percentage of low birth weight births (<2500g) South Gloucestershire PCT ...25
Figure 17: Male life expectancy at birth South Gloucestershire PCT..........26
Figure 18: Female life expectancy at birth combined data for BANES, South Gloucestershire and North Somerset..........27
Figure 19: Ethnic groups in South Gloucestershire..........30
Figure 20: Stop Smoking Service in South Gloucestershire: percentage quitting by gender and age 2005-2006..........38
Figure 21: Stop Smoking Service in South Gloucestershire: take up rate 2003-2004 and 2004-2005..........38
Figure 22: Stop Smoking Service in South Gloucestershire: quit rate 2003-2004 and 2004-2005..........39
Figure 23: BMI and its relation to weight..........39
Figure 24: Energy balance 40
Figure 25: Estimate of number of males and females in South Gloucestershire with BMI over 25 (overweight or obese) by age 42
Figure 26: Percentage of school entry children in South Gloucestershire in 2004-2005 overweight or obese..........42
Figure 27: Under 18s conception 1998-2004 (rate per 1000 female population in 15 –17 year olds) 44
Figure 28: Bristol Royal Infirmary Milne Centre new diagnoses of chlamydia and gonorrhea 2001-2005 45
Figure 29: Community assessment in general practice and its data sources. 49
Figure 30: Selected notifiable infectious diseases in South Gloucestershire 1999-2005..53
Figure 31: Monthly notifications of mumps in South Gloucestershire PCT Jan 2004-May 2006 54
Figure 32: Completed immunisations at age 2 years and 5 years 2005-2006..........54
Figure 33: Annual diagnosed cases of hepatitis B in South Gloucestershire..........55

Introduction

I used to doubt the value of an annual report from the Director of Public Health. I might have said that the population's health changes too slowly to justify the effort. Wouldn't it be better to spend the time actually doing something to improve things? But recently I have changed my mind, for several reasons.

Firstly, new challenges do crop up, particularly from infectious diseases such as the recent outbreaks of mumps and hepatitis B, as well as 'slower burn' issues such as the rise in obesity.

Secondly, there can be rare 'tipping points' when we need to reconsider our tactics and planning. The ban on smoking in public places is likely to be seen as a major public health tipping point and one we need to follow through to ensure the benefits are felt by all groups, including children and more deprived communities. A less welcome tipping point is either close or already upon us: climate change due to global warming. This report includes a review of the likely health effects of this on South Gloucestershire residents.

The environment in which we work is changing fast and this is a third reason for producing an annual report. The current NHS reorganisation places renewed emphasis on making sure that health services are commissioned to reflect health need and reduce inequalities in health. This fourth report includes an assessment of how well we are doing in reducing inequalities. The results are mixed. Although some of our key programmes are effectively targeting groups with poorer health, this is not reflected in outcomes, such as the inequalities in life expectancy. Any Primary Care Trust (PCT) end-of-term report would have to say *'could do better'*.

Fortunately, many things are in place for us to do better. The local reorganisation will mean closer working between the PCT and its partners, particularly the local authority. Although there are short term financial challenges for the health community, the anticipated *Choosing Health* funding should allow for meaningful investment in programmes to improve health. We are half way through the first year of our own Local Area Agreement (LAA), in which health is a cross-cutting theme. A summary of LAA outcomes particularly relevant to health is included on the next page and I have indicated links to the LAA throughout this report.

Finally, a Director of Public Health's report should reflect local health challenges and I look at two in particular this year. Older people will be the fastest growing age group in South Gloucestershire over the next 25 years and this report includes a section on health in later life. And I also touch on the challenge presented by the huge amount of new housing in the area and the need to ensure that it is designed in a way that improves health.

Dr Chris Payne
Director of Public Health, South Gloucestershire Primary Care Trust

Local Area Agreement

Local Area Agreements (LAAs) represent a new approach to the way local authorities and their partners can use government funding to support the implementation of national and local priorities. A set of aims and outcomes are drawn up between the local authority and its partners. Once agreed with government, these form the basis of a three year plan. Progress against the plan is monitored by the Local Strategic Partnership.

South Gloucestershire's first LAA was agreed in February 2006. The full document can be found at South Gloucestershire Council's website.[1] Health is a cross-cutting theme in the agreement and the table below shows the aims and outcomes particularly relevant to health.

Figure 1: Health links to South Gloucestershire's Local Area Agreement

Children & Young People	Healthier Communities & Older People	Safer & Stronger Communities
1.1 Halt the year-on-year rise in obesity among children under 11 by 2010 1.2 Promote healthy lifestyles including: • school meals • healthy schools • safe places to play 1.3 Reduce death and injury from accidents 2.1 Ensure early identification and preventative support for vulnerable children including: • access to CAMHS • levels of teenage pregnancy	1.1 Halt the rise in adult obesity 1.2 Increase breastfeeding 1.3 Reduce smoking 1.4 Reduce the number of falls experienced by older people 2.1 Increase the number of carers supported by services and registered with a GP 2.2 Enable more older people to live in their own homes within their communities and improve availability of housing for older people 2.3 Enable more older people to receive an integrated health and social care service 3.1 Increase treatment of mental health problems in primary and community settings 4.1 Increase provision of health services in the community 5.1 Reassure older people by reducing the fear of crime 5.2 Reduce the number of accidents in the home	3.1 Target support in the priority neighbourhoods in Filton, Patchway, Kingswood and Staple Hill 3.3 Reduce the number of people at risk of financial exclusion 3.4 Improve community health through healthy eating and participation in physical activity and sports including walking and cycling 5.1 Design and provide a high quality, healthy environment for developing new communities in which green infrastructure, schools, transport, community facilities and health provision are provided for, in line with the emerging needs of each community

[1] see LAA at www.southglos.gov.uk/ConsultationAndResearch/LatestNews.htm

Section 1: New Challenges

The health of the South Gloucestershire population is linked to wider changes in society. Economic growth and scientific advances have brought enormous benefits to health, but despite advances on some fronts (infectious diseases, smoking, cardiovascular disease) other areas, such as obesity and mental health, are getting worse. Some of the advances that are improving our standard of living are threatening our health. Just as 19th century society grappled with overcrowding, poor hygiene and air pollution, so we must tackle new challenges.

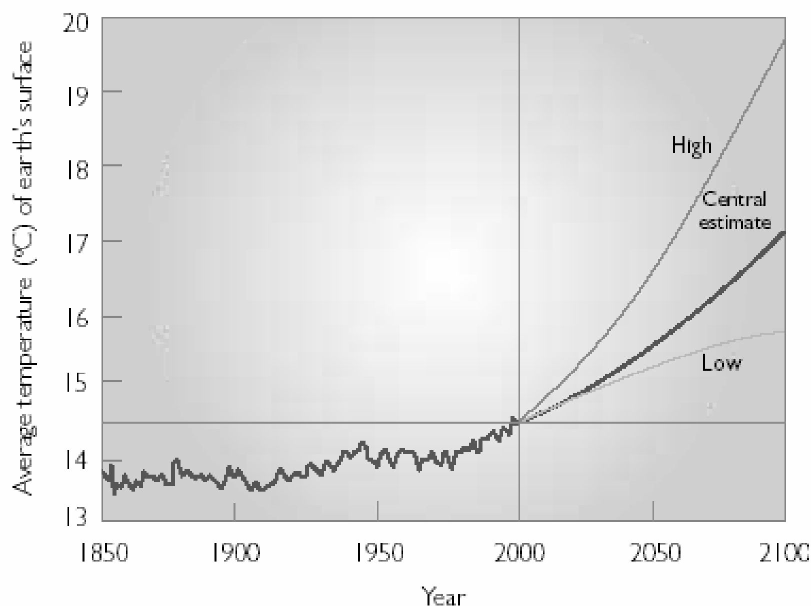
This section looks at three challenges in South Gloucestershire. The first is global warming. A second is more local and specific - the design of new communities. The third challenge relates to improved standards of living and increasing life expectancy and considers '*How do we stay well as we grow older?'*

Climate change

Local Area Agreement: *Environmental Sustainability Aim 1.*

The challenge created by climate change is viewed by many as the major challenge facing the world today.[2] It is estimated that the global average temperature will rise by several degrees centigrade (1.4 - 5.8°C) during this century.[3]

Figure 2: Global temperature record from 1860 projected to 2100 according to the IPCC



Source: IPCC 2001 Climate Change 2001 Third Assessment Report (Volume I). Cambridge: Cambridge University Press 2001 at www.who.int/globalchange/climate/summary/en/

[2] Amongst others - Jonathan Porritt, commentator on sustainable development - presentation at Our Coast and Public Health Conference: Bournemouth 25th May 2006
[3] The range reflects uncertainty about how much green house gas emissions will be reduced

Over the next 80 years, an increase in average annual temperatures of between 1.5ºC and 5.5ºC is predicted in the South West of England.[4] This may lead to the sea level rising by as much as 80 centimetres, although estimates which include progressive complete melting of the Greenland ice sheet (over hundreds of years) suggest an eventual rise in sea level of at least seven metres.[5]

In addition to these gradual changes, there will be greater seasonal variation. We will see drier summers and wetter winters, with rainfall increasing by up to 30% in winter, and decreasing by 25-55% in summer. We can expect a changing pattern of more extreme weather, with storms of greater severity and frequency, and both floods and droughts becoming the norm.

Causes

The increase in atmospheric temperature over the last 50 years is largely attributable to human emissions of greenhouse gases, particularly carbon dioxide.[6]

The contribution that aircraft emissions will make to climate change is a particular concern.[7] Forecasts suggest that, by 2030, aviation could account for a quarter of the UK's total carbon dioxide emissions. The impact of aviation on climate change is increased by other emissions and their effects at altitude.[8]

The government's White Paper on the future of air transport anticipates that the demand for air travel nationally may rise from 200 million passengers in 2003 to between 400 million and 600 million by 2030.[9] Locally, this increase would result in a trebling of passengers at Bristol International Airport to 12 million a year by 2030.[10] Short-haul passenger flights make a disproportionately large contribution to the global environmental impacts of air transport - much greater impacts than those from rail transport.[11]

The impact of climate change on health

The health effects of climate change will be both positive and negative, but with an overall negative effect. Those who will be most vulnerable are the elderly, those with cardiovascular or respiratory diseases, and those living in urban environments.[12]

---

[4] SWCCIP 2003 Warming to the idea....Meeting the challenge of climate change in the South West: SW Climate Change Impact Scoping Study at www.oursouthwest.com/climate/scopingstudy.htm

[5] Stabilising climate to avoid dangerous climate change - a summary of relevant research at the Hadley Centre found at http://www.metoffice.com/research/hadleycentre/pubs/brochures/

[6] Hadley Centre 2005 Climate change and the greenhouse effect. A briefing from the Hadley Centre: Exeter: Hadley Centre.

[7] Royal Commission on Environmental Pollution 2002 The Environmental effects of civil aircraft in flight at www.rcep.org.uk/aviation.htm

[8] Department for Transport. White Paper *The Future of Air Transport*. 16 December 2003. http://www.dft.gov.uk/stellent/groups/dft_aviation/documents/divisionhomepage/029650.hcsp

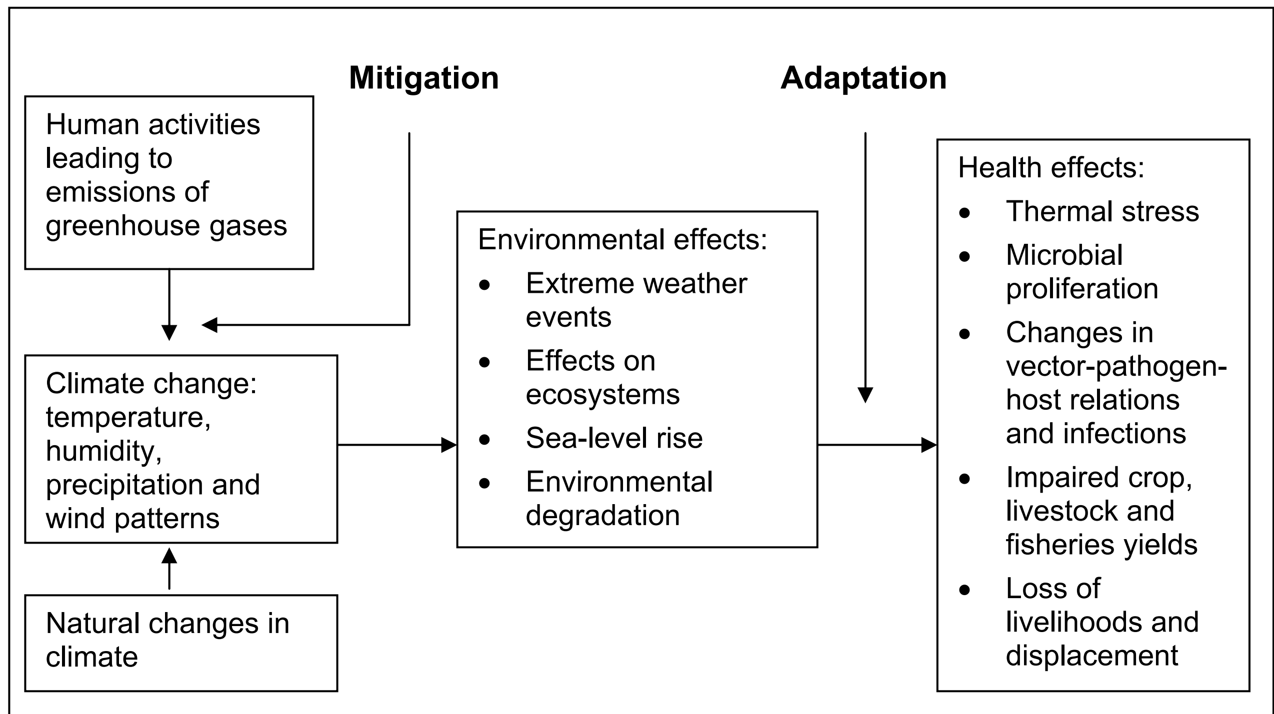
[9] as above

[10] Bristol International Airport. Bristol International Airport Master Plan 2005-2030. http://www.bristolairport.co.uk/upload/draft_master_plan_summary.pdf

[11] Royal Commission on Environmental Pollution 2002 The Environmental effects of civil aircraft in flight at www.rcep.org.uk/aviation.htm

[12] McMichael AJ, Woodruff RE, Hales S 2006 Climate change and human health: present and future risks: Lancet 367; 859-869

Figure 3: The main pathways by which climate change affects health



Source: adapted from McMichael AJ, Woodruff RE, Hales S 2006 Climate change and human health: present and future risks. Lancet 367; 859-869

Climate has a direct impact on health through extremes in atmospheric temperature and an indirect effect through patterns of infections, food availability and flooding.

- There were 30,000 excess deaths in Europe during the 2003 heat wave.[13]
- There are 22,000 excess winter deaths in England, each year.[14]
- It is estimated that the impact of climate change in 2000, compared to 1961-90, caused 160,000 deaths worldwide and the loss of 5,500,000 disability-adjusted life-years.[15]

At a global level, the impact of climate change will be more significant for people living in hot countries and low-lying countries. The World Health Organisation (WHO) estimates that the global impact on health will be:[16]

- milder winters will reduce the seasonal winter-time peak in deaths that occurs in temperate countries
- alterations in the geographic range (latitude and altitude) and seasonality of certain infectious diseases, including vector-borne infections, such as malaria and dengue fever, and food-borne infections (e.g. salmonellosis) which peak in the warmer months

[13] McMichael AJ, Woodruff RE, Hales S. Climate change and human health: present and future risks. 2006. Lancet 367; 859-869
[14] ONS. Excess winter mortality. http://www.statistics.gov.uk/downloads/theme_health/Methodology_excess_winter_mortality.pdf
[15] McMichael AJ, Woodruff RE, Hales S. Climate change and human health: present and future risks. 2006. Lancet 367; 859-869
[16] WHO. Climate change and health http://www.who.int/globalchange/climate/en/. Accessed on 16 May 2006

- increased climatic variability leading to rising sea-levels and population displacement because of physical hazard, land loss, economic disruption and civil strife, which may not become evident for up to several decades.

Impact on health in the UK

With medium to high levels of climate change, it is estimated that in 2050:[17]

- cold-related deaths will decline by about 20,000 per year
- heat-related deaths will increase by about 2,000 per year
- cases of food poisoning will increase by perhaps 10,000 cases per year
- vector-borne diseases may present local problems, but the increase in their overall impact is likely to be small
- water-borne diseases may increase but the overall impact may be small
- the risk of major disasters caused by severe winter gales and coastal flooding will increase significantly
- in general, the effects of air pollutants on health will decline, but the effects of ozone during the summer will increase: several thousand extra deaths and a similar number of hospital admissions may occur each year
- cases of skin cancer will increase by perhaps 5,000 cases per year and cataracts by 2,000 cases per year
- measures to reduce the rate of climate change by reducing greenhouse gas emissions could produce secondary health benefits.

In the short term, increasing energy prices could mean that more people are fuel poor and are at risk of health problems related to poorly heated homes.[18]

Targets

Some changes will be inevitable and we need to prepare to adapt our physical environment to reduce the impact on health. Figure 3 identifies the points at which we need to mitigate the impact and adapt to climate change.

The emission reductions needed to prevent dangerous levels of climate change are significant. The UK Government has set targets to reduce the level of carbon dioxide emissions by 20% by 2010, and 60% by 2050 (from the 1990 level). This reduction does not include emissions from international air travel. The Royal Commission[19] recommends that:

- airport development is restricted to encourage greater competition for longer-haul flights
- efforts are made towards a modal shift to rail for domestic journeys.

Local action

The emissions of carbon dioxide in South Gloucestershire are 10.9 tonnes per head of population - slightly higher than the UK average (10 tonnes per head).[20]

[17] Expert Group on Climate Change and Health in the UK 2001 Health effects of Climate Change in the UK: London: Department of Health

[18] Where more than ten percent of income is spent on heating the home

[19] Royal Commission on Environmental Pollution 2002 The Environmental effects of civil aircraft in flight at www.rcep.org.uk/aviation.htm

[20] South Gloucestershire Council 2006 Tomorrow's Climate, Today's Challenge. A climate change strategy and action plan for South Gloucestershire: Thornbury: S G Council.

