

8 Public Health

8.1 Key Themes

8.1.1 During 2006–09, the South West had the joint highest life expectancy of all the English regions for women (83 years) and one of the highest for men (79 years).

8.1.2 Mortality rates from major disease groups such as cancer and circulatory diseases are amongst the lowest in England (Table 8.10.2.1).

8.1.3 Children's health is also generally good in the South West, with levels of both physical activity and obesity better than the England average.

8.1.4 However, these positive overall statistics mask inequalities within the South West. People living in areas of greatest deprivation have shorter life expectancies than those in the least deprived areas. For example, men living in the most deprived areas of North Somerset die almost 10 years earlier than their neighbours in less deprived areas. Issues associated with reduced life expectancy include equality of access to education, employment and income, as well as differences in individual behaviour. Moreover, geographical differences might in part be a consequence of internal migration, whereby healthier and wealthier individuals move to more affluent areas.

8.1.5 Latest data for 2006–08 show that there are, on average, 35 conceptions per 1,000 females aged 15–17 in the South West each year, which is lower than the England average of 41. However, a number of areas in the South West have significantly higher rates than the England average: Torbay and Bristol are highest at 58 and 51 conceptions per 1,000 females aged 15–17 respectively.

8.1.6 The choices that adults make are key to improving the future health of the South West. While smoking rates have reduced in recent years, it is estimated that almost one in five adults still smoke, and this varies according to occupation. In Great Britain approximately 28% of those in a routine or manual occupation smoke, compared to 15% in professional and managerial roles: the percentages are likely to be the same in the South West.

8.1.7 Overall, the South West has relatively low rates of serious injury and death from road transport incidents, with 46 deaths per 100,000 residents compared to England's 52. However, this still equates to nearly 2,400 people being seriously injured or losing their lives on the South West's roads each year.

8.1.8 In 2008/09 there were an estimated 3,800 excess winter deaths in the South West, of which almost two-thirds occurred in those aged 85 years and older. In 2009/10 there were 2,700 excess winter deaths in the South West, with a lower proportion in those aged 85 years and older than in 2008/09.

8.1.9 GP consultation rates for influenza-like illness (ILI) from week 14 in 2009 (30th March to 5th April) to week 13 in 2010 (29th March to 4th April) in the UK and South West showed a peak in the summer weeks 28 to 32 (6th July to 9th August 2009) due to Swine Flu (Figure 8.5.1.1). The highest UK peak was 225.6 per 100,000 in week 30 (20th to 26th July 2009); the highest South West peak was 218 per 100,000, also in week 30. There was also a smaller peak over baseline levels (20 per 100,000 population) across the winter weeks.

8.2 Key Data

8.2.1 In 2006–09, the South West and South East had the joint highest life expectancy of all the English regions for women (83 years), and the South West had one of the highest for men (79 years). The comparable figures for England were 82 years for women and 78 years for men (source: [Office for National statistics \(ONS\), 2007–09 data 'Results for England and Wales'](#)).

8.2.2 In North Somerset, men in the least deprived areas (referred to as Quintile 1) have a life expectancy of nearly 83 years, compared to just over 73 years for those living in the most deprived areas (referred to as Quintile 5). This is the largest gap for men in any of the South West's Local Authorities. The largest gap for women is in Gloucester, where those living in the least deprived areas have a life expectancy of just over 86 years, compared to just under 79 years for those in the most deprived areas (source: [Health Profiles, life expectancy by deprivation quintile 2004–2008](#)).

8.2.3 Although mortality from 'all causes' and the major disease types is generally lower than in England as a whole (Table 8.10.2.1), the rates

of death from malignant melanoma in the South West are the highest in England (source: [National Centre for Health Outcomes Development \(NCHOD\)](#)).

8.2.4 Less than one in five (18%) adults in the South West smoke, with the proportion slightly higher in men (19%) than in women (17%); both groups have seen considerable reductions in prevalence since 2008 (source: [Smoking and drinking among adults, 2009](#)).

8.2.5 In 2009, 24% of women in the South West drank above recommended sensible daily limits (maximum of three units for women and four for men) on at least one day in the week prior to the survey (source: [Smoking and drinking among adults, 2009](#), p.80), lower than the 29% for England. 34% of males in the South West drank above current recommended sensible daily limits on at least one day in the week prior to the survey, slightly lower than the 37% figure for England.

8.2.6 Obesity has more than doubled since 1993, and it is now estimated that approximately a quarter of the South West's adults are obese (source: [Health Survey for England 2008](#)).

8.3 Determinants of Health

8.3.1 "People with higher socioeconomic position in society have a greater array of life chances and more opportunities to lead a flourishing life. They also have better health. The two are linked: the more favoured people are, socially and economically, the better their health. This link between social conditions and health is not a footnote to the 'real' concerns with health – health care and unhealthy behaviours – it should become the main focus." (source: [The](#)

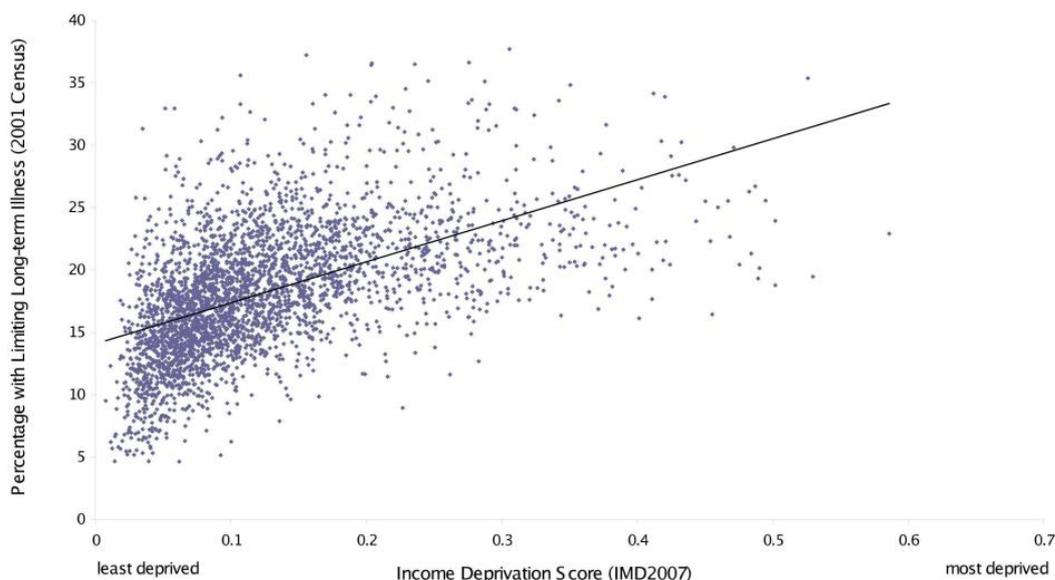
[Marmot Review, 'Note from the Chair' of the Executive Summary, 'Fair Society, Healthy Lives'](#)).

8.3.2 "Children who have low cognitive scores at 22 months of age but who grow up in families of high socioeconomic position improve their relative scores as they approach the age of 10. The relative position of children with high scores at 22 months, but who grow up in families of low socioeconomic position, worsens as they approach age 10." (source: [Fair Society, Healthy Lives, p.22](#)).

8.3.3 Using the income component of the [Indices of Multiple Deprivation \(IMD\) 2007](#), and information obtained from the 2001 Census, Figure 8.3.1 explores the relationship between deprivation and self-reported Limiting Long-term Illness in the South West. Each 'dot' represents the percentage of people in a particular [Lower Super Output Area \(LSOA\)](#) who reported at the 2001 Census a long-term illness, health problem or disability that limited their daily activities or work, according to the income deprivation score for that LSOA. The horizontal axis showing the income deprivation score, with values ranging from '0' to '0.7', indicates the level of deprivation in an area: the higher the score i.e nearer to '0.7' than '0', the more deprived the area.

Looking at Figure 8.3.1 from left to right, many of the 'dots' cluster towards the left hand side indicating lower levels of deprivation in the South West, but levels of self-reported Limiting Long-term Illness vary regardless of income. The fitted straight line shows an upward 'positive' slope indicating that areas with a high degree of income deprivation tend also to be those areas where a higher percentage of people report a Limiting Long-term Illness. The scatterplot does not show that there is necessarily a causal relationship between income deprivation and Limiting Long-term Illness, simply that there is an association between the two.

Figure 8.3.1 Income Deprivation Score (IMD 2007) and percentage of persons living with a Limiting Long-term Illness (2001 Census) by LSOA in the South West



Source: i) Census 2001 and ii) Department for Communities and Local Government Indices of Deprivation 2007

8.3.4 The 2010 Health Profiles, produced by the Association of Public Health Observatories (APHO) for the Department of Health (DH), provide a succinct account of patterns in health in the South West. The Marmot Indicators for Local Authorities in England show a number of key indicators of the social determinants of health, health outcomes and social inequality. The time periods used for the indicators in each of these two tools are not, however, always identical, and consequently exact comparisons are not always possible.

8.4 Climate Change

"The term 'climate change' usually refers to man-made changes that have occurred since the early 1900s. While there are noticeable highs and lows in year to year data, over longer periods of time there is a discernible warming trend across the globe. Natural causes can explain only a small part of this warming. The overwhelming majority of scientists agree that this is due to rising concentrations of heat-trapping greenhouse gases in the atmosphere caused by human activities" (source: Met Office).

A report by the South East Regional Public Health Group, 'The Health Impact of Climate Change', published in 2008, finds that: the NHS has started to predict the likely impacts on health from climate change and has outlined these in 'Health effects of climate change in the UK 2008: an update of the Department of Health report 2001/2002.' Public safety advice concerning severe weather is available from the Met Office.

8.4.1 Heat waves are projected to become more frequent. Following the August 2003 heat wave, during which an excess 2,000 deaths occurred in England and Wales, a 'heat-health watch' now operates from June to September. This includes alerts from the Met Office to the NHS and care homes when forecasts show high temperature thresholds will be exceeded. On Sunday 11th August 2003 the temperature in Gravesend in Kent reached 38.1C (100.6F), the highest recorded UK temperature since 1875. The previous record high temperature was in 1990 in Cheltenham, Gloucestershire when it reached 37.1C (98.8F) (source: BBC News).

8.4.2 If summers become sunnier, increased exposure to ultra-violet (UV) radiation could lead to an increase in the incidence of and mortality

from malignant melanoma of the skin: see 8.10.4.2 and the [SWPHO Skin Cancer Hub](#) website.

8.4.3 Each year there are approximately 70,000 reported cases of food poisoning in England and Wales. There is a seasonal summer increase associated with barbeques, poor food hygiene and improperly cooked food rather than an increase in temperature per se (source: [Health Protection Agency \(HPA\)](#)). Norovirus infections however can occur at anytime of the year, but are sometimes referred to as 'winter vomiting disease' because people often suffer from these infections during the winter months. Bivalves such as oysters can be contaminated with the norovirus, with higher rates of detection of the virus occurring between October and March (source: [HPA](#)).

8.4.4 Despite a discernible warming trend across the globe, we are, as recent events have shown, also susceptible to extremes in rainfall and cold weather, and the consequences can be severe.

