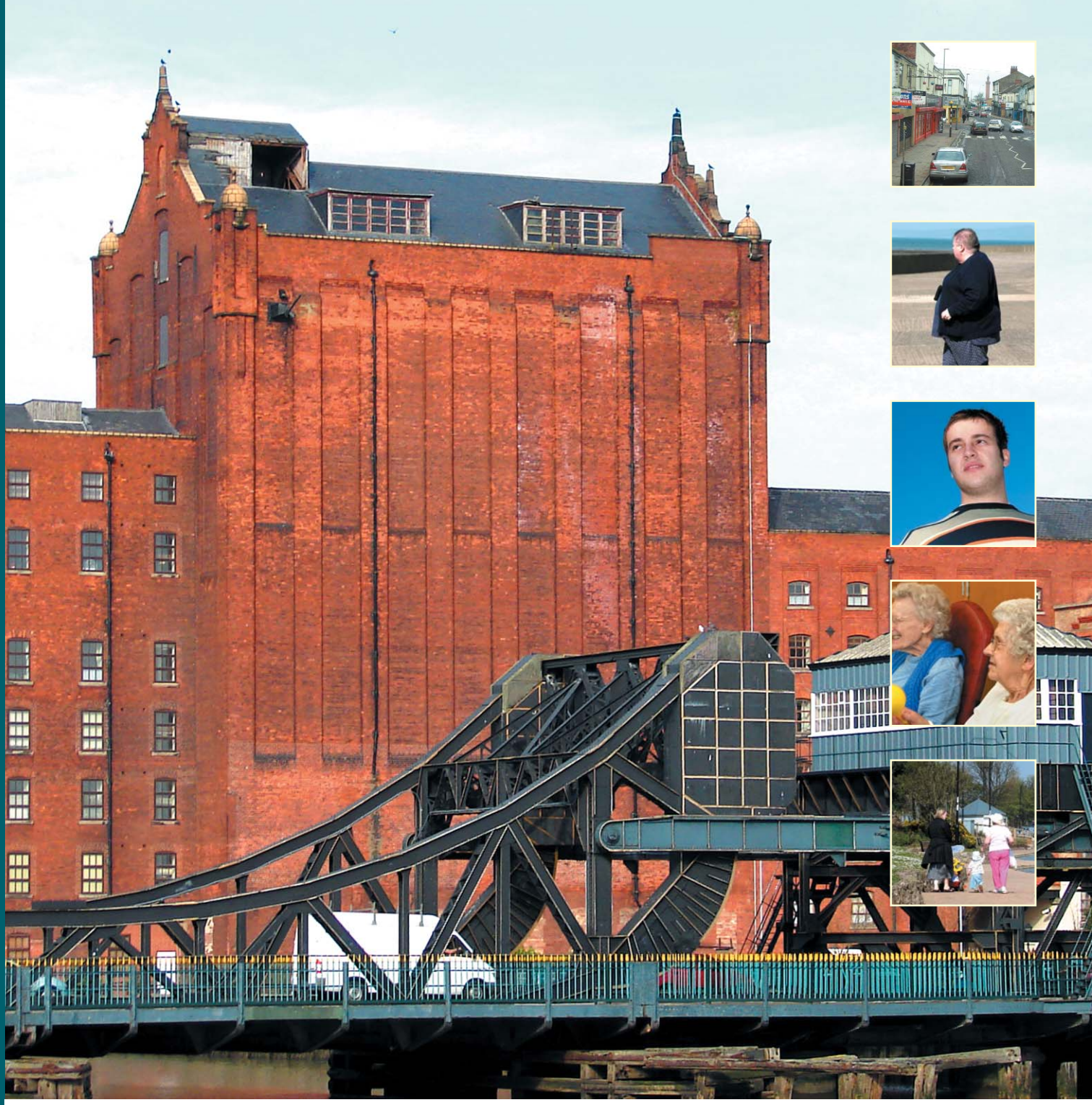

From the Director of Public Health

annual report 2008

on the health of the people of North East Lincolnshire

North East Lincolnshire NHS
Care Trust Plus

North East Lincolnshire Council
www.nelincs.gov.uk

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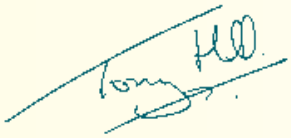
introduction

Welcome to the 2008 Annual Public Health Report which is presented to both the Council and the Care Trust Plus.

This year, a new and comprehensive approach to identifying needs and priorities has been required by Government. Publication of a Joint Strategic Needs Assessment (JSNA) is a statutory duty placed jointly on the Director of Public Health, the Director of Adult Social Services, and the Director of Children's Services. In North East Lincolnshire we have worked together and the report was published at the end of September 2008. The first Chapter of this Annual Report summarises the findings to ensure wide dissemination. The JSNA will be updated and produced annually and over this year we will be refining the datasets and working to give better predictions of future need.

An example of a needs assessment that begins to give predictions of need is the recently completed Older People's Needs Assessment which has now been used to help the development of a new Strategy for Older People's Services. This is reported in Chapter four. Chapter two reports inequalities in Diabetes and Diabetic Care and Chapter three concentrates on the lifestyle of our young people.

I hope that you find this report useful and interesting and I would appreciate any feedback you have.



Dr TONY HILL
Joint Executive Director of Public Health

Recommendation	Progress
• *Establish a Learning Disability Register (2004)* • *CHOICES needs better marketing (2005)*	• *This Register has not been established* • *A re-launch of CHOICES has been undertaken and the Adolescent. Lifestyle Survey shows increased awareness by young people*
• *Actions need to be developed and implemented urgently to tackle hotspots for road accidents*	• *Little progress has been made but an action plan has been developed*
• *The CHD Inequalities Action Plan needs to be implemented*	• *Some work under way but some actions are behind schedule*
• *Urgent attention is needed to reduce Childhood Obesity*	• *Some actions have been taken. A 'collaborative' approach has been commissioned. The MEND programme is underway. But a more systematic approach is still required*
• *Successful Neighbourhood Renewal projects need continued funding*	• *The Care Trust Plus has funded many of the projects for 2 years while evaluation is completed*
• *Continuing effort is needed to increase Childhood Immunisation rates*	• *Efforts seem to be resulting in higher rates*

chapter 1

joint strategic needs assessment

To improve health, well-being and independence for people in North East Lincolnshire requires individuals, communities and service providers to work together. The right support to help people to look after themselves needs to be in place and readily accessible. The best quality services that meet people's needs effectively and in a timely fashion and that make optimum use of available resources, need to be provided. It has been recognised that improving commissioning is key to this.

For this to happen we have to understand the needs of individuals and populations. The Joint Strategic Needs Assessment (JSNA) for North East Lincolnshire is an over-arching needs assessment. It reviews a range of information to identify key issues for the general population, for children and for older people to be used in planning, providing and commissioning programmes and services to meet the needs identified.

It includes and refers to information from our many previously published needs assessments. As far as possible, key data from these have been up-dated and projections over the coming years have been included. The JSNA does not replace these in-depth studies that include a wealth of information, the local 'voice', evidence of what works and recommendations for improving health and well-being. This JSNA summary report uses this wide range of information to identify priorities and provide overall strategic focus.

Demography

The basis of all descriptions and projections of need is the demography of our borough.

Population

Office for National Statistics (ONS) mid year estimates for 2007 show North East Lincolnshire's population to be approximately 158,400, although work commissioned to produce more accurate local estimates (based on ONS 2005 figures) shows about 2000 more. The proportion of 20-29s is less than for England as a whole and the proportion of over 65s is greater. Over the coming decades the area is expected to see a substantial growth in its elderly population and 'ageing' of the population at a faster rate locally than nationally. There is a more marked drop in the 20-24 age groups among the 20% most affluent population than among the 20% most deprived.

Based on the 2006 mid-year population estimates (most recent projection data), the population of North East Lincolnshire is projected to increase by 12.21% by 2031 (from 158,900 in 2006 to 178,300 in 2031). The greatest reduction in population is projected to be in the 15-19 age group (-11.76%). The greatest increase is projected to be in the 85+ age group (+126.47%). Births are projected to remain relatively constant at around 2000 per annum, declining to approximately 1900 per annum in 2026.

ONS mid year estimates for 2007 show North East Lincolnshire's population aged under 24 to be 50,900. Based on the 2006 mid-year population estimates (most recent projections data), the population of children and young people is projected to decrease to 50,600 by 2031. Births are projected to remain relatively constant at around 2000 per annum, declining to approximately 1900 per annum in 2026.

ONS mid year estimates for 2007 show North East Lincolnshire's population aged 65 and over to be 27,200. ONS projections suggest there will be a 43.4% increase in people aged 65 and over by 2031 (a 54.6% increase in the over 60s). The proportion of people aged 65 and over per 100 adults (the dependency ratio) is higher than that for England and is projected to be 30.4% by 2014. It will be almost another 10 years before the dependency ratio for England reaches this level.

Migration

Between mid-2006 and mid-2007, it is estimated that 4,100 people moved into North East Lincolnshire from within the UK and 4,800 people moved away to other parts of the UK, a net loss of 700 people. From outside the UK, between May 2004 and March 2007, some 965 migrants were registered on the Workers' Registration Scheme (WRS) with North East Lincolnshire as their place of work. Between April 2004 and March 2007, 1830 migrants to the UK, registered for a National Insurance Number as residents of North East Lincolnshire. Neither data base gives a complete measure of the total number of migrants in the area since people do not have to deregister with WRS when they leave the UK and not everyone registers for a National Insurance Number. The majority of migrant workers are from Poland, mainly working as process operatives. Between April and June 2006, 71% of WRS registrations were male and between October and December 2007, 67% were male. Between May 2004 and December 2007, 0.8% were aged under 18, 36.4% were aged 18-24, 36% were aged 25-34, 15.8% were 35-44 years, 9.9% were 45-54 years and 1.2% were 55-64 years. There were none aged 65 or over.

Ethnicity and Religion

Mid 2006 estimates show a much larger proportion of the population (95.53%) to be 'White British' than regionally or nationally. The next largest population group is categorised as 'Other White'. The majority of the local population class themselves as Christians.

Deprivation

North East Lincolnshire has been ranked 49th most deprived out of the 354 local authorities in England in 2007 in the Index of Multiple Deprivation 2007 (IMD 2007). The local authority's comparative position has deteriorated since ranking 52nd in 2004. Three Local Super Output Areas (LSOAs) within NEL rank within the 100 most deprived of the 32,482 LSOAs nationally and 8 rank within the 1000 most deprived. North East Lincolnshire has 26 of its 107 LSOAs ranked amongst the 10% most deprived in England, 16 among the 10-20% most deprived and a further 10 in the 20-30% most deprived, amounting to almost half (49%) in the 30% most deprived in the country. Seven LSOAs rank within the 1000 most deprived for the income domain, 9 for the employment domain, 3 for the health deprivation and disability domain, 11 for the education, skills and training domain and 37 rank in the 1000 most deprived for the crime domain with one being the most deprived in the country and 12 being in the most deprived 100 for this domain. Average gross annual pay is less for both men and women than regionally and nationally. Within the area, East Marsh, West Marsh and South wards have the lowest mean income (under £20,000).

The IMD 2007 includes an index of income deprivation affecting children. 37 (35%) of the 107 LSOAs in North East Lincolnshire are in the 25% most deprived nationally, 13 of which are in the 10% most deprived. 2 LSOAs in East Marsh ward are in the 15 most deprived nationally and 3 in the 5% most deprived are in South ward and 1 in Yarborough ward.

The proportion of children who live in families where out of work benefits are received was 24.5% in 2006 and 24.95 in 2007. The proportion of children receiving free school meals in 2007 was slightly higher than nationally, both at primary (14.1% compared to 13.1%) and secondary school level (11.0% compared to 9.6%).

Living alone

An estimated 33.9% of older people live alone, almost twice as many women as men, more aged over 75 years than 65-74 and more of those living in deprived areas.

Assessment of Needs

A wide range of local Health, Social, Housing and Children's Needs Assessments have been completed and published over the past few years. Many have been summarised in previous Annual Public Health Reports.

These include assessments and surveys on

- *Adolescent Lifestyle*
- *Alcohol Misuse*
- *Child and Adolescent Mental Health*
- *Coronary Heart Disease*
- *Children and Young People*
- *Diabetes*
- *Gypsies and Travellers*
- *Homelessness*
- *Housing*
- *Housing Market*
- *Housing Stock Condition*
- *Illicit Drug Use*
- *Learning Disability*
- *Mental Health*
- *Older People*
- *Respiratory Disease*
- *Supporting People*
- *Transport*

We have brought together all the needs identified in these separate reports and where possible updated the figures in them. This has then helped to confirm local priorities which had previously been identified using the original needs assessments.

Identified priorities for improving Health and Wellbeing

GENERAL POPULATION	CHILDREN AND YOUNG PEOPLE	OLDER PEOPLE
Worklessness	*Breast-feeding*	*Food and drink*
Transport	*Teenage pregnancy and sexual health*	*Unsafe & unhealthy housing*
Unsafe & unhealthy housing	*Obesity*	*Transport*
Accessible, quality health and social services	*Drugs and alcohol*	*Social isolation*
Health Inequalities	*Emotional well-being*	*Activities of daily living*
Domestic violence	*Bullying*	*Personalisation*
Drugs and alcohol misuse	*Domestic violence*	*Mental health services*
Children and families	*Educational attainment*	*End of life care*
Carers	*Accommodation*	*Dignity and respect*
Vulnerable adults	*Disability*	*Information and communication*
Offenders	*Young offenders*	*Carers*

The JSNA itself includes more information on why each of these is a priority in North East Lincolnshire and can be found at **http://www.nelctp.nhs.uk/about/jsna/default.aspx** . Below are a few examples which are of particular interest and concern.

Vulnerable adults

Many groups within our community consist of people who are especially vulnerable. Particularly this includes people with mental health problems, people with learning disabilities and people with physical disabilities. It could also include older people who are considered separately in this report. These are often communities of interest although they may have some geographical concentration as well, typically in areas of high deprivation.

There are clear links with some of the wider determinants of health such as unemployment, poor housing and social isolation which tend to result in a spiral towards poorer health. This is often exacerbated by reduced access to health care.

- *An estimated 13% or 1 in 7 of the population (21,525 people) may have a mental health problem in North East Lincolnshire, many of whom are not receiving any help.*
- *Only 13% of individuals treated in mental health services are employed in paid work. This is in comparison with 72% of the overall population in North East Lincolnshire.*
- *There are an estimated 425 people with learning disabilities known to services in North East Lincolnshire (236 males and 189 females). Prevalence in five-year age bands shows considerable fluctuation from a high of 4.29 per 1000 in the 20-24 year age band to a low of 0.15/1000 in the 70-74's.*
- *Approximately 8% of people with learning disabilities are in some form of employment, either open or sheltered.*
- *Most informal carers of people with learning disabilities still encounter some problems when the person they care for is admitted to hospital.*

Unsafe & unhealthy housing

Decent, affordable and suitable housing in decent surroundings has a key role in building sustainable communities. Nationally, over a third of all homes do not meet decent homes standards, homes which tend to be occupied by the most vulnerable. Housing is linked with quality of life and both physical and mental health outcomes. People living in homes without central heating and in fuel poverty have a greater risk of death in winter. Poor hygiene facilities can result in infection and food poisoning. Overcrowding exacerbates problems. Suitability and affordability of housing may change as people's needs and circumstances change.

