2005
public health annual report
1 Foreword .................................................................Page 2
2 Overview ....................................................................Page 4
3 Recommendations .....................................................Page 6
4 Progress ......................................................................Page 8
5 Demography and population ........................................Page 10
6 Tobacco control and smoking .......................................Page 25
7 Respiratory disease .....................................................Page 28
8 Alcohol ........................................................................Page 30
9 Obesity .........................................................................Page 34
10 Physical activity ..........................................................Page 37
11 Mental health services .................................................Page 40
12 Pregnancy and child birth ..........................................Page 44
13 Major causes of death .................................................Page 49
14 Accidents ....................................................................Page 52
15 Sexual health ............................................................Page 58
16 Communicable diseases ..............................................Page 64
17 Immunising for influenza ..........................................Page 69
18 Oral health ...............................................................Page 70
Glossary ........................................................................Page 78
I am pleased to present my third annual report as Director of Public Health for Milton Keynes. This year’s report, as well as updating much of the information presented last year, includes several new sections on important health issues such as alcohol, physical activity, influenza and mental health.

This report, as in previous years, is an independent assessment of the health of the people of Milton Keynes. Importantly, it also sets out recommendations for action to improve health and to tackle inequalities in health. The report and its recommendations are intended to help set an agenda for action for all groups and agencies whose decisions affect the health of people in Milton Keynes. Indeed, in the public sector, external inspectors such as the Audit Commission and the Healthcare Commission expect statutory organisations such as the NHS and local authorities to be able to demonstrate how they have taken the recommendations of their local Director of Public Health’s annual report into account as they set their priorities.

A number of issues emerge from this year’s report, some familiar and some new. They include:

- Milton Keynes’s rapid growth is associated with rapid changes in demography. In particular Milton Keynes is becoming increasingly ethnically diverse. All agencies need to build strong links with minority communities to make sure that their services meet the needs of all those they serve.

- There remain marked inequalities in expectation of life between the most deprived and other parts of Milton Keynes. Tackling this injustice must remain a long term priority. Particular care must be taken to make sure that growth does not widen these inequalities.

- There are relatively high death rates in Milton Keynes from respiratory diseases – including lung cancer.
This emphasises the importance that all employers attach to making sure that their employees are not exposed to tobacco pollution at work.

- There has been a steep rise in the number of alcohol related hospital admissions. A greater priority needs to be given to tackling alcohol misuse.

- There is a possibility that a new strain of pandemic may emerge in the coming months or years. This poses not just a direct threat to health, but because potentially a quarter of the workforce may be absent at any one time, all employers need to think how they will keep their businesses going in the face of such high levels of sickness.

An electronic version of this report, together with further information and data, can be found at the following websites:

- www.mkpublichealth.nhs.uk
- www.mkpct.org.uk
- www.mkiobservatory.org.uk

I am always pleased to receive any comments or feedback that you may have so that we can improve future editions. You can either write to me at the Milton Keynes Primary Care Trust (address on back cover) or contact me by e-mail Nicholas.Hicks@mkpct.nhs.uk.

Dr Nicholas Hicks
Director of Public Health

I very much hope you find this report both interesting and of practical use.
2 overview
The information in this, my third annual report on the state of health in Milton Keynes, describes many of the characteristics of the population of the city and the health issues and challenges that we face. The conclusions of my previous reports remain relevant, but the data presented in this report add to and extend the picture painted in my last report.

Clear messages that emerge from the data include:

**Demography**
- Milton Keynes is growing rapidly. It has – and will continue to have – a young population with significantly larger proportions of children and young adults than the average for England as a whole.
- Milton Keynes has become and is likely to continue to become increasingly ethnically diverse and multi-cultural.
- From 2006 onwards, about two-thirds of the population growth in Milton Keynes is likely to be accounted for by people moving to Milton Keynes.
- A lower than average proportion of 19 year olds achieve 5+ GCSE (grades A* to C) or 2 or more A-levels. Even so, employment rates for people with the lowest qualifications are higher than average. This reflects the currently relatively low skill base of the Milton Keynes economy.
- There are marked socio-economic inequalities in Milton Keynes. Woughton ward is among the 20% most deprived in the country, with parts in the 10% most deprived.

**Health**
- There are about 1500 deaths in Milton Keynes each year, a third of which are in people under 75 years old.
- The leading causes of death in Milton Keynes are the same as those in the country as a whole – circulatory diseases (especially heart disease and stroke), cancer and respiratory disease.
- Death rates from the major killers, especially heart disease, are falling in Milton Keynes, but the city has higher than average rates of respiratory deaths (chronic obstructive respiratory disease, lung cancer and pneumonia).
- Milton Keynes also has higher than average death rates from accidents – especially among elderly women, often following falls and hip fracture.
- Smoking remains the single largest cause of avoidable ill-health and premature death. It also accounts for about half the difference in life-expectancy seen between different social groups.
- Infant mortality rates in Milton Keynes (deaths under 1 year) are consistently slightly higher than average for England and Wales. This emphasises the importance of reducing smoking in pregnancy and around young children and of increasing breast feeding rates.
- Sexually transmitted diseases, including HIV, continue to increase. The current local services are struggling to cope with the rising demand.

**Inequalities**
- There is a strong association between socio-economic deprivation and ill-health. Woughton, the most deprived ward in Milton Keynes, has the highest death rates and lowest life expectancy in Milton Keynes. Life expectancy for babies born in Woughton is about five years less than the average for Milton Keynes. It has the lowest levels of income and the highest numbers of benefit claimants.
- Data suggest that people from deprived areas, where health needs are greater, may not be gaining access to elective healthcare services as readily as people from more affluent areas. This may be particularly true for some procedures such as hip replacement.
Milton Keynes should aim to have no wards and estates among the 10% most deprived in the country. Sustained work with residents should continue in an increasing number of defined areas of deprivation, with the long term aim of people in every estate being able to enjoy a safe, clean and pleasant environment, ready access to jobs for which they are well equipped, and access to high quality services.

As Milton Keynes expands, opportunities should be sought and taken to use growth to help physically, socially and economically regenerate the most marked areas of disadvantage in Milton Keynes, including deprived estates in Woughton and Eaton Manor.

All agencies should be aware of the growing ethnic diversity, especially among the young, in Milton Keynes and ensure that they have robust means of involving minority communities to ensure that they meet the needs and values of all. Quantitative data should be collected to allow analyses to be undertaken that will allow judgments to be made about the equity and fairness of service provision.

Milton Keynes is a young city with a young population. A high priority for all relevant agencies should be to maximise the life chances of young people. Priorities should include:

• Reducing inequalities in educational attainment
• Reducing smoking in pregnancy and reducing children’s exposure to second hand smoke
• Reducing obesity in childhood – through improvements in nutrition and reductions in physical inactivity.

Last year’s recommendations all remain relevant. These are my general recommendations for the community as a whole.
A high priority should be given to tackling the major killers in Milton Keynes, especially **heart disease**, **cancer** and **respiratory disease** by:

a) **Reducing smoking.** All employers and agencies should work to make Milton Keynes ‘smoke-free’ by 2008 i.e. no smoking in work places or enclosed public places.

b) **Smoking cessation** services in Milton Keynes should expand so that they can help 4000 people a year to quit smoking, with 50% of those helped coming either from disadvantaged communities or from groups at high risk of cancer or heart disease.

c) **Increasing levels of physical activity** in Milton Keynes. A specific target should be to double the number of cycling and pedestrian journeys on Redways each year for three years.

d) **Reducing levels of obesity** in Milton Keynes. In addition to measures to improve nutrition and increasing physical activity, the NHS should invest in weight management services.

e) Death rates from injury, especially among elderly women should be reduced by taking steps to **prevent falls**. The success of the fall prevention service should be judged by changes in hip fracture rates and death rates from injury in the elderly. The aim should be to reduce death rates from injury in women over 75 to the national average by 2008.

Milton Keynes Council and Milton Keynes PCT should lead the development of a resourced multi-agency plan to tackle **alcohol misuse** in Milton Keynes. The plan should include specific targets that can be monitored and an aim to reverse the rise in alcohol related hospital admissions.

The NHS in Milton Keynes should strengthen services for the prevention, diagnosis and treatment of **sexually transmitted diseases and HIV/AIDS**.

All people with **tuberculosis** should be offered testing for HIV/AIDS.

The capacity of services for people with **respiratory disease** in Milton Keynes should be reviewed.
Progress following last year’s recommendations

Last year’s annual report made a number of recommendations about what could be done to improve health and tackle inequalities in Milton Keynes. This section summarises progress that has been made in response to these recommendations.

1. No Milton Keynes wards among the 10% most deprived in the country

Milton Keynes Council and the Milton Keynes Local Strategic Partnership agreed that some of the most deprived areas in Milton Keynes – specifically Beanhill and parts of Tinkers Bridge in Woughton Ward – should be considered priority areas for working with residents to help tackle the economic, social and environment issues faced by many people living in these areas. This work has been helped by the award of nearly £2 million by the South East England Development Agency to help skills and economic development in multiply disadvantaged areas of Milton Keynes including Woughton. The 2004 index of multiple deprivation suggests that Woughton is on average no longer among the 10% most deprived wards in the country.

2. Regenerate the most disadvantaged parts of Milton Keynes as Milton Keynes grows

In addition to the area based programme described above, both the Milton Keynes Partnership and Milton Keynes Council – who together are the local planning authorities for Milton Keynes – have both expressed their acceptance of the need to try to link growth and regeneration. They are currently exploring mechanisms and options that will deliver this.

3. Plan new parts of Milton Keynes in ways that will encourage people to lead healthier lives

The Milton Keynes South Midlands NHS health sub-group commissioned and published guidance for planning authorities about the link between health and the environment. Increasingly, the planning authorities are reflecting this advice in their work. In addition the PCT, Council and voluntary agencies have launched or expanded a number of new schemes such as Active MK Exercise Referral Scheme (AMKERS) to promote physical activity and healthy eating.
4. Maximising the life chances of children in Milton Keynes
The Council have led a major city wide initiative to improve life chances for children in Milton Keynes. Their work is summarised in a new set of plans entitled Every Child in Milton Keynes Matters due to be launched in April 2006 which sets out new initiatives to help children be safe, healthy and successful.

5. Tackling major killers
The Council has passed a resolution – no votes against – setting out the aim to make Milton Keynes Smoke Free by 2008. The hospital – including its grounds – went smoke free on 1 January 2006. The Milton Keynes smoking cessation service has helped almost twice as many people stop smoking in 2005 as it did in 2004. Their work is particularly targeted at manual groups, and increasingly at those most at risk of heart disease.

