our area
our health

Annual report of the Director of Public Health 2004

South Gloucestershire NHS
Primary Care Trust

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Introduction

This is my second annual public health report for South Gloucestershire. Last year, I highlighted the strong link in our area between deprivation (low income and poverty) and poorer health. That first report focussed on the 'big killers' and outlined a strategy for improving health across the board, and for reducing inequalities.

Although this report includes a brief update on the major diseases, (see Appendices A and B), I have chosen this year, to focus on the health problems that cause major suffering and disability. These problems may not cause early death, but can greatly affect our *quality* of life. Typically they may only rarely take people to hospital: most of the management and coping with illness falls on individuals, their carers, GPs and community services. As much of the suffering is 'invisible', these problems may receive less attention from those who plan and pay for health services.

Last year's report described the links between health and the wider social conditions we live in. This report describes the progress made on tackling these 'wider determinants of health' - with our partners, such as the local authority, businesses, voluntary and community groups. The health service, particularly primary care, also has an important role in promoting health and preventing illness and this forms another key theme of this report. This is an area that has expanded greatly over the past ten years and is set to expand further, both in the traditional 'consultation' setting, as well as in wider community teams that are developing around the needs of children and older people.

These are exciting times for public health. In 2002, an evidence-based assessment of the long term resource requirements for the NHS, was produced by Derek Wanless, (ex-Group Chief Executive of NatWest). This highlighted the potential for good public health to reduce the financial demands on the health service. The government commissioned him to do further work on this and *'Securing Good Health for the Whole Population'* appeared in February 2004.

At the same time *Choosing Health?* a national consultation on action to improve people's health was launched. The launch coincided with Ireland's successful ban on smoking in public places and gives fresh impetus to the need for the UK to follow suit in implementing a measure that would have substantial and immediate health benefits.

More detailed information about local health is available at our public health web site http://www.avon.nhs.uk/phnet/spotlight/south_gloucestershire.htm

Dr Chris Payne
Director of Public Health South Gloucestershire PCT

Section 1: The Health of the Population of South Gloucestershire

Key messages

- *Health in South Gloucestershire is better than the national average but there are still marked inequalities in health.*
- *There are striking differences in age structure across the area with the poorer areas also having an older population and greater health needs.*
- *Looking at the burden of disease presents a picture of health need that is different from that which we see if we just consider the 'big killers'. These health needs include problems caused by mental illness, alcohol, dementia, chronic obstructive pulmonary disease (COPD), suicide and self-harm, and the need to support carers. Many of these 'burden' areas are unglamorous and have received relatively little recent local NHS investment.*
- *Making decisions on NHS investment in these areas will include considering the evidence of effectiveness and the role of partner agencies in providing care.*

Demographic Data

The resident population of South Gloucestershire, as measured in the 2001 Census[1], was 245,641, of which 49 per cent were male and 51 per cent were female. The population is projected to rise to 290,000 by the year 2021 and is the fastest growing in the South West.

Overall, the average age is slightly less than throughout England and Wales, with more 30-59 year olds and slightly more under 16 year olds.

Figure 1: Age structure of South Gloucestershire population

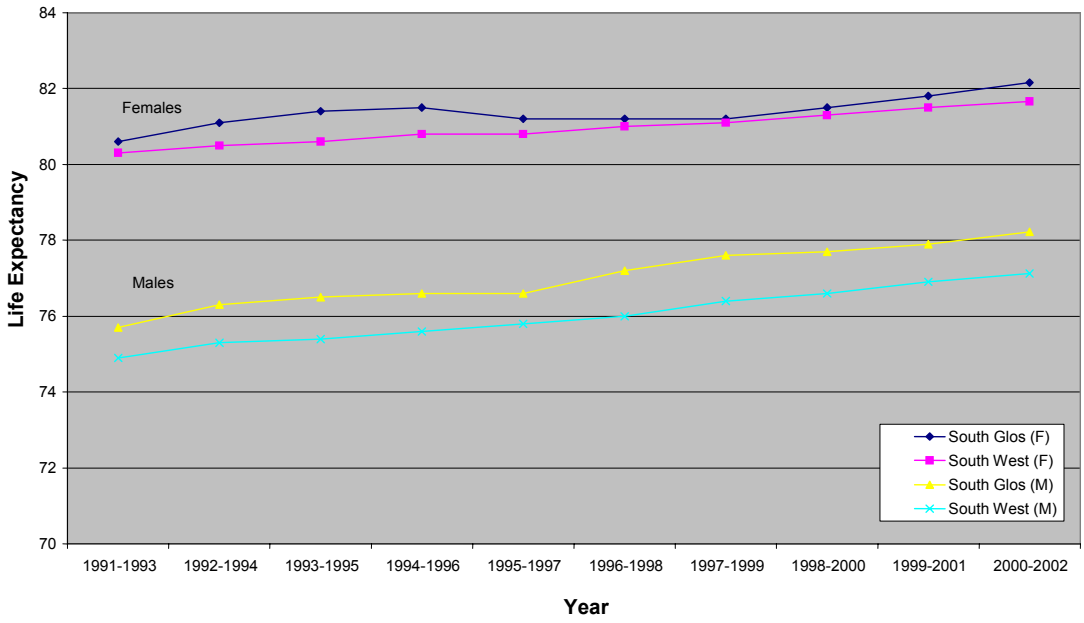
Age	South Gloucestershire %	England and Wales %
Under 16	20.8	20.2
16 to 19	4.6	4.9
20 to 29	11.4	12.6
30 to 59	43.9	41.5
60 to 74	13.0	13.3
75 and over	6.3	7.6
Average age	38.1	38.6

Source: 2001 Census

Life expectancy in South Gloucestershire continues to increase and is greater than that for the South West as a whole for both males and females.

[1] see 2001 Census at www.statistics.gov.uk for all data in this section

Figure 2: Life expectancy in South Gloucestershire 1991-2002



Source: 2001 Census

Health

In the 2001 Census, 72.4% of residents of South Gloucestershire described their health as 'good' over the preceding 12 months, compared with 68.6% for England and Wales as a whole.

Economic activity

South Gloucestershire has relatively low rates of unemployment, low percentages of people who are economically inactive and people who are permanently sick or disabled.

Housing and households

There were 99,038 households in South Gloucestershire in 2001. 82.1% were owner occupied compared with the England and Wales average of 68.9%.

The area includes relatively longstanding, stable communities on the outskirts of Bristol, surrounding market towns, and rural areas. Superimposed on these has been the rapid development of new housing, initially in the Yate area, but more recently around Bradley Stoke and other areas close to the new ring road.

Inequalities in health

Despite having good health overall in South Gloucestershire we have the same types of differences, or inequalities in health, as the rest of the UK[2]. Last year's report highlighted that residents in the poorest areas of South Gloucestershire are three times more likely to die of lung cancer and twice as likely to die before the age of 14 years, than those in the better off areas.

[2] Our Area Our health. Annual Report of the Director of Public Health 2003

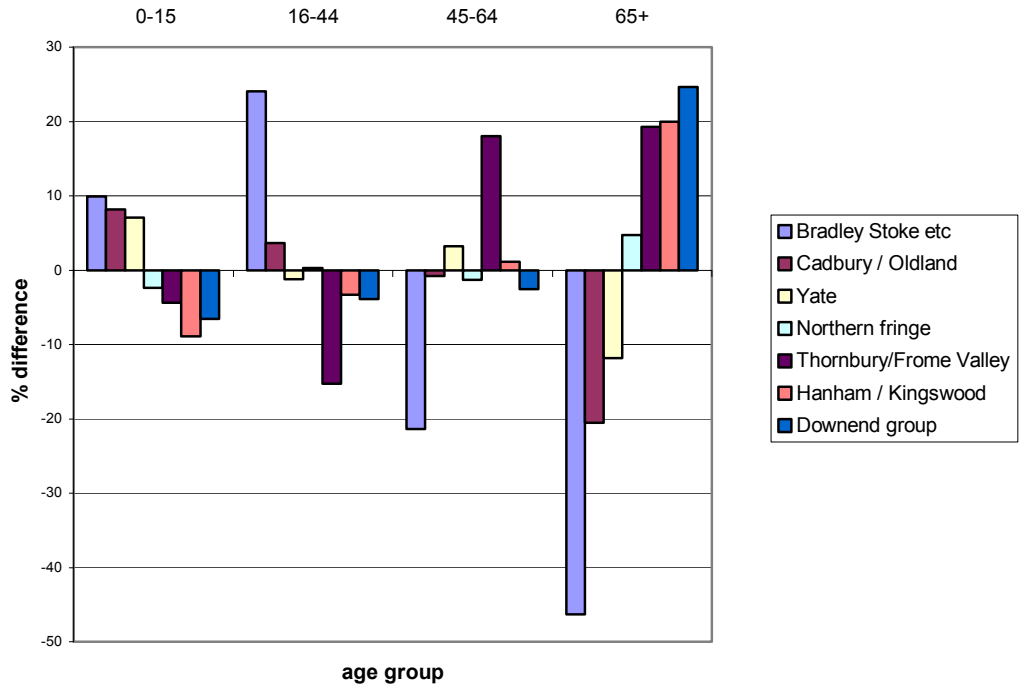
The Challenge for South Gloucestershire

Most local health care is delivered through GP practices and associated teams (for example, health visitors and district nurses). The skills and resources in teams should match the health care needs of the local population.

Recent analysis by the South Gloucestershire Primary Care Trust (PCT) of the profile of residents in each practice list, shows that the population age structure and levels of deprivation - and therefore the health care needs - vary markedly across South Gloucestershire.

In the following two figures, the populations of local practices are grouped together into 'natural communities.' The size of particular age groups in each of these 'communities' is then compared with the South Gloucestershire average. The results reveal a marked variation in age structure.

Figure 3: Age structure of practice groupings compared to the PCT average

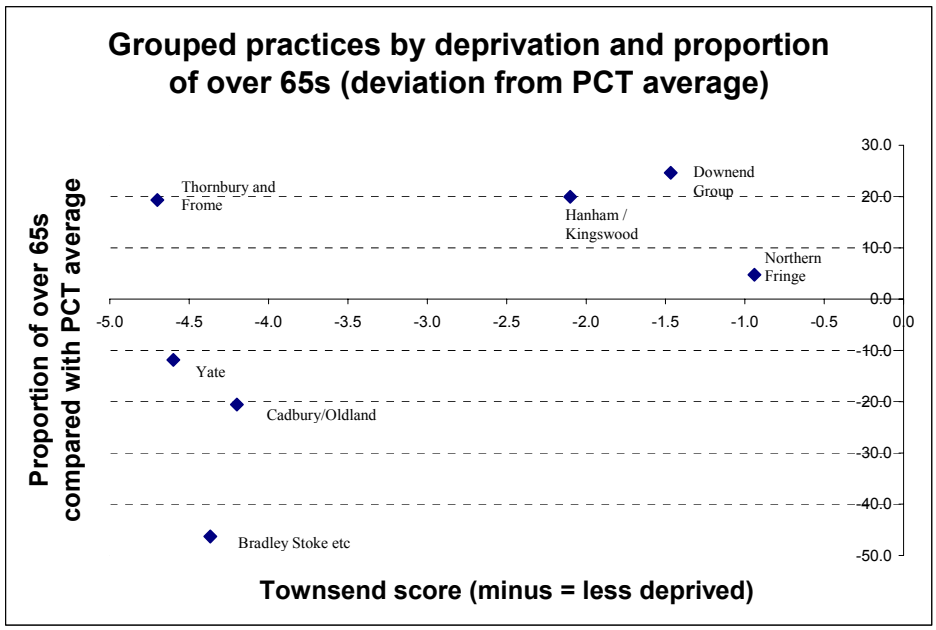


Source: South Gloucestershire PCT

For individual practices the differences are even more extreme, for example, a Bradley Stoke practice has 77% less elderly people than the average: a practice in Downend has 48% more.

Localities that have much higher proportions of elderly patients, (except Thornbury / Frome Valley), are *also* areas that are more deprived, and therefore have a higher burden of disease. This creates a particular challenge for primary care in providing high quality health care in these areas.