This is mainly due to above average emissions locally, from transport, industry and commerce. To meet the UK target of a 20% cut in emissions by 2010, emissions will have to be reduced to 7.9 tonnes per person across the UK.

Tomorrow's Climate, Today's Challenge

South Gloucestershire Council has produced a climate change strategy and action plan which aims to reduce emissions and increase energy efficiency.[21] It states that in South Gloucestershire we need to:

- design the built environment to discourage car use
- reduce the amount of biodegradable waste that goes to landfill
- build homes in areas not susceptible to flooding, that are energy efficient, adapted for warmer temperatures, and have ventilation and shading
- ensure large organisations, including the NHS, reduce emissions through staff education, energy efficiency projects, sustainable construction, green travel and sustainable procurement policies.[22]

South Gloucestershire PCT Heat Wave Plan

This plan aims to respond to a heat wave alert from the Met Office 'Heat-Health Watch' system.[23] The system has four levels of response based upon threshold temperatures. In the South West the thresholds are a maximum daytime temperature of 30°C and overnight temperature of 15°C.

Emergency response

The NHS and local authority need to prepare for extreme weather events. Multi-agency plans have been developed to respond to major incidents.

Recommendations

The local authority draft climate change strategy *Tomorrows Climate, Today's Challenge* should be supported and implemented. The NHS and other local strategic partners should set an example in reducing energy usage through adopting the recommendations contained within it.

The growth in air travel should be curbed through coordinated action at an international, national and regional level. Action is likely to include a change in culture (reducing trivial travel), increased cost to the consumer, improved alternative modes such as rail and restricting airport growth.

The emphasis in transport planning should shift from reducing congestion to reducing car use, promoting public transport and encouraging 'active travel'.

When choosing policies that provide incentives to individuals to reduce carbon emissions, such as taxation or 'carbon trading' schemes, account should be taken of people on low incomes and those living in poor housing stock, in order to avoid increasing inequalities in health.

[21] South Gloucestershire Council 2006 Tomorrow's Climate, Today's Challenge. A climate change strategy and action plan for South Gloucestershire. Thornbury: South Gloucestershire Council
[22] Coote A 2006 What Health Services could do about climate change. BMJ 332:1343-1344
[23] Met Office. Heat-Health Watch. www.metoffice.gov.uk/weather/Europe/uk/heat_health.html#more

New communities

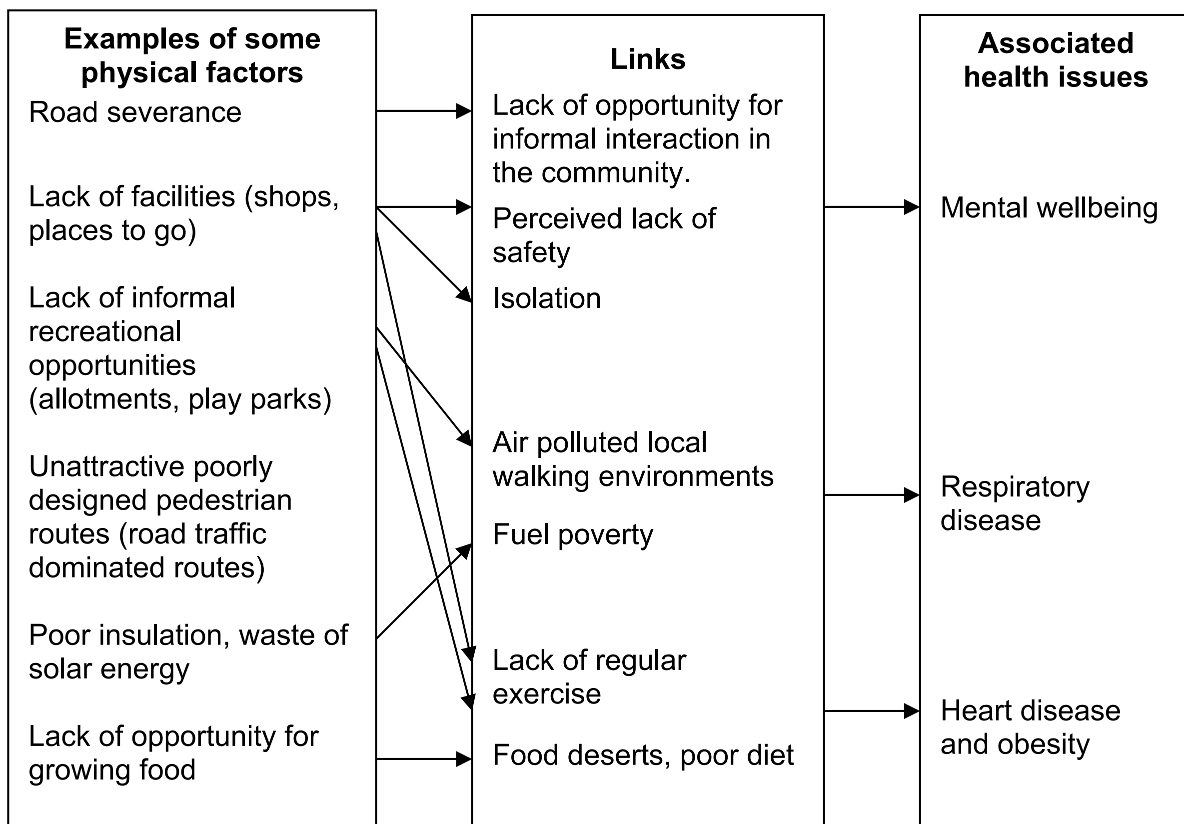
Local Area Agreement: *Safer & Stronger Communities Aim 5*

South Gloucestershire has a wide variety of communities. They range from the urban fringe of Bristol, through to rural areas and the older market towns of Chipping Sodbury and Thornbury. The past 50 years has seen a considerable growth in housing, particularly in Yate and around Bradley Stoke. Planned new developments in the Northern Fringe include the former Filton airfield site on the A38 and developments close to the ring road, from Harry Stoke to Emerson's Green. Developments are expected to provide an estimated 23,000 new homes.

Links between the built environment and health

The links between the built environment and health are wide and include those shown below.

Figure 4: Links between the built environment and health



Source: Design and Health - Exploring the Links. Power point presentation (slide 14) by Marcus Grant of the WHO Collaborating Centre for Healthy Cities and Urban Policy at a South Gloucestershire Better Health Seminar on May 2nd 2006

The health of new communities in South Gloucestershire

Although much of the new housing in South Gloucestershire has been of high quality, the design and layout has had some unfortunate consequences. The low density of housing, coupled with a design emphasising car use and, in some cases, poor provision of public spaces and facilities, all act to promote social isolation and car dependence.

Increasing car use has led to traffic congestion, reduced physical activity, increased emissions of carbon (with the consequent contribution toward global warming) and increased levels of adult and childhood obesity. There is now an opportunity to learn from the mistakes of the past and ensure that new communities are designed and built in a way that promotes health.

Local action

The new housing planned for South Gloucestershire will be built at much greater densities than existing developments, ensuring that far more people will live within walking distance of local shops and facilities. This should ensure that:

- a wider range of shops and facilities are economically viable
- local communities are more vibrant, pleasant places to be with enhanced local networks and increased local employment opportunities.

There is evidence to support follow up work with people who move in to new housing.[24] The use of targeted information and marketing for individual households that have expressed an interest in changing their mode of travel can result in enduring changes in travel behaviour.

Currently local action involves:

- including a 'New Communities' theme as part of the local authority Strengthening Communities strategy
- ensuring the Safer and Stronger Communities theme in the LAA includes an aim to plan and deliver a high quality environment in new developments
- building closer links between local planners and the PCT to ensure that health facilities are included from an early stage
- developing a health improvement checklist for consideration as part of the planning process
- ensuring a strategic approach to children’s play through the appointment of a play development officer
- appointing a new communities coordinator to work with stakeholders to ensure that community facilities and capacity are built into large scale new developments
- improving the accessibility and availability of transport
- further developing safer routes to school
- increasing opportunities for cycling and walking.

[24] www.nice.org.uk/page.aspx?o=346196

Evaluation of environmental change on lifestyle and physical activity behaviour - a case study

Although this is an initiative to address public health issues in an established community - in the Dings area of Bristol - these concerns apply equally to developing new communities.

The University of Bristol is carrying out this evaluation and is focusing initially on a Homezone development and the development of a cycle walkway. A Homezone is a street, or group of streets, where pedestrians, cyclists and vehicles share the space on equal terms with cars travelling at little more than walking pace. These initiatives help define the street as a valuable part of the local community's living space. A successful Homezone can make a contribution to delivering policies across transport, planning, sustainable communities, environment and health. Traffic calming schemes are associated with increases in walking, willingness to allow children to exercise outside, increased pedestrian activity, improvements in traffic related nuisances, improvements in physical health, wider benefits for the health of a local population, in addition to accident reduction.[25]

The evaluation is using a combination of methods. Focus groups with primary school children and adults have been used to gather baseline and interim information.

Both groups felt that the neighbourhood aesthetics had improved as a result of the developments.[26]

The adults viewed the Homezone as having potential for benefiting their wellbeing and felt greater ownership of the space. But they viewed the cycle-walkway less favourably, reflecting their concerns about community safety.

The children were more open to the cycle walkway and, although they had been concerned about losing pavements when the Homezone was being developed, they were supportive of opportunities for bike riding on the new smooth surfaces.

The children were also involved in collecting data through use of pedometers and personal activity diaries.[27] Although they should be treated with caution, the results showed that all the children who participated achieved the current recommended levels of physical activity, with home, school and local environments contributing towards this.

[25] Morrison DS, Thomson H, Petticrew M 2004 An evaluation of the health effects of a neighbourhood traffic calming scheme: Journal of Epidemiology and Community Health: 58:837-840
[26] Coulson JC. Lay versus professional priorities: evaluation of environmental change on lifestyle and physical activity behaviour (The Dings, Bristol). 6th Annual 'Better Health Seminar' hosted by South Gloucestershire Council & Primary Care Trust. S. Glos, UK, May 2006 (verbal presentation).
[27] Trayers T, Cooper AR, Riddoch CJ, Ness AR, Fox KR, Deem R, Lawlor DA 2006 Do children from an inner city British school meet the recommended levels of physical activity? Results from a cross sectional survey using objective measurements of physical activity. Archives of Disease in Childhood. 91, 175-176.

Recommendations

Ensure that strategic decisions on the location and nature of housing developments take into account issues of sustainability, particularly seeking to reduce carbon emissions.

Work with neighbouring authorities and other partners to develop efficient public transport links.

Consider whether the advent of high density housing presents an opportunity to develop more local work and leisure opportunities.

Inform the design of new communities by best practice such as that available at www.manualforstreets.org.uk

Design new communities in a way that encourages walking and cycling within the community and is linked to wider walking and cycling routes.

Target behaviour change programmes in new and existing communities to promote active travel and the use of public transport.

Healthy ageing

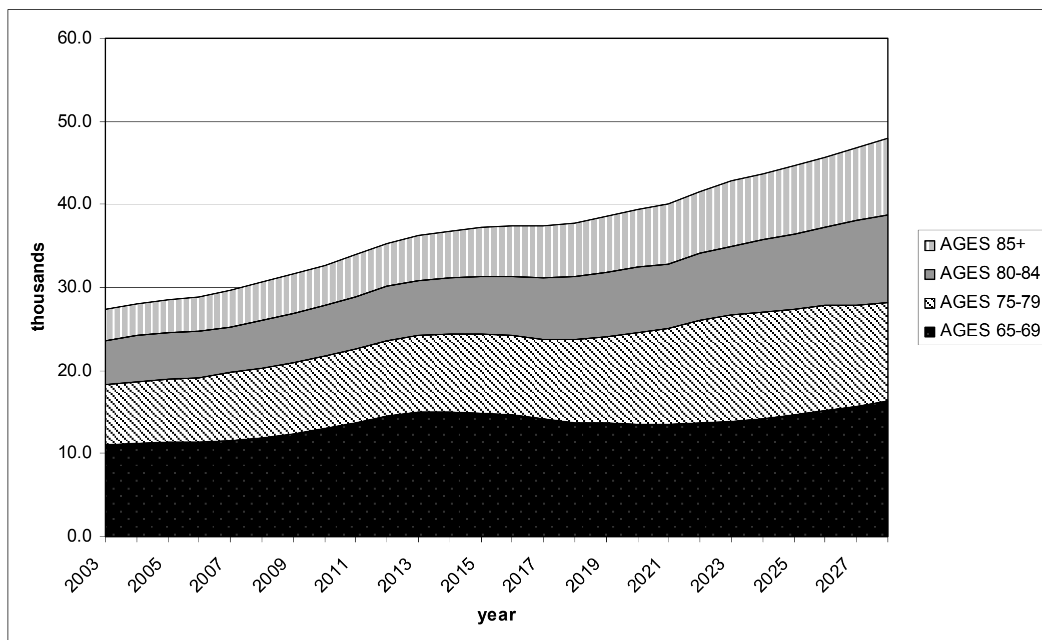
Local Area Agreement: *Healthier Communities & Older People Aims 1-5; Safer & Stronger Communities Aims 1 and 3*

Although South Gloucestershire has a lower proportion of elderly people than the UK average, people aged 85 years and over are the fastest growing age group.[28]

Population trends

Projections suggest that there will be an additional 15,100 people aged over 75 in South Gloucestershire, over the next 25 years. The biggest rise - by 140% - is expected in the over 85 age group.

Figure 5: Projected number of older people in South Gloucestershire 2003-2028



Source: ONS at www.statistics.co.uk 2003-based subnational population projections

The greatest concentration of older people live on the fringes of Bristol in the Kingswood, Downend and Filton areas. Thornbury and the more rural areas of South Gloucestershire also have a significant proportion of over 65s.

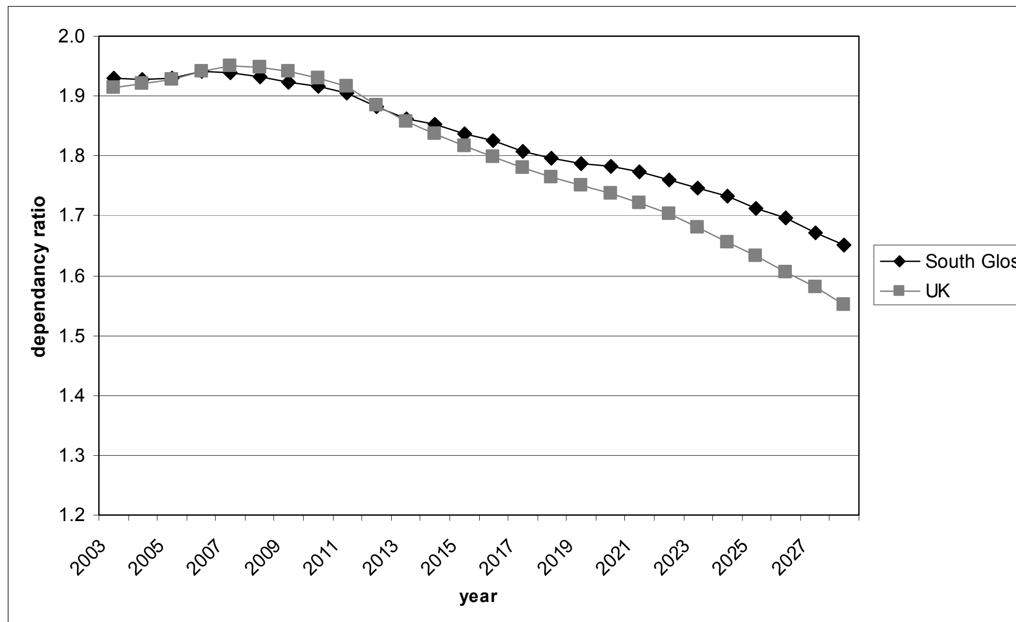
Dependency ratio

The proportion of people who are of working age is expected to decline as the numbers of older people increase and fertility rates fall. This is measured by the dependency ratio - the ratio of people of working age (16-64) to the non-working population (aged 0-15 and 65+).

[28] Tomassini C 2005 The demographic characteristics of the oldest old in the United Kingdom. Population Trends 120, p15-22.

The dependency ratio in South Gloucestershire is currently similar to the national average and is projected to decline in line with the national trend.

Figure 6: Trends in the dependency ratio in South Gloucestershire 2003-2028



Source: ONS at www.statistics.co.uk 2003-based subnational population projections

It is not clear if this trend, particularly when coupled with a rising divorce rate, will result in more people needing care facilities outside of the family. A number of factors may mitigate against this, including the increased probability of spouses surviving until old age, migration patterns, and the rise in the number of elderly with at least one child surviving.[29]

Health and life expectancy

As life expectancy increases, it is important to understand the extent to which these extra years are spent in good health. Two measures have been developed to monitor this.[30]

- Healthy life expectancy (HLE) is defined as the expected years of life in good or fairly good health.
- Disability-free life expectancy (DFLE) is defined as the expected years of life free from limiting long-standing illness or disability that restricts daily living.

[29] Tomassini C, Glaser K, Wolf D A et al 2004 Living arrangements among older people: an overview of trends in Europe and the USA. Population Trends 115, p24-34.
[30] Parliamentary Office of Science and Technology. Healthy Life Expectancy. Feb 2002 Number 257.

Figure 7: Life expectancy, HLE and DFLE at 65 years

	Life expectancy	**HLE**	**DFLE**
A man of 65 years can expect...	to live another **16.3 years**	to have **12.1 years** in good or fairly good health	to have **9.3 years** free from limiting long-standing illness or disability
A woman of 65 years can expect...	to live another **19.2 years**	to have **14.1 years** in good or fairly good health	to have **10.4 years** free from limiting long-standing illness or disability

Source: ONS data Health expectancies in the UK 2002 Health Statistics Quarterly 29 Spring 2006 p59-62

Over the last 20 years, life expectancy has increased - by 3.1 years for men and 2.2 years for women. Over the same period HLE and DFLE also increased, although they did not increase as much for men as for women.