By contrast, relatively little progress has been made on increasing the use of Redways.

6. Increasing educational attainment - especially in disadvantaged areas
Educational attainment in Milton Keynes continues to improve. Pupils and staff at Leon school can be congratulated on a particularly good set of public examination results in 2005. The Council is working closely with schools with low attainment levels in disadvantaged areas to explore new ways of improving performance.

7. Reducing teenage conceptions
Teenage pregnancy rates published during 2005 showed rates of teenage pregnancy to have fallen below national average rates for the first time in many years.

8. Ethnic diversity
The PCT published a new race equality scheme during 2005 and the Council is working to support a new Council of Faiths. Many agencies have started a new range of initiatives to promote health among minority ethnic groups, for example through the appointment of a Black African HIV out-reach worker, and by promoting flu immunisation among minority communities.

There is more to be done to fully involve minority communities in the planning and delivery of services.

9. Reducing death from falls
The Council and PCT together appointed a falls prevention co-ordinater. It is hoped the impact of this post will be apparent in future years.
5 demography and population
The PCT population is estimated from the numbers of patients registered with Milton Keynes GPs. The ward boundaries changed in 2002 and this report is based on the revised electoral boundaries. The boundaries of Milton Keynes Council and of the geographical area served by Milton Keynes NHS Primary Care Trust (Milton Keynes PCT) are similar but not identical (Map 1). The PCT is responsible for NHS services to all the Milton Keynes Borough population plus two extra electoral wards – Newton Longville and Great Brickhill. The population of these two wards was estimated to be 5482 in April 2004.

Figure 1 shows the official population estimates to 2004 and projected expansion up to 2031. It confirms the fast rate of growth which was described in the last annual report. The population of Milton Keynes was estimated to be 216,740 in June 2004. It is expected to rise to 247,500 people by 2011 and to reach 339,700 by 2031, according to current forecasts.
Maps 2-5 show how different age groups are concentrated in different parts of Milton Keynes. Under-20 year olds make up 28% of the population (Map 2); 61% are between 20 and 64 years (Map 3); 6% are aged between 65 and 74 (Map 4), and 5% are 75 plus (Map 5).

### Aged under 20 years
Population density of under-20s

- **By population quintile**
  - 29.78 to 33.7
  - 29.11 to 29.77
  - 27.49 to 29.10
  - 25.77 to 27.48
  - 21.9 to 25.76

### Aged 20 to 64
Population density aged 20 to 64

- **By population quintile**
  - 63.98 to 67.9
  - 62.37 to 63.97
  - 60.72 to 62.36
  - 59.09 to 60.71
  - 56.8 to 59.08

### Aged 65 to 74
Population density aged 65 to 74

- **By population quintile**
  - 8.40 to 10.29
  - 8.09 to 8.40
  - 7.77 to 8.09
  - 7.44 to 7.77
  - 6.83 to 7.44

### Aged 75 years plus
Population density aged over 75

- **By population quintile**
  - 6.83 to 9.15
  - 5.95 to 6.82
  - 5.0 to 5.94
  - 3.82 to 4.99
  - 1.53 to 3.81

The maps illustrate the concentration of population by age group in Milton Keynes PCT.
Migration and Natural Growth

Natural growth, defined as the number of births in a population minus the number of deaths experienced, is fairly stable at about 1500 a year in Milton Keynes. The number of migrants (i.e., people moving to Milton Keynes from elsewhere in the UK) has fallen recently as house-building slows down, but is set to grow as construction accelerates again.

The population of Milton Keynes is younger than the average for the UK (Figure 3) and projected growth trends suggest that this is a situation that will still exist in 2011 (Figure 4). Currently Milton Keynes also has fewer older people, especially males.

The population projection for 2011 shows increases within most of the younger age groups, with the percentage of older people growing substantially.
The difference in the growth of different age groups in Milton Keynes and England is apparent from this chart. Between 2004 and 2011, the population of 0-4 year olds is forecast to increase by almost 20% in Milton Keynes compared to a national increase of less than 4%. The population of 5-12 year olds is forecast to grow by 6.7% in Milton Keynes compared to a national contraction of 5.2%. The 13-19 year olds will be virtually unchanged in Milton Keynes in 2011, compared to a national 3.7% contraction. There will be higher growth in all older age groups compared to the national picture, most notably in the 65-74 year old population set to increase by 10% nationally, but by 31.8% in Milton Keynes.

The differences in the growth of different age groups in Milton Keynes and England become more apparent as we look further into the future. Between 2004 and 2021, the population of 0-4 year olds is forecast to increase by 41.5% in Milton Keynes compared to a national increase of 7.5%. The population of 5-12 year olds is forecast to grow by 32% in Milton Keynes compared to a national...
contraction of almost three per cent. The 13-19 year old age group will grow by 13.3% in Milton Keynes to 2021, compared to a national 8% contraction. There will be higher growth in all older age groups compared to the national picture, most notably in the 65-74 year old population, set to increase by 31% nationally, but by 104% in Milton Keynes. The differences are even more marked by 2031 (Figure 7).
Milton Keynes had a non-white and minority ethnic population of 9.3% or 19,890 people based on the 2001 census data, and mirrors England as a whole (9.1%).

The percentage of the population in different ethnic groups can be seen in Table 4, and the relative size of the different ethnic groups in Figures 8 and 9.

Asians are the largest minority group both in Milton Keynes and England. Blacks make up the second largest proportion, yet evidence suggests that this is a growing population when compared to the census data (Figure 10). There is a much larger proportion of mixed race and Chinese ethnic groups in Milton Keynes compared with England as whole.

The 2005 Pupil Level Annual School Census (PLASC) data for all pupils (Table 5) shows that 77.7% of all pupils are White British and 17.5% come from a non-white ethnic group. Comparison with the 2001 census data reveals that there has been a marked growth in ethnic diversity among school children in Milton Keynes.

The 2001 census for Milton Keynes residents aged 5-19 showed that 12% came from a non-white ethnic group, increasing to 17.5% in the 2005 school census. Groups showing the largest increases are Mixed and Black African. The ethnic groups that have reduced in proportion in the PLASC are White Other and Chinese.
Table 5
Pupil level annual school census (PLASC)

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>White British</td>
<td>77.7</td>
<td>86.8</td>
<td>85.9</td>
</tr>
<tr>
<td>White Other</td>
<td>3.2</td>
<td>3.9</td>
<td>2.1</td>
</tr>
<tr>
<td>Mixed</td>
<td>4.2</td>
<td>1.8</td>
<td>3.6</td>
</tr>
<tr>
<td>Asian Indian</td>
<td>2.2</td>
<td>1.9</td>
<td>2.0</td>
</tr>
<tr>
<td>Asian Pakistani</td>
<td>1.8</td>
<td>0.8</td>
<td>1.2</td>
</tr>
<tr>
<td>Asian Bangladeshi</td>
<td>1.3</td>
<td>0.5</td>
<td>0.9</td>
</tr>
<tr>
<td>Asian Other</td>
<td>1.0</td>
<td>0.4</td>
<td>0.4</td>
</tr>
<tr>
<td>Black African</td>
<td>3.9</td>
<td>1.3</td>
<td>1.1</td>
</tr>
<tr>
<td>Black Caribbean</td>
<td>0.8</td>
<td>0.9</td>
<td>0.7</td>
</tr>
<tr>
<td>Other Black</td>
<td>0.7</td>
<td>0.2</td>
<td>0.4</td>
</tr>
<tr>
<td>Chinese</td>
<td>0.8</td>
<td>0.9</td>
<td>1.2</td>
</tr>
<tr>
<td>Other Ethnic Group</td>
<td>0.8</td>
<td>0.5</td>
<td>0.5</td>
</tr>
</tbody>
</table>
The number of new arrivals in Milton Keynes has increased since 1999 and the rate of growth is faster than PCTs in the rest of Buckinghamshire. Figure 11 shows the number of new arrivals in Buckinghamshire since 1999 compared with the four other local PCTs. The numbers in Milton Keynes have been increasing steadily since 1999 reaching 781 new arrivals in 2003.

The majority of arrivals are those with work permits, their dependants and immigrants (Figure 12). The biggest increase has been among the dependants of work permit holders, which indicates longer term settlement for work permit holders. Compared with the same period last year, there has been a 20% decrease in the number of asylum seekers due to changes in immigration policy.

Figure 13 shows the number of new arrivals to Milton Keynes according to the results of their medical examination. Despite an increase in the total number of new arrivals, there was no increase in the number arriving with serious illness. There were two cases of significant illness diagnosed in 2003.

New entrants to the UK are meant to be subject to a medical examination and a chest X-ray at the port of entry or the country of origin, mainly to detect cases of active pulmonary TB. Since 1997, the number of incomplete medical examinations has been higher than the number of complete examinations. However in 2003, significantly more completed medical examinations were recorded.

Figure 11
Number of new arrivals in each Buckinghamshire PCT

The number of new arrivals in Milton Keynes has increased since 1999 and the rate of growth is faster than PCTs in the rest of Buckinghamshire. Figure 11 shows the number of new arrivals in Buckinghamshire since 1999 compared with the four other local PCTs. The numbers in Milton Keynes have been increasing steadily since 1999 reaching 781 new arrivals in 2003.

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Figure 12
Status of overseas arrivals in Milton Keynes
Oct-Dec 2003

- Refugee’s dependant
- Asylum seeker
- Asylum seeker’s dependant
- Immigrant
- Long stay visitor
- Student
- Student’s dependant
- Work permit holder
- Work permit holder’s dependant

34%
25%
13%
4%
2%
6%
14%

Figure 13
Number of overseas arrivals in Milton Keynes according to their health status, 1997-2003

- Immigrants completed medical examination and in satisfactory health
- Medical examination points to a significant disease
- Medical examination not completed, usually because chest X-ray is not performed

Year

- 31 55 88 78 134 198 412
- 62 83 150 294 400 501 527
- 0 0 0 1 3 2 2
Map 6 shows a measurement of deprivation known as the Index for Multiple Deprivation (IMD). An updated IMD was published by the Office of the Deputy Prime Minister (ODPM) in spring 2004 and there have been some significant changes to the index. The previous index comprised six separate components, each reflecting a different aspect of deprivation, while the new index now uses seven. These are:

- Income Deprivation
- Employment Deprivation
- Health Deprivation and Disability
- Education, Skills and Training Deprivation
- Barriers to Housing and Services
- Living Environment Deprivation
- Crime

Additionally, two other indices have been introduced:

- Income Deprivation Affecting Children
- Income Deprivation Affecting Older People

The most significant change has been the introduction of an area-based approach, rather than an electoral ward-based approach, as used in the previous IMD. These areas are known as Super Output Areas (SOAs) and avoid the problems caused by inconsistent and unstable ward geography. They are planned so they will not be subject to frequent boundary changes, making them more suitable for comparison over time. The SOAs are more consistent in size and have a specified minimum population (1000; mean 1500). In Milton Keynes there are 143 SOAs, with 1 being the most deprived and 143 being the least deprived SOA.

