Health

our area our health

Annual Report of the Director of Public Health 2004 - 2005

Focus on children and young people

South Gloucestershire NHS
Primary Care Trust

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Introduction

We have known for centuries that our early childhood experiences strongly influence the rest of our lives. In the 16th century St Ignatius Loyola said:

> *“Give me the child until he is seven, and I will show you the man.”*

Although such a statement sits uncomfortably to the modern ear, it captures the overwhelming importance of a child’s early years. We now know that influences on future health start well before birth and this, together with other evidence of the importance of childhood experience, led an enquiry into inequalities in health, chaired by Sir Donald Acheson, to recommend:

> *...a high priority is given to policies aimed at improving health and reducing health inequalities in women of childbearing age, expectant mothers and young children.*

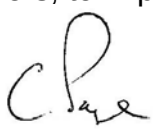
It is for this reason that my third Director of Public Health's annual report focuses on the health of children and young people.

Although the last century has seen remarkable improvements in child health, the beginning of the 21st century has brought its own challenges. Unhealthy behaviours such as teenage smoking and drug taking are a problem. More young people aged 11-15 years are drinking alcohol. More children are obese and levels of walking and cycling have declined. Inequalities in child health also persist, for example, in the UK, children from the poorest families are five times more likely to be killed as a result of accidents, than those from the most affluent.

In this report, I outline the major health challenges for children and young people and make comparisons with 50 years ago. These new health challenges require solutions that involve much wider planning and coordination than just within the health service. In South Gloucestershire, this planning is being drawn together into a single children and young people’s plan. This report highlights the parts of that plan that focus on health improvement.

The report also includes an update on local trends in the major causes of death, together with a description of the detailed work we have done on local health needs and the activities carried out to monitor and reduce health inequalities.

In the introduction to last year’s report, I commented that '*These are exciting times for public health*.' This promise continues with the publication of the White Paper *Choosing Health,* and I have highlighted some of the opportunities this offers, to improve the health of residents of South Gloucestershire.



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

Section 1: Children and Young People

How Healthy are Children and Young People?

The health of children and young people compared with 50 years ago...

- Death rates have dropped dramatically.
- Emotional and behavioural problems have increased.
- Children and young people are less physically active and consume more confectionery and soft drinks.
- Accidental injury is the leading cause of death in children over the age of one year.
- There are marked inequalities in child health, for example, children in poorer areas in South Gloucestershire are twice as likely to die before the age of 15, compared with children from better off areas.

Children's health has improved significantly during the last 50 years. Infant mortality has declined, as has the burden of death and disability from infectious diseases. This is due, in part, to an improvement in social conditions and medical advances, but also to the comprehensive national vaccination programme.

Figure 1: Leading causes of death in children aged 1-14 years in 2004 in England and Wales

Cause of death	Number of deaths
External causes (e.g. accidents, poisoning and assaults)	272
Neoplasms (including cancers)	247
Diseases of the nervous system	174
Respiratory diseases (pneumonia, asthma, bronchitis)	120
Congenital malformations and abnormalities	113
Infectious and parasitic diseases	80
Circulatory diseases	68
Endocrine, nutritional and metabolic diseases	67

Source: ONS

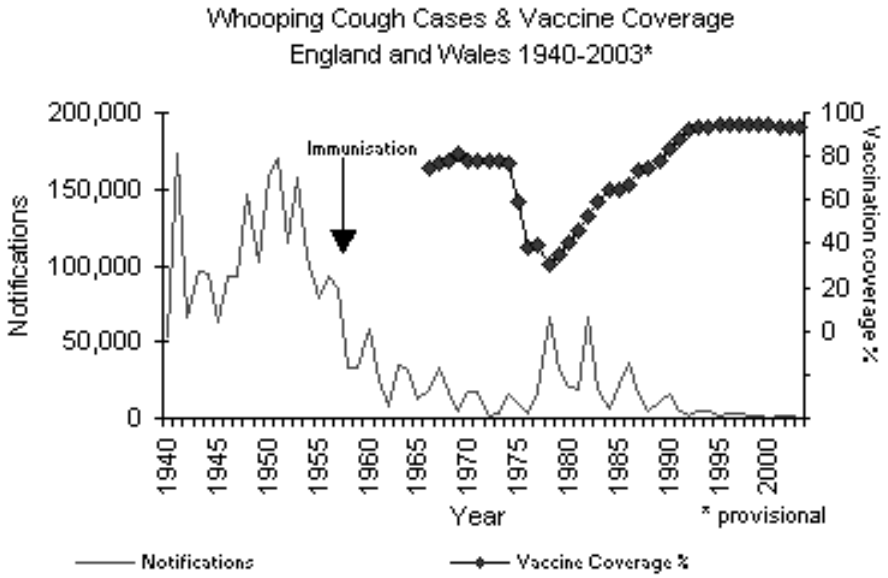
Although many children still die from preventable illnesses or injuries, infectious diseases are no longer major killers of children in the UK. Children today are more likely to die from injuries caused by accidents and cancer (see Figure 1).

In 1950 there were 5565 cases of acute poliomyelitis (paralytic) in England and Wales. In 2003 there were no cases and there is a campaign to eradicate it worldwide.[1]

[1] Health Protection Agency. Epidemiological data – Polio
http://www.hpa.org.uk/infections/topics_az/polio/data.htm

However, we cannot be complacent about the reduction in infectious diseases. The importance of maintaining a high uptake of immunisation can be seen from the incidence of whooping cough. Notifications for whooping cough in England and Wales have dropped dramatically since 1950 (see Figure 2).[2] But the vaccination rate fell in the mid 1970s, from 77% to 31%, following the publication of a controversial paper, which proposed a link between the pertussis vaccine and brain damage. Two epidemics of whooping cough followed, which led to an increase in take up of the vaccination and a reduction in incidence of disease.

Figure 2: Whooping cough cases and vaccine coverage in England and Wales 1940-2003



Source: Health Protection Agency

Infant mortality

Medical advances and improved living conditions have led to a decline in infant mortality, although mortality rates are higher for the most socio-economically disadvantaged infants and mothers (see Figure 3).

In 1945, 46 out of every 1000 infants born alive in England and Wales died by the age of one year. By 2002, the number had dropped to 5.2 per 1000 live births.[3] Maternal deaths also declined during the last century. In 1970, maternal death occurred in about one in every 5000 live births. In 2002, the risk had fallen to about one in 16,000 live births.[4]

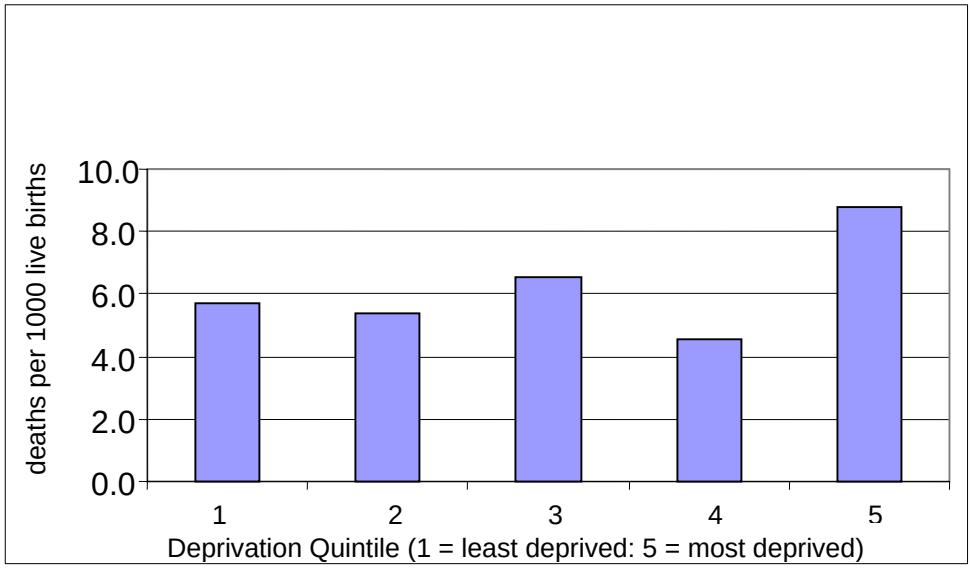
[2] Health Protection Agency. Whooping cough cases and vaccine coverage http://www.hpa.org.uk/infections/topics_az/whoopingcough/data_not_vaccyr.htm

[3] Hicks J and Allen G 1999 A Century of change: trends in UK statistics since 1900. Research paper 99/11., Social and general statistics section, House of Commons library. See http://www.parliament.uk/commons/lib/research/rp99/rp99-111.pdf

[4] MacFarlane A 2004 Confidential Enquiries into Maternal Deaths: developments and trends from 1952 onwards. Chapter 22 in CEMACH 2004 Why Mothers Die 2000-2002 - The 6th report of the confidential enquiries into maternal deaths in the United Kingdom. See http://www.cemach.org.uk/publications/WMD2000_2002/wmd-22.htm

The challenge today is to achieve good maternal and infant health for all, and to respond to the particular needs of the minority of women with higher risk of poor outcomes from pregnancy. Risk factors include smoking, substance misuse, ethnicity and greater maternal age. Access to care is a particular issue for Travellers and those in prison.

Figure 3: Infant deaths by deprivation quintile in South Gloucestershire 1999-2003



Source: ONS; 2004 - Index of Multiple Deprivation (Income Domain Index)

Parenting

The earliest years of life are a critical period for the development of emotional attachments that affect not only children's health, development and patterns of behaviour, but also mental and physical health in adulthood.[5] Of particular importance are the quality of the parent–infant relationship and the style of parenting. For example, a lack of warm sensitive parenting, failure to set age appropriate boundaries, and a lack of positive discipline is associated with:[6]

- severely impaired emotional and social development
- impaired cognitive development and underachievement in school
- physical and mental health problems in children and adults
- the adoption of unhealthy lifestyles
- hypersensitivity to stress
- anti-social behaviour
- difficulties in developing healthy relationships.

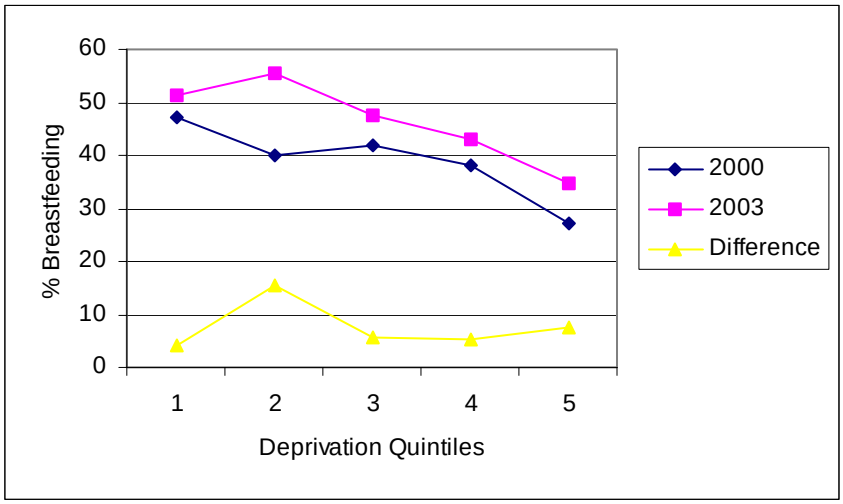
[5] Balbernie R 2004 An Infant Mental Health Service: The importance of the Early Years and Evidence Based Practice. The Association of Infant Mental Health UK

[6] Stewart-Brown S 2005 Promoting health in children and young people: identifying priorities. The Journal of the Royal Society for the Promotion of Health

Breastfeeding

Breastfeeding promotes health and prevents disease for both child and mother. In the UK, 71% of babies are initially breastfed, but this falls to 57% by the first week and 29% by four months. In 2003, 46.4% of mothers in South Gloucestershire were breastfeeding at 6-8 weeks. Mothers from disadvantaged groups are less likely to breastfeed.[7] In South Gloucestershire, rates have improved in all quintiles over the last few years, but particularly in Quintile 2.

