

# Health



## our area our health

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### Annual Report of the Director of Public Health 2007

*Focus on gender, alcohol and  
assessing neighbourhood  
health need*



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## Introduction

The health of the South Gloucestershire population is improving steadily. Local residents are living longer and in better health. Despite this reduction in the level of illness, it is striking how the overall pattern of the illness that does occur changes quite slowly. A local Director of Public Health report written 30 years ago would have reported a familiar pattern of cardiovascular disease and cancers as the leading causes of death. It may well have pointed out the strong link between ill health and social class and made recommendations familiar today, such as reducing smoking.

Despite this apparent stability in patterns of illness, there can be quite startling changes in particular risk factors, or illnesses. The alarming rise in obesity is an example of how, although the overall trends in health for the population of South Gloucestershire are reassuring, there are some that are getting worse. Other examples of adverse trends, or lack of progress, include the increasing harm from alcohol consumption and stubborn inequalities in health.

Many of these challenges have been covered in previous annual reports and are highlighted in the index to these, on page 47. This report includes a review of the increasing harm from alcohol consumption and examines persisting differences between the health of women and men.

This year's report marks a shift away from a traditional Director of Public Health report in a couple of ways.

Firstly, much of the analysis and presentation of routine health data is now undertaken by the Public Health Observatories. They produce annual community health profiles which provide a snapshot of health and health issues in each local authority area. Rather than duplicate that work, the 2007 profile for South Gloucestershire is included in Appendix A. It can also be seen on the website [www.communityhealthprofiles.info](http://www.communityhealthprofiles.info).

Secondly, this report reflects the increasing focus of the Primary Care Trust (PCT) and the council on understanding and planning for the specific needs of individual localities within South Gloucestershire. This document provides a broad overview of the health of the area and has three 'sister' documents providing more detailed assessment of need in Severnvale, Yate locality and Kingswood locality. This reflects the importance of understanding health need at a local level, in order to ensure that services planned by the local authority, PCT and other partners are tailored and targeted appropriately to improve health and reduce inequalities.



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





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## Section 1: Gender and health - comparing the health of women and men

### Key messages in South Gloucestershire

- Life expectancy for women and men is better than the English average.
- On average, women can expect to live 3.5 years longer than men.
- The gap in life expectancy between women and men is gradually narrowing, with men's life expectancy catching up with women's.
- Men are much more likely than women to die prematurely from circulatory disease, cancer, or from injury. Tackling these, and other major health problems, will benefit both sexes, but will tend to narrow the health gap, as men have worse health and therefore more to gain.
- Women have higher rates of mental illness and are more likely to suffer domestic violence.
- Unhealthy behaviours are shared fairly equally between women and men, with men drinking and suffering more harm from alcohol.
- The reduction in the number of men smoking has played a large part in narrowing the health gap between women and men.
- The gap in life expectancy between women and men is greatest in poorer communities.

### 1.1 Introduction

Overall, men have worse health than women. Males have a lower life expectancy, are more likely to die young in accidents and have higher death rates from cardiovascular disease and cancer. Why should this be? Is there anything we can do about it? Are there problems where the reverse is true – of women having worse health than men?

This section focuses on the differences in health between women and men in South Gloucestershire. It reviews existing work to reduce those differences and makes recommendations for the future.

Gender differences in health can be examined in two ways. Firstly, we can consider and compare the significant differences between the health and health behaviours of women and men.

Secondly, we can focus on conditions which are unique to one gender, such as some types of cancer. In this report we will provide both comparative information and information about key health problems unique to either women or men.



## Life expectancy

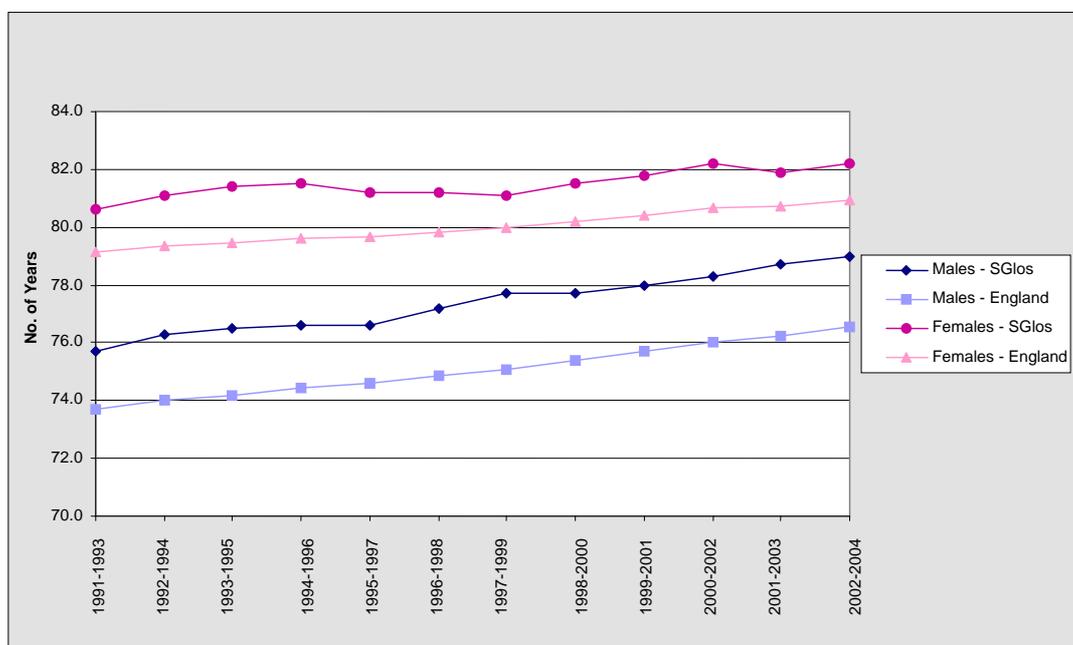
Life expectancy continues to increase - both nationally and in South Gloucestershire - and for both women and men.

South Gloucestershire is generally a healthy place to live. Between 2003 and 2005, life expectancy at birth was:

- 79.2 years for men (2.3 years more than the average for men living in England)
- 82.7 years for women (1.6 years more than the average for women living in England).

On average, in South Gloucestershire, women can expect to live 3.5 years longer than men. However, the gap between women and men is gradually narrowing, with men's life expectancy growing faster than women's.

**Figure 1: Trends in life expectancy at birth in South Gloucestershire 1991-1993 to 2002-2004**



Source: Compendium of Clinical and Health Indicators

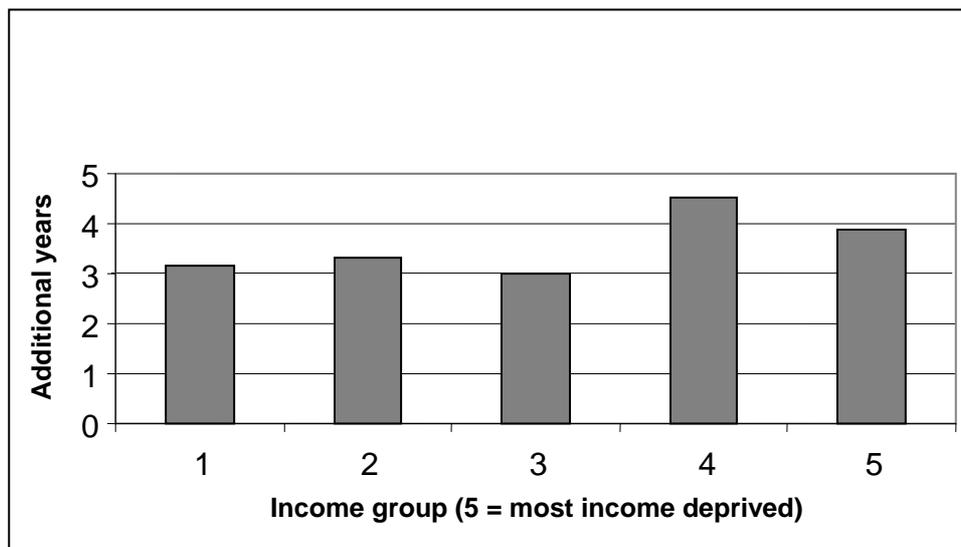
## Inequalities in health

The community health profile in Appendix A presents life expectancy for women and men according to the percentage of people on a low income in each area within South Gloucestershire. The areas are divided into five levels, or quintiles, of income deprivation. It shows (as previous annual reports have shown) that women and men in more deprived communities have a reduced life expectancy compared with those in less deprived areas.

Figure 2 shows the differences in life expectancy between women and men in each quintile. The difference is largest in the more deprived communities. There is around a four year difference in the two poorest quintiles, compared with a three year difference in the three least deprived.



**Figure 2: Additional life expectancy of women compared with men in each income group**



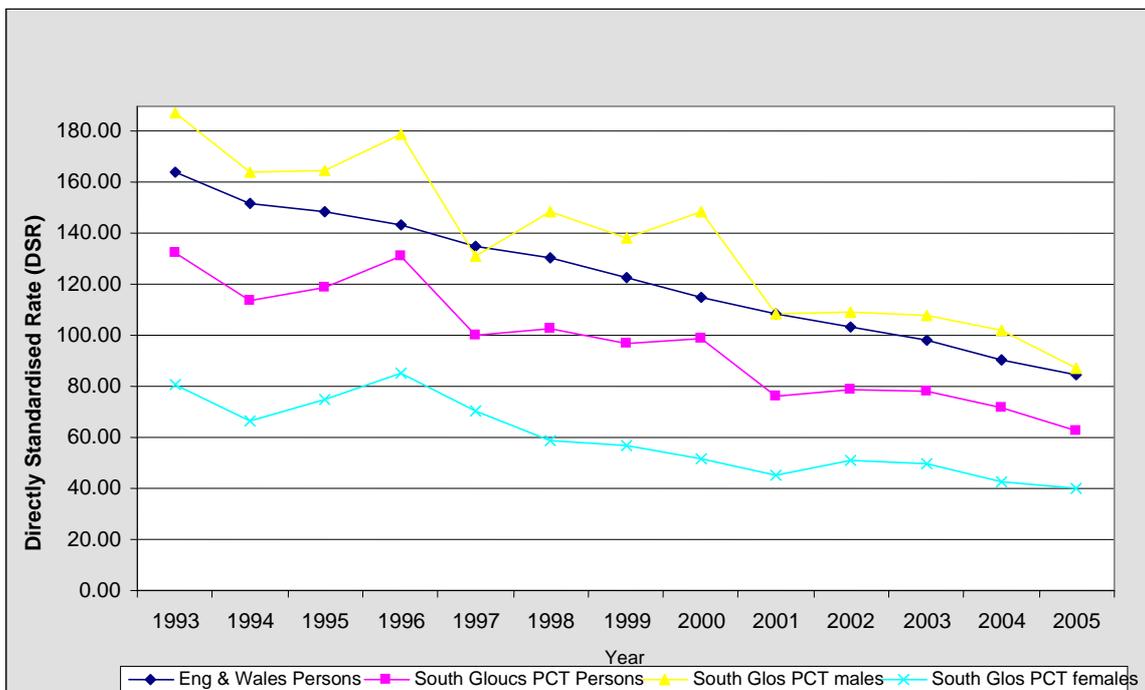
Source: [www.communityhealthprofiles.info/background\\_documents.php](http://www.communityhealthprofiles.info/background_documents.php)

## 1.2 Leading causes of ill health

This section focuses on how the common, major health problems affect women and men.

### Coronary heart disease

**Figure 3: Trends in mortality from circulatory diseases under the age of 75 yrs in South Gloucestershire 1993-2005**



Source: Compendium of Clinical Indicators



Death rates from circulatory disease (which includes coronary heart disease) are dropping steadily for both women and men. Rates for both sexes have fallen by about half over the past 15 years.

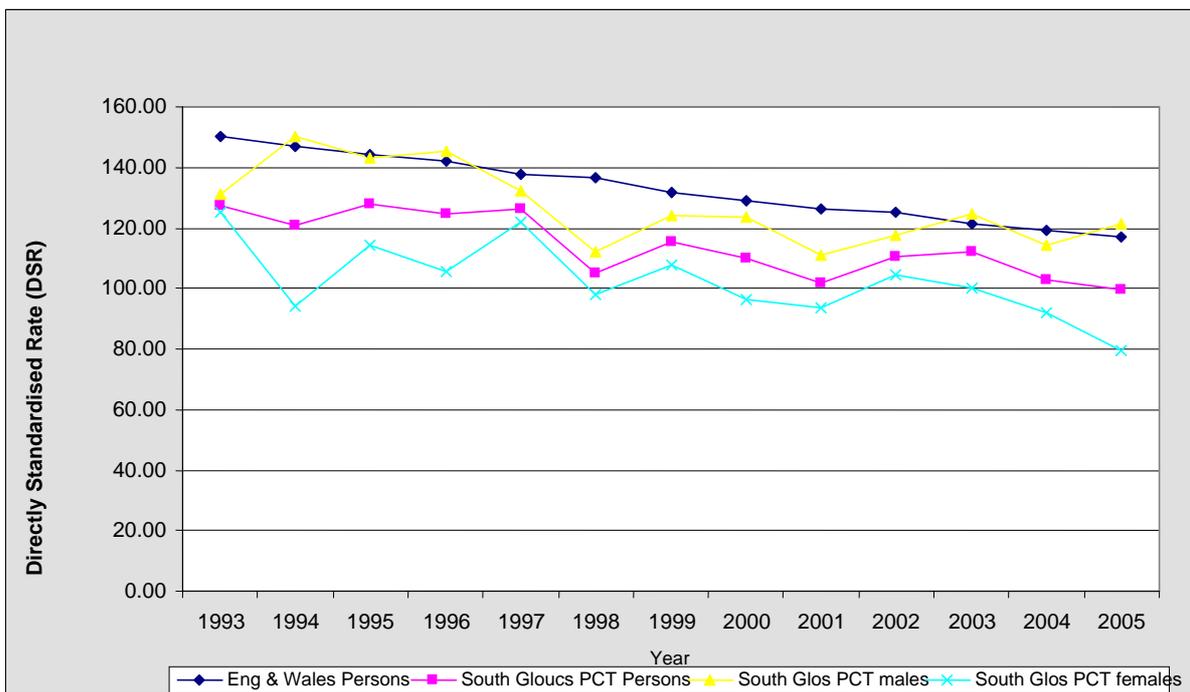
There is, however, a marked difference between the sexes, with women approximately half as likely as men to die from heart disease, or other circulatory disease, before the age of 75 years.

Figure 3 illustrates how a major improvement in health for both sexes has been of disproportionate benefit to men. Although premature death rates for both sexes have reduced, the absolute reduction for men has been greater. This shows that a programme to improve health can help reduce inequalities (in absolute rather than relative terms) whilst still benefiting all.

Diabetes is an important risk factor for circulatory disease and is more common in men. It affects 4.8% of men and 3.6% of women.<sup>1</sup>

**Cancers**

**Figure 4: Trends in mortality from all cancers under the age of 75 yrs in South Gloucestershire 1993-2005**



Source: South West Cancer Intelligence Service

More men than women under the age of 75 years die from cancer. The difference between men and women is smaller than for deaths from circulatory disease and masks the considerable differences in the types of cancer affecting each sex.

<sup>1</sup> Department of Health 2005 Health Survey for England 2004 London: DH



**Table 1: Average number of new cases of cancer per year in South Gloucestershire PCT 2001-2003**

	Male	Female	Total
Colorectal	72	55	127
Lung	62	39	101
Melanoma	16	20	36
Female breast	-	181	181
Cervix	-	15	15
Prostate	147	-	147
All cancers	547	544	1,091

Source: South West Cancer Intelligence Service

Colorectal and lung cancers are more common in men than in women.