More information about the IMD 2004 is available from the OPDM web site:

http://www.odpm.gov.uk/stellent/groups/odpm_control/documents/contentservertemplate/odpm_index.hcst?n=4610&i=3
The ward level averages of IMD 2004 are illustrated in Table 6 with the most deprived ward at the top of the table and the most affluent ward at the bottom of the table. In relation to the average IMD percentile the table indicates that Woughton Ward is within the 20% most deprived areas in the country on average, while Olney Ward is within the 10% least deprived. The seven domains of the IMD are shown in this table and indicate that Eaton Manor is within the 10% most deprived wards in England in relation to education, skills and training. Woughton is among the 20% most disadvantaged wards for four of the seven deprivations (income, health and disability, skills and training and crime).

Table 7 shows the percentage of benefits claimed per 1000 eligible population in different wards of Milton Keynes in 2004. Some wards feature in both the numbers of attendance allowance claimants and also pension credit claimants. Eaton Manor and Woughton wards are notable for the number of benefits claimed.

Table 8 shows the 20 estates with the most difficulties, as recorded in the Milton Keynes Council Social Atlas 2005. The atlas included some new indicators such as the uptake of Adult Continuing Education, as an indicator of community involvement. In addition, information on concessionary fares uptake, which was not available in the previous edition, has been added.

An average of the rankings over the last two years is shown in the right-hand column. This indicates that there have been few changes in the ten estates with greatest difficulties over this period. Netherfield has consistently been ranked as having significant difficulties and is ranked as the estate with most difficulties in the city. There may have been some improvement in Beanhill and Coffee Hall, areas which have previously been ranked near the top. However, Granby and Tinkers Bridge have moved up the ranking for the second year running. Other estates which have showing a deterioration are Water Eaton, Stacey Bushes, Greenleys, Hodge Lea, Fenny Stratford, Springfield, Bradville, Heelands and Leadenhall. Estates which have improved over last year’s ranking are Fishermead, Connniburrow, Fullers Slade, Central Milton Keynes and Stantonbury.
Table 7
2003 Benefits claimants as a percentage of population in Milton Keynes wards

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Incapacity Benefit &amp; Severe Disability Allowance (16-64)</th>
<th>Disability Living Allowance (All)</th>
<th>Attendance Allowance (65+)</th>
<th>Income Support (16-59)</th>
<th>Pension Credit (60+)</th>
<th>Job Seekers Allowance (16-64)</th>
</tr>
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<tbody>
<tr>
<td>Bletchley and Fenny Stratford</td>
<td>6.13</td>
<td>3.89</td>
<td>13.54</td>
<td>4.85</td>
<td>19.64</td>
<td>2.00</td>
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<tr>
<td>Bradwell</td>
<td>6.40</td>
<td>4.07</td>
<td>16.62</td>
<td>6.18</td>
<td>25.92</td>
<td>2.11</td>
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<tr>
<td>Campbell Park</td>
<td>7.53</td>
<td>4.38</td>
<td>13.34</td>
<td>8.13</td>
<td>22.57</td>
<td>3.33</td>
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<td>Danesborough</td>
<td>2.51</td>
<td>1.85</td>
<td>15.49</td>
<td>1.29</td>
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<td>Denbigh</td>
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<td>4.20</td>
<td>8.96</td>
<td>5.19</td>
<td>17.00</td>
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</tr>
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<td>Eaton Manor</td>
<td>10.34</td>
<td>5.65</td>
<td>16.16</td>
<td>11.64</td>
<td>26.86</td>
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<td>Emerson Valley</td>
<td>3.37</td>
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<td>Fureton</td>
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<td>4.12</td>
<td>25.70</td>
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<td>9.92</td>
<td>1.62</td>
<td>11.26</td>
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<td>Linford North</td>
<td>4.58</td>
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<td>17.89</td>
<td>3.31</td>
<td>21.05</td>
<td>1.33</td>
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<td>Linford South</td>
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<td>17.00</td>
<td>3.83</td>
<td>20.86</td>
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<td>Loughton Park</td>
<td>3.86</td>
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<td>11.94</td>
<td>1.29</td>
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<td>1.10</td>
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<td>Middleton</td>
<td>3.11</td>
<td>2.24</td>
<td>7.55</td>
<td>3.99</td>
<td>9.98</td>
<td>0.92</td>
</tr>
<tr>
<td>Newport Pagnell North</td>
<td>3.06</td>
<td>2.28</td>
<td>15.56</td>
<td>2.00</td>
<td>16.70</td>
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<tr>
<td>Newport Pagnell South</td>
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<td>1.76</td>
<td>17.40</td>
<td>0.56</td>
</tr>
<tr>
<td>Olney</td>
<td>3.78</td>
<td>3.45</td>
<td>15.90</td>
<td>1.21</td>
<td>15.09</td>
<td>0.65</td>
</tr>
<tr>
<td>Sherington</td>
<td>2.51</td>
<td>2.39</td>
<td>13.88</td>
<td>1.94</td>
<td>11.54</td>
<td>0.58</td>
</tr>
<tr>
<td>Stantonbury</td>
<td>6.34</td>
<td>4.24</td>
<td>13.45</td>
<td>5.37</td>
<td>23.10</td>
<td>1.79</td>
</tr>
<tr>
<td>Stony Stratford</td>
<td>6.83</td>
<td>4.08</td>
<td>17.40</td>
<td>6.57</td>
<td>22.60</td>
<td>1.95</td>
</tr>
<tr>
<td>Walton Park</td>
<td>3.51</td>
<td>2.27</td>
<td>12.39</td>
<td>3.57</td>
<td>15.48</td>
<td>1.02</td>
</tr>
<tr>
<td>Whaddon</td>
<td>3.81</td>
<td>3.23</td>
<td>11.95</td>
<td>3.77</td>
<td>17.73</td>
<td>1.21</td>
</tr>
<tr>
<td>Wolverton</td>
<td>4.98</td>
<td>2.83</td>
<td>9.78</td>
<td>5.28</td>
<td>15.56</td>
<td>1.54</td>
</tr>
<tr>
<td>Woughton</td>
<td>13.57</td>
<td>8.08</td>
<td>18.96</td>
<td>13.99</td>
<td>28.89</td>
<td>2.28</td>
</tr>
<tr>
<td>Milton Keynes</td>
<td>5.28</td>
<td>3.51</td>
<td>14.24</td>
<td>4.98</td>
<td>19.96</td>
<td>1.58</td>
</tr>
<tr>
<td>England</td>
<td>7.29</td>
<td>4.50</td>
<td>14.97</td>
<td>6.34</td>
<td>21.50</td>
<td>2.08</td>
</tr>
</tbody>
</table>

More than 50% above England average
Up to 50% above England average

Source: DWP, ONS and MKC Population Bulletin

Table 8
Top 20 Milton Keynes estates with difficulties, 2004-5

<table>
<thead>
<tr>
<th>Overall rank 2004/5 (top 20 of 103)</th>
<th>Estates with difficulties (consistently ranked with more difficulties)</th>
<th>Change from previous position</th>
<th>Comment</th>
<th>2 year average rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Netherfield</td>
<td>Moved up 1 place (worse?)</td>
<td>-1</td>
<td>1.5</td>
<td>1.5</td>
</tr>
<tr>
<td>2 Stacey Bushes</td>
<td>Moved up 8 places (worse?)</td>
<td>-8</td>
<td>6</td>
<td>6.5</td>
</tr>
<tr>
<td>3 Beanhill</td>
<td>Moved down 2 places (better?)</td>
<td>-2</td>
<td>2</td>
<td>2.5</td>
</tr>
<tr>
<td>4 Tinkers Bridge</td>
<td>Moved up 3 places (worse?)</td>
<td>3</td>
<td>5.5</td>
<td>5.5</td>
</tr>
<tr>
<td>5 Fishermead</td>
<td>Moved down 1 place (better?)</td>
<td>-1</td>
<td>4.5</td>
<td>4.5</td>
</tr>
<tr>
<td>6 New Bradwell</td>
<td>Moved up 2 places (worse?)</td>
<td>2</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>7 Water Eaton</td>
<td>Moved up 2 places (worse?)</td>
<td>2</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>8 Conibury</td>
<td>Moved down 3 places (better?)</td>
<td>-3</td>
<td>6.5</td>
<td>6.5</td>
</tr>
<tr>
<td>9 Grantby</td>
<td>Moved up 3 places (worse?)</td>
<td>3</td>
<td>10.5</td>
<td>10.5</td>
</tr>
<tr>
<td>10 Greenleys</td>
<td>Moved up 3 places (worse?)</td>
<td>3</td>
<td>11.5</td>
<td>11.5</td>
</tr>
<tr>
<td>11 Fullers Slade</td>
<td>Moved down 5 places (better?)</td>
<td>-5</td>
<td>8.5</td>
<td>8.5</td>
</tr>
<tr>
<td>12 Coffee Hall</td>
<td>Moved down 6 places (better?)</td>
<td>-9</td>
<td>7.5</td>
<td>7.5</td>
</tr>
<tr>
<td>13 Fenny Stratford</td>
<td>Moved up 14 places (worse?)</td>
<td>14</td>
<td>20</td>
<td>20</td>
</tr>
<tr>
<td>14 Hodge Lea</td>
<td>Moved up 2 places (worse?)</td>
<td>2</td>
<td>15</td>
<td>15</td>
</tr>
<tr>
<td>15 Central Milton Keynes</td>
<td>Moved down 4 places (better?)</td>
<td>-4</td>
<td>13</td>
<td>13</td>
</tr>
<tr>
<td>16 Leadenhall</td>
<td>Moved up 4 places (worse?)</td>
<td>4</td>
<td>18</td>
<td>18</td>
</tr>
<tr>
<td>17 Bravidge</td>
<td>Moved up 4 places (worse?)</td>
<td>4</td>
<td>19</td>
<td>19</td>
</tr>
<tr>
<td>18 Stantonbury</td>
<td>Moved down 3 places (better?)</td>
<td>-3</td>
<td>16.5</td>
<td>16.5</td>
</tr>
<tr>
<td>19 Springfield</td>
<td>Moved up 5 places (worse?)</td>
<td>5</td>
<td>21.5</td>
<td>21.5</td>
</tr>
<tr>
<td>20 Heelands</td>
<td>Moved up 2 places (worse?)</td>
<td>21</td>
<td>21</td>
<td>21</td>
</tr>
</tbody>
</table>