- *In 2006, 6068 households locally were in need of alternative accommodation to better suit their needs.*
- *North East Lincolnshire has an estimated annual shortfall of 445 units and over 70% of newly forming households cannot afford to buy or rent.*
- *Almost a third of private sector homes (19,200) in North East Lincolnshire do not meet the Decent Homes Standard, especially dwellings in the East and West Marsh, Cleethorpes and Hainton, Heneage and Park wards.*
- *Eleven percent of private sector homes (6,700) have at least one serious hazard (i.e. likely to result in very bad injury or illness). More are in need of repair and are likely to fail the thermal comfort standard than nationally.*
- *East Marsh has the highest number of houses that are overcrowded.*
- *There are estimated to be a minimum of 20 gypsy/traveller households in North East Lincolnshire, some experiencing unmet need for accessing health care and education services. There is an estimated need for a site in North East Lincolnshire and for approximately 13 additional residential pitches/plots to be provided between 2007 and 2016 to contribute to the 59 plots required in North and North East Lincolnshire.*

Emotional well-being of Children and Young People

Children and young people need a supportive, healthy and stimulating environment that fosters happiness and well-being. Emotional well-being is important for the social, physical, cognitive and educational development of young people and hence problems with mental health or emotional well-being can have effects on their general health, relationships, thoughts, feelings, behaviours, confidence, self-esteem and enjoyment of life. Although impacts may be short-term they can persist into adult life and include anxiety, depression, addictions and eating disorders.

- *85% of North East Lincolnshire pupils surveyed in the school-based Adolescent Lifestyle Survey 2007 said they feel happy about life.*
- *95% have one or more good friends and 66% feel they have a lot to be proud of. 93% feel that their family look out for them, suggesting they have someone to turn to in times of need and that they experience a level of security and stability which can build resilience.*
- *Over 25% of pupils often feel sad or tearful, 22% often feel anxious or depressed and 16% said they wished they had a different kind of life.*
- *47% of Year 7-11 pupils worry about tests and exams, particularly those in Years 9-11. TellUS2 survey results show that worry about exams is the most common concern locally (51%) and nationally (51%).*
- *Based on national prevalence rates it is estimated that 2595 children and young people aged between 5 and 16 in North East Lincolnshire have a mental health problem.*
- *Evidence from the child and adolescent mental health (CAMH) needs assessment showed that young people felt that they did not always receive the emotional support they needed following traumatic life events, with the focus being on behavioural problems.*
- *Many children have to wait more than a year to access CAMH services. Parents felt that this was an unacceptable length of time to wait in the life of a child.*

Bullying

Bullying includes deliberate attempts to hurt someone physically or emotionally. It impacts on a victim's self-esteem and may have long-term effects on emotional well-being. It can include obvious physical violence but also verbal taunts designed to humiliate, the spreading of rumours or personal, private facts. Victims of bullying may become withdrawn, may no longer wish to attend school and may become violent, become bullies themselves or even contemplate or attempt suicide.

- *43% of pupils who took part in the 2007 Adolescent Lifestyle Survey said they had been bullied while at their present school and 505 have been bullied at some point in their school life.*
- *31% of pupils who had been bullied had experienced physical bullying, 85% had experienced verbal/emotional bullying, 14% Cyber bullying, 11% had been forced to do things they hadn't wanted to do and 4% had experienced other types of bullying.*
- *Over a third of pupils (35%) thought they had been bullied because of the way they looked or the clothes they wore and 28% because of their size or weight. Almost a third did not know why they had been bullied. Some had been bullied because of their name or social group, their race, colour, religion, sexuality or disability.*
- *Research for the child and adolescent mental health needs assessment showed that many parents and carers of children with identified emotional, psychological or behavioural problems thought that their child/ren was bullied to some extent at school or after school as a result of their problem.*

chapter 2

diabetes equity profile

in north east lincolnshire

Diabetes Mellitus is a chronic disease whereby the body cannot regulate its glucose (sugar) levels and hence is typically characterised by high blood glucose levels (hyperglycaemia). There are two main types of diabetes. In Type 1 diabetes there is an inability of the pancreas to produce insulin and in Type 2 diabetes there is an inability of the body to respond to insulin (insulin resistance) and/or impaired secretion of insulin[1,2]. Diabetes is a progressive disease, which if not controlled can consequently lead to long term complications such as retinopathy, nephropathy and neuropathy, and also increase the risk of cardiovascular disease (CVD).

Diabetes affects infants, children, young people and adults of all ages, and Type 2 diabetes in particular is becoming more common. It currently affects around 5% of the world's population and the rate is doubling every generation[3].

Prevalence of Overweight and Obesity

In 2003, the prevalence of obesity in Yorkshire and the Humber region was higher than the national average in both men and women. The male prevalence was the highest across all English regions while the female prevalence was second highest. There is no routine available data on adult obesity for the North East Lincolnshire CTP area. However, synthetic estimates of prevalence of obesity show variation in estimated expected prevalence of obesity within the region, ranging from 18.0% in the former Leeds North West PCT to 27.1% in North Lincolnshire PCT. The estimated expected prevalence of obesity in the North East Lincolnshire CTP area is 24.5%. Childhood obesity is increasing steadily in the UK, and at a much faster rate than in adults. In England between 1995 and 2004, the prevalence of childhood obesity increased by over a half in girls and almost doubled in boys. In Yorkshire and the Humber region the picture is also alarming: it is projected that 33% of boys aged 2 to 10 will be overweight or obese by 2010 (second highest rate in Region), with girls on 30% (third highest rate in Region).

Obese figures for those aged 11 to 15 are even more stark – projected levels for boys are 33% by 2010 (Y&H sixth out of nine regions), and the projections for girls are the highest in England, with 28% of girls projected to be obese and a further 16% overweight, making a total of 44% of all girls aged 11 to 15 in the Region[4].

In North East Lincolnshire, the school nurses undertook the measuring of eligible children in reception and year 6 classes across all schools during the months of June/July 2007. The following table presents a summary of the results:

% of pupils with a BMI p-score		
	Year R	Year 6
>=0.85 (defined as overweight)	*248 (16.89%)*	*232 (14.60%)*
>=0.95 (defined as obese)	*147 (10.01%)*	*261 (16.43%)*

The 2007/8 results have yet to be fully validated & finalised, but provisional results showed that, obesity rates have risen by just over 1% in reception year (to just over 11%) and slightly over 3% for year 6 (to around 19.5%).

Differences in diets

In 2003 in the Yorkshire and the Humber region, approximately one fifth of adults consumed 5 or more portions of fruit and vegetables a day, which was lower than the England average. Synthetic estimates from the Yorkshire and the Humber Public Health Observatory for 2000/02 suggest that only 15% of North East Lincolnshire adults consume the recommended 5 or more portions of fruit and vegetables per day, which is lower than the synthetic estimate of 20% for the Yorkshire and the Humber average.

The Health Survey for England (2002) found that slightly fewer children in the Yorkshire and the Humber consume the recommended 5 or more portions of fruit and vegetables than the England average.

Data from the Adolescent Lifestyle Survey (2004) suggested that young adults in North East Lincolnshire consume similar amounts of fruit and vegetables to the national pattern. Results also show that it is likely that many pupils overestimated their average consumption, primarily due to confusion over portion sizes. Furthermore, data from the National Survey 2007 found that 25% of pupils (in schools years 6, 8 and 10) in North East Lincolnshire consumed the recommended 5 a day. This is 2% higher than the national average of 23%[5].

Prevalence of Physical Activity

The Active People Survey (2005) found that 3 out of 5 people in the Yorkshire and the Humber region were active and 2 out of 5 people were inactive. Men were more likely than women to participate in sport and active recreation. People from the higher social classes people of BME origin were much less likely than white people to be active in their leisure time. Adults who had a disability or long-term health problem limiting their daily activities were generally less active during their leisure time than people without a disability.

Adults in North East Lincolnshire CTP area were found to be less active in their leisure time than the average for the Yorkshire and the Humber region as a whole. The Active People Survey carried out in 2005 revealed that almost a quarter of the population (24%) of the Yorkshire and Humber Region were active in their leisure time, (35%) were nominally active and two in five were inactive (42%).

At the regional level, inequalities in levels of physical activity were also found between adults in the different social classes, ethnic groups, gender, ability and different age groups. Men were more likely to participate in physical activity than women and adults under 45 years were more likely than those over 45 years to be active. People in unskilled and partly skilled occupations were more active than those in professional, managerial and technical occupations. White people were more active than people from other ethnic groups.

Mortality from diabetes in North East Lincolnshire

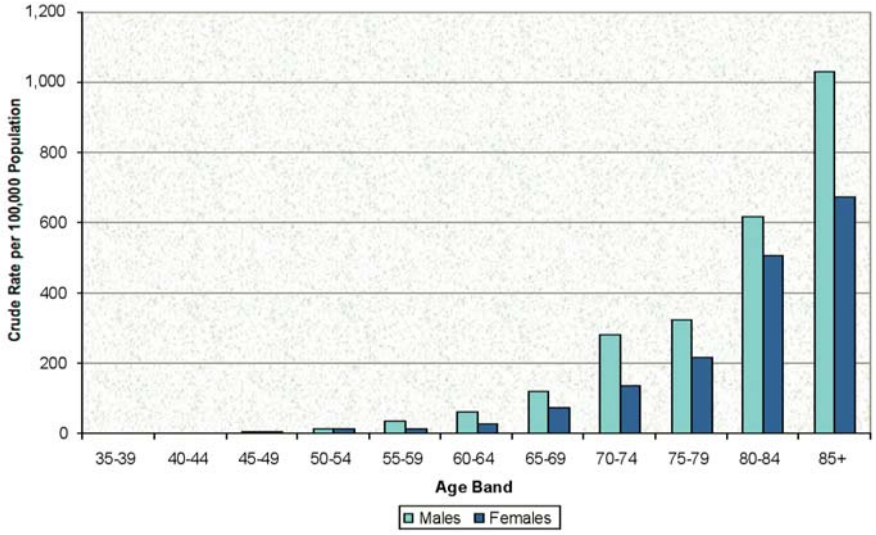
Direct deaths from diabetes

Diabetes deaths in North East Lincolnshire between 2002 and 2006 were analysed and it was found that the rate of mortality from diabetes was higher in males than it was in females. Crude age-specific death rates increased throughout each 5 year age band up to the age of 85 which had the highest mortality rate. The rate of premature mortality was higher in males than in females. The rate of mortality from diabetes within the NRF areas was lower among males and higher among females in comparison to the non-NRF areas, although the differences were not statistically significant.

Indirectly related deaths from diabetes

North East Lincolnshire data was also taken from 2002-06 where diabetes was listed as a contributory factor of death and it was found that those who suffered premature mortality accounted for a third of all deaths. The rate of mortality was statistically significantly greater among males than females figure 2.1.

Figure 2.1: Age & gender specific mortality rate per 100,000 from indirectly related diabetes in the North East Lincolnshire PCT area (2002-2006 Pooled Data)



Data Source: Public Health Mortality File (ONS)

Crude death rates increased with age up until the 85 + age band which had the highest mortality rate. The rate of premature mortality was also statistically significantly greater among males than females. The rate of mortality was greater in the NRF areas in comparison to the non-NRF areas, although these differences were only statistically significant amongst persons and females. The rate of premature mortality was greater in NRF areas in comparison to the non-NRF areas, although statistically these differences were only significant in persons and females.

The rate of mortality was greater among persons, males and females in the NRF areas in comparison to the non-NRF areas (Table 2.1). There is a larger gap in inequalities between females living in the most deprived areas and the most affluent areas in comparison to males.

Table 2.1: Local comparisons of age and sex standardised mortality rate per 100,000 from indirectly related diabetes, by area in the North East Lincolnshire PCT area (2002-2006 pooled data): Males, Females and Persons (all ages)

Area	Persons			Males			Females		
	Rate	LCI(95%)	UCI(95%)	Rate	LCI(95%)	UCI(95%)	Rate	LCI(95%)	UCI(95%)
NELPCT	34.58	31.36	38.03	43.97	38.35	50.17	27.62	23.86	31.77
NRF Areas	46.50	38.96	55.03	56.25	43.87	70.96	38.73	29.49	49.74
Non- NRF Areas	30.50	27.09	34.21	39.62	33.52	46.48	23.89	20.04	28.23

Data Source: Public Health Mortality File (ONS)

Inequalities - Age & Gender

Out of the 460 deaths amongst all ages, 231 were male (50%) and 229 were female (50%). The rate of mortality was statistically significantly greater among males (43.97/100,000) than females (27.62/100,000). Age at the time of death ranged from 36 to 98 years old for males and 43 to 99 years old for females.

Of the 158 premature deaths (under 75), 101 were male (64%) and 57 were female (36%). The rate of premature mortality was also statistically significantly greater among males (21.75/100,000) than females (11.83/100,000).

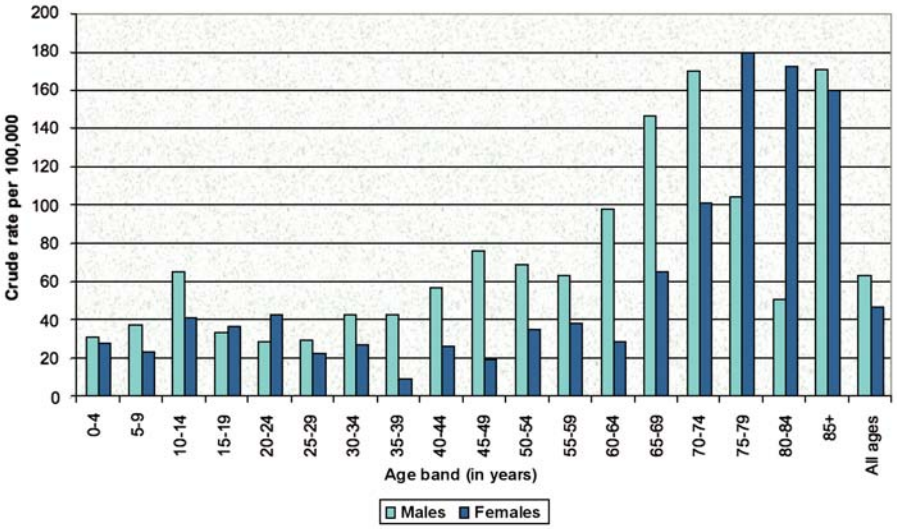
Prevalence of Diabetic morbidity

Diagnosed diabetes prevalence in North East Lincolnshire is approximately 4%, which is significantly higher than the National figure (from the Quality & Outcomes Framework England) and regional average of 3.6%.

Inequalities in hospital episodes for diabetes

Analysis at person level provided annual age-specific crude rates/100,000 by gender of people who were admitted to hospital with a primary diagnosis of diabetes as shown in Figure 2.2. Women were admitted to hospital as a result of diabetes significantly less than men. The rate of men being admitted to hospital as a result of diabetes was almost 1.5 times that of women.