Testicular and prostate cancers are unique to men; cancer of the cervix is unique to women.

Prostate cancer is the most common cancer in men. In South Gloucestershire, the average number of new cases each year is 17% higher than in England. However, nine per cent fewer men die from prostate cancer each year, than in England as a whole.<sup>2</sup>

The strongest known risk factor for prostate cancer is age, with men under 50 years at very low risk and a rising risk with increasing age after 50 years. Men can be tested for prostate cancer using the prostate specific antigen test (PSA) and this has led to calls for a screening programme (see page 16).

Testicular cancer commonly occurs in men aged between 20 and 40 years and is curable in the great majority of cases.<sup>3</sup>

## Injuries

Deaths, overall, from unintentional injury have decreased. However, there are persistent and widening inequalities between males and females, as well as between socio-economic groups and different age ranges.

Most studies reveal distinct patterns of injury for males and females. For most (but not all) types of injury the number of injuries sustained by males is greater than for females. The association between males and increased risk appears to apply at all levels of severity.

<sup>2</sup> South West Public Health Observatory Key Data South West Cancer Intelligence Service. 2006  
Bristol: South West Public Health Observatory

<sup>3</sup> South West Cancer Intelligence Service Factsheet No. 11: Testicular Cancer ICD - 10\*: C62.  
Bristol: South West Public Health Observatory



It is not fully understood why these differences exist. However, the factors associated with gender that may influence children’s injury risk have been identified as:<sup>4</sup>

- different rates of physical development
- motor coordination
- spatial ability
- cognition and intellectual development
- gender differences in behaviour (e.g. risk taking, peer pressure)
- different forms of play and levels of independence
- different levels of supervision and freedom of activities
- exposure to different environments.

The table below shows that boys and men are at an overall greater risk of death from injury than girls and women.<sup>5</sup>

**Table 2: Major causes of unintentional injury resulting in death in UK 2005**

Cause of death	Number of male deaths	Number of female deaths
Land transport accidents	2,252	748
Falls	1,557	1,583
Accidental drowning and submersion	134	51
Exposure to smoke fire and flames	168	109
Accidental poisoning	673	306

Source: Office of National Statistics at [www.statistics.gov.uk](http://www.statistics.gov.uk)

The exception to this pattern is the number of people who die as a result of a fall. More older women are involved in home accidents, particularly falls, than older men, partly due to the larger proportion of women in the older population. In 2006-2007, of the 340 people screened for a primary care falls assessment in South Gloucestershire following a fall, 253 (74%) were women and 87 (26%) were men.

Nationally, there is a strong association between socio-economic deprivation and childhood injury. In South Gloucestershire, there is a slight increase from the least deprived quintile to the most deprived quintile, but overall the difference is not very marked. This may reflect a narrower range of population deprivation in South Gloucestershire, compared with other regions. Social and economic factors that are associated with injury risk for children have been identified as:

- lack of money (ability to buy safety equipment)
- exposure to hazardous environments inside and outside the home
- ability of parents or carers to supervise children
- children’s attitudes and behaviour (risk taking)
- access to information and services.

<sup>4</sup> Health Development Agency 2005 Injuries in Children aged 0-14 years and inequalities

<sup>5</sup> Office for National Statistics 2007 Series DH4 no.30 Mortality Statistics Injury and Poisoning



## Mental health

There are a number of differences between women's and men's mental health.<sup>6</sup>

- Men are less likely than women to have depression, due to both social and biological factors, although gender differences are less apparent after middle age.
- 58% of remand prisoners and 39% of sentenced prisoners have mental health problems and men make up 96% of the UK prison population.
- Alcohol and substance abuse is five times more common in men than in women.
- One in seven men who become unemployed develops depression within six months.
- Men tend to have an earlier onset of schizophrenia and a poorer prognosis than women.

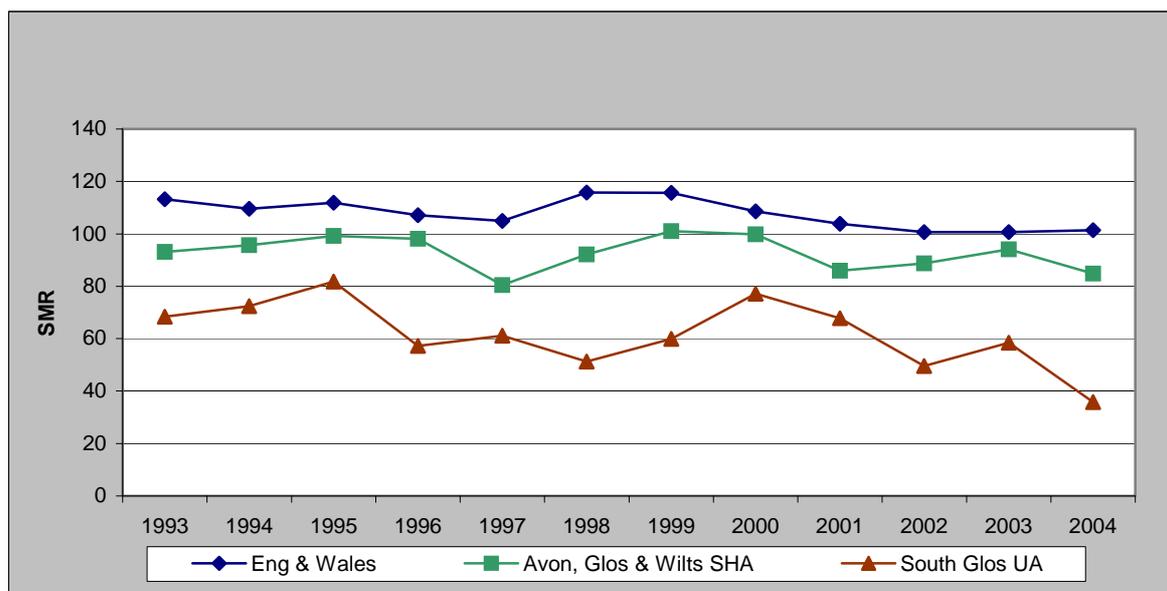
The reasons for these differences may be that:

- many men have been brought up not to talk about their problems, or express their feelings. One effect of this may be that men are reluctant to ask for help for their emotional problems.
- men are less likely than women to go to their GP with psychological problems. If they do go, they are more likely to present with physical problems and their mental distress may not be recognised.

## Suicide

National suicide rates fluctuate year on year, but have shown a downward trend since the early 1980s.

**Figure 5: Trends in mortality from suicide and undetermined injury in South Gloucestershire 1993-2004**



Source: Compendium of Clinical Indicators. (Note: SMR = Standardised Mortality Ratio)

<sup>6</sup> MIND Men's Mental Health at [www.mind.org.uk/Information/Factsheets/Men](http://www.mind.org.uk/Information/Factsheets/Men)

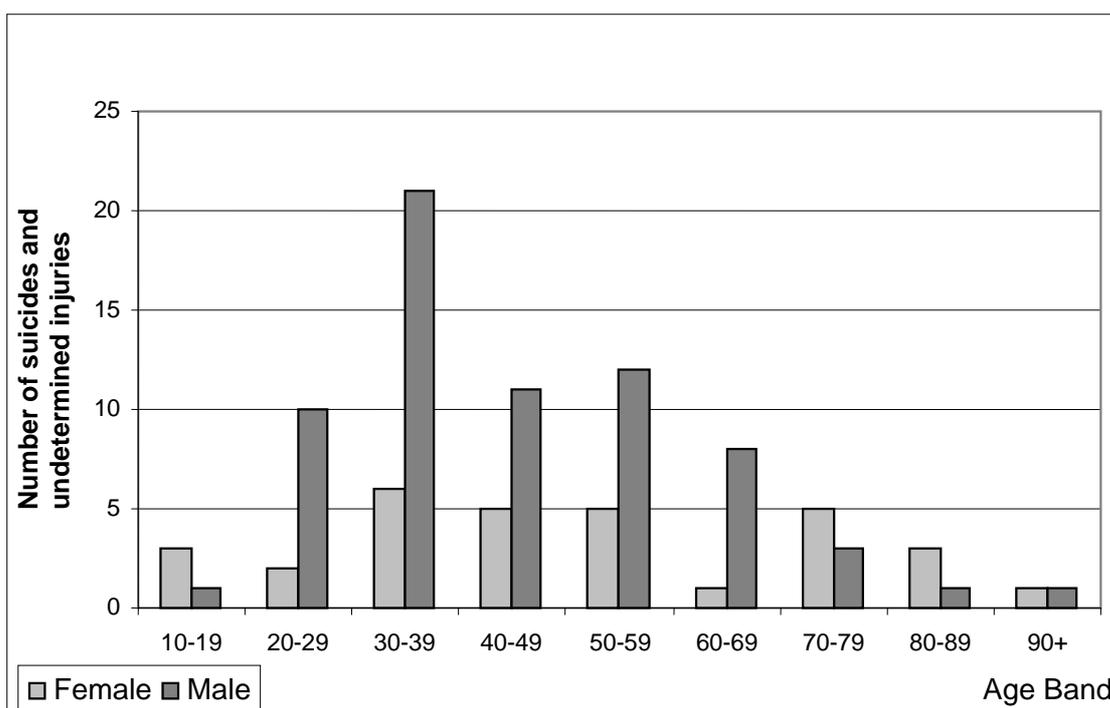


Men are around three times more likely to commit suicide than women and this is true across all ages.<sup>7</sup> It may be that men's reluctance to seek help and access services results in them taking this extreme action.

In South Gloucestershire, the rates of suicide are much lower than the national rates, although every year, on average, 12 people die here from suicide and undetermined injury. In 2004, 63% of suicides were men and 37% women. The highest number of suicides occurred between the ages of 30 and 39 years.

The average male age of suicide locally is 44.5 years; the average female age is 50.3 years. These ages are slightly higher than the national average.<sup>8</sup>

**Figure 6: Variations in the age of suicide and undetermined injury victims in South Gloucestershire 1994-2003 (pooled data)**



Source: Public Health Mortality File

### Self-harm

Rates of self-harm have been increasing since the mid 1980s. They are highest in women aged between 15 and 19 years and in men between 20 and 29 years.

### Young people and mental health

Between October 2005 and July 2006, 807 young people in South Gloucestershire were referred to the Child and Adolescent Mental Health Service (CAMHS). More boys were referred than girls - 58% boys and 42% girls. Behavioural problems were the largest presenting problems. Approximately four per cent of young people were referred because of issues to do with self-harm.

<sup>7</sup> Department of Health 2002 National Suicide Prevention Strategy for England. London: DH

<sup>8</sup> South Gloucestershire Audit of Deaths by Suicide and Undetermined Injury occurring between 1994 and 2003



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## Depression

Around 17,000 people are treated locally for depression every year. Of these, 71% are women and 29% are men. This supports the belief that women access services more, so helping to prevent deterioration in their mental health. Locally, around 140,000 prescriptions are issued annually for antidepressants.

## Domestic violence

Domestic violence is the least likely crime to be reported. It is estimated that less than one third of incidents are reported and that, on average, a woman suffering domestic violence will experience 35 incidents before seeking help.<sup>9</sup>

Domestic violence is defined as any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are, or have been, intimate partners, or family members, regardless of gender or sexuality.

Every year, 120 women and 30 men in Great Britain are killed by a current or former partner. In general, men experience abuse that is less frequent and less severe than that experienced by women. Women are more likely than men to experience threats, to be repeatedly assaulted and require medical help. Statistically, levels of fear and trauma are higher for women and have longer lasting effects. Women are also at greater risk of violence at separation from their male partner.

South Gloucestershire has recently started collecting data through the specialist domestic violence courts. So far, one month's data shows that:

- 80% of victims were female and 20% were male
- 78% of perpetrators were male and 22% were female (the apparent disparity is because some incidents are between people of the same sex)
- there were 167 recorded incidents - 57% (96) involved current or ex-partners and 43% (71) involved family members
- of the family-related incidents, 31% (22) were same sex incidents.

## Sexually transmitted infections

See page 43 in Section 5.

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<sup>9</sup> Home Office 2004 Domestic Violence, sexual assault and stalking: findings from the British Crime Survey



### 1.3 Health-related behaviours in women and men

This section looks at the main differences in women's and men's lifestyles that impact on health. With the exception of alcohol, there are broad similarities between the sexes.

#### Smoking

Smoking remains the single biggest preventable cause of death nationally. Around ten million adults smoke tobacco in Great Britain. Smoking is no longer more common in men than women: 22% of men and 23% of women are smokers.<sup>10</sup> The equalising of smoking rates is very probably a major explanation for the narrowing health gap between men and women.

Approximately 21% of people in South Gloucestershire smoke.

Recent reductions in smoking have come about largely through smokers quitting, rather than less young people starting to smoke. Approximately 21% of women and 27% of men are now ex-smokers.

In England, one fifth of 15 year olds are regular smokers - 16% of boys and 25% of girls. Over 80% of smokers start as teenagers. Since October 2007, it has been illegal for people under 18 years old to buy tobacco.

#### Alcohol

Drinking alcohol at above the recommended levels carries an increased risk of liver disease, some cancers and heart disease.

It also has an indirect impact on health through crime and anti-social behaviour, domestic violence and road traffic accidents.

The recommended safe levels of drinking are:

- men should drink no more than 21 units of alcohol per week (and no more than four units in any one day)
- women should drink no more than 14 units of alcohol per week (and no more than three units in any one day)
- pregnant women and women trying to become pregnant should not drink at all.

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<sup>10</sup> Department of Health 2005 Health Survey for England 2004. London: DH



A Department of Health review in 2004 reported that nationally:<sup>11</sup>

- 38% of men and 16% of women (aged 16 to 64 years) have some level of alcohol disorder (ranging from binge drinking to dependence)
- 21% of men and 9% of women are binge drinkers
- 6% of men and 2% of women are alcohol dependent (people drinking above 'sensible' levels and experiencing harm and symptoms of dependence).

See Section 2 for more information on alcohol and its impact on health in South Gloucestershire.

## Overweight and obesity

Overweight and obesity are defined by Body Mass Index (BMI), a measurement that takes account of the relationship between height and weight. It is calculated by dividing weight (measured in kg) by height squared (measured in metres).<sup>12</sup>

**Table 3: Body Mass Index and its relation to weight**

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

Using estimates from national surveys for the South Gloucestershire population, more men than women are overweight - 46% of men compared to 35% of women. Similar percentages of men and women are obese - 23.6% of men and 23.8% of women.<sup>13</sup>

In contrast to women, many overweight men are unaware of their weight problem.<sup>14</sup> In a national survey only around half of men who would benefit from weight reduction, when asked said that they were trying to lose weight. Few of them had received advice from health professionals.

Local data gathered at school entry reveals that over ten per cent of Reception Year children (aged four to five years) in South Gloucestershire are obese. In wards with lower rates of breastfeeding there are higher rates of obesity among children aged four to five years.

<sup>11</sup> Department of Health 2004 Alcohol Needs Assessment Research Project (ANARP) London: DH

<sup>12</sup> World Health Organisation 2000 Obesity: preventing and managing the global epidemic. Report on WHO consultation. WHO Technical report series No. 894, 1-253 Page 40

<sup>13</sup> Department of Health 2005 Health Survey for England 2004. London: DH

<sup>14</sup> Wardle J, Johnson F 2002 Weight and dieting: examining levels of weight concern in British adults. *Int J Obes Relat Metab Disord.* 2002 Aug; 26(8):1144-9



## Diet

The government recommends that all healthy individuals should eat plenty of fruit and vegetables - at least five portions of a variety of fruit and vegetables a day.