8.4.5 "Residents rescued from homes as floods hit Cornwall" (source: [Guardian.co.uk 17th November, 2010](#)).

8.4.6 Colder weather affects mortality, particularly amongst the elderly. In 2008/09 there were an estimated 3,800 excess winter deaths in the South West, of which almost two-thirds occurred in those aged 85 years and older (source: [SWPHO](#)). Excess winter mortality, however, can vary from year to year. All-age excess winter deaths in the South West in 2009/10 numbered 2,700 with a lower proportion in those aged 85 years and older than in 2008/09 (source: [ONS](#)). Towards the latter part of 2010,

many parts of the UK experienced severe weather conditions: temperatures fell to -11C in parts of Somerset during December (source: [BBC News](#), 3rd December, 2010); and

"November [2010] saw the UK's most widespread snowfall since 1965, and December has continued to be exceptionally cold and snowy." (source: [BBC Weather](#)).

It remains to be seen what impact this spell of cold weather will have on mortality.

8.5 Influenza and Respiratory

This section contains information provided by the [HPA South West](#).

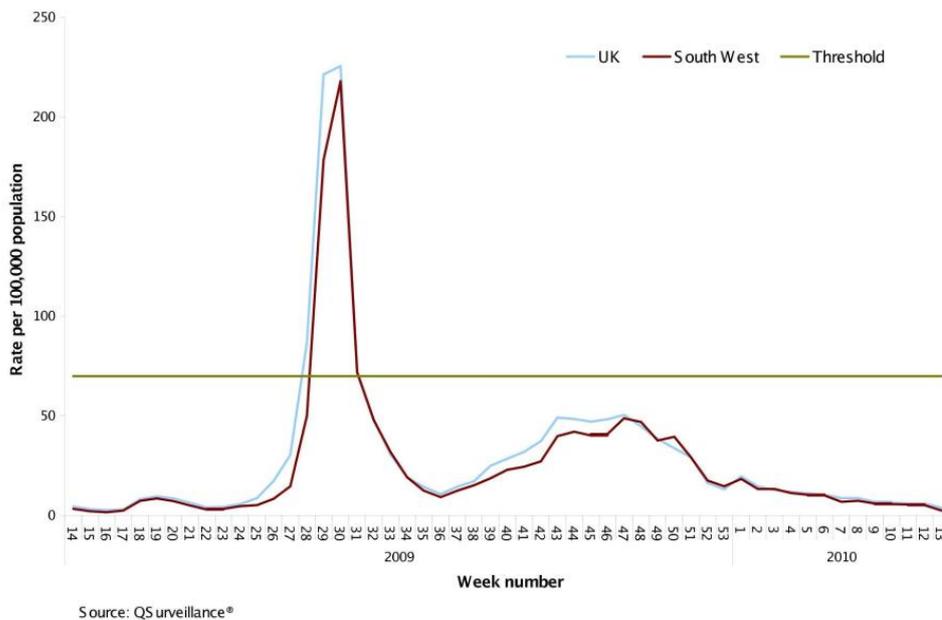
Influenza and influenza-like illness (ILI) result in increased activity in the health service. In 2009/10 there was a pandemic of a new influenza virus, H1N1v (Swine Flu).

8.5.1 GP Consultation Rates for Influenza-like Illness

8.5.1.1 GP consultation rates for influenza-like illness in the UK and South West from week 14 in 2009 (30th March to 5th April) to week 13 in 2010 (29th March to 4th April) showed a peak in the summer weeks 28 to 32 (6th July to 9th August 2009) which exceeded normal seasonal activity (20 to 70 per 100,000 population): this was due to swine flu. The highest UK peak was 225.6 per 100,000 in week 30 (20th to 26th July 2009), and the highest South West peak, also in week 30, was 218 per 100,000 (Figure 8.5.1.1). There was also a smaller peak over baseline levels (over 20 per 100,000 population) during the winter weeks. The source for these data is QSurveillance®.⁽¹⁾

1 [QSurveillance®](#) is based on data from 43% of England's population (about 3000 practices). There are 320 practices who contribute to QSurveillance® in the South West.

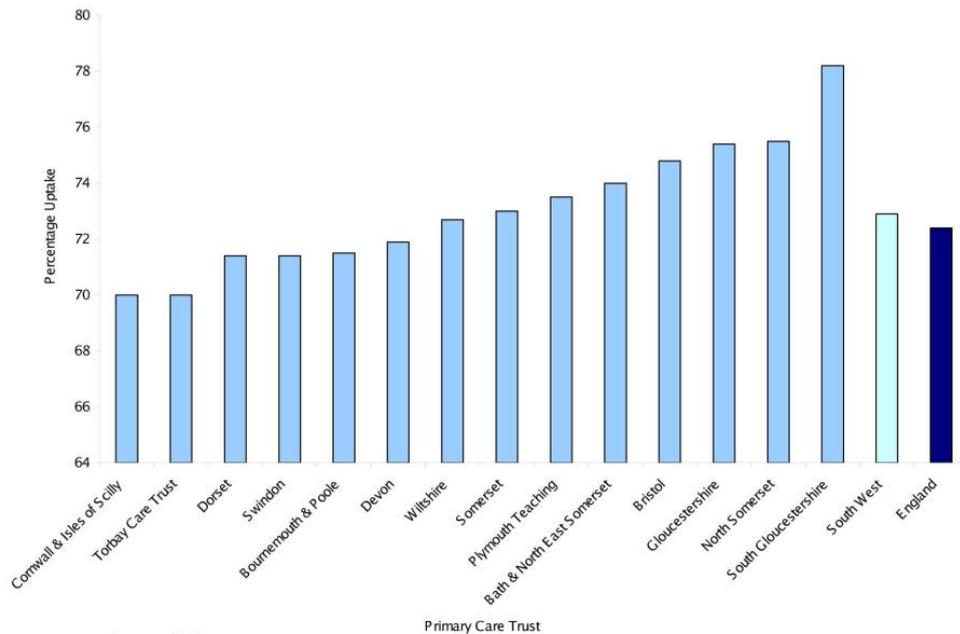
Figure 8.5.1.1 GP consultation rates for influenza-like illness (ILI) in the UK and South West from week 14 in 2009 to week 13 in 2010



8.5.1.2 Uptake of the flu vaccine remains low. Seasonal flu uptake percentages in persons aged 65 years and over for 2009/10 for the Primary Care Trusts in the South West, the South West as a whole, and for England as a whole are shown in Figure 8.5.1.2. Nationally,

vaccine uptake for people aged 65 years and over was 72.4%, a decrease compared with 74.1% during the 2008/09 season. Uptake for the South West for 2009/10 was similar to the national figure at 72.9%.

Figure 8.5.1.2 Seasonal flu vaccine uptake in persons aged 65 years and over in Primary Care Trusts in the South West, 2009/10



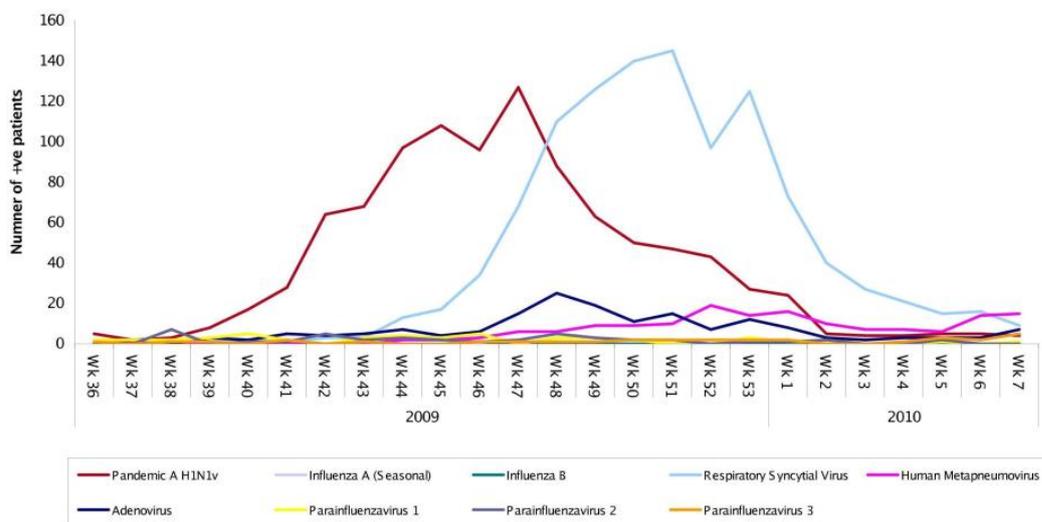
Source: HPA

8.5.2 Respiratory Virus Testing

8.5.2.1 Figure 8.5.2.1 indicates numbers of patients identified with respiratory virus infection from week 36 in 2009 to week 7 in 2010. The

viruses with the highest peaks in the 2009/10 winter season were Pandemic A H1N1v and Respiratory Syncytial Virus (RSV). H1N1v peaked at 127 patients in week 47, while RSV peaked at 145 patients in week 51.

Figure 8.5.2.1 Numbers of patients identified with respiratory infection from week 36 in 2009 to week 7 in 2010 in the South West



Source: CoSurv, HPA

8.6 Life Expectancy

8.6.1 Life Expectancy at Birth

8.6.1.1 The life expectancy of an individual at birth is a good measure of the overall health of a population. People in the South West can expect to live longer than the England average of 82.3 years for women and 78.3 years for men (source: [ONS, 2007–09 data 'Results for England and Wales'](#)). In fact, women in the South West and the South East jointly enjoy the highest life expectancy (estimated at birth) of 83.3 years, and men in the South West one of the highest at 79.2 years.

8.6.1.2 However, these figures mask variation by Local Authority across the South West. For example, men, in Bristol and Plymouth, jointly have the lowest life expectancy (estimated at birth) in the South West of 77.2 years, and women in Bristol, Plymouth and Torbay have a lower life expectancy, estimated at 81.9 years, compared to other women in the South West (source: [ONS, 2007–09 data 'Results for England and Wales'](#)). Of course, many factors affect individual life expectancy and the above

figures are estimates only. More information regarding the calculation of these estimates may be found on the [ONS](#) website.

8.6.2 Inequalities in Life Expectancy

8.6.2.1 In North Somerset, men in the least deprived areas (referred to as Quintile 1) have a life expectancy of nearly 83 years, compared to just over 73 years for those living in the most deprived areas (referred to as Quintile 5). This is the largest gap for men in any of the South West's Local Authorities. The largest gap for women is in Gloucester, where those living in the least deprived areas have a life expectancy of just over 86 years, compared to just under 79 years for those in the most deprived areas (source: [Health Profiles, life expectancy by deprivation quintile 2004–2008](#)).

Issues associated with reduced life expectancy include equality of access to education, employment and income, as well as differences in individual behaviour. Moreover, geographical differences might in part be a consequence of internal migration, whereby healthier and wealthier individuals move to more affluent areas.

It is worth noting however that the difference between Quintiles 1 and 5 is not always linear, and that men or women in Quintiles 2, 3 and 4 might experience better or poorer life expectancy than those at either end of the spectrum (source: [Health Profiles life expectancy by deprivation quintile 2004–2008](#)).