Comment:
Moved up/down 1 place (worse/better)
Moved up/down 2 places (worse/better)
Moved up/down 3 places (worse/better)
Moved up/down 4 places (worse/better)
Moved up/down 5 places (worse/better)
Moved up/down 6 places (worse/better)
Moved up/down 7 places (worse/better)
Moved up/down 8 places (worse/better)
Moved up/down 9 places (worse/better)
Moved up/down 10 places (worse/better)
Moved up/down 11 places (worse/better)
Moved up/down 12 places (worse/better)
Moved up/down 13 places (worse/better)
Moved up/down 14 places (worse/better)
Moved up/down 15 places (worse/better)
Moved up/down 16 places (worse/better)
Moved up/down 17 places (worse/better)
Moved up/down 18 places (worse/better)
Moved up/down 19 places (worse/better)
Moved up/down 20 places (worse/better)
Moved up/down 21 places (worse/better)
Moved up/down 22 places (worse/better)

2 year average rank
‘Floor target’ is a generic term used to describe national targets that set a minimum standard for disadvantaged groups or areas, with the goal of narrowing the gap between them and the rest of the country.

Floor targets were first introduced in 2000 as the social equivalent of the Minimum Wage. More funding has been provided to back up these goals. Such targets are now a fixed part of government policy and were further strengthened in 2002 when the Government announced the outcome of that year’s spending review, setting out its priorities for the coming three years. The review made resources available to key priority areas, including education, health, crime, housing and transport. It also set new targets for each department, most of which came into effect in April 2005.

The floor targets are a mechanism which the Government uses to try to make sure that a good standard of service is available for all, because for the first time Government departments, many local authorities and other service providers are judged on their performance of service in areas where they are doing worst, rather than on the national average. No longer should the poorest areas and groups go unnoticed.

Figures 14 and 15 describe the floor targets and compare Milton Keynes against the national average in terms of being better than the national average or worse than the national average.

Figure 14 shows that Milton Keynes had 33.33% fewer robberies and 27.89% fewer recorded burglaries per 1000 population in 2004/05 when compared with the national average. Employment rates overall, and in disadvantaged groups, were higher than average in 2004/05. More local residents were satisfied with local parks and open spaces. Mortality rates from suicide and circulatory diseases were lower, as was the road accident casualty rate.

In contrast, Milton Keynes was worse than the national average for educational attainment (Figure 15), although improvements have been made in recent years, and the vehicle crime rate. The cancer mortality rate is higher than average as was the conception rate of 15-17 year olds from 2001-03, although latest figures show that Milton Keynes has now dropped below the average for England and Wales. (See page 61 for further information).
**Figure 14**
Floor targets where Milton Keynes is better than England – percentage difference

- Percentage of residents satisfied with local parks and open spaces 2003/04
- Fire fatalities 2003/04
- Road accident casualty rate: children killed or seriously injured per 1,000 population 2003
- Road accident casualty rate: all people killed or seriously injured per 1,000 population 2003
- Male life expectancy at birth (years) 2001/03
- DASR Suicide mortality per 100,000 population 2001/03
- DASR Circulatory disease mortality per 100,000 population 2001/03
- Recorded burglaries per 1,000 households 2004/05
- Recorded robberies per 1,000 population 2002/03
- Employment rate of those with no qualifications 2004/05
- Employment rate of over 50 year olds (to age 69) 2004/05
- Employment rate of over 50 year olds (to age 59/64) 2004/05
- Employment rate of ethnic minorities 2004/05
- Employment rate of lone parents 2004/05
- Overall employment rate

**Figure 15**
Floor targets where Milton Keynes is worse than England – percentage difference

- Road accident casualty rate: all people, all severities per 1,000 population 2003
- Conception rate of under 18 year olds (per 1000 15-17 year olds) 2001/03
- Female life expectancy at birth (years) 2001/03
- DASR Cancer mortality rates per 100,000 population aged under 75 2001/03
- % of schools where 50% of pupils are at Key Stage 3 level 5 Science (LAD) 2003/04
- % of schools where 50% of pupils are at Key Stage 3 level 5 Maths (LAD) 2003/04
- % of schools where 50% of pupils are at Key Stage 3 level 5 English (LAD) 2003/04
- % of schools where 65% of pupils are at Key Stage 2 level 4 Maths (LAD) 2003/04
- % of schools where 65% of pupils are at Key Stage 2 level 4 English (LAD) 2003/04
- % of schools where 30% of pupils achieving 5+ A*-C GCSEs (LAD) 2003/04
- % of pupils achieving 5+ A*-C GCSEs (LAD) 2003/04
- % of pupils achieving Key Stage 3 Level 5 Science (at LEA level) 2003/04
- % of pupils achieving Key Stage 2 Level 4 Maths (at LEA level) 2003/04
- % of pupils achieving Key Stage 2 Level 4 English (at LEA level) 2003/04
- % of pupils achieving 5+ A*-C GCSEs grades A*-C (at LEA level) 2003/04
- Recorded vehicle crime per 1000 population 2004/05
- Recorded crime rate (UK Comparator) per 1,000 population 2004/05
tobacco control and smoking
Smoking is the single most important cause of avoidable ill health and premature death. More than a quarter of the adult population in Milton Keynes smoke – and half of all smokers will die prematurely because they smoke. Smoking accounts for about half of the seven year mortality gradient between social groups and of the 12 year difference in life expectancy between the most affluent and most disadvantaged wards in Milton Keynes.

About a quarter of all smokers die in middle age (39-60). Smoking is the cause of many serious diseases and conditions, including cancer, coronary heart disease, stroke, asthma and osteoporosis. In the United Kingdom it is estimated that £410 million a year is spent treating childhood illness related to second hand smoking. Second hand smoke accounts for at least 1000 deaths in adults who are non-smokers, at an estimated cost of about £12.8m a year at 2002 prices. One person a week working in the hospitality trade dies from passive smoking.

Towards a smoke-free Milton Keynes

A new multi-agency group, the Milton Keynes Tobacco Control Alliance, has been formed to work towards making all public places and enclosed workplaces in the city smoke free by 2008. This group consists of officers and elected members of Milton Keynes Council, public health specialists from Milton Keynes Primary Care Trust and representatives of the Milton Keynes General Hospital NHS Trust, the Chamber of Commerce and the Buckinghamshire Fire and Rescue Service.

All NHS premises will also be smoke free in 2006. At the time of writing, it was unclear how comprehensive national legislation would be.

MK Stop Smoking Service

The MK Stop Smoking Service has become an effective and well-used support service since it was established in 2003. The service targets those communities where smoking is more prevalent and this helps to reduce health inequalities.

Of the total number of people setting a quit date in 2004/05, 30% were from wards experiencing high rates of deprivation and premature death. Some 27% of these successfully quit after four weeks.

The service continues to expand as more smokers feel confident to quit. During the year, clinics have been established at a wider choice of locations. This has led to an increasing number of workplaces becoming smoke-free and provided better access for a wider range of people.

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Performance of MK Stop Smoking Service 2003-2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall rank</td>
<td>2003-4</td>
</tr>
<tr>
<td>People setting a quit date</td>
<td>1441</td>
</tr>
<tr>
<td>Numbers quitting after four weeks</td>
<td>393</td>
</tr>
</tbody>
</table>

Recommendation 1

Milton Keynes local strategic partnership should seek to ensure all workplaces are smoke free, promoting a local Act of Parliament to achieve this if necessary.
Although the NHS Stop Smoking Service has exceeded its targets in 2004/5, there are more than 60,000 smokers in Milton Keynes. More than 70% of them say they want to stop. Quitting smoking produces long and short term benefits – for example, the risk of acute heart disease drops by 50% within six to 12 months of stopping smoking. For long term quitters, mortality rates improve to match those of people who have never smoked.

**Figure 1**
Smoking quitters by age and gender for 2004/05

<table>
<thead>
<tr>
<th>Age band and gender</th>
<th>Number of clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;18</td>
<td>Males: 102</td>
</tr>
<tr>
<td>18-34</td>
<td>Females: 112</td>
</tr>
<tr>
<td>35-44</td>
<td>Males: 117</td>
</tr>
<tr>
<td>45-59</td>
<td>Females: 119</td>
</tr>
<tr>
<td>Over 60</td>
<td>Males: 120</td>
</tr>
<tr>
<td></td>
<td>Females: 120</td>
</tr>
</tbody>
</table>

**Recommendation 2**
The NHS Stop Smoking Service is not yet large enough to meet the needs of smokers in Milton Keynes. The NHS in Milton Keynes should increase the size of the service to meet the needs of all smokers in the city.
Death rates from respiratory disease (Chronic Obstructive Pulmonary Disease – COPD – lung cancer and bronchopneumonia) in Milton Keynes have been consistently higher than the national average. COPD and bronchopneumonia are common reasons for emergency hospital admissions in Milton Keynes, especially over the winter. COPD and lung cancer are more prevalent in more disadvantaged parts of Milton Keynes, mainly because they are both the result of smoking, which is more prevalent among people living in deprived areas.

The PCT has mapped where people with COPD and lung cancer are likely to live in Milton Keynes. The findings, grouped by ward and plotted against ward smoking prevalence, are illustrated in Figure 1 showing where people are likely to live, based on national demographic and hospital statistics. Health mapping and other analysis has identified that the people most likely to be admitted to hospital with COPD and lung cancer are elderly people living on low incomes in council accommodation and those on low incomes mainly reliant on the council for accommodation and benefits. However, although they are at the highest risk of admission, they form only 4% of the total Milton Keynes population and so comprise a relatively small proportion of total admissions.

Although efforts by both the council and the NHS may help to keep these people reasonably well and out of hospital, the overall impact on the health of the Milton Keynes population will be small. On the other hand, working with people in areas like Bletchley and Bletchley Park could have a greater impact on hospital admissions. Ultimately, however, the best way of ensuring that morbidity and mortality from respiratory disease falls is through prevention, especially smoking cessation and influenza and pneumococcal immunisation.