For women, HLE increased by the same amount as life expectancy, although the increase in DFLE was less.

Figure 8: Additional years of life expectancy and healthy life expectancy 1981-2002

	Life expectancy (increased years)	**Healthy life expectancy** (increased years)	**Disability free life expectancy** (increased years)
Men	3.1	2.1	1.5
Women	2.2	2.2	1.8

Source: ONS data Health expectancies in the UK 2002 Health Statistics Quarterly 29 Spring 2006 p59-62

Health service usage increases with advancing age. For example, nationally, nearly half of all people aged 85 and over receive district nursing care. A third of people over 75 years take four or more prescribed medications.[31]

The evidence on the future health of the elderly is mixed.[32] Certain factors, such as trends in smoking, indicate that future generations of older people will be healthier. Conversely, the proportion of people (of the same age) reporting limiting long-standing illnesses has increased, and younger age groups are facing higher levels of stress and unemployment. Research indicates that increasing life expectancy is accompanied by a rise in light to moderate disability, but a decrease in severe disability.

[31] Wanless 2006 Social Care review - Securing good care for older people. King's Fund. p169.
[32] Evandrou M 2000 Looking back to look forward: lessons from four birth cohorts for ageing in the 21st Century. Population Trends 99, Spring: p27-35.

Promoting healthy ageing

The White Paper *Our health, our care, our say; a new direction for community services* [33] strongly favours preventative approaches. It calls for 'an increased commitment to spending on prevention,' in order to prevent, or delay, the need for social care services, by reducing people's dependency, disability and ill health.

Many of the risk factors that particularly contribute to poor health in the older population are the same as for the population as a whole, although the ways we address them may be different.[34] These factors include low income, poor housing, poor nutrition, obesity and lack of physical exercise.

Tackling poverty

Poverty is closely associated with poor health, but many older people are not aware of the benefits that they are entitled to. The benefits system is complicated and this alone can prevent people from claiming.

Older adults are more at risk of dying in the winter during periods of cold weather.[35]

Healthy homes

Health is affected by the conditions in which people live. Simple low-cost interventions are highly valued by older people - services such as help with gardening, DIY, and the provision of inexpensive home adaptations.

The Small Change, Big Difference campaign

Research shows that small changes in diet and daily physical activity can significantly increase a person's lifespan.[36] This national campaign encourages people to make minor changes in their lifestyles, to give them a better chance of living longer healthier lives.

For example:

- giving up smoking can add an extra five years to life
- moderate exercise can add three years to life and any additional activity has a measurable impact on health.

[33] DH 2006 Our health our care our say: a new direction for community services. DH
[34] SWPHO 2005 Second blooming: towards achieving a healthy and active mature population in the South West: p26 SWPHO
[35] Wanless 2006 Social Care Review - Securing good care for older people. King's Fund. p169.
[36] The Small Change, Big Difference campaign. DH April 2006

Falls prevention

Falls are amongst the most common and serious problems for older people.

Figure 9: Falls in people 65 years and over in South Gloucestershire

	Number
Population aged 65 years and over	35,326[37]
Number who fall per year	approx 10,598[38]
Number who fall on multiple occasions per year	approx 6,299
Number of admissions to hospital because of falls per year.	approx 720[39]
Hip fractures per year	336[40]
Deaths per year (2002-2004)	16[41]

What works in falls and fracture prevention?[42]

Specialised falls services and population programmes to reduce falls are required by Standard 6 of the National Service Framework for Older People. The growing burden of falls-related illness and associated NHS costs are well recognised.[43]

Priorities for implementation are:[44]

- encouraging older people to take part in falls prevention programmes
- identifying those most at risk or those that have already fallen
- carrying out multifactoral falls risk assessments
- multifactoral interventions to prevent falling may include:

  - education and information
  - strength and balance training
  - promoting exercise in people living in extended care settings
  - home hazard and safety intervention
  - reviewing and minimising the use of psychotropic medications
  - providing a cardiac pacemaker for some types of irregular heartbeat.

[37] National statistics website at www.statistics.gov.uk Figures from the 2001 Census
[38] DH 2003 How can we help older people not fall again? Implementing the NSF Falls Standard: Support for commissioning good services
[39] 3 year average of admissions of S Glos PCT patients aged 65years and over for fractured neck of femur 2001 to 2003
[40] South Gloucestershire in-patients aged 65 years and over with a main diagnosis of fractured neck of femur 2003/04
[41] Compendium of Clinical Indicators 2006
[42] Based on the Cochrane Database of Systematic Reviews 2005 Issue 2 Interventions for preventing falls in elderly people LD Gillespie, WJ Gillespie, MC Robertson, SE Lamb, RG Cumming, BH Rowe This version first published online: 20 October 2003 in Issue 4, 2003 Date of Most Recent Substantive Amendment: 14 July 2003 http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD000340/frame.html accessed 28.6.05, and subsequent new randomised controlled trials, meta analyses and systematic reviews.
[43] Parrott S 2000 The Economic Cost of Hip Fracture in the UK. University of York http://www.dti.gov.uk/homesafetynetwork/pdf/hipfracture.pdf?nourl=www.dti.gov.uk/publications/pdflink/&pubpdfdload=00%2F1503
[44] NICE 2004 Clinical Guideline 21. Falls: The assessment and prevention of falls in older people at http://www.nice.org.uk/page.aspx?o=233610

Mental health

One of the biggest challenges to people as they age is the feeling of isolation, which may eventually cause depression. Approximately one in ten people aged 65 and over report feeling lonely and this loneliness increases with age. Many factors may contribute to feelings of isolation including:

- bereavement
- retirement, or loss of work
- taking on a caring role
- fear of crime
- declining physical and mental health, mobility and the senses
- other factors include living alone, or in rural or deprived areas, lack of transport, age discrimination and public attitudes.

At any one time, about 10-15% of the population over 65 will have depression and this may often go undiagnosed.

About five percent of the population over 65 years has dementia affecting up to 750,000 people in the UK.

Evidence supports the following:

- Participation in individual or collective activities such as the arts and physical activity will enhance mental wellbeing.
- Remaining productive and maintaining, or building up, new social networks will be healthier.
- Physical activity can reduce anxiety, maintain independence and protect against the development of depression.
- Independence and a sense of autonomy protect against mental ill health.[45]

Carers of someone with a mental health problem may need extra support. Whilst women are more likely to provide care generally, it is men who are more likely to be carers in the over 65 age range.[46]

Local action

The South Gloucestershire Local Area Agreement includes the theme 'healthier communities and older people'. Aims include targeting health promotion activity at individuals with high health need and helping older, vulnerable people to live at home.

[45] Literature and Policy Review for the Joint Inquiry into Mental Health and Well-being in Later Life, Age Concern and the Mental Health Foundation

[46] A Sure Start to Later Life. Ending Inequalities for older people. A Social Exclusion Unit Final Report 2006

Current local action includes:

- **welfare benefits project** - a joint project between the health service, local authority and Age Concern which provides advice on entitlement to benefits
- **healthy homes** - the Joint Accommodation and Care Strategy for Older People in South Gloucestershire[47] focuses on good health and quality of life
- **Warm and Well** - the council delivers grants to improve home energy efficiency
- **Safer South Gloucestershire Handy Van Security Scheme** - provides window locks and other simple adaptations
- **Age Concern and Care and Repair -** provide practical help
- **promoting physical activity** - through Walking to Health and Exercise on Prescription
- **fire safety -** free home fire safety visits and smoke alarms fitted
- **an integrated falls service -** a care pathway for those at risk of falling
- **training -** to promote health and independence in older people
- **safety education -** 'Learning for Living' programme at the Lifeskills Centre
- **South Gloucestershire Primary Mental Healthcare Service -** provides short courses and one-to-one counselling
- **health visitors -** supporting people with mental health problems and their families and carers
- **stopping smoking** - supporting people to quit.

Recommendations

Programmes to promote healthy eating, physical activity and stopping smoking need to be tailored to the needs of older people and address barriers to participation, such as low income and fear of crime.

Current programmes to increase physical activity (Walking to Health) and the uptake of welfare benefits should be supported and extended.

Investment in mental health services, maintaining independence and supporting carers should remain a priority.

[47] South Gloucestershire Council and South Gloucestershire PCT 2006 Joint accommodation and Care Strategy for Older People in South Gloucestershire

Section 2: An Update on Health and Inequalities

Local Area Agreement: *Children & Young People Aim 2; Healthier Communities & Older People Aims 1 and 2; Safer & Stronger Communities Aims 3 and 6; Economic Development & Enterprise Aims 4 and 5*

The Director of Public Health's annual report in 2003 highlighted the inequalities in health in South Gloucestershire and set out an approach to tackle them. This echoed national priorities and targets for several indicators, including cancer death rates, cardiovascular disease, smoking and life expectancy.

The launch of a national drive to reduce inequalities was set against a longstanding trend of widening differences in health. We knew that reversing that trend would be challenging, and that it could not be addressed by the health service alone. A comprehensive set of interventions at a national level was launched, including measures to reduce teenage pregnancy and some redistribution of income.

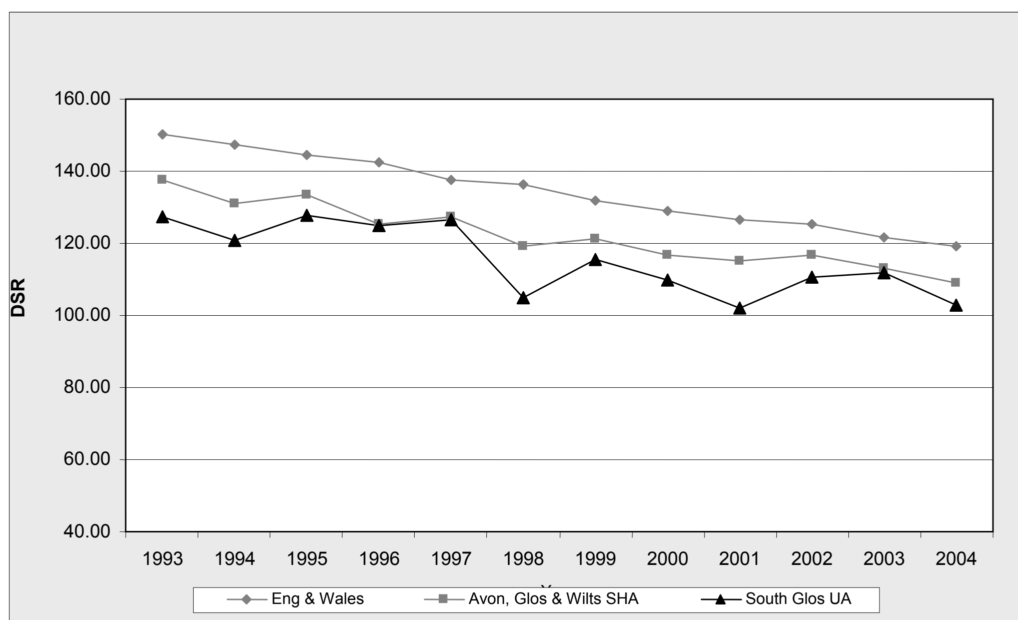
This section reviews progress on the main health indicators. It also presents updated data on inequalities and uses national and local sources to try and answer the question *'Are inequalities in health improving or getting worse?'*

Major causes of ill health

Cancers

The directly standardised mortality rate (DSR) for all cancers (ages under 75) shows a downward trend from 1993 to 2004, in line with national trends. It stayed below that for England and Wales and for Avon, Gloucestershire and Wiltshire.

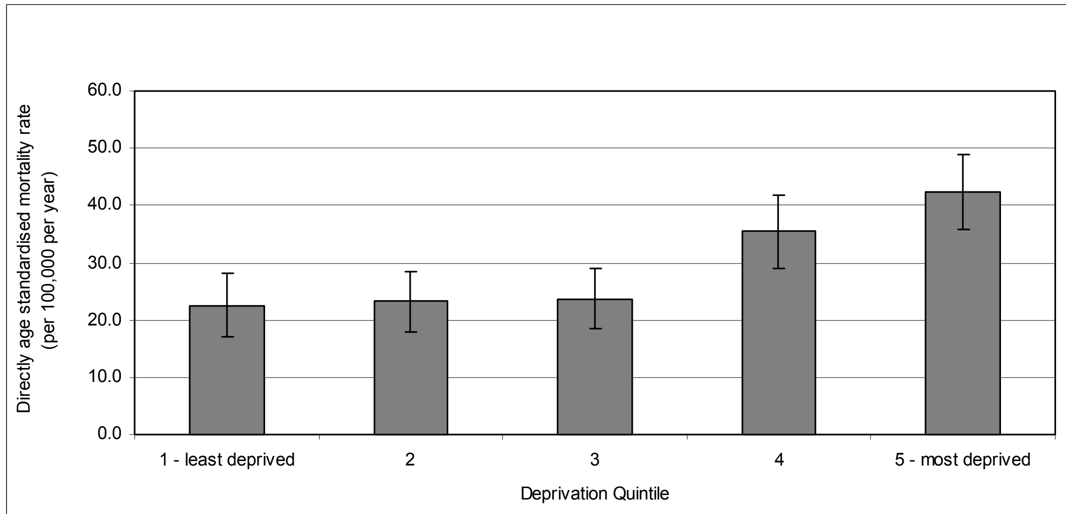
Figure 10: Trends in mortality from all cancers in under 75 year olds in South Gloucestershire UA 1993-2004



Source: Compendium of Clinical Indicators: release date Feb 2006

The relationship between cancer mortality rate and deprivation varies with the type of cancer. Higher mortality rates are not always associated with the most deprived areas. High mortality rates for lung cancer are consistently associated with more deprived areas, reflecting the fact that smoking prevalence is higher.

Figure 11: Mortality from lung cancer in South Gloucestershire by deprivation quintile, all ages 2000-2004

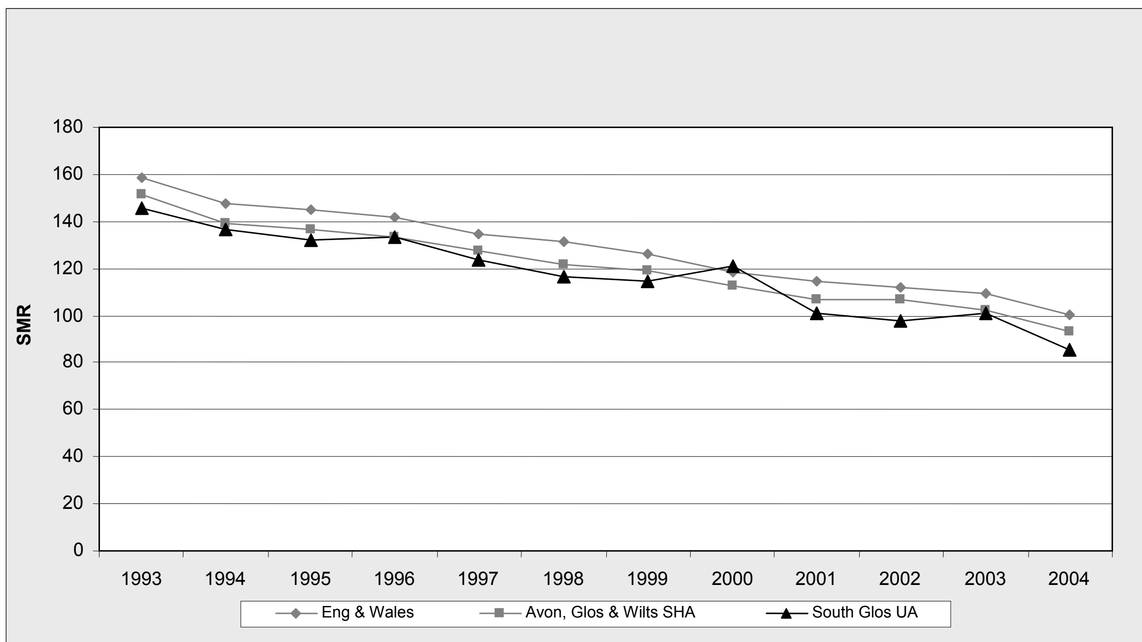


Source: Avon IM&T Consortium. ONS mortality and birth files; IMD 2004 Income Domain Index

Circulatory diseases

The standardised mortality ratio (SMR) for circulatory diseases for under 75s shows a downward trend from 1993 to 2004, in line with the national trend.

Figure 12: Trends in mortality from all circulatory diseases in South Gloucestershire in under 75 year olds 1993-2004

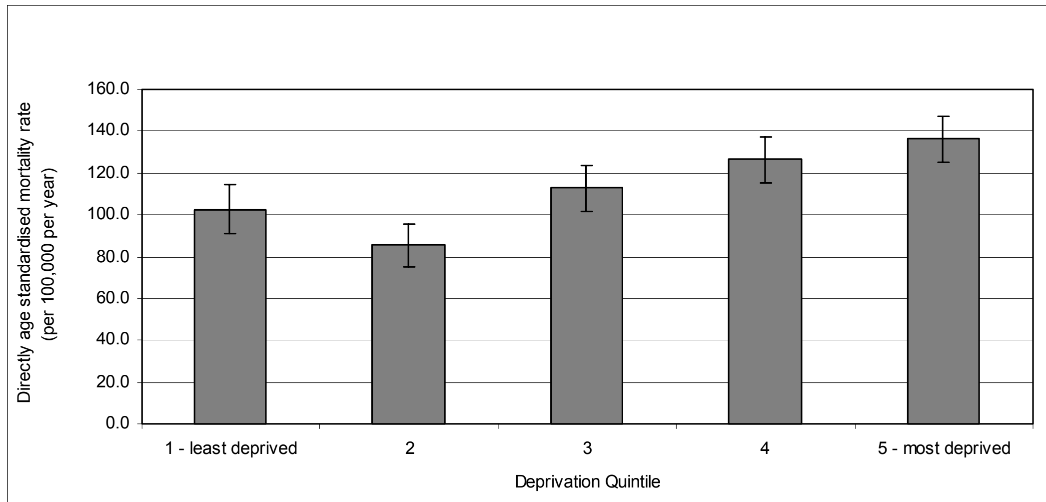


Source: Compendium of Clinical Indicators; release date Feb 2006

Higher mortality rates for coronary heart disease tend to be associated with more

deprived areas. This is true for all ages, the 35-64 age group and the under 75s. Mortality rates for stroke do not consistently show as strong an association.