Figure 2.2: Age and gender specific rates per 100,000 (2001/02 – 2005/06 pooled data) – Persons (All ages)



Data Source: Public Health Mortality File (ONS)

Inequalities in diabetes type

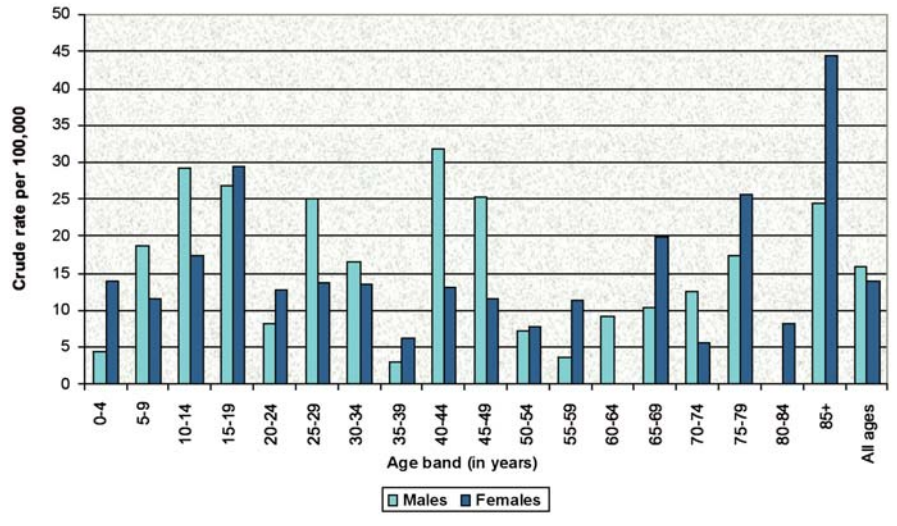
Insulin dependant diabetes is much higher in the younger populations but more so in males aged 0-14 years than females of the same age. Rates for non-insulin dependant diabetes are very low in younger adults, but rise steadily from the 40-44 age band up to the 75-79 age band.

For persons admitted into hospital for insulin dependant diabetes, the rate in the NRF areas was higher than the rate in the non-NRF areas and the North East Lincolnshire CTP average, although the differences were not statistically significant. For persons admitted into hospital for non-insulin dependant diabetes, the rate in the NRF areas was higher than the rate in the non-NRF areas and the North East Lincolnshire CTP average, although the differences were also not statistically significant.

Inequalities in complications and use of services

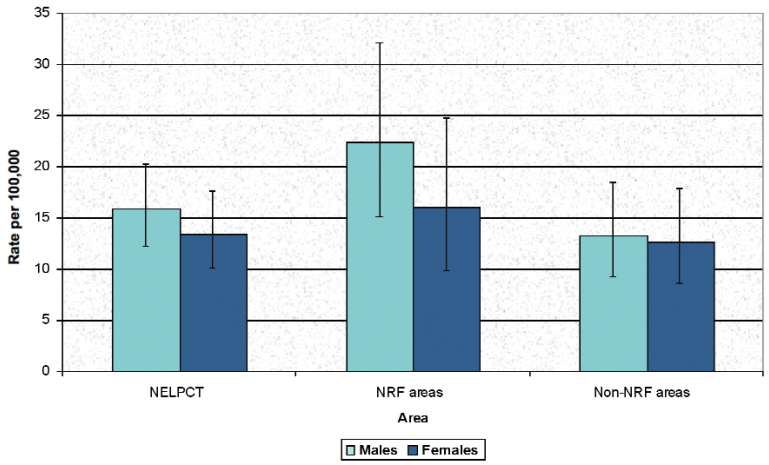
Rates of coma and ketoacidosis as a result of diabetes are lower in women than in men although the difference was not statistically significant. For men, the highest rate was in the 40-44 age band and in women the highest rate occurred in the 85+ age band.

Figure 2.3: Coma and ketoacidosis crude rates per 100,000 2001/02 – 2005/06: Persons (all ages)



Coma and ketoacidosis as a result of diabetes was higher in the NRF areas compared to the non-NRF areas and the North East Lincolnshire CTP average, although the differences were not statistically significant. Women also experienced significantly lower rates of lower limb amputations than men. For men, the highest rate was in the 65-74 age band, whilst in women the highest rates were in the 75-84 age band. Lower limb amputations were higher in NRF areas compared to non-NRF areas and the North East Lincolnshire CTP average, although these differences were also not statistically significant.

Figure 2.4: Age and sex standardised rates of coma and ketoacidosis per 100,000 in the North East Lincolnshire CTP, NRF and non-NRF areas – (2001/02 – 2005/06 pooled data): All ages



Recommendations

There are several recommendations from this report.

It was concluded that obesity prevention should be a high priority for North East Lincolnshire Care Trust Plus (CTP) and its partners. Action should be directed to the entire population but particular focus should be given to those from areas of higher deprivation, such as those living in East Marsh, West Marsh, Nunsthorpe and the other neighbourhood renewal areas, in addition to those from ethnic minority backgrounds such as asylum seekers. Therefore, access to services should be prioritised to the deprived, the elderly and those from ethnic minorities.

Diabetes prevention and prevention strategies and services should be targeted at those from areas of higher deprivation and also at other individuals at higher risk of developing diabetes, such as obese individuals and those with glucose intolerance.

Further training should be encouraged for all general practitioners (GPs) and other primary care staff in diabetes who have not yet taken specialised training, and in particular for those who are currently not meeting QOF targets for diabetes.

This should be accompanied by upgrading the level of service provision by practices, so that no practice in North East Lincolnshire provides less than Level 2 care to people with diabetes.

The appointment of a GP with special interest in diabetes or the assurance of diabetes consultants' time in GP practices or the community should be considered, so that the majority of patients with diabetes are seen in the community.

GPs in general, and particularly those not achieving QOF targets, should be aiming to attain metabolic control in a larger number of patients, including safely achieving HbA1c values below 7.4% for most patients, as well as cholesterol values below 5 mmol/L and blood pressure target for diabetic patients should be 140/85 and 130/70 if there is any nephropathy present.

Pharmacists should be encouraged to take more active roles in monitoring and advising people with diabetes on their medications and on Self Monitoring of Blood Glucose, particularly in areas of higher deprivation and diabetes prevalence.

The high prevalence of diabetes and particularly of undiagnosed diabetes in the elderly should be acknowledged by health professionals and health promotion activities should address this issue.

Community based education initiatives that are accessible to all groups of people (including working people and the elderly) should be encouraged.

chapter 3

adolescent lifestyle survey

The Public Health Directorate carried out an Adolescent Lifestyle Survey (ALS) for the first time in 2004. The aim of the survey was to provide baseline data on the health and well-being of local children and young people. Findings from this survey were used extensively to improve and develop services in relation to: Neighbourhood Renewal Fund bids, the 'Choices' programme, Healthy Schools, Smoking Cessation Services for young people and to efficiently target resources.

The ALS was repeated in 2007. The principal aim of the survey in 2007 was to measure progress of the key issues through time. The survey was administered throughout participating secondary schools in North East Lincolnshire during the winter term October – December 2007. A randomly selected sample of Year 7-11 pupils was asked to fill in a self-completion questionnaire during the school day. Nine schools took part in the survey in 2007 compared with eleven in 2004, resulting in a total sample size of 2339 young people invited to take part in 2007.

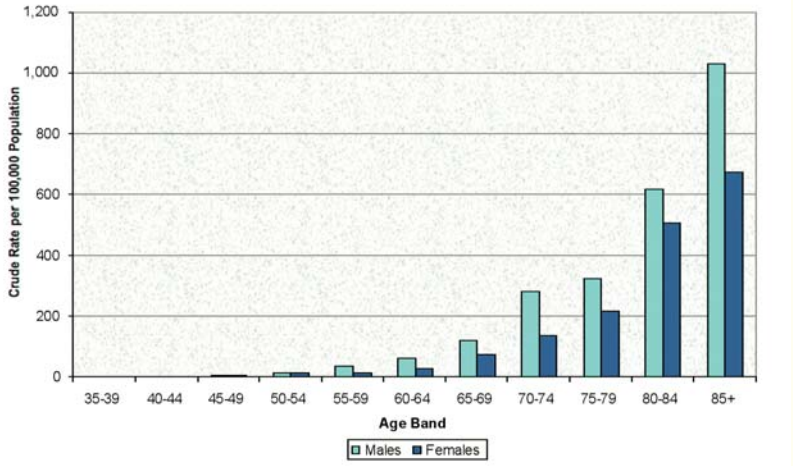
This figure is around 69% of the sample size for 2004 (which was 3390), even though the 2007 survey includes year 11 pupils. However, a sample size of 2339 represents 23% of the Local Education Authority's 11-15 year old secondary school pupil population and 28% of the possible sample from nine schools. Overall the gender characteristic of the sample reflects the gender population of 11-16 year olds in the area.

A wide range of questions were grouped into a number of themes and this report gives an overview of three of these themes. The full report and a technical support document are available at http://www.nelctp.nhs.uk/about/publications/default.aspx.

Food and Exercise

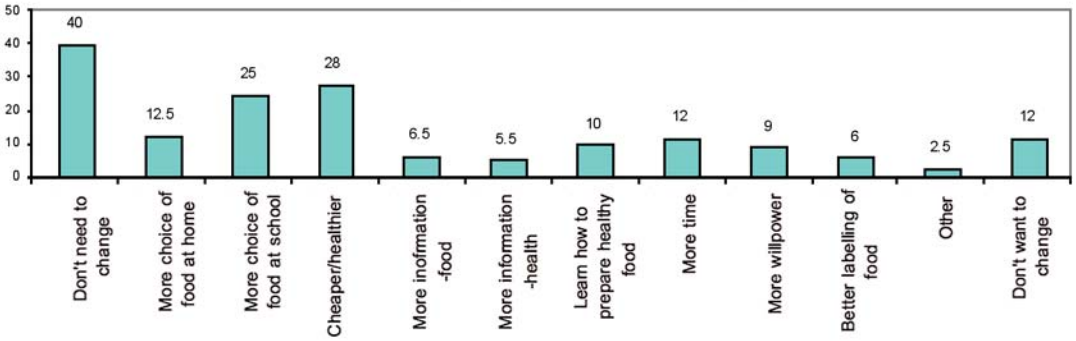
Healthy eating habits established in childhood can set the foundations for a healthier approach to food into adult life and have significant beneficial effects on health and well-being, including achieving and maintaining a healthy Body Mass Index and boosting self-esteem. A key factor in healthy eating regimes is to ensure a healthy breakfast is eaten every day. However, our findings (see Figure 3.1) suggest that 14% of all pupils never eat breakfast and around a third of males and females only eat breakfast 'sometimes'. Girls in particular are less likely to eat breakfast daily and more likely never to eat breakfast; they are also more likely to be unhappy with their body weight.

Figure 3.1: Percentage of pupils who normally eat breakfast on a school day by gender



Schools are ideally placed to have an influence on the eating habits of young people and the findings of this study (Figure 3.2) suggest that young people would like the opportunity to eat healthier meals at school (25%) and have access to cheaper and healthier drinks in school (28%). Interestingly, 10% of our sample would like the opportunity to learn how to cook healthily.

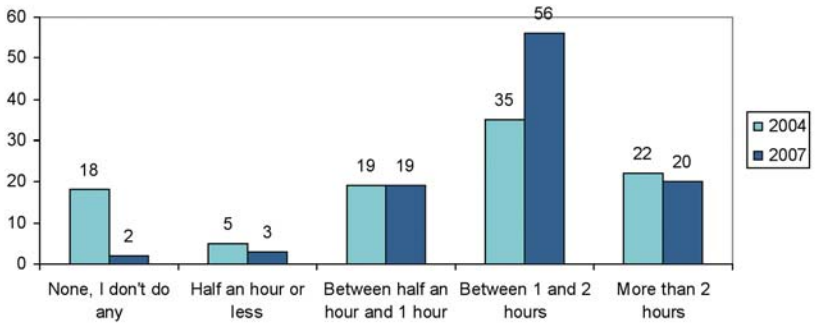
Figure 3.2: What would encourage pupils to eat in a healthier way? Percentage of pupils



Physical activity is a crucial factor in the prevention and control of obesity. Physical activity also promotes mental health and well-being and can increase self-confidence and self-esteem. As such, young people should be afforded every opportunity to access sport/activities both within school, after school and within the community.

Our findings suggest that, while an encouraging 90% of pupils said that they undertake some vigorous physical exercise for at least an hour during the previous week, only 18% met the Department of Health Guidelines of 60 minutes of vigorous exercise everyday. Encouragingly (Figure 3.3), the percentage of pupils taking part in P.E. in school for between one and two hours has risen from 35% in 2004 to 56% in 2007. Those pupils not taking part in any P.E. in school has fallen to 2% in 2007 compared to 18% in 2004. While this is a step in the right direction, more pupils should be encouraged to take part in P.E. in school and more out of school opportunities should be available for young people to undertake physical activity of some sort.

Figure 3.3: Time spent taking part in Physical Education at school in North East Lincolnshire



Obesity is a major issue in North East Lincolnshire. Food choices are critical and proper eating patterns for children set the scene for their whole life. Similarly, patterns for physical activity are extremely important.

- *We need to ensure all children and young people understand the importance of breakfast and are able to afford and eat breakfast everyday. Consideration should be given to making breakfast more available in school settings.*
- *Targeted work with young people around the importance of healthy eating and maintaining a 'healthy' body weight should be introduced in schools with a focus on young females who are more likely to never eat breakfast and more likely to be unhappy with their weight than their male peers.*
- *All children need to have access to more physical activity, not just P.E. and games, both in school time, after school and elsewhere.*

Smoking

Smoking has negative consequences on the physical health of young people and is a major risk factor for many diseases and premature death in adulthood. Encouragingly, the number of young people smoking in North East Lincolnshire in 2007 does appear to be decreasing compared to the findings of the 2004 ALS (see Figure 3.4). In 2004, 12% (404) of year 7-10 pupils smoked either occasionally, regularly or daily. In 2007 this figure was 10% (232) of pupils in years 7-11. While the 2007 ALS had a smaller sample size, it does include year 11 pupils, who, research suggests, are more likely to smoke as the incidence of smoking increases with age. In conjunction with the numbers of young people smoking decreasing, the number of young people trying cigarettes for the first time also appears to be declining with two thirds (66%) of young people never trying cigarettes in 2007.

It would also appear that fewer young people are being able to obtain cigarettes from supermarkets and shops/garages, suggesting that legislation is being more effectively policed locally. However, around a quarter of young people still manage to obtain cigarettes from shops, suggesting more work needs to be undertaken in this area.

Figure 3.4: Smoking Prevalence by year group in North East Lincolnshire

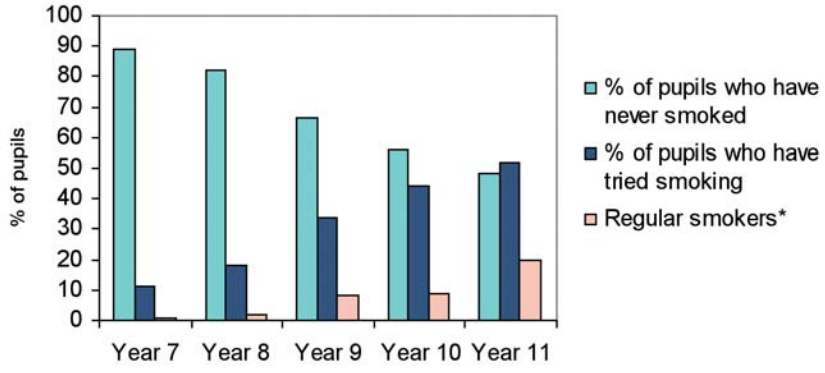
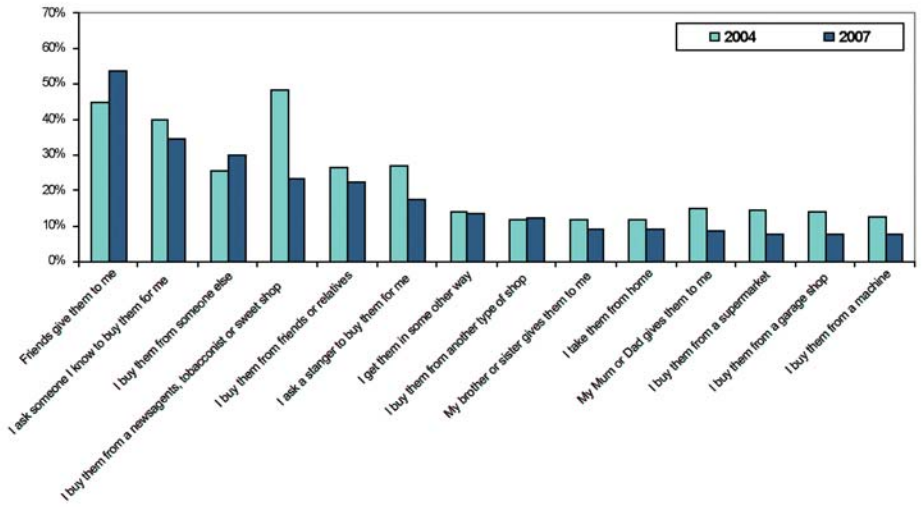


Figure 3.5: Comparison of where young people in North East Lincolnshire obtain cigarettes 2004 and 2007



Alcohol

There are no 'safe' recommended levels of alcohol consumption for young people in this country and any drinking, especially 'binge' drinking, poses a potential health threat to young people. Furthermore, establishing excessive drinking habits early in life may increase the risk of excessive drinking in adulthood and so increase the risk of associated health risks and diseases.