Figure 4: Deprivation and the proportion of over 65s in practice groupings



Source: South Gloucestershire PCT

The Burden of Chronic Disease

There is a certain irony that the best quality information about health comes from death certificates. Mortality data provides useful information about how long we live and what we die from, but very little about the effects of health problems on the quality of our lives. Some health problems reduce quality of life substantially, but are not fatal, for example, arthritis and painful joints. Any snapshot of health that relies entirely on mortality data does not give due recognition to these chronic (long lasting) conditions.

From a public health perspective it would be extremely useful to know which illnesses have the biggest impact on the local population - either on quality of life, or premature death, or both. We could then compare the 'burden of disease' from, say, heart disease, with that from depression, and we could focus our efforts on the problems that create the biggest burden.

However, these are difficult comparisons to make. How do you compare, for example, the distress caused by becoming blind with the pain and restriction of mobility caused by severe arthritis, or with the disabling effect of severe depression? And how do you compare any of these with death? Attempts have been made to translate these different types of health problems into something comparable. Most techniques rely on asking a panel to judge the quality of life of being in a particular condition on a scale from zero (as bad as being dead) to one (perfect health).

For example, one way of deriving this rating is to ask 'How many years of perfect health would you give up to avoid being like this?' Given ten years left to live, a willingness to give up five of them to avoid a particular condition would give a weighting of 0.5. From these weightings it is possible to compare the

burden of problems causing disability with those that cause early death, by expressing each as the number of years of *healthy* life lost.

The measure known as *Disability Adjusted Life Years* (DALYs) takes into account the number of years lost from the condition and the quality of life weighting (scale 0 to 1). It also makes an adjustment in order to value years lost in young adulthood more highly than those lost in old age. DALYs give us a very different picture to that gained from mortality data. The World Health Organisation calculated the burden of disease for similar countries in Europe (essentially EU countries) and listed the following highest DALY scores.

Figure 5: Diseases with the highest disability adjusted life years (DALY) scores

Disease	Total European DALY burden	Trend in UK
Depression	4117	Increasing
Coronary heart disease	3572	Decreasing deaths, more people living with the disease
Cerebrovascular disease (stroke)	2656	Decreasing
Alcohol related problems	2227	Increasing
Alzheimer and other dementias	1989	Increasing with ageing population
Chronic bronchitis and other chronic obstructive pulmonary disease (COPD)	1745	Decreasing deaths, more people living with the disease
Lung cancer	1670	Decreasing
Road traffic injuries	1227 *	Decreasing
Osteoarthritis	1187	Increasing with ageing population
Diabetes	1106	Increasing
Colon cancer	1029	Decreasing deaths, more people living with the disease
Self inflicted injury (including suicide)	889	Suicide decreasing, Self-harm increasing

*Likely to be substantially lower for UK

Source: World Health Report 2003 at www.who.int/whr/2003/en/Annex3-en.pdf

The Government White Paper *"Saving Lives: Our Healthier Nation"*[3] set targets for reducing death rates from cancer, heart disease and stroke, accidents and suicides. There are heartening downward trends in these causes of death (see Appendix A). However, figure 5 shows a substantial burden of illness from other

[3] Secretary of State for Health 1999 Saving Lives: Our Healthier Nation

causes, many of which are increasing in prevalence. Some of that increase is over and above that expected from an ageing population.

The health problems with the highest DALY scores are the following:

Depression and other mental health problems

Depression is common. It is an 'undefined and hidden' burden, both economic and social, for families, communities and countries. Every year 15 people in South Gloucestershire die from suicide and undetermined injury, but suicide rates on their own do not give an accurate picture of mental health problems and their impact on the quality of people's lives.

People with mental health problems have the highest rate of unemployment amongst people with disabilities, and 47% of people with mental health problems say that they have experienced discrimination at work. Stress related absences account for half of all sicknesses from work. Around one in ten children between the ages of five and 15 in the UK, are experiencing a problem serious enough to require professional help.

Treatment for people with mental health problems may include prescribed drugs, talking therapies, social and family support, or a combination of these. The role of talking therapies is an important one with evidence to support effectiveness and endorsement by people who use them. These therapies fulfil the need to feel listened to, accepted and understood. Whilst they do not make problems go away, people feel better able to cope. However, the demand for these therapies is very high and local services struggle to keep up with demand.

Alcohol related problems

Over 90% of the adult population drink alcohol and the majority do so with no problem, most of the time. In fact, alcohol in moderation can provide some health and social benefits. But for others, alcohol misuse is a very real problem.

Alcohol misuse costs the UK approximately £20 billion a year, affecting health, family, and society. It is linked with crime and anti-social behaviour and the loss of productivity/profitability. It is connected with 22,000 premature deaths, 360,000 incidents of domestic violence, up to 1,000 suicides and 17 million lost working days per year. Between 780,000 and 1.3 million children are affected by parental alcohol problems. Nationally, specialist alcohol treatment costs £95 million per year.

The Government has recently published an alcohol harm reduction strategy for England[4], which brings together interventions to prevent, minimise and manage alcohol related harm.

[4] Prime Minister's Strategy Unit 2004 Alcohol Harm Reduction Strategy for England

Alzheimer's and other dementias

Dementia describes various brain disorders that have in common a loss of brain function that is usually progressive and eventually severe. Symptoms include loss of memory, confusion and problems with speech and understanding. The most common types are Alzheimer's disease and vascular dementia.

There are estimated to be over 750,000 people in the UK with dementia and the numbers are increasing.[5] Around 18,000 of them are under 65 years. It affects one person in 20 over 65 years and one person in five over the age of 80.

Dementia costs over £2 billion annually in the UK. The cost of Alzheimer's disease alone is £5,400 - £5,800 million. The costs increase with the severity of disease: the average cost per person per year with mild Alzheimer's is £24,000 rising to £52,000 for a person with severe disease.

These figures underestimate its true cost. For example, the costs of caring by partners and children of people with dementia are substantial. The greatest proportion of direct costs of dementia care are associated with institutional support. This is often provided at a crisis point, is always costly, and often precipitated by a lack of effective support in the community.

Chronic bronchitis and chronic obstructive pulmonary disease

Chronic obstructive pulmonary disease (COPD) is a common respiratory disorder that causes considerable patient suffering and mortality. It includes chronic bronchitis, emphysema, long standing irreversible asthma and small airways disease. Symptoms include breathlessness and coughing, leading to premature disability. It often results in social isolation, depression and increased dependence on carers, relatives and the health service.

Currently over 600,000 people are diagnosed with COPD in the UK and 26,000 die each year as a result of the disease - accounting for about six per cent of all male and four per cent of all female deaths. It is most common in male smokers. Cigarette smoking is the major risk factor for its development, but the considerable variability in risk from smoking suggests that additional environmental factors, genetic factors, or both, contribute to its impact.

The disease is often diagnosed at a late stage, when the health interventions required to manage it are costly, and the damage to lungs may already be severe. Patients may suffer recurrent exacerbations of their symptoms, which can result in hospital admission, which impacts on quality of life for patients and costs for the NHS. Prevention of exacerbations is an important goal in its management. COPD costs the health service over £500 million per year.

[5] Estimated by the Alzheimer's Society see www.alzheimers.org.uk

Osteoarthritis

Osteoarthritis of the hips and knees is a major cause of pain and disability amongst older people. At least 4.4 million people in the UK have moderate to severe osteoarthritis in their hands; half a million have moderate to severe osteoarthritis in their knees. As the population ages these numbers are rising.

NHS treatment for arthritis cost £5.5 billion in 2001. The costs to the nation include 206 million lost working days in the UK in 1999-2000. In 2001 £2.4 billion was paid in incapacity benefits, £389 million paid to community services and £1.3 billion paid to social services to support people with osteoarthritis[6].

Diabetes

The number of people with diabetes is increasing. Although some of this increase is likely to be due to an ageing population, as well as better diagnosis and the recording of information, there is also evidence of a real increase. Some of this increase is linked to an increase in obesity in the population.

Obesity is defined as an excess of body fat frequently resulting in a significant impairment of health and longevity[7]. Body Mass Index (BMI)[8] is used to measure the degree of obesity. BMI over 25 is 'overweight' and over 30 is 'obese'. Around two thirds of the population of England are overweight or obese, with a recent rapid increase in both adult and childhood obesity. The increase in children can be linked to poor diet and low levels of physical activity.

Diabetes can lead to complications, including problems with eyesight, blood supply to lower limbs, and increased risk of kidney failure and cardiovascular disease. However, good quality care can reduce long term problems and the Diabetes National Service Framework (NSF)[9] sets standards for improving care.

There were an estimated 362 new cases of diabetes in South Gloucestershire in 2003[10]. The observed prevalence (that is the number of people living with diabetes that we know about) is 2.51%. However, we estimate that if we could include undiagnosed cases the real figure would be approximately 3.64%. This is likely to rise to nearly 4% by 2008.

Colon cancer

Colorectal cancer (cancers of the colon and rectum combined) accounts for 13% of all cancers in England and Wales. After lung cancer, it is the second most common cancer in the UK. In South Gloucestershire there were 129 new cases diagnosed in 2001 and 55 deaths[11].

[6] see www.arc.org.uk
[7] Faculty of Public Health 2004 see www.fphm.org.uk
[8] calculated by dividing an individual's weight (in kg) by their height (m^2)
[9] see NSF for Diabetes at www.doh.gov.uk/nsf
[10] Health Care Needs Assessment for Diabetes in South Gloucestershire 2003
[11] see www.clinicalevidence.com

Although in the UK, there has been a slight decrease in mortality in recent years, reflecting better treatment, the incidence of colorectal cancer has continued to increase gradually. This means there are more people living with the disease, or its after effects (such as colostomy). Although incidence increases with age, colorectal cancer is a significant cause of premature mortality, 48% of deaths occur in the under-75 age group.

If detected in the earlier stages it is highly treatable. There is good evidence that deaths from colorectal cancer could be reduced by a screening programme for people over 50. Last year the Government launched such a scheme as part of the new NHS Bowel Cancer Programme. All screening programmes need careful planning and implementation, to ensure that the benefits outweigh the inevitable harm and anxiety caused by investigations and operations on people who, subsequently, turn out not to have the disease.

Suicide

Local death rates from suicide and undetermined injury have remained relatively steady over the past ten years, at approximately 40% lower than the national average (see Appendix A). Nationally, men are three times more likely to commit suicide than women, a pattern also seen in South Gloucestershire. The death rate in younger men, (15 –34 years) is particularly low in South Gloucestershire at 6.3 per 100,000, compared with the national figure of 23.8.[12]

Deliberate self-harm

Rates of deliberate self-harm have been increasing since the mid 1980s. In contrast to suicide, deliberate self-harm rates are highest in young females, the peak incidence occurring in 15-19 year olds. In males the highest rates are in 20-29 year olds and are considerably lower amongst those aged over 50. A national inquiry is being conducted to investigate this behaviour which appears to affect one in ten young people in the UK.[13]

The impact of help from carers

In addition to the burden of disease on the patient, all these diseases have considerable impact on those who provide care for patients. There are 5.2 million carers in England and Wales providing unpaid care for a family member, or friend. Over a million provide more than 50 hours per week, more than half are over 55 years and a quarter state that they are in 'not good health' themselves.

In South Gloucestershire, the percentage of people providing unpaid care is slightly less than the national average. Nevertheless, there are over 24,000 people providing some unpaid care and 4,054 of these are providing unpaid care for 50 hours, or more, per week.

[12] Compendium of Clinical and Health Indicators 2002 / Clinical and Health Outcomes Knowledge Base (nww.nchod.nhs.uk))

[13] NeLMH Young People and self-harm - a national inquiry. See www.nelmh.org

Section 2: Improving Health and Reducing Inequalities

This section describes the role of primary care in promoting health and reducing inequalities. It also describes local partnership working and new initiatives set up to reduce inequalities in South Gloucestershire.