More women than men eat five or more portions of fruit and vegetables per day - 27% of women compared with 24% of men.<sup>15</sup>

## Physical activity

The government recommendation is that every adult takes at least moderately intense physical activity for 30 minutes on at least five days a week.

In a health survey carried out nationally:

- more men than women achieved the minimum of 30 minutes of moderate intensity activity at least five times a week - 35% of men compared to 24% of women.<sup>16</sup>

In a South Gloucestershire survey:

- only 22% of adults reported having taken any moderately intense physical activity in the previous four weeks.<sup>17</sup>

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<sup>15</sup> Department of Health 2005 Health Survey for England 2004 London: DH.

<sup>16</sup> Department of Health 2005 Health Survey for England 2004 London: DH

<sup>17</sup> Survey carried out by South Gloucestershire Council

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## 1.4 Screening programmes for women and men

Screening involves the testing of healthy people, in order to find and treat conditions at an early stage, in the hope of stopping them from progressing.<sup>18</sup>

### Cancer of the cervix

The cytology test, aimed at preventing death from cancer of the cervix in women, was first offered in England during the 1960s. The first twenty years of the programme was fraught with difficulty.<sup>19</sup> Insufficient prior research had taken place and despite widespread testing, with hundreds of thousands of women being treated, by 1984 there had been no impact on death rates.

It was not until the programme was relaunched in the late 1980s that the numbers of deaths began to reduce. The programme is now successfully preventing around 80% of fatal cervix cancers. Important lessons were learned about the need for research, the need for strict quality controls, and the scope for screening to do more harm than good.

Cervical screening had revealed that pathological changes are present in many women at some time or another. This applies to cancer-like changes, or small changes in blood vessels, or biochemical changes. Most of these apparent abnormalities are repaired, or kept in check naturally, by the body's defence mechanisms. Current screening tests are not capable of telling for certain who will go on to develop serious disease - so lots of people with 'innocent' changes have to be treated, in order to catch those few people who will develop cancer.

The cervical screening experience prompted the development of national mechanisms for research and policy formulation in the UK, to ensure that screening is only carried out when we are sure that benefit outweighs harm.

### Breast cancer

The NHS Breast Cancer Screening Programme was introduced in 1989 following results from worldwide randomised controlled trials. These trials showed that high-quality screening may cut deaths from breast cancer by around 25%. Initially, screening was for women aged 50 to 65 years, but recently this has expanded to include women up to their 71st birthday. Invitations are sent three-yearly. Women under 50 are not routinely invited because of lack of clear research evidence showing that benefit outweighs harm.

The screening test involves a breast x-ray known as mammography. Around one in ten women have some abnormality picked up by mammography and go on to have a further assessment. If breast cancer is confirmed at this stage, then the woman is referred urgently for treatment to a specialist multi-disciplinary team. Since 1989, there has been a sharp fall in death rates from breast cancer in

<sup>18</sup> For further information on national policy visit [www.screening.nhs.uk](http://www.screening.nhs.uk)

<sup>19</sup> Raffle AE, Gray JAM 2007 Screening: evidence and practice. Oxford: Oxford University Press



England and Wales. It is estimated that one third of this drop is directly attributable to mammography screening.<sup>20</sup>

The main downside of breast screening is over-detection of latent breast cancers that would never have caused a problem in the woman's lifetime. A Cochrane Review in 2006 concluded that for every 2,000 women invited for screening throughout ten years, one will have her life prolonged. In addition, ten healthy women, who would not have been diagnosed if there had not been screening, will be diagnosed as breast cancer patients and will be treated unnecessarily.<sup>21</sup>

Breast cancer does occur in men, but is far less common than in women. Screening is not feasible for men.

### Prostate cancer

There have been high hopes that screening might be effective against prostate cancer, which causes around 150 to 200 deaths in men in the old 'Avon' area each year. Twenty per cent of these deaths are men under the age of 70 years. The National Screening Committee called for two independent reviews of the research evidence on prostate specific antigen (PSA) screening for prostate cancer.<sup>22</sup> They concluded that there was no evidence to show that potential benefit from screening outweighed the harm. The NHS therefore recommended not having a national screening programme. Instead it commissioned a research trial - the ProtecT study, due to report in 2008. Bristol is one of the trial centres.

In 1998, public and political pressure for prostate screening was very strong. The NHS therefore launched a programme called the Prostate Cancer Risk Management Programme, which gives information to men about the limitations and potential side effects of testing, and enables men to choose to have PSA testing if they wish to. This has led to a rise in the number of new cases (incidence) of prostate cancer diagnosed in Avon (see Figure 7).

The rise is undoubtedly due to greater ascertainment of cases that would have remained latent, rather than a real increase in disease. It is now levelling off as awareness of the limitations of testing is growing. There has been no impact on the number of deaths.

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<sup>20</sup> Estimates made by the Office of National Statistics

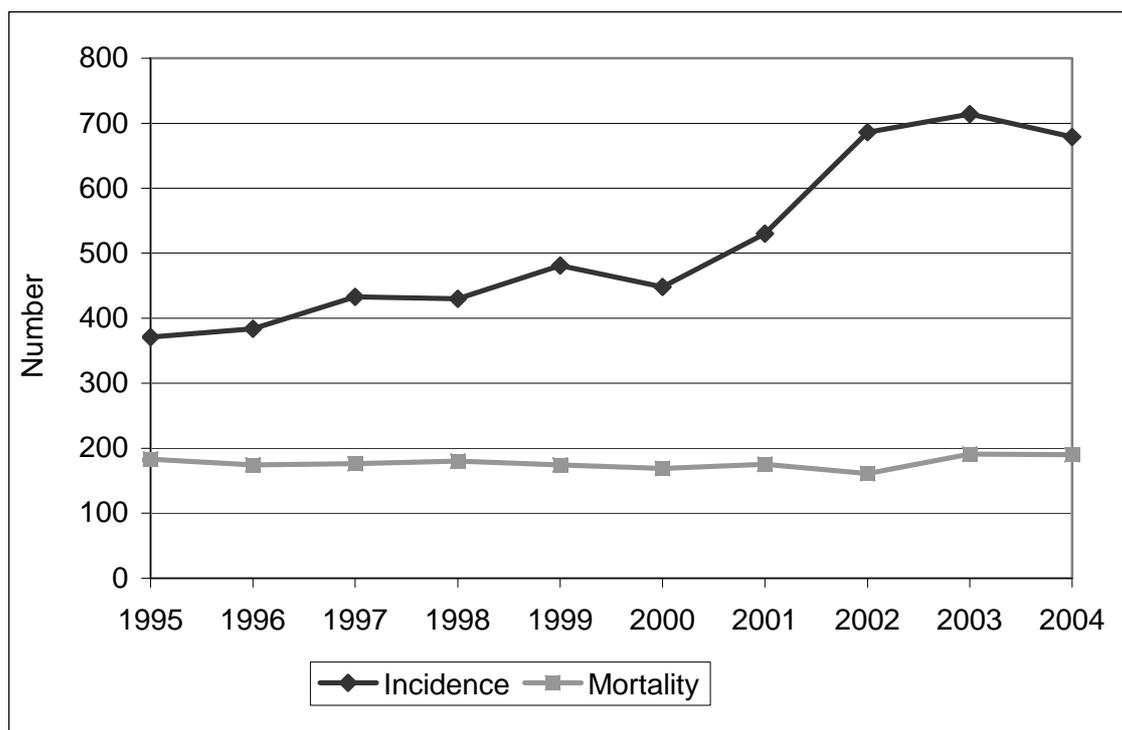
<sup>21</sup> Gøtzsche, P. C. & Nielsen, M. Screening for breast cancer with mammography. Cochrane Database of Systematic Reviews Art No CD00187[Issue 4], DOI: 10.1002/14651858.CD001877.pub2. 2006 Wiley.

<sup>22</sup> National Screening Committee 2006 National Screening Committee policy - prostate cancer screening at [www.library.nhs.uk/screening](http://www.library.nhs.uk/screening)

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**Figure 7: Prostate cancer numbers of diagnosed cases, and numbers of deaths in Avon residents 1995-2004**



Source: South West Cancer Intelligence Service 2006

In the USA, where annual tests have been widely promoted, the number of diagnosed cases rose to a peak incidence of 240 per 100,000, compared to 90 per 100,000 in the UK. Yet the rate of deaths in the USA and the UK are virtually identical.

As an eminent USA professor summed it up:

*'..over a million more men [in the USA] were diagnosed in the last quarter of a century but there has been little change in the number of deaths...most of these one million extra cases represent pseudo-disease: disease that would never progress far enough to cause symptoms...'*<sup>23</sup>

## Testicular cancer

Another male cancer where one might consider screening is testicular cancer. This mainly affects young men and is rare. Although the number of cases has risen in recent years, the death rate has fallen significantly.

There are no good screening tests. Instead the NHS supports publicity campaigns aimed at raising awareness amongst young men, so that they get any abnormalities checked out and diagnosed promptly. Most cases of testicular cancer can be completely cured.

<sup>23</sup> Welch HG 2004 Should I be tested for cancer? Maybe not and here's why. Los Angeles: University of California Press



## Bowel cancer

There have been two major randomised controlled trials showing that screening for bowel cancer can reduce deaths by about 15%. A national programme is in the process of being rolled out. Within a few years all men and women age 60 to 69 years will be offered a test every two years. The test is done at home. If it is positive, then an investigation called colonoscopy is needed. If cancer is found then treatment involves surgery and possible chemotherapy.

## Aortic aneurism

An aortic aneurysm occurs when the main artery from the heart (aorta) develops a swelling (aneurysm). These can be harmless, but some enlarge and eventually burst causing death. Aortic aneurysms develop in later life and are much more common in men than women.

It is likely that a screening programme will be introduced in the UK, for men aged 65, to detect early aneurysms and reduce the number of men who die from rupture.

The treatment involves major surgery and it is therefore essential that this surgery is done to a high quality, so that complications are kept to a minimum. Men need to be fully informed about the harms, benefits, and limitations of the screening before choosing to have a test.

## Other screening

For all other conditions where screening is recommended, such as newborn screening, childhood screening, diabetic retinopathy screening, and chlamydia testing, recommendations are identical for men and women.



## 1.5 Addressing the different health needs of women and men

This overview shows that there are marked differences in health between women and men.

Men have a slightly lower life expectancy and are more likely to die at a younger age from causes that include heart disease and injuries. Women live longer but are more prone to depression, are more likely to be victims of domestic violence and are prone to a range of sex specific cancers, most notably breast cancer.

The differences in life expectancy appear to be narrowing, perhaps reflecting the adoption of unhealthy lifestyles by women, in particular the increasing proportion of women smoking compared to men.

Men may be at greater risk of premature death because:<sup>24</sup>

- they are biologically more vulnerable than women
- their lifestyles create more life-limiting disease
- they are more reluctant, or unable, to seek early medical attention.

It is likely that a combination of factors is at work. The pattern is similar across the world and suggests a biological vulnerability. Closer to home, the markedly higher accident rates in males, even at an early age, suggest a biological difference in risk-seeking behaviour, although there may also be a culturally determined element. Lifestyle differences have played a part, most notably the historical differences in smoking rates.

Both sexes experience marked differences in health according to level of deprivation, with those living in more deprived areas benefiting less, if at all, from recent overall improvements in life expectancy.

The differences in health, illnesses, habits and beliefs between men and women mean that different approaches may be needed in order to make sure that both sexes benefit fully from health promotion, illness prevention and effective treatment of illness.

### Promoting health

Differences between the sexes in relation to health may run deeper than they appear from the relatively small differences in lifestyle. They may also relate to motivation and barriers to adopting healthier lifestyles. For example, men and women have different reasons for wanting to stop smoking and women are reported as being more emotionally dependent on cigarettes than men.<sup>25</sup>

*'..health promotion policies that take women's and men's differential biological and social vulnerability to health risks and the unequal power relationships between the sexes into account are more likely to be successful and effective...'*<sup>26</sup>

<sup>24</sup> White A and Cash K 2003 The state of men's health in Europe. Eurohealth 9, 28-31

<sup>25</sup> West R and McEwen A 1999 Sex and smoking – comparisons between male and female smokers: a report for No Smoking Day March 1999

<sup>26</sup> Health Promotion International 2006 21(Supplement 1):25-35; doi:10.1093/heapro/dal048



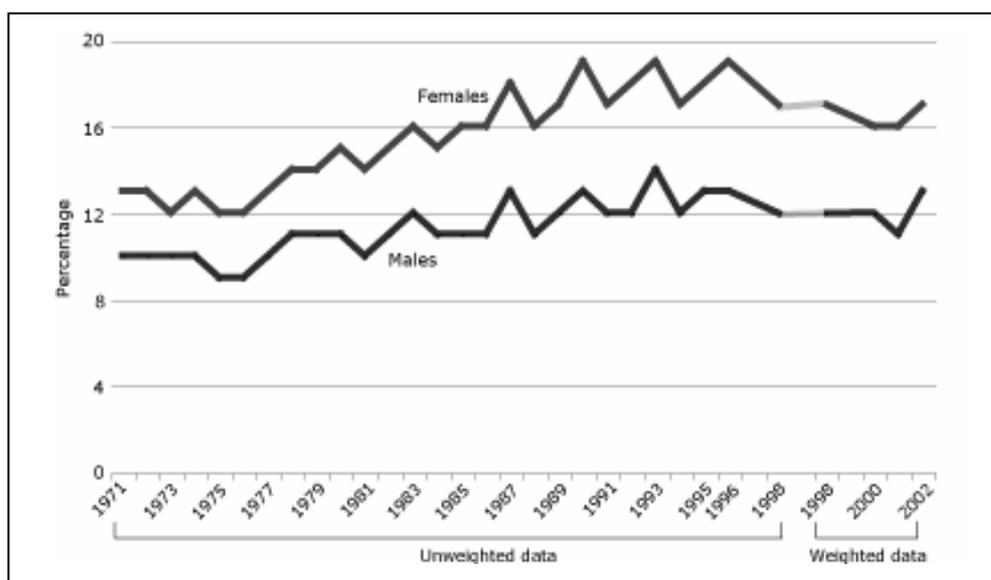
Social and cultural differences need to be taken into account too. For example, although consumption of the recommended five daily portions of fruit and vegetables is higher in women than men, it also varies across the socio-economic groups. Men in routine and semi-routine occupations are the lowest consumers of fruit and vegetables.<sup>27</sup>

It is important that differences are addressed in terms of inequalities. Health promoting policies need to address the differences between women and men in an equitable manner in order to be effective.

### Accessing primary care services

Fewer men than women access primary health care services.<sup>28</sup> Reasons given for delay in seeking help include practical issues about accessing services, as well as perceptions of health services and embarrassment.<sup>29</sup> Lower attendance rates may also reflect less need to attend, for reasons relating to contraception and pregnancy.

**Figure 8: Percentage of males and females consulting an NHS GP in the 14 days prior to interview: Great Britain 1971-2002**



Source: General Household Survey 2004 Living in Britain in 2002

This lower attendance at primary care, particularly for younger men, means that it is important to offer services in other settings.

### Sexual health services

In November 2006, a review of sexual health services provided by local GP practices showed that 91% of tests for sexually transmitted infections were carried out on women and only 9% on men.

<sup>27</sup> Department of Health 2005 Choosing a Better Diet: a food and health action plan

<sup>28</sup> National Statistics 2004 General Household Survey: Living in Britain in 2002. London

<sup>29</sup> White A and Cash K (undated) Men's Health in Bradford – Developing the Evidence Base for Practice at [www.healthofmen.com](http://www.healthofmen.com)



In contrast, a community based outreach service, commissioned from Brook Clinic to provide contraception, advice and non-invasive sexual health screening, attracts more young men than young women.