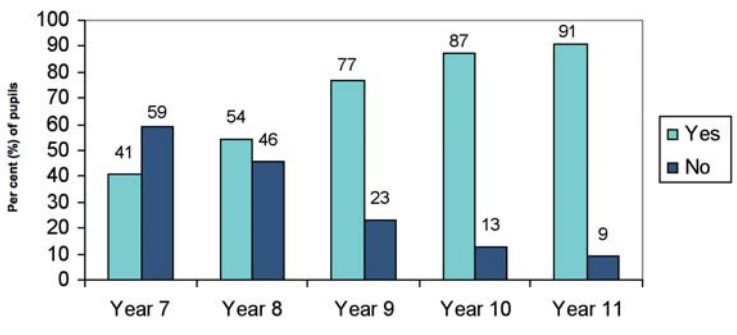
The findings from the 2007 ALS suggest that, as with national trends, alcohol consumption increases with age with 41% of year 7 pupils stating that they have had 'a whole alcoholic drink' compared to 91% of year 11 pupils. The findings from the 2007 ALS may suggest that drinking is slightly decreasing with 90% of young people aged 14 (year 10) having had 'a whole alcoholic drink' compared to 87% in the 2007 ALS (see Figure 3.6).

Drinking among young people does appear to be more prevalent in North East Lincolnshire with 31% of pupils saying they have never had 'a whole alcoholic drink' compared to 45% nationally. Furthermore, young people in North East Lincolnshire appear to be more likely to 'binge drink' with 41% having been 'very drunk' at some point during the past 4 weeks compared to the national figure of 19% of young people. This was also an issue in the 2004 ALS and further work should target young people and raise awareness about the dangers of binge drinking and the associated risks.

As with other lifestyle choices, behaviours established early in life can often set the pattern for later lifestyle choice and health related behaviours. Alcohol consumption, though legal in this country, carries health warnings and excessive consumption can be a major factor for many important illnesses and diseases. North East Lincolnshire young people appear more likely to try alcohol and to binge drink with twice as many local young people saying they have been 'very drunk' in the previous four weeks than nationally.

- *Additional emphasis in school lessons needs to be placed upon the associated risks to health from alcohol consumption, and in particular the risks associated with 'binge drinking'*
- *Additional emphasis should be placed on the social and emotional impacts of alcohol consumption on young people and 'risk' associated with alcohol consumption placed in context for young people*
- *All those working with young people should be able to undertake brief interventions and know where to signpost young people who identify the need for support with their drinking habits.*

Figure 3.6: Percent of young people Year 7-11 who have had a whole alcoholic drink



chapter 4

older people,

assessing health and local needs in north east lincolnshire

In 1999 an assessment of the needs of older people in North East Lincolnshire revealed much unmet need and was used to inform strategy and action plans to address these. Since then progress has been made with some of the issues identified, for example the current rate for hip and knee replacements locally is no longer significantly lower than the national average. The 2006 strategy for improving the quality of life for older people locally, *Choosing Life*[1], recommended re-assessing the needs of older people to further establish progress, re-affirm need and identify other needs.

As well as identifying the current needs of our older population, this new needs assessment study aimed to forecast future needs and the likely demand on services. Determining older people's perceptions of their needs was a key part, as was exploring some needs in more depth. This involved sending a postal questionnaire to 3400 of people aged 65 and over living in North East Lincolnshire and some older people taking part in focus group discussions. One requirement identified was to comprehensively assess older people's mental health needs and to review older people's mental health service provision. This included interviewing carers of older people with dementia and interviewing many health and social care professionals involved in service provision.

Older people's physical health and their care needs

Health status and staying healthy

Self reported health status is an important indicator of the general health of the population. Most people who responded to our survey reported good health: 62% said their health was excellent, very good or good, 29% said fair and 9% thought they were in poor health. As might be expected, a higher proportion of the 'younger elderly', i.e. 68% of people aged 65-74 said their health was good, very good or excellent compared to 55% of those aged 75 and over. Those reporting their health as fair or poor was higher in the 75 and overs (45%) than in the 65-74 age band (32%). Significantly more people living in more affluent (non-Neighbourhood Renewal Funded) areas reported their health to be better than those living in more deprived areas (NRF). 35% of those surveyed living in non-NRF areas and 48% in NRF areas said their health was fair or poor.

There is a wealth of evidence to show that stopping smoking, taking more exercise, eating a healthier diet and drinking less alcohol can reduce the prevalence of chronic diseases (e.g. circulatory diseases, cancers, respiratory diseases, diabetes, etc) as well as deaths. It is recognised that people are increasingly knowledgeable about the importance of such lifestyle choices for improving health but that they, for many reasons, may not be able to make healthy choices and may need additional support to overcome barriers. This survey showed that older peoples' knowledge about making healthy choices was good. 71% reported doing something to keep healthy or to improve their health, significantly more men (73.9%) than women (68.5%), more of those aged 65-74 (76.52) than the 75 and overs (63.56) and similarly more from affluent non-NRF areas (74.1%) than deprived NRF areas (60.2%). Only 39% of respondents living in a care home said they were doing something to maintain or improve their health. Barriers to staying healthy were mainly illness related but affordability was also an issue.

Central heating and keeping warm

People are deemed to be living in fuel poverty when more than 10% of the household income is spent on fuel to adequately heat the home[2]. Adequate heat is defined as 21°C in the living room, and 18°C in other rooms . Below 16°C, there is a reduced resistance to respiratory disease, below 12°C cardiovascular and blood pressure risks increase and below 5°C there is a risk of hypothermia[3]. In many cases, older people have a temperature of between 6 and 12°C in their living room in the morning.

The amount of time older people spend in the home, combined with a greater fall in body temperature in older people exposed to the cold (compared to younger people) and a reduced ability to thermo-regulate in some older people is linked to excess winter mortality[3].

The proportion of older people without central heating in North East Lincolnshire in the 1999 survey was 18.8%. A considerable programme of work under the 'Healthy Homes' affordable warmth scheme has since been undertaken and in this latest study only 6.4% of older residents report not having central heating, more so in those aged 75 and over, those living in NRF areas and those that were privately renting. 77% of older people who responded said they could afford to keep their home as warm as they liked, more especially women, those in the older age group and those living in more affluent non-NRF areas. Of those without central heating only 28.6% could not afford to keep their homes as warm as they would like compared to 46% in 1999, suggesting that energy efficiency measures were also having an impact on non-centrally heated homes. Rising costs however was also a concern for study participants and given that this study was undertaken before the more recent price rises and economic downturn there will be many more older people in fuel poverty this winter, and at risk of poor health, hospital admission or death.

"I haven't got central heating so I have to leave my gas fire on all night."

Nutrition

Adequate nutrition and hydration are important for older people in the community to maintain good health. Obesity is associated with diseases such as diabetes, CHD and some forms of cancer. In addition to causing some diseases, it can also exacerbate existing conditions. Malnourished older people are more likely to catch infections and have longer stays in hospital when admitted.

There are estimated to be 6775 older people with a Body Mass Index of 30 or above locally and hence considered to be obese, with numbers projected to rise to 9275 by 2025 (source: POPPI[4]).

Of those older people who returned questionnaires, 7% said they had a problem eating well. 6.2% did not have a hot meal every day (suggesting 1,700 older people in North East Lincolnshire do not), a fifth did not eat 3 meals a day (equating to approximately 5,700 in NEL) and 8.1% had difficulties buying food and 10.5% cooking and preparing food. 1% had run out of food in the previous 12 months and could not afford to buy any more (an estimated 270 older residents in NEL). Given current rates of inflation, some older people are likely to be faced with the very difficult decisions about whether to eat adequately or heat their homes.

The suggested fluid intake is 8-10 glasses of water a day, with other fluid counting towards this total[5] . However, some older people, particularly those with mobility problems may try to consume less in an attempt to avoid having to use the toilet, or to reduce symptoms of urge incontinence[6]. Among survey respondents over half (1,341, 61.3%) drank less than the recommended 8 drinks per day, suggesting over 16,000 local older residents may suffer varying degrees of dehydration. A care home study in Suffolk[7] has shown that efforts aimed at increasing resident's fluid intake, providing water coolers and jugs of water in bedrooms, resulted in fewer falls recorded, less GP call-outs, reduced use of laxatives and incidence of urinary infections, better sleep and less agitation among dementia sufferers.

Ability to manage activities of daily living

Increasing age and accompanying health and mobility problems often result in the need for help and support for people to continue to manage their everyday lives at home. It has been recognised that meeting social care needs and costs will become increasingly unsustainable without radical changes to current provision. Avoiding or delaying residential or nursing homecare via preventive interventions has become recent policy.

The majority of those aged 65 and over who took part in the questionnaire survey locally indicated that they did not need help with self care or most activities of daily living (ADL). However significant numbers do and table 4.1 shows reported needs, support received and unmet need.

The greatest need is for tasks requiring mobility and heavier tasks, including gardening and household repairs, cleaning, doing the laundry and shopping/collecting pension. Unmet need also exists for help with caring responsibilities. To maintain independence at home there will clearly be a requirement to increase the focus of service provision on prevention, but also early intervention and rehabilitation.

Table 4.1: People aged 65 and over who need help with activities of daily living, NEL estimates, source of help and those needing help but who do not get it

	% of respondents	NEL Estimates	Relative /friend	Paid carers	Voluntary sector	Need help but don't get
Personal care	(10%)	2,722	56%	36%	3%	5%
Getting in/out of bed	(5%)	1,361	69%	23%	2%	6%
Getting out and about	(19%)	5,171	86%	9%	1%	4%
Preparing meals	(16%)	4,354	80%	15%	2%	2%
Shopping/pension	(24%)	6,532	88%	9%	1%	1%
Cleaning	(26%)	7,076	64%	30%	1%	5%
Doing the laundry	(19%)	5,171	84%	14%	0%	2%
Money matters	(15%)	4,082	93%	5%	1%	1%
Caring for others	(16%)	4,354	70%	15%	5%	10%
Gardening/repairs	(38%)	10,341	73%	17%	2%	9%

*Excludes care homes. %s expressed are the proportion of people who answered each element of the ADL question.

End of Life care

The government's End of Life Care Strategy was recently published[10].

Recognising the developments in end of life care that have taken place, particularly in cancer services, in 2003 the Department of Health committed to training staff to ensure that eventually all people at the end of life would have a choice about where they wish to die and how they wish to be treated[8]. The Government[9] plans for more person-centred services to support people to remain in their own homes to the end of their lives and has pledged to double the investment in palliative care services.

In 2006 there were 1,667 registered deaths in North East Lincolnshire CTP area; 1,349 (81%) were people aged 65 or over. Circulatory disease is the main cause of death in adults aged 65 and over, (39%) followed by cancer (25%) and respiratory disease (16%). Only 16% of people died at home. 57% died in hospital, 22% died in a care home, and 3% in a hospice. When asked where they would prefer to be when their life was coming to an end, 84.6% of men and 82.8% of women said they wanted to die at home. By implementing some of the suggested measures it has been shown that numbers achieving their wishes to die at home can be increased and that changes can be cost effective.

"I would have liked my husband to be at home. I looked after him and he was only hospitalised…when he had the cancer. For that last week of his life he had to be in hospital and had to die in the hospital. It was horrendous for me."

Older people's mental health and their care needs

Older people's physical health and mental health are closely linked and clearly their health care should be commissioned as part of a single integrated system that focuses on the person, based on need. This needs assessment largely focuses on anxiety, depression and dementia.

Mental health status and caring for people with dementia

Analysis of routine data, shows almost twice as many women as men aged 65 and over had outpatient appointments and almost twice as many women as men were admitted to hospital for mental health problems between 2002 and 2007. Survey results showed significantly more older people resident in deprived areas compared to more affluent areas 'always' or 'often' felt anxious, and similarly significantly more 'always', 'often' or 'sometimes' felt depressed. Fear of crime, antisocial behaviour, ill-health, being alone and bereavement were all cited as reasons.

There were estimated to be approximately 1,900 people aged 65 and over with late onset dementia in North East Lincolnshire (6.9%) in 2007 with an associated cost of paid and unpaid care (including loss of earnings for carers) in excess of £42 million per year. Numbers are projected to increase to 2,849 by 2025 (source Planning4Care[12]). Caring for a relative with dementia was deemed by needs assessment interviewees to be a 24 hour a day commitment with profound physical and emotional impact on their lives, including social isolation as a result of giving up work, difficulties in social situations, constant tiredness and worry about the future when no longer able to cope, coping with the mood swings and aggression or violence shown by their relative/person cared for with dementia. Some interviewees had no relatives close by to offer support and others found their relatives were less able to cope with seeing the impact of dementia or didn't understand the impact. Unmet needs identified were for more information about the condition and what was happening to the sufferer, practical advice, stimulating activities for people with dementia, where to get help in an emergency and for their needs to be considered as an individual and not just a carer (including health checks for themselves).

"It does upset me. In May it's our golden wedding anniversary... It means nothing to her…50 years of my life…all the things we've done, gone. That's what gets me most."

"It's constant, day and night. I'm in and out of bed all night, if he's out of bed I'm out. I have to sleep when he sleeps…. I do get terribly tired, I do get fed up…"

Mental health services

Despite the introduction of the National Service Frameworks for Mental Health[13] and Older People[14], mental health services for older people have generally not seen the strides in service development that mental health services for adults under the age of 65 have seen. The publication of *Securing Better Mental Health for Older Adults in 2005*[15] was an attempt to overcome this policy divide and drive the improvement of services for older people with mental health problems. *Everybody's Business. Integrated Mental Health Services for Older People*[16] followed shortly after as a 'service development guide' with the aim of improving front line practice. The guide has been used as part of this needs assessment to undertake a review of local mental health service provision to inform the development of an agreed vision for future services and a commissioning strategy to implement this vision.

Key points from the review are:

Commissioning strategy: There is no commissioning strategy for older people's mental health in North East Lincolnshire and as such there is no shared vision. This needs a named individual to champion and develop this and to ensure users, carers and all key stakeholders are involved. It should include outcome indicators and an action plan, resource requirements, timescales and named leads.

Health promotion: There is no mental health promotion strategy for older people in North East Lincolnshire and this needs including in the commissioning strategy to be developed. There is a general Healthy Ageing Action Plan and the Older People's Health and Well-being programme aims to address social isolation and alleviate depression among older people.

Primary care: Older people sometimes do not recognise that they have a mental health problem and are often reluctant to seek help. Interviews with carers of people with dementia indicated that they were generally satisfied with care received from their GP, mainly receiving care from older people's mental health services. Insufficient advice and support and accessing the GP in an emergency were cited as unmet needs as was health checks for carers. Professionals raised the need for more training in mental heath for primary care staff.