Improving Health through Primary Care

Key messages:

- *Primary care and community staff have an important role in promoting health and preventing illness.*
- *There are enormous commercial pressures that emphasise the role of drugs in preventing illness. However changing the food we eat, stopping smoking and increasing physical activity all play an essential role in prevention and are often more cost effective than drug treatment.*
- *Equity audits are an important way of checking for, and improving, inequalities of access to services.*

There are 30 GP practices in South Gloucestershire with 131 GPs, over 150 nurses and a total of 500 staff working in primary care.

Nationally, 97% of the population are registered with a GP and on average each person consults their GP five times a year. This varies considerably with age:[14]

- two consultations a year for 5-15 year olds.
- eight consultations a year for over 75s.

The traditional patterns of primary care are changing. Nurses are playing an increasing role in managing both minor illness and the long term care of chronic disease. The pattern of out-of-hours care has moved away from each practice doing their own on-call and this, coupled with the changes in the workforce (more part time GPs and greater job mobility), means that the traditional, long term relationship between doctor and patient is likely to weaken.

However, the average patient stays on a practice list for 12 years, so there are good opportunities for primary care professionals to form strong relationships with their patients and gain a valuable depth of knowledge of their families and circumstances. Such a personal and trusting relationship provides a good opportunity for helping individuals choose a healthy lifestyle.

This section focuses on some of the most important contributions of primary and community staff in promoting health and preventing disease.

[14] see General Household Survey 2002 at www.statistics.gov.uk

Health promotion in primary and community care

Health promotion is a key element of primary care and may be:

- primary prevention - this relates to those activities that help avoid a health problem completely, for example, immunisation, or encouraging someone who is well to adopt a healthier lifestyle.
- secondary prevention - this identifies and treats people who may not have symptoms, but who have already developed risk factors or pre-clinical disease, for example, breast screening, or treating a person with multiple risk factors of heart disease with a drug to lower cholesterol.
- tertiary prevention - this involves the care of established disease, to minimise the negative effects and prevent disease related complications, for example, making sure a patient's diabetes is well controlled.

Some health promoting activities will be effective at all three levels of prevention, for example, stopping smoking will help prevent illness developing, prevent risk factors progressing to disease and prevent the worsening of established disease.

Health promotion and prevention takes place throughout primary and community care and may include, for example:

- a health visitor giving advice about parenting skills and healthy infant feeding.
- a practice nurse checking blood pressure, taking a cervical smear, giving an immunisation or monitoring diabetic control.
- a community nurse discussing with an elderly patient how to modify their home to avoid tripping and falling.
- a GP encouraging a middle aged man with a chest infection to give up smoking.

Monitoring risk factors and preventing cardiovascular disease

The risk of developing coronary heart disease (CHD), or having a stroke depends on many factors including family history, blood pressure, smoking status, weight, age, sex, physical activity level, social class, dietary habits, blood cholesterol level and pre-existing disease.

It is routine practice in primary care to use tables to calculate the approximate risk of an individual developing cardiovascular disease. This can help the doctor and patient to consider the likely benefit of drug treatment, and may encourage the patient to reduce the risk, by say, stopping smoking, or losing weight.

Those at highest risk have the most to gain, whether from drug treatment or changing habits. Patients with diabetes and established heart disease, (either angina, or a history of a heart attack), are at particular risk. There is now a comprehensive programme to improve the preventive care in these groups.

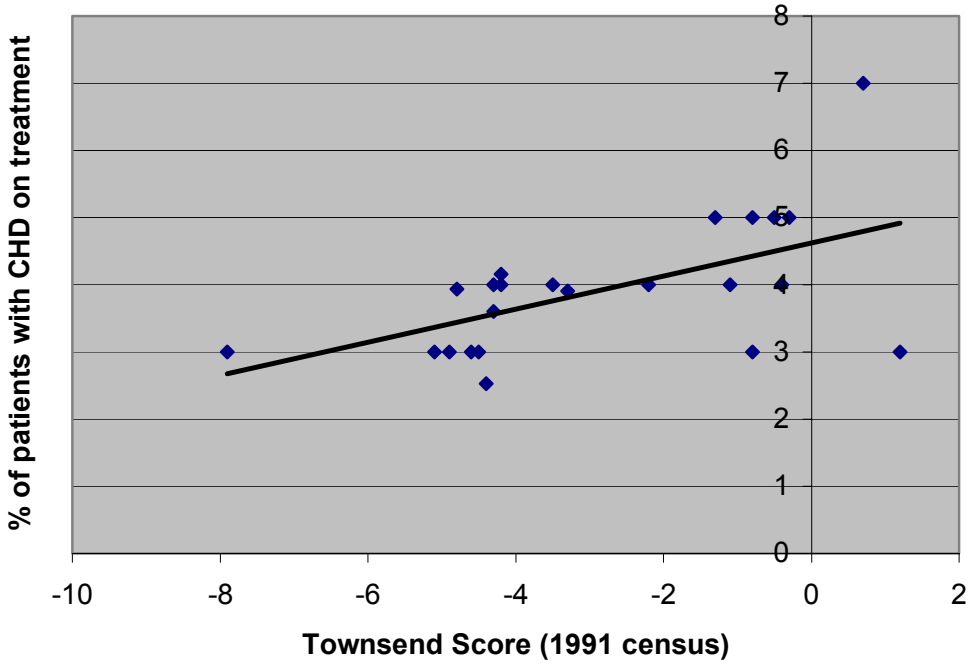
Equity of access to primary care – an example of an audit

It has been observed that those most in need of health care are least likely to receive it – the so called 'Inverse Care Law'.[15] There is some evidence that patients in more deprived areas are less likely to receive effective interventions. This does not necessarily reflect on the quality of practice and, at least in part, is likely to reflect health seeking behaviour.

Most patients who have had a heart attack, or who have angina, should be on a range of drugs, including aspirin and/or a statin. The CHD NSF [16] sets a range of standards that primary care should achieve which the PCT monitors through audits of computerised primary care records (known as MIQUEST searches).

The recent MIQUEST audit of CHD data in South Gloucestershire provided an opportunity to examine whether the inverse care law applies to the local care of CHD patients. Data from GP practices gave the prevalence of CHD for each practice. A deprivation (Townsend) score was calculated from census data for each practice according to the postcodes of patients on its list (least deprived = negative score; more deprived = positive score). Figure 6, below, demonstrates that people in poorer areas have worse health than those in the less poor areas and the correlation between deprivation and CHD is illustrated.

Figure 6: Correlation between the percentage of practice population with a diagnosis of coronary heart disease against deprivation score

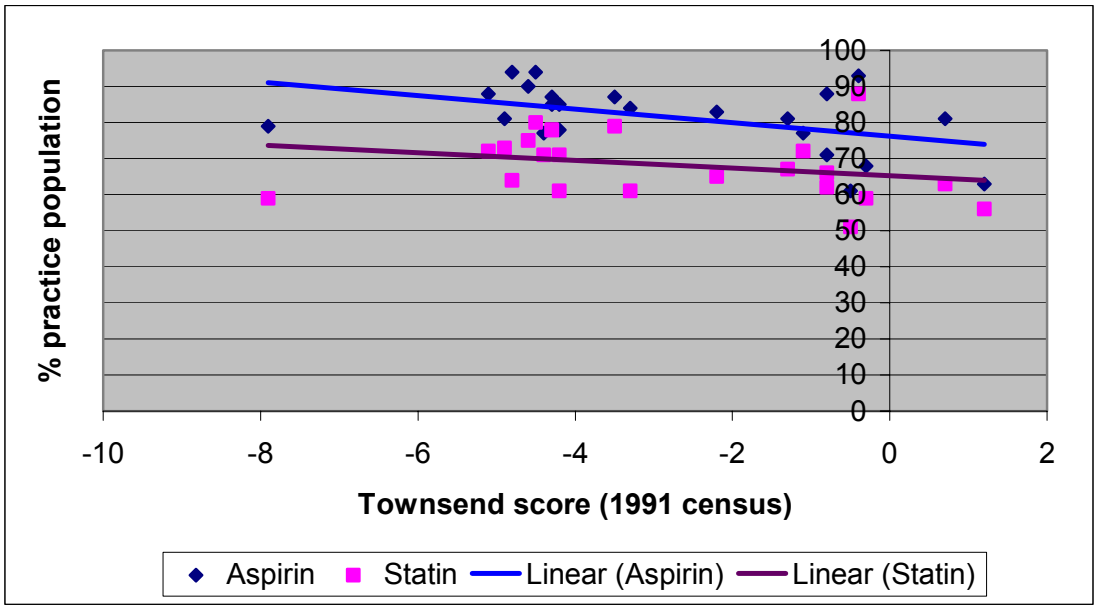


Source: South Gloucesteshire PCT

[15] Tudor Hart, J 1971 The Inverse Care Law. The Lancet February 27th 1971
[16] see CHD NSF at www.doh.gov.uk/nsf

A high proportion of patients with CHD need to take aspirin and/or a statin. The practices with more deprived populations, and therefore the higher burden of CHD, have lower levels of uptake of these two drugs.

Figure 7: Practice deprivation scores and the percentage of diagnosed coronary heart disease patients prescribed aspirin/statin



Source: South Gloucestershire PCT

This is an example of one part of a health equity audit, a process which looks for differences of access, or uptake, by different groups (see page 28).

Practices receive some differential payments to reflect deprivation and older populations. The new general medical services (GMS) contract includes provision for linking income both to deprivation and to the burden of disease.

Whilst practices have the freedom to tailor services to meet local need, PCT provided services (health promotion, pharmaceutical advice, etc.) and community services (district nursing, health visiting, etc.) need to put extra resources into poorer areas and configure services quite differently across the patch.

Chronic disease management – a look at diabetes

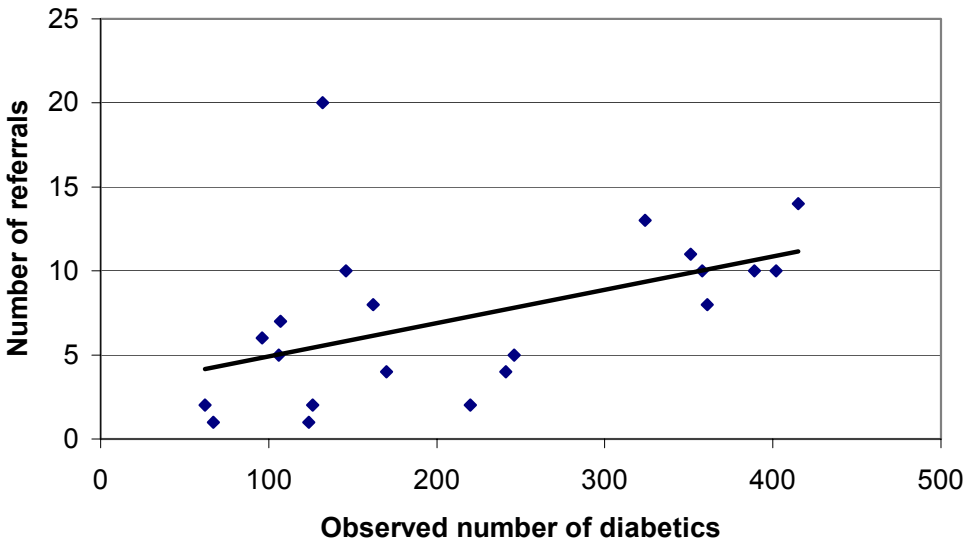
Diabetes is one of the commonest chronic diseases and most diabetic patients are looked after in primary care, most of the time. Research supports the provision of diabetic care in the community, provided that practices have a structured approach - recording, recalling and regularly reviewing patients. There are a number of models where 'intermediate services' have been developed to provide more specialised care in the community, thereby changing the type and number of patients referred to secondary (hospital) care. This enhanced service is usually provided by nurses, or GPs, with a special interest in diabetes.

In 2003, a comprehensive needs assessment[17] found many local examples of good practice, including integrated care pathway (ICP) training events. ICPs are multidisciplinary outlines of anticipated care for patients with a similar diagnosis, or set of symptoms. They aim to improve coordination and consistency of care.

The PCT has run five ICP days for practice teams with 89 people attending and all 30 practices represented. North Bristol NHS Trust has trained five practice nurses to start selected diabetics on insulin. They are all continuing to convert patients to insulin using the protocols.