Figure 4: Breastfeeding rates at 6-8 weeks in South Gloucestershire (2000 and 2003)

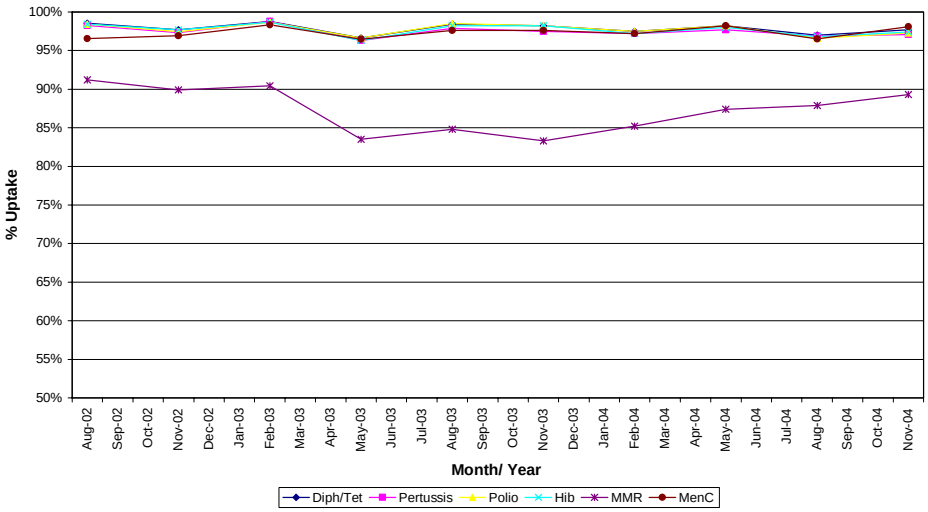


Source: Child Health Surveillance breastfeeding data 2000 and 2003

Childhood vaccinations

There is evidence that the recent controversy over the MMR immunisation is subsiding as fears of a link to autism recede. Uptake of the first dose of MMR vaccine in South Gloucestershire is climbing steadily (see Figure 5).

Figure 5: Immunisation uptake before second birthday

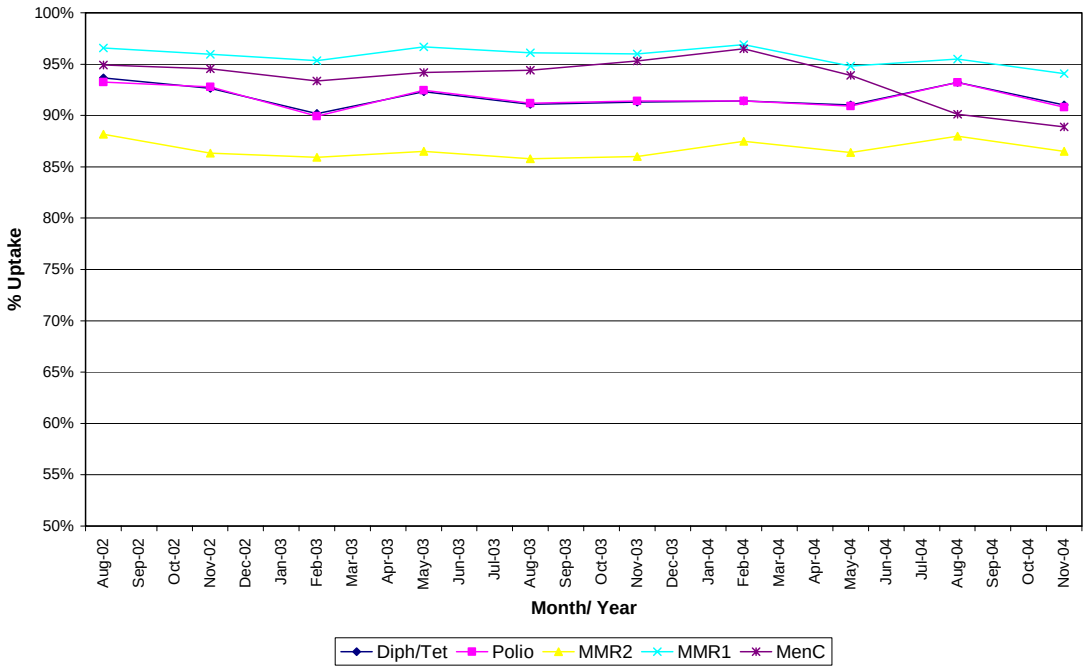


Source: Child Health Surveillance, Avon

[7] Hamlyn B, et al 2002 Infant Feeding 2000. London: Department of Health.

However, the same does not apply to the second dose, at age four years (see Figure 6). The importance of the second dose in conferring lasting immunity was shown by the recent mumps outbreak (see Section 4).

Figure 6: Immunisation uptake before fifth birthday



Source: Child Health Surveillance, Avon

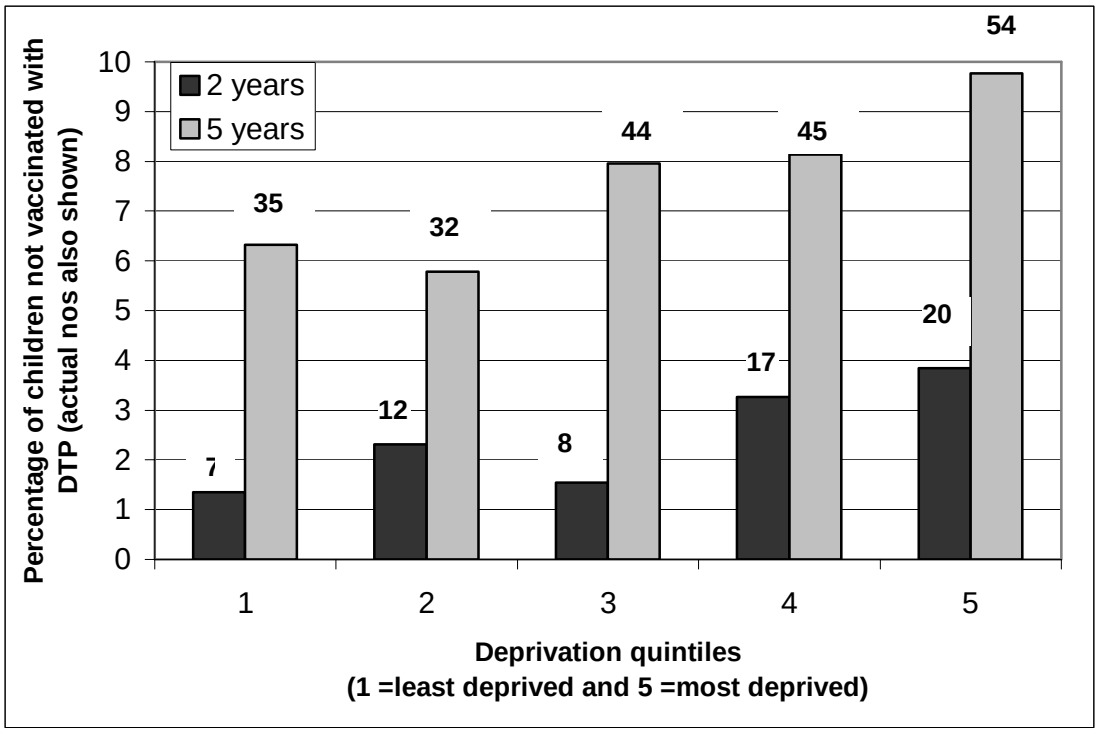
Meningococcal C immunisation (MenC), introduced in 1999, has had a dramatic effect in reducing cases of group C meningococcal meningitis and septicaemia. This fall contrasts with meningococcal B disease, for which there is currently no vaccine. The lower MenC vaccination rate for children aged five years in 2004 may reflect the concerns in the media about the safety of the MMR vaccine in 1999 (see Figure 6). The MenC vaccination rate has subsequently increased to coverage of over 98% (see Figure 5).

Health equity audit of childhood vaccinations

As part of a series of equity audits the uptake of the two triple vaccines for children at the age of two years and five years were analysed according to deprivation quintile. The vaccines were MMR (measles, mumps and rubella) and DTP (diphtheria, tetanus and pertussis – whooping cough).

There are lower vaccination rates for children in more deprived areas for DTP at both two years and five years. The pattern for MMR is not as clear. Although the differences in vaccination rates appear small, the cumulative pool of unvaccinated children will be much larger in poorer communities, if this difference persists (see Figure 7).

Figure 7: Percentage of children not vaccinated with DTP at two years and five years in South Gloucestershire by deprivation quintile



Source: Child Health Surveillance

Nutrition

Children and young people eat more sugar, salt and saturated fat than is recommended and less fruit and vegetables. Many children also have poor intakes of key micronutrients such as iron (particularly older girls) and calcium.

The Nutrition and Diet Survey of Children aged 4-18 years in 2000[8] found:

- the foods most commonly consumed by children were white bread, savoury snacks, potato chips, biscuits, chocolate confectionery, boiled, mashed and jacket potatoes.
- on average, children were eating less than half the recommended five portions of fruit and vegetables a day.
- 60% had eaten no cooked leafy green vegetables.
- 4% did not eat any vegetables.
- 20% had not eaten any fruit.

In 1950, tea was the most common drink for children. These days, children drink 66% more fizzy drinks than milk.[9]

[8] Gregory J 2000 National Diet and Nutrition Survey: young people aged 4-18 Vol 1. London: Stationery Office.
[9] Gregory J 2000 as above.

Foods eaten by pre-school children have changed dramatically in the past 50 years:[10]

Figure 8: The diets of four year olds in the 1950s and the 1990s

Diets of 4 year olds in the 1950s (per day)	Diets of 4 year olds in the 1990s (per day)
1445 kcal	1228 kcal
117g starch	77g starch
120g bread (approx 5 ½ slices)	48g bread (just over one slice)
<1g confectionery	25g confectionery
13g soft drinks/juice	446g soft drinks (just under 1 ½ cans)

In the 1950s, most of our vitamin C came from potatoes. Today we get most of our vitamin C from fruit and fruit juice.[11]

Obesity and inactivity

Nationally, the proportion of children aged 2-11 years who are obese increased from 9.9% to 13.7% between 1995 and 2003.[12] The greatest increase was in 8-10 year olds.

The Body Mass Index (BMI)[13] is used to measure obesity. BMI for children can be assessed using the same calculation as for adults, but is also charted against age separately for boys and girls.[14] A child whose BMI falls above the 98th centile is considered obese: above the 91st centile as overweight.

The recommended level of physical activity for children and young people is a minimum of 60 minutes of at least moderate intensity physical activity each day. Twice a week this should include activities to improve bone health (i.e. produce high physical stress on the bones), muscle strength and flexibility.[15]

Physically active people have a 20-30% reduced risk of premature death and up to 50% reduced risk of major chronic disease, such as coronary heart disease, stroke, diabetes and cancer.

Obesogenic (obesity creating) environment

Burning off the calories in a fast food chain's cheeseburger, fries and a shake equates to a nine-mile walk.[16] Yet nationally, one fifth of 5-16 year olds said they had not walked for 20 minutes or more in the previous year. The proportion of

[10] Prynne CJ, et al 1990 Food and nutrient intake of a national sample of 4-year-old children in 1950: comparison with the 1990s. Public Health Nutrition. Dec;2(4):537-47.
[11] Food Standards Agency website at www.eatwell.gov.uk/healthydiet
[12] Jotangia D et al 2005 Obesity among children under 11. London: National Centre for Social Research.
[13] BMI is weight in kg divided by height x height in metres
[14] Published by the Child Growth Foundation
[15] DH (2004) At Least Five a Week: evidence on the impact of physical activity and its relationship to health. London: DH.
[16] Department of Health 2004 *Choosing Health – making healthy choices easier.* London: Department of Health.

primary school-aged children who were driven to school increased from 30% to 40% from 1992/4 to 2002/3.[17]

Of 11-15 year olds in England:

- 72-76% *do not* eat fruit every day
- 30-33% *do* eat sweets every day
- 35-45% drink sugared soft drinks every day
- 24-31% watch more than four hours of television on weekdays.[18]

Accidental injuries

Accidental injury is one of the biggest single causes of death in the UK for children aged over one year. In 2003, 291 children under 15 years in the UK died as the result of injury or poisoning.[19] Every year, over two million children are taken to hospital after having an accident. Around half of these accidents happen at home.

> *The number of children under ten years of age dying from poisoning in England and Wales, dropped by 82% between 1968 and 2000. Improvements in safety in the home, including changes in the packaging of drugs, may be partly responsible.*[20]

The burden of accidental injury is disproportionately heavy on the most disadvantaged. Children from the poorest families are more likely to die from accidents, more likely to be admitted to hospital, and more likely to be admitted with more severe injuries.[21]

A year-on-year reduction in fatal road accidents (all ages) in South Gloucestershire has resulted in fatalities in 2004 being at their lowest level since 1996.