Attendance figures at the genito-urinary (GUM) Milne Clinic in Bristol (South Gloucestershire residents) show a similar preponderance of men. In 2006 to 2007:

- 60% of new attendees were men
- 40% were women
- follow-up attendance figures show that 62% were men and 38% women.

### NHS Stop Smoking Service

Although smoking rates are similar, fewer men than women use the South Gloucestershire Support to Stop Smoking service. However, men have slightly more success in quitting than women.

In 2006-2007, over a thousand smokers in South Gloucestershire quit smoking with help from the Support to Stop service.

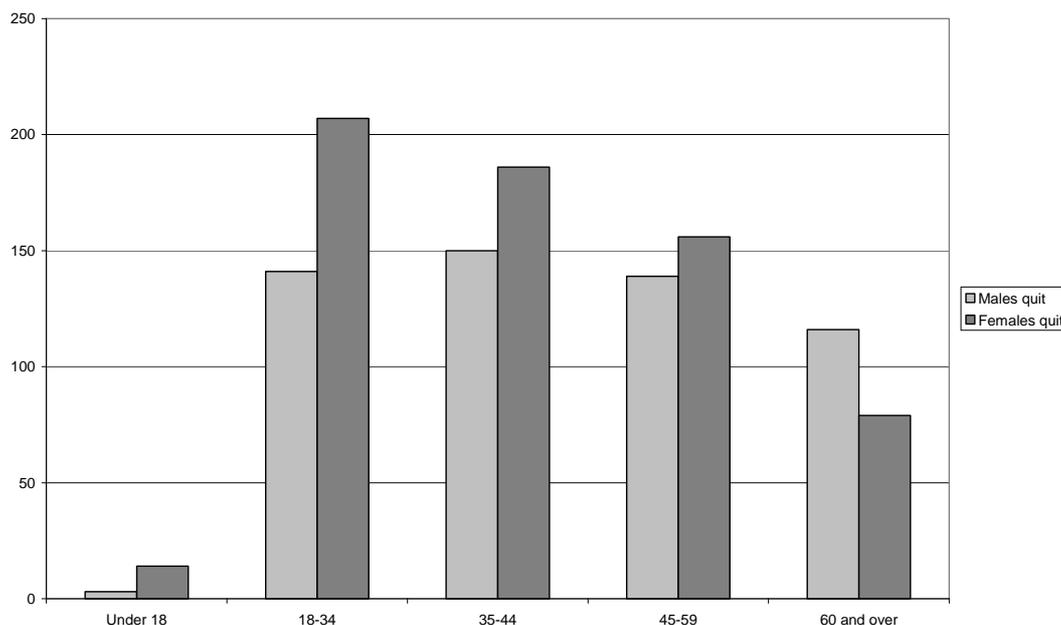
**Table 4: Smokers receiving support from Support to Stop 2006-2007**

	Numbers who set a quit date	Numbers who quit
<b>Women</b>	1,374	643
<b>Men</b>	1,092	548
<b>All</b>	<b>2,466</b>	<b>1,191</b>

Source: Support to Stop

Smokers from all age groups accessed the service. The highest number setting a quit date were young women in the 18-34 years age group - see Figure 9.

**Figure 9: Support to Stop: total number of women and men in each age range successfully quitting smoking 2006-2007**



Source: Support to Stop



Most smokers who sought help in stopping smoking through the NHS, went to their GP practices, but other settings included:

- 115 women and 88 men set a quit date with local pharmacies that had a trained advisor offering support and advice
- 61 people were supported in prison to quit – 67% were female and 33% were male.

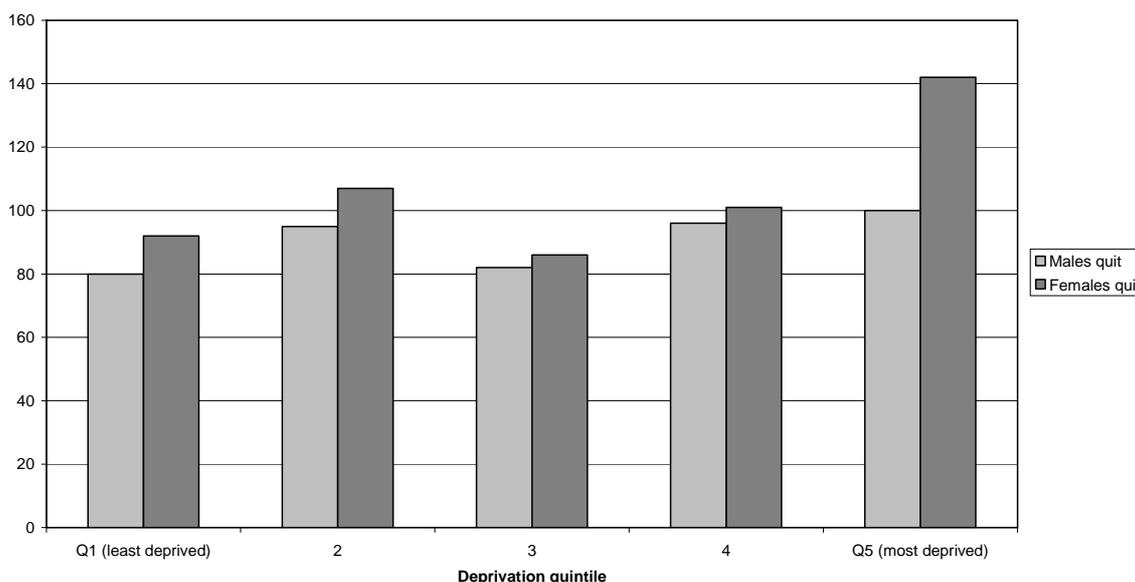
A couple of settings were particularly successful with men, and show the value of experimenting with service delivery:

- 27 men and 26 women accessed support via a specialist stop smoking advisor
- a local workplace advisor helped 32 men and four women in their attempts to quit.

More smokers accessed the service from Quintile 5 (most deprived) but the quit rate was higher for those in Quintile 1 (least deprived).

More females from the most deprived areas (Quintile 5) accessed the service and 42% of them successfully quit.

**Figure 10: Support to Stop: total number of women and men in each deprivation quintile successfully quitting smoking 2006-2007**



Source: Support to Stop

### Effective interventions

It is not sufficient to ensure that women and men have equal access to health services. Equally important is whether they are actually receiving interventions that have been shown to be effective.

Looking for gender differences in rates of intervention is a type of 'health equity audit', an important tool in tackling inequalities. The key is to check whether men and women are receiving care at a rate that reflects their need – is it matched to need (equitable) rather than the same (equal)?



Several examples of health equity audit have been presented in previous Director of Public Health annual reports. The data presented in this report on the stop smoking service is an example of information being used to constantly check and refine service delivery, to ensure that services are delivered according to need. An example of using primary care data to check for gender bias in service delivery is presented here.

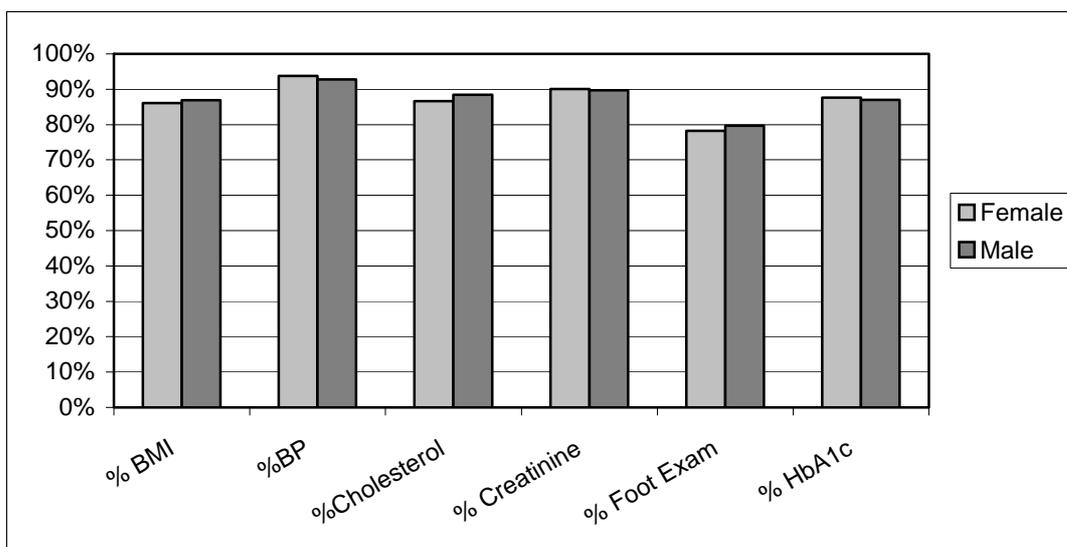
### Diabetic equity audit

It is important that diabetic patients receive regular health checks and most of these are carried out in primary care. Part of the payment to GPs is based on the practice making sure that all diabetics are offered regular reviews. A high level attend and receive the relevant care.

Early in 2007, most practices took part in a voluntary audit of diabetic care with eleven practices returning detailed computerised data for further analysis. This was used to investigate whether or not men and women are receiving a similar standard of care.

The key results are shown in Figure 11. They show that similar proportions of men and women with diabetes are receiving each of the health checks.

**Figure 11: Proportion of diabetic patients receiving specific health checks in preceding 12 months (11 practices)**



Source: South Gloucestershire PCT 2007

Similar audits are planned for the next 12 months to cover other aspects of preventive care.



### **Recommendations**

- Further progress in reducing differences in life expectancy between men and women will be made by tackling the major causes of premature death in both sexes. This should include tackling injuries, cancer and cardiovascular disease.
- Reductions in the gap between the health of men and women should not be the result of worsening health in women. Efforts should be redoubled to tackle high levels of smoking and increasing alcohol consumption in young women.
- Health promotion initiatives should be particularly targeted at more deprived communities and tailored to ensure that they are accessible and acceptable to men and women.
- Health promotion campaigns, aimed at changing personal behaviour, need to be carefully planned and delivered to ensure they resonate with the different priorities and motivation of men and women.
- Effective prevention and disease management programmes should be regularly audited to ensure that they are being accessed equally by men and women and, if necessary, changes made to correct any imbalance.



## Section 2: Alcohol and its effects on health

### Key messages

- Consumption of alcohol has increased over the past ten years, particularly by women and young people.
- Alcohol is implicated in approximately 35% of all attendances at Accident and Emergency departments.
- Young people are now drinking twice as much as they were in 1990.
- Some 24.7% of men and 14.1% of women are estimated to be drinking at hazardous or harmful levels.
- The incidence of liver cirrhosis in South Gloucestershire has almost tripled in the last ten years.
- Local alcohol-related hospital admissions are rising annually for men and women.

Over 90% of the adult population of the UK drink alcohol.<sup>30</sup> Alcohol is a deeply ingrained part of the way in which our culture chooses to celebrate, socialise and relax. For the majority of people it causes no harm. So why should we be concerned about the amount of alcohol and the way in which it is being consumed?

It is estimated that the cost of alcohol-related harm in England is in the region of £20bn per year. This harm includes direct damage to health in the form of liver disease, some cancers and heart disease, crime and anti-social behaviour, domestic violence, death and injury from road traffic accidents and loss of productivity in the work place through days of absence from work.

Alcohol is implicated in approximately 35% of attendances at Accident and Emergency (A&E) departments and this rises to 70% on weekend evenings.

### 2.1 Patterns of drinking

Patterns of drinking have changed over the last ten years.<sup>31</sup> Consumption of alcohol has increased, particularly by women and young people. More alcohol is being bought from off-licences and consumed at home, despite the change in licensing hours introduced in 2003.

Since 2001, the number of young people aged 11 to 15 years who drink alcohol has decreased slightly, but those who do drink are drinking more heavily. Young people are now drinking twice as much as they were in 1990, although it appears that the amount being drunk by 11 to 13 year olds is increasing, whilst the amount drunk by older adolescents has remained more stable.

<sup>30</sup> Cabinet Office 2004 Alcohol Harm Reduction Strategy for England

<sup>31</sup> DH 2007 Safe Sensible Social. The Next steps in the National Alcohol Strategy



There are two main patterns of drinking that are considered more likely to be harmful. Firstly, binge drinking, which is where the individual is more likely to go out with the express intention of becoming drunk. This group largely comprises under 25 year olds. Binge drinking is associated with a higher incidence of violent offences and attendances at A&E with either alcohol-related poisoning, or assault-related wounds, compared with those who drink sensibly.

The second group are chronic drinkers whose alcohol consumption is consistently above the nationally recommended levels of 14 units per week for women and 21 units per week for men. This group has a much increased risk of developing liver disease. They are more likely to be aged 30 years or older and approximately two thirds of them are men.

## 2.2 The size of the problem

The Department of Health undertook the first ever alcohol needs assessment in England in 2004.<sup>32</sup> The study identified categories of drinking as:

- hazardous - drinking more than the guidelines (drinking 22-50 units per week for men and 15-35 units per week for women)
- harmful - drinking more than the guidelines and experiencing harm (over 50 units for men and 35 for women)
- alcohol dependent - drinking more than the guidelines and experiencing harm and symptoms of dependence.

This needs assessment produced national estimates of the percentages of people drinking alcohol at different levels (see page 13). However, consumption varies greatly across regions and, more recently, data from the General Household Survey shows that in the South West:

- some 24.7% of men and 14.1% of women drink at hazardous or harmful levels
- the prevalence of binge drinking is 17.6% of men and 7.3% of women
- dependence on alcohol is in the region of six percent of men and two per cent of women.<sup>33</sup>

In Table 5 these estimates have been used to calculate the number of people at risk from harm in South Gloucestershire.

However, given that the University of the West of England (in South Gloucestershire) has an enrolment of around 26,000 students, the figures for binge drinking may be higher. In a study by the University of Swansea<sup>34</sup> it was found that over 50% of students questioned, admitted to drinking over the weekly recommended levels for safe drinking.

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<sup>32</sup> Department of Health 2004 Alcohol Needs Assessment Research Project (ANARP)

<sup>33</sup> General Household Survey 2005 data analysed by NW Public Health Observatory in Deacon L et al (eds) Indications of Public Health in the English Region 8: Alcohol NWPFO

<sup>34</sup> Clark D 2000 Department of Psychology, University of Swansea

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**Table 5: Estimated percentage of the population of South Gloucestershire aged 15-75 years harmed by alcohol**

	Percentage male (%)	No. of males	Percentage female (%)	No. of females	Total
Hazardous (21-50 units for men, 15-35 units for women/week)	18.9	17,903	11.8	10,973	28,876
Harmful (more than 50units/week for men or 35/week for women)	5.8	5,494	2.3	2139	7,633
Binge drinking (more than 8 units for men or 6 units for women on heaviest drinking day)	17.6	16,672	7.3	6,789	2,346
Alcohol dependence	6	5,684	2	1,860	7,544

Source: General Household Survey 2005. NOTE: these figures are more recent and therefore differ from those in the locality health profiles. Dependence figures from Department of Health 2004 Alcohol Needs Assessment Research Project (ANARP)

Excess alcohol is known to increase the risk of a number of medical conditions.