There are several practices with high levels of diabetic expertise, as demonstrated by high numbers of diagnosed diabetics, low referral rates and low numbers of patients followed up in secondary care. But there is considerable variation in how many patients practices refer to hospital outpatients.

Figure 8: Number of diabetics and number of referrals to North Bristol NHS Trust (2000-2003) by practice



Source: Health Care Needs Assessment for Diabetes in South Gloucestershire Oct 2003

Assuming the nature of diabetic problems is similar across the area, if practices had similar referral criteria, we would expect a straight line with little or no 'scatter'. In fact there is wide 'scatter.' Some practices with a low number of diabetics refer more of them than practices with higher numbers.

The report[18] proposes a model for discussion - to create a community diabetes service, as an alternative to referral to secondary care for some patients. A number of possibilities for the provision of such a service are proposed.

[17] South Gloucestershire PCT 2003 Health Care Needs Assessment for Diabetes in South Gloucestershire

Health promotion programmes in primary care – two examples

The PCT and its partners have developed strategies for promoting healthy eating, increasing physical activity and reducing smoking, and these are described in more detail in the section on partnership working. However, two schemes are described here because of the particular involvement of primary care: the newly expanded exercise referral scheme and the smoking cessation service.

Exercise on Prescription

Physical activity has enormous benefit for emotional and physical health for those with, or at risk of, heart disease. In the UK, 39% of men and 42% of women over the age of 50 are totally sedentary. The promotion of physical activity is essential if targets for health are to be met. The government wants to see 70% of the population taking regular physical activity by 2020.

The *Exercise on Prescription* scheme is a partnership project between South Gloucestershire Council and the PCT. It aims to promote change in habitual levels of physical activity and support long term adherence to active lifestyles. It focuses on areas of higher health need across South Gloucestershire.

A referral pathway was developed in 2003, targeting Patchway, Stoke Gifford, Yate West and Kingswood Chase and 21 out of 30 GP surgeries are now referring patients to the scheme. So far, 430 patients have been referred, with over 50% adherence to activity. Reasons for referral include weight related issues, diabetes and cardiac rehabilitation.

The *Exercise on Prescription* GP referral scheme

Some examples of patients who have benefited from the scheme are:

A woman cardiac rehabilitation patient who smoked, and had weight issues. After twice weekly gym based sessions she recorded improved self confidence and controlled weight loss. She is now thinking of stopping smoking.

A 26 year old sedentary, obese mother with depression who started on a supervised home walking programme. She is now active on most days, walking up to an hour daily and doing resistance exercises at home. Total weight loss to date - two stone.

A 72 year old man, BMI 38, who was awaiting a knee replacement operation, which was delayed due to weight. The operation was carried out after weight loss. The patient will now return to the scheme for rehabilitation.

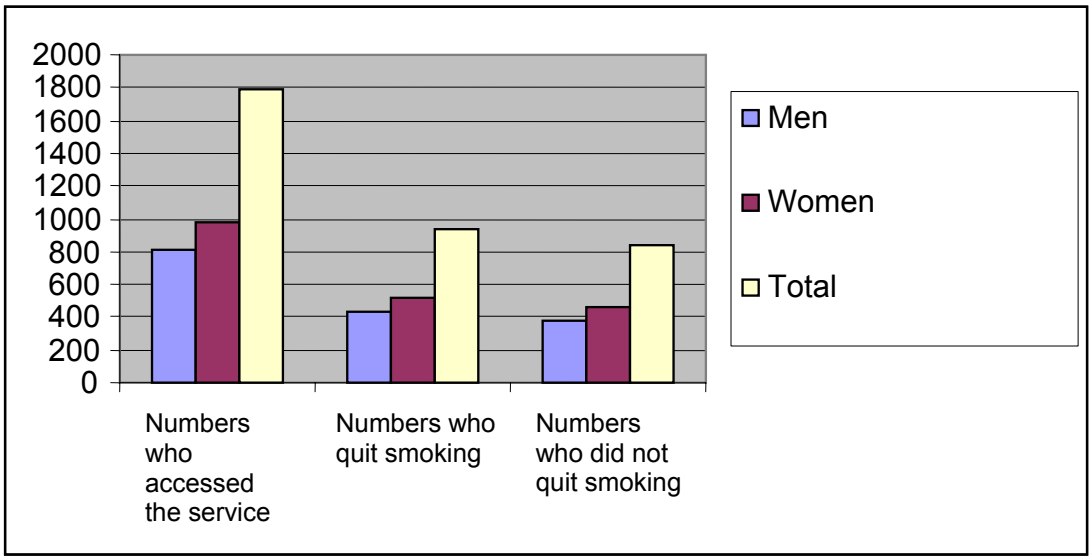
Support to Stop

Smoking is the biggest single preventable cause of illness and death. One hundred and twenty thousand people in the UK die every year from smoking

related diseases. Most die from one of three main diseases associated with smoking: cancer, chronic obstructive lung disease (bronchitis or emphysema) or coronary heart disease.

Support to Stop was established in South Gloucestershire in 2002, and is structured in accordance with guidelines set by the Department of Health. All GP practices are actively involved in smoking cessation. Regular training enables health care and other professionals to provide information, advice and support to their clients including pregnant women, young people, employees in the workplace and those living in areas of high health need. Research in South Gloucestershire[18] found that over half of current smokers (55%) wish to give up. In 2003, 944 residents, or 53% of those who accessed the service, quit smoking for at least four weeks as a result of *Support to Stop*.

Figure 9: Number of people who accessed *Support to Stop* in 2003



Source: *Support to Stop*

In October 2003, three part-time specialist advisors were employed by the PCT to enhance the work of the service. They are liaising with community development workers to offer smoking cessation support to community groups. *Support to Stop Smoking* courses are provided in Kingswood, Staple Hill, Yate West, Patchway and Bradley Stoke. North Bristol maternity services provide a specialist advisor (midwife) to support pregnant smokers who want to quit.

Acquitted!

A steering group has been formed to implement tobacco control and smoking cessation in prisons, with representatives from the three prisons in South Gloucestershire. Prison health care staff have been trained as *Support to Stop* advisors and bespoke training (*Acquitted)* has been piloted. All three prisons in South Gloucestershire now have trained staff who are helping both inmates and staff to kick the habit.

[18] South Gloucestershire Viewpoint Survey 2002

Wider public health work and primary care - the health visitor review

The recent health visitor review, carried out by the PCT, provides a future vision for health visiting in South Gloucestershire. This is based on actual and projected demographic changes, public health priorities, a review of evidence and national and local policy directives.[19]

Reducing inequalities in health is high on the Government's agenda.[20] Locally, this is being addressed through a strategic framework which sets out a number of different approaches. One of these is to target improvement in the geographical areas with greatest health needs, using a community health development approach and through other health promotion initiatives. The review of the health visitor's role is set to increase this type of work.

The review put forward proposals to strengthen health visitors' contribution to public health work. These proposals would involve the allocation of three half time posts to work exclusively with communities on local health issues, and to help build the capacity of communities to tackle their own health needs.

This community health development approach is about helping people to help themselves and work together to overcome disadvantage, resulting from a variety of circumstances such as poverty, social isolation, unemployment and discrimination.

> *'Community development is a way of tackling the community's problems by using the energy and leadership of the people who live there.'*[21]

Studies have shown the benefits of a community development approach in increasing the amount of community group activity and voluntary effort - or 'social capital.' This in itself is known to improve health.[22]

A further proposal made in the review is that the generic role of health visitors is split to allow them to focus effectively on *either* children and families, *or* older people.

Consultation with service users and key stakeholders has informed the review and will continue to do so, as the PCT moves towards a period of formal consultation on the review recommendations.

[19] Tosen, R. Phillips, N. Parris, S. and Hennessy, M. 2004 Strategic Review of the Health Visiting Service Final Report.
[20] See DOH 2003 Tackling Inequalities - A Programme for Action
[21] DN Thomas 1983 The Making of Community Work George Allen and Unwin
[22] Chanan G, Garratt C, and West A 2000 The New Community Strategies: how to involve local people. Community Development Foundation.

Immunisation

Immunisation is one of the most effective of all preventive health care measures, and high uptake in the UK has virtually eradicated many of the infectious diseases that used to cause widespread death and disability.

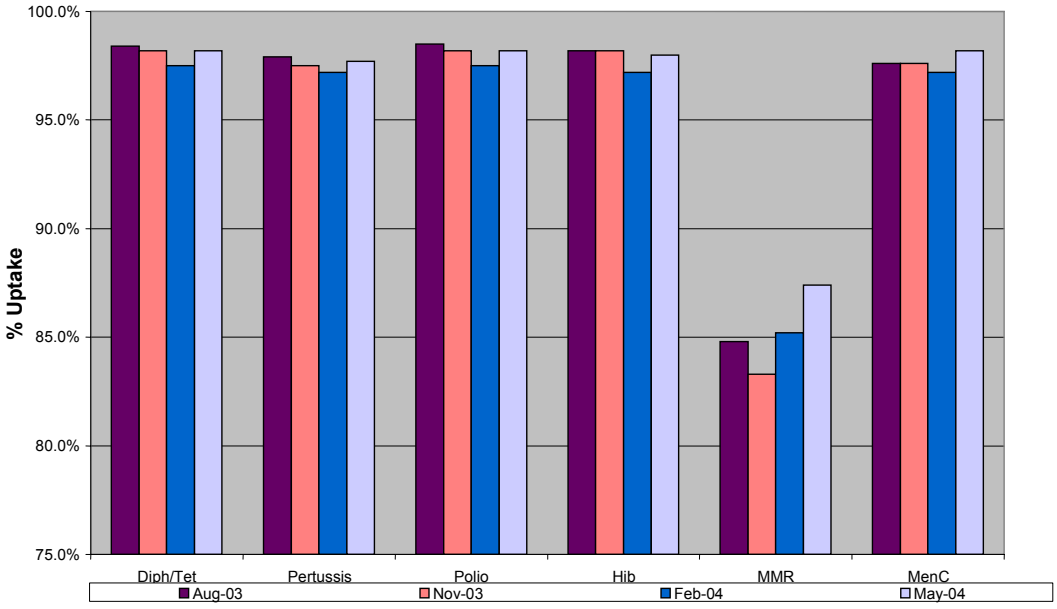
However, none of these diseases has disappeared and a continuing high level of immunisation is important. A sustained uptake by 95% of the population is needed to provide a good level of immunity for the population as a whole.

Childhood immunisations

Overall, the uptake rates of childhood immunisations in South Gloucestershire remain high - well over 90% for most vaccines. The exception to this is the second measles, mumps and rubella vaccine (MMR2).

The MMR vaccine is given twice, once at 13 months and again before school age. Studies have not shown any link between the MMR vaccine and autism or bowel disease, but there has been considerable parental anxiety leading to falls in MMR rates. However, uptake before second birthday, shown below, indicates that rates appear to be rising again.

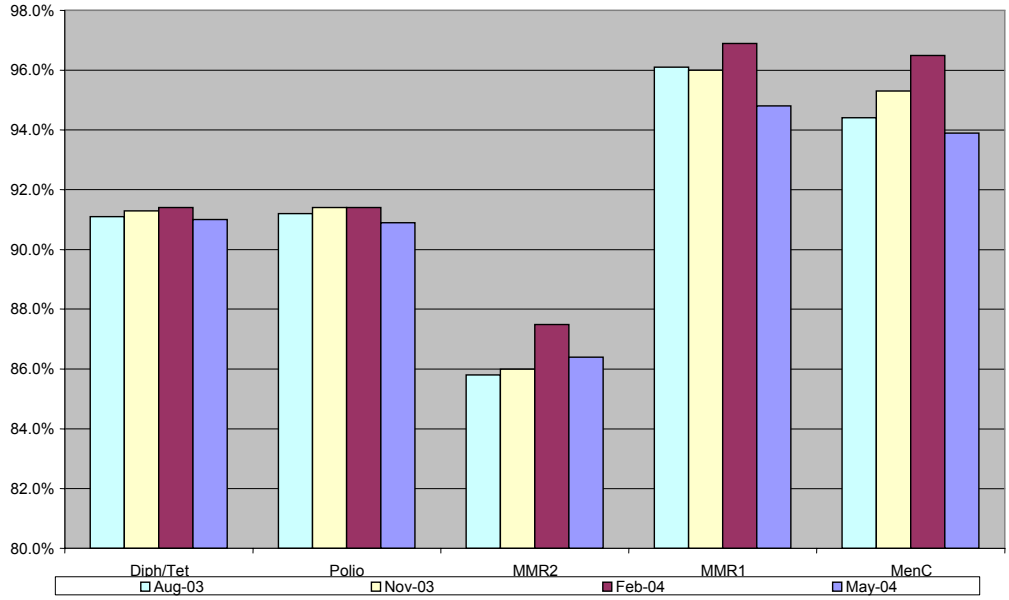
Figure 10: Immunisation uptake before second birthday Aug 2003-May 2004



Source: Child Health Surveillance

In addition, by the age of five years 94% of children in South Gloucestershire had had the MMR1 vaccine, although the uptake rate for the MMR2 vaccine, given just before school, was low with only 86% of children vaccinated.