Emotional and behavioural problems

It is estimated that 3,000 children (5-15 years) in South Gloucestershire have a mental disorder. That is 9.5% of the total population of children and young people. The majority of these will have conduct and emotional disorders, such as anxiety and depression. An estimated 240 South Gloucestershire young people (16-19 years) experience neurotic disorders such as depression, phobias, or obsessive-compulsive disorders, with 113 likely to seek professional help.

[17] Department for Transport 2005 *Focus on Personal Travel: England: 2005 Edition* http://www.dft.gov.uk/stellent/groups/dft_transstats/documents/downloadable/dft_transstats_037494.pdf

[18] Currie C et al (eds) 2004 Young people's health in context. Health Behaviour in School-aged Children (HBSC) study: international report from the 2001/2002 survey. WHO Health Policy for Children and Adolescents, No. 4

[19] The Child Accident Prevention Trust at www.capt.org.uk

[20] see www.sciencedirect.com;do1:10.1016/jforsciint.2004.04.083

[21] Towner E, et al at Community Child Health, Department of Child Health University of Newcastle upon Tyne 2005 Injuries in children aged 0–14 years and inequalities. A report prepared for the Health Development Agency. London: HDA

Children more at risk of developing mental health problems include those who:

- have a significant learning disability
- are looked after
- suffer physical illness
- are within the criminal justice system.

Mental health in babies and the under-fives should not be overlooked. It has been estimated that 7% of under-fives have severe mental health problems.[22]

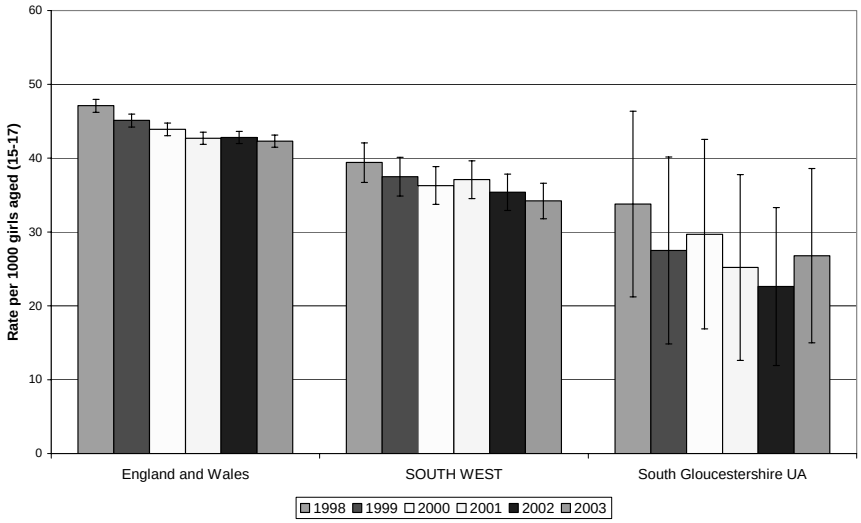
> *There has been a considerable increase in psychosocial disorders in young people since the 1950s, which sharply contrasts with the improvement in physical health.*[23]

Teenage pregnancy

The teenage pregnancy rate in South Gloucestershire has dropped from 33.8 per 1000 female population (aged 15-17 years) in 1998, to 26.8 per 1000 in 2003 (Figure 9). This is a 20.8% reduction compared to 13.3% in the South West and 9.8% in England. There is always considerable delay in collating and publishing the figures, but the current trend means that we expect to have met the target rate of 28.7 for 2004 and 27.3 for 2005.

Conception rates in 13-15 year olds are also decreasing in South Gloucestershire with a rate of 3.0 per 1000 female population, compared to 6.2 (South West) and 7.9 (England) in 2002.

Figure 9: Conceptions in the under 18s (1998-2003)



Source: Teenage Pregnancy Unit

Although maintaining a low teenage conception rate, South Gloucestershire has fluctuating pockets of high rates - generally, but not exclusively, in urban areas.

[22] Mental Health Foundation at www.mentalhealth.org.uk
[23] Rutter, M. and Smith, D. (eds) 1995 Psychosocial Disorders in Young People, Time Trends and Their Causes, Chichester, John Wiley & Sons/Academia Europaea.

Drugs and alcohol

In 2002, research showed that in England:[24]

- the prevalence of drinking alcohol in pupils aged 11-15 years increased from 21% in 1990 to 24% in 2000.
- boys aged 11-15 years were likely to consume more units of alcohol than girls in the same age group.
- beer, lager and cider were the most popular types of alcohol drunk by both boys and girls.

Cannabis was the most widely used drug amongst 11-19-year-olds. In 2003:[25]

- 13% of 11-15 year olds in England were using cannabis.
- 26% of 16-19 year olds in England and Wales were using cannabis.
- The prevalence of using cannabis and Class A drugs increased with age.
- Between 1994 and 2000, the use of amphetamines, LSD and poppers decreased among 16-19-year-olds.

Teenage smoking

In 2002, 10% of pupils aged 11-15 years were regular smokers (defined as usually smoking at least one cigarette a week). This proportion has fluctuated since 1982, but has been quite stable since 1998.[26]

Adult smoking rates vary only slightly between different parts of the country. In the UK, there is a strong association between smoking and markers of social disadvantage.[27]

The highest recorded level of smoking amongst men was 82% in 1948, when surveys started. In 1974, 51% of men and 41% of women smoked - nearly half the adult population of the UK. Now just over one quarter smoke, but the decline in recent years has been heavily concentrated in older age groups i.e. almost as many young people are taking up smoking, but more established smokers are quitting. More than 80% of smokers take up the habit as teenagers.

[24] National Centre for Social Research and the National Foundation for Educational Research (on behalf of DH) 2003 Smoking, drinking and drug use among young people in England in 2002. London: Stationery Office

[25] DH 2004 Statistics on young people and drug misuse: England 2003 Bulletin 2004/13 at www.dh.gov.uk

[26] National Centre for Social Research and the National Foundation for Educational Research (on behalf of DH) 2003 Smoking, drinking and drug use among young people in England in 2002. London: Stationery Office.

[27] Health Development Agency (2004) The Smoking Epidemic in England. London: HDA.

Improving the Health of Children and Young People

Our priorities for improving the health of children and young people in South Gloucestershire are tackling or preventing:

- low uptake of certain childhood vaccinations, such as MMR
- low breast feeding rates
- poor nutrition
- obesity and inactivity
- accidental injuries
- emotional and behavioural problems
- unhealthy behaviours such as smoking, drugs and alcohol
- teenage pregnancy and sexually transmitted infections, in particular chlamydia.

Tackling these problems will involve coordinated action at all levels. Local coordination has received a major boost from the national *Change for Children* agenda. Over the past year, South Gloucestershire Primary Care Trust (PCT) has worked in partnership with the local authority, and others, to review the health and achievement of local children and the services they receive.

The review led to the development of the *South Gloucestershire Charter for Children and Young People*. The Charter expresses a shared commitment to improving opportunities for all local children and young people, by describing six outcomes against which the performance of all services will be measured.

The South Gloucestershire Charter for Children and Young People

We believe that all children and young people have a right to a life in which they:

- enjoy the best possible physical and mental health and live a healthy lifestyle
- have equality of opportunity
- are given encouragement and opportunities to learn, develop, enjoy and achieve, both in and outside school
- are protected from harm and neglect and feel safe both at and outside of home and school
- are supported by their parents and carers, and their peers
- are encouraged to play a full part in their communities and behave in a socially responsible manner.

We will work together to deliver this Charter.

A single joint children and young people's plan for 2005/6 has been developed, organised according to each of the six outcomes listed in the charter, highlighting current gaps and priorities for action.

An important step in improving services is to bring scattered services together to work in better integrated teams. The PCT has entered into discussions on a proposed transfer of community children's health services from the North Bristol (acute) NHS Trust to the PCT.

All of the charter outcomes have an impact on health. The PCT is involved in a wide range of activities that promote or protect children's health. Primary care services care for children when they are ill and also deliver a comprehensive programme of health promotion and prevention through GPs, health visitors and other staff. In this report, current vaccination coverage is described in Section 2. Here we describe some of the key health promotion work in which the PCT is involved.

Charter Outcome: 'Children and young people enjoy the best possible physical and mental health and live a healthy lifestyle.'

Breastfeeding

The South Gloucestershire Breastfeeding Network supports the implementation of newly developed PCT breastfeeding guidelines and encourages the expansion of breastfeeding support groups. There are currently five in South Gloucestershire.

Skilled breastfeeding support, either by peers, or professionals, has been shown to be effective in improving the initiation and continuation of breastfeeding.[28] A community midwife has been involved with training volunteer peer supporters.

The Government is introducing the Healthy Start Scheme to replace the Welfare Food Scheme. All eligible pregnant women (including all under 18s), mothers, and young children in low income families, will have greater access to and encouragement to eat a healthy diet, particularly fruit and vegetables. Vouchers will still be available to exchange for milk or infant formula.

An increase in breastfeeding rates will help to reduce the growing numbers of obese children.

Childhood obesity

In *Choosing Health*, the Government has committed to raising awareness of obesity, producing a weight loss guide, developing a care pathway and providing funding for prevention and treatment. Physical activity will be supported through initiatives in schools, communities, workplaces and the NHS.

Over 85% of children walked to school in 1948,[29] but only 48% did in 2001.[30]

[28] Department of Health 2004 Good Practice and Innovation in Breastfeeding. DH
[29] The United Kingdom Parliament. *Select Committee on Health Appendix 27: Memorandum by the Food Advertising Unit (OB 44).* Prepared 14 June 2004 http://www.publications.parliament.uk/pa/cm200304/cmselect/cmhealth/23/23we28.htm

Baseline information about obesity is being collected from the child health surveillance system to map geographical trends in obesity in 4-5 year olds, in South Gloucestershire. We are also exploring opportunities to access the Avon Longitudinal Study of Parents and Children (ALSPAC)[31] data to establish the levels of obesity in children in South Gloucestershire. Local food and health action plans include:

- school nurses offering advice to parents of children identified as obese
- developing interventions at a population level and a pathway of care for children who are obese
- nutrition and physical activity as essential elements of the *Healthy Schools* Programme (see below)
- the *School Fruit and Vegetable Scheme*, in which every 4-6 year old receives a free piece of fruit, or vegetable, each school day (83% of schools are participating)
- a six week healthy eating course for parents of young children, developed in partnership with health visitors and South Gloucestershire Family Learning and Community Development staff. It has already been delivered in Little Stoke and at Eastwood Park Prison Mother and Baby Unit.

Promoting health in schools

Schools provide an important setting for promoting health.

> *'School health programmes that coordinate the delivery of education and health services and promote a healthy environment could become one of the most efficient means available for almost every nation in the world to improve significantly the wellbeing of its people (WHO 1997:9).*

Schools for Health

The National Healthy School Standard (NHSS) is part of the Government's drive to reduce health inequalities, promote social inclusion and raise educational standards. A highly successful scheme has been running for nine years in South Gloucestershire, with 70% of schools now participating.

Figure 10: *Healthy Schools* in South Gloucestershire

	Total schools	**No of *Healthy Schools***	**% of *Healthy Schools***
Primary schools	98	64	65%
Secondary schools	15	13	87%
Special schools	3	3	100%
Pupils Referral Unit	2	2	100%
		Total	**70%**

[30] Office for National Statistics. Trips to and from school: by main mode of transport, 1999-2001: Regional Trends 37. http://www.statistics.gov.uk/STATBASE/ssdataset.asp?vlnk=6034

[31] ALSPAC see www.alspac.bris.ac.uk

'We have introduced fruit pots, water bottles, more things to do in the playground, whole school health week, visits from outside organisations and awareness of shade issues.' (Schools for Health Coordinator)

Three new publications highlight the importance of the *Healthy Schools* Programme in delivering better health to children in schools.

- *Healthy Living: The Blueprint*[32] has a focus on food and activity in the fight against childhood obesity. It recognises the programme as a key vehicle for supporting the Public Service Agreement (PSA) to reduce obesity in children by half, by 2010.
- The Department for Education and Skills (DfES) five-year strategy[33] states the Government's commitment that all schools should become *Healthy Schools.*
- *Choosing Health*[34]sets a target of half of all schools becoming healthy schools by 2006, and all schools working towards *Healthy School* status by 2009.