Figure 13: Coronary heart disease in under 75 year olds 2000-2004 by deprivation quintile

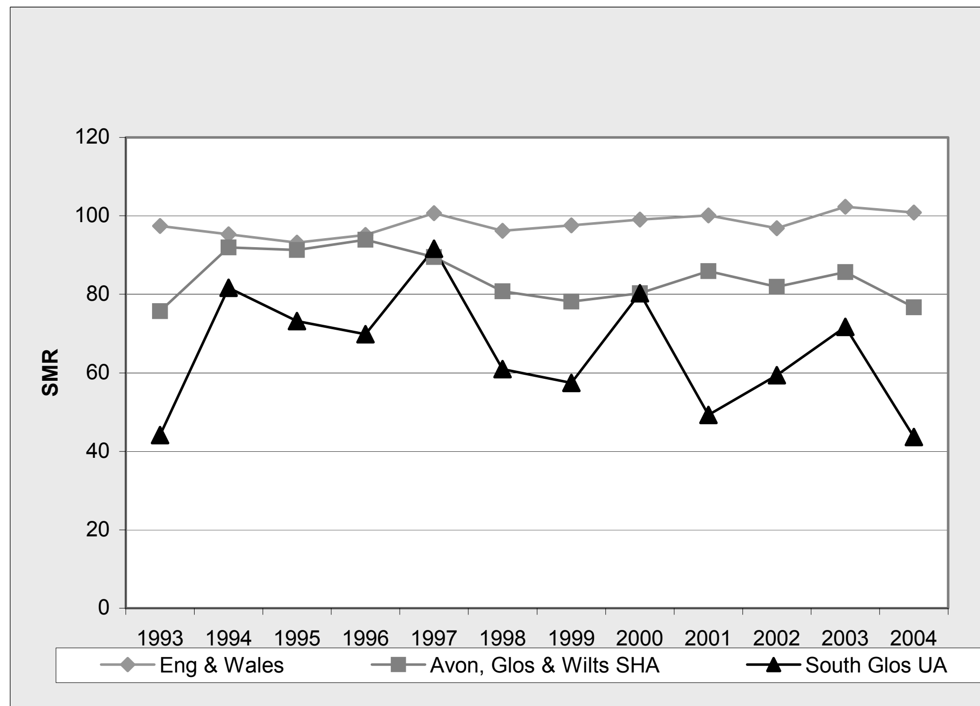


Source: Avon IM&T Consortium. ONS mortality and birth files; IMD 2004 Income Domain Index

Accidents

There were on average 28 accidental deaths a year in South Gloucestershire 2002-2004. The mortality rate shows an overall downward trend between 1993 and 2004. Accidents are the single largest cause of death in young people in the UK.

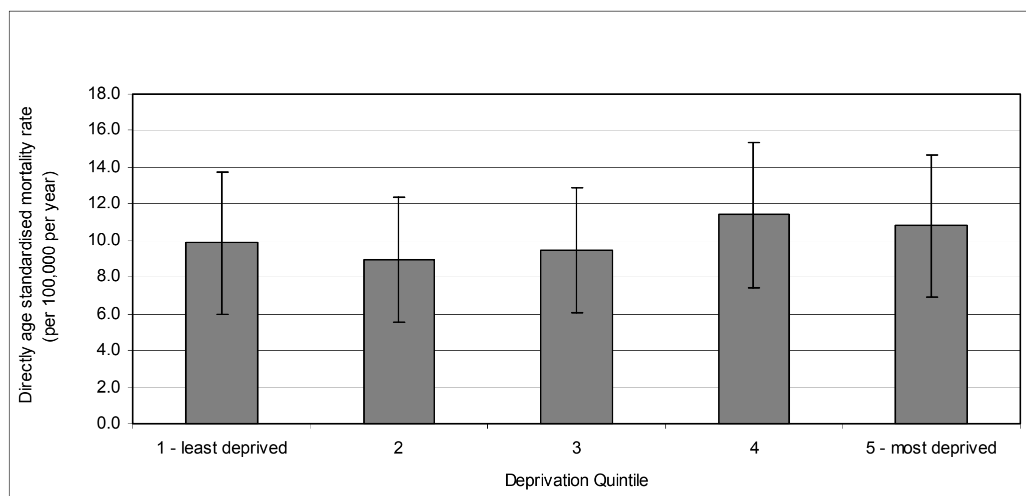
Figure 14: Trends in mortality from accidents South Gloucestershire UA 1993-2004



Source: Compendium of Clinical Indicators. Release date Feb 2006

The mortality rates for accidents for 2000 - 2004 are slightly higher in the more deprived quintiles, but the difference between the least deprived and the most deprived is very small.

Figure 15: Accidents, all ages, 2000-2004 by deprivation quintile



Source: Avon IM&T Consortium; ONS mortality and birth files; IMD 2004 Income Domain Index

Health inequalities

A wide and complex range of factors determine both a population's health and the inequalities within it. The differences in health between the rich and the poor have widened over the years and it is expected that this will take time to reverse.

The national picture

Reducing health inequalities, as well as improving health, is one of the top priorities for the government. It has outlined several policies and programmes in *Tackling Health Inequalities: A Programme for Action* which are expected to have an effect in the longer term on both the life expectancy and the infant mortality gap.

The national public service agreement (PSA) target for inequalities is to *'Reduce inequalities by 10% by 2010 as measured by infant mortality and life expectancy at birth'.* [48]

Infant mortality

The target for infant mortality is a 10% reduction in the relative gap (i.e. percentage difference) in infant mortality rates between 'routine and manual' socio-economic groups and England as a whole. This is from the baseline year of 1998 (pooled rate for 1997-1999) to the target year of 2010 (pooled rate for 2009-2011).

Although infant mortality rates have fallen in the 'routine and manual group' since the baseline was set, the rate of decline has been faster in other groups. This has resulted in a widening of the relative gap in infant mortality between 1997-1999 and the latest position as at 2002-2004. The infant mortality rate for the 'routine and

[48] DH 2005 Report on Progress against 2004 Spending Review Health Inequalities PSA Target – Dec 2005; DH 2005Tackling Health Inequalities: Status Report on the Programme for Action

manual' group was 19% higher than for the population overall in 2002-2004. In the baseline period of 1997-1999 it was 13% higher.

Life expectancy

The target for life expectancy is a 10% reduction in the relative gap in life expectancy at birth between the fifth of areas with the worst health and deprivation indicators (the Spearhead Group) and England as a whole. This is from the baseline year of 1996 (pooled figures for 1995-1997) and the target year of 2010 (pooled figures for 2009-2011).

Life expectancy has improved in both the Spearhead Group and for England as a whole. However, it has improved more slowly in the Spearhead Group. For males the relative gap in 2002-2004 is one percent wider than the gap at the baseline year. For females the gap is 8% wider in 2002-2004 than the baseline year.

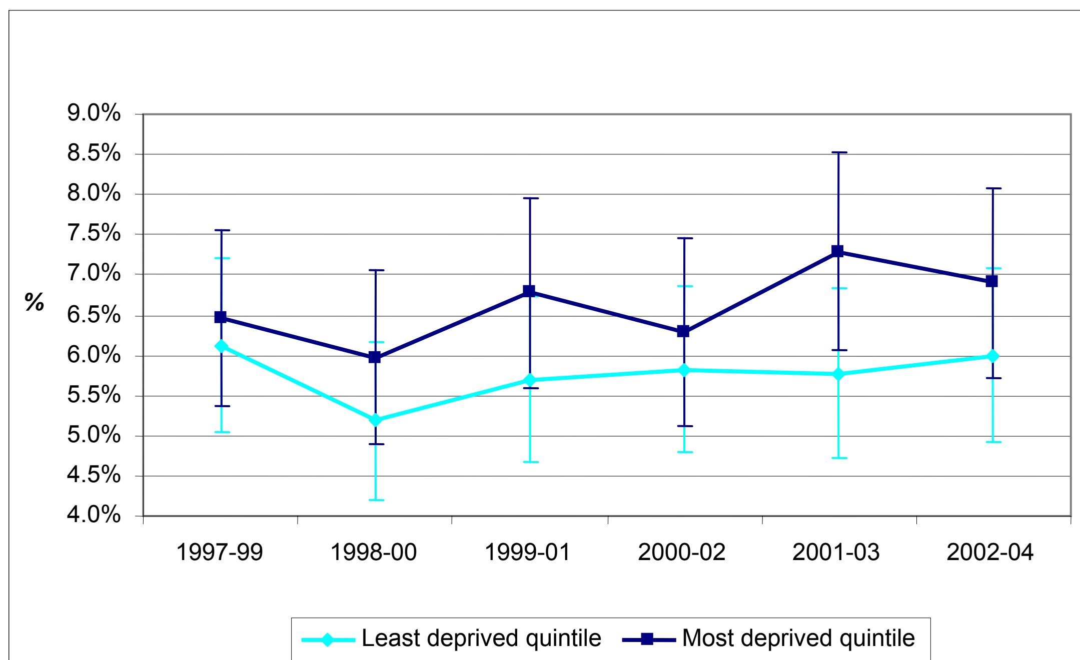
The local picture

Health data, such as death rates, at a local level always show more year-on-year variation than national data. However the trend seen in South Gloucestershire appears to be similar to the national one of widening inequalities in health.

Infant mortality

There are too few infant deaths to look at the trend in the relationship between infant mortality and deprivation at PCT level. However, the number of low birth weight babies (under 2,500 grams) is generally used as a proxy indicator.

Figure 16: Percentage of low birth weight births (<2500g) South Gloucestershire PCT



Source: Avon IM&T Consortium. ONS mortality and birth files; IMD 2004 Income Domain Index

In South Gloucestershire:

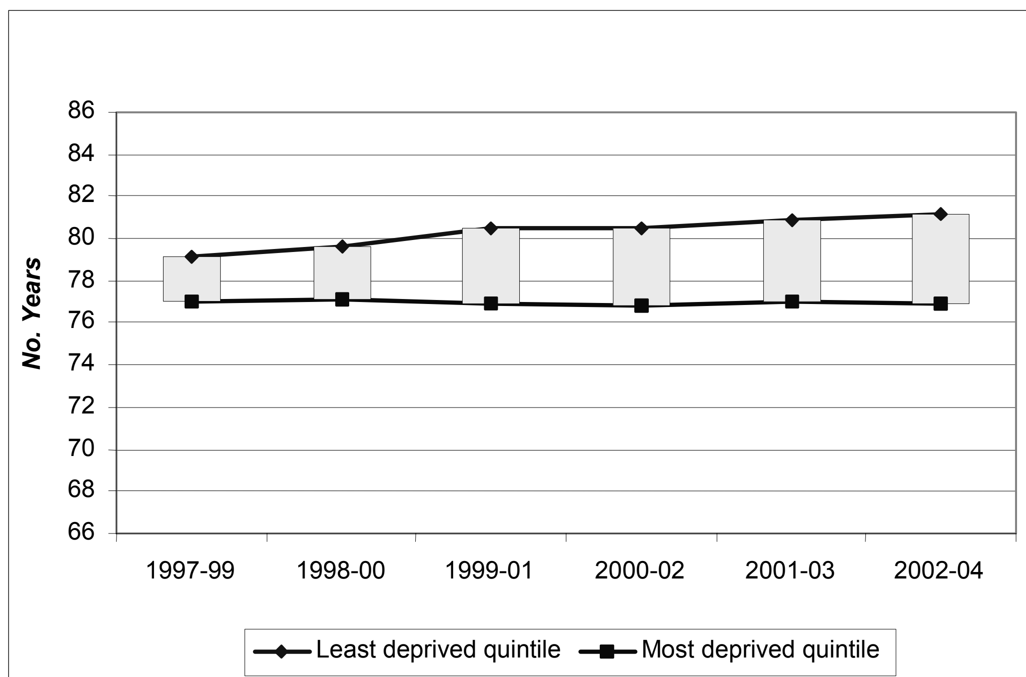
- the percentage of low birth weight births in the least deprived quintile has fallen fractionally from 6.1% in 1997-1999 to 6.0% in 2002-2004
- the percentage of low birth weight births in the most deprived quintile has risen from 6.5% in 1997-1999 to 6.9% in 2002-2004.

This suggests that the inequalities gap could be getting wider. However, the percentages fluctuate and neither quintile exhibits movement in the same direction year-on-year.

Life expectancy

In South Gloucestershire, the gap in male life expectancy at birth between the most deprived and least deprived quintiles has increased over the period 1997-1999 to 2002-2004 from 2.1 to 4.2 years.

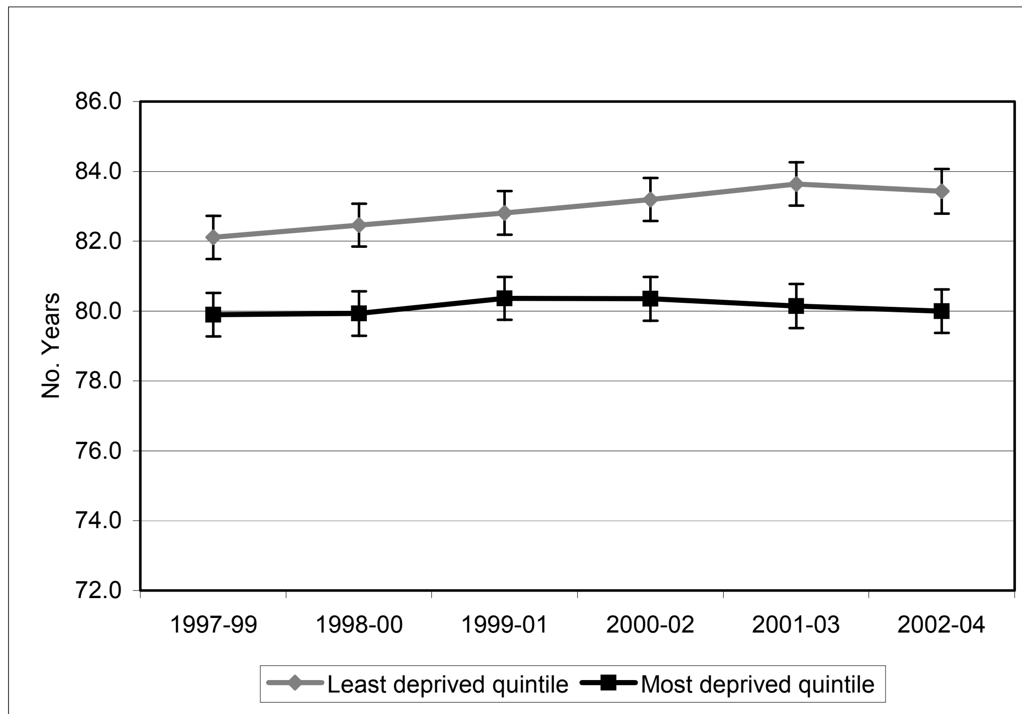
Figure 17: Male life expectancy at birth South Gloucestershire PCT



Source: Avon IM&T Consortium. ONS mortality and birth files; IMD 2004 Income Domain Index

The local pattern for female life expectancy shows no clear trend and significant year-on-year variation. Combining the data with neighbouring PCTs gives a clearer picture with less random variation. Taking all three areas together shows a similar pattern as for male life expectancy - a narrower but widening gap between better off and poor areas, the difference increasing from 2.2 to 3.4 years.

Figure 18: Female life expectancy at birth combined data for BANES, South Gloucestershire and North Somerset



Source: Avon IM&T Consortium. ONS mortality and birth files; IMD 2004 Income Domain Index

The data suggests that in South Gloucestershire:

- life expectancy for men is improving but more rapidly for better off groups
- life expectancy for women is also improving overall
- the gap between more deprived areas and better off areas is smaller for women than for men, but probably widening for both
- life expectancy for women in deprived areas does not appear to have improved.

Are inequalities in health widening or narrowing?

Health inequalities are continuing to widen nationally. South Gloucestershire data is mixed but shows

- no improvement in inequalities in low birth weight babies
- that life expectancy for men is increasing faster in better off areas
- that it is likely that a similar pattern is occurring in women.

This emphasises the importance of continuing to focus action to improve health on more deprived communities.

Recommendations

Efforts to reduce tobacco consumption in more deprived communities need to be redoubled, in particular reducing exposure to tobacco smoke in the home and providing services and support to stop smoking.

PCT commissioning needs to be more explicitly linked to health needs. In particular, the uptake of services should be monitored to check for inequalities of access.

The PCT, local authority and other partners should seize the opportunity offered by the Local Area Agreement for improving coordination and services to priority neighbourhoods.

The creation of the new Sure Start Centres and Children's Hubs should be used as an opportunity to ensure that there is improved support to vulnerable families.

Black and minority ethnic communities (BME) and health

The local composition of Black and minority ethnic groups is constantly changing, reflecting shifting patterns of migration. Some groups have worse health than average and need particular help to protect and improve their health. Some may need health services that are tailored to specific health needs. The health of two particular groups is covered in more detail in this report - Travellers and Gypsies and asylum seekers.

Black and minority ethnic communities in South Gloucestershire

The 2001 census showed that Black and minority ethnic communities made up 2.4% of the population of South Gloucestershire compared to the national average of 10%.[49] In a number of neighbourhoods, however, the proportion is much higher. Bradley Stoke ward has the highest ward percentage at 5.9% and there are some Super Output Areas (SOAs), such as Hambrook/Stoke Park, where 8.9% of the population are from Black and minority ethnic communities.