8.7 Children and Young People's Health

8.7.1 Infant Mortality

8.7.1.1 Infant mortality is defined as death within the first year of life. Some deaths in infants are caused by congenital anomalies or extreme prematurity, and are probably unavoidable. However, factors which might increase infant mortality are smoking during pregnancy, and poor quality neonatal care.

8.7.1.2 Smoking during pregnancy has well known detrimental effects on the growth and development of a baby. In 2008/09, 14.8% of women in the South West were current smokers at the time of delivery, similar to the England average of 14.7%. In Torbay, which has the highest rate in the South West, more than one in five (22%) mothers were smokers at time of delivery (source: [Health Profiles 2010](#)).

8.7.1.3 Breast feeding has a number of health benefits for both baby and mother (source: [NHS Breastfeeding](#)). Breast milk helps protect babies against infections, as well as reducing the risk of developing asthma or eczema. For mothers, breastfeeding can help prevent developing certain diseases in later life, such as ovarian or breast cancer. Data for 2007/08 suggest that over 78% of babies were breastfed within 48 hours of birth in the South West, a rate which is higher than the England average of 72% (source: [Health Profiles 2010](#)).

8.7.1.4 Deaths under one year of age per 1,000 live births have been falling in England and in the South West. In 1981 there were 10.9 deaths per 1,000 live births in England and by 2008 this had dropped to 4.6 deaths per 1,000 live births. Similarly in the South West, the infant death rate dropped from 10.4 deaths per 1,000 live births in 1981 to 4.0 in 2009 (source: [National Centre for Health Outcomes Development \(NCHOD\)](#)). While the South West's infant mortality rate is lower than for England as a whole, there is variation by deprivation within the South West. Analysis conducted by the

[SWPHO](#) shows that in 2007–09, there were 5.3 deaths per 1,000 live births in the most deprived areas of the South West, more than 30% higher than the rate for the South West as a whole.

8.7.2 Childhood Physical Activity, Diet and Obesity

8.7.2.1 The latest [National Child Measurement Programme \(NCMP\)](#) data for 2009/10 show that nearly one in ten children in Reception year in England were obese (9.8%), and nearly double this proportion of children in Year 6 were obese (18.7%). The South West had lower childhood obesity levels than England for both Reception year (9.2%) and Year 6 (16.1%). In contrast the percentage of children who were overweight in Reception year in the South West (14%) was higher than England (13.3%). The percentage of Year 6 children who were overweight was similar in the South West (14.3%) to England (14.6%).

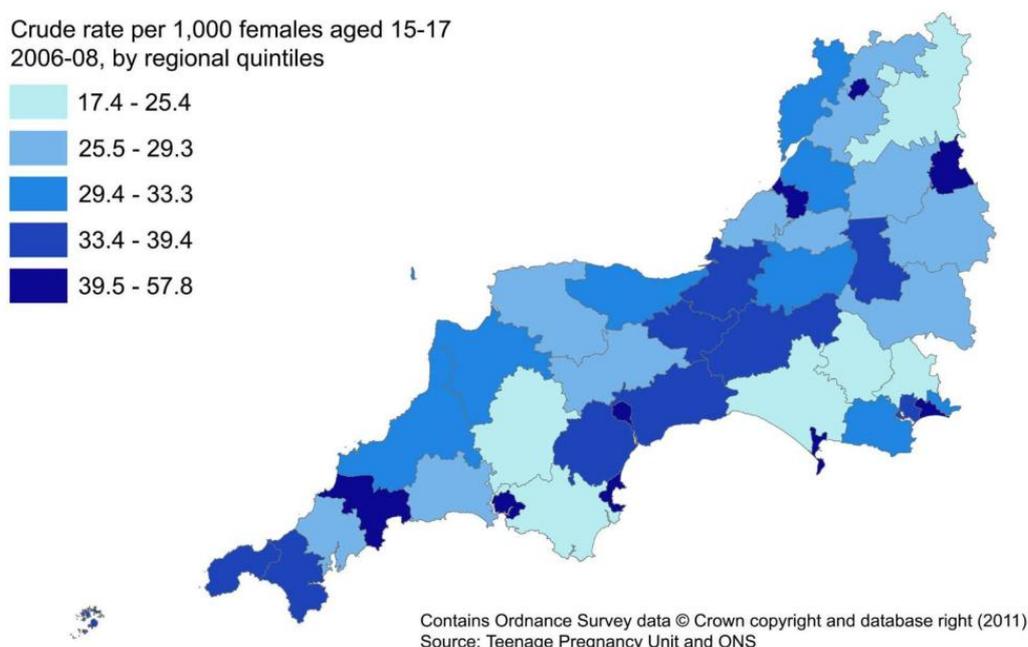
8.7.2.2 Physical activity during childhood has a range of benefits including healthy growth and development, maintenance of energy balance, psychological well-being and social interaction. Through improved concentration and self-esteem, it can also improve school attendance, behaviour and attainment. A survey of state schools conducted in 2008/09 suggests that in the South West, 52.4% of children in state maintained schools take part in at least 3 hours of physical activity each week, a rate which is better than the England figure of 49.6 % (source: [Health Profiles 2010](#)).

8.7.2.3 In England between 2001 (when monitoring started) and 2008, the mean portions of fruit and vegetables consumed by boys aged 5–15 years changed from 2.4 to 3.1 portions per day while the mean portions that girls consumed changed from 2.6 to 3.3 portions per day. In 2008 mean portions of fruit and vegetables consumed by boys aged 5–15 in the South West were the same as England (3.1 portions per day) but consumption by girls in the South West (3.1 portions per day) was lower (source: [Health Survey for England 2008](#)).

8.7.2.4 Data from the British Association for the Study of Community Dentistry shows that in 2007/08, the South West's five-year-olds had an average of 1 tooth decayed, missing or filled, which is lower than the England average of 1.1 (source: [Health Profiles 2010](#)).

8.7.3 Teenage Pregnancy

Figure 8.7.3.1 Under 18 conceptions data for local authorities (all LAs including county districts), South West, 2006-08



8.7.3.1 While the United Kingdom is experiencing its lowest rate of teenage pregnancy in 20 years, it is still far higher than comparable European countries (Teenage Pregnancy Strategy: Beyond 2010; A Snapshot of the Health of Young People in Europe, 2009). The overall South West rate is low compared to England. In 2006–08 there were, on average, 35 conceptions per 1,000 females aged 15–17 in the South West, which is lower than the England average of 41. However, a number of areas in the South West have significantly higher rates: Torbay and Bristol have the highest rates at 58 and 51 conceptions per 1,000 females aged 15-17 respectively.

8.7.3.2 Teenage pregnancy is associated with health and wellbeing risks for mothers and new babies. Teenage mothers are prone to poor antenatal health, lower birth weight babies and a higher risk of infant mortality. Their long-term health and that of their children is worse than average. They are also less likely to finish their

education, less likely to find a good job, and more likely to become single parents and raise their children in poverty (source: Teenage Pregnancy Research – Briefing1).

8.7.3.3 Young people and teenagers are also particularly vulnerable when it comes to repeat abortions. The rate of women undergoing a second or subsequent abortion can be viewed as an indicator of inadequacy in relation to contraception, whether insufficient service access, sub-optimal service provision or ineffective individual use of contraceptive method. A quarter (25%) of abortions in females aged under 25 years in England in 2009 were repeat abortions, and over a tenth (11%) of abortions in females aged under 19 years were repeat abortions (source: SWPHO, Sexual Health Balanced Scorecard).

8.7.3.4 In the South West, a fifth (20%) of all abortions in females under 25 are repeat abortions. While this percentage is lower than

England as a whole, Torbay and Swindon have percentages similar to the England average (26% and 24% respectively).

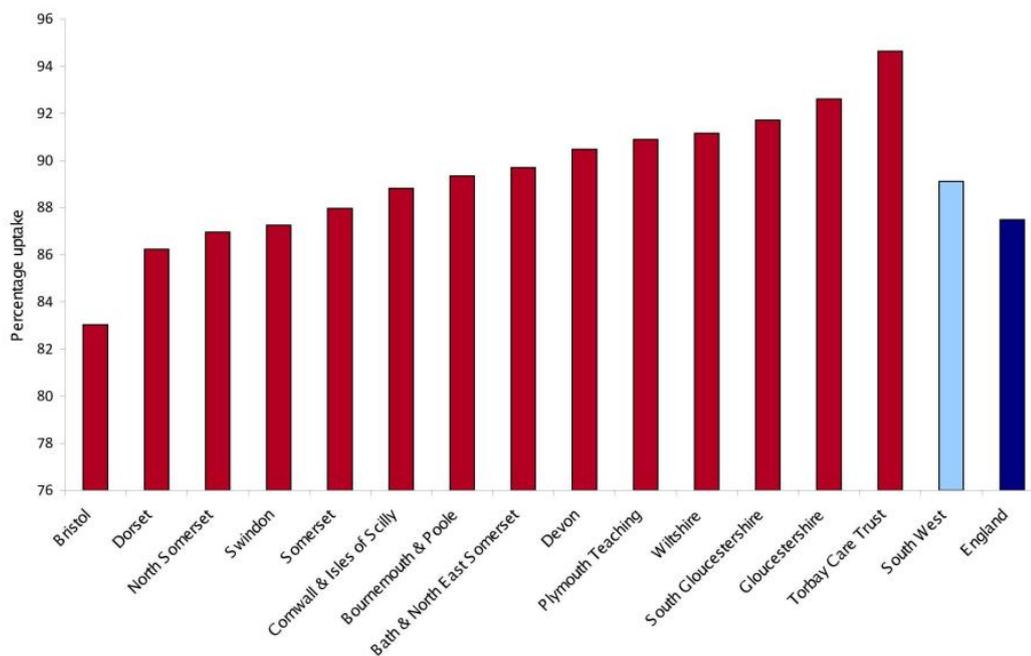
8.7.4 Immunisation

This section has been provided by the [HPA South West](#).

8.7.4.1 The measles-mumps-rubella vaccine (MMR) is a safe and highly effective vaccine that was introduced in 1988 with a coverage of over

90% between the early 1990s and 1998. However, a fall in uptake was observed from 1997 (down to 81% in 2003/04) as a result of adverse publicity about the vaccine. More recently in 2009/10, the uptake has increased significantly, reaching 89.1%. Within the South West there is wide variation in MMR uptake by Primary Care Trust (PCT) (Figure 8.7.4.1).

Figure 8.7.4.1 Uptake of MMR vaccination by second birthday by Primary Care Trust in the South West, 2009/10



Source: HPA COVER data

8.7.4.2 The incidence of mumps has fallen dramatically since the introduction of the MMR vaccine, but in recent years outbreaks of mumps have occurred in the cohort of children born in the few years before 1984. These children were too old to be offered the MMR vaccine (introduced in 1988) but were susceptible as they had no previous exposure to the virus and therefore did not have natural immunity.

8.7.4.3 More recently, the HPA has observed cases of measles in traveller communities in England. Whilst it is encouraging that coverage of MMR vaccination is increasing, there is still a need for uptake rates to increase further to be confident of avoiding outbreaks.