In South Gloucestershire we will continue to recruit new schools and support those schools already engaged with the programme. We have already achieved the 2006 target with predicted totals of schools achieving Level 3 NHSS status.

Through the Healthy Schools Partnership, the Tobacco Action Network (TAN) supported a road show for Year 7 pupils to raise awareness about tobacco issues. Trading standards, schools and the youth service are working in partnership to reduce tobacco product sales to under 16s.

Personal, Social and Health Education (PSHE)

PSHE is an important part of the national curriculum and covers a wide range of health related topics including:

- drugs, alcohol and tobacco
- emotional health and wellbeing
- nutrition and physical activity
- safety
- sex and relationship education.

This year the national certification programme for the teaching of PSHE was launched. Fourteen teachers in the first cohort have completed their portfolios of evidence and to date nine have successfully achieved certification. The second cohort of 17 teachers started in 2005.

[32] DfES 2004 Healthy Living : The Blueprint.. London: DfES
[33] DfES 2004 DfES: Five Year Strategy for Children and Learners. London: The Stationery Office.
[34] DH 2004 Choosing Health: making healthier choices easier. Norwich: The Stationery Office.

Emotional and behavioural problems

The multi-agency Emotional Wellbeing Promotion Group's aim is that all children and young people are able to develop the best possible mental health, enabling them to make the most of their abilities and opportunities, and be resilient enough to cope with stress and difficulty. Achievements this year include:

- 207 people attended training days on how to develop resilience in children, young people, their families and communities. Many attendees now include this within their own in-house training
- 106 people attended an anti-bullying seminar which provided schools with practical help on tackling bullying. Seven workshops provided an opportunity to find out about different approaches such as drama and peer mentoring
- 20 people have been invited to a multi-agency training day about young people and deliberate self-harm. It is planned that the attendees will form a network within South Gloucestershire.

The local Child and Adolescent Mental Health Service (CAMHS) has been the subject of a comprehensive review. This review recommended that services should be developed with a much expanded team able to include closely integrated staff from other agencies, such as Connexions, Barnardo's, Youth Offending Team, education and social services. Part of the work of the expanded team will be to enhance skills of front line staff, such as teachers and health visitors.

Drugs and alcohol

The Audit of Crime, Disorder and Drugs 2002 – 2004[35] identified a range of priorities and issues that the Safer South Gloucestershire partnership will address in their three year strategy. These are:

- 16 and 17 year old white males make up the majority of young drug offenders
- Using the demographic data available, the following wards emerge as the most prominent areas of drug activity:
    - Kingswood (Kings Chase and Woodstock)
    - Cadbury Heath (Parkwall)
    - Yate (West and Central)
    - Filton
    - Staple Hill
    - Hanham
- Children and young people's views need to be captured and a consultation strategy will be developed using the *Hear by Right* toolkit.[36]

[35] Safer South Gloucestershire 2004 Crime, Disorder and Drugs Audit 2002 – 2004 Safer South Gloucestershire

[36] Local Government Association and National Youth Agency 2003 *Hear by Right* toolkit London: LGA and NYA.

The Young People's Drug and Alcohol Service is a small team based within the Safer South Gloucestershire partnership. It aims to improve work with mainstream services to enhance identification and support for young people at risk of, or using, drugs. This year, 50 vulnerable young people at risk of substance misuse have received targeted drug education, and 86 young people have received treatment for substance misuse.

Achievements this year include:

- 1,434 workers have participated in training in identifying and responding to substance use
- Over 490 sixth form pupils have attended workshops on the effects of drugs and alcohol and on where to get help
- 90% of Year 8 and 9 pupils have been visited by the police drug worker
- Young people have assisted in designing and creating a drug guidance video resource, which has been distributed to all secondary schools
- Nine primary schools have had a drama workshop day, involving 401 Year 6 pupils and 18 staff
- 2,536 Year 6 pupils in South Gloucestershire have visited the Life Skills Centre, which teaches children about the dangers of drugs
- Nine secondary schools sent delegates to a consultation event to help shape how drug education is delivered in schools.

'I learnt a lot from this workshop, it made me think more about how hard it must be for people who are surrounded by drugs' (Pupil)

Barnardo's has completed a local study into the needs of children of substance misusing parents who often fall between adult and children's services. The service is currently piloting a project to support these young people.

Charter Outcome: 'Children and young people are given encouragement and opportunities to learn, develop, enjoy and achieve, both in and outside school.'

Teenage pregnancy

The national Teenage Pregnancy Strategy,[37] includes action to halve the under 18 conception rate by 2010, and to provide support to teenage parents to reduce the long term risk of social exclusion, by increasing the proportion in education, training and employment.

[37] see Social Exclusion Unit report on teenage pregnancy 1999 at www.dfes.gov.uk/teenagepregnancy

Key priorities from the South Gloucestershire Teenage Pregnancy Action Plan are:

- the further development and evaluation of the *No Worries* initiative. Condom distribution, access to pregnancy testing and professional support need to be improved in key target areas and with vulnerable groups.
- to develop and sustain an effective data collection and sharing system that can contribute to informed service delivery and development - both preventive and supportive - and improved outcomes for young people, particularly those who are most vulnerable.

Support to young parents in South Gloucestershire will include:

- developing peer mentoring
- involving younger mothers in groups
- addressing equality issues by providing increased support for boys and young men
- encouraging and supporting young parents into education, employment and training, and improving take-up of the *Care to Learn* grant.

Charter Outcome: *'Children and young people are protected from harm and neglect and feel safe both at and outside of home and school.'*

Child protection

On average, in England:

- one child is killed by their parent or carer every week
- 7% of children suffer serious physical abuse
- 6% suffer frequent emotional abuse
- 6% suffer neglect
- 20% are sexually abused.[38]

The sustained maltreatment of children physically, emotionally, sexually and through neglect, can have long-term effects on all aspects of a child's health, development and wellbeing. The longer a child is subjected to an abusive situation, the worse the outcomes are likely to be. Living with domestic violence can also have a significant emotional impact on children.

In South Gloucestershire, we are working with other agencies to ensure that we have safe policies and procedures in place and that staff have access to good quality training in child protection. All PCT staff have access to advice and support in their work from the designated/named professionals for child protection. All health visitors and school health nurses have regular supervision of their child protection work, and there are audit processes in place to monitor the quality of services.

[38] Cawson et al 2000 Child Maltreatment in the UK: A Study of the Prevalence of Child Abuse and Neglect. London: NSPCC.

Efforts are made to support children who have been abused to remain within their families, but sometimes this is not possible, or in the best interests of the child. Children looked after away from home are acknowledged as being particularly vulnerable. The PCT, together with the local authority, have appointed a designated nurse for looked after children, to coordinate the health needs of these children and young people.

The PCT is a member of the Area Child Protection Committee and will be working closely with partner agencies to make the transition to a Local Safeguarding Board as required by the Children Act[39] 2004.

Injury prevention

Much of the local injury prevention work is delivered by Avonsafe, our regional multi-agency injury prevention alliance. The Avonsafe co-ordinator post is hosted by South Gloucestershire PCT.

Avonsafe uses a multi-agency approach to raise the profile of childhood accidental injury. It does this through local and national safety campaigns, such as Child Safety Week, speed reduction initiatives and firework safety.

> *In 1844, Rev Patrick Bronte drew attention to the flammability of children's nightwear made of cotton or linen compared to those of wool or silk. He said that in 20 years at Howarth he had performed the funeral service on over 90-100 children and in every case the child had been clothed in cotton or linen. It was not until 100 years later that the work of Colebrook drew attention to the problem. The fireproofing of children's nightwear, the marked increase in the use of pyjamas, and the advent of central heating, has led to a significant reduction in the proportion of deaths from clothing fires compared to house fires.*[40]

In 2004/2005, the focus has been the promotion of the safe use and wise purchase of child safety equipment. The *Buy Wise – Be Safe* video and teaching pack has been promoted widely.[41]

Injury prevention can be costly. A community nurse grant enabled a safety equipment support scheme to be made available for Traveller families in South Gloucestershire. Under another scheme, health visitors are able to supply free safety gates and fireguards to vulnerable families, aiming to reduce inequalities in accidental injury.

The *Lifeskills – Learning for Living Centre* received 2536 Year 6 pupils from South Gloucestershire this year. *Lifeskills*, supported by the PCT, is increasingly being recognised as a centre of excellence for the delivery of safety education.

[39] Children Act 2004. Norwich: The Stationery Office.
[40] from Hugh Jackson OBE Founder of the Child Accident Prevention Trust.
[41] Produced by South West of England Regional Coordination of Trading Standards (SWERCOTS).

The evaluation of the Year 6 programme (2001-2003) has been disseminated at British and International conferences throughout the year.[42]

We will be participating in the *Choosing Health* project, led by RoSPA,[43] to establish an accreditation scheme for safety centres across England.

Road casualty reduction schemes in South Gloucestershire with a value of £300,000 have paid for themselves in accident savings within one year.[44]

Achievements include:

- a drop in casualties at the 54 camera sites in South Gloucestershire.
- a reduction in fatal and serious child casualties from 11 to 7.
- accidents involving drivers providing a positive breath test reduced from 38 to 32.[45]

Charter Outcome: *'Children and young people are supported by their parents and carers, and their peers.'*

Positive parenting

The promotion of secure attachments and positive parenting is an important part of the health visitor's role. In partnership with parents of children aged 0-5 years, family health needs assessments are carried out at critical times to determine positive and negative factors within child development, parenting capacity and the environment. These assessments enable early identification and effective intervention, and the provision of additional support for vulnerable children and families.

Structured home visiting has been shown to be an effective means of improving parenting skills. Parenting programmes such as *Webster-Stratton* can be particularly cost-effective for the promotion of positive parenting.[46] The effectiveness of these interventions depends on:

- the ability of the facilitator to develop a therapeutic relationship with parents[47]
- whether they also address factors, such as adult lifestyle and mental health problems, that negatively impact on the parent/child relationship.[48]

[42] Study completed by Oxford/Oxford Brookes Universities.
[43] The Royal Society for the Prevention of Accidents.
[44] Safer South Gloucestershire - Community Safety and Drugs Partnership 2005 A Strategy for the reduction of Crime, Disorder, Drugs and Alcohol misuse in South Gloucestershire 2005 - 2008. Safer South Gloucestershire.
[45] Safer South Gloucestershire - Community Safety and Drugs Partnership 2005 Annual Report 2005. Safer South Gloucestershire.
[46] Bidmead C and Whittaker S 2004 Positive parenting a public health priority. CPHVA. London
[47] Hall D, Elliman D 2003 Health for All Children 4th Edition. Oxford
[48] Faculty of Public Health 2005 Parenting and Public Health. A Policy Statement. London: Faculty of Public Health Medicine and Bidmead C and Whittaker S 2004 Positive parenting a public health priority. London: CPHVA.

The evidence supports the provision of universal parenting programmes, rather than only for 'high risk' groups. Drop-ins or mutual support groups may attract more parents as they are seen as less stigmatising.[49] To address different levels of need effectively, there should be flexibility, a balance of universal and targeted approaches, and a combination of individual and community interventions facilitated by skilled personnel.

A database of parenting courses and informal support groups has been set up and is accessible through the Children's Information Service at South Gloucestershire Council.

> ***Parenting course at Cadbury Heath***
>
> *This course enables small groups of parents to support each other in a relaxed informal atmosphere as they learn to use respectful communication skills with their children. It helps parents to learn skills, such as listening and giving encouragement, which they in turn can pass on to their children.*
>
> *'I feel less stressed and I feel that I can deal with my daughter easier.' (A parent)*

Supporting young parents

There are eight young mothers' groups in South Gloucestershire who, together, support over 150 mothers aged 14 to 25 years. Most of these groups are in the voluntary sector.

We provide support to the Umbrella Young Mums' Group, bringing all the groups together to develop new projects, share good practice, and provide support to workers and volunteers. Examples of activities and projects are:

- a three-day residential at Butlins Minehead for 19 young mums and their children, with three family learning sessions for the mums
- a feasibility study to explore the needs of young fathers in South Gloucestershire, and to find out more about how to reach them and support them as parents[50]
- a peer mentoring scheme to train young mums to befriend younger mums, with the aim of increasing the number of teenage mothers attending the groups.