People from minority ethnic groups living in England are typically younger than the White British population, with the exception of White Irish and White Other communities.[50]

A local study of Black and minority ethnic communities in 2003 found that:[51]

- members of some communities (for example, the Chinese) were scattered throughout the area
- fewer women were in work than the national average
- nearly 25% of the female minority ethnic population were caring for other family members
- seven percent of the ethnic minority residents participating in the study could not read English - this was 29% amongst the over 65s.

Neither the 2001 census, nor this local report, identified the growing numbers of new immigrants to South Gloucestershire, particularly in the Kingswood area. There are a small number of asylum seekers, but others are from many different countries, particularly those in Eastern Europe. The health needs of these groups have not yet been fully identified.

This perception fits with UK population estimates made since 2001 which identify:

- a rise in the Black African and Other White groups
- the highest growth rates in local authority areas which currently have only small ethnic minority populations.[52]

[49] 2001 census at www.statistics.gov.uk. Note that in this section the terms used to classify ethnic groups are those used in the census - see the next page
[50] Association of Public Health Observatories. 2005 Indications of Public Health in the English Regions: 4: Ethnicity and Health: SEPHO
[51] South Gloucestershire Council & PCT 2003 Black and Minority Ethnic Groups Research Project: BMG Group
[52] http://www.kingsfund.org.uk/health_topics/bme_work.html

Figure 19: Ethnic groups in South Gloucestershire

	Kingswood Locality		Severnvale Locality		Yate Locality		TOTAL PCT	
		%		%		%		%
White: British	94277	96.4	72120	94.48	69026	96.51	235423	95.84
White: Irish	476	0.49	578	0.76	419	0.59	1473	0.6
White: Other	883	0.9	1239	1.62	827	1.16	2949	1.2
Mixed: White & Black Caribbean	316	0.32	252	0.33	154	0.22	722	0.29
Mixed: White & Black African	78	0.08	58	0.08	37	0.05	173	0.07
Mixed: White & Asian	198	0.2	217	0.28	119	0.17	534	0.22
Mixed: Other	137	0.14	167	0.22	148	0.21	452	0.18
Asian or Asian British: Indian	368	0.39	537	0.74	175	0.25	1080	0.46
Asian or Asian British: Pakistani	151	0.15	95	0.12	69	0.11	315	0.13
Asian or Asian British: Bangladeshi	55	0.06	22	0.03	44	0.06	121	0.05
Asian or Asian British: Other	103	0.11	145	0.19	78	0.11	326	0.13
Black or Black British: Caribbean	254	0.26	202	0.26	125	0.17	581	0.24
Black or Black British: African	72	0.07	120	0.16	47	0.07	239	0.1
Black or Black British: Other Black	53	0.05	29	0.04	24	0.03	106	0.04
Chinese or other ethnic group: Chinese	234	0.24	395	0.21	120	0.17	749	0.3
Chinese or other ethnic group: Other ethnic group	139	0.14	158	0.52	107	0.15	404	0.16
Total population	**97794**		**76334**		**71519**		**245647**	
Total Black and minority ethnic population							**10224**	

Source: Office of National Statistics at www.statistics.gov.uk Data from 2001 census

Health of Black and minority ethnic communities

> *'Research suggests that socio-economic disadvantage is a major contributor to the poor health of African-Caribbean, Bangladeshi and Pakistani groups – and exposure to racism is an important part of why they are more disadvantaged than the wider population. In addition, there is evidence that the experience of discrimination takes an additional toll on the health of Black and Asian communities.'* [53]

There are several cultural aspects of the Black and minority ethnic experience in the UK which influence health. These include issues of cultural identity, socio-economic disadvantage and the impact of racial harassment and discrimination. There is evidence that there are direct links between the reporting of poor health and perceived racial discrimination, experienced racial harassment and socio-economic disadvantage.[54]

The South Gloucestershire study[55] found that, in general, people's perceptions of their own health were comparable with the population as a whole, but only 18% of people over 65 classified their health as ‘good’ or ‘very good’. In some communities, older people were suffering from a loss of identity and role within the family, resulting in social isolation and depression. Twenty-two percent of respondents indicated that they had a longstanding illness, or disability. This rose to above 60% for age groups over 45 years. The main conditions mentioned were asthma, arthritis, high blood pressure, heart disease, diabetes and back pain.

A combination of genetic, cultural and environmental factors can lead to poorer health. For example:

- people born in Bangladesh and Pakistan have higher mortality rates from coronary heart disease and stroke, which is, in part, because of an increased prevalence of diabetes[56]
- Indian and Pakistani communities have a higher incidence of cataracts, which again is related, in part, to the higher prevalence of diabetes[57]
- smoking rates are higher in Bangladeshi men (44%) compared to White British men (27%)
- the reported rate of schizophrenia is higher in Black Caribbean men than other groups

[53]Graham H, Kelly MP 2004 Health Inequalities: concepts, frameworks and policy Health Development Agency, UK. Referring to Karlson S and Nazroo JY 2002 The relationship between racism, social class and health among ethnic groups: American Journal of Public Health 93:624-631
[54] Karlson S and Nazroo JY 2000 The relationship between racism, social class and health among ethnic minority groups: Health Variations Newsletter http://www.lancs.ac.uk/fss/apsocsci/hvp/newsletters/karlson5.htm
[55] South Gloucestershire Council & PCT 2003 Black and Minority Ethnic Groups Research Project: BMG Group
[56] Association of Public Health Observatories 2005 Indications of Public Health in the English Regions: 4: Ethnicity and Health: SEPHO
[57] Association of Public Health Observatories 2005 Indications of Public Health in the English Regions: 4: Ethnicity and Health: SEPHO

- hypertension is a common problem, with an increased risk of cardiovascular disease and stroke associated with rising blood pressure levels. African Caribbean and South Asian populations in the UK have a higher prevalence of hypertension compared to the White population[58]
- the risk of tuberculosis (TB) is associated with having lived in parts of the world where TB is more widespread. Consequently, given patterns of migration, the disease occurs more frequently in those born abroad. Nationally the highest TB diagnoses rates are in the ‘Other’ ethnic group and Black African group, and lowest in the White group
- sickle-cell and thalassaemia are inherited blood disorders. Thalassemia is most common in Mediterranean, Indian, and Pakistani people. Sickle cell is most common in people from Africa, the Caribbean, the Eastern Mediterranean, Middle East and Asia, and their descendants. Pregnant women from these groups are offered ante-natal screening.

Access to services

In the NHS currently, the trend is towards offering patients a more personalised service and ending the ‘one-size fits all’ approach. This requires service providers to be more aware of cultural, linguistic and religious diversity.

Not only have some Black and minority ethnic communities experienced poorer health than others (i.e. health inequalities) but they have also had poorer access to services and poorer quality of services. There is evidence that people from ethnic minority backgrounds have experienced unfair or inequitable treatment.

However, it is not known which minority groups are most affected by this and to what extent this is an issue of ethnicity, over and above socio-economic deprivation. Evidence has been difficult to gather as primary care has only recently begun to collect ethnicity data on patients.

The Kings Fund is currently undertaking a major study on the nature and extent of difficulties in access to healthcare.[59] It aims to 'summarise the nature and scale of inequalities in access to healthcare facing Black and minority ethnic communities; identify the effectiveness of solutions being tried and suggest new ones.' This will provide PCTs with useful advice on improving access to services.

The health needs of two groups in South Gloucestershire

Asylum seekers and refugees

Asylum seekers are people who have lodged an application for asylum under the 1951 Refugee Convention. A refugee is 'a person who has a well-founded fear of persecution for reasons of race, religion, nationality, membership of a particular social group or political opinion,' who has been granted refugee status.[60]

The number of asylum seekers in South Gloucestershire is relatively small. The

[58] Lane DA Lip GYH 2001 Ethnic differences in hypertension and blood pressure control in the UK. Q J Med: 94: 391-396
[59] http://www.kingsfund.org.uk/health_topics/bme_work.html
[60] Information Centre about asylum and refugees in the UK. Definitions and abbreviations: http://www.icar.org.uk/?lid=5981. Accessed 16/5/06

Home Office reports that 90 asylum seekers in South Gloucestershire were in receipt of National Asylum Support Service dispersed accommodation, in 2005.[61] This is likely to be an underestimate of overall numbers, however, as some asylum seekers will be staying with friends or relatives.

The Haven, in central Bristol, provides initial health assessments for asylum seekers. Currently asylum seekers are coming from Iran, Iraq, Eritrea, Somalia and Afghanistan. Their health needs include TB, HIV, gastrointestinal infections, sexual abuse, mental trauma and a number of infectious diseases. Following a comprehensive health assessment, they are helped to register with a local GP practice.

In the year February 2005 to January 2006, there were 41 asylum seekers seen at the Haven who were placed with South Gloucestershire practices, mainly in the Kingswood locality. However, not all asylum seekers are seen at the Haven. If they have been living in other parts of the UK, they may simply register with a GP near their new home.

Travellers and Gypsies

Travellers include a range of different groups, such as English Romany Travellers or Gypsies, Welsh, Scottish and Irish Travellers and circus or fairground workers. Approximately half of Travellers live in houses and half in trailers.[62]

Gypsy Travellers have significantly poorer health status and more self-reported symptoms of ill health than other UK residents, English speaking ethnic minority UK residents and economically disadvantaged white UK residents. There are marked inequalities in self-reported anxiety, respiratory problems (including asthma and bronchitis) and chest pain. There is also a higher prevalence of miscarriages, stillbirths, neonatal deaths and premature death of older offspring.[63] Explanations for this suggest poor living conditions, discrimination, lack of access to healthcare, low levels of educational attainment and poverty as causative.

In South Gloucestershire, there are 16 authorised sites for Gypsies and Travellers. Two of these are local authority sites. In 2005-2006 there were an additional 51 unauthorised camps and 14 private sites. Overcrowding and a lack of basic facilities are common and safe play areas for children can be very limited. An assessment of Gypsies and Travellers accommodation needs is currently underway nationally and will soon be started locally.

Discrimination and prejudice can take the form of openly expressed hostility in the press and elsewhere. This has the effect of further isolating these marginalised communities. Children are not immune to this hostility and Gypsy and Traveller children may be victims of bullying at school. Not surprisingly, school attendance is poor, particularly at secondary level, and educational attainment is very low. Pre-school provision is limited and access is difficult, particularly for the more mobile families and those on unauthorised sites.

[61] Home Office 2006 Asylum Statistics: 4th Quarter 2005: UK: London: Home Office.
[62] Janet Maxwell (personal correspondence)
[63] Parry G et al 2004 The Health Status of Gypsies & Travellers in England: University of Sheffield: School of Health and Related Research.

Local action

In 2005, the PCT developed a Race Equality Scheme three year action plan covering commissioning, health improvement, primary care and community services. Recent progress includes:

- improving the collection of data in primary care and on the ethnicity of PCT staff
- protecting ten percent of the health inequalities small grant for BME groups
- ensuring the Kingswood and District public engagement exercise (see section 4) included the views of 'hard-to-reach' groups.

The Traveller's Health Project is hosted by South Gloucestershire PCT on behalf of four partner PCTs and provides an outreach health visiting service.

Recommendations

The collection of ethnicity data in primary care should be encouraged and audited for completeness. Once it is adequate, there should be a series of health equity audits to check for inequalities in access to primary care prevention (immunisation, coronary heart disease prevention, etc) and access to secondary care.

The high levels of inability to read English, particularly in older ethnic minority residents, should be taken into account when planning and providing healthcare and health promotion.

In view of rapidly changing migration patterns, particularly with the expansion of the EU, the PCT and partner agencies should explore better use of 'front line' data from GP practices, charities and social services to build a picture of health need and help plan services.

Section 3: Choosing Health

Local Area Agreement: *Children & Young People Aim 1; Healthier Communities & Older People Aims 1 and 5*

This section describes local progress toward three of the key priorities set out in the government White Paper *Choosing Health.*[64]

- Reducing the number of people who smoke
- Reducing obesity, with a particular focus on children
- Improving sexual health

Reducing the numbers of people who smoke

> *'Smoking has been identified as the single greatest cause of preventable illness and premature death in the UK... It is estimated that half the difference in survival to 70 years of age between social class 1 and V is due to higher smoking prevalence in class V.'* Wanless 2004 [65]

Smoking causes one in three cancer deaths in the UK and accounts for 84% of all lung cancer deaths. It is estimated that 371 deaths a year in South Gloucestershire are attributable to smoking.

It is also a cause of many other serious conditions such as heart disease, stroke, diabetes, chronic obstructive lung disease, asthma and other respiratory diseases, peripheral vascular disease and osteoporosis. Smokers are also at an increased risk of type-2 diabetes.[66]

Tobacco control seeks to improve the health of the population and to reduce inequalities in health using six approaches:

- control of advertising and promotion
- taxation and reduction in the supply of tobacco
- protecting the population from the effects of second hand smoke
- supporting people to stop smoking
- regulating tobacco products
- organisation of media, marketing and education campaigns.

Smoke-free legislation

The legislation to make all public and workplaces smoke-free will take effect from summer 2007, bringing England in line with the UK and Ireland.[67] It will:

- apply to all enclosed workplaces and hospitality and entertainment venues

[64] DH 2004 Choosing Health – making healthy choices easier. London: Department of Health.
[65] Wanless D 2004 Securing good health for the whole population - final report HM Treasury
[66] Action on Smoking and Health 2005 Smoking and disease - basic facts
[67] DH 2005 Health Improvement and Protection Bill - smoke-free elements.

- encompass all pubs, bars and private members' clubs
- cover taxis, buses, trains, delivery vehicles and any vehicle being used for business purposes.

The legislation may also cover partially ‘enclosed’ public places, for example, seating at sports stadia. There will be some exemptions, including places designated as a person’s home, such as bedrooms in hotels, nursing and care homes and prisons. Exemptions may also apply if only one person is employed at a location and wishes to smoke.

In South Gloucestershire, we have 400 Easy Breathing smoke-free award holders. Over 200 of these businesses have already made their premises totally smoke-free. These include one public bar, a large number of cafes and restaurants and many of the major employers in South Gloucestershire. This year, these include:

- the Mall at Cribbs Causeway
- North Bristol NHS Trust
- Avon and Wiltshire Mental Health Partnership NHS Trust.

Ashfield Young Offenders Institution and both the youth wing and mother and baby unit of Eastwood prison went smoke-free last year. Other local businesses, including Airbus at Filton, are working towards going smoke-free ahead of legislation.

The Council and the PCT are working in partnership to secure a public commitment to a smoke-free charter for South Gloucestershire.

Why smoke-free?

Second-hand smoke is harmful to health. The International Agency for Research on Cancer reviewed the evidence on second-hand smoke and cancer and concluded that second-hand smoke is carcinogenic to humans and that exposure to other people’s smoke:

- increases the risk of lung cancer in non-smokers by 20-30 percent
- increases the risk of coronary heart disease in non-smokers by 25-35 percent.[68]

There is no safe level of exposure to second-hand smoke. On the grounds of health and safety legislation and the public health benefits, action is needed to protect the health of all workers from second-hand smoke.

International experience shows that tobacco control programmes work when supported by national legislation. A review of smoke-free workplaces in the USA, Australia, Canada and Germany estimated that bans reduce the prevalence of smoking by four percent and total cigarette consumption per employee by 29 percent.[69] Smoke-free workplaces and social venues not only deter people from starting to smoke, but also provide support for people who have given up. Data from Australia shows that current and former smokers who work in smoke-free

[68] WHO International Agency for Research on Cancer. Monograph on the evaluation of carcinogenic risks to humans, Volume 83: Tobacco smoke and involuntary smoking, Lyons, World Health Organisation International Agency for Research on Cancer, 2002.

[69] Fichtenberg CM and Glantz SA. Effect of smoke-free workplaces on smoking behaviour: systematic review. BMJ 2002;325:188.

environments are more likely to have smoke-free homes.[70]

Smoke-free laws have significant short and long term health benefits. In Ireland[71] and California[72] research studies have shown significant improvements in bartenders' respiratory health. In one Montana city, the rate of acute myocardial infarction (heart attack) declined over six months while a smoke-free law was in place, only to increase again once the law was revoked after pressure from the tobacco industry.[73]

In addition to the direct benefit from a smoke-free environment, smoke-free laws have a major public health impact because they encourage smokers to quit.[74] Reducing smoking rates by one percent per year over ten years is estimated to save nearly 70,000 lives in UK smokers aged 35 to 74.[75] The biggest single factor in reducing deaths from heart disease in the last 20 years has been smokers giving up. Quitting prevented nearly 30,000 heart disease deaths from 1981-2000 in England and Wales.[76]

Smoke-free NHS

NHS organisations are now taking action to eliminate tobacco use from all premises.[77] By the end of 2006, all NHS healthcare facilities in England should be smoke-free.

In January 2006, the South Gloucestershire PCT policy on smoking in the workplace came into force, providing smoke-free premises for staff, patients and visitors. On 8th March (No Smoking Day), as part of North Bristol NHS Trust's policy, Frenchay Hospital became a smoke-free site.

NHS Stop Smoking Service

Support for smokers is offered in all GP practices, as well as many workplace and community settings across the area. In October 2005, nine pharmacies were successful in their bid to be part of a local enhanced service pilot scheme, and now offer appointments for customers who want to stop smoking.