**Table 6: Increased risk of ill health to harmful drinkers**

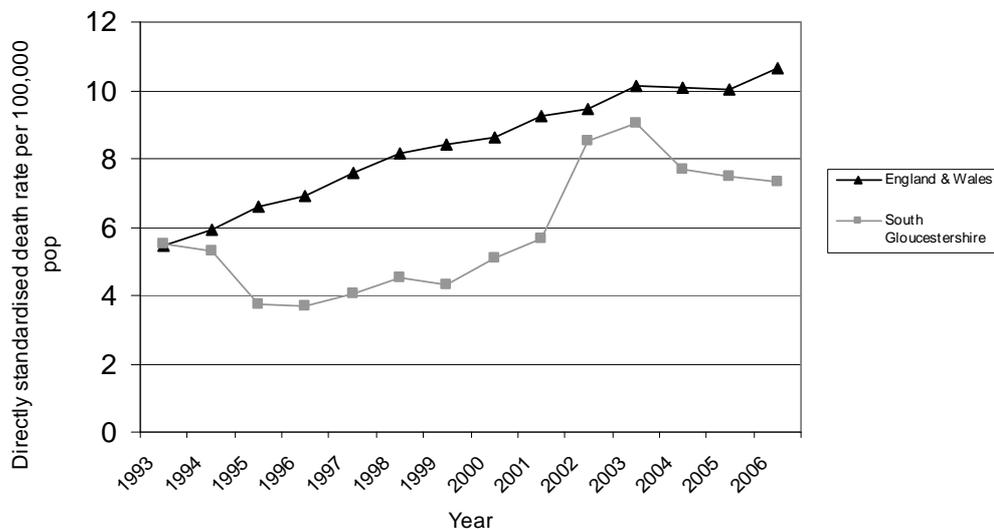
Condition	Men (increased risk)	Women (increased risk)
Hypertension (high blood pressure)	4 x	2 x
Stroke	2 x	4 x
Coronary heart disease (CHD)	1.7 x	1.3 x
Pancreatitis (inflammation of the pancreas)	3 x	2 x
Liver disease	13 x	13 x

Source: Anderson P 2007 The scale of alcohol related harm (unpublished) Department of Health as cited in Safe Sensible Social, Next Steps in the Alcohol Strategy

Nationally, the incidence of liver cirrhosis has doubled in the last decade and South Gloucestershire appears to be following a similar trend (Figure 12).



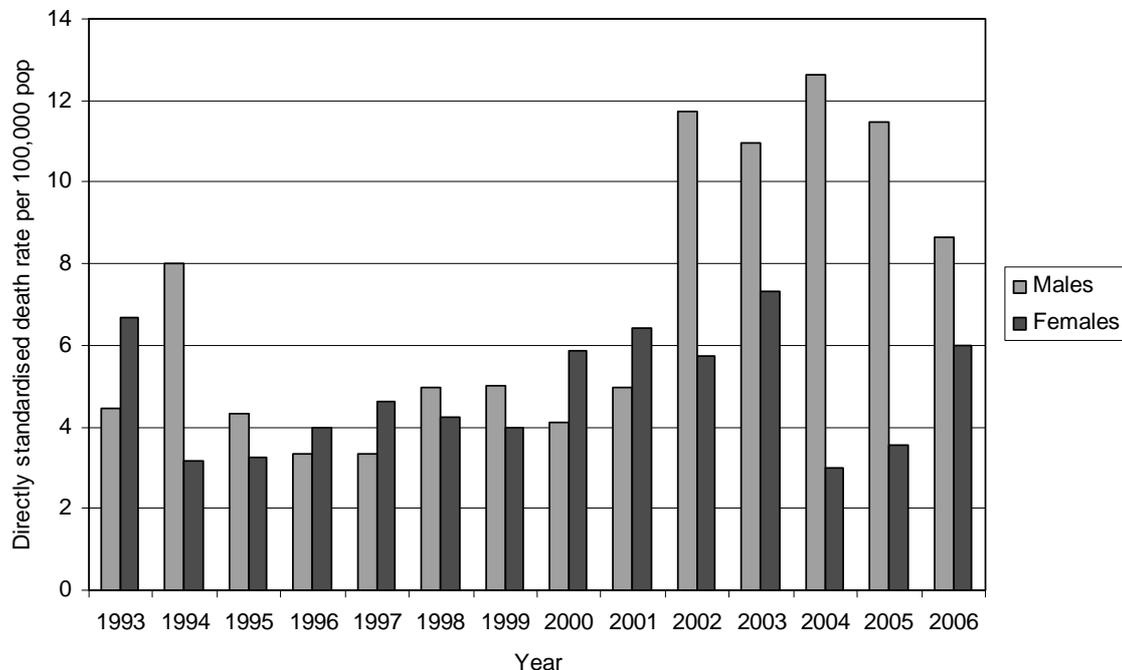
**Figure 12: Standardised rate of mortality from chronic liver disease 1993-2006**



Source: NCHOD Compendium of clinical indicators  
<http://www.nchod.nhs.uk/NCHOD/compendium.nsf/>

This increase in the incidence of liver cirrhosis is currently more marked amongst men than women.

**Figure 13: Directly standardised mortality for males and females from chronic liver disease in South Gloucestershire 1993-2006**

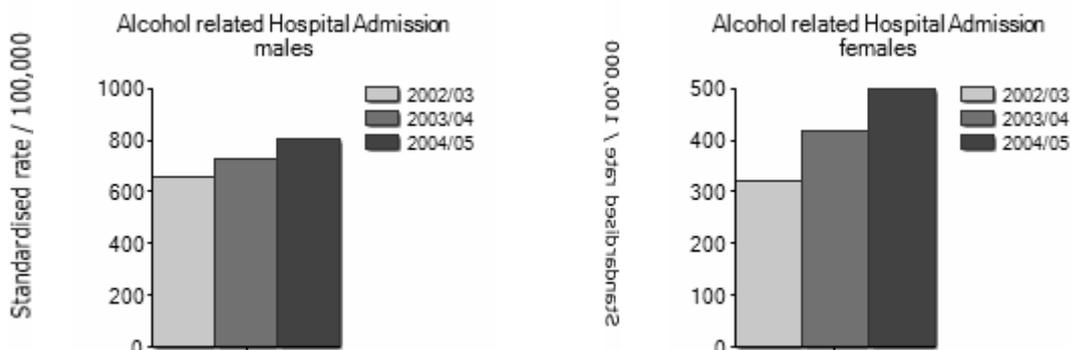


Source: NCHOD Compendium of clinical indicators  
<http://www.nchod.nhs.uk/NCHOD/compendium.nsf/>



There has also been a steady increase in the number of alcohol-related admissions of South Gloucestershire residents to hospital in recent years.

**Figure 14: Alcohol related admissions 2002-2005**



Source: North West Public Health Observatory 2007 [www.nwph.net/alcohol/lape/Regions.htm](http://www.nwph.net/alcohol/lape/Regions.htm)

Admissions may be considered in two ways. There are those that are due directly to alcohol ingestion, such as liver cirrhosis. There are also those in which alcohol is implicated indirectly, such as road traffic accidents and violent assault. Both are increasing.

### Alcohol and inequalities

Drinking over the 'sensible' levels is more common in areas of higher deprivation. Department of Health analysis of Office of National Statistics data suggests that alcohol related deaths are 45% higher in more deprived areas. Alcohol-related death rates in women are three times higher in the most deprived areas compared with the least deprived areas: for men, the rates are five times higher.

### Alcohol and road traffic accidents

Drink-driving causes a significant number of casualties each year. A report of the South Gloucestershire Policing Unit for 2002-2004 estimated that five per cent of all road collisions were related to alcohol. It reported that 90% of drink-drivers were males aged between 20 and 34 years.

South Gloucestershire's Road Safety Report stated there were 102 accidents in the 'killed or seriously injured' category, which suggests that at least five could be related to drink-driving.<sup>35</sup>

### Alcohol and crime

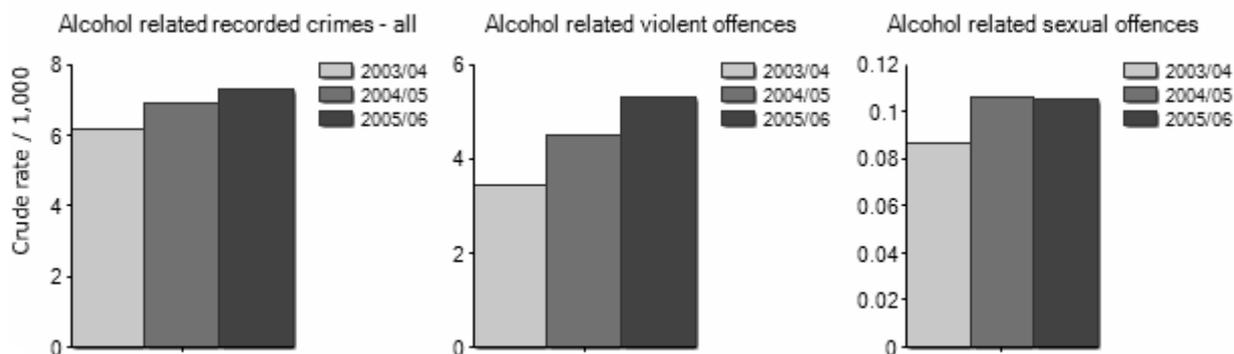
Around half of all violent crime nationally is associated with alcohol.<sup>36</sup> Many violent crimes lead to hospital admissions. This creates a significant burden on the ambulance and A&E services. The graphs in Figure 15 reflect the alcohol-related crime in South Gloucestershire between 2003 and 2006.

<sup>35</sup> South Gloucestershire Road Safety Report 2005

<sup>36</sup> Home Office 2006 Crime in England and Wales 2005-2006 Home Office Statistical Bulletin



**Figure 15: Alcohol related crime in South Gloucestershire 2003-2006**



Source: [www.nwph.net/alcohol/lape/LAPProfile.aspx?reg=k](http://www.nwph.net/alcohol/lape/LAPProfile.aspx?reg=k)

### Alcohol and domestic violence

A Home Office study in 2003 found that alcohol, whilst not the cause, was a feature in 32% of all domestic violence.<sup>37</sup> Local police statistics for April 2007 report that out of 167 reports of domestic violence, 48 (29%) were associated with alcohol.

### Alcohol and drug misuse

The majority of problematic drug misusers also use alcohol. Local treatment services report 122 clients with primary alcohol-related problems in 2006-2007. This was a slight reduction compared with the 138 treated in 2005-2006. Under the Local Area Agreement there is a stretch target to increase treatment provision by 50%.

## 2.3 What can we do to reduce harm?

Reducing the harm from alcohol requires a multi-faceted, multi-disciplinary approach. The PCT is currently working in partnership with Safer South Gloucestershire to produce an alcohol harm reduction strategy.

### Current services

Safer South Gloucestershire commissions services through the South Gloucestershire Drug and Alcohol Services (SGDAS). The main provider for this service is the Drugs and Homeless Initiative (DHI). There are two main centres for service delivery in Warmley and Yate.

The Young People's Drug and Alcohol Team, located within the South Gloucestershire Council (at Bowling Hill), provides a range of drug and alcohol educational and awareness training for professionals who work with children and teaching staff within schools, via the Healthy Schools programme.

They also work with young people through outreach and can arrange a variety of

<sup>37</sup> Mirrlees-Black C 1999 Domestic Violence: findings from a new British Crime Survey self-completion questionnaire Home Office Research Study No. 191 London: Home Office



drug and alcohol interventions specifically aimed at young people including advice, support, one-to-one counselling and, where appropriate, a detoxification and rehabilitation service.

### What makes a difference?

There is little evidence that education and public information on its own helps to reduce harm. School-based alcohol education has become increasingly thorough, but whilst knowledge may be increasing, it seems that influencing drinking behaviour is much more challenging.<sup>38</sup>

There is some evidence to suggest that the use of screening tools such as the AUDIT (Alcohol Use Disorder Identification Test) questionnaire, brief interventions and self-help materials can help.<sup>39 40</sup> The AUDIT questionnaire provides an individual score which indicates the most useful interventions:

- low positive range (8-15) - brief interventions
- medium range (16-19) - brief interventions and regular monitoring, including consideration of referral for a more formal assessment, if heavy drinking continues
- those scoring (20-40) - a diagnostic assessment and consideration of further treatment.

In terms of treatment, even modest interventions can be beneficial.

- Brief interventions are helpful for non-dependent drinkers. For every eight people receiving a brief intervention, one will change their behaviour. Brief interventions are relatively cheap at a cost of £30-£50 per session. Currently patients seen by the local treatment service have an average of four sessions.
- Specialised treatment programmes and mutual help groups are helpful for more dependent drinkers. Through South Gloucestershire's Local Area Agreement, new stretch targets have been introduced to ensure that there is a doubling of capacity, so that hazardous drinkers can access the treatment they need, quickly and easily.

Alcohol consumption is known to be directly correlated to price and availability. Alcohol related problems can be reduced by restricting access, reducing the number of hours and days that it can be purchased and the number of outlets.<sup>41</sup>

- A ten per cent rise in the price of alcohol would produce an estimated seven per cent reduction in mortality from liver cirrhosis in men and an eight per cent reduction in women. It could also lead to a fall of almost 29% in men and 37% in women in deaths from alcohol-related causes.

<sup>38</sup> Room R, Babor T, Rehm J 2005 Alcohol and Public Health The Lancet Vol 365 February 5 2005

<sup>39</sup> Mulvihill C et al 2005 Prevention and reduction of alcohol misuse evidence briefing- 2<sup>nd</sup> edition. NICE. London

<sup>40</sup> Royal College of Physicians 2001 ALCOHOL- can the NHS afford it? Sarum ColourView Group, Wilts

<sup>41</sup> Babor T et al 2003 Alcohol: No ordinary commodity- research and public policy. Oxford: OUP



- There is strong evidence from the USA that raising the drinking age diminishes both alcohol consumption and traffic casualties for the ages involved.<sup>42</sup>
- In South Gloucestershire, the local authority and the police work to ensure that trade and licensing laws are adhered to and to minimise under age purchase of alcohol.
- Research suggests that training of bar service staff, to deny service to those already intoxicated, reduces drink-driving casualties, particularly if service training policies are backed up by active enforcement.<sup>43 44</sup>

### **Recommendations**

To reduce the harm caused by alcohol, action is needed at a national and local level. This should include:

- an increase in the price of alcohol and consideration of ways to restrict access, for example by reducing the number of outlets licensed to sell alcohol
- careful assessment of the effects of the 2006 extension of licensing hours and, if necessary, a modification of that legislation
- strengthening the power of, and requirement on, local authorities to limit the number and nature of licences issued
- discouragement, or outlawing, of certain types of drink, such as alcopops, and promotions such as 'two for the price of one' and 'happy hours'
- introduction of a Public Service Agreement (PSA) target to reduce the harm from alcohol, by increasing counselling and treatment opportunities
- encouraging the routine recording of alcohol intake in general practice, either nationally through the inclusion of a Quality and Outcomes (QOF) target or through local contract negotiation
- developing primary care capacity for brief intervention and advice, particularly for drinkers that are not heavily dependent
- ensuring that the public are well-informed about the risks from alcohol misuse, the number of units in various alcoholic drinks and the national guidelines
- ensuring that every opportunity is taken in primary care, secondary care and elsewhere, to screen, using a tool such as AUDIT
- ensuring that there is sufficient capacity to provide information, counselling and more intensive support.

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<sup>42</sup> Wagenaar AC, Toomey TL. 2003 Effects of minimum drinking age laws: review and analyses of the literature from 1960 to 2000. *J Stud Alcohol* 2003; 64: 393-401

<sup>43</sup> Holder HD, Wagenaar AC 2004 Mandated server training and reduced alcohol-involved traffic crashes: a time series analysis of the Oregon experience *Accid Anal Prev* 2004; 26: 89-97

<sup>44</sup> Graham K et al 2004 The effect of Safer Bars Program on physical aggression: results of randomised controlled trial *Drug Alcohol Rev* 2004; 23: 31-41

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## Section 3: Health needs in localities

### Key messages

- The PCT and local authority have split South Gloucestershire into three localities - Severnvale, Yate and Kingswood - with the aim of providing better, joined up, local services.
- A separate health profile has been produced for each area.
- In all three localities a small number of geographical areas are highlighted as having the worst health indicators. These tend to be the areas of relatively high deprivation designated as 'priority neighbourhoods.'
- The priority neighbourhoods have particularly poor health indicators for children and young people, including:
  - low rates of breast feeding
  - high levels of childhood obesity
  - poor dental health in children
  - high rates of teenage pregnancy.
- All localities have poor access to planned (elective) specialist investigation and treatment of coronary heart disease.