**Recommendation 1**
The NHS Stop Smoking Service should target vulnerable groups in disadvantaged areas of Milton Keynes.
Figure 1
Estates by deprivation score
alcohol
Over 90% of people in Milton Keynes drink alcohol. Of these, a quarter drink more than the recommended levels of alcohol and chronic liver disease is now more prevalent in England than in France. Excessive or ‘binge’ drinking, which can contribute to accidents and poisonings, is most prevalent among the 16-24 age group, a section of the population set to grow in the next few decades. Chronic alcohol abuse is most common in men over 30 and can lead to liver disease and violence, placing heavy burdens on the local NHS and other services. Extrapolations of national figures suggest that between 14,000 and 15,000 people in Milton Keynes could benefit from guidance and advice regarding alcohol consumption.

About 9% of diseases are caused by alcohol, but it also contributes to death and injury from accidents, crime, child abuse and domestic violence. Although there is a national strategy for alcohol abuse, there is not yet one for Milton Keynes.

Deaths in Milton Keynes from alcohol-related issues are shown in the Table 1. Most of these were due to liver disease and there was no significant difference between males and females.

The Directly Aged Standardised Rate for Milton Keynes PCT for alcohol-related deaths was not statistically significantly different from other PCTs in Buckinghamshire (Figure 1).

<table>
<thead>
<tr>
<th>ICD10 Code</th>
<th>Alcoholic liver disease (including fibrosis and cirrhosis of the liver)</th>
<th>Number of deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>K70, K73, K74</td>
<td>All persons</td>
<td>2001</td>
</tr>
<tr>
<td></td>
<td>Males</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>Females</td>
<td>9</td>
</tr>
</tbody>
</table>

**Recommendation 1**

Agencies in Milton Keynes should develop an alcohol strategy with clear recommendations and a timescale for implementation.
alcohol-related hospital admissions

Table 2 shows alcohol-related admissions to hospital in Milton Keynes. The majority are recorded as due to mental and behavioural disorders resulting from alcohol and liver diseases. This includes intoxication (drunkenness). There has been a rapid rise in the number of alcohol-related hospital admissions is recent years with a doubling during 2004-5 compared with the previous year. Hospital admissions (either for primary diagnosis or any diagnosis related to alcohol) were higher among males than females. Three quarters of the admissions (148 out of 198) were men.

The majority of hospital admissions by ethnic category for wards in Milton Keynes PCT are White British.

Figure 2 shows admissions for specific alcohol-related causes. Milton Keynes has statistically significantly higher DASR per 100,000 of the population compared with other PCTs in Buckinghamshire. Admission for injuries, with secondary specified alcohol related causes, is also statistically significantly higher in Milton Keynes (Figure 3).

Figure 4 shows that the DASR for admissions was higher in the most deprived wards. Between 300 and 400 people with alcohol problems receive assistance in Milton Keynes each year, with the Community Drug and Alcohol Clinic being the main service provider. The capacity of local alcohol services is well below that required to meet the needs of the enhanced numbers of people with alcohol-related problems.
Recommendation 2
The capacity of multi-agency alcohol treatment and prevention services in Milton Keynes should be expanded to cope with the need, bearing in mind the cost-effectiveness of such services and the dramatic increase in alcohol-related hospital admissions.
The last 20 years have seen a 300% rise in obesity in the UK. In 2002, almost six out of ten women and seven out of ten men were overweight or obese.

Obesity causes coronary heart disease, hypertension, many cancers (including colorectal, ovarian and endometrial), osteoarthritis, stroke, gallstones, respiratory problems (including obstructive sleep apnoea), and reproductive problems. It greatly increases the risk of heart disease, cancer, type 2 diabetes and high blood pressure. Those who are obese - with a body mass index (BMI) of 30 or above - can expect to live seven years fewer than those who are not overweight, independently of gender or whether they smoke. A BMI of 35 or more has a stronger adverse health effect than smoking, heavy drinking or poverty. Women who are overweight or obese are at least 12 times more likely to develop diabetes and overweight or obese men are at least 5 times. There are also social and psychological costs.

The Parliamentary Health Select Committee calculated the NHS costs of treating obesity in England in 2002 as £46-49 million, of which two-thirds was spent on drugs. The cost of treating the consequences of obesity (such as diabetes, cardiovascular disease and cancers) was estimated at between £945 and £1071 million and the indirect costs (premature death and sickness absence) in the same year as £2.3-£2.55 billion. In total, obesity costs the economy in England between £3.3 and £3.7 billion each year.

The extent of the problem locally can be estimated from three sources:

1. Extrapolation from national prevalence statistics

These calculations suggest that in Milton Keynes there are 34,000 obese people, with over 2,000 being morbidly obese and at very high risk of (if not already suffering from) illnesses caused by their weight (Table 1). By 2031, if nothing changes, there could be as many as 55,000 obese people in Milton Keynes.

2. Primary care measures of body mass index (BMI)

The proportion of people who have their weight and height recorded in their GP records varies widely from practice to
practice. However, only around 25% of registered patients have a recent BMI recorded (Figure 2). Unfortunately, this level of recording of BMI status in general practice is currently not comprehensive enough to aid understanding of the local position.

Table 1
Estimated numbers of people with obesity in Milton Keynes by sex and age group, 2005

<table>
<thead>
<tr>
<th>Age group (years)</th>
<th>2-15</th>
<th>16-24</th>
<th>25-34</th>
<th>35-44</th>
<th>45-54</th>
<th>55-64</th>
<th>65-74</th>
<th>75+</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men Overweight (BMI 25-30)</td>
<td>2982</td>
<td>3010</td>
<td>6888</td>
<td>8976</td>
<td>8003</td>
<td>6029</td>
<td>3205</td>
<td>1934</td>
<td>41,108</td>
</tr>
<tr>
<td>Obese (BMI 30+)</td>
<td>901</td>
<td>690</td>
<td>2711</td>
<td>3167</td>
<td>3263</td>
<td>2691</td>
<td>1294</td>
<td>641</td>
<td>15,322</td>
</tr>
<tr>
<td>Women Overweight (BMI 25-30)</td>
<td>3502</td>
<td>1949</td>
<td>4528</td>
<td>5415</td>
<td>5455</td>
<td>4426</td>
<td>2651</td>
<td>2558</td>
<td>30,485</td>
</tr>
<tr>
<td>Obese (BMI 30+)</td>
<td>903</td>
<td>1256</td>
<td>2724</td>
<td>3688</td>
<td>3611</td>
<td>3229</td>
<td>1862</td>
<td>1416</td>
<td>18,689</td>
</tr>
</tbody>
</table>

✓ Recommendation 1
BMI figures should be recorded by all GPs to help in gaining a more accurate picture of obesity among the local population.
3. Child health records

All children starting Year 1 in Milton Keynes schools have weight and height measurements taken and recorded on the PCT’s central child health surveillance database. Among almost 2,500 children measured during 2004 and 2005, 6% were already obese.

A recent local survey of children showed that around 6% of Years 5 and 6 pupils and 14% of pupils in Years 8 and 10 eat nothing for breakfast. It reported that 41% of boys and 37% of girls in Years 5 and 6 (and 44% boys and 41% girls in Years 8 and 10) said they ate chocolate and sweets on most days of the week; these figures are similar to results seen elsewhere in the country.

Only one in 11 Milton Keynes secondary school pupils said they normally eat five pieces of fruit and vegetables on a school day. In secondary schools, almost a third of boys and more than half the girls surveyed said they wanted to lose weight.

Recommendation 2

Health professionals, voluntary and local authorities should develop new ways of delivering effective messages about diet and oral hygiene and should support the healthy food policy.
physical activity
Adults require at least 30 minutes of daily moderate physical activity five times a week and children one hour. At least twice a week these should include activities to improve bone health, muscle strength and flexibility. The recommended levels of activity can be achieved either by doing all the daily activity in one session, or through several shorter bouts of activity of 10 minutes or more. The activity can be part of an active lifestyle (such as climbing the stairs, carrying groceries, or housework) or structured exercise and sport - or a combination of these.

There has been a decrease in routine physical activity in England in the past 20 or 30 years, but a small increase in the proportion of people taking physical activity for leisure.

The National Diet and Nutrition Survey 2004 suggests that only 36% of men and 26% of women in England are reaching the recommended levels of physical activity for health. Only 61% of boys and 42% of girls reached the recommended levels of physical activity to benefit their health, with the majority of adults who achieved their recommended levels doing so at work (64%).

In general, participation in active leisure pursuits such as walking or sports and exercise, is higher in non-manual groups and those with higher incomes. Adjusting for age, the highest proportions of people reaching the recommended level of activity are found in Black Caribbean and white populations.

The survey suggests that people living in the South East and London participate in the least amount of moderate exercise each day (1.7 hours for men and 1.1 hours for women). Trends for the South East suggest activity levels remained stable in all age groups between 1998 and 2003 (Health Survey for England) apart from middle aged women of 45 to 54 years, whose activity levels have significantly increased (Figure 1).
The cost of physical inactivity in England is estimated at about £8.2 billion a year, which includes the cost to the NHS and economy as a whole. This does not include the contribution of inactivity to obesity – an estimated further £2.5 billion cost to the economy each year (DH, 2004). Nationally it is estimated that 33.4 million are inactive at an average cost of £208 per person. Within Milton Keynes this would equate to approximately £31.9 million a year.

Milton Keynes has a unique infrastructure for physical activity, with an extensive Redway network of over 155 miles and a leisure route network of over 43 miles, plus parks and open spaces. Information on opportunities for taking more physical activity is available at www.mkweb.co.uk/mkactive

**Recommendation 1**
Cycling and walking on the Redways and parks in Milton Keynes should be more strongly promoted.
11

mental health services
Data from April to October 2005 shows there were 634 instances of patients attending A&E for mental health problems. These included overdose and poisoning, self-harm, and the need to speak to a community psychiatric nurse. Figure 1 shows the distribution of A&E attendances for mental health problems across Milton Keynes. A similar pattern is shown for mental health hospital admissions between 2002 and 2004 (Figure 2). This highlights the correlation between disadvantage and ill-health, with the higher rates of A&E attendance coming from the most disadvantaged areas.