8.7.4.4 Actions taken and planned to raise uptake include:

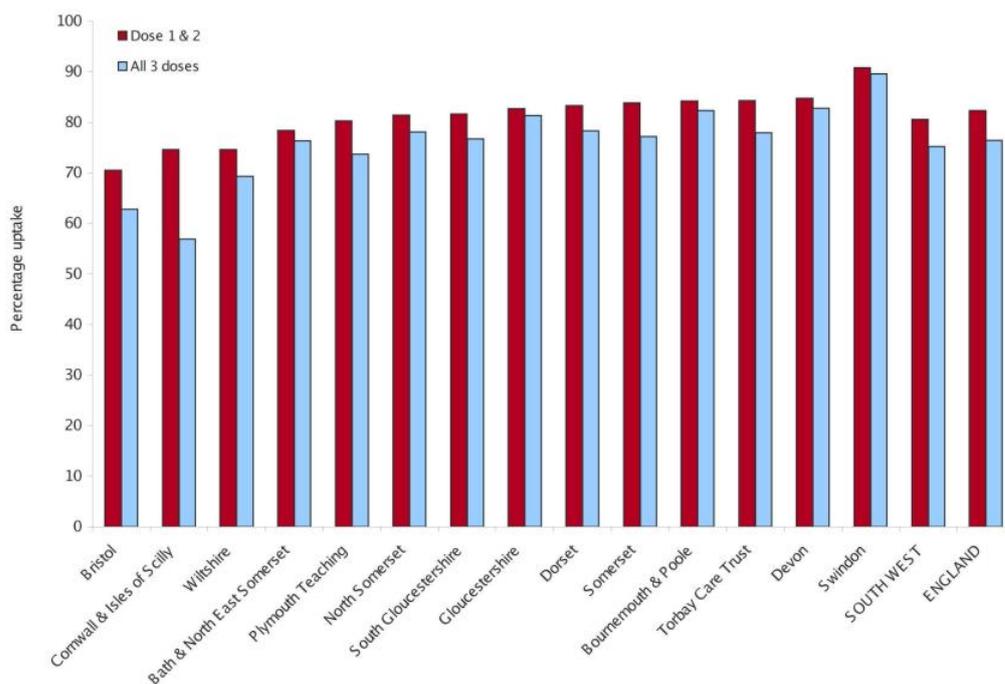
- work with practices with particularly low uptake
- MMR conferences and training days targeted to health visitors, practice nurses and GPs
- improvements in information systems in some areas.

8.7.4.5 Strong and urgent efforts are needed to improve uptake of MMR vaccination and exploit all opportunities to vaccinate children of any age who have not received two doses of MMR. In August 2008, the Chief Medical Officer

announced the MMR catch up programme to reduce the risk of a measles epidemic in the UK. Research and analysis conducted by the HPA indicated that around 1.9 million school children and 300,000 pre-school children were not completely vaccinated against measles in England. This suggested that the number of susceptible children had now reached a level where measles transmission could be sustained, leading to the potential for an outbreak of between 30,000 and 100,000 cases.

8.7.4.6 The National Human Papilloma Virus (HPV) Vaccination Programme started at the beginning of September 2008. Certain HPV infections can cause cervical cancer, other cancers and genital warts. The national immunisation programme uses the bivalent HPV vaccine (Cervarix TM, GlaxoSmithKline) and will protect girls against infection with HPV 16 and 18 which are associated with 70% of cervical cancers. Annual HPV vaccine uptake data for 2009/10 are presented by PCT in the South West for Year 8 girls aged 12–13 (Cohort 7) in Figure 8.7.4.2.

Figure 8.7.4.2 Uptake of the HPV vaccine in girls 12 - 13 in Primary Care Trusts in the South West September 2009 - August 2010



Source: Department of Health

8.8 Health Related Behaviour and Lifestyle

8.8.1 Smoking

8.8.1.1 Smoking is the largest single cause of preventable death in Great Britain. The National Centre for Social Research (NatCen) estimates the mortality rate from smoking-related diseases in the South West to be more than 170 deaths

per 100,000 population (2006-08). According to population estimates for that period, this equates to 8,892 deaths in the South West or approximately 17% of all mortality. This compares with an England average of 22.5% (source: ONS).

8.8.1.2 Smoking is the single most important avoidable risk factor for cancers (especially lung cancer), heart disease and many other diseases. It is estimated that smoking causes around 87%

of lung cancer deaths, 57% of all cancer deaths and 17% of deaths due to circulatory disease (source: [Health Development Agency 2004](#)).

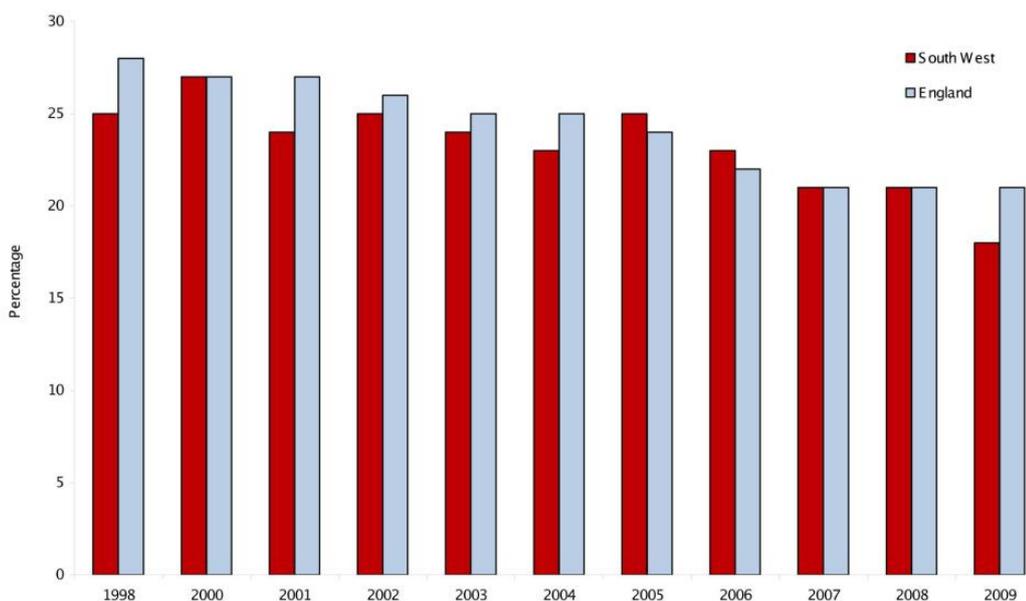
8.8.1.3 Approximately 5.5% of the NHS budget is spent on smoking-related healthcare. In 2008/09, smoking-attributable hospital admissions in the South West cost in excess of £96m (source: [Local Tobacco Control Profiles for England](#)).

8.8.1.4 The adult (age 16+) smoking prevalence in England for 2009 is estimated to be 21%. Between 1998 and 2009, the number of adult men (aged 16+) who smoke reduced

from 30% to 22%, while the number of women smokers reduced from 26% to 20% (source: [Smoking and drinking among adults, 2009](#)).⁽²⁾

8.8.1.5 The General Lifestyle Survey 2009 also estimates that in the South West fewer than one in five (18%) adults is a smoker (Figure 8.8.1.1). This represents a three percentage point drop from 21% in 2008, and compares very favourably with the 21% figure for England as a whole. The proportion of smokers is slightly higher in men than in women, but both groups have seen considerable reductions in prevalence since 2008, with men dropping from 21% to 19% in 2009 and women from 22% to 17%.

Figure 8.8.1.1 Proportion of adults aged 16+ who smoke in England and the South West (persons, 1998 - 2009)



Source: General Lifestyle Survey 2009

8.8.1.6 In Great Britain in 2009, the prevalence of smoking in people with routine or manual occupations is estimated to have been 28%, almost double the 15% prevalence of those in managerial and professional roles. Although reliable data for the South West are not currently available, these percentages are likely to be reflected in the smoking population in the South West.

8.8.2 Alcohol Consumption

8.8.2.1 Studies have shown that the regular use of alcohol above sensible daily limits (more than two to three units for women, and three to four units for men) is associated with an increased risk of certain types of cancers,

2 'The Smoking and drinking among adults, 2009' report uses information collected by the General Lifestyle Survey (GLF) in 2009.

haemorrhagic stroke, hypertension, and accidents (source: Smoking and drinking among adults, 2009, p.46).

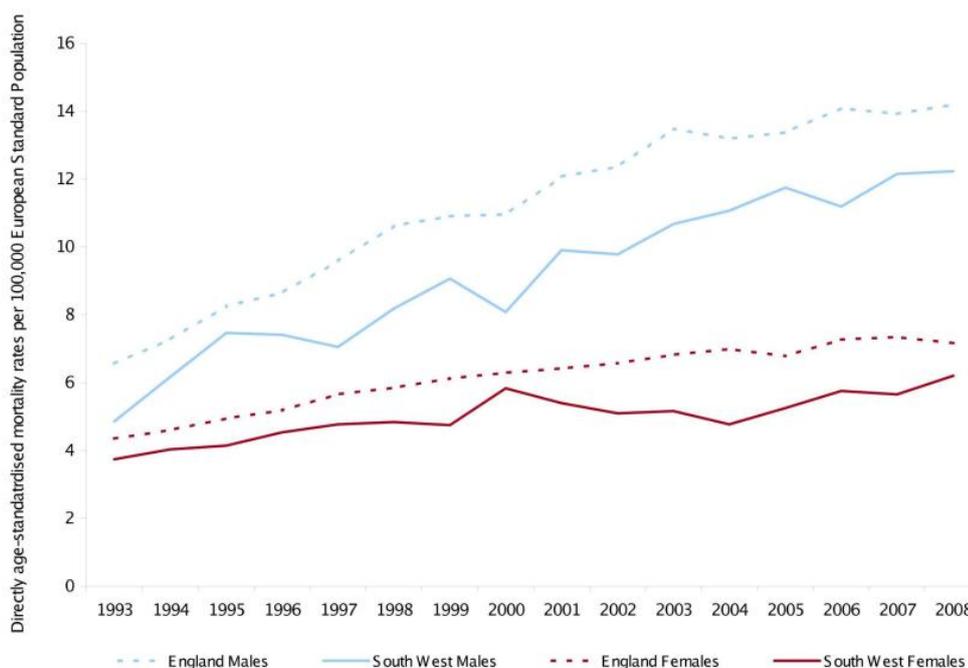
8.8.2.2 Alcohol consumption accounts for 10% of disease burden, surpassed only by tobacco and blood pressure (source: Alcohol Needs Assessment Research Project 2004). Patterns of drinking, as well as volume consumed, determine the harm caused by alcohol.

8.8.2.3 The NHS recommends that men should not exceed three to four units per day. For women, the recommended daily maximum is two to three units. One unit is the amount of pure alcohol in a 25ml single measure of spirits (40% alcohol by volume (ABV)), a third of a pint of beer (5 to 6% ABV) or half a 175ml 'standard' glass of red wine (12% ABV). With respect to wine it is now assumed that a small glass (125ml) contains 1.5 units, a standard glass (175ml) contains 2 units and a large glass (250ml, or approximately one-third of a normal size bottle of wine) contains 3 units.