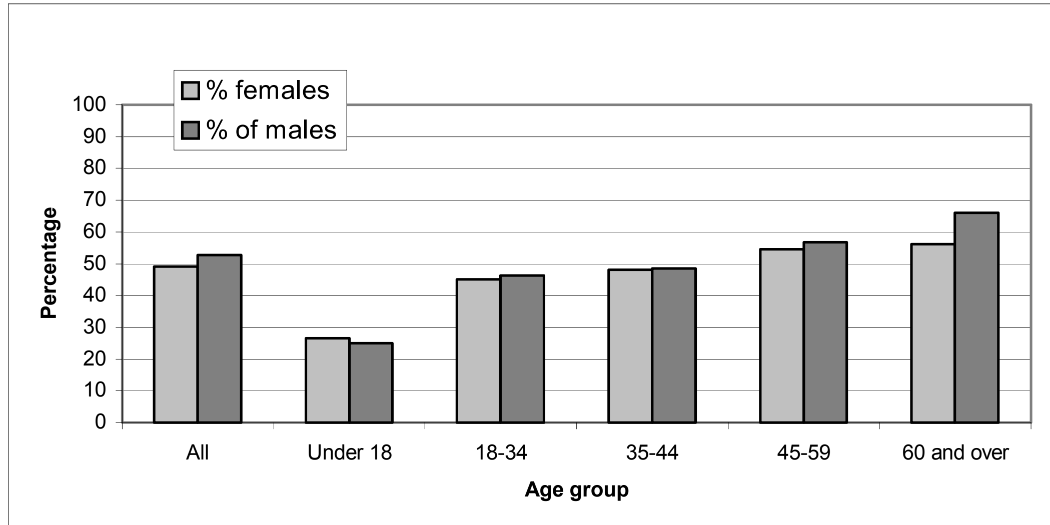
In 2005-2006, 58% of those accessing local services were female and 42% were male and 2,463 smokers set a quit date. Fifty-one percent, or 1,248 smokers, were successful in quitting.

---

[70] Merom D, Rissel C 2001 Factors associated with smoke-free homes in NSW: results from the 1998 NSW Health Survey. Australian and New Zealand Journal of Public Health; 25(4):339-45.
[71] Office for Tobacco Control 2005 Smoke-free workplaces in Ireland: A one year review. Office for Tobacco Control: Clane, Ireland
[72] Eisner M, Smith A, Blanc P 1998 Bartenders' respiratory health after establishment of smoke-free bars and taverns. Journal of the American Medical Association 280:1909-14
[73] Sargent RP, Shepard RM, Glantz SA 2004 Reduced incidence of admissions for myocardial infarction associated with public smoking ban: before and after study. BMJ 328:980
[74] Fichtenberg CM and Glantz SA 2002 Effect of smoke-free workplaces on smoking behaviour: systematic review. British Medical Journal 325:188
[75] Lewis S, Arnott D, Godfrey C, Britton J. 2005Public health measures to reduce smoking prevalence in the UK: how many lives could be saved? Tobacco Control 14(4):251-4.
[76] Unal B, Critchley JA, Capewell S 2005 Modelling the decline in coronary heart disease deaths in England and Wales, 1981-2000: comparing contributions from primary prevention and secondary prevention. British Medical Journal, doi:10.1136/bmj.38561.633345.8.
[77] Health Development Agency 2004 The case for a completely smoke-free NHS in England. HDA

Males were more successful in quitting than females - 53% compared with 49% - and males in the 60 and over age group had the highest success rate of all.

Figure 20: Stop Smoking Service in South Gloucestershire: percentage quitting by gender and age 2005-2006

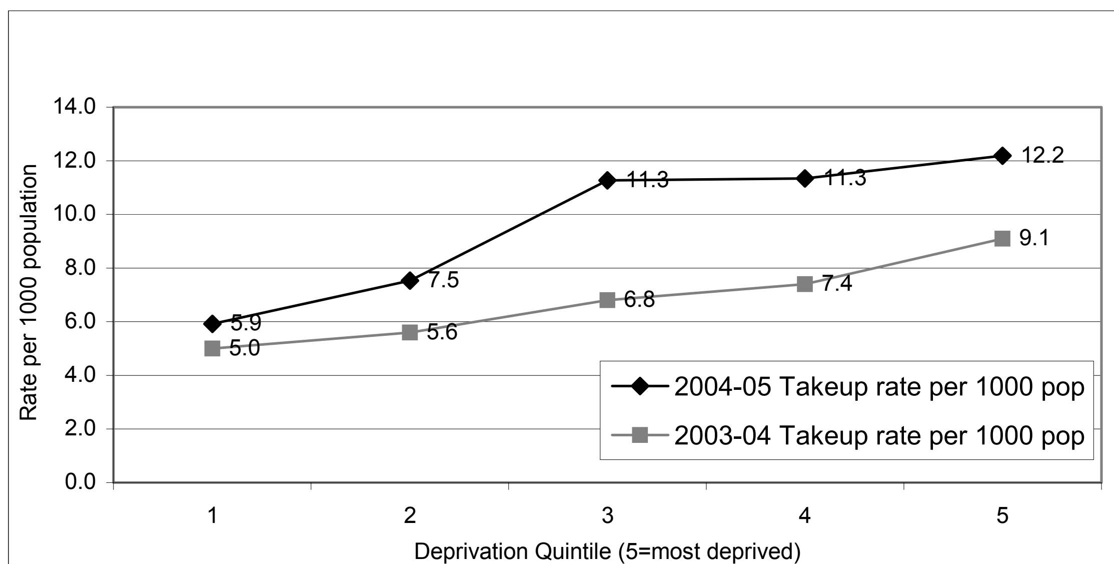


Source: NHS Stop Smoking Service

Smoking Cessation Health Equity Audit 2004-2005

The number of smokers setting a quit date, increased by 26% in 2004-2005, compared to the previous year. Take up of the service increased across all deprivation quintiles, but increased more in the more deprived areas (quintile 5).

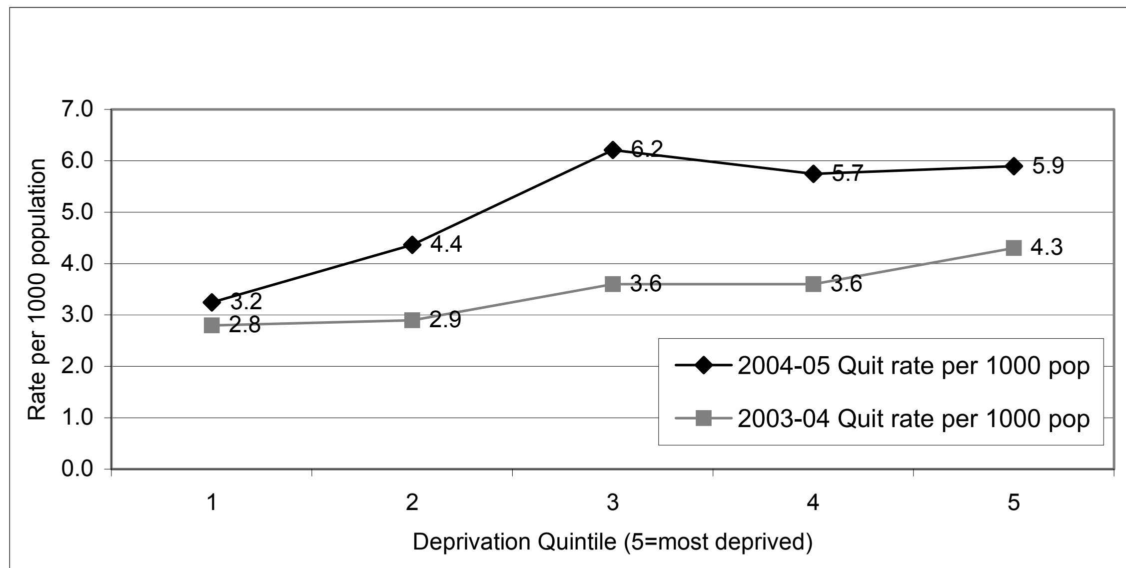
Figure 21: Stop Smoking Service in South Gloucestershire: take up rate 2003-2004 and 2004-2005



Source: NHS Stop Smoking Service

The number of successful quitters increased by 27.7%.

Figure 22: Stop Smoking Service in South Gloucestershire: quit rate 2003-2004 and 2004-2005



Source: NHS Stop Smoking Service

The overall percentage successfully quitting increased slightly to 53%. Figure 22 shows that quit rates have increased in all areas, but by a greater amount in areas of 'medium' deprivation. We know that smokers in the least deprived quintile have more success in quitting (55%), compared to those in the most deprived quintile (48%). This difference did not change in 2004-2005.

In order to reduce inequalities in smoking, we need to continue to recruit more smokers from the more deprived areas. It is encouraging to see that the take-up rate increased in the more deprived areas in 2004-2005.

Tackling obesity

What is obesity?

Overweight and obesity are defined by Body Mass Index (BMI). This is a measurement that takes account of the relationship between height and weight. It is calculated by dividing weight (measured in kg) by the height squared (measured in metres).[78]

Figure 23: BMI and its relation to weight

Body Mass Index	**Classification**
18.5 and under	Underweight
Over 18.5-25	Desirable weight
25-30.0	Overweight (Grade I)
Over 30	Obese (Grade II)
Over 40	Morbidly obese (Grade III)

[78] World Health Organisation 2000 Obesity: preventing and managing the global epidemic. Report on WHO consultation. WHO Technical report series No. 894, 1-253 Page 40

National data indicates that 13.7% of children under 11 years are obese and 14% are overweight. The increase in overweight has arisen from environmental and behavioural changes, which have led to a more energy-dense diet and a rise in the level of sedentary behaviours.

Figure 24: Energy balance

Weight gain	Happens when more energy is consumed than expended and the excess is then stored, mainly as fat.
Weight loss	Happens when more energy is expended than consumed.
Energy balance	Occurs when energy consumed is equal to the energy expended.
Energy balance: Energy consumed = Energy expended	

Energy consumed is the energy found in food and drinks. Energy expended is the energy used for activity, resting metabolism and thermogenesis.

Overweight and obesity are conditions in which excess body fat has accumulated to an extent that health may be adversely affected. The prevalence of obesity has trebled since the 1980s and 22% of men and 23.5% of women are now obese. Well over half of all adults are either overweight or obese - 65% of men and 55% of women.

Obesity reduces life expectancy on average by nine years and is responsible for 9000 premature deaths a year, in England.

Local action

Overweight and obesity strategy for South Gloucestershire

The PCT and local authority have developed a strategy to provide a planned and coordinated approach to the prevention and management of overweight and obesity in the local population, during 2006-2008. The strategy focuses on:

- collecting better local information about levels of obesity
- prevention
- management of overweight and obesity in children and adults.

There is not a strong evidence base to guide the choice of strategies to prevent and manage obesity. However, there is a range of good practice and some evidence to support prevention. Management includes weight loss (or maintenance for children) using lower energy (calorie) diets and increased activity, as well as the use of drugs and surgery for some adults.

There is a range of work underway described in the Food and Health Strategy and Physical Activity Strategy which aims to prevent obesity by promoting healthy eating and increasing physical activity.[79] However, there are gaps in information

[79] These strategies can be seen at www.sglos-pct.nhs.uk/Public_Health

collection on levels of obesity, management of childhood obesity and some aspects of weight management for adults. We plan to:

- carry out local measurements of height and weight in schools and audits of primary care records
- extend the pilot ‘Active for Life Year 5’ school obesity prevention project to all Year 5 classes (see below)
- develop a care pathway for children, including community treatment programme for obese children and their families
- develop a communication strategy
- extend ‘Walking to Health’, targeting more deprived communities
- develop a care pathway for obese adults which will include Exercise On Prescription, primary care interventions through a locally enhanced service, and commercial weight management services
- ensure the impact on health is considered by the Local Strategic Partnership when considering planning applications for new communities and transport.

School obesity prevention project - Active for Life Year 5

The PCT and the council successfully bid for regional funding to adapt lesson plans developed in the USA to prevent obesity in Year 5 school children (aged 9-10 years). The project has been set up as a cluster randomised controlled trial.

The lessons aim to increase healthy eating, increase physical activity and decrease sedentary behaviours such as watching TV. They are being used in ten primary schools and will be in a further nine schools in the autumn. Bristol University and the PCT will evaluate the impact of the project on body mass index, eating and activity levels.

Exercise on Prescription

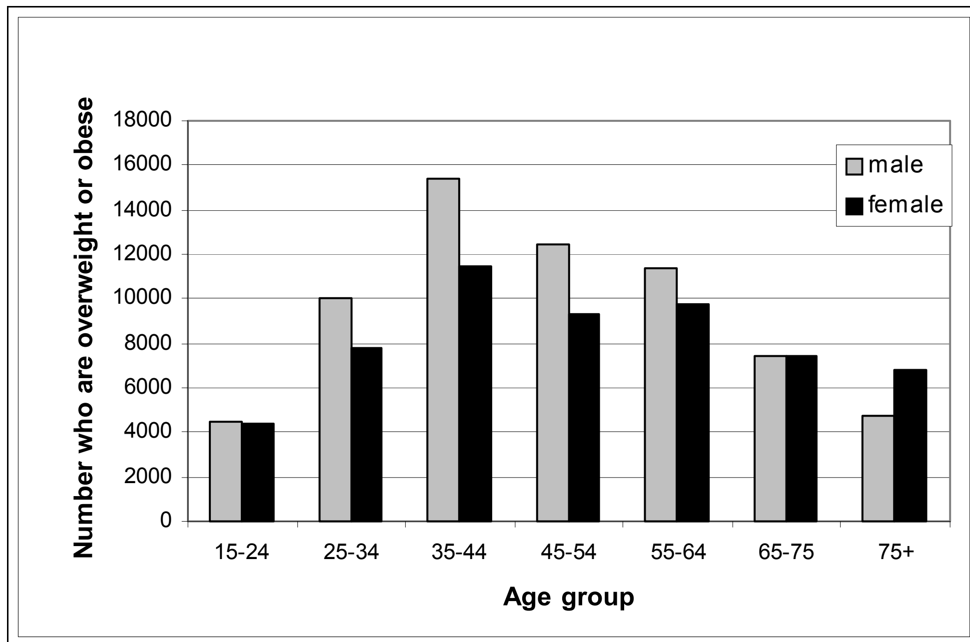
Exercise on Prescription is a local scheme which aims to have a positive effect on health through the promotion of physical activity. Health professionals from across South Gloucestershire PCT have now referred approximately 2000 patients with a wide range of health conditions, to the scheme.

The service is now piloting some weight management sessions. These sessions help patients to make small, easily achievable changes to their lifestyle. Effective weight management must include dietary energy restriction, as well as increased physical activity.

Obesity monitoring

In 2006-2007, new data will be collected to monitor levels of obesity. GPs are building a register of patients in their practice, aged 16 and over, who have a Body Mass Index of 30 or more.

Figure 25: Estimate of number of males and females in South Gloucestershire with BMI over 25 (overweight or obese) by age

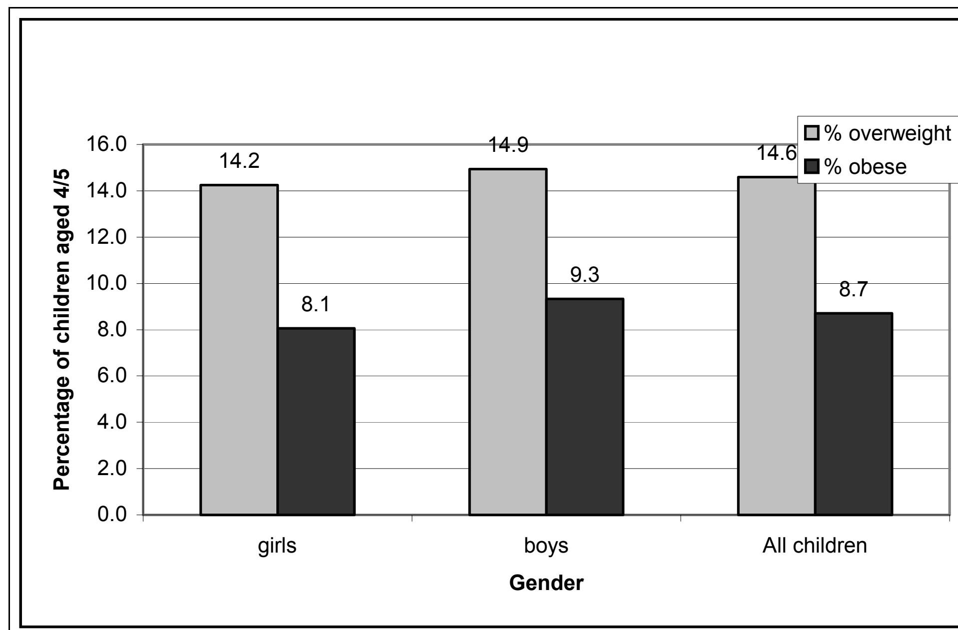


Source: Department of Health 2004 Health Survey for England 2003

An estimate of the number of adults in South Gloucestershire who are overweight or obese (extrapolated from national prevalence data) is shown above.

Overweight and obesity are also increasing in children and young people. PCTs are now required to measure the height and weight of all children in state schools in Year 1 (aged 4-5) and Year 6 (aged 10-11) each year.

Figure 26: Percentage of school entry children in South Gloucestershire in 2004-2005 overweight or obese



Source: Avon Primary Care Support Agency Child Health System (Note: using the UK reference data 1990 85th centile cut-offs for age 5 boys and girls)

In 2004-2005, 14.6% of 4-5 year olds in South Gloucestershire were overweight and a further 8.7% were obese.

Breastfeeding

There is evidence to show that breast-fed babies are less likely to become overweight in later life, or to develop associated conditions such as diabetes and heart disease.

In 2005, 71% of all newborn babies in South Gloucestershire were breastfed. However, by the time the babies were six to eight weeks old, fewer than four out of ten mothers were still breastfeeding (39.8%). This is slightly less than in 2004 (43.7%).

Chipping Sodbury, Dodington, Kings Chase, Parkwall, Patchway and Yate West wards have significantly lower rates of breastfeeding than the average rate for Bristol, North Somerset and South Gloucestershire. Downend is the only ward in South Gloucestershire with a significantly higher rate than this average.

More support is needed for mothers to help them to continue breastfeeding. One way of providing this is through support groups, which are usually run by a health visitor or a community midwife. There are currently six groups in South Gloucestershire.

Improving sexual health

South Gloucestershire PCT works closely with Bristol and North Somerset PCTs to implement a joint sexual health strategy to achieve national and local targets.