[49] Faculty of Public Health 2005 see above and Fan A.P., Eaton W.W. 2001 Longitudinal study assessing the joint effects of socio-economic status and birth risks on adult emotional and nervous conditions. British Journal of Psychiatry 178 (40) 78-83

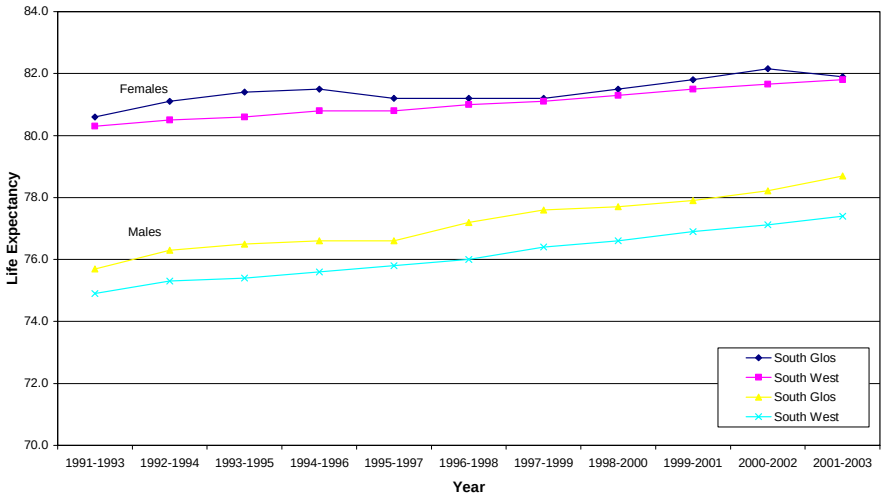
[50] Quinton D, Pollock S, et al 2004 The Transition to Fatherhood in Young Men Influences on Commitment. School for Policy Studies, Bristol University.

Section 2: The Health of the Population

In this section we review overall health trends and inequalities in South Gloucestershire.[51] People are generally healthier in South Gloucestershire than the national average and life expectancy has increased over the past ten years. Male life expectancy is considerably greater than in the South West as a whole.

Life expectancy

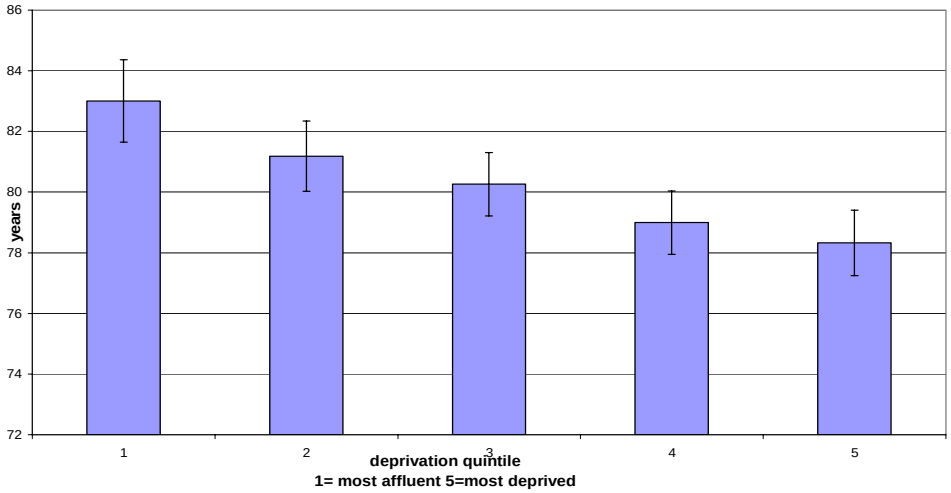
Figure 11: Life expectancy in South Gloucestershire 1991-93 to 2001-03



Source- Compendium of Clinical and Health indicators 2003

However, there are marked differences between areas - approximately 4.7 years between the most and least deprived areas.

Figure 12: Life expectancy at birth by deprivation quintile in South Gloucestershire (1999-2003)



Source: ONS Deaths, 2001 census, Income Domain of IMD 2004

[51] Data in this section relates to various years and ranges. For the sake of readability these have been included on the graphs only. More detailed information can be obtained from www.avon.nhs.uk/phnet/spotlight/south_gloucestershire.htm

Deprivation

South Gloucestershire is ranked 298 out of 354 local authorities in England for the average level of deprivation (354 is the *least* deprived authority).[52] However, this masks considerable variation and some small areas are relatively deprived, with worse health.

Figure 13: Deprivation in South Gloucestershire[53]

Ten most deprived wards:

Staple Hill

Kings Chase

Patchway

Woodstock

Filton

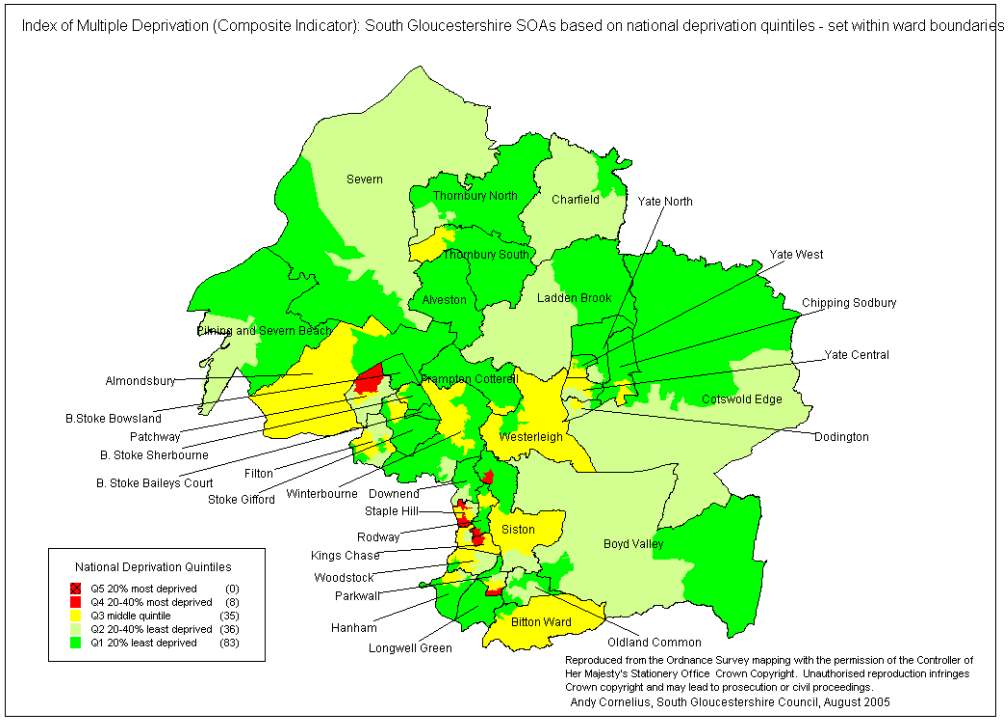
Parkwall

Yate Central

Almondsbury

Rodway

Dodington



Ten most deprived Super Output Areas:

Pendennis Road area (in Staple Hill Ward)

Coniston North area (in Patchway Ward)

New Cheltenham Road area (in Kings Chase Ward)

Coniston Bradley Road area (in Patchway Ward)

New Cheltenham - Lees Hill/Frys Hill/High View Road area (in Rodway Ward)

Beaufort Road area (in Siston Ward)

Upper Soundwell - Gladstone Street/Leicester square/Kingswood Leisure Centre area (in Staple Hill Ward)

North of California road/Orchard Boulevard/Long Handstones Road area (in Parkwall Ward)

Holy Trinity Church / Orchard Road / Cecil Road area (in Woodstock Ward)

Streamleaze / High Street area (in Thornbury South Ward.)

Source: South Gloucestershire Council

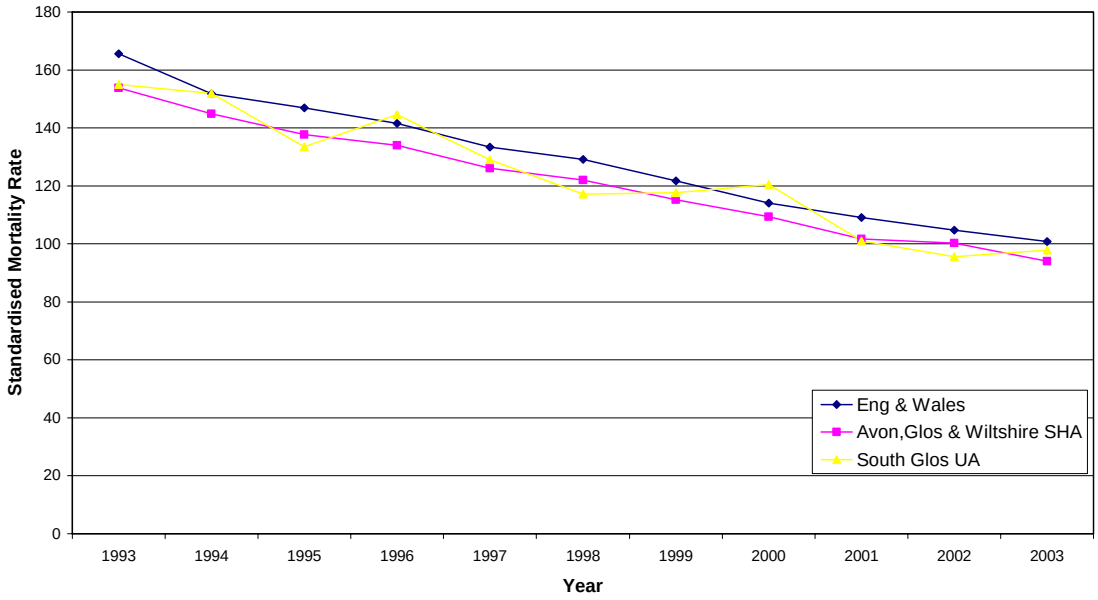
[52] Office of the Deputy Prime Minister. *Indices of Multiple Deprivation 2004. LA Summaries 2004 – Revised.* http://www.odpm.gov.uk/odpm/SOA/LASummaries 2004.xls

[53] see Glossary for Index of Multiple Deprivation

Circulatory disease

Circulatory diseases are the second main cause of premature death in adults under 75 years in South Gloucestershire. The mortality rate is significantly lower than the England and Wales average, but not significantly different to the South West regional average.

Figure 14: Trends in mortality from coronary heart disease (CHD) in South Gloucestershire (1993-2003)



Source- Compendium of Clinical and Health Indicators 2003

On average, 792 people in South Gloucestershire die of circulatory diseases every year. Of those, 28% are under the age of 75 years. Approximately half of all circulatory deaths are from coronary heart disease.

Cancer

Cancer is the most common cause of premature death in under 75s in South Gloucestershire. There is an average of 533 deaths a year with 51% before the age of 75. South Gloucestershire residents have significantly lower mortality rates from cancer than England and Wales, and the South West.

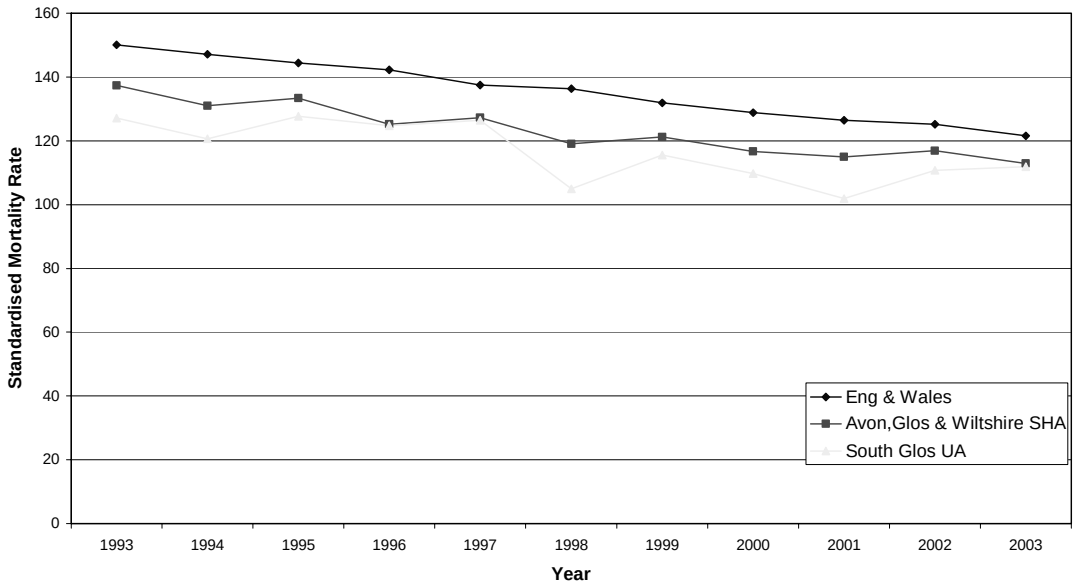
Each year, in South Gloucestershire, there are around 1000 new diagnoses of cancer. Breast, lung and colorectal (bowel) cancer account for almost 45% of all cases. There were an estimated 3105 people living with cancer during 2000 in South Gloucestershire, of which 51% were under the age of 65 years.