8.8.2.4 In 2009, 24% of women in the South West drank above recommended sensible daily limits (maximum of three units for women and four for men) on at least one day in the week prior to the survey (source: Smoking and drinking among adults, 2009, p.80), lower than the 29% for England. 34% of males in the South West drank above current recommended sensible daily limits on at least one day in the week prior to the survey, slightly lower than the 37% figure for England. Approximately one in eleven women (9%) and one in six men (17%), in the South West, drank more than six or eight units respectively on at least one day during a week period, more than twice the recommended sensible daily limit (source: Smoking and drinking among adults, 2009, p.80).

8.8.2.5 Deaths from chronic liver disease and cirrhosis of the liver (Figure 8.8.2.1) have unfortunately continued to increase since the early 1990s. While the rates of death are lower in the South West than England as a whole, the disease nonetheless costs many lives in the South West every year. Increasing rates highlight this as an important and continuing public health issue.

Figure 8.8.2.1 Directly age-standardised mortality rates (using European standard) from chronic liver disease including cirrhosis, 2008 males and females, all ages, South West and England, 1993 - 2008



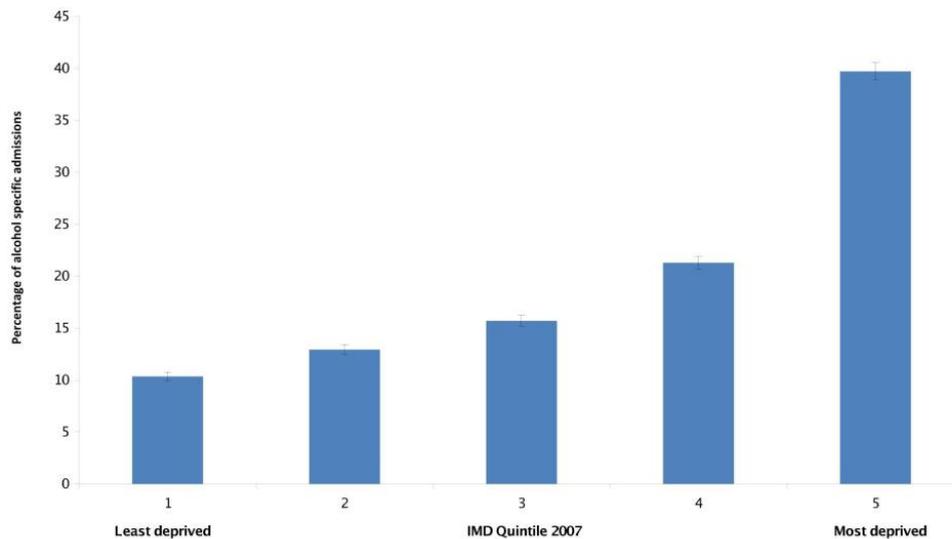
Source: NCHOD

8.8.2.6 In the years 2006–08, over a thousand males in the South West died from chronic liver disease (including cirrhosis of the liver), nearly double the number in 1995–97 (1,031 deaths compared to 564). A much smaller increase can be seen in females in the South West with 597 deaths in 2006–08, compared to 415 in 1995–97 (source: [NCHOD](#)).

8.8.2.7 Residents of the most deprived areas (Quintile 5) in the South West account for 40% of alcohol-specific admissions to hospital and

are four times more likely to be admitted for those conditions than residents of the least deprived areas (Figure 8.8.2.2). Examples of alcohol-specific conditions include alcoholic liver disease, chronic pancreatitis (alcohol-induced), degeneration of the nervous system due to alcohol. More detailed information on Figure 8.8.2.2 and on hospitalisations due to alcohol in general may be found in the publication '[Alcohol attributable hospital admissions \(NI39\) in the South West](#)' (SWPHO, 2011).

Figure 8.8.2.2 Percentage of alcohol specific hospital admissions by IMD quintile, South West, 2008/09



Source: NI39 HES 2008/09, Department of Health; and IMD 2007, Department for Communities and Local Government. Analysis by the SWPHO.

8.8.2.8 Alcohol is estimated to play a part in half of all violent crimes and impacts on physical, mental and sexual health. The Centre for Public Health, Liverpool John Moores University, and the North West Public Health Observatory have produced online [profiles](#) of alcohol related harms for every Local Authority in England. The South West, on average, is estimated to have one of the lowest violent crime rates attributable to alcohol of the English regions: 5.1 per 1,000 population in 2009/10 compared to 5.8 per 1,000 population for England as a whole. However, a number of areas in the South West have rates above the England average. Bournemouth, and the City of Bristol, for example, have the highest rates at 9.3 and 10 alcohol-attributable violent crimes per 1,000 population respectively, which are almost double the rate (5.1 per 1,000 population) for the South West as a whole (source: [Local Area Profiles for England](#)). As these rates suggest, the level of alcohol-attributable violent crime varies significantly within the South West, as indeed it does throughout England.

8.8.3 Drug Misuse

8.8.3.1 Drug misuse is associated with a number of health issues. People with drug problems are more likely to have mental health

problems, self harm and overdose with suicidal intent. Drug misuse can also result in premature mortality, with fatal overdoses (leading to cardiac arrest or respiratory failure) the most common causes of death. Increased disease and mortality may also occur as a consequence of sharing injecting equipment.

8.8.3.2 The [British Crime Survey](#) (2008/09) shows that across Britain overall drug misuse among 16–59 year olds (defined by the use of ‘any illicit drug’ in the last year) was 10.1%. It has remained relatively stable since the previous year, when the proportion was 9.6%. Between 2007/08 and 2008/09 the proportion of 16–59 year olds who had used Class A drugs in the preceding year increased from 3% to 3.7%. As with any survey, care needs to be taken in interpreting results for any one year, due to sample size considerations.

8.8.3.3 On 30 April 2010 there were 19,376 clients in drug treatment in the South West, of which 70.7% were male and 15.2% were aged under 25 years (source: [National Drug Treatment Monitoring System](#)). Around 50.7% were referred through adult services (which includes social services, community drugs or alcohol team, sex

worker projects, outreach services, Job Centre Plus, employment services and probation services).

8.8.3.4 In the 12 months up to the end of April 2010, the age-group with the most people in treatment in the South West was the 30–34 year old age-group (21.7%). The main drugs of misuse were heroin (71.2% of those in treatment), cannabis (10.1%), cocaine freebase (3.8%) and amphetamines (2.6%).

8.8.4 Physical Activity, Diet and Obesity

8.8.4.1 Obesity is associated with an increased risk of premature death and a wide range of health problems, including heart disease, stroke, Type II diabetes (non-insulin dependent) and complications in pregnancy and surgery.

8.8.4.2 Estimates of obesity are derived using the Body Mass Index (BMI), which estimates an individual's body fat based on their height and weight. A BMI of 30 kg/m² or more suggests an individual is obese.

8.8.4.3 Results from the [Health Survey for England 2008](#) suggest that just over a quarter (27%) of men in the South West are obese. Obesity in men is estimated to have doubled in prevalence since 1993, when the proportion was 13%. Nearly a quarter (23%) of women in the South West are estimated to be obese, an increase from 16% in 1993. These figures are

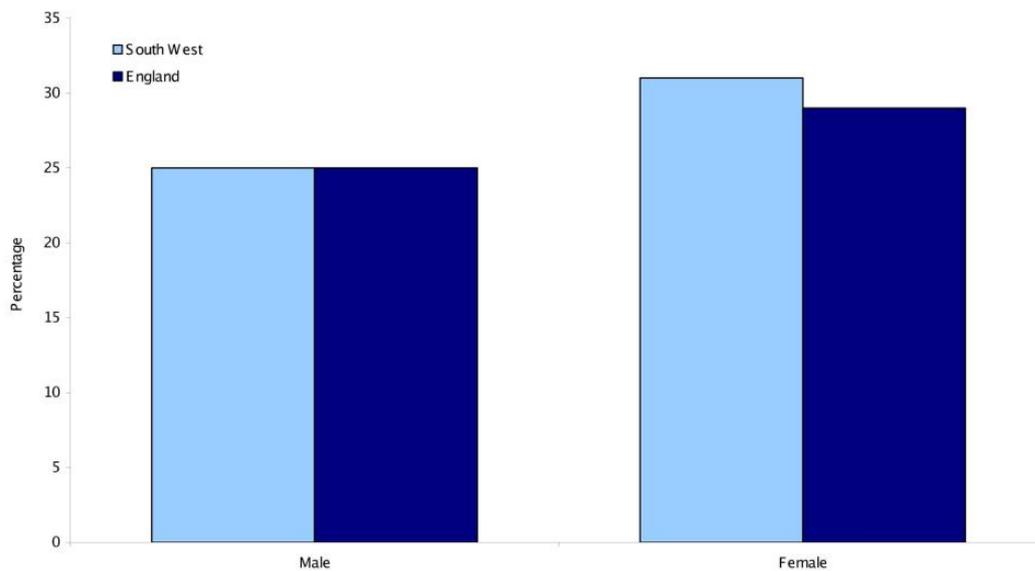
broadly similar to England as a whole, where an estimated 24% of men and 25% of women were obese in 2008.

8.8.4.4 Regular exercise is an important factor in reducing obesity. In the South West, the proportion of people who reported taking part in 30 minutes moderate exercise five or more times a week was 44% for men and 32% for women (source: [Health Survey for England 2008](#)).

8.8.4.5 A healthy, balanced diet is also essential for good health. The [Health Survey for England 2008](#) found that people in the South West have similar eating habits to those in England as a whole. This is a change from the 2001 survey which suggested that adults aged 16 and over in the South West were more likely to have healthy eating habits. However, care should be taken when comparing years or areas, as natural variation is expected from the relatively small sample size involved in the survey. Figure 8.8.4.1 illustrates that in the South West in 2008, 25% of men and 31% of women consumed the recommended five portions of fruit and vegetables a day (compared to 25% and 29% for men and women respectively in England).

8.8.4.6 Whilst results from the [Health Survey for England 2009](#) are not available at a sub-regional level, the survey shows that consumption of fruit and vegetables varies considerably by income level and deprivation.

Figure 8.8.4.1 Percentage of the population aged 16+, by sex, consuming 5 or more portions of fruit and vegetables per day in the South West and England, 2008



Source: Health Survey for England, 2008

8.8.5 Travel, Transport & Health

8.8.5.1 There are aspects of road transport that are beneficial to health: transport allows people to access employment, education, social networks, healthy food choices and services such as the NHS, all of which can be said to improve health. However, transport also has a negative impact on many determinants of health. Injuries and air pollution are often thought of as the major direct impacts but the indirect effects on physical activity, social cohesion and health inequalities all have an influence on the health of individuals, communities and the environment.

8.8.5.2 Road traffic collisions are an important cause of premature death in the South West and account for a greater number of years of life lost than stroke (source: [A Heavy Toll, SWPHO 2007](#)).