South Gloucestershire PCT and South Gloucestershire Council have divided South Gloucestershire into three geographical localities. This is to ensure better local working and stronger partnerships with communities. The three localities are Kingswood, Severnvale and Yate. The Public Health Team have developed a health profile for each locality. A brief summary of these profiles is given here and the full profiles are available on the PCT website.<sup>45</sup>

### 3.1 Similarities and common themes

The similarities and common themes across all three localities include:

- life expectancy better than the national average
- most of the deaths of people under 75 years are due to either cancer, or coronary heart disease. Death rates from both are falling
- smoking remains the single biggest preventable cause of death
- from national estimates, high numbers of people are likely to have alcohol problems and mental health problems
- rising levels of obesity and low levels of physical activity
- poor access to planned (elective) specialist investigation and treatment of coronary heart disease.

A particularly striking finding across all three localities is a tendency for a small number of geographical areas to be highlighted as having the worst health indicators. These tend to be (but are not exclusively) the areas of relatively high

<sup>45</sup> South Gloucestershire PCT website at [www.sglos-pct.nhs.uk](http://www.sglos-pct.nhs.uk)



deprivation designated by the local authority as 'priority neighbourhoods'. The types of problem that tend to cluster in these areas include:

- low rates of breast feeding
- high levels of childhood obesity
- poor dental health in children
- high rates of teenage pregnancy.

### 3.2 Differences between localities

#### Population density

The localities are outlined on the map (Figure 16) and vary markedly in density of population and the extent to which they are rural or urban. In particular:

- Kingswood locality has the largest proportion of the total population (43%) in the smallest area (10% of South Gloucestershire)
- Severnvale locality has just under a third of all residents (32%) in just over a third of the area (38%)
- Yate locality covers over half of the South Gloucestershire area (53%) but houses only 25% of its population.

#### Health needs

The overall number of residents in an area does not always indicate health need. Areas of disadvantage are likely to have higher health needs than more affluent areas. In addition, two other influential factors determine the need for services:

- the number of elderly residents (over 65 years)
- the number of children under five years old.

**Table 7: Percentage of population by age group and locality**

Locality	People aged			Percentage of geographical population			Total population
	0-4 yrs	65 yrs and over	75 yrs and over	0-4 yrs	65 yrs and over	75 yrs and over	
Severnvale	4,648	10,515	4,721	5.6%	12.7%	5.7%	82,983
Yate	3,445	10,077	4,449	5.4%	15.8%	7.0%	63,744
Kingswood	5,984	17,002	8,271	5.8%	16.3%	7.9%	104,054
<b>South Glos PCT</b>	<b>14,077</b>	<b>37,594</b>	<b>17,441</b>	<b>5.6%</b>	<b>15.0%</b>	<b>7.0%</b>	<b>250,781</b>

Source: Based on practice register population December 2006

Table 7 shows that:

- Kingswood locality has more elderly residents and more families with children under five than the other localities
- the population in Severnvale locality is generally younger than in other localities, with a lower percentage of over 65s
- Yate locality comes between the two - although it has the lowest percentage of under five year olds.



## New housing developments and increasing demand for health services

South Gloucestershire is an area of high population growth and a number of possible sites for development have been identified. These include:

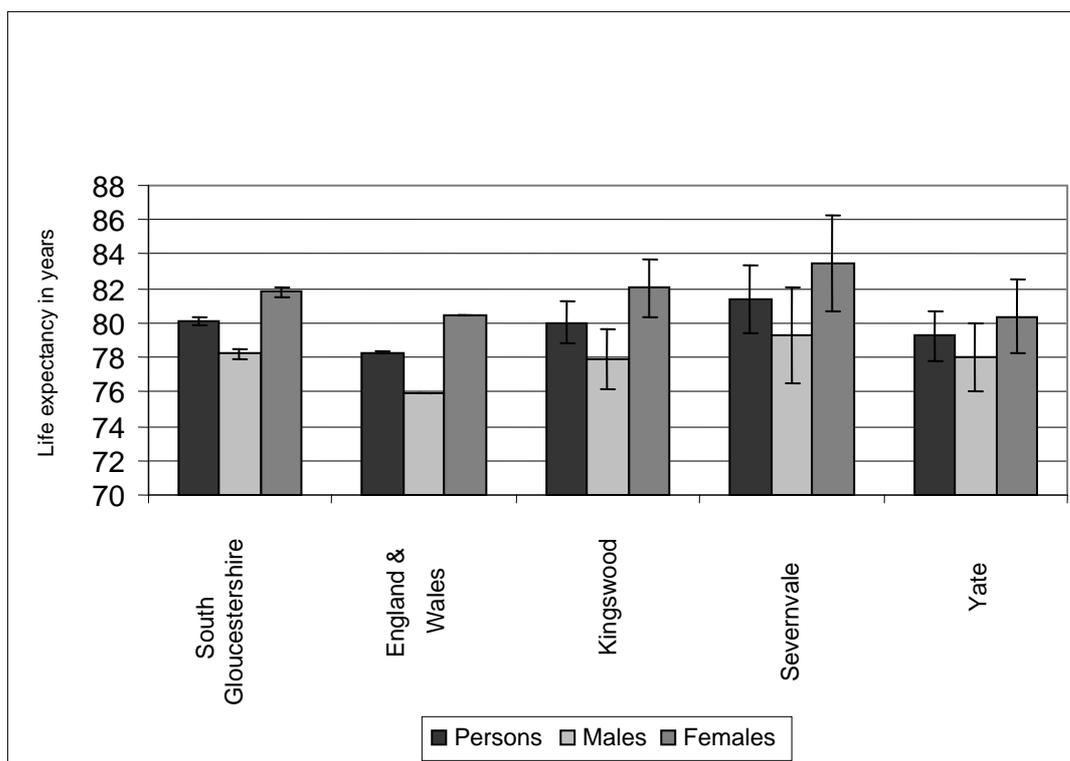
- Northfield - a proposed high density development that will extend the town of Patchway
- Emerson's Green East - 177 hectares of land. Proposals include 2,000 new homes with a range of supporting community and leisure facilities, a 25-hectare science park and 20 hectares of mixed employment development
- a further 30 hectares of land, to include 15 hectares for 750 dwellings, will be safeguarded to meet development needs beyond 2011
- other sites yet to be identified.

New housing developments will increase demand for health services in these areas.

### Life expectancy

Of the three localities, people living in the Severnvale locality have - on average - the longest life expectancy and those in Yate locality, the lowest. But people in all three areas have a life expectancy greater than the average for England and Wales.

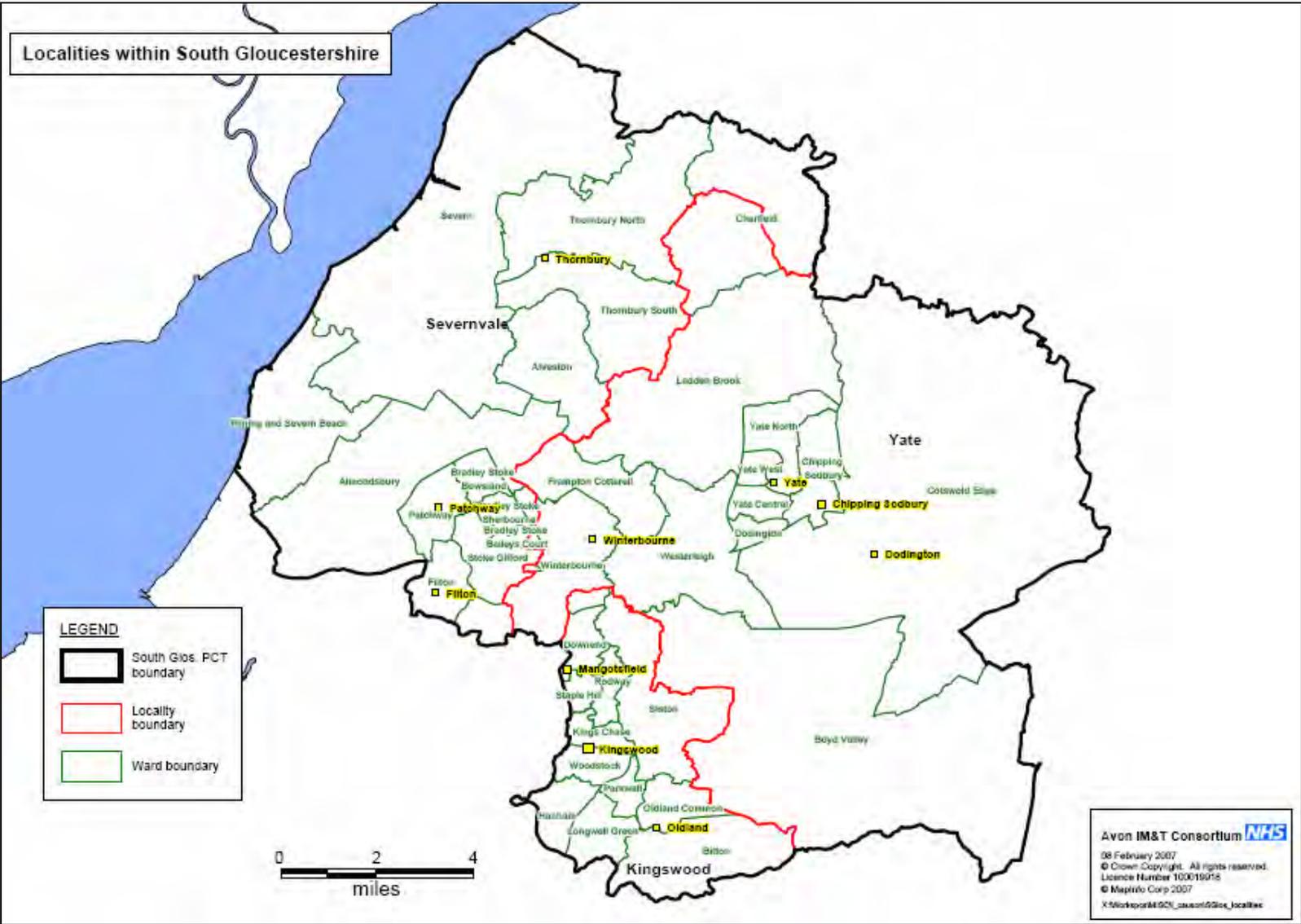
**Figure 16: Life expectancy at birth in South Gloucestershire 1999-2003**



Source: Avon IM&T Consortium



Figure 17: Localities within South Gloucestershire



## Kingswood locality

Kingswood locality consists of 11 wards covering the eastern suburbs of Bristol and part of the green belt separating Bath and Bristol. It borders the city of Bristol to the west, Bath and North East Somerset to the south and Yate locality to the north and east.

### Some other key facts about Kingswood locality

- It contains three priority neighbourhoods - Staple Hill, Kings Chase and Cadbury Heath.
- Teenage pregnancy rates are high in Staple Hill.
- Breast feeding rates are generally low in Kingswood, but particularly low in Kings Chase and Parkwall wards.
- Some wards with the highest level of childhood obesity in Kingswood also have the highest levels of dental decay amongst six year old children, especially Bitton, Oldland Common, Staple Hill and Kings Chase.

## Severnvale locality

Severnvale locality consists of 12 wards covering the northern suburbs of Bristol, and green belt land to the North. It is bordered by the River Severn to the west and Yate locality to the east.

### Some other key facts about Severnvale locality

- All age all cause mortality is lowest in Severnvale locality, suggesting a healthier population.
- In the three wards where there are high percentages of children under five years - Bowsland, Bailey's Court and Sherbourne, all in Bradley Stoke - there is likely to be greater demand for primary health care services.
- Parts of Patchway, Filton, Almondsbury and Thornbury South wards are amongst the most deprived areas in South Gloucestershire and health need is likely to be higher.
- Wards with the highest percentage of elderly residents are Alveston, Almondsbury and Filton.
- Severnvale locality has two priority neighbourhoods - Filton and Patchway.
- These two areas have the highest crime rates which tend to be caused by youths and are largely alcohol associated.



## Yate locality

Yate locality covers 11 wards in the eastern area of South Gloucestershire. Its main population is centred on Chipping Sodbury and Yate. It is more rural than the other two areas.

### Some other key facts about Yate locality

- Yate locality has the lowest life expectancy compared with the other two localities, this is unexpected as it does not have any wards that are as deprived as some in Kingswood or Severnvale.
- Yate West, Dodington and Yate Central have higher deprivation levels compared to the rest of Yate locality.
- Breastfeeding rates are particularly low in Yate West and Dodington. The wards with the two lowest rates have the highest percentage of children aged under five years.
- Based on measuring children at school reception, Yate locality appears to have the highest prevalence of childhood obesity, compared with the other two localities.
- Yate West has a high teenage conception rate.
- Winterbourne has the highest crime rate per 1,000 of population in Yate locality. Frampton Cotterell has the highest rate of youth offending. Yate West has a high proportion of drug-related crime.
- There are no priority neighbourhoods in Yate locality.



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## Section 4: Partnership working

It is important that action to improve health is coordinated across the whole of society and at all levels. This sounds ambitious - and it is. But an example of such success is the gradual reduction in smoking, following years of increasing national legislation, ongoing local support to businesses and day in day out work in the NHS to help individuals who want to stop.

Major challenges to public health, such as tackling the increasing harm from alcohol, or the rise in obesity, will require a similar approach - from a range of national measures, which may include legislation and taxation, through to helping individuals choose a healthy lifestyle.

### 4.1 Key influences on health

At a local level, many of the things that need to be done to improve health lie outside the health service. Key influences on health (to name just a few!) include:

- high quality of education
- good work opportunities
- low levels of crime
- efficient public and private transport
- safe attractive public spaces
- goods and services compliant with legislation
- high community cohesion
- good support to families
- high quality social services
- effective pollution control and waste management
- attractive recreation and sports facilities.

### 4.2 Local partnerships

Efforts to improve health need to engage partners from the health service, local authority, businesses, police, local communities and the voluntary sector. In the last few years, local authorities and partners have been required to form a Local Strategic Partnership and develop a shared strategic vision for the area.

For the past two years the partners in South Gloucestershire have been working to a shared set of detailed aims and objectives called the Local Area Agreement. The agreement is for three years and is split into five themes locally, with 'health improvement' cutting across all themes. The health specific aims and targets were highlighted in last year's Director of Public Health annual report.

The past 12 months have seen some important developments in local partnership working. These include:

- the Director of Public Health role has become jointly accountable to the PCT and the local authority



- development and consultation on a new South Gloucestershire sustainable community strategy – setting out a vision for how the local community would like the local area to evolve over the next 20 years
- the start of development and consultation on a local planning framework which will determine how the vision from the community strategy is translated into housing, transport and other building on the ground
- development of much stronger planning at the level of the three localities of Kingswood, Yate and Severnvale. This planning is increasingly being carried out jointly between the local authority, the PCT and local users. It is also based on an increasing understanding of local health needs
- plans for the Yate health facility finalised, to include an integrated 'Children's Hub', with early planning for similar facilities in the Patchway and Kingswood area.