Day services: The numbers of older people with mental health problems, current levels of provision and a waiting list at the Willows, which provides services for people with moderate to severe mental health problems, suggests unmet need.

Carers spoke positively of the services they received, including support groups such as the Memory Café at The Gardens and the Carers Support Unit. There needs to be a coordinated approach to the commissioning of adequate day service places, which offer a range of services to meet people's needs, e.g. health promotion activities to improve health and well-being.

Care in a residential setting: There was some concern expressed that staff in care homes may not be able to cope with the needs for high level mental health care and that this can lead to unnecessary admissions to older people's mental health services. High turnover of staff made adequate training difficult to achieve. Independent care home providers need to be involved in long-term planning, to meet the needs of older people with mental health problems. Carers wanted more information about respite care.

Intermediate care: Intermediate care (IC) is provided when people are not sufficiently ill to require admission/further stay in hospital but also not sufficiently well to manage on their own at home. Inadequate capacity in the Community Mental Health Team to deliver mental health training and support for intermediate care staff is an issue. The number of IC places available will need to grow as the population of older people increases. Addressing some of the increased demand may be met with care in the person's home but would need adequate resources. There is a need to develop care pathways to address the lack of clarity about admission processes to the Willows.

General hospital: Training in older people's mental health issues among staff is inadequate. There appears to be a lack of awareness of the scale of the problem and the impact mental illness can have on recovery from a physical illness. Lack of capacity in the Older People's Mental Health Liaison Team to provide out-of-hours advice and support, along with a lack of skills and knowledge to deal with challenging behaviour among mainstream hospital staff, can lead to patients being inappropriately sedated. Stakeholder interviewees and numbers locally versus the expectation from *Raising the Standard: Specialist services for older people with mental illness* suggest the capacity of psychology services is inadequate.

Specialist community mental health services: A community mental health team (CMHT) for older people with mental health problems provides specialist health and social assessment, treatment and care to service users and their carers either at home or in the community. Current staffing levels are inadequate compared to those suggested in *Raising the Standard*[17]. Care pathways to the CMHT need to be developed with primary and social care.

Memory services: The local memory assessment service is based at The Gardens (a recently refurbished service area in the grounds of The Diana, Princess of Wales Hospital in Grimsby). Having a person-centred approach, the support workers undertake a significant amount of work with carers to develop coping strategies. A home-based service is also offered. The lack of a common assessment framework between health and social care has been a concern when patients are requiring other services. Care pathways for the service need developing.

Inpatient Care: The Gardens, encompasses The Haven Suite for assessment and treatment of organic mental illness and the Konar Suite, for those with functional illness. It is regarded as an excellent service, by service users and carers and not only meets but regularly exceed expectations in many areas in relation to *Everybody's Business*[16].

Social Isolation

Although the Government has set up the Social Exclusion Taskforce and an associated action plan to tackle social isolation, it has been criticised by Age Concern for failing to adequately consider older people. Age Concern[18] recently estimated that 760,000 people aged 65+ in England are severely excluded from society.

Older people surveyed in North East Lincolnshire were asked how many types of social contact (e.g. spouse, parents, children, neighbours, etc) they spoke to (in person or on the telephone) at least once every 2 weeks. Over a third (34.7%) had a low social network score. Women, those in the older age group and those living in more deprived areas were more likely to be isolated. Over two thirds of older people (68.7%) said they 'never' or 'almost never' felt lonely and 28% 'sometimes' did. However, 2.4% felt lonely 'most of the time' and 0.9% felt lonely 'all of the time' together amounting to an estimated 900 older people in North East Lincolnshire. 64.3% felt part of the community they lived, especially those living in more affluent areas. Barriers to participating in social activities were cited as mobility or disability, age, personal choice, caring responsibilities or shyness. Transport, costs and language were also issues.

> *"I can go a whole week without having a meaningful conversation. That's one of the main reasons I go (to carers meeting), it gets me out of the house…but it gives me general conversation…sit and have a cup of coffee and a biscuit and a chat. People just want to sit round, have a cup of coffee and forget about it for a few hours."*

Dignity and Respect

In November 2006, Health Services Minister Ivan Lewis announced a national campaign placing dignity and respect at the heart of caring for older people.

Older people account for the highest use of acute hospital services and 45% of NHS expenditure. Maintaining a patient's dignity and treating them with respect is of paramount importance to older people[20]. The majority (73%) of needs assessment questionnaire respondents felt they had been treated with the same dignity and respect as younger people when accessing social care services, 19% felt they had been treated with more and 8% with less dignity and respect then younger people. The majority of respondents (84%) also said that they were treated with the same amount of dignity and respect as younger people when accessing health care services, 12% said they thought they had been afforded more dignity and respect and 4% thought less. The older age group (over 75s) and those living in more deprived areas thought they had been treated with more dignity and respect but this may reflect lower expectations, being less empowered to complain and, given higher needs in these groups, more anxiety about their future care being affected.

Respondents reported having received excellent care from health care services although a tendency to be condescending towards older people was one criticism. In addition, older people taking part in the needs assessment reported a dislike of treatment on mixed wards and unsatisfactory experiences in relation to toileting was another issue raised.

Retirement

The current retirement age is 65 for a man and 60 for a woman born prior to 5th April 1950. For women born between 6th April 1950 and 5th April 1959, the state pension age rises to 65, with further increases planned to raise the retirement age for both men and women to 68 between 2024 and 2046[21]. Retirement for many older people is associated with a considerable reduction in income, a loss of contact with other people and often ensuing poorer health and well-being. Hence, planning for retirement long before the event is important, but all too often overlooked. Recent figures suggest that the number of pensioners living in poverty has increased by 300,000 to 2,900,000 nationally, the first increase since 1998[22]. The current economic climate with rising fuel, utility and food bills will place further pressure on pensioner's finances. An estimated 2 million (almost 1 in 5) pensioners nationally are reliant on their children for financial support for care and living expenses[23].

95.6% of older people surveyed were not in paid employment, not surprising given the age group. However, although 40.3% had retired at state retirement age, almost as many (39.3%) had retired earlier, suggesting raising the retirement age may only be applicable to two fifths of the population. 9.4% of people locally had continued to work beyond retirement age and 5.1% retired at retirement age but had worked since. 20% of people who retired at retirement age would have liked to continue working but ill-health, caring responsibilities and company policy had presented barriers. Only 10.3% of older people said the were involved in voluntary work and of those who were not, almost all (96.4%) said that they did not wish to be.

Only 15.4% of older people said they had received retirement advice, more so male respondents, those in the younger age group and those living in more affluent areas. Over half of respondents thought pensions advice, information on how to stay healthy, social activities and how to access health services would have been useful and large numbers also thought information about learning opportunities, lunch clubs and befriending schemes would have been beneficial.

"I did not make any plans at all for retirement. They fired me for being 60. This was standard company policy."

Housing

Housing needs can change as a result of getting older, with certain health conditions and mobility problems resulting in difficulties getting around the home or with maintaining the home. Lack of repair work or adaptations to meet needs can make the accommodation unsuitable. The needs assessment set out to determine older people's views on housing issues and whether 'extra care housing' was something local older people would aspire to. Extra care housing includes housing in a group of properties (bought, part-bought or rented houses, bungalows or flats). It includes 24 hour on site health and social support, sometimes built alongside a care home. A range of facilities and services may include a resident's lounge, guest suite, laundry, bar/restaurant or dining room, health and fitness facilities, hobby/computer room, alarm systems, assistive technology (e.g. remote controls to operate curtains, central heating etc.), cleaning and gardening. Extra care housing has been found to have a positive impact on older people with mental health problems, by preventing them becoming isolated, and also for people with dementia. For some needs assessment study participants, owning their home was becoming a problem to them in terms of maintenance, keeping it clean and other heavy chores such as putting out the refuse/re-cycling.

"Both my wife and I suffer lung problems and other things. We own our three bedroomed semi house which we find hard to maintain."

"I can see the day when my large garden is going to be a millstone round my neck. I am finding it particularly hard at the moment as any undue exertion aggravates my hernia."

The largest proportion of respondents (28.3%) expressed a preference for more warden controlled homes for older people, 25.4% wanted to see more bungalows built and only a fifth (20.7%) cite extra care housing as preferred developments for older people in North East Lincolnshire. However, over three quarters (76.5%) did consider extra care housing in North East Lincolnshire would be a 'good idea' for older people.

Transport

Transport is a key enabler to participation in society and a means of accessing employment, services (education, health, advice etc), amenities and social activities. As well as access issues impacting on health, transport and health links include traffic accidents, pollution (air, noise and light), global warming, and community severance. Motorised transport may result in less physical activity as a result of fewer journeys on foot or by cycle but may increase physical activity by enabling access to sports and leisure facilities. Research shows lack of transport can contribute to social exclusion in urban areas but cause social exclusion in rural areas[24]. Although more older people now hold a driving licence as a result of middle aged drivers reaching older age and more women driving, people over 70 are less likely to be car drivers than adults aged between 21 and 70 years[25].

The postal survey undertaken as part of this the needs assessment showed that the most common modes of transport used by older residents to get around North East Lincolnshire are: car or van (63%), bus (37%) or on foot (28%). Not surprisingly those living in more deprived NRF areas (20%) found it more difficult to travel around North East Lincolnshire and felt more limited due to lack of transport compared with those living in non-NRF areas (14%). People who mostly used a car for their main mode of transport found it easier to get to their GP. Lack of transport exacerbates inequalities in access, with only 10% of those living in more affluent non-NRF finding it difficult to get to their GP compared to 17% in NRF areas. Similarly, travelling to the hospital is less difficult for those living in more affluent, non-NRF areas (13%), than those living in NRF areas (22% difficult). Of the 15% of people who said they are limited due to lack of transport, 43% cited a reason, most (41%) saying it was because of poor transport services and 24% saying there was a lack of transport that was suitable for their needs.

Communication

Help the Aged argue that older people from lower social groups are among the most disadvantaged in terms of access to new technology, but are also likely to be some of the most in need of public services which often (and in some cases exclusively) now publish information online. In June 2006, the government adopted the EU Riga Declaration which set out a number of targets, one of which involved halving the gap in internet use by 2010 for groups otherwise at risk of exclusion, such as older people[26].

Almost three quarters of needs assessment survey respondents (73.7%) said they did not use the internet. Significantly more men (28.8%) than women (14.0%) used the internet, more people in the 65-74 age band (28.1%) than those aged 75 and over (10.6%) and more living in non-NRF areas (23.6%) than in more deprived NRF (9.9%) used it. 72.3% said that nothing would encourage internet use, but 17.7% thought that more information and training would encourage them to use it.

72.5% of survey respondents said they have digital TV and 31.2% used the red button facility to obtain further information. More men (75.9%) than women (69.6%) have digital TV, over three quarters (79.6%) of the 65-74s having digital TV compared to 62.6% of those aged 75 and over. Similar proportions of people living in NRF areas (69.6%) and non-NRF areas (73.4%) have digital TV. Despite new technology most older people said they preferred to receive information by leaflet or magazine.

Key recommendations

The older people's needs assessment report, available on the Care Trust Plus or Council websites (www.nelctp.nhs.uk or www.nelc.gov.uk) includes detailed recommendations for every issue. However overall recommendations are:

- a need for better demographic information with which to model and forecast service requirements.
- a need to age-proof mainstream services and to develop well-planned, targeted services that support independent later life.
- that the information from this needs assessment is used to review the older people's strategy for North East Lincolnshire, *Choosing Life* and that detailed action plans are developed and implemented.
- that a commissioning strategy is developed, including older people's mental health and that the service review information is used to inform the older people's mental heath service development strategy currently being developed.
- that an outcomes framework is developed and championed for older people, similar to the very successful children's framework, Every Child Matters[27].

chapter 5

health protection

Health Protection includes the prevention and control of communicable diseases and environmental hazards, and aspects of emergency planning and response. The health protection function is not provided by any one agency, although the Health Protection Agency leads on this area. The Health Protection Partnership Board oversees the collaborative working of organisations with a health protection role; the Health Protection Partnership Plan sets out the joint priorities of all agencies with a health protection role for the period 2007 to 2009.

Communicable Diseases

A summary of the main surveillance information for notifiable diseases and gastrointestinal illnesses for 2007 is shown in tables 5.1 and 5.2 respectively. There have been no confirmed cases of measles or rubella in the area this year, although elsewhere in the country, including elsewhere in the Yorkshire and Humber region, cases have occurred and this virus remains a concern for the appreciable numbers of susceptible children and young adults in the area. There were ten notifications for mumps but only one of these was confirmed, indicating a decline in this infection from previous years.

There were 41 positive laboratory reports for hepatitis C antibodies reported during 2007, a similar number to last year but it is not possible to tell how many of these represent current infection. Most hepatitis C cases (both locally and nationally) are associated with current or former injecting drug use, the virus being transmitted by sharing contaminated injecting equipment. There was a single case of acute hepatitis B reported in addition to seven chronic hepatitis B infections. There were no hepatitis A infections confirmed during the year.

There were five laboratory confirmed cases of meningococcal infection (meningitis or septicaemia) during 2007. There were eight notifications for tuberculosis during the year including six laboratory confirmed cases. Although this represents a low incidence in the local population, each case requires careful management and follow-up, including contact tracing.

Table 5.1. Notifiable Diseases, North East Lincolnshire, 2007

Disease		Notified	Laboratory confirmed
Diphtheria		0	0
Dysentery		1	1
Food Poisoning		269	269
Leptospirosis		1	1
Malaria		1	1
Measles		8	0
Meningitis	Meningococcal	4	4
	Pneumococcal	2	2
	Viral	2	1
	Haemophilus influenzae	0	0
Meningococcal septicaemia		2	1
Mumps		10	1
Ophthalmia neonatorum		0	0
Rubella		3	0
Scarlet Fever		12	1
Tuberculosis		8	6
Typhoid Fever		0	0
Viral Hepatitis	Hepatitis A	0	0
	Hepatitis B – acute	1	1
	Hepatitis B – chronic/unknown	7	7
	Hepatitis C antibody positive	41	41
Whooping cough		2	1

Source: Humber Health Protection Unit

Food Poisoning and Gastrointestinal Infections

The commonest gastrointestinal organism was Campylobacter, with 208 cases. Less commonly identified gastrointestinal organisms included salmonella (32), giardia (10) and cryptosporidium (9).

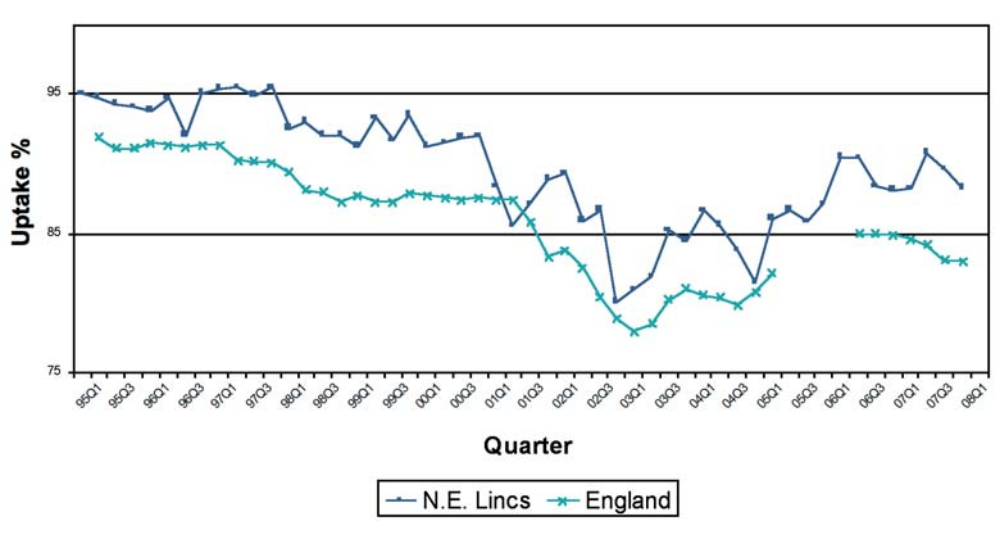
Organism	
Salmonella	32
Campylobacter	208
E.coli 0157	0
Shigella	1
Giardia Lamblia	10
Cryptosporidiosis	9

Source: Humber Health Protection Unit

Immunisation

Figure 5.1 shows that the uptake of the first dose of MMR by 24 months has reached a plateau after some recovery in previous years. The Department of Health has launched a programme to increase coverage of this vaccine in older children and young adults to prevent outbreaks among the increasing numbers of susceptible persons in the population.