8.8.5.3 Between 2005 and 2009 police records (source: Stats 19) show 869 transport related fatalities, with over half of these involving those aged between 15 and 39. Overall, the South West has relatively low rates of serious injury and death from road transport incidents, with 46 deaths per 100,000 residents compared to England's 52 (source: [Health Profiles 2010](#)).

However, this still equates to nearly 2,400 people being seriously injured or losing their life on the South West's roads each year.

8.8.5.4 Variation in serious injuries and deaths on the South West's roads shows distinct patterns relating to urban–rural classification. Age-specific rates of serious injury and death for road transport incidents involving cars and motorcycles are significantly higher in rural areas than town and fringe or urban areas. Conversely, rates of pedestrian casualties and fatalities are significantly higher in urban areas. Differences exist when looking at rates by a casualty's or fatality's place of residence, with a relative reduction in the rate of rural deaths and serious injuries compared with analysis by incident location. This suggests many incidents that occur in rural locations involve people who live outside the local area.

8.8.5.5 The majority, 73%, of admissions to hospital for cycling related injuries are not related to road transport collisions per se, but are classified as non-collision incidents. Analysis of these hospital admissions by age shows that these non-collision incidents account for a greater proportion of all cycling related admissions for those aged under 19 compared to those aged between 20 and 64. This suggests

that road or environmental conditions and/or insufficient skill levels may be the root cause of these injuries. A recent survey by Better by Bike, the project behind the Cycle City scheme in Greater Bristol, reports that slipping on ice is the leading cause of non-collision cycling incidents, followed by slipping on wet surfaces, and slipping on mud/gravel (source: [Avon Public Health Network](#)).

8.8.5.6 A persistent concern is the association between socioeconomic deprivation and road transport injuries, particularly among pedestrians and cyclists in urban areas. A forthcoming report on transport and health shows that the rates of incidents resulting in death or serious injury to pedestrians and cyclists are three times higher in the most, compared to the least, deprived urban areas. Comparing data from hospital episodes to that of police records shows that there is a greater degree of inequality in terms of where an incident occurs, as recorded by the police, compared to the deprivation status of where someone lives, as recorded by [Hospital Episode Statistics](#).

8.8.5.7 People in the South West are currently extremely dependent on private transport, particularly in rural areas, and 83% of households in the region own one or more cars (source: [National Travel Survey: 2009](#)). Data from the last Census (2001) show that pensioner households, particularly single pensioner households, are less likely to own a car than other household types. As the South West has the highest proportion of those aged 64–84 and over 85, the relatively low car ownership in these older age-groups, along with increased demand for services is a concern, especially in relation to planning for an ageing population. Proposed cuts in public transport subsidies may disproportionately disadvantage those without access to a car.

8.8.5.8 It is also important to view road safety in the wider context. Local transport should encourage the use of and make provision for modes of transport that are accessible, environmentally friendly and encourage physical activity. Road danger is a strong disincentive to using active modes of transport such as walking and cycling, especially in relation to parents' perception of their children's safety, and can indirectly contribute to rising levels of obesity.

8.8.5.9 The amount of social interaction among residents living on busy streets is inversely correlated with traffic levels in residential streets (Appleyard, D. 1981, *Livable streets*. University of California Press, Berkeley). Communities can become physically separated where roads have high levels of motor traffic. This limits or disrupts interpersonal networks, reduces social contact and limits children's ability to play freely in their immediate neighbourhood. Reductions in social contacts are associated with higher mortality and morbidity in the elderly and possibly poorer mental health.

8.8.5.10 A decrease in motor traffic has the potential to reduce danger from road death or injury, reduce pollution and allow neighbourhoods and communities to reclaim the streets for social interaction and active modes of travel such as walking and cycling. Evidence for safety in numbers suggests that risk declines for each cyclist and pedestrian the more cyclists and pedestrians there are (Jacobsen, P. *Safety in numbers: more walkers and bicyclists, safer walking and bicycling*. *Inj Prev* 2003;9:205-209 doi:10.1136/ip.9.3.205). Overall, policies to increase the acceptability, appeal, and safety of active travel and discourage travel in private motor vehicles would provide greater public health benefits than would policies that focus solely on lower emission motor vehicles. An increase in the safety, convenience and comfort of walking and cycling and a reduction in the attractiveness of the private motorcar (speed, convenience and cost) are essential to achieve the changes necessary to improve health.

8.9 Sexually Transmitted Infections

This section has been provided by the [HPA South West](#).

8.9.1 Sexual health is identified as one of the key national public health priorities for action due to concern about increasing national rates of diagnosed HIV and sexually transmitted infections (STIs) and also the continued high level of teenage conceptions. STIs are common and associated with serious long-term complications such as pelvic inflammatory disease, chronic abdominal pain, infertility, ectopic pregnancy, stillbirth and genital cancers. Sexual ill health particularly affects young people, certain minority ethnic groups and men who have sex with men. There is also a strong link with social deprivation.

8.9.2 New diagnoses of HIV infection have gradually increased since 1993 but over recent years have begun to stabilise with 315 new diagnoses recorded during 2009 compared to 307 in 2008 (source: [HPA South West](#)). A third of diagnoses of HIV are made late, by which time the immune system is severely affected by the virus. This indicates that access to testing should be increased.

8.9.3 An improved STI surveillance system (source: [GUMCAD](#)⁽³⁾) was introduced in England in 2009. The HPA reports that between 2008 and 2009 the total number of new STI diagnoses⁽⁴⁾ made in genito-urinary medicine clinics decreased by 7.9% in the South West region from 29,930 in 2008 to 27,552 in 2009. This compares to a 2.3% decrease nationally. The infection that showed the greatest increase in new diagnoses was gonorrhoea which increased from 745 new diagnoses in 2008 to 805 in 2009, an increase of 8.1%. Diagnoses of herpes in the region rose by 5.4% between 2008 and 2009 to 2,345; the percentage increase was similar to that for England (5.1%).

8.9.4 It should be noted that new diagnoses do not necessarily correlate to the prevalence of an infection. For example, screening or raising awareness of a particular infection can increase the number of people presenting at genito-urinary medicine clinics. This, in turn, could increase the numbers of new diagnoses without necessarily suggesting an increase in the overall level of infection in the population.

8.10 Major Diseases and Causes of Death

8.10.1 Measuring and Comparing Mortality

8.10.1.1 [The National Centre for Health Outcomes Development \(NCHOD\)](#) uses the standardised mortality ratio (SMR) to compare mortality within an aggregated three-year time

period (2006–08) and across sub-populations: these are used in Table 8.10.2.1. England is used as the reference (index) population and consequently the SMR for England is always 100. If an SMR in one of the comparison (study) populations is below 100, then the study population has a lower rate of mortality, for a given cause of death than England as a whole.

8.10.1.2 Confidence intervals CIs provide information regarding the precision of estimated values since they take into account the variability of the SMR estimate. The narrower the confidence interval, the greater the degree of precision of the SMR estimate. Using 'accidents', and 'bronchitis and emphysema' as examples, if the ranges of the CI values, respectively 93–99 or 103–123 of the study populations, shown in Table 8.10.2.1, do not include 100, then the SMRs for those study populations can be considered significantly different (statistically) to those of England. An SMR is significantly higher than that of England if both lower and upper values of the CI of the study population are above 100, and significantly lower if both are below 100.

8.10.2 All Causes of Mortality

8.10.2.1 The 'all cause' mortality rate in the South West (Table 8.10.2.1) during the combined period 2006–08 was significantly lower than the average for England. However, there were variations within the South West. For example, Bristol Primary Care Trust (PCT) had rates significantly higher than those of England, whilst Somerset PCT had significantly lower rates (source: [NCHOD](#)).

3 Unlike the KC60 return which was used previously, duplicate records in [GUMCAD](#) can be identified and removed resulting in a slight reduction in the number of diagnoses reported. The 2008 data in this report have therefore been statistically adjusted to enable fair comparisons of STI diagnoses over time. Data for these years will not match previous publications but are more accurate.

4 Chlamydial infection (uncomplicated and complicated), gonorrhoea (uncomplicated and complicated), infectious and early latent syphilis, genital herpes simplex (first episode), genital warts (first episode), new HIV diagnoses, non-specific genital infection (uncomplicated and complicated) chancroid/lymphogranuloma venerum (LGV)/donovanosis, molluscum contagiosum, trichomoniasis, scabies, pediculus pubis.

Table 8.10.2.1 Number of deaths and age-standardised mortality ratios (SMRs) for selected causes of death in the South West

Cause of death	Number of deaths aged 1+ in 2008	Age-standardised Mortality Ratio (England = 100, 2006–08 pooled)	Confidence interval	Comparison to England
All causes	53,168	92	92-93	Lower
Circulatory	18,083	93	92-94	Lower
All Cancers	14,467	94	93-95	Lower
Accidents	1,228	96	93-99	Lower
Asthma	89	81	71-91	Lower
Bronchitis and Emphysema	196	113	103-123	Higher
Suicide and injury undetermined	442	104	98-109	Similar
Land transport accidents	274	106	99-114	Similar
Malignant Melanoma	245	129	120-139	Higher
Prostate Cancer	1,137	103	100-107	Similar

Source: Number of Deaths (aged 1+): 2008; SMRs: 2006-08 pooled, [NCHOD](#)

8.10.2.2 During the 1990s "There was a clear socioeconomic gradient in 'all cause' mortality for all countries of the United Kingdom and regions of England, with mortality increasing between Social Class I [professional occupations] and V [unskilled occupations]." (source: [ONS Decennial Supplement DS16 Chapter 12](#)).

8.10.2.3 The ONS publication [Social Inequalities in Female Mortality by Region and by Selected Causes of Death, England and Wales 2001–03](#) shows a marked socioeconomic gradient, with those in the most deprived social class experiencing higher rates of mortality. There is little, if any, statistically significant difference in the gradient (Figure 2 of the ONS publication) however, when comparing Wales or the different sub-national areas to England and Wales as a whole. Figure 3, in contrast, shows that "most mortality rates in the South West are statistically significantly lower than the corresponding NS-SEC class rates for England

and Wales." (source: [Social Inequalities in Female Mortality by Region and by Selected Causes of Death, England and Wales 2001–03, p.9](#)).

8.10.2.4 Age-standardised mortality rates by socioeconomic classification in the North East and South West, for men aged 25–64 during the period 2001–2003, may be found on page 44 of [Fair Society, Healthy Lives](#). "Flattening the gradient is the ambition of proportionate universalism and of the recommended policies that we [The Marmot Review] outline in Chapters 4 and 5." (source: [Fair Society, Healthy Lives, p.41](#)).

8.10.3 Circulatory Diseases

8.10.3.1 The group of circulatory diseases (ICD10 codes I00 to I99) is comprised of a number of different disorders and diseases

including heart disease and stroke. Table 8.10.2.1 shows that circulatory diseases caused approximately one third of all deaths in the South West in 2008. Prevention includes controlling high blood pressure and, obesity, taking adequate exercise, eating a healthy range of foods, avoiding excessive alcohol consumption and not smoking. There are also some inherited risk factors which may vary according to ethnic group.

8.10.3.2 Although over 18,000 people in the South West died from a circulatory disease in 2008, the South West in fact had a lower SMR than England (Table 8.10.2.1). More information on what people died from in England and Wales is available from the [ONS](#).