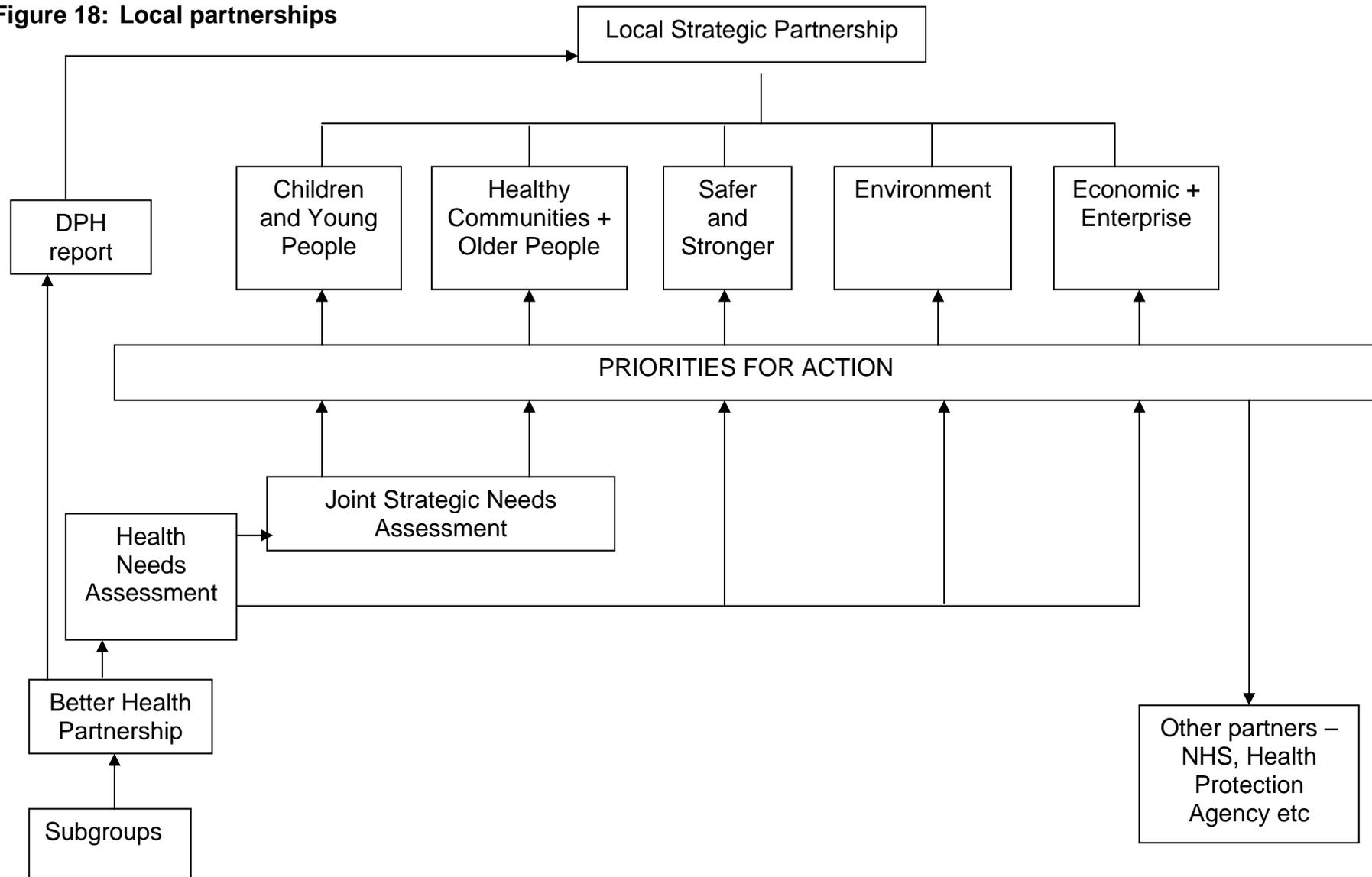
The Local Strategic Partnership and supporting partnership groups are shown in the diagram over the page.

The Better Health Partnership is the group responsible for taking an overview of health improvement across the whole of the partnership. It draws up plans to improve health and reduce inequalities and makes sure that health improvement work is developed in each of the theme partnership groups, or by other partners.

The Better Health Partnership will also oversee the development of the new Joint Strategic Needs Assessment, which will provide a holistic assessment of health need and ensure that services are commissioned to meet need and improve health.



Figure 18: Local partnerships



## Section 5: Health protection

This section has been produced with the help of the Avon Health Protection Unit, which is part of the national Health Protection Agency.

### 5.1 Infection control in the community

The Avon Health Protection Team (AHPT) provides reactive infection control advice to:

- members of the general public
- some 169 nursing, care, or learning disability homes
- all schools within South Gloucestershire.

Over the past year, approximately three incidents per week were dealt with by the AHPT. These ranged from individual cases of communicable disease requiring public health action, to managing outbreaks of gastrointestinal disease in schools, or care homes.

### 5.2 Vaccine preventable diseases

#### Vaccination coverage

The percentage of children immunised by 24 months of age with the first dose of the measles, mumps and rubella (MMR) vaccine has steadily increased over the last five years and reached 91.6% in 2006. Consequently, the number of notified (suspected) cases of measles, mumps or rubella in children up to 24 months has decreased from 35 in 2003 to 19 in 2006.

#### Incidence of vaccine preventable diseases

During 2006, there were ten cases of meningitis in South Gloucestershire. There were no cases of measles and just one case of rubella in South Gloucestershire's children in 2006.

Following the 2004-2005 outbreak of mumps among older teenagers and adults, the incidence of mumps has fallen significantly to 26 cases during 2006. This decrease is likely to have been positively influenced by the vaccination campaign in 2005.

Only one case of pertussis was notified in the South Gloucestershire community and is likely to reflect the high levels of childhood immunisations achieved.

#### Vaccination of poultry workers

In early 2007, the Public Health Team in South Gloucestershire worked with GPs and district nurses to vaccinate poultry workers against winter flu, in accordance with Department of Health policy. This was done to protect individual workers from winter flu and at a population level help prevent emergence of a new virulent strain of pandemic flu.

A total of 46 vaccinations were given, achieving coverage of 73% of eligible poultry workers.



### 5.3 Food poisoning

One of the most common notifiable diseases is food poisoning. Campylobacter and salmonella remain the most common organisms identified in food poisoning.

In South Gloucestershire there were over 460 cases of food poisoning notified in 2006. There were three cases of E.Coli O157 which is a strain of bacteria that can cause particularly severe illness after food poisoning. The three cases were all in adults.

The Avon Health Protection Team works closely with local authority environmental health services in the management of food poisoning cases, some of which have been part of a larger outbreak.

### 5.4 Hepatitis

Following the outbreak in 2001-2004 there has been a significant decline in the number of hepatitis B cases. There were no cases in 2006.

Estimates of hepatitis C vary, but there are likely to be around 1,000 people living with hepatitis C in South Gloucestershire. Approximately half of these people will be aware of their diagnosis.

Infection with hepatitis C often causes no symptoms initially, but can have serious long term consequences of liver cirrhosis and carcinoma. Prevention remains the key to reducing the number of cases of blood-borne hepatitis. In addition, treatment has become more effective, so it is important that individuals in high risk groups, such as injecting drug users, are offered testing and treatment, in addition to advice on prevention.

**Table 8: Incidence of infectious diseases in South Gloucestershire 2001-2006**

	2001	2002	2003	2004	2005	2006
<b>Measles</b>	13	15	22	5	6	0
<b>Mumps</b>	4	4	7	91	158	26
<b>Rubella</b>	13	4	6	0	1	1
<b>Pertussis</b>	2	5	2	1	3	1
<b>Meningitis</b>	15	14	5	3	8	5
<b>E Coli 0157</b>	1	6	1	2	2	3
<b>Scarlet fever</b>	0	13	12	4	2	1
<b>Tuberculosis</b>	11	5	8	9	6	12
<b>Typhoid fever</b>	0	0	0	0	0	2
<b>Hepatitis B</b>	2	9	13	3	2	0

Source: Health Protection Agency South West. NOTE: Any changes from previously reported data are likely to be due to de-notifications of cases i.e. a case diagnosed as TB may subsequently be de-notified, as other organisms are identified as the cause of illness.



## 5.5 Sexual health

Table 9 shows the number of new episodes of selected sexually transmitted infections diagnosed at genito-urinary (GUM) clinics in the South West in 2006. The data indicates that for all ages, more men than women were diagnosed with infections - except in the case of herpes. A similar pattern is seen in analysis of local data.

There has been an increase in new episodes of chlamydia and syphilis since 2005 and a slight decrease of gonorrhoea, herpes and warts.

**Table 9: Number of new episodes of selected diagnosis by sex in the South West 2006**

Sexually transmitted infection	Males	Females	Total
Chlamydia	4,304	3,978	8,282
Gonorrhoea	642	306	948
Syphilis	134	12	146
Herpes	551	851	1,402
Warts	3,506	3,130	6,636

Source: Health Protection Agency

### Chlamydia

Chlamydia is the most common sexually transmitted infection. In the UK, the number of uncomplicated chlamydia diagnoses increased by six per cent in women and 12% in men, between 2003 and 2004.<sup>46</sup>

Infection rates vary according to age between men and women. In the UK in 2004, the highest rates of chlamydia were among:

- 16-19 year old women (1,310 per 100,000)
- 20-24 year old men (1,026 per 100 000).

A chlamydia screening programme is being introduced in South Gloucestershire during 2007, which aims to offer tests to 15% of all 15-24 year olds by March 2008.

### Human immunodeficiency virus (HIV)

Men who have sex with men remain the behavioural group at greatest risk of acquiring HIV infection within the UK. They accounted for over half (58%) of infections diagnosed in 2004 that were probably acquired within the UK.<sup>47</sup>

<sup>46</sup> Health Protection Agency. *Epidemiological Data – Chlamydia*. www.hpa.org.uk

<sup>47</sup> Health Protection Agency 2006 Mapping the Issues HIV and other Sexually Transmitted Infections in the United Kingdom: 2005. London: HPA.



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## Key observations and recommendations

These are the major observations and recommendations from this year's report.

### Differences in health between women and men

- The gap in life expectancy between women and men is gradually narrowing, with men's life expectancy growing faster than women's.
- The gap in life expectancy between women and men is greatest in poorer communities.
- Men are much more likely than women to die prematurely from circulatory disease, cancer, or from injury. Tackling these, and other major health problems, will benefit both sexes, but will tend to narrow the health gap because men have worse health and hence more to gain.
- Reduction in the number of men smoking has played a large part in narrowing the health gap between women and men.

### Alcohol

- Consumption of alcohol has increased over the past ten years, particularly by women and young people.
- Alcohol is implicated in approximately 35% of all attendances at Accident and Emergency departments.
- Young people are now drinking twice as much as they were in 1990.
- The incidence of liver cirrhosis in South Gloucestershire has almost tripled in the last ten years.
- Local alcohol-related hospital admissions are rising annually for both men and women.

Local services should be enhanced to include:

- the routine recording of alcohol intake in general practice
- developing primary care capacity for brief interventions and advice, particularly for drinkers that are not heavily dependent
- ensuring that the public are well-informed about the risks from alcohol misuse, the number of units in various alcoholic drinks and the national guidelines
- ensuring that every opportunity is taken in primary care, secondary care and elsewhere, to screen, using a tool such as AUDIT.



## Locality health needs

- In each locality a small number of geographical areas are highlighted as having the worst health indicators. These tend to be (but are not exclusively) the areas of relatively high deprivation designated by the local authority as 'priority neighbourhoods'. The types of problem that tend to cluster in these areas include:
  - low rates of breast feeding
  - high levels of childhood obesity
  - poor dental health in children
  - high rates of teenage pregnancy.
- Tackling ill health in priority neighbourhoods and other relatively deprived areas will require coordinated, wide-ranging action involving local residents, the PCT, local authority and other statutory and voluntary organisations. The emerging structures and processes overseen by the Local Strategic Partnership, such as the 'Planning for Real' exercises, provide a useful first step and should be developed further.



## **Index of Director of Public Health annual reports**

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

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

Major health problems  
Tackling inequalities in health

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

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

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

#### ***2004 - 2005 Focus on children and young people***

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

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

#### ***2005 - 2006 - Focus on the environment and healthy ageing***

Climate change  
New communities  
Healthy ageing  
Choosing Health  
Improving community health and services





## **Appendix A: NHS community health profile for South Gloucestershire**

**- can also be seen at [www.communityhealthprofiles.info](http://www.communityhealthprofiles.info)**





# South Gloucestershire Health Profile 2007



This profile gives a snapshot of health in your area. With other local information, this Health Profile has been designed to support action by local government and primary care trusts to tackle health inequalities and improve people's health.

Health Profiles are funded by the Department of Health and produced annually by the Association of Public Health Observatories.

To view Health Profiles for other local authorities and to find out how they were produced, visit [www.communityhealthprofiles.info](http://www.communityhealthprofiles.info)



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DH 100020290 2007. Other map data © Collins Bartholomew.

## South Gloucestershire at a glance

- South Gloucestershire is a mixed urban and rural authority. Health indicators are generally better than for England.
- 7% of residents are dependent on means-tested benefits, compared with 13% in England. Around 5,700 children live in households dependent on means-tested benefits.
- On average, people in South Gloucestershire live longer than in England as a whole. Life expectancy is rising for both men and women.
- Early death rates from heart disease & stroke and from cancer have been falling and the rates are lower than the England average.
- Smoking and binge drinking rates are below the England average. The proportion of adults who are obese is below average (these are all estimates based on national surveys).
- Although the death rate from smoking is low, smoking still kills around 350 people every year.
- The rate of people claiming sickness benefit because of mental health problems is lower than average.
- Although the percentage of people with recorded diabetes in the South Gloucestershire population is low, around 8,200 people are registered as having diabetes.
- Local plans for 23,000 new homes at higher densities could provide more local work and leisure opportunities with improved sustainability and higher levels of walking and cycling.
- The latest report from the Director of Public Health can be found at [www.sglos-pct.nhs.uk](http://www.sglos-pct.nhs.uk) and the Local Area Agreement at [www.ourareaourfuture.org.uk](http://www.ourareaourfuture.org.uk)

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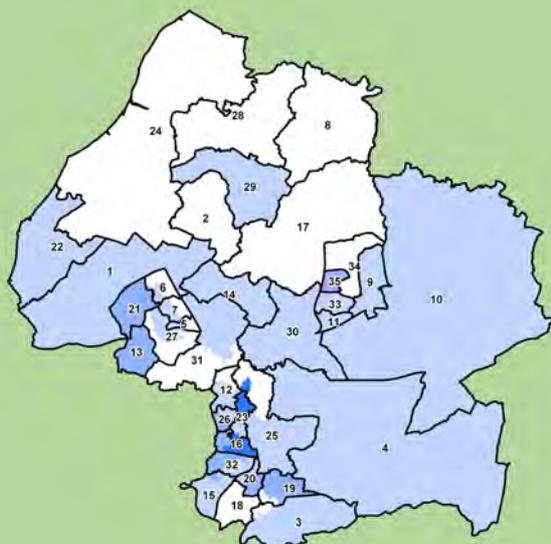


## Income inequalities: a national perspective

This map shows variation in the percentage of people on low income, between small areas in this local authority *in relation to the whole of England* (2003).

### National income groups

- 1 Least income-deprived fifth of areas in England
- 2
- 3
- 4
- 5 Most income-deprived fifth of areas in England

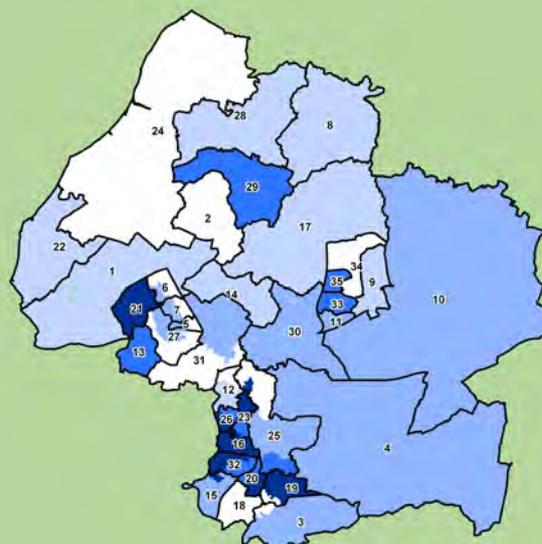


## Income inequalities: a local perspective

This map shows variation in the percentage of people on low income, between small areas *within this local authority* (2003).