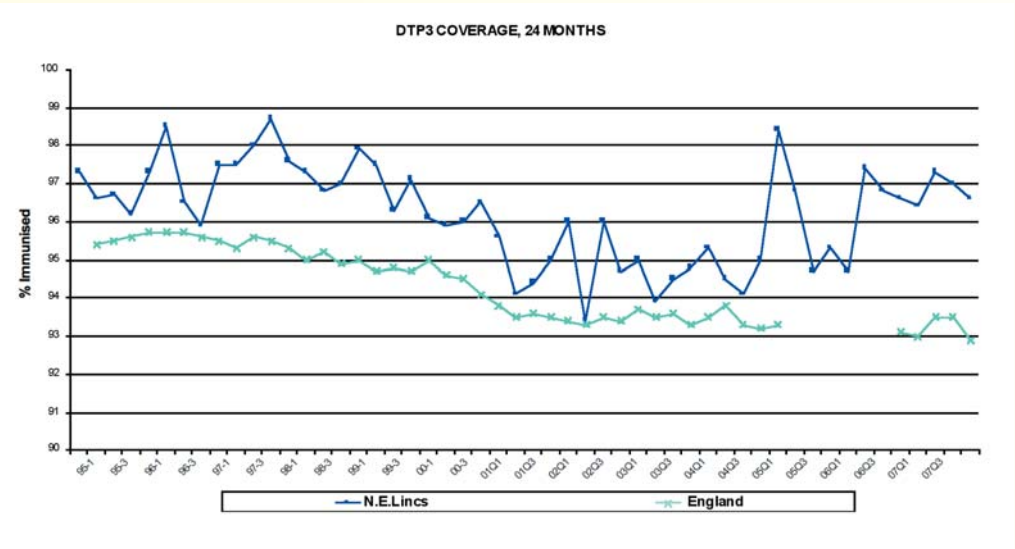
Figure 5.1. Quarterly uptake of first dose of MMR vaccine (MMR1) in North East Lincolnshire and England at 24 months, 1995-2007



(Data for England incomplete owing to problems with Child Health systems in some areas)

Figure 5.2 shows national and PCT uptake of completed primary courses of diphtheria vaccine (D3) at age 24 months, thus providing an indication of the uptake of the infant primary schedule. Overall uptake has improved in recent years and has remained fairly stable at around 97% over the last year.

Figure 5.2. Quarterly uptake of completed primary courses of diphtheria vaccine (D3) in North East Lincolnshire and England at 24 months, 1995-2007



The Care Trust Plus, with support from the Health Protection Agency, is in the process of implementing the new human papillomavirus (HPV) vaccine programme for adolescent girls which started in September 2007. This is the first widely used vaccine in the UK which is aimed at preventing cancer, in this case cervical cancer in women.

HIV and AIDS

During 2007, a total of 36 people from North East Lincolnshire accessed treatment and care services for HIV/AIDS (four more than last year and eleven more than 2005), nine female and 27 male. 26 patients are known to be receiving various combinations of anti-retroviral drugs, ranging from dual to quadruple therapy; this is five more than last year. There were no deaths recorded in this group during the year.

All nine female cases and 11 of the 27 male cases were acquired heterosexually. 16 of the 27 male cases were acquired through sex between men. In terms of ethnic group, overall 25 are white and 9 of black African origin.

KEY POINTS

- *The Care Trust Plus is working closely with the North Yorkshire and Humber Health Protection Unit on a range of health protection issues set out in the three year Health Protection Partnership Plan*
- *The Care Trust Plus has launched the implementation of the new human papillomavirus (HPV) vaccination programme for teenage girls this autumn*
- *Further information is available in the North Yorkshire and Humber Health Protection Unit Annual Report*

chapter 6

conclusions and recommendations

One of the great things about North East Lincolnshire is the enthusiasm to improve our lot, whether that be the huge response of older people to our long and complicated questionnaire that over 2000 people returned to us as part of the Older Peoples Needs Assessment, the 2300 teenagers who completed the Adolescent Lifestyle Survey or the staff who went above and beyond to produce the Joint Strategic Needs Assessment. With all this information now available on health and social needs, we have the opportunity to develop a range of new activities and approaches to meet these needs. In this way we will be able to justify this enthusiasm and add to the wellbeing and quality of life for residents of the borough. My recommendations are largely about putting this in place.

1. *I recommend that the Joint Strategic Needs Assessment is used to inform the development of the Care Trust Plus Strategic Commissioning Plans, the review of the Sustainable Community Strategy and the Councils Medium Term Financial Plan*
2. *I recommend that obesity prevention should be a high priority for the Council, Care Trust Plus and other partners. Action should be directed to the entire population but particular focus should be given to those from areas of higher deprivation, such as those living in East Marsh, West Marsh, Nunsthorpe and the other neighbourhood renewal areas*
3. *I recommend that diabetes prevention and prevention strategies and services should be targeted at those from areas of higher deprivation and also at other individuals at higher risk of developing diabetes, such as obese individuals and those with glucose intolerance*
4. *I recommend that we ensure all children and young people understand the importance of breakfast and are able to afford and eat breakfast everyday. Consideration should be given to making breakfast more available in school settings*
5. *I recommend that consideration is given to reducing the availability of illicit and illegally imported tobacco*
6. *I recommend that all those working with young people should be able to undertake brief interventions and know where to signpost young people who identify the need for support with their drinking habits*
7. *I recommend that the Older Peoples Needs Assessment is used to inform the revision of the Older Peoples Strategy.*

Dr Tony Hill

Joint Executive Director of Public Health

chapter 7

epidemiological overview

This chapter provides demographic and health status information for the population of North East Lincolnshire. Regional data included are those for the government office region of Yorkshire and the Humber, and national data are for England. Where data is not available for the North East Lincolnshire Unitary Authority area, data for the North East Lincolnshire CTP area is included for information.

The data source is the Compendium of Clinical and Health Indicators (http://www.nchod.nhs.uk) as of December 2008, unless otherwise stated. Numbers and rates that are based on a count of less than five have not been disclosed, as advised by the Department of Health and the Office for National Statistics. Local data has also been collected and incorporated for the section on Public Health Programmes.

Although the Care Trust Plus was not established until 1st September 2007 and these data apply to time periods prior to this, for consistency the terminology North East Lincolnshire CTP area has been used in this section.

chapter 6

conclusions and recommendations

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Section A – Population and Demography

Table A1: 2007 Mid-year Resident Population Estimates (2001 Census Based)

Ages	0-4	5-9	10-14	15-19	20-24	25-29	30-34	35-39	40-44
Males	4,800	4,700	5,300	6,100	5,300	4,000	4,100	5,300	5,900
Females	4,500	4,500	5,100	5,800	4,800	4,500	4,300	5,700	6,300
Persons	9,200	9,200	10,400	11,800	10,100	8,500	8,400	11,000	12,200

Ages	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80-84	85+	All Ages
Males	5,600	4,900	5,000	4,600	3,700	3,200	2,400	1,500	1,000	77,400
Females	5,600	4,900	4,900	4,700	3,900	3,700	3,000	2,400	2,500	80,900
Persons	11,300	9,800	9,900	9,300	7,500	6,900	5,500	3,900	3,400	158,400

Source: Office for National Statistics

Table A2: Life Expectancy (EOL), Number of Years and Rank, 2005-2007, by Gender

	MALES				FEMALES			
	ENGLAND	Y&H	NELUA	NELUA RANK	ENGLAND	Y&H	NELUA	NELUA RANK
EOL	77.65	76.89	76	304	81.81	81.10	80.8	285

*Rank out of 352 Local Authorities

Section B – Pregnancy, Mother and Child

Table B1: General Fertility Rate (2007)*

England	62.13
Yorkshire & the Humber	60.35
North East Lincolnshire CTP	63.19

*Live births per 1000 women aged 15-44 years

Table B2: Abortions 2007 – NHS/Non-NHS

	NHS	NHS Agency*	Non-NHS
England	37.0%	51.4%	11.6%
Yorkshire & the Humber	57.0%	33.5%	9.5%
North East Lincolnshire CTP	94.0%	+	+

*Operations carried out in the private sector on NHS patients

+Figures have not been presented due to data suppression at source.

Table B3: Abortion Rates by Maternal Age (per 1,000 women) - 2007

	<18years	18-19 years	20-24 years*	25-29 years	30-34 years	35+ years
England	19.9	34.1	32.3	23.9	15.9	7.0
Yorkshire & the Humber	20.7	30.9	26.4	19.6	12.8	5.7
North East Lincolnshire CTP	24.7	41.2	37.0	26.0	14.6	5.3

*Includes age unknown

Table B4: Number of Abortions by Maternal Age - 2007

	<18years	18-19 years	20-24 years*	25-29 years	30-34 years	35+ years
England	19,246	22,457	54,322	39,997	26,217	27,495
Yorkshire & the Humber	2,090	2,246	4,999	3,194	1,968	2,186
North East Lincolnshire CTP	85	97	179	117	63	64

*Includes age unknown

Table B5: Percentage of Abortions by Gestational Age (in weeks) - 2007

	Under 10 weeks	10-12 weeks	13+ weeks
England	70.3%	19.5%	10.3%
Yorkshire & the Humber	63.8%	25.5%	10.7%
North East Lincolnshire CTP	67.4%	24.3%	8.3%

Table B6: Percentage of births under 1500 grams & under 2500 grams - 2007

	<1500g	<2500g
England	1.4%	7.5%
Yorkshire & the Humber	1.5%	8.1%
North East Lincolnshire CTP	1.7%	8.0%

Table B7: Number of Live and Still Births by Maternal Age - 2007

		1-15 years	16-19 years	20-24 years	25-34 years	35-39 years	40 years+	Total
England	Live births	1,064	40,714	122,968	355,842	110,424	24,345	655,357
	Still births	11	226	656	1,771	565	185	3,414
NELCTP	Live births	7	266	555	934	190	39	1,991
	Still births	<5	<5	<5	<5	<5	<5	14

Table B8: Perinatal Mortality (Stillbirths & Deaths under 7 days – Rate per 1,000 Total Births) and Infant Mortality (Deaths under 1 year – Rate per 1,000 Live Births) Numbers and Rates (2007)

	England			Yorkshire & the Humber			NE Lincolnshire CTP		
Area	No.	Rate	CI	No.	Rate	CI	No.	Rate	CI
Perinatal Mortality	5,095	7.7	(7.5-7.9)	566	8.8	(8.1-9.5)	25	12.5	(8.4-18.4)
Infant Mortality	3,127	4.8	(4.6-4.9)	362	5.6	(5.1-6.2)	17	8.5	(5.3-13.7)

*CI is the range of the Confidence Interval at 95%

Section C – Public Health Programmes

Table C1: NELPCT Antenatal Screening Uptake 2004-2007

YEAR	2004	2005	2006	2007
Total Bookings	2373	2438	2582	2648
Rubella	2276 (95.8%) tested 1 declined / 97 missing 35 (1.9%) negative/low level for antibodies	2360 (96.8%) tested 62 (2.6%) negative/low level for antibodies	(98.8%) tested 93 (3.6%) negative/low level for antibodies	2591 (98%) tested 163 (6%) negative/low level for antibodies
Syphilis	2180 (91.8%) tested 0 positive tests	2327 (95.4%) tested 4 positive tests	2576 (98.5%) tested 4 positive tests	2578 (97%) tested 3 positive tests
Hepatitis B	2086 (87.9%) tested 1 declined / 287 missing 1 (0.05%) positive tests	2330 (95.6%) tested 7 (0.3%) positive tests	2567 (98.2%) tested 2 positive tests	2572 (97%) tested 5 positive tests
HIV	2162 (91%) tested 211 missing data 0 positive tests	2240 (91.9%) tested 0 positive tests	2434 (93.1%) tested 36 missing data 1 positive test	2513 (95%) tested 0 positive tests
Alpha Feto Protein (AFP)/Down's Syndrome Screening	1309 (55.2%) screened 74 increased risk 5.7% screen positive rate 16 (1.2%)raised AFP	1269 (52%) 49 increased risk 3.9% screen positive rate	1163 (44.5%) screened 57 increased risk 4.9% screen positive rate	1256 (45.8%) screened 46 High risk 3.6% screen positive rate

Source: NE Lincolnshire CTP Antenatal and Child Health Screening Annual Report 2008

Table C2: Uptake of Newborn Hearing Screening in 2006/7 and 2007/8 in NELCTP

	Total Number of Newborns in CTP 2007/8	Total No. Tested	Percentage Uptake 2007/8	Outcome (No. Referred) in 2007/8	Percentage Uptake 2006/7
Newborn Hearing Screening	2009	Attempted 1996 Completed 1939	Attempted (99.4%) Completed (96.5%)	Bilateral 9 (0.5%) Unilateral 33 (1.7%)	Attempted (99.0%) Completed (95.0%)

Source: NE Lincolnshire CTP Antenatal and Child Health Screening Annual Report 2008

Table C3: Breast Cancer Screening in NELCTP for 2006 and 2007 (Women aged 53-64 years)

	As At 31st March 2006			*As At 31st March 2007*		
	Eligible Population	No. of Women Screened	Coverage (Less than 3 years since last test) %	Eligible Population	No. of Women Screened	Coverage (Less than 3 years since last test)
England	3,633,181	2,756,716	75.9	3,690,074	2,805,717	76.0
Yorkshire & the Humber	367,582	285,477	77.7	373,320	282,165	75.6
North East Lincolnshire CTP	12,004	8,514	70.9	12,142	9,572	78.8

Source: NHS Cancer Screening Programmes (http://www.cancerscreening.nhs.uk)

Table C4: Cervical Cancer Screening in NELCTP for 2006/07 and 2007/08 (Women aged 25-64 years)

	2006-07			*2007-08*		
	Eligible Population	Coverage (Less than 3.5 yrs since last adequate test) %	Coverage (Less than 5 years since last adequate test) %	Eligible Population	Coverage (Less than 3.5 yrs since last adequate test) %	Coverage (Less than 5 years since last adequate test) %
England	13,192,900	69.4	79.2	13,305,200	69.0	78.6
Yorkshire & the Humber	1,281,000	69.0	80.2	1,286,500	68.0	79.8
North East Lincolnshire CTP	39,600	66.4	79.8	39,300	64.2	80.2

Source: NHS Cancer Screening Programmes (http://www.cancerscreening.nhs.uk)

Table C5: Uptake of Chlamydia Screening in 2006/7 and 2007/8 in NELCTP

	Total No. Tested	**Results (Males)**	**Results (Females)**
Chlamydia Screening	1841	Positive - 92 (16.9%) Negative - 440 (80.9%) Other - 12 (2.2%)	Positive - 173 (13.3%) Negative - 1085 (84.7%) Other - 39 (3%)

Source: COAST

Table C6: Smoking – Setting a Quit Data and Successful Quitters per 100,000 Population (2007/08)

	Number Setting A Quit Date	No. Successfully Quit at 4 weeks (Self Reporting)	% Successfully Quit at 4 weeks (Self Reporting)	No. Successfully Quit per 100,000 of Population (16 yrs and Over)
England	680,289	350,800	52.57	853.76
Yorkshire & the Humber	66,545	35,440	53.26	851.67
North East Lincolnshire CTP	1,283	761	59.31	593.55

Source: NHS Information Centre

Table C7: Health Trainer Programme Activity (2007-2008)

Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Tot
Total New Clients	13	40	47	57	24	44	31	36	12	39	32	41	416
Ongoing Clients				1	4	8	8	10	10	8	6	6	61
Total Sessions	14	90	127	172	124	150	162	167	95	119	132	168	1520
Formal Stands	11	18	35	14	15	15	11	14	14	13	12	20	192
Signposted to Other Services	0	35	34	57	76	96	102	51	27	90	70	58	696
Referrals to Smoking Cessation	0	1	0	3	2	3	1	2	2	2	0	0	16

Source: Health Trainer Monthly Outcomes Database

Section D – Cancers

The source for the following data is provided by the Northern and Yorkshire Cancer Registry Information Services (NYCRIS). The data is the age-standardised rates per 100,000 of the population (European) for selected cancers, by gender (1997-2006).