8.10.3.3 The number of deaths from circulatory diseases in the South West fell by 33% between 1993 and 2008. Both stroke and heart disease show similar patterns of variation by social class, with higher rates amongst the most deprived, which, in part, is linked to health-related behaviour such as the higher prevalence of smoking.

8.10.4 Cancers

Cancers are a group of diverse diseases which collectively accounted for around 27% of deaths from all causes in the South West in 2008. The mortality rate for all cancers combined in the South West is lower than in England as a whole, but is higher for malignant melanoma skin cancer (Table 8.10.2.1).

Cancers must be tackled on two fronts. The first is to reduce incidence, the number of people developing the disease. The second is to reduce mortality, the number of people dying from the disease. Different cancers are susceptible to different strategies, but it is recognised that giving up smoking is the single most useful strategy for the individual. Healthy eating, limiting sun exposure, and avoiding excessive alcohol consumption can also reduce the risk of cancer. Early detection is key to improving outcomes, so making people aware of the symptoms and encouraging attendance at screening programmes is important.

8.10.4.1 Lung Cancer

8.10.4.1.1 Lung cancer is the third most common cancer for both males and females in the South West (after excluding non-melanoma

skin cancer) and equates to more than 3,100 new cases per year between 2004 and 2008. It is the leading cause of cancer deaths for males and the second most common cause of cancer deaths after breast cancer for females in the South West. Lung cancer has a poor prognosis. For people who develop lung cancer, the survival rate in the South West one year after diagnosis is 27.2%, a figure which drops to 8.3% after five years. Because of this, mortality trends closely mirror incidence trends, with more than 2,550 deaths per year between 2004 and 2008 in the South West (source: [SWPHO](#)).

8.10.4.1.2 South West male lung cancer incidence and mortality rates are among the lowest in England.

8.10.4.1.3 Incidence rates have decreased for males and increased for females over the last twenty years, while mortality rates have fallen for males and remained relatively stable for females.

8.10.4.1.4 It is projected that, if current national trends in lung cancer incidence continue to apply to the South West rates and demographics, then by 2030 the numbers of cases of lung cancer in males and females in the region will be approximately equal.

8.10.4.1.5 Lung cancer incidence and mortality rates are high in deprived populations of the South West. Rates in the most deprived areas are more than double that of the most affluent areas in the region.

8.10.4.1.6 In the South West, there is steady progress in reducing lung cancer mortality in patients aged under 75. Under-75 lung cancer mortality rates fell from 37.4 to 25.4 per 100,000 between 1996 and 2008 for males, but showed only a slight (though not statistically significant) decrease in females from 15.7 to 15.3 per 100,000 females.

8.10.4.1.7 This reduction in lung cancer mortality in males has not contributed to narrowing the inequalities between the most and least deprived populations in the South West, which have remained constant. The widening trend in lung cancer mortality between the most and least deprived populations in females has contributed to widening health inequalities among females in the South West.

8.10.4.1.8 The only way that significant impacts will be made on lung cancer incidence and mortality will be through reducing smoking prevalence in the population. There is a strong need to increase efforts to tackle the inequality gaps in smoking between the most and least deprived sections of the population.

8.10.4.2 Skin Cancer

8.10.4.2.1 Exposure to ultra-violet (UV) light is generally recognised as a risk factor associated with the development of skin cancer. Skin cancer is the most common form of cancer, and there are two main types: malignant melanoma and non-melanoma skin cancer. Malignant melanoma is the most serious type. Non-melanoma is rarely fatal and can be treated easily, but it is very common and can cause disfigurement.

8.10.4.2.2 The South West has the highest incidence of, and mortality from, malignant melanoma in the UK. It also has the highest incidence of non-melanoma skin cancer. Incidence rates for both types of skin cancer for males and females are rising. Mortality rates from malignant melanoma are rising for males. However, five-year relative survival rates from malignant melanoma showed no statistically significant difference between the South West and England for both males and females diagnosed in 2001–03. The survival rate for males was 81.7% in the South West and 82.7% in England, while for females the rates were 91% in the South West and 90.5% in England (*source: UK Cancer Intelligence Service (UKCIS)*).

8.10.4.2.3 The South West is one of the sunniest parts of the UK, and approximately a quarter of its population are beyond retirement age. People who enjoy spending time in the sun are believed to preferentially retire to coastal parts of the South West. This may result in a concentration of elderly people with a long history of UV exposure along the South West coast. Research by the SWPHO examining the geographic distribution of melanoma cases has shown that the incidence of melanoma is significantly higher on the South West coast, particularly in more rural regions.

8.10.4.2.4 Along with older people with a history of high sun exposure, melanoma also affects younger age-groups more than most other cancers. Deaths from melanoma – of which there were 245 in the South West in 2008 (Table

8.10.2.1) – are almost entirely preventable. Prevention and early diagnosis are possible either by taking precautions against exposure to excess UV or by seeking advice at the earliest opportunity about suspicious skin lesions. UV radiation was recently classified as a carcinogen category 1 ([IARC 2009](#)) and therefore sunbed use by younger people should be discouraged. In April 2010 the Sunbed (Regulation) Act was passed, which will come into force in April 2011, prohibiting the use of sunbeds by under 18s.

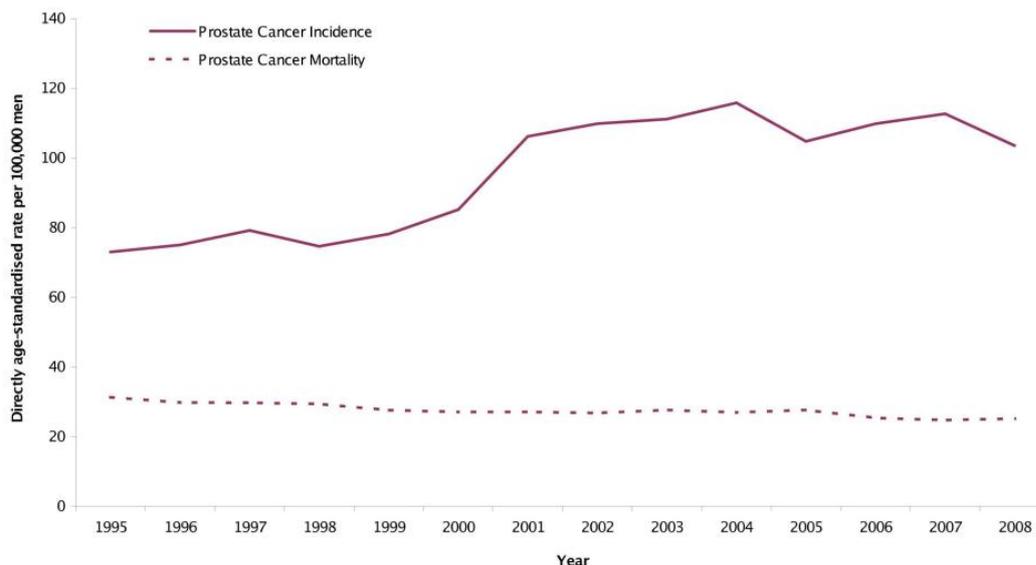
8.10.4.2.5 In 2010 the [SWPHO](#) undertook two research projects which aimed to: (i) describe current sun protection policy and practice in schools; and (ii) explore pupils' sun protective knowledge attitudes and behaviour. The findings highlighted the lack of consistent policy and practice in schools in the South West, and it is hoped will contribute to the development of national policy and guidance. Some of the key findings from these projects are highlighted in the following two paragraphs.

8.10.4.2.6 Forty one percent of schools had either a dedicated sun protection policy or a section on sun protection in the general health and safety policy, while 35% had no policy and no plans to develop one. In addition, most schools (65%) do not provide sunscreen, but encourage their pupils to bring their own. Hat wearing was enforced in 17% of schools. A small number of schools had undertaken a shade assessment (8%).

8.10.4.2.7 The pupil questionnaire highlighted low protective behaviours being adopted by pupils. Many pupils reported never bringing sun protective items to school: sunscreen (48%), sunhats (34%) and sunglasses (61%). Under two-thirds (60%) apply sunscreen before going to school. Those most exposed in the school environment are the 'physically active' (23%), who play all lunchtime without seeking shade.

8.10.4.3 Prostate Cancer

Figure 8.10.4.3.1 Incidence and mortality for prostate cancer (directly age-standardised rate per 100,000 males) in the South West, 1995 - 2008



Source: National Cancer Information Service (NCIS)

8.10.4.3.1 Prostate cancer is the second most common cancer in men. The most common is non-melanoma skin cancer, but this is rarely fatal. In 2008 there were 3,920 new cases of prostate cancer in the South West. This is equivalent to an age-standardised rate of 104 per 100,000 men (Figure 8.10.4.3.1). In 2008, the South West had the equal highest rate in England.

8.10.4.3.2 The age-standardised mortality rate from prostate cancer in the South West in 2008, 25 per 100,000 men, was the equal highest in England. This rate is steadily declining (Figure 8.10.4.3.1).

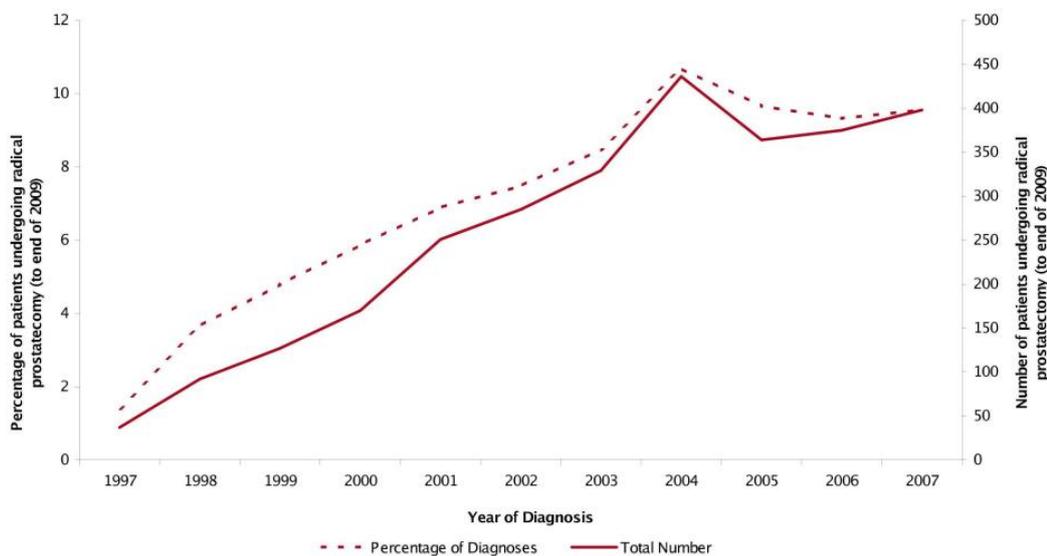
8.10.4.3.3 The sharp increase in incidence of prostate cancer evident from 1999 onwards is likely to be due to an increased uptake of Prostate Specific Antigen (PSA) testing, which detects asymptomatic prostate tumours.