Figure 11: Immunisation uptake before fifth birthday Aug 2003-May 2004



Source: Child Health Surveillance

Influenza vaccination – a health equity audit

Influenza is a highly infectious cause of acute respiratory infection. It causes major morbidity and can be life-threatening for the elderly and chronically unwell. 20,000-30,000 excess winter deaths in the UK are attributable to influenza.

In the last three years, the Department of Health has set targets for PCTs for influenza vaccination in those aged over 65. General practices are paid a fee for carrying out each vaccination. In 2003, for the first time, patients under 65 years who were on practice 'at risk' registers for chronic disease were also eligible for flu vaccination.

In South Gloucestershire, 35,769 patients are aged over 65 (14% of the total population). The uptake rate of flu vaccination in 2002-3 ranged from 62.9%-89.1% with an average of 72.6%. Despite flu vaccination campaigns, a number of practices did not meet the 70% target figure.

The average uptake fell below the target rate in the five most deprived areas - coincidentally areas with the highest proportion of elderly residents.

Figure 12: Average percentage uptake of flu vaccination and [ranges] amongst people aged 65 or over

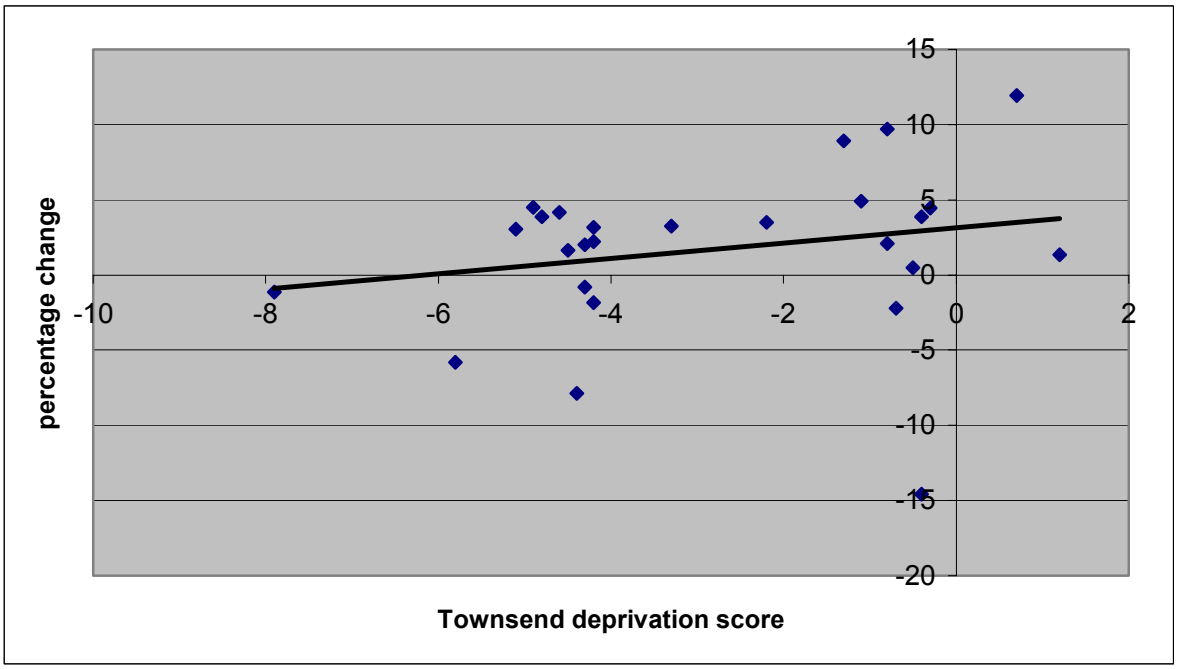
Year	South Gloucestershire	Practices in five most deprived areas	Practices in five least deprived areas
2002-3	72.6 [62.9-89.1]	69.3 [62.9-89.1]	72.8 [70.7-87.5]
2003-4	74.2 [66.0-89.6]	73.9 [71.1-74.9]	76.0 [73.5-81.7]

Source: South Gloucestershire PCT

In 2003, using a health equity model,[23] a programme of action was set up to improve the uptake of flu vaccination within the most deprived areas. This programme included using local newsletters, mail shots, extra community nursing time and allocations to practices on a weighted capitation basis. A bonus reward payment was given to practices on achieving 73% uptake.

All 30 surgeries provided extra clinics, with some hiring community venues for the vaccination programme. Community staff visited the housebound, concentrating on the areas where over 20% of patients are over 65. Practice managers followed up non-attendees with letters and phone calls.

Figure 13: Changes in flu vaccination uptake amongst the over 65s in more and less deprived areas (2002-2004)



Source: South Gloucestershire PCT

The programme resulted in significant improvements. Final figures showed:

- an average uptake of 74% was achieved - an increase of approximately two per cent in the target population.
- a four per cent increased uptake rate was achieved in the most deprived areas. These practices improved markedly, compared with those in less deprived areas.

[23] DOH 2004 Health Equity Audit: a self assessment tool

Partnership Working

Key messages:

- *The interventions that can have the greatest impact on health lie outside the health service and include reducing smoking, increasing physical activity, increasing the eating of fruit and vegetables, reducing poverty, preventing injuries, increasing participation in education, and providing more support to young families and vulnerable children.*
- *The single most easily achievable intervention with the greatest impact on health would be to ban smoking in public places.*
- *Controlling traffic speed is unpopular but saves lives.*
- *Joint work between the PCT and local authority is now well established at all levels, but the role and involvement of the voluntary sector in improving health, needs further development.*
- *Priorities for improvement include prison health services and sexual health services.*
- *PCT commissioning needs to include consideration of inequalities more explicitly. This should include any changes in services taking place as part of the local financial recovery.*

The health theme within the community strategy 'Our Area – Our Future' is overseen by the Better Health Partnership (BHP). This brings together senior representatives from the PCT, local authority and the voluntary sector.

The BHP oversees joint health improvement activity. A Joint Health Promotion Work Programme[24] is produced annually, which details plans for health promotion activities and initiatives. This year, for the first time, it includes contributions from practice nurses, school health nurses and health visitors.[25]

The BHP also organises an annual Better Health Seminar and quarterly meetings to discuss particular topics.

At the third annual Better Health Seminar, in May 2003, the first Director of Public Health (DPH) annual report was presented. A report on the seminar is available.[26]

[24] Joint Health Promotion Work Programme 2003/04
[25] available at www.sglos-pct.nhs.uk
[26] Better Health Seminar Report May 2003 available from South Gloucestershire PCT (see back cover for contact details)

The BHP receives reports from the following subgroups:

- Tobacco control
- Food and health
- Physical activity
- Inequalities
- Mental health
- Schools for Health
- Injury prevention

This section briefly describes the work of these groups as well as providing an update on teenage pregnancy and on prison health.

During 2003/04, the Physical Activity Group, Tobacco Action Network and the Food and Health Network developed strategies on behalf of the Better Health Partnership, to ensure that there is a co-ordinated, multi-agency approach to healthy lifestyle issues. These strategies offer a framework for local action based on evidence of effectiveness. All have health inequalities as an underpinning theme and link into the local inequalities strategy.

Tobacco control strategy

South Gloucestershire Tobacco Action Network group is a multi-agency alliance involving the NHS, local authority, Drug Action Team, and other local organisations. It is part of a nationwide network of nationally funded alliances.

The strategy aims to reduce the prevalence of smoking in South Gloucestershire and address issues associated with second hand smoke (passive smoking). Action includes:

- continuing to provide smoking cessation services.
- ensuring health and other professionals provide information and advice on tobacco control, including prevention and second hand smoke.
- working to reduce the prevalence of smoking in pregnant women, manual workers and young people.
- providing smoking cessation support in hospitals for staff and patients.
- supporting comprehensive tobacco control programmes in prisons, schools, the youth and community services and social services.
- reducing illegal sales of tobacco to under 16's.
- increasing the provision of no smoking environments.
- raising public awareness regarding smoking issues and cessation services.

Banning smoking in public places

Whether or not smoking in public places should be banned is currently one of the most important public health topics under debate. There is no doubt that a ban could have an enormous impact on health.

Findings from the regional Big Smoke Debates reveal that 78% of people are in favour of a total smoking ban in all workplaces. Both smokers and non-smokers voted in support of a ban. Banning smoking at work would reduce the 700 deaths a year caused by second-hand smoke in the workplace.[27] In addition, a ban could reduce the proportion of people who smoke by around 4% and so help to cut the death rate from smoking related illnesses.

Banning smoking in public places is one of the most positive actions South Gloucestershire could take to improve the health of residents. This would appear to have the support of the majority of the local population. Towns and cities that have already gone smoke-free have reported significant health benefits, particularly for the health of restaurant and bar staff. It is to be hoped that the Government takes action at a national level to implement a ban. Failing that, legislation may allow local authorities, including South Gloucestershire, to introduce smoking bans.

Easy Breathing

"We estimate that second-hand smoke kills at least 1,000 people in the UK every year." (Imperial College, London)

Second-hand smoke affects the health of those who do not smoke. Through the *Easy Breathing* project, organisations are encouraged and supported to provide smoke-free environments. To date 69 businesses have received awards for smoke-free premises and 83 public houses in the area have been awarded *Easy Breathing* certificates by increasing their no-smoking areas. On No Smoking Day three local pubs went smoke-free for the day.

An *Easy Breathing* project worker is based in Kingswood, thanks to a successful bid for funding to the National Tobacco Control Alliance.

Food and health strategy

This strategy includes the promotion of breastfeeding, and will contribute to health and well-being by:

- improving availability and accessibility of healthy food, particularly fruit and vegetables.
- preventing overweight and obesity.
- helping clients and patients turn health messages into practice.
- targeting the nutritional needs of school-aged children.
- promoting the nutritional health of children, expectant mothers and women of childbearing age.
- supporting the local food economy.
- using local and national campaigns and other media opportunities.

[27] Estimated by Imperial College, London

The strategy framework is based on a 'cradle to grave' approach with links to appropriate settings for each age band. The settings include the community, workplace, primary care, prisons and schools.

The Department of Health will publish a national Food and Health Action Plan in Autumn 2004. The South Gloucestershire strategy will then be reviewed and revised so that it follows national guidance.

Physical activity strategy

This strategy aims to contribute to an increase in the physical activity levels of the population of South Gloucestershire. It will ensure a co-ordinated approach that will enable people to improve their health and well-being through physical activity. It will do this by:

- working towards making the environment conducive for people to be physically active.
- helping to prevent people becoming overweight and obese.
- targeting levels of physical activity in both school-aged children and older people.

Walking to Health – safety in numbers!

This is a three year joint project between the PCT, the Council and the Forest of Avon. It aimed to get 500 people aged over 50 from the Chase area walking – over 350 have walked with the project so far.

It has recruited, trained and managed 32 volunteer walk leaders and over 60 routes have been mapped, risk-assessed and graded. Just over 100 led walks have been held with an average attendance of 25 people. 3,750 miles have been walked in total: more than Lands End to John O'Groats and back - twice!