Table D1a: Incidence (Males)

Cancer/Site	MALES 1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
C67: Bladder	29.1	30.3	20.0	20.5	24.4	19.3	16.5	21.0	25.0	19.3
C18-C20: Colorectal	48.5	50.2	50.8	53.2	48.8	63.0	51.3	50.3	50.9	48.0
C00-C14 + C30-C32: Head & Neck (exc. Thyroid)	18.7	16.0	21.3	26.7	17.0	18.5	17.5	21.4	13.0	17.9
C64: Kidney, except renal pelvis	8.2	7.3	11.9	17.5	8.2	13.8	8.2	8.3	8.0	15.0
C91-C95: Leukaemia	15.0	16.7	12.1	18.0	12.8	12.4	9.8	15.9	14.1	13.3
C33-C34: Trachea, Bronchus and Lung	62.9	75.4	76.8	81.9	59.8	73.0	70.1	72.8	55.7	54.8
C82-C85 + C96: Non-Hodgkin's lymphoma1	6.5	15.4	12.0	11.9	17.2	12.2	20.7	12.1	16.1	21.4
C15: Oesophagus	17.5	17.2	15.8	12.6	9.4	8.9	29.3	9.9	15.7	11.2
C25: Pancreas	11.2	11.8	12.9	8.7	8.3	9.6	1.2	5.8	9.2	7.3
C61: Prostate	62.5	57.2	62.3	76.0	110.8	119.4	101.5	82.1	93.0	92.9
C16: Stomach	25.8	16.5	20.0	25.4	14.8	18.1	21.0	11.6	26.6	15.2
C50: Female Breast	-	-	-	-	-	-	-	-	-	-
C53: Cervix uteri	-	-	-	-	-	-	-	-	-	-
C56-C574: Ovary	-	-	-	-	-	-	-	-	-	-
C00-97: All malignant (exc. NM Skin)	402.2	387.4	392.9	426.5	431.3	443.1	412.9	395.3	404.3	392.4

Table D1b: Incidence (Females)

Cancer/Site	FEMALES 1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
C67: Bladder	9.0	7.8	9.4	5.2	2.4	6.2	6.0	6.9	7.2	1.9
C18-C20: Colorectal	39.5	37.6	37.0	36.0	28.1	32.1	26.8	31.0	34.8	25.2
C00-C14 + C30-C32: Head & Neck (exc. Thyroid)	10.0	5.5	5.1	10.1	5.2	10.0	8.1	10.3	6.8	2.8
C64: Kidney, except renal pelvis	5.7	6.6	10.2	9.4	6.0	1.7	4.3	4.5	5.7	4.7
C91-C95: Leukaemia	3.2	6.5	5.7	6.8	7.2	9.9	6.6	5.6	7.3	8.1
C33-C34: Trachea, Bronchus and Lung	29.0	32.3	37.6	29.6	41.0	28.8	34.0	37.5	27.9	32.6
C82-C85 + C96: Non-Hodgkin's lymphoma	3.6	9.2	7.4	9.1	10.2	7.9	7.8	11.1	16.7	12.4
C15: Oesophagus	6.0	8.0	6.8	5.2	4.3	6.3	2.2	8.4	6.4	5.6
C25: Pancreas	15.8	6.5	8.4	8.5	3.2	9.5	7.7	6.7	6.6	6.7
C61: Prostate	-	-	-	-	-	-	-	-	-	-
C16: Stomach	4.7	7.3	3.0	6.2	9.1	8.8	7.0	5.3	7.3	4.8
C50: Female Breast	107.1	112.2	103.4	120.9	127.2	128.2	105.1	101.9	131.9	106.2
C53: Cervix uteri	10.3	13.4	18.0	13.3	26.4	17.2	12.5	15.3	18.5	15.2
C56-C574: Ovary	23.6	28.4	14.2	17.9	19.5	14.3	10.4	14.4	17.5	12.6
C00-97: All malignant (exc. NM Skin)	331.8	344.4	332.3	349.8	368.9	353.3	319.4	337.8	384.3	328.7

Source: NYCRIS

Table D1c: Incidence (All Persons)

PERSONS										
Cancer/Site	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**
C67: Bladder	19.0	19.1	14.7	12.8	13.4	12.8	11.3	14.0	16.1	10.6
C18-C20: Colorectal	44.0	43.9	43.9	44.6	38.4	47.6	39.1	40.7	42.9	36.6
C00-C14 + C30-C32: Head & Neck (exc. Thyroid)	14.3	10.7	13.2	18.4	11.1	14.2	12.8	15.9	9.9	10.4
C64: Kidney, except renal pelvis	7.0	7.0	11.1	13.5	7.1	7.7	6.3	6.4	6.9	9.9
C91-C95: Leukaemia	9.1	11.6	8.9	12.4	10.0	11.1	8.2	10.8	10.7	10.7
C33-C34: Trachea, Bronchus and Lung	46.0	53.9	57.2	55.7	50.4	50.9	52.0	55.2	41.8	43.7
C82-C85 + C96: Non-Hodgkin's lymphoma	10.1	12.3	9.7	10.5	13.7	10.0	14.3	11.6	16.4	16.9
C15: Oesophagus	11.7	12.6	11.3	8.9	6.9	7.6	15.8	9.2	11.1	8.4
C25: Pancreas	13.5	9.2	10.7	8.6	5.7	9.6	4.4	6.2	7.9	7.0
C61: Prostate-	-	-	-	-	-	-	-	-	-	-
C16: Stomach	15.2	11.9	11.5	15.8	11.9	13.5	14.0	8.5	17.0	10.0
C50: Female Breast	-	-	-	-	-	-	-	-	-	-
C53: Cervix uteri	-	-	-	-	-	-	-	-	-	-
C56-C574: Ovary	-	-	-	-	-	-	-	-	-	-
C00-97: All malignant (exc. NM Skin)	367.0	365.9	362.6	388.2	400.1	398.2	366.2	366.6	394.3	360.5

Table D2a: Mortality Rates (Males)

MALES										
Cancer/Site	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**
C67: Bladder	13.8	15.3	7.1	11.2	10.8	7.1	10.1	14.1	10.8	8.5
C18-C20: Colorectal	30.2	40.6	25.7	20.8	24.8	29.8	18.8	24.4	27.4	24.5
C00-C14 + C30-C32: Head & Neck (exc. Thyroid)	11.0	4.3	5.5	6.3	6.6	5.5	11.2	8.9	5.3	4.5
C64: Kidney, except renal pelvis	8.8	3.1	5.4	10.3	3.3	4.6	4.2	3.6	3.6	6.7
C91-C95: Leukaemia	5.9	7.1	6.9	3.2	6.7	7.7	8.3	6.4	4.9	6.9
C33-C34: Trachea, Bronchus and Lung	76.1	62.3	68.6	81.4	59.8	62.4	65.7	59.8	53.5	58.0
C82-C85 + C96: Non-Hodgkin's lymphoma	8.2	9.6	6.9	8.3	7.2	9.5	8.8	9.6	6.6	5.1
C15: Oesophagus	20.5	13.6	13.6	15.9	19.8	10.0	11.3	19.0	18.5	16.6
C25: Pancreas	12.0	11.1	13.3	4.6	8.1	7.1	4.6	3.2	7.7	9.8
C61: Prostate	37.1	20.8	27.1	32.1	34.8	37.0	33.4	26.1	27.4	24.8
C16: Stomach	13.5	15.0	13.8	8.9	13.4	12.1	9.4	10.9	15.7	3.8
C50: Female Breast	-	-	-	-	-	-	-	-	-	-
C53: Cervix uteri	-	-	-	-	-	-	-	-	-	-
C56-C574: Ovary	-	-	-	-	-	-	-	-	-	-
C00-97: All malignant (exc. NM Skin)	289.2	256.5	249.2	264.9	255.9	250.7	252.6	247.1	220.8	231.4

Table D2b: Mortality Rates (Females)

FEMALES										
Cancer/Site	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**
C67: Bladder	6.9	5.3	7.0	4.8	3.3	4.7	2.1	6.3	1.6	3.9
C18-C20: Colorectal	17.2	19.3	11.9	19.9	13.9	8.4	15.8	13.4	12.9	20.7
C00-C14 + C30-C32: Head & Neck (exc. Thyroid)	3.7	2.9	2.5	0.0	6.2	1.6	4.3	4.4	3.6	3.6
C64: Kidney, except renal pelvis	3.3	6.6	3.2	4.2	1.8	1.3	2.8	2.4	1.4	2.9
C91-C95: Leukaemia	3.3	2.2	1.4	1.6	3.2	6.1	2.8	1.3	9.4	1.2
C33-C34: Trachea, Bronchus and Lung	21.2	24.8	29.7	33.3	34.6	26.0	31.1	20.7	28.6	33.2
C82-C85 + C96: Non-Hodgkin's lymphoma	5.5	5.2	1.9	8.6	0.4	3.7	5.3	0.8	7.9	1.2
C15: Oesophagus	6.9	3.9	4.4	3.6	4.4	4.7	1.2	5.1	6.1	5.6
C25: Pancreas	12.3	8.2	9.0	7.2	1.7	8.7	10.1	5.3	6.4	8.2
C61: Prostate	-	-	-	-	-	-	-	-	-	-
C16: Stomach	7.1	5.6	7.0	2.9	2.8	4.8	4.6	4.3	6.1	1.0
C50: Female Breast	35.0	34.9	30.6	31.6	32.0	27.0	38.9	27.2	25.2	21.3
C53: Cervix uteri	7.3	6.0	5.7	5.0	2.3	4.5	2.7	1.8	6.6	7.6
C56-C574: Ovary	13.8	18.6	16.8	3.5	8.2	14.7	9.3	4.1	13.9	11.0
C00-97: All malignant (exc. NM Skin)	181.4	171.7	162.1	165.4	159.2	159.2	170.2	135.4	166.3	163.1

Table D2c: Mortality Rates (All Persons)

Cancer/Site	PERSONS 1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
C67: Bladder	10.3	10.3	7.1	8.0	7.1	5.9	6.1	10.2	6.2	6.2
C18-C20: Colorectal	23.7	29.9	18.8	20.4	19.4	19.1	17.3	18.9	20.1	22.6
C00-C14 + C30-C32: Head & Neck (exc. Thyroid)	7.3	3.6	4.0	3.2	6.4	3.6	7.8	6.6	4.5	4.0
C64: Kidney, except renal pelvis	6.0	4.9	4.3	7.3	2.5	2.9	3.5	3.0	2.5	4.8
C91-C95: Leukaemia	4.6	4.6	4.1	2.4	4.9	6.9	5.5	3.9	7.1	4.1
C33-C34: Trachea, Bronchus and Lung	48.7	43.6	49.2	57.4	47.2	44.2	48.4	40.3	41.1	45.6
C82-C85+C96: Non-Hodgkin's lymphoma	6.9	7.4	4.4	8.5	3.8	6.6	7.1	5.2	7.2	3.2
C15: Oesophagus	13.7	8.7	9.0	9.7	12.1	7.3	6.3	12.1	12.3	11.1
C25: Pancreas	12.1	9.6	11.1	5.9	4.9	7.9	7.3	4.3	7.1	9.0
C61: Prostate	-	-	-	-	-	-	-	-	-	
C16: Stomach	10.3	10.3	10.4	5.9	8.1	8.5	7.0	7.6	10.9	2.4
C50: Female Breast	-	-	-	-	-	-	-	-	-	
C53: Cervix uteri	-	-	-	-	-	-	-	-	-	
C56-C574: Ovary	-	-	-	-	-	-	-	-	-	
C00-97: All malignant (exc. NM Skin)	235.3	214.1	205.6	215.1	207.6	204.9	211.4	191.3	193.5	197.3

Section E - MORTALITY DATA

Table E1: Numbers (2007, Ages 1yr+) and SMRs (2005 - 2007, All Ages) for Selected Causes of Death

CONDITION	PERSONS No.	SMR	(95% CI)	MALES No.	SMR	(95% CI)	FEMALES No.	SMR	(95% CI)
All Cancers	436	106	(100-112)	219	106	(98-114)	217	107	(99-115)
- Lung Cancer	106	107	(95-120)	68	115	(99-134)	38	96	(79-115)
- Colorectal Cancer	35	102	(86-121)	20	104	(82-131)	15	100	(76-128)
- Bladder Cancer	20	126	(94-167)	10	122	(84-173)	10	134	(79-212)
- Melanoma	<5	90	(49-150)	<5	93	(40-184)	<5	85	(31-185)
All Circulatory Diseases	594	111	(106-117)	303	113	(106-121)	291	110	(103-117)
Accidents	39	123	(103-147)	24	139	(110-174)	15	105	(77-138)
- Land Transport Accidents	15	160	(114-127)	>5	144	(95-209)	<5	206	(110-353)
Suicide & Undetermined Injury	12	83	(56-116)	>5	100	(67-144)	<5	30	(6-88)

Table E2: Numbers (2007) and SMRs (2005 - 2007) for All Causes of Death by Age Range

ALL CAUSES	PERSONS No.	SMR	(95% CI)	MALES No.	SMR	(95% CI)	FEMALES No.	SMR	(95% CI)
Ages under 1	17	122	(91-161)	>5	128	(86-182)	<5	115	(70-177)
Ages 1-14	<5			<5			<5		
Ages 15-64	278	118	(110-126)	177	117	(107-128)	101	119	(106-132)
Ages 65-74	315	118	(111-126)	195	122	(112-132)	120	113	(102-125)
Ages 75+	1,116	*	*	456	*	*	660	*	*
All ages	1,711	108	(105-111)	830	111	(107-116)	881	106	(102-110)

*Data not available

Age-standardised Mortality Rates per 100,000 Population, by Gender, 1998-2007. (Selected Indicators, Saving Lives: Our Healthier Nation)

Table E3a: All Circulatory Disease (Males)