Figure 1
A&E Attendances for Mental Health problems April-October 2005

MK Wards 2005 by annual risk of mental health admissions
April 2002 to March 2004 annual average

- 4.5 to 6.2 – much higher than average
- 3.1 to 4.5 – above average
- 2.9 to 3.1 – MK average
- 1.5 to 2.9 – below average
- 0 to 1.5 – much below average

Map 1
Refer to page 11 for map references
Analysis of hospital admission data and socio-demographic data allows detailed estimates of risk of admission for mental health problems to be calculated for Milton Keynes as shown opposite (Figure 3). Postcodes where the risk of mental illness is highest can be seen. This information is helping the PCT to develop strategies for reviewing mental health resources, including restructuring the current mental health teams so areas of greatest need receive increased staff.

Investigations into the mental health needs of ethnic minorities shows areas of high demand, such as schizophrenia (Figure 4) and the PCT is looking closely into providing a service that meets these needs.
**Recommendation 1**
The PCT and Milton Keynes Council should demonstrate how these data are influencing their strategy for providing mental health services in Milton Keynes.

**Recommendation 2**
The PCT and Milton Keynes Council should ensure that information on ethnicity is routinely collected on all persons accessing mental health and social services.

**Recommendation 3**
Specialist day activities for young people with serious mental illness should be further developed in Milton Keynes.

**Recommendation 4**
A joint Milton Keynes Council and PCT mental health service should be developed to provide further outreach capacity for black and minority ethnic communities, young people and the homeless.

---

**Figure 4**
Actual and expected proportion of admissions for schizophrenia by minority ethnic original

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Actual</th>
<th>Expected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mixed – White and Black Caribbean</td>
<td>0.7</td>
<td>0.7</td>
</tr>
<tr>
<td>Mixed – Other minority</td>
<td>3.5</td>
<td>1.1</td>
</tr>
<tr>
<td>White and Asian</td>
<td>4.2</td>
<td>0.2</td>
</tr>
<tr>
<td>Black or British – Other Black</td>
<td>3.5</td>
<td>1.3</td>
</tr>
<tr>
<td>Black or British – African</td>
<td>3.5</td>
<td>0.9</td>
</tr>
<tr>
<td>Black or British – Caribbean</td>
<td>5.6</td>
<td>1.9</td>
</tr>
<tr>
<td>Asian or British – Indian</td>
<td>0.7</td>
<td>0.5</td>
</tr>
<tr>
<td>Asian or British – Bangladeshi</td>
<td>0.7</td>
<td>0.8</td>
</tr>
<tr>
<td>Asian or British – Pakistani</td>
<td>0.7</td>
<td>0.4</td>
</tr>
<tr>
<td>Asian or British – Other Asian</td>
<td>0.7</td>
<td>1.4</td>
</tr>
<tr>
<td>Other Ethnic Groups – Other Ethnic</td>
<td>9.8</td>
<td>0</td>
</tr>
<tr>
<td>Not recorded</td>
<td></td>
<td>0</td>
</tr>
</tbody>
</table>
pregnancy and child birth
Live birth rates in Milton Keynes remained unchanged from 1997 to 2002 with an upward trend since then. The provisional number of live births in 2004 is 3192 (Figure 2).

There were 3140 live births in Milton Keynes during 2003. The average birth rate in Milton Keynes was statistically significantly higher than in England and Wales (61.75 against 54.72), but the percentage of births in various age groups was similar to those in the country as a whole (Figure 1). This reflects the high number of young adults in Milton Keynes.
In 2003, 1.5% of Milton Keynes babies had a birth weight of less than 1500 grams and 8% had a birth weight less than 2500 grams. The percentage of low birth weight babies born in Milton Keynes was not significantly different from the national rate (Figure 3). Smoking in pregnancy is one single avoidable cause of low birth weight. There were 14 stillbirths in Milton Keynes in 2003. The stillbirth rate (Figure 4) for Milton Keynes was 4.4 per 1000, which was slightly less than the average for England and Wales, where the rate was 5.7 per 1000 in 2003.

Almost 500 women smoke at the beginning of their pregnancy each year in Milton Keynes. Yet fewer than 20 pregnant smokers were referred to the NHS Stop Smoking Service during 2005.

**Recommendation 1**

More efforts should be made to target pregnant smokers and to assist them in giving up.
The number of deaths in infants across England and Wales declined slowly from 1997 until 2002, but in Milton Keynes the rate has fluctuated, with an increase in 2003 (Figure 5 and 6). The infant mortality rate records deaths in babies under one year old and in 2003 there were 27 in Milton Keynes. There were also 17 deaths in babies fewer than 28 days of age (neonatal mortality rate) and 16 deaths among babies less than seven days (perinatal mortality rate).

The infant mortality rate, neonatal mortality rate and perinatal mortality rate were all higher than the national rates (Figure 5). However, analysis of Milton Keynes rates relating to stillbirth and neonatal mortality rate showed them to be within the normal range of variation within England, Wales and Northern Ireland, as shown in figures 6 and 7.

Note: places outside the clutter lines are statistically significant outliers.
Figure 7
Neonatal mortality rate in NHS trusts, England, Wales and Northern Ireland 2000-2003 95% CI

Note: places outside the clutter lines are statistically significant outliers.

Figure 8
Infant mortality rates, 2003

<table>
<thead>
<tr>
<th>Region</th>
<th>Infant mortality</th>
<th>Neonatal mortality</th>
<th>Perinatal mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td>England &amp; Wales</td>
<td>5.3</td>
<td>3.6</td>
<td>2.8</td>
</tr>
<tr>
<td>South East Region</td>
<td>4.3</td>
<td>2.8</td>
<td>2.1</td>
</tr>
<tr>
<td>Thames Valley Health Authority</td>
<td>4.8</td>
<td>3.1</td>
<td>2.6</td>
</tr>
<tr>
<td>Milton Keynes UA</td>
<td>8.6</td>
<td>5.4</td>
<td>5.1</td>
</tr>
</tbody>
</table>
Life Expectancy

There are important differences in life expectancy at birth between wards in Milton Keynes. Since my last report, population estimates have been updated in line with the revisions to the 2001 census. The range of life expectancies in Milton Keynes now stands at 9.05 years. The ward with the lowest life expectancy, Woughton, is almost 6 years below the average for Milton Keynes. In England and Wales, the range of life expectancy among local authority areas for males is 8.3 years, with the lowest being Manchester with a life expectancy of 71.9 years. The range of male life expectancy within Milton Keynes was 12 years, with the lowest, Woughton, being 70.6 years. Nationally the range in female life expectancies between local authorities in England and Wales is 8 years, with the lowest being 77.3 years and the highest 85.3 years. In Milton Keynes that range was 74.2 years to 84.4 years, the lowest female life expectancy also being in Woughton.
The total number of deaths in Milton Keynes in 2004 was 1563, of which 640 were in people under 75 years of age (400 in males and 240 in females). In 2004, the most common causes of death were from circulatory diseases (33%) and cancers (28%). Of the circulatory diseases, most deaths were from coronary heart disease (50%), and stroke (27%). Lung cancer is still the most common cancer and accounts for 8% of all deaths in both males and females.

In people under 75 years, cancer accounted for 41% of all premature deaths. Circulatory disease was the second biggest cause of death at 25%, found more in men (73%) than in women (27%). In men, the top five killers were coronary heart disease (20%), lung cancer (12%), COPD (6%), accidents (6%) and stroke (5%). In women, the top killers were lung cancer (10%), breast cancer (8%), coronary heart disease (7%) and stroke (5%). Lung cancer was the most common form of cancer, causing 11% of all premature deaths.
Figure 3 shows the standardised mortality ratio (SMR) for the major causes of death in Milton Keynes, 2001-2003. The rates for lung cancer (118), pneumonia (133), COPD (185), accidents (132), prostate cancer (143) and asthma (176) were all significantly higher than the average for England. Smoking is a common contributory factor to mortality from lung cancer, pneumonia, COPD and asthma.

The ward level Directly Aged Standardised Ratio (DASR) in Figure 4 shows that Woughton, Whaddon and Newport Pagnell North wards had a significantly higher mortality rate than the rest of Milton Keynes. Olney, Newport Pagnell South, Linfoord North and Bradwell wards had a statistically significant lower rate of death compared to the rest of Milton Keynes.
14 accidents
The number of accidental deaths has changed very little in the last year. The Directly Aged Standardised Mortality rate (Figure 1) for accidents per 100,000 of the population was statistically significantly higher in Milton Keynes (21) compared with Thames Valley Health Authority’s area (16), the South East Region (15) and England & Wales (16).

Figure 2 shows the trends in the mortality rate from accidents in Milton Keynes and England and Wales, with a gradual rise since 1993. The Milton Keynes trend has levelled over the last two years, but it is still higher than the average for England and Wales.
deaths from selected causes

Figure 3
Mortality from accidents – All causes 2001-2004 pooled

Figure 4
Mortality from accidents – Transport 2001-2004 pooled
Road accidents

Figure 4 shows that the crude death rate due to road accidents in Milton Keynes is higher in males from 15-35 years of age. The public health team is working with Milton Keynes Council and other agencies to determine whether there are specific issues causing high rates of mortality in this age group.
Figure 6 shows that the directly aged standardised rates (DASR) for accidents in women in age groups of 65 and over were statistically significantly higher than national rates for 2001-03.

By contrast, death rates from accidents in people under 65 years are average. The higher than average death rates from accidental falls in Milton Keynes is to some extent explained by the high death rate from accidents among older women – predominantly these accidents are falls.

Figure 6 also shows that the DASR for accidental deaths in females aged 65 and over was statistically significantly higher in Milton Keynes than in the Thames Valley Health Authority, the South East Region and England and Wales. In Milton Keynes all accidental deaths in females had the underlying cause of death recorded as a fall, with a secondary cause of death as hip fracture.

Falls continue to cause many deaths among the older population in the United Kingdom. It is estimated that 400,000 older people in England attend an A&E department annually following an accident and 14,000 people die each year as a result of falling. Women are at a greater risk of falling than men, particularly women who live alone. Among older people, the most common injuries in women arise from falls.

Figure 7 shows that there are certain wards in Milton Keynes which continue to have more deaths from accidents in females aged over 65. Woughton ward, the most deprived ward, continues to have a high mortality rate from accidents Olney ward, the least deprived, but where many older people live, also has a high mortality rate from accidents. The picture differs little from last year.
Since 2003, a falls administrator has been employed who keeps a database of all falls reported to her. Although notifications of falls can be made by anyone, most reports come from staff in the health, social care and voluntary sector. The completeness and accuracy of these notifications is not known.