Targets

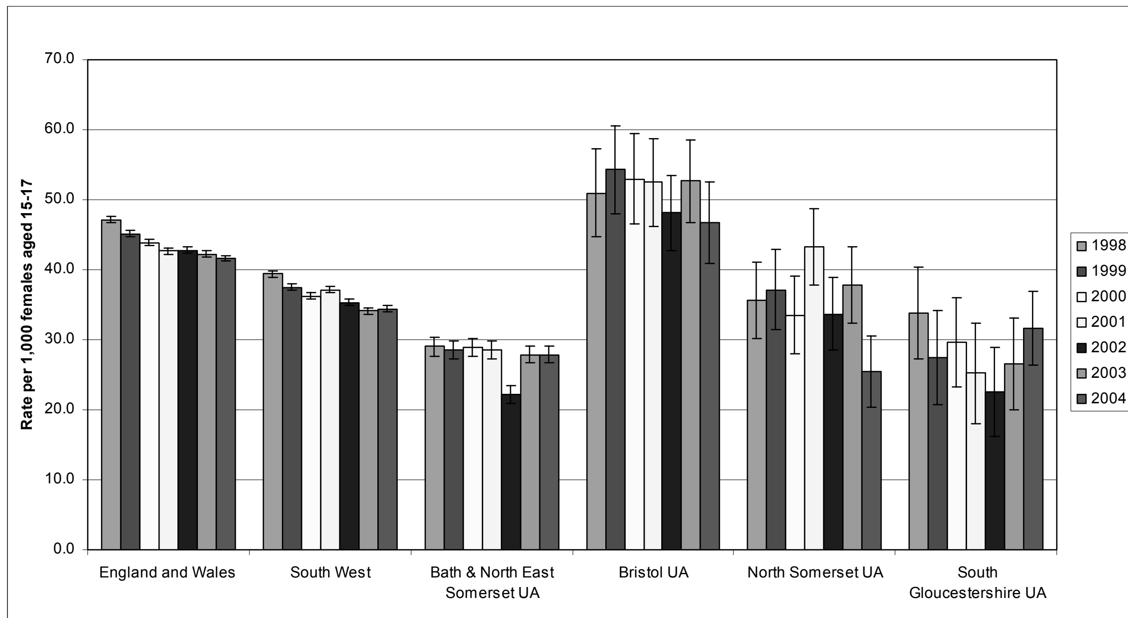
Government targets are to:

- reduce teenage pregnancy by 50% by 2010
- increase the number of people attending genito-urinary medicine (GUM) services who are seen within 48 hours
- increase the number of sexually active 15 to 24 year olds accepting chlamydia screening
- decrease the number of new diagnoses of sexually transmitted infections, in particular gonorrhoea and chlamydia per 100,000 population
- enable women who meet the criteria for legal abortion to have access to an abortion within three weeks of referral.

Teenage pregnancy

Teenage pregnancy rates in South Gloucestershire are below the national average and showed an overall decline between 1998 and 2004.

Figure 27: Under 18s conception 1998-2004 (rate per 1000 female population in 15 –17 year olds)



Source: Office of National Statistics and Teenage Pregnancy Unit

However, although the 2004 level of under 18 conceptions was 6.6% lower than the baseline year of 1998, the latest two years of available data show an upward trend. In view of this increase, the local Teenage Pregnancy Strategy Group has reviewed the local work programme and taken steps to ensure:

- better use of timely and detailed local data to develop targeted services in areas which are showing high conception levels
- improved access to young people-friendly services, including outreach services
- promoting a wider choice of contraception, particularly alternatives to oral contraception.

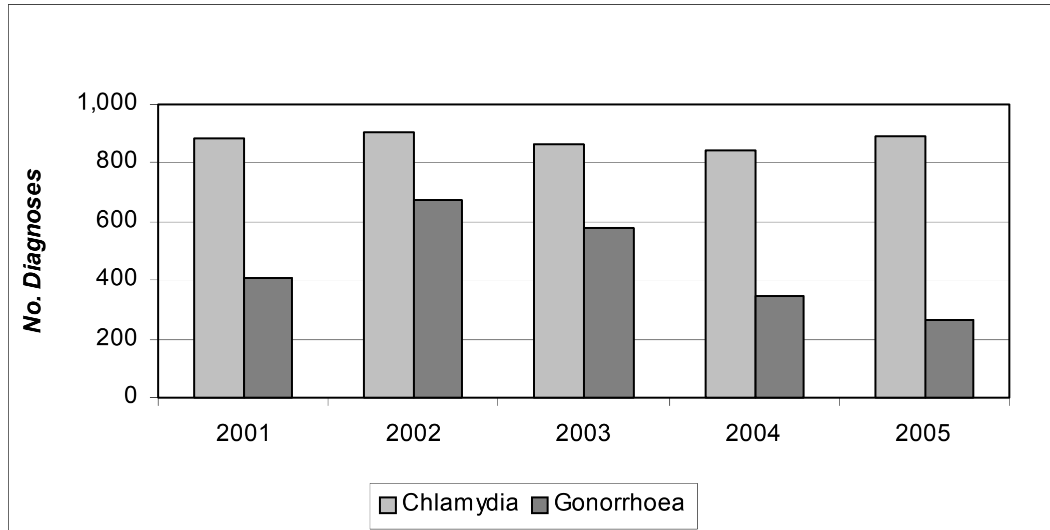
Sexual health strategy for South Gloucestershire

The PCT carried out a needs assessment to inform the development of a sexual health strategy for South Gloucestershire. It assessed the demographics of the area, indicators of sexual health and disease, populations with specialist needs and sexual health services. It showed that:

- South Gloucestershire has a relatively low risk population in terms of its demographics and socio-economic make-up
- It has similar levels to the rest of the country of chlamydia and gonorrhoea amongst young people
- HIV diagnosis remains low within the Avon, Gloucestershire and Wiltshire Strategic Health Authority area. This could reflect genuine low

levels of infection, or that there are still many undiagnosed cases in the community.

Figure 28: Bristol Royal Infirmary Milne Centre new diagnoses of chlamydia and gonorrhea 2001-2005



Source: KC60. Produced by Avon IM&T Consortium. It is assumed that most Bristol and South Gloucestershire residents will attend the Milne Centre

Figure 28 shows the number of cases of chlamydia and gonorrhoea diagnosed in each of the past five years at the Milne Centre (the GUM clinic in Bristol). As data is anonymous, it is not possible to identify South Gloucestershire residents separately.

Overall there has been a welcome decline in the diagnosis of gonorrhoea. Diagnoses of chlamydia appear to be fairly stable, but an increasing number of cases are being detected and treated in other settings, such as primary care.

Achieving a target of 48 hour access to GUM services will require a combination of:

- increased capacity and investment in sexual health services, including specialist GUM services
- continued implementation of a three level service, with level one (primary care) and level two (more specialised community services) dealing with more straightforward problems and avoiding referral to specialist GUM services
- better coordination of services across Bristol and the surrounding area by the creation of a single managed service, bringing sexual health services provided in various settings under single management.

Local sexual health services

The past 12 months has seen considerable work to increase capacity in South Gloucestershire, to provide a better local sexual health service. Services include those available through GP practices, through the contraception and sexual health clinics and through young people’s clinics. There is additional provision for young people through the 'No Worries' scheme and the 'Clinic in a Box' nurse service.

GP practices

South Gloucestershire PCT has an agreement with the majority of GP surgeries to provide comprehensive accessible sexual health services. The aim is to offer, (amongst other services) the testing and treatment of most sexually transmitted infections. By providing services through GP practices, we aim to reduce the perceived stigma attached to accessing sexual health services.

No Worries

This year, after a review of the service, the 'No Worries' scheme for young people was re-established and expanded. The scheme was set up to encourage young people to access primary care, with regard to contraceptive and sexual health issues. It provides young people-friendly services.

Young people can ask for a No Worries appointment at a participating surgery. Initially a nurse sees them to assess urgency of need, deal with the problem, or refer to a doctor if necessary. Young people do not need to be registered with that particular surgery. There are currently 12 GP surgeries participating in the programme and plans are being developed to recruit more.

Clinic in a Box

The Clinic in a Box nurse service targets young people under 20 years of age, who are unlikely to access, or find it difficult to access, current mainstream services. Started in February 2005, it takes sexual health services to young people outside established clinical settings. The service has been very successful with weekly drop-in sessions in Soundwell, Patchway, Staple Hill, Kingswood, Chipping Sodbury and Bradley Stoke.

Training

The PCT has initiated sexual health awareness training for professionals working with young people. Youth workers, teachers, Connexions advisers and priority youth housing workers have all participated. The training provides recipients with the increased knowledge and confidence to enable them to deal with issues related to sexual health with young people.

Section 4: Improving Community Health and Services

Local Area Agreement: *Healthier Communities & Older People Aims 2 and 4; Safer & Stronger Communities Aims 2 and 3*

The major tasks of the PCT can be expressed as:

- assessing the health and healthcare needs of the local population
- working with partners to protect and improve the population's health
- commissioning appropriate services to improve health and meet healthcare needs.

A key first step is to understand the health and healthcare needs of the population - which is the purpose of this and previous Director of Public Health reports. These present an overview of the health of South Gloucestershire and variations in health within it (see page 58 for a list of topics covered each year).

However, a report such as this can be limited by:

- focusing only on the health statistics for which there is data
- ignoring other important quality of life issues such as crime, transport, environment and education
- ignoring the experience of people that live in an area, whose perception of problems may be quite different from those of professionals
- suggesting solutions to problems that are either impractical, or ignore the existing work of other agencies, or the voluntary sector.

To successfully tackle the health problems of any particular area we need to:

- gather information about an area from other agencies and from local residents, to create a 'whole picture'
- map out what services and resources already exist
- identify the gaps in services and opportunities to improve health
- seek advice from local people about what will work and what are priorities
- work with partners to provide new or reconfigured services.

There are several changes taking place locally, both within and outside the health service, that mean we are now much better able to achieve this 'knitting together'. This section summarises some of these changes and describes how health needs assessments can go beyond reliance on traditional statistics.

New opportunities

A number of new partnerships are creating the potential for a much better coordinated understanding of need and existing services in each area.

Decisions on how to spend money in the health service are devolving from the PCT to GP practices, a process known as practice based commissioning. In South Gloucestershire, practices have grouped together to split the area into three

localities: Kingswood, Severnvale and Yate. This means that the commissioning and provision of health services will be better tailored to a locality's needs. The locality based commissioning groups are widening their membership, initially to include partners from the local authority.

Quite separately, the newly formed Children's Directorate in the local authority is leading a transformation of children's services. These will also be organised into the same three localities. The process is overseen by a newly formed strategic partnership group, which brings together the PCT and other local partners.

These initiatives, together with new partnership arrangements involving adult social services, create the potential for greater coordination and consequently better commissioning and service provision.

Another promising development is the evolution of the Local Area Agreement (LAA). South Gloucestershire's first LAA was agreed in February 2006 and will be monitored by the Local Strategic Partnership. It includes health as a cross-cutting theme.[80]

Assessing local need

It is possible to predict health problems and priorities by looking at the social deprivation indicators for an area and the age profile of the population.[81] This is a quick and efficient way of identifying health inequalities and deciding where to target services. However, it does not capture local residents' perceptions of their own area and the things that affect their health and wellbeing.

Since the early 1990s, the importance of involving patients, carers, service users and other members of the community has been recognised.

Community involvement

The Minister for Health in 1994 made the following statement:

> *'Knowledge of people's perceptions, preferences and experiences of health services is essential in assessing health needs and how to meet them. We must get away from the notion that health services can be designed for the community by 'experts' who define people's needs but ignore their wishes.'* [82]

The introduction of practice based commissioning and the devolving of many PCT functions means that this is a good time to find out about the strengths and resources within communities, as well as local people's views about what would help them to improve their own health.

Community development methods have frequently been used to gather this sort of information. Local people themselves have often been involved in the process, to a

[80] www.southglos.gov.uk/ConsultationAndResearch/LatestNews.htm
[81] see previous Director of Public Health reports on page 58
[82] Purchasing for health: involving local people: a speech by Dr Brian Mawhinney MP, Minister for Health, 13 April. London: NHS Executive

greater or lesser extent, depending on the time and resources available.

> *'New approaches tend to recognise that most people living or working in an area have something sensible to say about the factors which affect their health and about the health services they would like to see.'* [83]

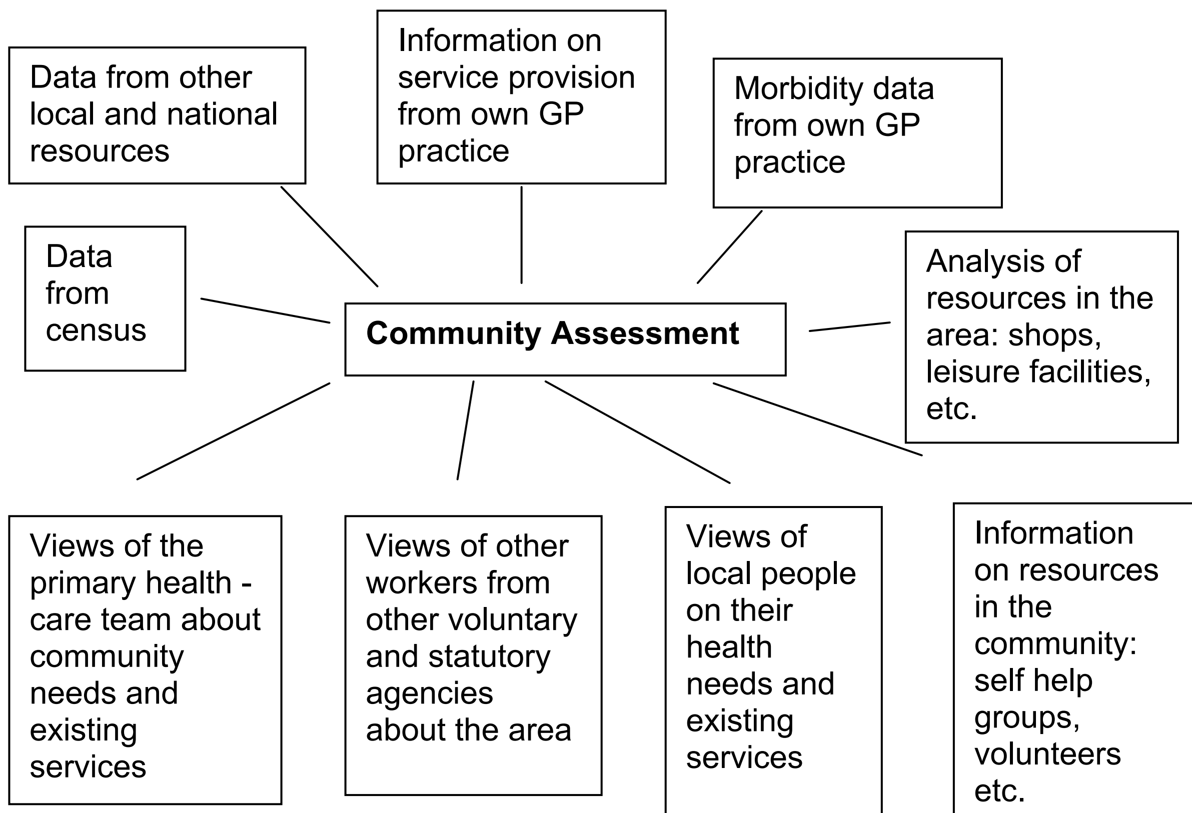
Community health assessments and profiles

A community health profile is:

> *'…a description of the social, economic and environmental factors that local people see as having most influence on their health and well-being, which is produced collaboratively by local residents and professionals and is used to inform local decision making.'* [84]

The figure below summarises the kind of information available in a locality.

Figure 29: Community assessment in general practice and its data sources.



Source: Neve H 1996 Community Assessment in General Practice in Burton P and Harrison L 1996 Identifying Local Health Needs: The Policy Press: Bristol.

[83] Burton P, and Harrison L, 1996. Identifying Local Health Needs. The Policy Press, Bristol.
[84] as above

The unpublished data is that shown in the lower half of the figure and can be found through community involvement and working with other agencies. Other methods that may be used are:

- surveys and questionnaires - training can be provided for local people so that they can carry these out, either door-to-door, or in the street
- focus groups
- semi-structured interviews
- guided discussions in existing community groups
- public meetings
- action research or rapid appraisal.

The role of health visitors in assessing local need

Health visitors have a unique role in terms of public health. They work with individual families and with communities. Each new family is assessed holistically to identify their strengths and the areas where they may need support. Health visitors look at all the factors that could affect the development of the children - the family's health, how well the parents are bonding with the children, housing, the surrounding community and their economic circumstances.[85]

Health visitors also have a role assessing the health needs of the whole community. What is happening in the community has an impact on the health of local families, and vice versa. Health visitors may be able to draw out some generalisations about the local community from what families tell them and from what they observe (maintaining client confidentiality is obviously essential).

How health visitors set about this task depends on many things, including timing and what has been done by colleagues, local authority staff and local community groups in the past. When they arrive in a new area, they may find out about it by a 'rapid appraisal' method, working on their own, talking to others working in the area and walking around the patch. Or they may decide that the time is right to do something more thorough, in which case they will usually involve other workers, community activists and local residents.

The Children's Centres and Sure Start Centres that are being introduced in South Gloucestershire over the next four years will be a great opportunity for some new community profiles and health needs assessments. If more time is taken, then the rewards are greater. The interest and commitment generated within the local community can be channelled into positive action, which may well reduce future demands on health services. Here are two quotes from initiatives in other areas that illustrate this.

> *'Early analysis of the results showed that many of the concerns expressed could be dealt with by local people or by relatively modest expenditure from the service provider organisations.'* [86]

[85] DH 2001 Health Visitor Practice Development Resource Pack: DH: London.
[86] Snee K 1994 Neighbourhood needs: Community Outlook.