There are no wards which have a significantly higher mortality rate than the Avon average for ages 65 and under. Of the common cancers, lung cancer is highly associated with deprivation, mainly because smoking is higher in deprived areas.

Over the last ten years, the age standardised mortality rate for all cancers in the under 75s in South Gloucestershire has shown considerable fluctuation, but has

fallen in line broadly with the national average. A decrease in smoking rates, improved diet and new cancer therapies are likely to have contributed to this.

Figure 15: Trends in mortality from all cancers in South Gloucestershire in under 75s 1993-2003

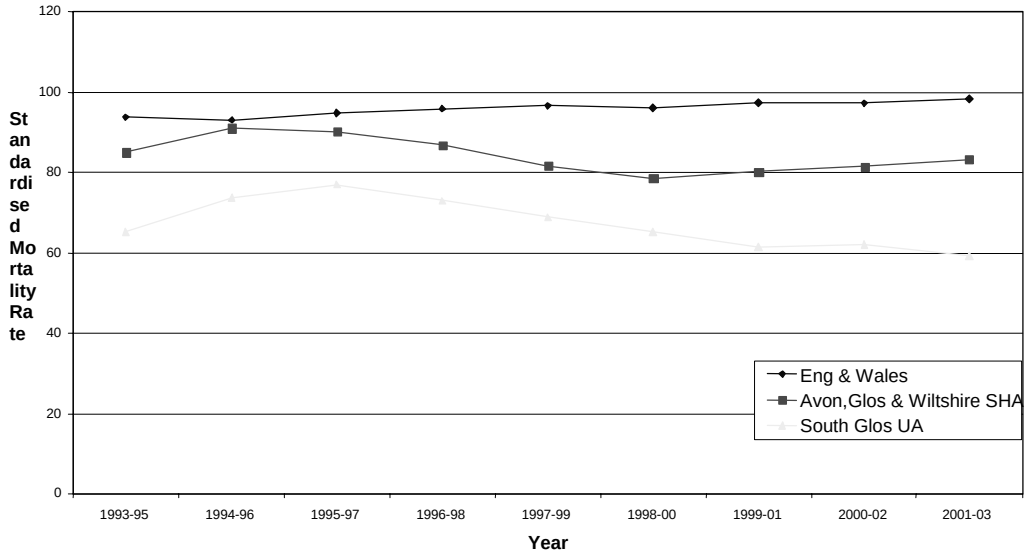


Source- Compendium of Clinical and Health Indicators 2003

Accidental deaths

There are approximately 29 accidental deaths a year in South Gloucestershire.

Figure 16: Trends in mortality from accidents in South Gloucestershire (3 year rolling rates) 1993-2003



Source- Compendium of Clinical and Health Indicators 2003

The Directly Standardised Rate for South Gloucestershire is significantly lower than for England and Wales.

In the UK:

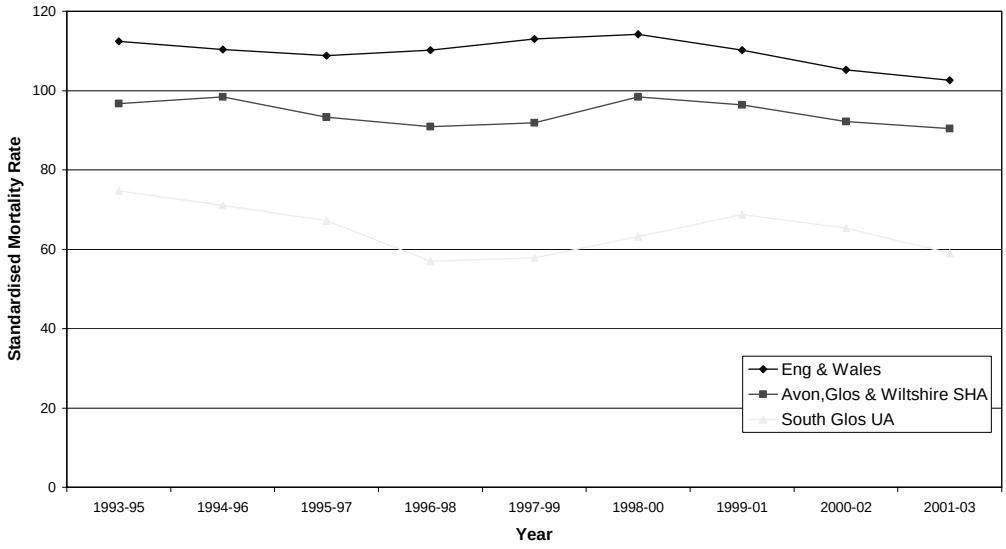
- approximately two thirds of deaths due to accidents happen to men
- falls are the main cause of accidental death in older people
- road traffic accidents cause 50% of deaths in the under 24s
- children in poorer households are at a greatly increased risk of injury or death from accidents. Accidents are the single largest cause of death in young people in the UK (see Section 1).

There has been a continuing slight decline in accidental death rates in South Gloucestershire, in contrast to a slight overall increase in Avon, Gloucestershire and Wiltshire (AGW), and England and Wales.

Suicide

Approximately 15 people die each year in South Gloucestershire as a result of suicide. Taken together with self-inflicted injury, or self harm, it is a significant cause of disability and death. The death rate is much lower than in England and Wales, or AGW. It appears to be gradually declining, although the small numbers can make trends unreliable.

Figure 17: Trends in mortality from suicides and undetermined injury in South Gloucestershire (three year rolling rates 1993-2003)



Source- Compendium of Clinical and Health Indicators 2003

Section 3: Improving Health and Reducing Inequalities

Local Action

In the 2003 Director of Public Health's annual report we set out a local framework for improving health and reducing inequalities. It proposed that in order to have greatest impact we should focus on:

- health problems that are common and serious, in particular, cardiovascular disease, cancer and accidental injuries
- those groups with the most to gain, that is, the most deprived communities (including people in prison and minority ethnic groups such as Travellers) and low income groups, children and young people
- activities that have been shown to be effective and make a difference, for example, reducing smoking, increasing physical activity, increasing consumption of fresh fruit and vegetables
- supporting efforts that help communities and individuals tackle basic needs, such as those created by poverty, unemployment and fear of crime, as a stepping stone toward a healthier lifestyle.

The local *Better Health Partnership* brings together senior representatives from the local authority, the PCT and the voluntary sector to oversee the development of strategies and a programme of work to achieve improved health. This section includes an update on the strands of work that support these aims.

The past 12 months have seen important national developments that hold promise for substantially improving local health.

These include:

- progress in implementing the national *Change for Children* agenda, including the appointment of a local authority children's director, and much closer working between agencies, leading to a shared children and young people's plan
- the publication of the public health White Paper *Choosing Health*, with additional funding and key targets for health improvement
- a proposal to introduce legislation to ban smoking in enclosed workplaces, including pubs, restaurants and other public venues
- the piloting of local area agreements, which will be overseen by the Local Strategic Partnership. These will provide a flexible way of using different mainstream funding streams to achieve agreed outcomes, including improved health or health services. South Gloucestershire has agreed to be a pilot site for the next round.

Choosing Health and new opportunities

The Government White Paper *Choosing Health*[54] sets out the following priorities:

- reducing the number of people who smoke
- reducing obesity, with a particular focus on children
- increasing physical activity
- supporting sensible drinking
- improving sexual health
- improving mental health and wellbeing.

The extra funding available means that we will be able to expand our current work. In particular, over the next three years, we need to:

- increase public health capacity, including specialist skills for analysing public health information, so that health interventions are better targeted and evaluated
- improve sexual health services, including introducing a chlamydia screening programme
- help more people stop smoking
- help more mothers to breast feed
- help people become more physically active and to adopt healthier diets
- recruit and train the new NHS accredited 'health trainers' who will offer health advice and encourage the adoption of healthy lifestyles
- tackle the prevention and treatment of childhood obesity.

Last year's report included a summary of three local strategies that have been developed to improve diet, reduce tobacco consumption and increase physical activity.[55] This year we focus on an update on action to address smoking.

The Impact of Smoking

The *Choosing Health* White Paper highlights the need to reduce the prevalence of smoking in the population, with a particular focus on routine and manual groups, in addition to reducing the percentage of women who smoke during pregnancy. The set targets are to:

- reduce adult smoking rates from 26% in 2002 to 21% or less by 2010
- reduce prevalence among routine and manual groups from 31% in 2002 to 26% or less by 2010
- deliver a 1% point reduction per year in the proportion of women continuing to smoke throughout pregnancy, focusing especially on smokers from disadvantaged groups.

Smoke-free workplaces

Choosing Health states that by 2006 all Government departments and the NHS will (subject to limited exceptions) be smoke free. The Government will consult on detailed proposals for regulation, with legislation where necessary, so that by

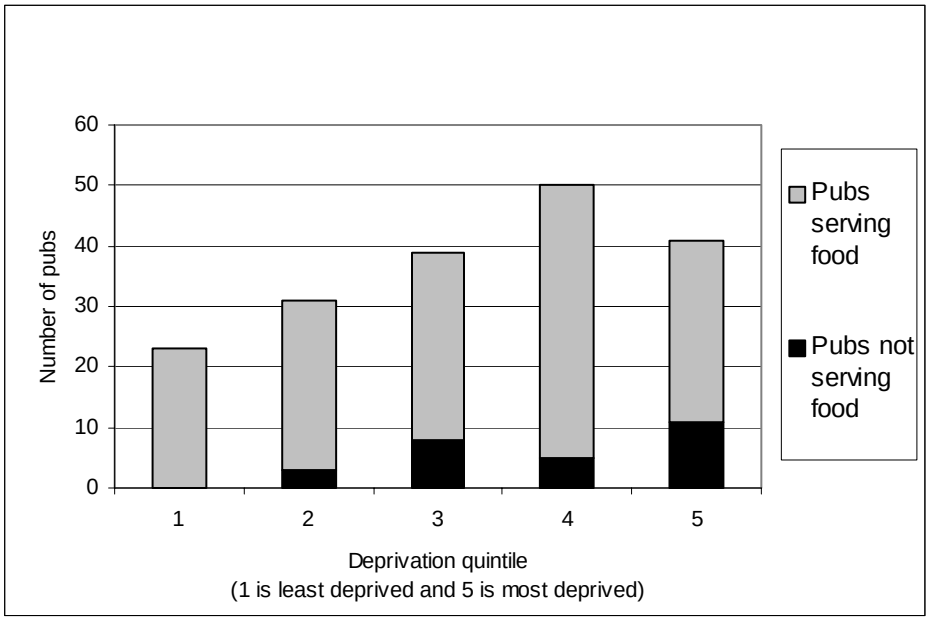
[54] Department of Health 2004 *Choosing Health – making healthy choices easier.* London: Department of Health.
[55] see at www.sglos-pct.nhs.uk

the end of 2008, all enclosed public places and workplaces (except those specifically exempted) will be smoke-free.

The proposed legislation will allow 'wet' pubs, (those which do not serve food), to continue to allow smoking. The Government estimates this will apply to 10-30% of pubs nationwide. This means the smokiest pubs, inevitably situated in areas of the highest health need, will remain unaffected, putting staff and customers at increased risk from second hand smoke and depriving the most disadvantaged of an incentive to quit.

A recent mapping survey of local pubs found 41% of South Gloucestershire's 'wet' pubs are located in the most deprived quintile.