### Local income groups

- 1 Least income-deprived fifth of areas in this local authority
- 2
- 3
- 4
- 5 Most income-deprived fifth of areas in this local authority



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## Ward legend

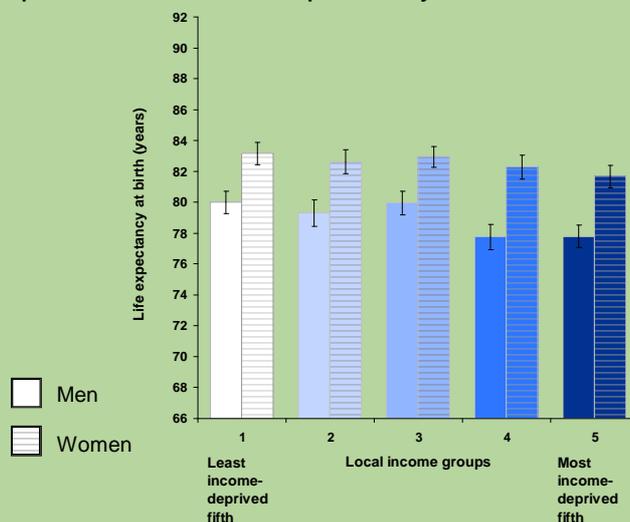
- |                               |                    |
|-------------------------------|--------------------|
| 1 Almondsbury                 | 29 Thornbury South |
| 2 Alveston                    | 30 Westerleigh     |
| 3 Bitton                      | 31 Winterbourne    |
| 4 Boyd Valley                 | 32 Woodstock       |
| 5 Bradley Stoke Baileys Court | 33 Yate Central    |
| 6 Bradley Stoke Bowsland      | 34 Yate North      |
| 7 Bradley Stoke Sherbourne    | 35 Yate West       |
| 8 Charfield                   |                    |
| 9 Chipping Sodbury            |                    |
| 10 Cotswold Edge              |                    |
| 11 Dodington                  |                    |
| 12 Downend                    |                    |
| 13 Filton                     |                    |
| 14 Frampton Cotterell         |                    |
| 15 Hanham                     |                    |
| 16 Kings Chase                |                    |
| 17 Ladden Brook               |                    |
| 18 Longwell Green             |                    |
| 19 Oldland Common             |                    |
| 20 Parkwall                   |                    |
| 21 Patchway                   |                    |
| 22 Pilning and Severn Beach   |                    |
| 23 Rodway                     |                    |
| 24 Severn                     |                    |
| 25 Siston                     |                    |
| 26 Staple Hill                |                    |
| 27 Stoke Gifford              |                    |
| 28 Thornbury North            |                    |

Ward boundaries 2005 superimposed upon MSAO (Middle Super Output Area) boundaries. Numbers correspond to ward legend. Ward boundaries may have changed.



## Health inequalities: a local perspective

This chart shows inequalities in life expectancy (2001-05) at birth for men and women for the five local income groups presented in the map directly above.



95% confidence interval. These indicate the level of uncertainty about each value on the graph. Longer/wider intervals mean more uncertainty. When two intervals do not overlap it is reasonably certain that the two groups are truly different.



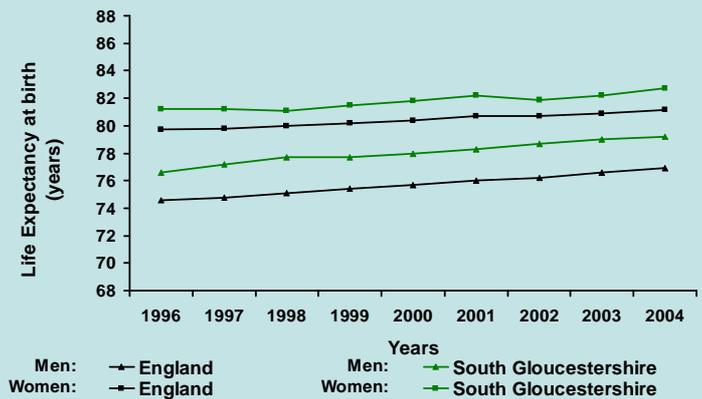
## Health inequalities: changes over time

Trend 1 compares the trend in life expectancy at birth for men and women in this local authority with that for England.

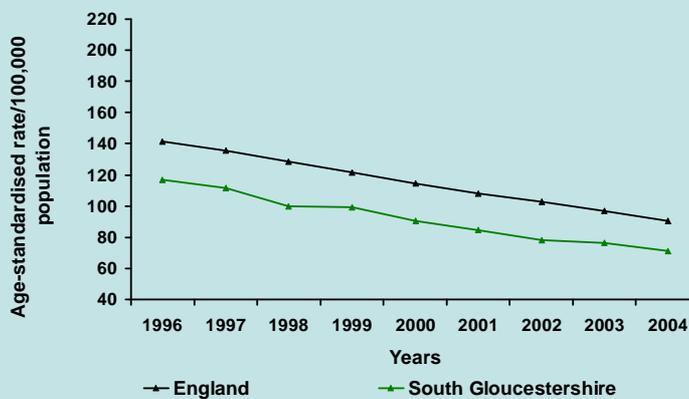
Trend 2 compares the trend in early death rates (all persons under 75 years) from heart disease and stroke in this local authority with that for England.

Trend 3 compares the trend in early death rates (all persons under 75 years) from cancer in this local authority with that for England.

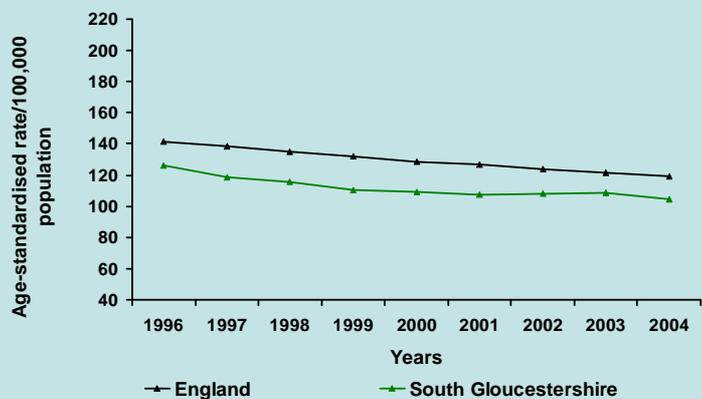
**Trend 1:**  
Life expectancy at birth



**Trend 2:**  
Early death rates from heart disease and stroke



**Trend 3:**  
Early death rates from cancer

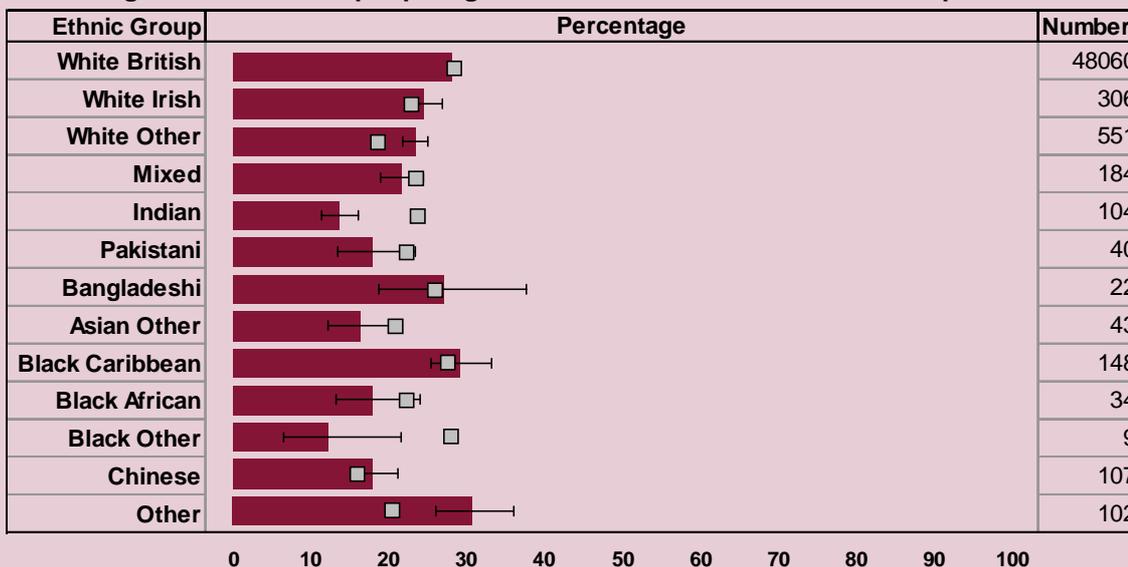


## Health inequalities: ethnicity

This chart compares the percentage of the population of each ethnic group in the local authority who are in routine and manual occupations. People in these occupations have poorer health than those in professional

occupations, and are more likely to be smokers. The infant death rate is higher than average among babies born into this group. There are national targets to address these health inequalities.

Percentage and number of people aged 16-74 in routine and manual occupations



Note: This chart is based on the 2001 Census. Where the total population in an ethnic group in the local authority is less than 30, no data have been presented and the number column shows n/a. Where the number is less than 5, no percentage is shown.

Confidence intervals are shown for local data

□ England - average  
■ South Gloucestershire

The chart below shows a number of indicators of people's health in this local authority. It shows the local value for each indicator compared to the England worst, England best, England average and Regional average. The circle indicating the local value is shown as amber if it is significantly better or red if it is significantly worse than the England average. An amber circle may still indicate an important public health burden. A white circle is not significantly different from the England average. For technical information about each indicator, see [www.communityhealthprofiles.info](http://www.communityhealthprofiles.info)

Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	<b>1</b> Income deprivation	16810	6.8	12.9	31.1		3.3
	<b>2</b> Ecological footprint	n/a	5.150	5.470	6.430		4.904
	<b>3</b> Homelessness	297	7.3	7.8	35.8		0.0
	<b>4</b> Children in poverty	5712	11.2	21.3	58.8		5.2
	<b>5</b> GCSE achievement *	1691	54.9	57.5	33.6		81.9
	<b>6</b> Violent crime	3563	14.4	19.8	41.1		5.0
Giving children and young people a healthy start	<b>7</b> Smoking in pregnancy						
	<b>8</b> Breast feeding						
	<b>9</b> Obese children						
	<b>10</b> Physically active children *						
	<b>11</b> Teenage pregnancy (under 18) *	121	27.0	42.1	95.3		12.8
The way we live	<b>12</b> Adults who smoke *	n/a	20.9	26.0	37.3		15.5
	<b>13</b> Binge drinking adults	n/a	15.0	18.2	29.2		8.8
	<b>14</b> Healthy eating adults	n/a	23.2	23.8	11.4		38.1
	<b>15</b> Physically active adults	n/a	12.9	11.6	7.5		17.2
	<b>16</b> Obese adults	n/a	19.3	21.8	31.0		14.6
	How long we live and what we die of	<b>17</b> Life expectancy - male *	n/a	79.2	76.9	72.5	
<b>18</b> Life expectancy - female *		n/a	82.7	81.1	78.1		86.2
<b>19</b> Deaths from smoking		345	196.4	234.4	366.5		147.6
<b>20</b> Early deaths: heart disease & stroke *		193	70.9	90.5	151.3		44.9
<b>21</b> Early deaths: cancer *		280	104.8	119.0	168.0		81.6
<b>22</b> Infant deaths *		10	3.4	5.1	9.9		1.2
<b>23</b> Road injuries and deaths		109	44.2	59.9	214.1		20.2
Health and ill health in our community	<b>24</b> Feeling 'in poor health'	16427	6.1	7.8	15.4		4.2
	<b>25</b> Mental health	2310	15.1	27.4	72.0		8.5
	<b>26</b> Hospital stays due to alcohol	588	233.5	247.7	652.4		85.6
	<b>27</b> Drug misuse	1501	9.2	9.9	34.9		1.3
	<b>28</b> People with diabetes	8208	3.3	3.7	5.9		2.1
	<b>29</b> Children's tooth decay	n/a	1.5	1.5	3.2		0.4
	<b>30</b> Sexually transmitted infections						
	<b>31</b> Older people: hip fracture	256	568.8	565.3	936.8		259.7

- Significantly better than England average
- Significantly worse than England average
- Not significantly different from England average
- \* PSA Target Measure 2005-2008



**Note** (numbers in bold refer to the above indicators)

**1** % of residents dependent on means-tested benefits. 2003. **2** Land (hectares per capita) required to support an average resident's lifestyle; no significance calculated. 2001. **3** % of households on local authority housing register who are statutorily homeless. 2004/05. **4** % in low-income households. 2001. **5** % achieving 5 A\*-C. 2005/06. **6** Crude rate/1,000 pop 2005/06. **7 8 9 10 30** No comparable local data currently available. **11** Crude rate/1,000 female pop. aged 15-17. 2002-04. **12 13 14 16** % . Modelled estimates from the Health Survey for England. **12 13 16** 2000-02. **14** 2001-02. **15** % . 2005/06. **17 18** Years. 2003-05. **19** Directly age standardised rate/100,000 pop. aged 35 or over. 2003-05. **20 21** Directly age standardised rate/100,000 pop. under 75. 2003-05. **22** Crude rate/1,000 live births. 2003-05. **23** Crude rate/100,000 pop. 2003-05. **24** Directly age standardised % . 2001. **25** Crude rate claimants of benefits/allowances for mental or behavioural disorders/1,000 working age pop. 2005. **26** Directly age sex standardised rate/100,000 pop. 2005/06. **27** Crude rate/1,000 pop. aged 15-64; no significance calculated for lower tier authorities. 2004/05. **28** % . 2005/06. **29** Average no. of decayed, missing and filled teeth in children aged 5; data incomplete or missing for some areas. 2005/06. **31** Directly age standardised rate/100,000 pop. aged 65 and over. 2005/06.

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## Thanks to...

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

### Public Health/Health Promotion Team

Lindsey Thomas	Assistant Director Public Health – Health Promotion
Lesley Causon	Health Improvement Specialist
Maggie Sims	Health Improvement Specialist
June Martin	Health Improvement Specialist
Jane Kilpatrick	Health Improvement Specialist
Nicola Ravenscroft	Health Improvement Specialist
Richard Merrett	Health Improvement Specialist
Faiza Khan	Public health trainee
Alison Bell	Public health trainee
Kirsty Alexander	Public health trainee
Cindy Chesterman	Designated nurse for child protection

### Public Health Network Specialists

Dr Chris Hine	Consultant in Public Health, Acute Commissioning
Dr Angela Raffle	Consultant in Public Health, Cancer and screening
Kate Conlon	Health Protection Agency

Particular thanks to Marie Barnes for masterminding the analysis and presentation of health information.

### Production

Sally Bramley	Editing
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### Dr Chris Payne

Director of Public Health, South Gloucestershire Primary Care Trust

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This report was produced by:

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

Telephone: 0117 330 2479  
email: [Chris.Payne@sglos-pct.nhs.uk](mailto:Chris.Payne@sglos-pct.nhs.uk)

Further copies of this report can be obtained from:  
[www.sglos-pct.nhs.uk](http://www.sglos-pct.nhs.uk)

*or*

Sue Shortman  
Telephone: 0117 330 2479

18th December 2007