One participant said: *Fresh air, exercise and meeting with others lifts your spirits. It's good therapy if you are feeling down.*

The physical activity and food and health work, together, are helping to address the rising epidemic of obesity.

Tackling inequalities

The first DPH annual report set out a draft strategy for reducing inequalities in health. Over the past year this has been developed further by the inequalities subgroup of the Better Health Partnership. The strategy has two strands:

- targeting improvement at geographical areas with high health need, such as Kings Chase, Staple Hill, Patchway / Filton, West Yate, Cadbury Heath and Ventura Farm.

- targeting improvement at particular groups and individuals. This means ensuring services and support intended for the most needy reach them regardless of where they live. Health equity audits are an important tool to help make sure this happens.

Targeting improvement at geographical areas with high health needs

Four areas in South Gloucestershire have been identified with high health needs. A senior health promotion specialist for community health development has been appointed to work on issues such as:

- providing support to young mothers' groups and other groups working with families.
- developing a strategy for children's play with local partner organisations.
- providing fundraising and management support for community groups in areas of higher health need.
- strengthening the community development role of health visitors.
- developing links with Black and other minority ethnic groups.

Two grant programmes to reduce inequalities in health have been introduced to pump-prime health promoting activities in communities. From this the following projects have been set up:

- cooking courses for young care leavers.
- football coaching for disabled children.
- a social support group for Asian women.
- a toddler group on an isolated housing estate.
- an activity programme for a young mothers' group.
- publicity materials for domestic violence services.
- a deaf awareness course for health centre staff.

Health equity audits (HEAs)

Differences in health outcomes are, in many cases, a consequence of differences in opportunity, access to services and material resources. The Department of Health identifies Health Equity Audit (HEA) as a key tool in addressing health inequalities.[28] Its purpose is to help services use evidence on inequalities to inform decisions on investment, service planning, commissioning and delivery and to review the impact of that action.

HEAs identify how fairly services, or other resources, are distributed in relation to the health needs of different groups and areas, and the action needed to provide services relative to need. Otherwise, inequities may occur which lead to health inequalities.

The HEA cycle involves six stages:

1. Agree partners and issues
2. Equity profile to identify the gap

[28] Health Equity Audit: a self assessment tool. Department of Health Publications 2004

3. Agree action to narrow the gap
4. Agree priorities
5. Secure changes in investment and service delivery
6. Review progress and assess the impact.

The audit cycle is complete when changes are made which are likely to reduce inequalities. For NHS services these are likely to be changes in resource allocation, commissioning, service provision, or care outcomes.

The Government publication *Tackling Health Inequalities – A Programme for Action*[29] identified HEA as a key tool to embed evidence on inequalities into mainstream NHS activity. The Priorities and Planning Framework for 2003-06 sets out targets that support the Programme for Action, including the requirement for service planning to be informed by an HEA and an annual public health report.

Examples of the PCT looking formally at the equity of provision of services over the past year include:

- a paper on health inequalities, age profile and primary care provision discussed at the Professional Executive Committee. This included some of the results of the computerised audits of GP practices for coronary heart disease (CHD) and diabetes.
- the use of health equity audits to look at flu vaccination uptake.

Consideration of inequalities in health have influenced PCT strategic decisions, such as ensuring local re-provision of services currently provided at Cossham Hospital. Discussions with the Council about the links between poverty and ill health have been reflected in its corporate service plan and the strong emphasis on improving the uptake of welfare benefits.

In the past, the PCT has done less work on considering the impact of its commissioning decisions on inequalities. However, some examples do exist and these include an audit of patient access to cardiac interventions which informed commissioning priorities for better access to angiography.

Mental health

This year, work on promoting positive mental health has primarily focused on children and young people. A multi-agency development group has been created and this has developed a number of work streams.

A multi-agency training programme has been set up to raise awareness of resilience theory and how it can be applied in practice to building resilience in young people. It consists of seven days; one pilot day, three related to early years and three for adolescence: 168 people have attended so far. This training is applicable for people working on prevention, as well as those working with

[29] Department of Health 2003

vulnerable children and young people who need more targeted help and support in times of adversity.

The group also coordinated the World Mental Health Day campaign this year, which aimed to raise awareness of mental health issues, and reduce stigma and discrimination. The PCT funded a small local grant scheme which provided funding for 14 community projects including arts, drama, dance, physical activity for young people, relaxation days and displays. Five hundred complimentary display/information packs were distributed.

Anti-bullying seminars are planned to provide support to schools. These seminars will include information on national and local strategies, policy development and implementation, advice on how to involve young people, free resources for school room activities and input from agencies such as school health nurses and Connexions.

The next step in implementing the South Gloucestershire mental health promotion strategy will focus on planning work around vulnerable adult populations such as Black and ethnic minority groups, young mums, parents with mental health problems, and individuals in prison.

The South Gloucestershire Suicide Prevention Strategy, 2004/05, has been developed to reduce the local suicide and undetermined injury rate.

Schools for Health

The local *Schools for Health* programme is run by the PCT and South Gloucestershire Education Service. Fifteen South Gloucestershire schools achieved Schools for Health status in 2003 making it the most successful year yet. Forty-four schools have now completed the programme which is accredited to the National Healthy School Standard (NHSS), and 28 more have started the process.

Schools for Health

The participating schools present their projects at an annual celebration event. Projects this year included:

- introducing Fair Trade products into a secondary school canteen.
- improving awareness of recycling.
- looking at the provision of shade in the playground area.
- introducing daily fruit tuck.
- developing lunchtime and playground activities.
- a healthy eating week.

A teacher commented:

This gives an opportunity to ask the whole school community about issues not related solely to the curriculum and we can focus on our school needs, as identified through the initial review.

In 2003, the programme was monitored by the NHSS Team. The report said:

> *'South Gloucestershire Schools for Health is an extremely good, well managed programme. It has much to be proud of and a great deal has been accomplished.*[30]*'*

Aspects of healthy schools' work are being used as performance indicators for both the national drug strategy and the teenage pregnancy strategy. NHSS is growing in depth, accountability and profile as the policy climate changes.

New certification for personal, health and social education (PHSE) will further enhance healthy schools' work and raise the profile of PHSE.

Injury prevention strategy

Accidental injury takes a heavy toll on society, particularly on children and older people, and it strikes hardest at the most disadvantaged. The agenda for injury prevention work is set by *Preventing Accidental Injury Priorities for Action.*[31] This document formed the basis of a special South Gloucestershire Better Health Forum at which the local strategy *Preventing Injuries in South Gloucestershire* was presented.

The South Gloucestershire Injury Prevention Joint Strategy Group agreed to generate sustained support for this work through the delivery of the Avonsafe Injury Prevention Alliance Strategy 2001-2006 and other local plans. The PCT continues to host the Avonsafe co-ordinator's post.

Successes this year have included:

- support of national and local campaigns, including speed reduction initiatives and a disposal of unwanted medicines campaign.
- work at the Lifeskills Centre (see over).

Safety for Traveller children

Avon Consortium Traveller Education Service and the Traveller Health Project (with support from health promotion staff) set up a safety project based on research into accidental injury carried out by the Traveller Health Project.

Eight children attended six safety sessions with speakers from the fire, ambulance and road safety services. All eight children continued to attend and were enthusiastic participants. They were given folders, notebooks and disposable cameras to take away, which they used to do drawings and make notes. In the final two sessions, they wrote and designed their own safety booklet.

[30] NHSS Team 2003 monitoring report of South Gloucestershire Healthy Schools Programme.
[31] The Accidental Injury Task Force 2002 Preventing Accidental Injury Priorities for Action Report to the Chief Medical Officer

The Lifeskills Centre

This provides and evaluates safety training courses for children, people with learning difficulties and older people and is based at the Create Centre in Bristol.

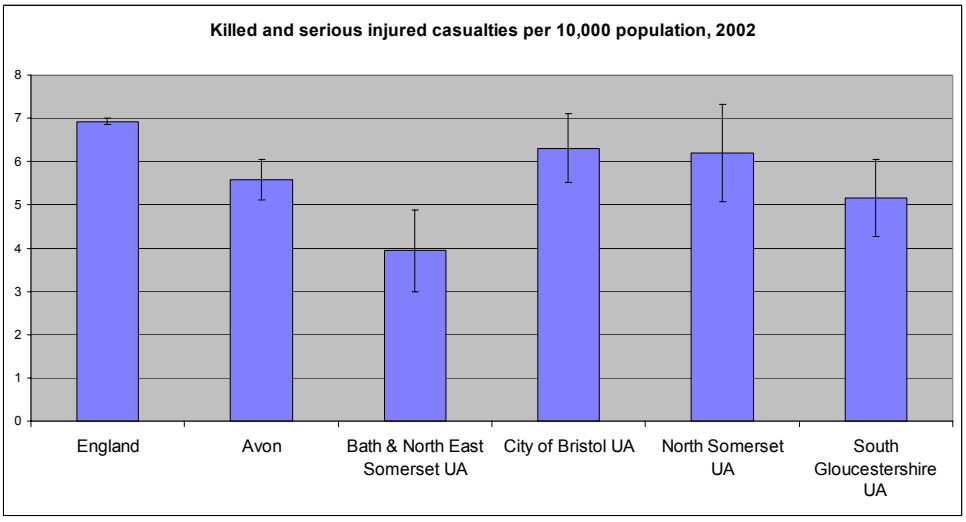
Two thousand, three hundred pupils in Year 6 from South Gloucestershire schools visited the Lifeskills Centre this year. A two year evaluation study[32] showed that the children's programme achieved its aims of increasing knowledge and behavioural change. A presentation about this work was made at the World Injury Prevention Conference in Vienna in 2004. A Community Fund grant of £135,000 will enable the work with adults and children with special needs to develop further.[33]

Safety cameras and the safety camera partnership

Road traffic collisions are a major cause of death and disability in the UK. Each year around 3,500 people are killed and 330,000 are injured on the roads. The national road safety strategy,[34] sets targets to reduce these numbers.

In 2002 there were 830 accidents in South Gloucestershire, resulting in 127 people being fatally or seriously injured.

Figure 16: Killed and seriously injured casualties per 10,000 population



Source: Department for Transport Road Casualty Report, 2002

The killed and seriously injured casualty rate in South Gloucestershire is lower than expected when compared to the national average, and not significantly different to the other local authority rates within the former Avon area. At least one third of collisions are speed-related. Speed related road injuries and deaths cost Avon and Somerset an estimated £19,000,000 a year, through loss of output and medical costs. Speed related road accidents result in an estimated 559 hospital in-patient admissions each year, equating to approximately 3,187

[32] Study completed by Oxford/Oxford Brookes Universities
[33] See **www.lifeskills-bristol.org.uk** for further information.
[34] 2000 Government Road Safety Strategy: Tomorrows Roads - Safer for everyone

bed days. Measures to reduce traffic speed are key to reducing casualties on the road. Safety cameras help reduce traffic speeds, collisions and casualties.

The Avon, Somerset and Gloucestershire Safety Camera Partnership oversees the running of safety cameras, making sure that they are sited in the locations where they most benefit road safety and health. Research shows that in the UK the number of people killed or seriously injured at sites where safety cameras are in use fell by 40%. Around 80% of the population support safety cameras.