Currently those people about whom the administrator is notified are contacted and offered a home visit by the home safety team, who provide advice and help to ensure the home is as safe and free as possible from environmental hazards.

Both the administrator and the home safety team are employed by Age Concern, but funded by Milton Keynes Council.

In 2005 a falls prevention co-ordinator was appointed, funded jointly by the PCT and the council. The post holder is employed by the PCT with the work overseen by a steering group which will develop the project and share good practice.

**Recommendation 1**

A study should be carried out to find ways of reporting more accurately the number of falls among older women to improve the work of the Falls Prevention Service.
The White Paper Choosing Health reinforces the government’s commitment to transform sexual health services and to tackle the high rate of sexually transmitted infections in England. The main sexual health targets in Choosing Health are the implementation of a national screening programme for chlamydia by 2007 and improving access to sexual health services so that everyone will be seen within 48 hours by 2008.

Chlamydia

Chlamydia can lead to infertility and pelvic inflammatory infection. The chlamydia screening programme will aim to screen annually 50% of the sexually active 16-24 population.

Table 1
Summary of genitourinary medicine waiting times, May 2005

<table>
<thead>
<tr>
<th>N</th>
<th>&lt;48 hours</th>
<th>3 days - 2 weeks</th>
<th>&gt;2 weeks</th>
<th>% not seen due to busy clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td>88</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: HPA

Access to Services

Currently 41% of patients meet this target nationally, but 11% have to wait for two weeks or more (Table 1). The PCT has invested in an additional GUM consultant and support staff to improve the poor access to genitourinary services in Milton Keynes. A local enhanced service is to be piloted offering a range of community-based sexual health services to the public.

Recommendation 1

Sexual health services need to be more responsive, diverse and welcoming – and provide better prevention and treatment.
Figure 1
Diagnosis of selected Sexually Transmitted Infections in England 2001-2004 (males and females)

Figure 2
Diagnoses of selected STIs at Milton Keynes GUM 2001-2004

Source: HPA
Note: The data shown for 2003 is estimated from the number of positive tests from the Milton Keynes microbiology laboratory.
The number of Milton Keynes people living with HIV seen by healthcare services in 2004 rose to 151, an increase of 37% over 2003 (Figure 3). There are two main patterns of HIV infection in the UK – HIV infection acquired within the UK and HIV acquired outside the UK. Table 2 shows the probable route of infection of diagnosed HIV infected patients. African people, of whom 64% are African women, make up 75% of HIV infections in Milton Keynes. These infections were mainly acquired abroad in countries with a high prevalence of HIV, such as sub-Saharan Africa and reflect the situation in the rest of the country. Although only 7% of all infections occurred through sex between men, they are still the main group at risk of HIV infection acquired within the UK. The PCT has recruited an outreach worker to work with African communities and to raise awareness of STIs and HIV, with the aim of encouraging safer sex practices and increasing the uptake of HIV testing.

### Table 2

Numbers of diagnosed HIV infected patients by probable route of infection

<table>
<thead>
<tr>
<th>Probable route of infection</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex between men</td>
<td>11</td>
<td>0</td>
<td>11</td>
</tr>
<tr>
<td>Injecting drug use</td>
<td>&lt;5</td>
<td>&lt;5</td>
<td>&lt;5</td>
</tr>
<tr>
<td>Sex between men and women</td>
<td>40</td>
<td>83</td>
<td>123</td>
</tr>
<tr>
<td>Blood/blood products recipient</td>
<td>&lt;5</td>
<td>&lt;5</td>
<td>&lt;5</td>
</tr>
<tr>
<td>Mother to child transmission</td>
<td>5</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>Other/not known</td>
<td>&lt;5</td>
<td>&lt;5</td>
<td>&lt;5</td>
</tr>
</tbody>
</table>

Source: SOHPID 2005

---

**Recommendation 1**

Identified funding should be used to create new consultant posts to improve access to HIV and sexual health services in Milton Keynes and access to those services.
Conceptions among under-18 year olds have declined by 20.9% between 1998 and 2003. There were 173 under-18 conceptions in Milton Keynes. Figure 4 shows that although the rate may fluctuate from year to year, the overall trend is downwards. These figures demonstrate that Milton Keynes is in line to meet the national target of a 50% reduction in under-18 conceptions by 2010. The teenage conception rates in under-18s are no longer statistically significantly higher than the rate for England and Wales.

The total number of conceptions for those under-16 in Milton Keynes was 42 in 1999, 37 in 2000 and 30 in 2001. Figure 5 shows the steady decline in under-16 conception rates since 1999.
The percentage of teenage pregnancies that have ended in abortion has dropped from 43% in 1998 to 38.7% in 2003. This does not mirror the rest of the country, which has seen an increase in the percentage of abortions over the same period.
Brook offers education and clinical services to young people who don’t visit the city centre premises.

Teenage pregnancies are most common among the least well off in society (Figure 7). Rates are statistically significantly higher among the most deprived wards in Milton Keynes – Woughton, Eaton Manor, Campbell Park and Wolverton – when compared with the average. This is demonstrated by Map 1, which shows the distribution of under-18 conceptions in Milton Keynes. Other wards with statistically significantly higher rates are Denbigh, Bletchley and Fenny Stratford, Whaddon and Stony Stratford.

Contraception and delaying the age of first intercourse is the key to protection against STIs and unplanned pregnancies.

Teenagers taking sexual risks face unwanted pregnancies and sexually transmitted infections, and the confidential ‘young people-friendly’ sexual health service at the Brook clinic in Central Milton Keynes is a cornerstone of the local teenage pregnancy strategy. An increasing number of young clients are visiting the centre, up 8% in the first five months of the year compared to 2004. More young men are also visiting the centre, where a Brook’s boys’ worker, is available to talk to them. From late 2005, a sexual health outreach nurse based at Brook, advised the benefits of delaying their first sexual experience while ensuring that they understand the real risks of unprotected sex. Ten young people, mainly mothers, are assisting as peer educators, working with the Brook outreach team in sex education workshops. Brook also provide educational and clinical services to young people outside the city centre.

Training in sexual health will continue to be offered to all those working with young people, so they can discuss the issues and offer confidential advice about services.

**Recommendation 1**

The PCT should pilot a free condom scheme aimed at young people under 25 who should also be offered sexual health advice from community-based professionals.
communicable diseases
In 2004 the number of cases of tuberculosis (TB) notified in Buckinghamshire and Milton Keynes fell to 57 (8.1 per 100,000). There were 72 (10 per 100,000) cases of TB notified in 2002 and 78 (11 per 100,000) in 2003. The current overall rate for England and Wales is 13 per 100,000.

Figure 1 shows the rate of tuberculosis notifications per 100,000 population by PCT. The highest rates are still in Wycombe PCT (14.21 per 100,000), followed by Chiltern and South Bucks (9.68 per 100,000), and Milton Keynes (8.77 per 100,000). The number of cases notified by TB services at Wycombe General Hospital was 27 (47%) compared to 40 (51%) in 2003, 44 (61%) in 2002. 21 cases (37%) were notified from Milton Keynes TB services.
The greatest numbers of cases were amongst those of African and Pakistani origin resident in the UK for less than 5 years, but in over 20% of cases of tuberculosis this information is not reported (Figure 2).

The majority of tuberculosis cases occur among those who live in the economically deprived areas (Figure 3). The Department of Transport quintiles are a measure of ward level deprivation.
The largest proportion of notifications of communicable diseases in Buckinghamshire and Milton Keynes is food poisoning (82% in 2004, 81% in 2003 and 79% in 2002). In Milton Keynes, the most common food poisoning organisms are: Campylobacter spp. (64%), Salmonella spp. (18%) and Rotavirus (9%) - detailed in Table 2.

Table 1
Food poisoning notifications in Buckinghamshire and Milton Keynes Unitary Authority 2004

<table>
<thead>
<tr>
<th></th>
<th>Buckinghamshire Total</th>
<th>Rate/100,000</th>
<th>Milton Keynes UA Total</th>
<th>Rate/100,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Campylobacter</td>
<td>925</td>
<td>120.25</td>
<td>237</td>
<td>97.17</td>
</tr>
<tr>
<td>Salmonella</td>
<td>227</td>
<td>29.51</td>
<td>68</td>
<td>27.88</td>
</tr>
<tr>
<td>Cryptosporidia</td>
<td>60</td>
<td>7.8</td>
<td>8</td>
<td>3.28</td>
</tr>
<tr>
<td>Giardia</td>
<td>60</td>
<td>7.8</td>
<td>22</td>
<td>9.02</td>
</tr>
<tr>
<td>Rotavirus</td>
<td>89</td>
<td>11.57</td>
<td>33</td>
<td>13.53</td>
</tr>
<tr>
<td>Shigella</td>
<td>21</td>
<td>2.73</td>
<td>3</td>
<td>1.23</td>
</tr>
<tr>
<td>E.Coli O157</td>
<td>2</td>
<td>0.26</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Table 2
Number of food poisoning notifications in Milton Keynes Unitary Authority 2002-2004

<table>
<thead>
<tr>
<th></th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>Campylobacter</td>
<td>322</td>
<td>239</td>
<td>237</td>
</tr>
<tr>
<td>Salmonella</td>
<td>107</td>
<td>75</td>
<td>68</td>
</tr>
<tr>
<td>Cryptosporidia</td>
<td>0</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Giardia</td>
<td>24</td>
<td>18</td>
<td>22</td>
</tr>
<tr>
<td>Rotavirus</td>
<td>38</td>
<td>80</td>
<td>33</td>
</tr>
<tr>
<td>Shigella</td>
<td>7</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>E.Coli O157</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

The largest proportion of food poisoning notifications in Buckinghamshire and Milton Keynes is food poisoning, with 82% in 2004, 81% in 2003 and 79% in 2002.

Typhoid and Paratyphoid
There were no reports of Salmonella Typhi or Salmonella Paratyphi in 2004.

Whooping Cough
There were eight reports of Whooping Cough in 2004, compared with three in 2003 and four in 2002.

Legionella
There was one notified case of Legionella in 2004 compared with two in 2003 and one in 2002.

Scarlet Fever
There were 32 probable cases of Scarlet Fever notified in 2004, compared with 17 in 2003 and 16 in 2002.

Malaria
There were nine laboratory cases of Malaria in 2004, compared with seven in 2002 and 12 in 2001.

Measles, Mumps and Rubella
Nine laboratory cases of Measles were confirmed in 2004, compared to one in 2003. There were 126 laboratory confirmed cases of Mumps in 2004 and 166 probable cases, compared to one laboratory confirmed case in 2003.