Figure 18: Number of pubs in South Gloucestershire, by deprivation quintile, serving food and not serving food



Source: South Gloucestershire Council Survey of Pubs

Support to Stop

To help reduce the prevalence of smokers in South Gloucestershire to 21% by 2010, targets have been set at:

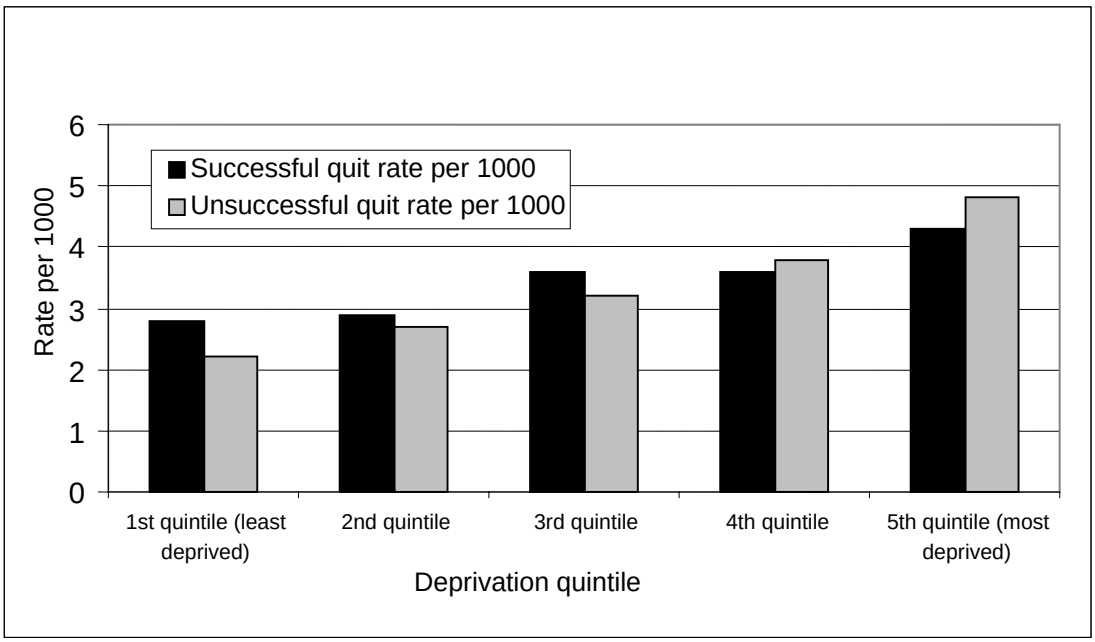
- 3,076 successfully quitting in the three years from April 2003 to March 2006 and 2,406 in the following two years.

Helping an individual to stop smoking is one of the most cost effective interventions available to the health service. In South Gloucestershire PCT, *Support to Stop* services are provided in all GP practices, community groups, workplaces, prisons and homes. To date, 2,250 smokers have succeeded in quitting and we are on track to reach the 2003-2006 target of 3,076 quitters.

Access to the *Support to Stop* service has been audited, to check that it is not increasing inequalities. The audit showed the number and rate of smokers accessing the service increases with deprivation. The number of smokers quitting is 59% higher in the most deprived quintile compared to the least. There

is a wide variation in quit rates by GP practice, ranging from 37% to 81%. These figures provide some reassurance that the service is reaching the groups that need it most, but further data collection is proposed to ensure that the service is sufficiently targeted to help reduce inequalities.

Figure 19: Smoking quit rates per 1000 total population by deprivation quintile



Source: *Support to Stop*

During the year, a further 46 people trained as *Support to Stop* advisors. In partnership with the Bristol Smoking Advice Service, we organised the second *Building on Success* conference and 120 participants attended. The profile of the service was raised with *Wake to No Smoking Day* on 9th March. The Mall, Yate Shopping Centre, pubs, GP surgeries and many more venues offered information.

As employers, the local authority and the PCT have developed a policy on smoking in the workplace. This includes support for staff who want to quit. The *Easy Breathing* award was achieved by 353 local businesses. This promotes smoke-free policies in public and work places. We have provided training for prison staff to help Ashfield Young Offenders Institute to go smoke-free.

During 2005/6 we plan to:

- use 'locally enhanced service' funding to support additional primary care activity to encourage practices in more deprived areas, with low uptake, to increase their activity
- support the development of smoking cessation services in poorer communities and in novel settings such as pharmacies
- conduct a computer audit to help understand the differences in smoking prevalence across South Gloucestershire and between GP practices.

Support to Stop in South Gloucestershire has been greatly helped by Ray Hogarth who became a non-smoker through attending a community-based course in February 2004.

After smoking for over 40 years and several unsuccessful attempts to give up, Ray has been so pleased to be finally free from the habit that he has been visiting Support to Stop courses to encourage others who are in the process of quitting.

Telling his story has been a great inspiration and motivation for others especially as he has been feeling so much more energetic and has since started Salsa dancing.

Focusing on Local Health Needs

Health needs assessment

Over the past year the PCT has worked closely with the local authority to develop a way of predicting the health problems and priorities for each area. Classic public health data relies heavily on death and survey information. The problem with such sources is that for small areas (ward level and below) the actual numbers may be small, making it difficult to interpret the figures.

Another approach is to use the reliable link between deprivation and illness, combined with the age profile of the population, to predict the illness in any given area. Figure 13 in Section 2 shows the South Gloucestershire area mapped in terms of levels of deprivation.

We can classify the 35 wards in South Gloucestershire into nine cells, depending on the level of deprivation (using the Index of Multiple Deprivation[56]) and age structure (see Figure 20). Cell 1 has the lowest deprivation and lowest proportion of over 65s, and cell 9 has the highest.

For each of the nine cells a summary of health needs has been written to form the basis of a local health needs assessment (see Figure 21). The summaries include the predicted incidence, compared to the PCT average, of coronary heart disease/stroke, cancer, chronic bronchitis and other chronic obstructive pulmonary disease (COPD), mental health, falls in the elderly, obesity/diabetes and sexually transmitted infections (STIs). The likely lifestyle, or health promotion issues, including smoking, obesity, eating fruit and vegetables, breast feeding and support to young families are also given.

[56] see Glossary

Figure 20: Wards in South Gloucestershire by deprivation and percentage of population aged 65+

Increasing deprivation →

increasing age ↓

1 Bradley Stoke Baileys Court Bradley Stoke Bowsland	2 Dodington Yate West Bradley Stoke Sherbourne Stoke Gifford Charfield Oldland Common Yate North	3
4 Ladden Brook Longwell Green Thornbury North	5 Siston Parkwall Chipping Sodbury Cotswold Edge Yate Central Frampton Cotterell Bitton Boyd Valley Severn Pilning and Severn Beach Rodway Thornbury South Woodstock	6 Patchway
7 Downend	8 Westerleigh Winterbourne Almondsbury Alveston Filton Hanham	9 Kings Chase Staple Hill

The summaries of health needs (see Figure 21) can be used to:

- spot geographical areas with likely high health needs or to check out 'on the ground' impressions
- form the basis of a local health needs assessment, strengthened by local knowledge of problems and priorities
- prioritise health promotion on certain topics, or with particular groups
- prioritise what services are commissioned
- shape the skill mix of teams e.g. more emphasis on children and young families, or on older people etc
- target resources at high health need areas.

Although the summary shows whole wards, a similar table can be produced for much smaller Super Output Areas. This is useful in highlighting pockets of high health need in otherwise unremarkable areas.

Figure 21: Example of a health summary

Box 9: Areas with highest deprivation and highest % population aged 65+

Whole wards	**Locality**
Staple Hill Kings Chase	Kingswood
Individual Super Output Areas	**Locality**
• Upper Soundwell - Gladstone Street / Leicester Square / Kingswood Leisure Centre area • South of Coronation Park - Newton Road / Parkwall primary school area • North of California Road / Orchard Boulevard / Long Handstones Road area • Beaufort Road area • Pendennis Road area	Kingswood
• Streamleaze / High Street area • Conygre Grove / Bude Road / Holmdale Road area • Filton Roundabout / Charborough Road area	Severnvale
• High Street / Flaxpits Lane / Beacon Lane and surrounding rural area	Yate

Diseases

Disease	**Predicted incidence compared to the PCT average**
Coronary Heart Disease / Stroke	Higher incidence linked to deprivation and older population
Cancer	Higher incidence of all major cancers linked to older population. Higher incidence of lung cancer linked to deprivation.
COPD	Higher incidence linked to deprivation and older population
Mental health	Higher incidence linked to deprivation, possible issues of isolation and mental health for carers.
Falls in the elderly	Higher incidence linked to older population
Obesity/diabetes	Higher incidence linked to deprivation and older population
Sexual health	Higher incidence of STIs and teenage pregnancy linked to deprivation

Lifestyle/health promotion priorities

Health promotion priorities are less affected by the age structure, although the workload relating to health promotion will differ according to the size of the client group. *Increasing physical activity is a priority for the whole population.*

Lifestyle/health promotion priority	**Likely rate compared to the PCT average**	**Relative level of need for health promotion**
Smoking	Higher rate all ages	High
Obesity	Higher rate all ages	High
Eating fruit and vegetables	Lower consumption all ages	High
Breast feeding	Lower rates	High
Support to young families, including injury prevention	Higher need	High

Section 4: Health Protection

Infectious diseases have been always been a threat to people's survival, health and wellbeing. New infections can arise at any time, as shown by the devastation caused by human immunodeficiency virus (HIV), or more recently severe acute respiratory syndrome (SARS).

Over the past two years the threat of an influenza pandemic has increased significantly, and, with the speed and extent of modern international travel, the disease could spread much faster than in the past. Therefore, careful preparation is now underway to ensure that there is a local mechanism to provide antiviral therapy and mass vaccination should the need arise. This is based on the Chief Medical Officer's pandemic flu plan launched in March 2005.[57]

In order to quickly detect outbreaks and epidemics, a notification system has been in place since the end of the 19th Century. The list of diseases included in this now stands at around 30, in all. The data is very useful for spotting changes.

Figure 22: Selected notifiable infectious diseases in South Gloucestershire 1999-2004

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

Source: Avon Health Protection Team

[57] Department of Health 2005 Explaining pandemic flu: A guide from the Chief Medical Officer. London: Department of Health.

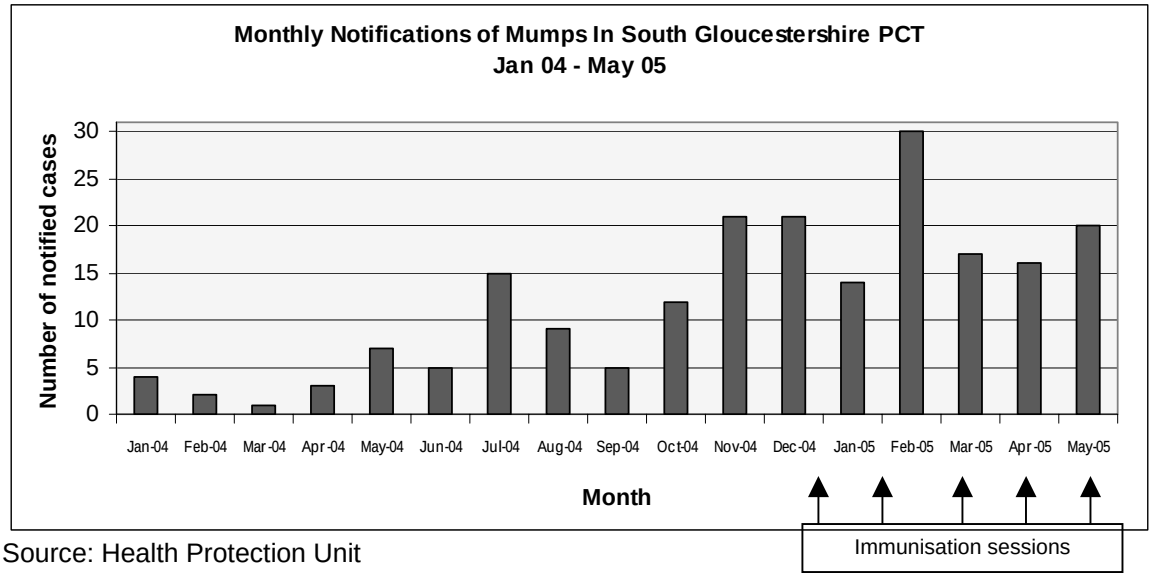
Mumps

Mumps is caused by a virus infection. Symptoms begin with a headache and fever before a characteristic swelling of the salivary glands by the jaw. Although rarely fatal, complications of mumps can include inflammation of a number of organs including the testicle (which can cause sterility) and deafness.

There has been a marked increase in mumps infections over the past year, reflecting a national pattern. Many of the cases have occurred in adolescents and young adults who missed out on the measles, mumps, rubella (MMR) vaccine, introduced into the national childhood immunisation schedule in 1988.