Sexual health and teenage pregnancy strategy

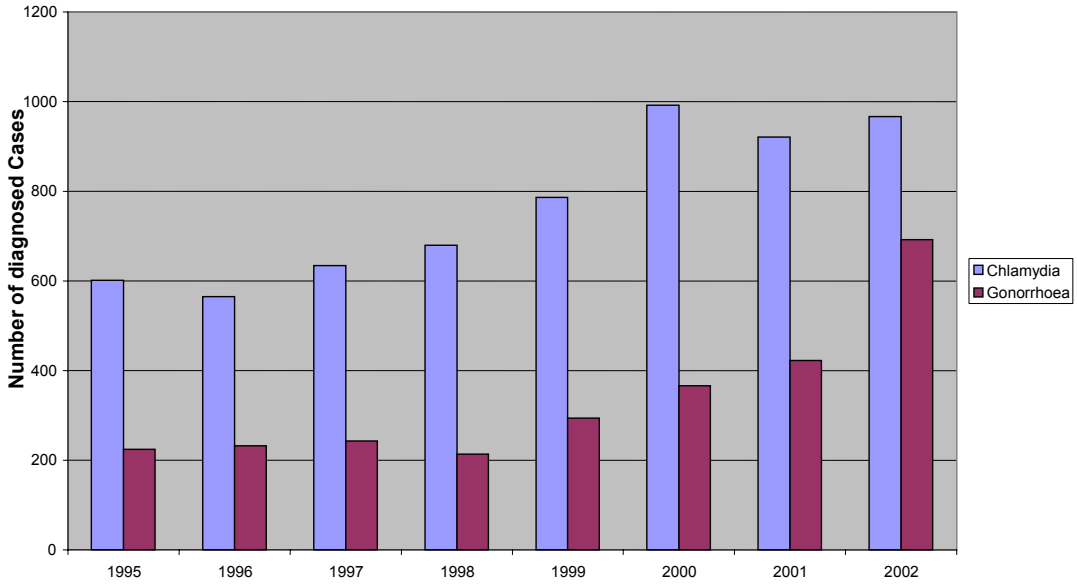
The under 18's conception rate in South Gloucestershire continues to fall (see Appendix B). In 2002, it was 35% lower than the baseline year of 1998. The under 16's conception rate has fluctuated over the past four years, (as would be expected from the smaller numbers) and no clear trend has yet emerged.

The Teenage Pregnancy Board has been strengthened in the last 12 months, with the formation of three subgroups focusing on contraceptive services, better prevention and support to young mothers.

Sexually transmitted infections

Although, for reasons of confidentiality, there is no population based data for the rate of sexually transmitted infections (STIs) in South Gloucestershire, data from the Milne Clinic at Bristol Royal Infirmary shows an increase in sexually transmitted infections, particularly chlamydia and gonorrhoea, in line with national trends. Part of the increase in chlamydia reflects increased testing. The consistent increase in gonorrhoea and other STIs is of great concern.

Figure 14: Diagnosed chlamydia and gonorrhoea cases at the BRI



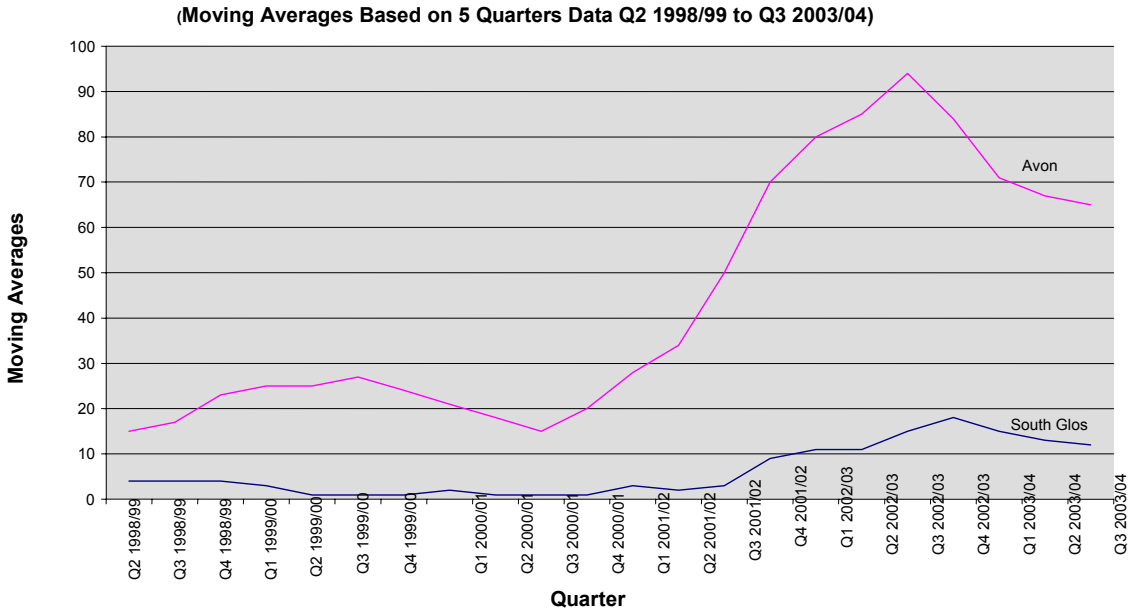
Source: KC60 returns

There is an urgent need to improve the facilities and capacity of the Milne clinic and to develop community services along the lines of the national sexual health strategy.[35] The PCT is appointing a new sexual health programme manager to take forward this work.

Hepatitis B outbreak

There has been an outbreak of acute Hepatitis B cases in the former Avon area since mid 2001. Over this time there has been an increase from approximately 17 cases to approximately 72 per year. Despite a drop in 2003, new cases are still occurring at a much higher rate than before the outbreak began.

Figure 15: New cases of Hepatitis B in the former Avon area



Source: Avon Health Protection Unit

All age groups which include those aged over 14 appear to be affected - with the exception of females aged 55 and over. The major risk factors identified so far are injecting drug use and heterosexual sex.

The PCT has co-operated closely with the local Health Protection Agency (HPA), Drug Action Team and GPs. In response to guidance from the HPA, a multi-pronged approach has been adopted:

- GPs and health professionals were informed of the outbreak through letters, newsletters and training sessions, and their help was sought in immunising patients at risk, that is, injecting drug users and commercial sex workers. A nominal payment was to be made by the PCT.
- The Drug Action Team supported this by keeping a database and reminding practice managers of those whose vaccinations were overdue.

[35] see at www.doh.gov.uk

This approach has resulted in 150 patients receiving a total of 269 Hepatitis B vaccinations to date - a direct result of the joint efforts of the PCT, the drug lead, the Drug Action Team, Communicable Disease Control and GPs.

Prison health

In 2003, the responsibility for commissioning prison health services was transferred from the Home Office to the NHS. This move should ensure that services work to common quality standards such as those outlined in the NSFs and NICE guidance.[36] Health services provided for prisoners should be as good as those provided by the NHS for the general population.

Approximately 65,000 people in England and Wales are admitted to penal institutions each year. Around 70% will have significant health problems, primarily concerning mental health. Drug and alcohol misuse, self-harm and suicide, personality disorders and psychotic illness dominate the clinical picture.

There are also a range of physical problems for a population who tend to lead more unhealthy lives than their peer group. More than 90% of prisoners will come from deprived communities and the majority of male prisoners will not have used the NHS when able to do so. Prison, therefore, is probably the primary area where health problems can be addressed and opportunity afforded for integration into NHS services on release.

Prisons and PCTs have lead responsibility for developing and managing the implementation of local prison health delivery plans. The South Gloucestershire Prison Cluster aims to develop new arrangements for commissioning health services. It is seeking to provide high quality, evidence-based health care and equality of access; to actively seek prisoners' views on their health care; and to commission services according to need.

The Prison Health Local Implementation Group is commissioning the University of the West of England to carry out a comprehensive health needs assessment as a basis for future commissioning. A clinical governance baseline audit has been carried out for each prison. An action plan will be developed based on the findings and future progress will be monitored. Clear needs have arisen in:

- substance misuse/detoxification 'dual diagnosis'
- primary care
- clinical governance
- IT/administration
- dental health
- mental health
- health promotion
- workforce development.

[36] NICE see www.nice.org.uk

Closing Remarks

This is the second annual public health report for South Gloucestershire. The first concentrated on the 'big killers' and highlighted the strong link in our area between deprivation (low income and poverty) and poorer health. This report has focussed on the health problems that cause major suffering and disability.

I have described the progress that has been made in building an alliance with the local authority in tackling the root causes of ill health, and the fundamental role of primary health and community care in promoting good health.

This is an area that is changing fast, and this presents both challenges and opportunities. The challenges include getting around (transport), potential social isolation for young families and the designing of services to meet very different needs in each area. The opportunities include the chance to get the design and servicing of new housing developments right, and to help established and new communities to take control of changing their lives for the better.

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	Mental health; young people
Graham Simmonds	Physical activity
Maggie Sims	Injury prevention; Schools for Health
June Martin	Smoking Cessation and Tobacco Control
Jane Kilpatrick	Community Health Development
Nicola Ravenscroft	Food and Health
Paul Pilkington	Public health trainee
Fiona Taylor	Public health trainee
Ruth Kipping	Public health trainee

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Sally Bramley	Editing
Julia Rowley	Final production

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Dr Viv Harrison	Consultant in Public Health, CHD and diabetes
Dr Chris Hine	Consultant in Public Health, Acute commissioning

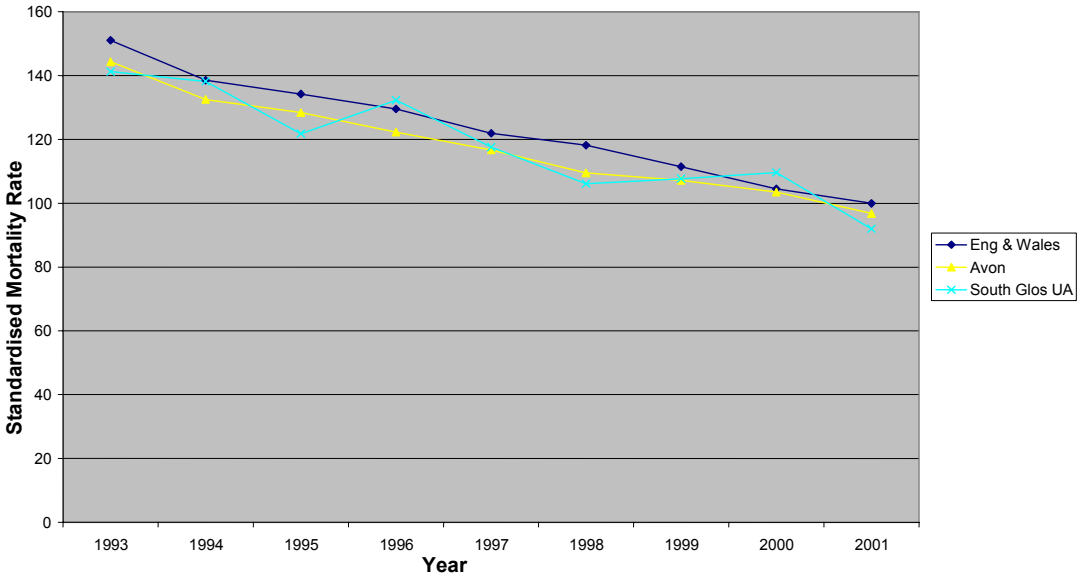
Particular thanks to Marie Barnes for masterminding the analysis and presentation of health information, with a major contribution from Paul Perks.