Hepatitis
There were 24 notifications in 2004 of which 17 (71%) were Hepatitis A, three (13%) were Hepatitis B, three (13%) were Hepatitis C and one was unknown. This compares with 25 notifications of viral Hepatitis in 2003 of which 12 (48%) were Hepatitis A, six (24%) were Hepatitis B, and five (20%) were Hepatitis C.

Dysentry
There were three cases of Shigella dysenteriae (one in Aylesbury Vale and two in Chiltern) compared to one case of Shigella dysenteriae (Milton Keynes) in 2003 and two in 2002 (Chiltern and Milton Keynes). All cases were acquired abroad.
The number of probable or confirmed cases of meningococcal septicaemia and meningococcal meningitis in PCTs in Buckinghamshire and Milton Keynes has decreased in the past three years. The age distribution of meningococcal cases is shown in Figure 5, with, as expected, the highest rate in children under the age of four years. There is an indicated downward trend that can be attributed to the introduction of the MenC vaccine in 2000.
In 2004, 72% of the population in Milton Keynes over the age of 65 was vaccinated for Influenza. The uptake of flu vaccine was between 63% and 65% depending on the practice (Figure 1). The graph plots flu immunisation uptake in the over-65s against the Additional Needs Index which is used to measure and calculate resources by the Department of Health for each practice.

Comparing the percentage of flu vaccinations for over-65 year olds with the Additional Needs Index for each practice (a measure of deprivation of the population registered with each practice) shows that there was lower uptake of the vaccination in practices which had a more deprived population.

Recommendation 1
The PCT should create a plan to increase uptake of flu vaccinations among the more deprived areas of Milton Keynes.
oral health
Child oral health

The 2003/2004 British Association for the Study of Community Dentistry (BASCD) co-ordinated a national study which showed that 61.3% of five year old children in England were caries-free and the mean number of decayed, missing or filled teeth (dmft) in five year old children in England was 1.49.

In Milton Keynes, the data for the national BASCD survey was collected by the PCT’s salaried dental services and gave useful information about how the area compares to the rest of the country. In Milton Keynes PCT’s area, the number of decayed, missing or filled teeth was lower than the national and Strategic Health Authority figures at 1.23, but still outside the national target for dental decay.

Some dental decay is present in 39% of five year olds and there are groups in deprived areas who have a clinically significant burden of preventable dental disease. Figure 1 shows the mean dmft across the Buckinghamshire and Milton Keynes PCTs compared with county, TVHA and national levels of dental disease.

Although oral health has been improving in the last 20 years, there has been no improvement in the oral health of five year olds nationally in the last two years and in Milton Keynes there has been a steady deterioration in the last five years. Figure 2 shows the trend of dmft in five year old children in Buckinghamshire and Milton Keynes, while Figure 3 shows the number of children who are caries free. Milton Keynes is outside the national target of being 70% caries free.
Figure 2
Decayed, missing and filled teeth in five year old children in Buckinghamshire and Milton Keynes 1985-6 – 2003-4

Figure 3
Percentage of children with decayed, missing and filled teeth

Source for Figures 1-3: British Association of Study of Community Dentistry five year olds survey, 2003/2004
Adult oral health

PCTs are expected to monitor dental health within all age groups and provide local dental services to improve oral health. However, there is a lack of local information on adult oral health in many areas, including Milton Keynes.

National surveys conducted every 10 years show that adult dental health is improving and almost a third of young adults (aged 16-24 years) have no fillings.

However, just over half (51%) of adults with teeth in the UK reported having an oral problem during the year preceding the survey and 40% of these adults had experienced dental pain.

Mouth Cancer

Mouth cancers only account for about one per cent of all new UK cancers in the UK per year, but on average around four people a day in the UK die from them. The age standardised rate of mouth cancer can be seen in Figure 4. Care should be taken in drawing firm conclusions from this graph, due to the small numbers.

Anyone can develop mouth cancer, but older age groups are more at risk – 80% of those who are diagnosed with mouth cancer are over 50 years old. Men are more likely than women to develop mouth cancer and it is more common in socially deprived groups and those who use health services infrequently. There is a strong link between tobacco use (both smoking and chewing tobacco) and mouth cancer. There is evidence that alcohol and tobacco use are risk factors for mouth cancer.

Despite improvements in treatment, there is still a 50% mortality rate for those with mouth cancer and incidence rates have not improved in the last 20 years. This is shown in Figure 5.
Water fluoridation

Caries can be prevented by fluoridation of water supplies. The evidence is very clear that decay rates remain consistently lower in fluoridated areas. Data suggest that the effect may be greater where background levels of decay are higher.

Fluoridation is cheap, acts over the whole community and decreases inequalities in dental caries between areas and between socio-economic groups.

Oral health promotion

Lifestyle influences, including diet, effective oral hygiene, and smoking are key factors in preventing oral diseases. There is also a correlation between oral health status and social and environmental factors. In many instances oral ill health is the result of diet, poor housing and social deprivation, including unemployment and poor educational opportunities.

Key ways to improve oral health are:
- Reduce the consumption and frequency of intake of food and drink containing sugar
- Clean the teeth and gums thoroughly each day with fluoride toothpaste
- Visit a dentist regularly
- Fluoridation

Multi-disciplinary work is essential to enable common risks such as tobacco use to be addressed and oral health to improve. MK PCT has an active oral health promotion team located within the salaried dental services.

Recommendation 1

Continuous efforts should be made to raise awareness of the benefits of fluoride to the population and key stakeholders.

Recommendation 2

The PCT should ensure that primary care workers are aware of oral health problems, particularly affecting the elderly, especially those which could lead to the detection and prevention of oral cancer.
During the 2004-2005 financial year, around £1.59 billion was spent by the NHS on dental care in England and Wales. National targets for PCTs include ensuring the resident population has adequate access to NHS dental care services and improving the quality of these services. There are 129 NHS dentists within Milton Keynes PCT working in 39 practices.

New growth money from the Department of Health has been used by the PCT to set up Personal Dental Services in Milton Keynes; the number of NHS registrations has decreased in the area over the past year. This is due to dental practices in the area choosing to provide private rather than NHS care for their patients. Figure 6 shows the total population registration rates.

**Figure 6**
Registrations per 100 population in Milton Keynes PCT Dec 02-Jun 05

<table>
<thead>
<tr>
<th>Date</th>
<th>Registrations per 100 population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dec 02</td>
<td>49.5</td>
</tr>
<tr>
<td>Mar 03</td>
<td>49.3</td>
</tr>
<tr>
<td>Jun 03</td>
<td>49.7</td>
</tr>
<tr>
<td>Sep 03</td>
<td>49.8</td>
</tr>
<tr>
<td>Dec 03</td>
<td>50.5</td>
</tr>
<tr>
<td>Mar 04</td>
<td>46.1</td>
</tr>
<tr>
<td>Jun 04</td>
<td>46.7</td>
</tr>
<tr>
<td>Sep 04</td>
<td>48.9</td>
</tr>
<tr>
<td>Dec 04</td>
<td>48.5</td>
</tr>
<tr>
<td>Mar 05</td>
<td>44.81</td>
</tr>
<tr>
<td>Jun 05</td>
<td>38.23</td>
</tr>
</tbody>
</table>

Source for Figures 1-3: British Association of Study of Community Dentistry five year olds survey 2003/2004

**Recommendation 3**
Access to NHS primary dental care services, specialist and secondary care oral health services, and out of hours emergency dental services must be continued in Milton Keynes during changes to dental contracts.
Milton Keynes has less than the national average of 53.1% of the population registered with an NHS dentist.

Reforms to dental services mean that as from April 2006, PCTs will commission General Dental Services for the first time. The budget for these services, currently managed centrally, will be devolved to PCTs.

The aims of the reforms are to improve patients’ experience and to make dental charges more transparent; to have locally commissioned services which match the needs of the local population; and to remove dental practices from the present burden of being paid a fee for each treatment. Concerns have been expressed over the new contract from local dental teams and, as independent practitioners, they would be free to withdraw from the NHS and provide only private work.

The PCT will work closely with them to ensure continued and improved access to NHS dentistry.

The role of the salaried Personal Dental Service in Milton Keynes is mainly that of a specialist dental service treating children and adults with special needs, though they also provide a ‘safety net’ for those not registered with a dentist. They continue to provide an essential and valuable role offering dental care to the most vulnerable members of the population. The local Out of Hours dental service is run by the salaried service in partnership with local general dental practitioners.

The PCT is offering good quality dental care to the prison community in Woodhill.

Recommendation 1
The PCT should use the new dental contract to commission services responsive to local oral health needs.
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<tr>
<td>BASCD</td>
<td>British Association for the Study of Community Dentistry</td>
</tr>
<tr>
<td>BMI</td>
<td>Body mass index</td>
</tr>
<tr>
<td>COPD</td>
<td>Chronic Obstructive Pulmonary Disease</td>
</tr>
<tr>
<td>Conception rates</td>
<td>The number of conceptions among females in an area, per 1,000</td>
</tr>
<tr>
<td>DASR</td>
<td>Directly Aged Standardised Rate</td>
</tr>
<tr>
<td>DMFT</td>
<td>Decayed, missing or filled teeth</td>
</tr>
<tr>
<td>DTR</td>
<td>Department for Transport and the Regions</td>
</tr>
<tr>
<td>GUM</td>
<td>Genitourinary medicine</td>
</tr>
<tr>
<td>MK PCT</td>
<td>Milton Keynes Primary Care Trust</td>
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<tr>
<td>MK UA</td>
<td>Milton Keynes Unitary Authority</td>
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<tr>
<td>SOPHID</td>
<td>Survey of Prevalent HIV Infections Diagnosed</td>
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<td>STI</td>
<td>Sexually Transmitted Infection</td>
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<td>TVHA</td>
<td>Thames Valley Strategic Health Authority</td>
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<tr>
<td>TB</td>
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<td>SER</td>
<td>South East Region</td>
</tr>
<tr>
<td>SMR</td>
<td>Standardised Mortality Ratio</td>
</tr>
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</table>
I would like to place on record my thanks to the following for their important contributions to this report:

Dr Sanhita Chakrabarti, John Evans, Rachel Flowers, Dr Diane Gray, Dr Ivo Haest, Dr Jharna Kumbang and Tony Welch (Milton Keynes PCT); Lesley Bailey (Milton Keynes Council); Nikkie Ginsberg and Sandra White (Bucks Shared Services).