8.10.4.3.4 Radical prostatectomy is the complete removal of the prostate and its surrounding capsule. It is an effective treatment in terms of added years of life, but can cause

unpleasant side-effects. In 2002 the National Institute for Health and Clinical Excellence (NICE) published guidelines to improve the treatment of men with prostate cancer. It recommended that the treatment of patients be managed by multi-disciplinary teams incorporating surgeons, oncologists, radiologists and others, to ensure the best treatment for each patient.

8.10.4.3.5 Consistent with the publication of the guidance was a reduction in the numbers and rates of radical prostatectomies for men diagnosed in 2005, 2006 and 2007 compared to men diagnosed in 2004 (Figure 8.10.4.3.2). This could be the result of multi-disciplinary teams being more likely to recommend treatments other than surgery, compared to cases handled by surgeons alone, or of better informed consent. The 2002 guidelines also emphasised the option to postpone or forgo treatment, known as 'Active Monitoring' or 'Watchful Waiting', which may have caused a number of men to delay treatment until it was thought necessary. This would have the effect of temporarily reducing numbers in the short-term, with an associated rise in numbers of radical prostatectomies later.

Figure 8.10.4.3.2 Radical prostatectomies for prostate cancer, total numbers and as a percentage of all new patients diagnosed, by year of diagnosis, in the South West, 1997 - 2007



Source: National Cancer Information Service (NCIS); Hospital Episode Statistics (HES)

8.11 Mental Health

8.11.1 Mental health problems have been associated, for example, with financial difficulties, work-related stress, the health of a partner, age, ethnicity and being female, but the risk of developing mental health problems can be multi-factorial and the direction of the associations can be unclear. An individual's mental and physical health can also be interlinked.

8.11.2 The Adult Psychiatric Morbidity in England Survey, 2007 (Table 2.8 of the survey) shows that, in the South West, approximately 11% of men and 19% of women reported a common mental disorder (CMD), such as depression or anxiety, in the previous week. Compared to age-standardised percentages for other areas in England (Table 2.8 of the survey) the reported CMDs in the South West were amongst the lowest in England.

8.11.3 Psychiatric admissions to hospital for conditions such as depression, anxiety or obsessive compulsive disorder amongst 16–64 year olds resident in the South West totalled 1,916 between period 1 April 2009 and 31 March 2010 (source: Hospital Episode Statistics,

primary diagnosis ICD-10 F32–F49). Just over 60% of these admissions were for women. However, a number of these patients were admitted on multiple occasions in the same year. Once this is taken into account, the number of men and women admitted for psychiatric conditions is more similar, i.e. women accounted for 55% of people with one or more psychiatric admission, and men 45%.

8.11.4 There were 442 deaths (aged 1 year and above) from intentional self-harm and undetermined injuries in the South West in 2008 (ICD-10 X60–X84, Y10–Y34 excluding Y33.9) (source: NCHOD). In the combined years 2006–08, the 'all age' directly standardised mortality rate of 7.95 per 100,000 European Standard Population in the South West was similar to that of England as a whole: 7.76 per 100,000 European Standard Population (source: NCHOD).

8.12 Older People's Health

8.12.1 Ageing

8.12.1.1 The South West has an ageing population as a consequence of long life expectancy, falling conception rates, the 'baby boom' generation reaching retirement age and

net inward migration. Between 2010 and 2030 the population aged 65 years and over is projected to increase by over 500,000 with 150,000 of this increase projected to be in those aged over 85. This is a doubling in number of the region's oldest age group (source: [ONS](#)). While mature adults in the South West are healthier than those in the rest of England, a growing older population still presents many challenges for the South West. For instance, the population aged over 85 years reporting a limiting long-term illness is projected to increase to over 160,000, and those suffering from dementia to increase to 70,000 by 2030 (source: [POPPI](#)).

8.12.2 End of Life

8.12.2.1 [A UK Parliament 'Early Day Motion'](#) on 11 January 2005 drew attention to the Marie Curie Cancer Care 'Supporting the Choice to Die at Home' campaign, and noted that a 2004 survey commissioned by the charity found that 64% of Britons would prefer to die at home. However, as reported some four years later in the Department of Health's [End of Life Care Strategy \(2008\)](#), only a minority actually die at home. In 2009, there were about 460,000 deaths in England, with almost two-thirds in people aged over 75 (source: [ONS](#)). The large majority of deaths follow a period of chronic illness. A recent report by SWPHO on behalf of the National End of Life Care Intelligence Network, [Variations in Place of Death in England](#), found that 58% of deaths in England in 2005–07 were in hospital and 19% occurred at home. In 2005–07, the South West had the lowest proportion of deaths in hospital (54%) when compared with other regions and 20% of deaths were at home.

8.12.2.2 The quality of care also varies quite considerably. The Department of Health acknowledges that, while some people do indeed die as they wish, there are distressing reports of people not being treated with dignity and respect as well as not dying where they choose.

8.12.2.3 The national End of Life Care Strategy aims include:

- improving the provision of community services by, for example, making rapid response community nursing services available in all areas 24 hours a day seven days a week, and improving coordination of care between Local Authorities and PCTs;

- equipping health and social care staff at all levels with the necessary skills to communicate with, and deliver care to people approaching the end of life, and their carers;
- developing specialist palliative care outreach services by encouraging PCTs and hospices to work together to provide appropriate support to all adults in the community, regardless of their condition (source: [National Audit Office](#)).

8.12.2.4 Future plans for end of life care will have to be mindful of the predicted rise in the number of deaths per year, by approximately 17% between 2010 and 2030. The largest increase is predicted for those aged 85 years or older (source: Gomes, B. & Higginson, I. (2008). *Where people die (1974–2030): past trends, future projections and implications for care.* *Palliative Medicine*, 22, 33–41). For the South West this will mean an increase in deaths each year from over 50,000 to over 60,000. This increase impacts on the national End of Life Care Strategy. To maintain the current pattern of place of death, a corresponding increase in provision would be required. The likely greater age at death in the future will impact on the care requirements of the dying as deaths in older people are more likely to be associated with multiple morbidities.

8.13 NHS Structure and Performance

8.13.1 The following extract outlining the future structure and goals of the NHS is taken from pages 8 and 9 of the recent Public Health White Paper (2010),

[Healthy Lives, Healthy People: Our strategy for public health in England.](#)

A new public health system with strong local and national leadership

12. To support this new approach and avoid the problems of the past, we need to reform the public health system. Localism will be at the heart of this system, with responsibilities, freedoms and funding devolved wherever possible; enhanced central powers will be taken where absolutely necessary, for example in areas such as emergency preparedness and health protection. Within this system:

a. Directors of Public Health will be the strategic leaders for public health and health inequalities in local communities, working in partnership with the local NHS and across the public, private and voluntary sectors. The Government will shortly publish a response to the recent consultation on proposed new local statutory health and wellbeing boards to support collaboration across the NHS and local authorities in order to meet communities' needs as effectively as possible.

b. A new, dedicated, professional public health service – Public Health England – will be set up as part of the Department of Health, which will strengthen the national response on emergency preparedness and health protection.

c. There will be ring-fenced public health funding from within the overall NHS budget to ensure that it is not squeezed by other pressures, for example NHS finances, although this will still be subject to the running-cost reductions and efficiency gains that will be required across the system. Early estimates suggest that current spend on areas that are likely to be the responsibility of Public Health England could be over £4 billion.

d. There will be ring-fenced budgets for upper-tier and unitary local authorities and a new health premium to reward them for progress made against elements of the proposed public health outcomes framework, taking into account health inequalities.

e. The core elements of the new system will be set out in the forthcoming Health and Social Care Bill and will therefore be subject to Parliament's approval.

f. The best evidence and evaluation will be used, supporting innovative approaches to behaviour change – with a new National Institute for Health Research (NIHR) School for Public Health Research and a Policy Research Unit on Behaviour and Health. There will be greater transparency, with data on health outcomes published nationally and locally.

g. The Chief Medical Officer will have a central role in providing independent advice to the Secretary of State for Health and the Government on the population's health. He or she will be the leading advocate for public health within, across and beyond government, and will lead a professional network for all those responsible for commissioning or providing public health.

h. Public health will be part of the NHS Commissioning Board's (NHSCB) mandate, with public health support for NHS commissioning nationally and locally. There will be stronger incentives for GPs so that they play an active role in public health.

Making it happen

13. We are implementing our strategy to make early and substantial progress, so that we make a real difference to health from the earliest opportunity. Subject to the passage of the Health and Social Care Bill, the Government plans to:

a. enable the creation of Public Health England, which will take on full responsibilities from 2012, including the formal transfer of functions and powers from the Health Protection Agency (HPA) and the National Treatment Agency for Substance Misuse (NTA);

b. transfer local health improvement functions to local government, with ring-fenced funding allocated to local government from April 2013; and

c. give local government new functions to increase local accountability and support integration and partnership working across social care, the NHS and public health.

14. The transition to Public Health England will be developed in alignment with changes to Primary Care Trusts (PCTs) and Strategic Health Authorities (SHAs), and the creation of the NHSCB. The detailed arrangements will be set out in a series of planning letters throughout the course of 2011.

15. To get the details of the new system right and ensure that it delivers significant improvements to the health of the population, we will be consulting on some elements. A number of consultation questions are set out in Chapter 4 and summarised in Chapter 5 of this White Paper, and we would welcome your views. The consultation on these questions closes on 8 March 2011.

16. The Department of Health has published a review of the regulation of public health professionals by Dr Gabriel Scally. A consultation question about this is in Chapter 4 of this White Paper. We would welcome views on this report.

17. Forthcoming consultation documents will set out the proposed public health outcomes framework, and funding and commissioning arrangements for public health.

8.14 Conclusions

8.14.1 Good health is both a contributor to, and an effect of, the high quality of life enjoyed by South West residents. Measures of socioeconomic prosperity such as education, employment and income are all closely linked to health. Population groups most likely to suffer from poor health are those most at risk of social exclusion, or most likely to live in areas of poor environmental quality, or both.

8.14.2 Despite the overall picture of good health in the region there is no room for complacency.

8.14.3 Matching the best health in Europe. Being the best in England should not necessarily be seen as a measure of success. When the South West is compared to other equivalent populations, such as other countries in Europe, there are still substantial health gains to be achieved. Moreover, at small area level there are very real inequalities. This is why the NHS in the South West has developed the Strategic Framework for Improving Health in the South West 2008/09 to 2010/11. This sets out an ambitious vision for health in the South West and the future direction and priorities for action. The ambitions are designed to ensure that people in the South West experience the best that the NHS can offer – a world class service, leading to world class standards of health. They include:

- match the highest life expectancy in Europe by 2013.
- halt the rise in hospital admissions for alcohol-related harm and achieve a downward trend by 2013.
- achieve a minimum of 50% reduction in under-18 conception rates by 2013 (from 1998 baseline).
- reverse the trend in childhood obesity to achieve a clear downward trend in the level of childhood obesity by 2013 (in both Reception and Year 6).

- continue to reduce maternal death and stillbirths each year.
- increase the percentage of women breastfeeding their children at six to eight weeks to 60% by 31 March 2011.