Dr Chris Payne

Director of Public Health South Gloucestershire Primary Care Trust

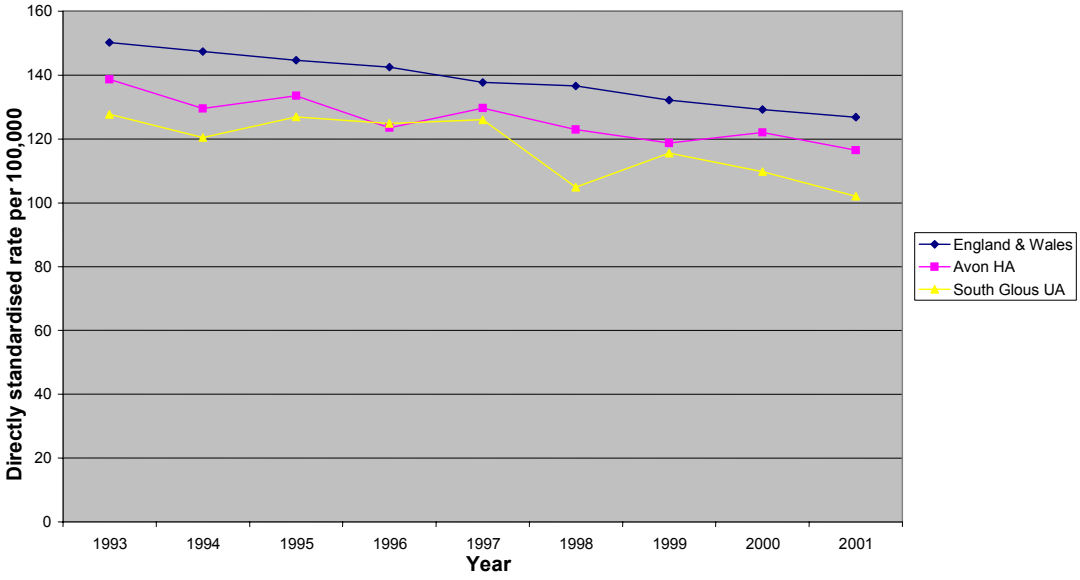
Appendix A: An Update on the Major Causes of Ill Health

Figure 17: Trends in mortality from coronary heart disease in South Gloucestershire (1993-2001)



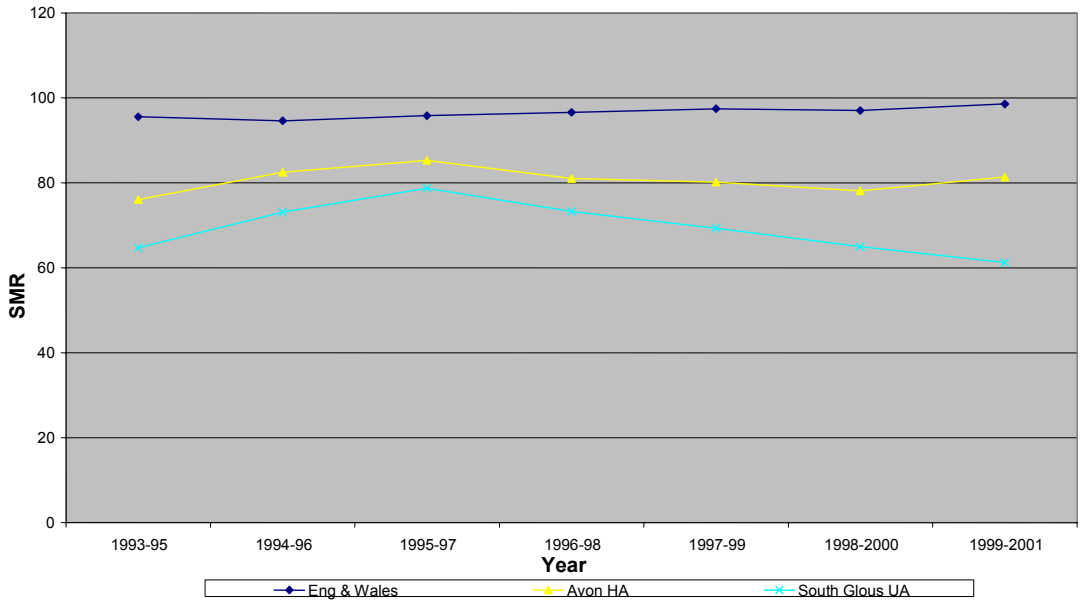
Source: Compendium of Clinical Indicators DOH 2002

Figure 18: Trends in mortality from malignant neoplasms in the under 75s in South Gloucestershire (1993-2001)



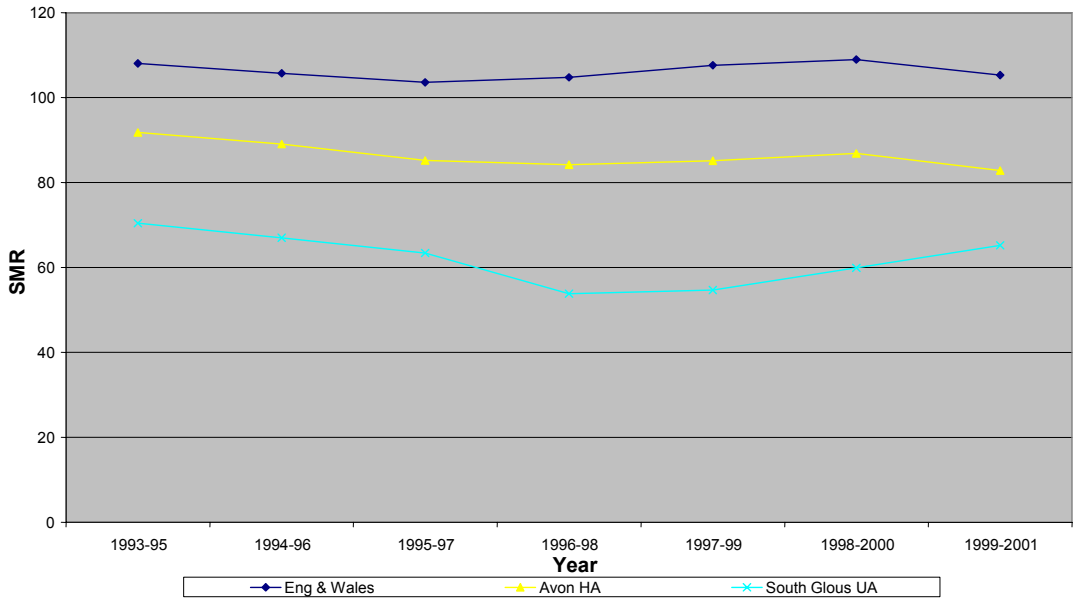
Source: Compendium of Clinical Indicators DOH 2002

Figure 19: Trends in mortality from accidents in South Gloucestershire three year rolling rates 1993-2001



Source: Compendium of Clinical Indicators DOH 2002

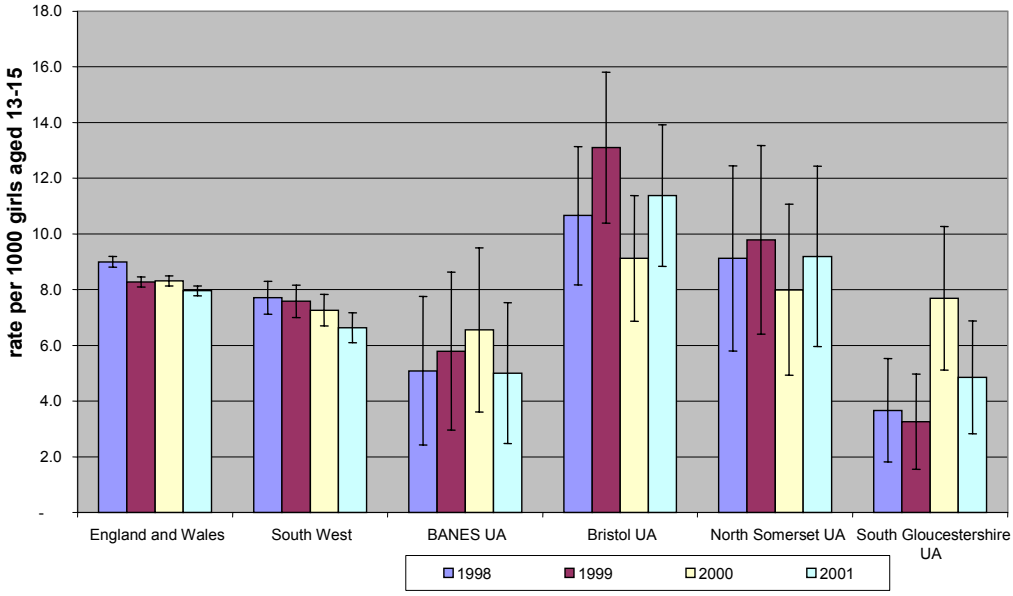
Figure 20: Trends in mortality from suicides in South Gloucestershire three year rolling rates 1993-2001



Source: Compendium of Clinical Indicators DOH 2002

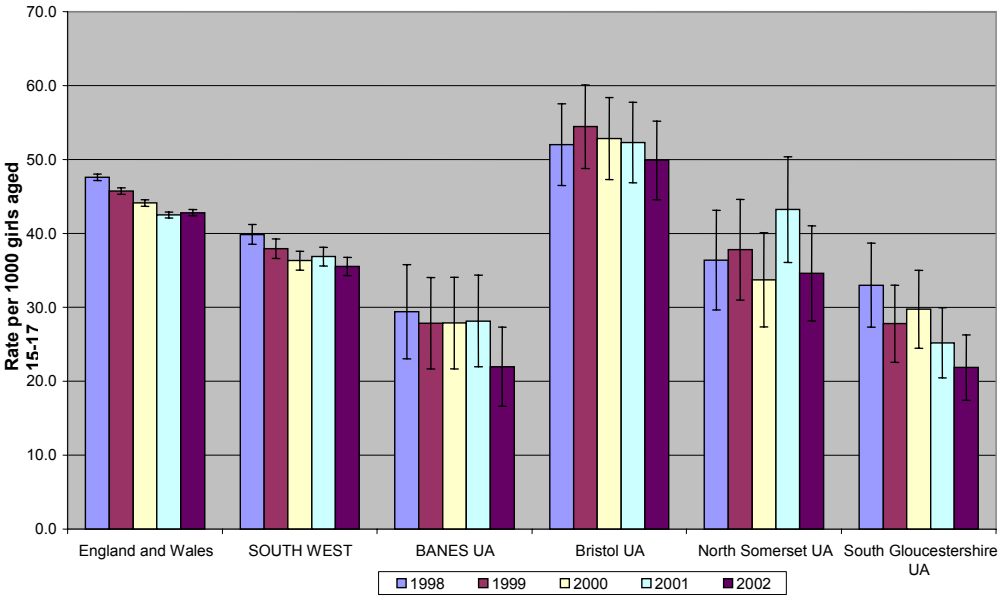
Appendix B: An Update on Maternity and New Born Health

Figure 21: Conceptions in the under 16s (1998-2001)



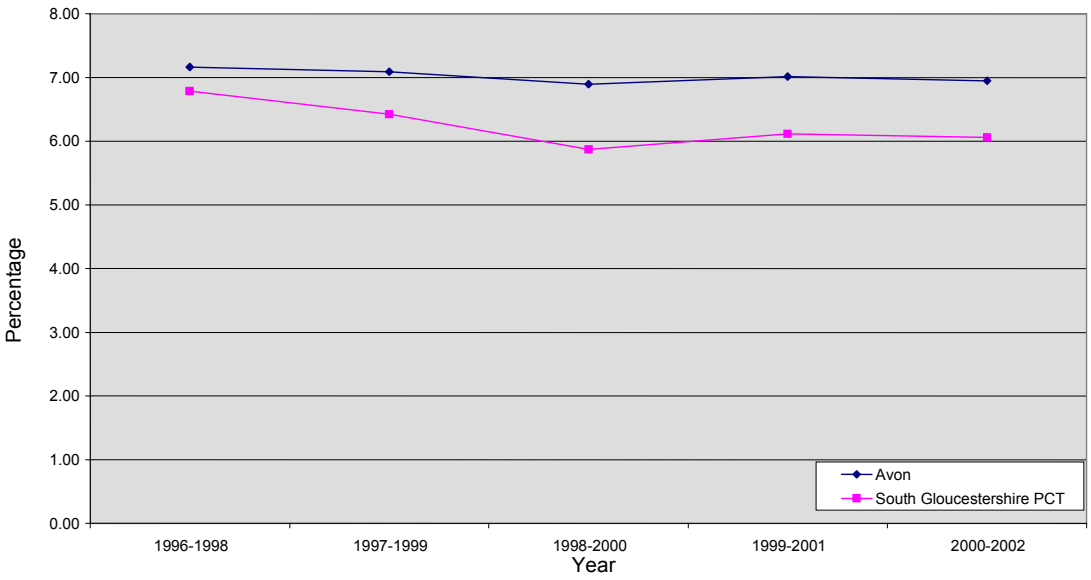
Source: ONS

Figure 22: Conceptions in the under 18s (1998-2002)



Source: ONS

Figure 23: Percentage of low birth weight babies (under 2500g) as a percentage of total births.



Source: Compendium of Clinical Indicators DOH 2002

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

1st October 2004

South Gloucestershire NHS
Primary Care Trust