	AREA	MALES 1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
Ages under 65	NELUA	95.34	80.04	88.17	93.08	67.04	73.88	65.30	67.47	76.06	72.49
	NELCTP	-	-	-	-	66.30	73.07	65.92	66.70	75.21	75.42
Ages 65-74	NELUA	1467.88	998.68	1108.57	1315.29	1041.70	1035.86	956.70	858.06	898.78	1069.74
	NELCTP	-	-	-	-	1033.71	1072.13	964.43	850.42	919.32	1089.10
Ages under 75	NELUA	195.42	147.03	162.57	182.20	138.11	144.03	130.30	125.12	136.05	145.20
	NELCTP	-	-	-	-	136.84	145.92	131.43	123.85	136.76	149.34
All ages	NELUA	390.92	330.22	352.24	347.27	327.73	299.33	295.79	265.98	279.63	284.84
	NELCTP	-	-	-	-	328.18	302.52	298.60	263.77	279.40	288.23

Table E3b: All Circulatory Disease (Females)

		FEMALES									
	AREA	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
Ages under 65	NELUA	44.86	42.92	28.32	25.72	19.80	16.34	38.67	30.19	38.29	17.40
	NELCTP	-	-	-	-	19.62	16.18	38.27	29.87	37.91	18.40
Ages 65-74	NELUA	805.82	610.24	653.02	597.23	611.75	500.70	504.89	488.90	445.63	395.74
	NELCTP	-	-	-	-	607.42	496.78	500.95	498.69	441.95	392.35
Ages under 75	NELUA	100.34	84.28	73.87	67.39	62.96	51.65	72.66	63.64	67.99	44.99
	NELCTP	-	-	-	-	62.48	51.22	72.01	64.06	67.37	45.66
All ages	NELUA	251.20	225.32	207.29	196.65	190.34	189.34	185.49	178.66	180.69	152.26
	NELCTP	-	-	-	-	190.12	188.74	184.87	178.99	179.94	152.79

Table E3c: All Circulatory Disease (All Persons)

		ALL PERSONS									
	AREA	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
Ages under 65	NELUA	69.86	61.26	58.02	59.29	43.42	45.12	52.10	48.95	57.21	44.91
	NELCTP	-	-	-	-	42.98	44.65	52.21	48.42	56.61	46.88
Ages 65-74	NELUA	1114.33	793.82	861.44	933.79	813.99	752.10	716.51	662.24	658.69	719.08
	NELCTP	-	-	-	-	807.97	767.24	718.17	663.80	666.53	727.29
Ages under 75	NELUA	146.02	114.68	116.60	123.06	99.60	96.67	100.54	93.67	101.07	94.07
	NELCTP	-	-	-	-	98.76	97.34	100.77	93.29	101.08	96.50
All ages	NELUA	310.75	269.34	267.07	264.30	246.36	242.75	233.72	219.61	225.49	212.99
	NELCTP	-	-	-	-	246.30	243.69	234.58	218.85	225.11	215.05

Table E4a: Coronary Heart Disease (Males)

		MALES									
	AREA	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
Ages under 65	NELUA	68.44	63.74	65.11	65.94	46.81	48.05	40.34	42.19	55.89	50.88
	NELCTP	-	-	-	-	46.29	47.52	41.23	41.71	55.26	52.86
Ages 65-74	NELUA	944.52	582.80	781.74	896.02	690.83	743.87	583.39	592.60	586.29	722.65
	NELCTP	-	-	-	-	685.52	782.55	593.99	587.31	609.70	714.82

Table E4b: Coronary Heart Disease (Females)

		FEMALES									
	AREA	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
Ages under 65	NELUA	21.72	20.81	17.98	12.81	4.30	8.16	18.00	12.97	12.78	5.58
	NELCTP	-	-	-	-	4.27	8.08	17.82	12.83	12.65	6.71
Ages 65-74	NELUA	534.01	301.24	354.78	376.92	266.18	258.53	238.50	272.33	229.92	229.42
	NELCTP	-	-	-	-	264.31	256.50	236.65	283.92	228.03	227.43

Table E4c: Coronary Heart Disease (All Persons)

		ALL PERSONS									
	AREA	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
Ages under 65	NELUA	44.85	42.07	41.30	39.35	25.53	28.15	29.25	27.64	34.39	28.19
	NELCTP	-	-	-	-	25.27	27.86	29.61	27.33	34.03	29.75
Ages 65-74	NELUA	725.08	433.64	551.37	619.99	465.81	486.33	400.25	423.21	397.58	466.93
	NELCTP	-	-	-	-	462.36	503.59	404.38	426.82	407.72	462.50

Table E5a: Stroke (Males)

		MALES									
	AREA	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
Ages under 65	NELUA	16.85	5.88	14.20	13.22	10.17	11.02	10.07	17.43	5.42	6.60
	NELCTP	-	-	-	-	10.06	10.89	9.96	17.24	5.36	7.73
Ages 65-74	NELUA	247.84	230.80	195.35	239.14	261.56	86.90	243.78	96.98	168.81	132.03
	NELCTP	-	-	-	-	259.58	86.19	241.91	96.12	167.28	146.05

Table E5b: Stroke (Females)

		FEMALES									
	AREA	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
Ages under 65	NELUA	7.90	13.13	9.13	4.31	9.77	8.18	8.03	5.63	10.00	6.82
	NELCTP	-	-	-	-	9.68	8.09	7.95	5.57	9.89	6.75
Ages 65-74	NELUA	192.10	192.16	181.67	102.85	191.04	124.96	152.23	148.91	59.29	87.36
	NELCTP	-	-	-	-	189.69	124.01	151.03	147.66	58.72	86.62

Table E5c: Stroke (All Persons)

ALL PERSONS

	AREA	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
Ages under 65	NELUA	12.37	9.51	11.65	8.67	9.99	9.59	9.12	11.55	7.74	6.68
	NELCTP	-	-	-	-	9.89	9.49	9.02	11.43	7.65	7.20
Ages 65-74	NELUA	217.81	211.12	187.14	166.83	224.00	107.31	194.91	124.43	110.88	109.15
	NELCTP	-	-	-	-	222.37	106.47	193.39	123.35	109.89	115.63

Table E6a: Cancers (Males)

MALES

	AREA	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
All Cancers											
Ages under 65	NELUA	80.24	76.63	83.49	80.72	76.17	84.23	95.38	71.32	73.54	52.13
	NELCTP	-	-	-	-	75.33	83.29	97.03	71.85	74.31	51.53
Ages 65-74	NELUA	1254.40	1014.65	1458.86	1013.48	1284.63	1154.06	960.76	1108.49	1129.87	983.07
	NELCTP	-	-	-	-	1304.22	1144.53	968.43	1098.59	1119.38	972.60
Ages under 75	NELUA	165.86	145.02	183.77	148.73	164.28	162.24	158.48	146.95	150.56	120.01
	NELCTP	-	-	-	-	164.94	160.67	160.57	146.72	150.51	118.69
All ages	NELUA	265.46	250.68	272.62	258.78	251.83	253.67	247.67	228.08	229.49	207.78
	NELCTP	-	-	-	-	252.82	252.28	249.10	227.30	231.46	206.92
Breast Cancer											
Ages 50- 69	NELUA	-	-	-	-	-	-	-	-	-	-
	NELCTP	-	-	-	-	-	-	-	-	-	-
Lung Cancer											
Ages under 75	NELUA	37.79	44.13	59.06	34.30	48.08	44.11	43.26	40.42	37.66	34.91
	NELCTP	-	-	-	-	48.78	43.68	44.08	40.01	37.27	34.52

Table E6a: Cancers (Females)

FEMALES

	AREA	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
All Cancers											
Ages under 65	NELUA	88.44	67.80	81.50	71.85	73.04	75.24	55.48	77.40	70.64	63.53
	NELCTP	-	-	-	-	72.36	74.52	54.89	78.09	69.91	62.83
Ages 65-74	NELUA	669.54	699.32	735.45	589.65	567.93	757.93	595.04	687.79	789.25	689.55
	NELCTP	-	-	-	-	563.66	751.89	590.40	682.14	794.68	698.41
Ages under 75	NELUA	130.81	113.85	129.18	109.60	109.12	125.02	94.82	121.91	123.04	109.17
	NELCTP	-	-	-	-	108.19	123.91	93.94	122.14	122.76	109.17
All ages	NELUA	175.87	163.51	170.55	159.06	160.10	173.28	135.73	168.46	164.77	161.71
	NELCTP	-	-	-	-	158.92	172.76	135.14	168.43	164.24	161.39
Breast Cancer											
Ages 50- 69	NELUA	62.86	61.60	55.48	62.81	56.26	63.61	61.96	50.63	54.20	48.62
	NELCTP	-	-	-	-	55.69	63.00	61.41	50.16	53.72	48.11
Lung Cancer											
Ages under 75	NELUA	19.15	21.01	28.03	22.71	19.65	23.77	14.01	24.95	27.50	20.92
	NELCTP	-	-	-	-	19.48	23.56	13.88	24.69	27.26	20.71

Table E6a: Cancers (All Persons)

ALL PERSONS

	AREA	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
All Cancers											
Ages under 65	NELUA	84.14	72.09	82.46	76.01	74.58	79.74	75.33	74.30	72.13	57.84
	NELCTP	-	-	-	-	73.83	78.90	75.87	74.90	72.16	57.20
Ages 65-74	NELUA	944.46	845.63	1073.40	790.17	903.85	943.32	766.88	885.45	948.70	828.22
	NELCTP	-	-	-	-	910.89	935.69	768.14	877.86	946.65	827.88
Ages under 75	NELUA	146.87	128.49	154.72	128.08	135.05	142.71	125.76	133.44	136.05	114.02
	NELCTP	-	-	-	-	134.86	141.38	126.35	133.45	135.92	113.39
All ages	NELUA	212.12	196.88	213.83	198.05	199.21	204.17	183.34	192.53	191.42	178.87
	NELCTP					199.04	203.33	183.94	192.18	191.87	178.27
Breast Cancer											
Ages 50- 69	NELUA	-	-	-	-	-	-	-	-	-	-
	NELCTP	-	-	-	-	-	-	-	-	-	-
Lung Cancer											
Ages under 75	NELUA	27.90	32.09	42.88	28.21	33.07	33.52	28.30	32.31	32.39	27.54
	NELCTP	-	-	-	-	33.32	33.20	28.65	31.99	32.08	27.25

Table E7a: Suicide & Undetermined Injury (Males)

MALES

	AREA	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
Suicide & Undetermined Injury											
All ages	NELUA	31.92	24.17	17.79	13.69	23.86	10.46	23.17	13.04	9.28	13.78
	NELCTP	-	-	-	-	23.65	10.35	23.00	12.93	9.21	14.72
Suicide											
All ages	NELUA	22.98	18.24	14.59	4.32	15.96	7.86	11.52	7.70	7.71	8.95
	NELCTP	-	-	-	-	15.81	7.78	11.44	7.63	7.65	9.94

Table E7b: Suicide & Undetermined Injury (Females)

FEMALES

	AREA	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
Suicide & Undetermined Injury											
All ages	NELUA	6.15	4.69	3.54	2.75	3.18	3.81	5.75	1.17	2.80	0.00
	NELCTP	-	-	-	-	3.15	3.78	5.70	1.16	2.78	0.00
Suicide											
All ages	NELUA	0.00	1.93	1.03	1.32	1.79	0.00	4.60	1.17	1.51	0.00
	NELCTP	-	-	-	-	1.78	0.00	4.56	1.16	1.50	0.00

Table E7c: Suicide & Undetermined Injury (All Persons)

ALL PERSONS

	AREA	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
Suicide & Undetermined Injury											
All ages	NELUA	18.93	14.29	10.42	7.90	13.36	7.18	14.21	6.76	5.63	6.59
	NELCTP	-	-	-	-	13.24	7.11	14.10	6.71	5.58	7.06
Suicide											
All ages	NELUA	11.32	10.08	7.73	2.73	8.82	3.81	7.89	4.37	4.21	4.33
	NELCTP	-	-	-	-	8.74	3.77	7.83	4.33	4.18	4.82

Table E8a: All Causes (Males)

MALES

	AREA	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
All ages	NELUA	982.38	917.06	914.38	921.26	915.56	893.15	847.16	811.03	774.63	810.34
	NELCTP	-	-	-	-	919.72	893.47	850.72	805.49	774.23	814.93

Table E8b: All Causes (Females)

FEMALES

	AREA	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
All ages	NELUA	624.44	625.31	611.17	533.48	565.12	570.11	541.89	531.59	566.05	539.44
	NELCTP	-	-	-	-	564.03	567.75	539.43	531.16	563.31	540.28

Table E8c: All Causes (All Persons)

ALL PERSONS

	AREA	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
All ages	NELUA	774.83	747.39	739.76	702.95	709.56	712.36	676.33	656.36	660.08	659.52
	NELCTP	-	-	-	-	711.11	711.19	676.94	653.79	658.40	662.26

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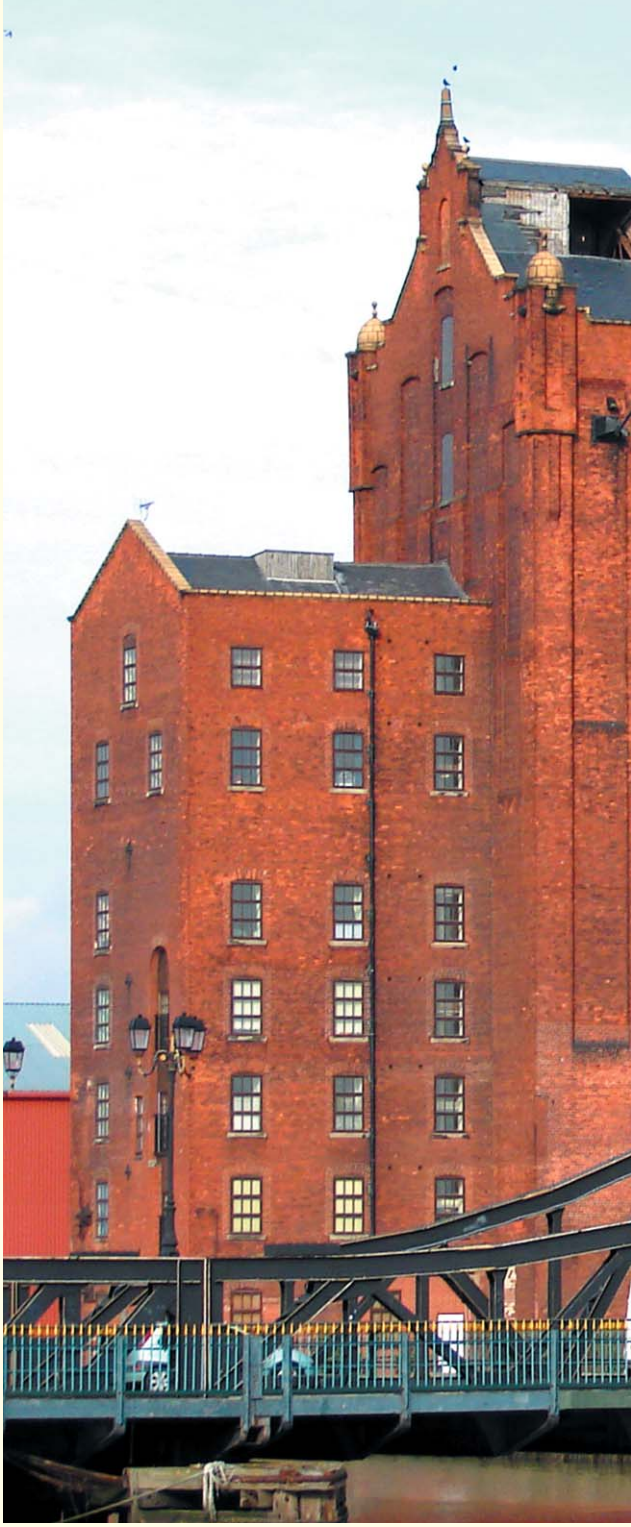

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