'Even though we did not go out to ask what some of the answers to the problems talked about were, many people came up with good workable solutions of their own.' [87]

Many health visitors undertake community initiatives along with local residents or colleagues from the council or voluntary sector. They do this on the basis of an overview of the area gleaned from both family and community needs assessments. Currently in South Gloucestershire, they are involved in a huge range of public health activity, including:

- parenting classes
- breastfeeding support groups
- healthy eating courses
- weaning groups
- young parents' groups
- community safety groups
- teenage pregnancy strategy workgroups.

Kingswood and District Health Needs Assessment

In 2005, as a result of the strong local opposition to the proposed closure of Cossham Hospital, a steering group was established by Bristol North and South Gloucestershire PCTs to review the health needs of the population surrounding the hospital.

The steering group analysed all the demographic, health and social care data available. The Chase and King's Forest Community Project (a local community organisation) was contracted to go out to meet local residents, community groups and workers from different agencies, in the more 'hard-to-reach' communities. They were to use 'rapid appraisal' methods.

'…rapid appraisal offers very specific insights, helping to define what the problems are rather than how many people are affected by them. It helps to identify the strength of feeling within the community on key issues.' [88]

Kingswood and District includes a range of urban, suburban and more rural settings, covering a wide area. The health needs assessment included four wards in Bristol which were identified as being part of this community.

Access to services is a key issue as 18% of the population live in households without a car. When compared to the rest of South Gloucestershire, the area has more people aged over 65. It also has over 25,000 under 16 year olds (almost 22% of the population). The higher levels of deprivation indicate that their health needs are greater than children living elsewhere in South Gloucestershire.

[87] Roberts E 1990 We live here…we should know. A report on the health needs of Hartcliffe. Health Promotion Service Avon (unpublished.)
[88] Murray et al 1994 in Freeman et al 1997 Community Development and Involvement in Primary Care. King's Fund: London

While the population is less deprived than the Bristol population, it is more deprived than the rest of South Gloucestershire. Major chronic diseases including cancer, chronic obstructive lung disease, diabetes, coronary heart disease and stroke, affect more people in Kingswood and District than in the rest of South Gloucestershire.

The community project consulted widely including the following groups, (or workers) - carers and disabled people, mental health service users, parents with young children, young people, lesbian, gay and bisexual people and Black and minority ethnic people. The key issues to arise were concerned with:

- access to specialist services such as physiotherapy
- physical access for disabled people to clinics, health centres, etc
- a desire for a more holistic approach to a patient’s wellbeing, more consideration of families' and carers' needs and more 'joined-up' services
- difficulties getting appointments at GP surgeries
- a need for improvement in the translation and interpreting services for patients whose first language is not English.[89]

These issues have fed into the development of options for the future of health services in the local area.

[89] Future of Health Services in Kingswood and District: Seeking the views of hard-to-reach communities. Final Report, February 2006 The Chase and Kings Forest Community Project.

Section 5: Communicable Diseases

Micro organisms co-exist with people, sharing a common environment. Despite great progress in our understanding of infectious diseases, they remain a major global threat to health. Problems can arise from:

- new or adapted strains of virus
- bacteria becoming resistant to antibiotics
- infections transmitted through food
- the return of illnesses previously prevented by vaccination.

Infectious diseases in Britain are monitored by a reporting system covering over 30 diseases. Tracking infectious diseases is vital to the process of effective control and prevention work. It allows us to identify threats from new infections and to spot serious outbreaks whilst there is still the opportunity to prevent further spread. Reporting of infections is currently incomplete, so there are gaps in the system designed to protect us.

Figure 30: Selected notifiable infectious diseases in South Gloucestershire 1999-2005

	1999	2000	2001	2002	2003	2004	2005
Measles	8	5	13	15	22	5	6
Mumps	7	3	4	4	7	91	158
Rubella	6	5	13	4	6	0	1
Dysentery	4	5	1	4	8	5	7
Scarlet Fever	10	3	0	13	12	4	2
Whooping Cough	6	4	2	5	2	1	3
Tuberculosis	8	10	11	5	10	8	12
Meningitis	19	29	15	14	8	10	11
Food Poisoning	43	16	26	32	21	20	
E.Coli 0157	1	1	1	6	1	2	2
Salmonella	83	69	68	61	79	56	59
Campylobacter	340	360	358	285	212	220	330
Giardia	30	20	27	9	23	35	30

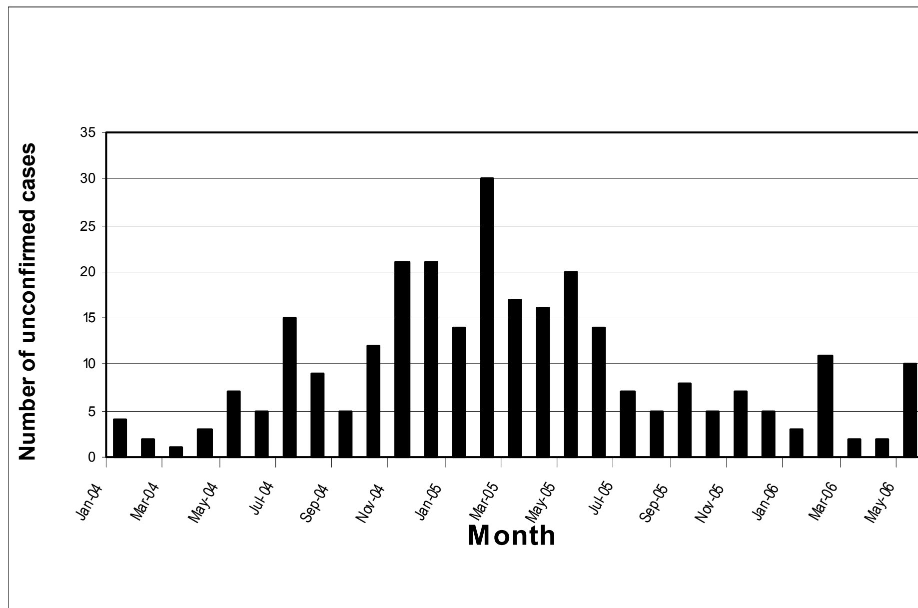
Source: Avon Health Protection Team

Mumps

There was a striking increase in the reporting of mumps in 2005, reflecting the continuing outbreak described in last year's report. This particularly affected older teenagers and young adults. PCTs across the former Avon area initiated a widespread vaccination campaign in GP surgeries, schools and colleges.

The campaign probably contributed to the decline in notifications over the second half of 2005 and it will remain important to continue to offer young adults the chance of vaccination with the measles, mumps and rubella vaccination (MMR) if they have not received this.

Figure 31: Monthly notifications of mumps in South Gloucestershire PCT Jan 2004-May 2006

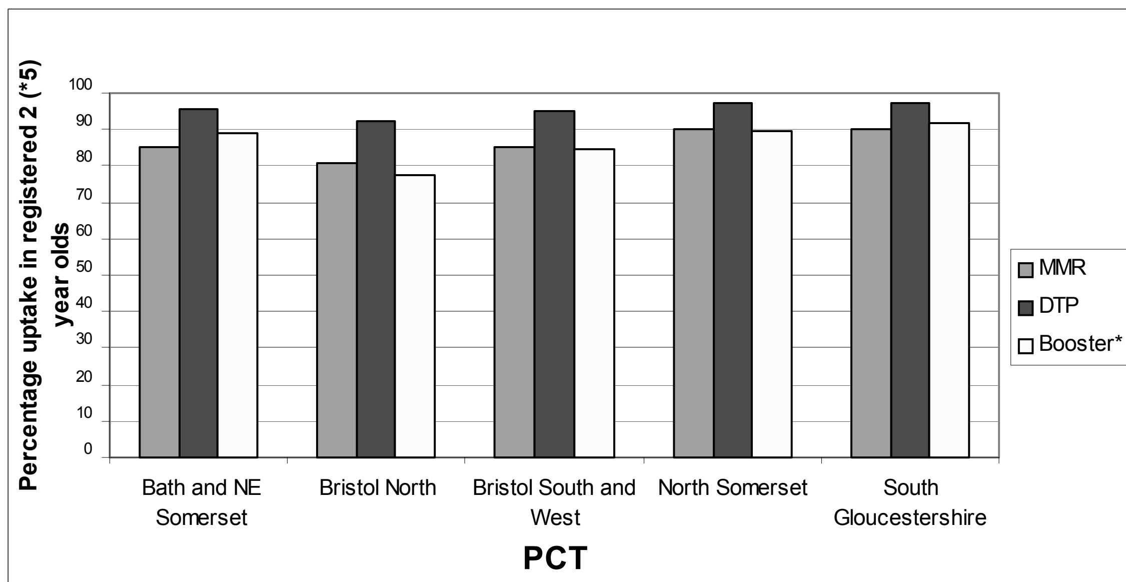


Source: Avon Health Protection Team

Immunisation

Immunisation is the safest and most effective available way of controlling many infectious diseases.

Figure 32: Completed immunisations at age 2 years and 5 years 2005-2006



Source: Avon Health Protection Team

In the UK we have seen dramatic reductions in all infections covered by the immunisation programme. However, as a result of the successes, people have forgotten the seriousness of some of these infections, and some have declined immunisation. As the pool of people not immunised grows, the likelihood of

outbreaks increases. The time is ripe now for a measles outbreak.

South Gloucestershire has very good immunisation rates but there is room for improvement. Confidence in the MMR is being restored, as people realise that the 1990s scare was without good scientific foundation.

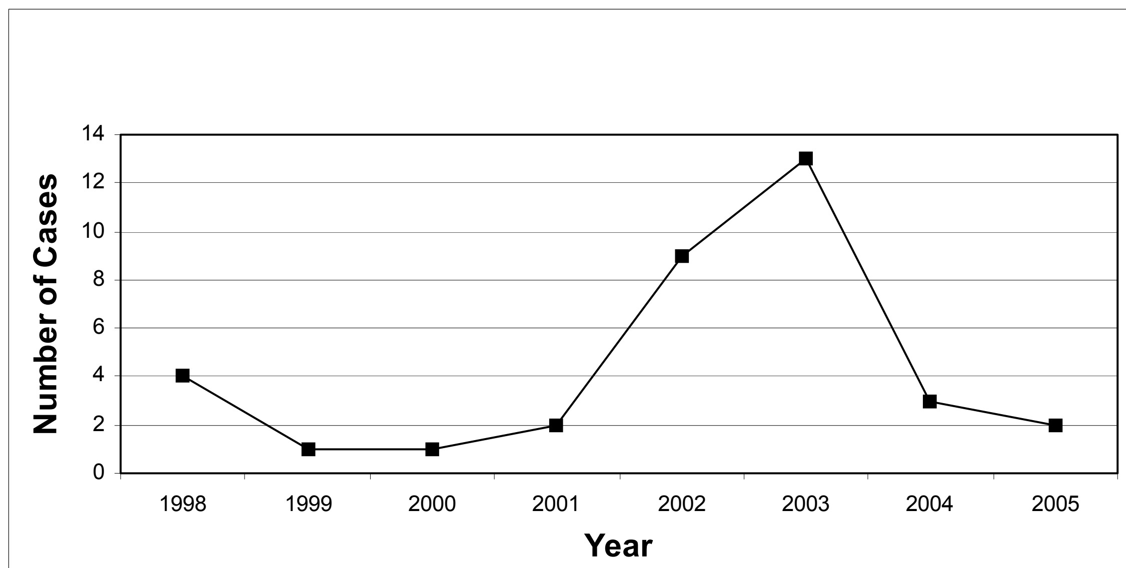
Measles is more infectious than mumps and the complications are more severe. This year saw the first measles death in England for 14 years. Cases have increased across the country, although South Gloucestershire has not seen this rise. Two doses of the MMR vaccine provide the best chance of protection.[90]

There will always be a small proportion of the population that have not been vaccinated, for example, babies under the age of 12 months. A high level of vaccination in the rest of the population will help protect this small group. Young babies have some protection through older siblings that have been immunised.

Hepatitis B

There has been a multi-pronged approach to tackling hepatitis B and the evidence suggests that the outbreak in 2002-2003 has come under control.

Figure 33: Annual diagnosed cases of hepatitis B in South Gloucestershire



Source: Avon Health Protection Team

Hepatitis C

Estimates of infection vary, but there are likely to be around 1000 people with hepatitis C living in South Gloucestershire. About half of those will have been diagnosed and know they have the disease.

An infection with hepatitis C often causes no symptoms initially, but can have serious long-term consequences of liver cirrhosis and carcinoma. Prevention remains the key to reducing the number of cases of blood-borne hepatitis. In

[90] See www.mmrthefacts.nhs.uk

addition, treatment has become more effective, so it is important that individuals in high risk groups, such as injecting drug users, are offered testing and treatment, as well as advice and help to prevent transmission of the virus.

The PCT is working closely with the local drug action team to ensure a coordinated approach to reducing the various types of harm caused by drug misuse. This approach includes education, access to clean needles and syringes, testing, treatment and vaccination against hepatitis B.

Sexually transmitted infections

See Improving Sexual Health section on page 43.

Food poisoning

One of the commonest notifiable diseases is food poisoning. Campylobacter and salmonella cause most infections and it is recognised that only a proportion of these infections are notified. In South Gloucestershire, there were over 300 cases of confirmed Campylobacter in 2005. Wherever food is prepared, cleanliness, thorough cooking, effective refrigeration and eliminating cross-contamination of raw and cooked products reduce the risk of infection.

Emerging threat of pandemic influenza

The influenza virus can change to become quite different from those seen previously. This has happened three times in the last century - in 1918-1919, 1957-1958 and 1968-1969. The population had little, or no, immunity and the infection spread from person-to-person causing a more severe illness than the usual seasonal influenza. It resulted in many deaths.

Many experts believe that there will be another influenza pandemic. This may arise by chance from a big change in the seasonal influenza. Or it might be the result of seasonal influenza mixing with bird influenza to make a new strain.

Vaccine will not be available in the initial stages of an influenza pandemic, as it will take time to produce a vaccine of the right strain. Anti-viral drugs are of some use, as are basic infection control measures, such as hand washing. Any pandemic is likely to pose a major challenge to the health service and the functioning of society. There is detailed planning taking place for such an eventuality within the NHS and with partners such as the local council and police.

Recommendations

The major observations and recommendations from this year’s report are:

1. Inequalities appear to be widening, both nationally and locally. Action to tackle this needs to include the following:
    - Efforts to reduce tobacco consumption in more deprived communities need to be redoubled, in particular reducing exposure to tobacco smoke in the home and providing services and support to stop smoking.
    - The PCT, local authority and other partners should seize the opportunity offered by the Local Area Agreement for improving coordination and services to priority neighbourhoods.

2. Obesity is increasing rapidly. Action to address this needs to be wide ranging and should include better design of the built environment, to encourage physical activity.

3. Improving services for people with a mental illness and for carers should remain a priority.

4. Access to sexual health services needs to be improved, in particular GUM services.

5. Global warming and associated climate changes pose a long-term threat to the health of South Gloucestershire residents. Steps to reduce carbon emissions are urgently needed. Some changes will have health benefits in themselves, such as improved thermal efficiency of housing and increased active travel. Other changes, such as increased cost of fuel, include a risk that inequalities in health could widen.

Index of Director of Public Health annual reports

Previous annual reports are available on the South Gloucestershire PCT website at www.sglos-pct.nhs.uk or from Dr Chris Payne on 0117 330 2479, or email: Chris.Payne@sglos-pct.nhs.uk. Each year they provide an update on the major causes of ill health, health inequalities and health promotion targets, such as those related to smoking, and on health protection.

Our area our health: Annual Report of the Director of Public Health 2003

Focus on the major health problems
Tackling inequalities in health

Our area our health: Annual Report of the Director of Public Health 2004

Partnership working
Quality of life measures and the burden of chronic disease
Improving health and reducing inequalities through primary care
Identifying health needs - population age structure and deprivation
The health visitor review
The use of health equity audits
Health equity audit - influenza vaccination

Our area our health: Annual Report of the Director of Public Health 2004 - 2005 Focus on children and young people

The health of children and young people and the South Gloucestershire Charter for Children and Young People
Choosing Health
A local health needs assessment tool
Health equity audit - access to Support to Stop smoking

Thanks to...

I am very grateful to the following people who did much of the work in producing this report.

Public Health/Health Promotion Team

Lindsey Thomas	Assistant Director Public Health – Health Promotion
Lesley Causon	Senior Health Promotion Specialist (SHPS) Mental Health; Young People
Maggie Sims	SHPS Injury Prevention; Schools for Health
June Martin	SHPS Smoking Cessation and Tobacco Control
Jane Kilpatrick	SHPS Community Health Development
Nicola Ravenscroft	SHPS Food and Health and Breastfeeding
Richard Merrett	SHPS Sexual Health
Susan Hamilton	Public Health Trainee
Ruth Kipping	Public Health Trainee
Maria Hennessy	Clinical Lead Manager Children and Family Services

Production

Sally Bramley	Editing
Julia Rowley	Final production

Public Health Network Specialists

Dr Charles Irish	Communicable Disease Consultant
Dr Joyshri Sarangi	Communicable Disease Consultant
Dr Chris Hine	Consultant in Public Health, Acute Commissioning
Marion Roderick	Public Health Trainee

Particular thanks to Louise Casper for masterminding the analysis and presentation of health information, with a contribution from Paula Perks.

Dr Chris Payne

Director of Public Health, South Gloucestershire Primary Care Trust

Licences and permissions

Crown Copyright material is reproduced with the permission of the Controller of HMSO.
Reproduced under the terms of the click-use licence. Licence Number C2006010815.
Figure 2 is reproduced with the permission of the World Health Organisation.

This report was produced by:

Dr Chris Payne
Director of Public Health
South Gloucestershire Primary Care Trust
1 Monarch Court
Emerald Business Park
Emerson's Green
South Gloucestershire
BS16 7FH

Telephone: 0117 330 2479
email: Chris.Payne@sglos-pct.nhs.uk
Web site: www.sglos-pct.nhs.uk

Further copies of this report can be obtained from:
Ann Brothers on 0117 330 2479

Copies of the community strategy Our Area: Our Future can be seen at
http://www.southglos.gov.uk

1 November 2006