South Gloucestershire PCT, in conjunction with the Bristol PCTs, launched a vaccination campaign from November 2004 to March 2005 aimed at secondary school children and young adults. Altogether 6,383 doses of vaccine were given in schools, general practice and higher and further education. It is likely that the outbreak was modified as a result of this campaign.

Figure 23: Monthly notifications of mumps in South Gloucestershire PCT January 2004 – May 2005



Source: Health Protection Unit

Tuberculosis

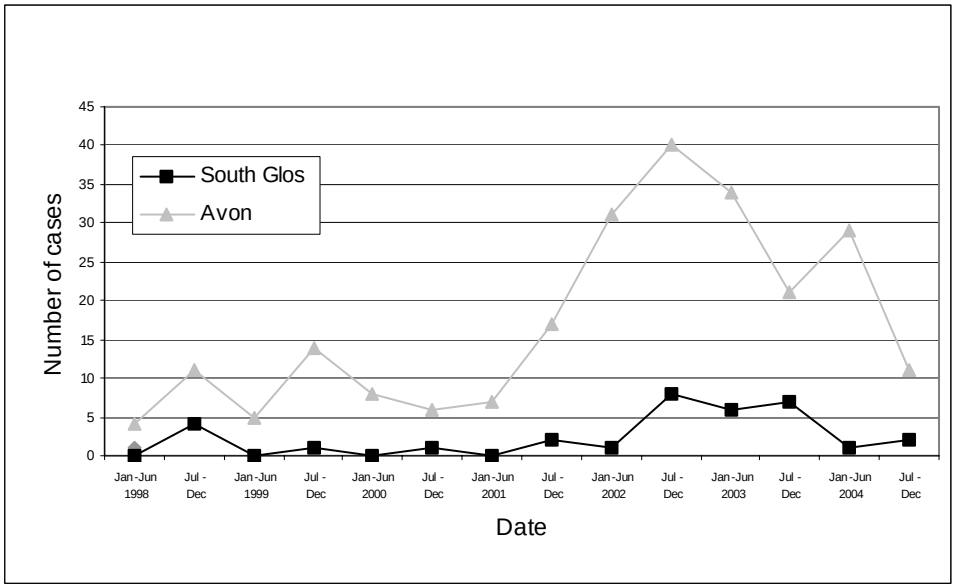
Tuberculosis in England increased by 25 per cent over the last ten years and is still rising. This has occurred primarily in inner cities and, so far, South Gloucestershire has not seen the same rise. Following the release of the national tuberculosis action plan[58] the PCT is working with the local Health Protection Agency to produce an action plan to ensure vulnerable patient groups are appropriately screened and treated.

[58] Department of Health 2004 Stopping tuberculosis in England: An Action Plan from the Chief Medical Officer: London: Department of Health, London.

Hepatitis B

Last year's report described an outbreak of hepatitis B across Avon, evolving since mid 2001 and the multi-pronged approach taken to tackle it. There is now good evidence that the incidence of disease is reducing.

Figure 24: Hepatitis B cases in Avon and South Gloucestershire PCT 1998-2004



Source: Health Protection Unit

Sexually Transmitted Infections (STIs)

Between 1991 and 2001, the number of new episodes of sexually transmitted infections (STIs) seen in genitourinary medicine (GUM) clinics in England, Wales and Northern Ireland doubled from 669,291 to 1,332,910.[59] Young people, in particular females under the age of 20 years, bear the burden of sexually transmitted infections.

The demographics of South Gloucestershire are similar to those of Britain as a whole, with fewer people in the 16-30 years age group (16% versus 17.5%). However, there are still problems with STI incidence, in particular chlamydia, gonorrhoea and genital warts. Figures for the Bristol, North Somerset, South Gloucestershire group (BNSSG) as a whole, suggest a rise in the prevalence of chlamydia and gonorrhoea over the last ten years. This is shown in Figure 25, although this only shows the number of cases diagnosed in the Milne Clinic in Bristol. The apparent reduction in number of cases of gonorrhoea is likely to reflect the trend for this to be diagnosed and treated in the community.

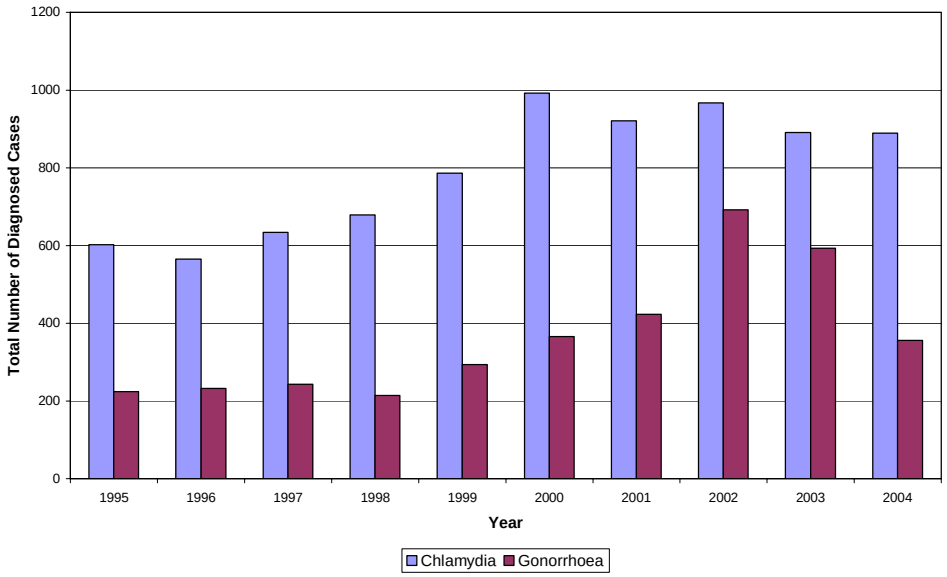
The recent release of the public health White Paper: *The Sexual Health and HIV Strategy*[60] provides impetus to address the rising problem of sexually transmitted infections amongst young people. Collaborative working has been initiated with the University of Bristol and the Health Protection Agency to identify and quantify

[59] Office for National Statistics. The Health of Children and Young People 1990-2001 http://www.statistics.gov.uk/children/

[60] Department of Health 2002 Sexual Health and HIV Strategy. London: Department of Health.

infection related illnesses and deaths. *Choosing Health* has reaffirmed a national commitment to improving sexual health.

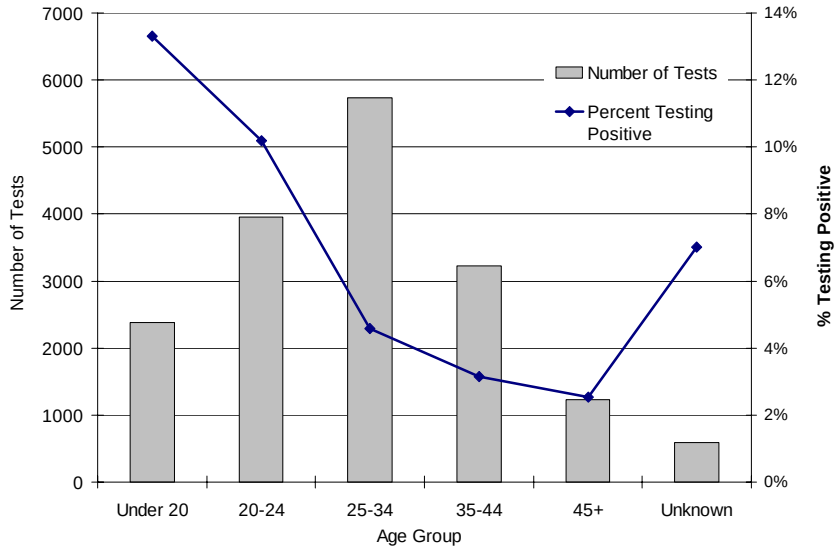
Figure 25: Diagnosed cases of chlamydia and gonorrhoea at the Milne Centre 1995-2004



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

Chlamydia is the most commonly diagnosed sexually transmitted infection. It is asymptomatic in 70% of women and 50% of men and can cause pelvic inflammatory disease and infertility in women. The highest rate of tests are carried out in the 25-35 year old age group, although the most likely positive tests are those of females 16-19 years old and males 20-24 years. The need for higher rates of testing in younger age groups will be the focus of the new national screening programme for chlamydia to be introduced in 2006.

Figure 26: Total GP practice chlamydia testing by age group 2002



Source: Avon System for Surveillance of STI (ASSIST), 2002

Human Immunodeficiency Virus (HIV)

HIV continues to be one of the most important communicable diseases in the UK. It is an infection associated with serious morbidity, high costs of treatment and care, significant mortality and high numbers of potential years of life lost. The infection is still frequently regarded as stigmatising and has a prolonged 'silent' period during which it often remains undiagnosed.

Highly active antiretroviral therapies have resulted in substantial reductions in AIDS (the fully developed disease) incidence and deaths in the UK. However, these therapies can only be offered to those that are aware of their diagnosis. Therefore it is important to increase the offer of testing for HIV, so ensuring earlier access to treatment and limiting further transmission of the virus.

Healthcare associated infections

There has been considerable professional, political and media interest in the challenge of healthcare associated infections (HCAI). This is reflected in a Government target to reduce the number of MRSA (methicillin resistant *Staphyloccocal aureus*) blood borne infections. Although MRSA captures the headlines, this is only one particular type of infection. Others such as *Clostridium Difficile,* and less serious infections, are responsible for a high burden of illness and occasional deaths.

The number of cases and rates of blood borne MRSA infections during April 2004 to March 2005 at the two local NHS trusts in Bristol are shown in Figure 27.[61] The data should be interpreted with caution as MRSA rates tend to be highest in specialist trusts. This is because these trusts have more vulnerable patients and undertake more invasive and high risk specialist care. Also, the MRSA bacteraemias reported by an acute trust may not necessarily have been acquired in that trust.

Figure 27: Numbers and rates of MRSA bacteraemia cases at local hospitals

NHS Trust	April - Sept 2004		Oct 2004-March 2005	
	Number of cases	Rate per 10,000 bed days	Number of cases	Rate per 10,000 bed days
North Bristol NHS Trust	32	1.3	60	2.5
United Bristol Healthcare NHS Trust	31	1.8	24	1.4

The PCT has an important role to play in decreasing the risk of HCAIs. In particular, scrupulous hand washing and other techniques are important for community nursing staff. The PCT has a control of infection committee with membership from Bristol North PCT and North Bristol NHS Trust. A PCT control of infection nurse supports the group and has a work programme which includes training staff and auditing everyday practice.

[61] Department of Health 2005 Mandatory Bacteraemia Surveillance Scheme – MRSA Bacteraemia by NHS Trust. http://www.dh.gov.uk/assetRoot/04/11/40/14/04114014.pdf

Closing remarks and recommendations

In this annual public health report I have chosen to focus on the health of children and young people in South Gloucestershire. I have highlighted the changing nature of children and young people's health needs and shown how the action needed to improve health is linked to the local children and young people's plan.

I would particularly recommend that action to improve health in children and young people is focused on:

- increasing levels of physical activity
- improving diet, particularly increasing fruit and vegetable consumption
- reducing accidental injuries
- supporting young families including help with parenting skills
- strengthening communities, improving life chances through education and reducing poverty
- support for young people to resist unhealthy behaviours such as smoking and drugs
- coordinating services to children and families, particularly those that are vulnerable or have complex needs.

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

Glossary

AGW	Avon, Gloucestershire and Wiltshire
Body Mass Index (BMI)	BMI is weight in kilograms divided by height multiplied by height in metres.
DfES	Department for Education and Skills
DH	Department of Health
DTP	Diptheria, tetanus and pertussis (whooping cough)
GUM	Genitourinary medicine
HCAI	Healthcare associated infections
Index of Multiple Deprivation (IMD)	The IMD contains seven domains of deprivation to create a score for the area: income, employment, health and disability, education, skills and training, barriers to housing and services, living environment deprivation and crime.
MenC	Meningococcal C immunisation
MMR	Measles, mumps and rubella
MRSA	Methicillin resistant *Staphyloccocal aureus*
NHSS	National Healthy School Standard
PCT	Primary care trust
PSHE	Personal, social and health education
RoSPA	The Royal Society for the Prevention of Accidents
STIs	Sexually transmitted infections
Super output area	Super output areas refer to sub-divisions of electoral wards, identified in order to examine variations within wards. They have an average population of 1,500.

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