Health and Well-Being Improvement Strategy for Great Yarmouth and Waveney Primary Care Trust

Prof. Philip Milner¹
Gary Calderwood²
Dr Tim Winters³
Jim Lane²
Dr Alistair Lipp⁴

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¹ Visiting Professor of Public Health, University of Bath.
² Analyst, Finnamore Management Consultants.
³ Epidemiologist, Great Yarmouth and Waveney PCT.
⁴ Director of Public Health, Great Yarmouth and Waveney PCT.
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- Replaced all trend charts to show the 10th centile (or 90th centile) areas instead of the “fastest improving” area. It is these 10th/90th centile areas which are the benchmark trajectories that the PCT aims to follow.
- Updated text, table and chart on deliberate self-harm.
- Updated summary data on mental health indicators – table 4.6.8.
- Corrected table in section on Low Birth Weight.
- Corrected DMFT section text to reflect data in the table (Wrong area quoted in text).
- Still awaiting data on alcohol-related hospital admissions.
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1 Overview

1.1 What is this strategy about?
The PCT wants to improve the health and well-being of local people in the fastest possible ways. This will entail ensuring there are support services for people who wish to move away from unhealthy behaviours, as well services to support people with established diseases to prevent further ill-health. To do this the PCT needs to know where the biggest gaps are in ill-health locally. It also needs to know how to measure that progress is being made quickly. And finally it needs to know what are the best service developments based on research evidence to achieve this. This strategy spells out these elements in greater detail.

1.2 What is the current health and well-being of local people?
The current health problems in Great Yarmouth and Waveney are:

- The people of Great Yarmouth usually have worse health than those of Waveney.
- But Waveney consist of two communities – Lowestoft and the rest of Waveney and the people of Lowestoft are more deprived.
- Men in Great Yarmouth have worse health than women there but comparatively the women of Waveney have a worse health experience than the men there
- Lifestyle behaviours of smoking, eating healthily, taking physical activity, keeping a healthy weight, and drinking alcohol are poor.
- Ill health and disability are comparatively more prevalent.
- Mental health problems are comparatively more prevalent.
- CHD.
- Teenage pregnancy.
- Low breastfeeding rates.
- The chronic conditions of diabetes, stroke, and chronic obstructive pulmonary disease arising from the poor lifestyle behaviours and poor ill-health record.

The poor lifestyles found locally are very important causes of disability and premature deaths. The World Health Organisation (WHO) have shown that smoking, eating unhealthily,
not taking physical activity, not keeping a healthy weight, and drinking excess alcohol cause
the major components of disability and premature mortality in our lives in the developed
world.

1.3 How can we measure we have the fastest-improving health?
The WHO defines health as a state of complete physical, mental and social well-being and
not merely the absence of disease or infirmity. We need population measures of general
health, mortality, mental health, sickness and illness (the burden of disease).

The best way of measuring ‘fastest improving’ is to analyse the historical trends at 3 yrs, 5
yrs and 10 yrs or longer for Great Yarmouth and Waveney districts. Our preliminary analyses
of all-cause all-age mortality rates for local authority areas showed that nearly all of the fast-
est improvers were in the London area (such as Westminster and Islington) and had started
from a high rate position. We did not think it rational or fair to therefore use as comparators
those districts with very high mortality rate reductions achieved probably through an internal
healthy migrant effect and have not done so.

The three key pledges in it relating to health and inequalities of the East of England Strategic
Health Authority health strategy have been incorporated.

The rates of improvement for all-ages all-causes mortality show a similar picture to those for
life expectancy and CHD mortality with Waveney doing better than Great Yarmouth. How-
ever for premature mortality and life-years lost Great Yarmouth is doing better than Wave-
ney. The age-specific death rates for young men in Great Yarmouth must be improving at a
faster rate than for Waveney. For life-years lost Great Yarmouth is already in the top ten
percent of improvement nationally. For life expectancy for men Waveney is also already in
the top ten percent nationally. In general achieving the rates of improvement of the fastest-
improving districts seems almost impossible given the wideness of gaps and the impact of
any residual healthy migrancy effect. Aiming to be in the top ten percent nationally for each
indicator is a much more realistic yet still challenging target. If this were achieved across all
the indicators, on a balanced score card approach the people of Great Yarmouth and Wave-
ney would have the fastest-improving health nationally. It would also allow becoming the
fastest-improving district on each indicator by the year 2017.

Waveney’s suicide trend and Great Yarmouth and Waveney’s trends for chronic liver dis-
ease are all increasing. Thus for these indicators the two districts need to reverse these
trends and then catch up with the falls in the comparators.

Great Yarmouth and Waveney’s trends for cancer incidence and comparative illness and
disability ratios are all increasing, as is the number of diseased teeth in five-year olds, the
fractured neck of femur rate, and the abortion rate in Great Yarmouth and the teenage pregnancy rate in Waveney. Thus for these indicators the two districts need to reverse these trends and then catch up with the reductions in the comparators. Only the cancer incidence, the fractured neck of femur rate, teenage pregnancy rate, and the low birth weight percentage trends and thus forecasts are built on significant numbers of yearly data points. The forecasts and trends for the comparative illness and disability ratio, oral health of 5 year olds, and the abortion rate are based on only two year’s worth of data that are at least four years out-of-date. For all but one of these burden of disease indicators Great Yarmouth trends are currently worsening. The same is true for Waveney for 3 out 7 of them. The PCT thus faces great challenges again.

1.4 Where to do we want to be?
Armed with the data on best performer we have quantified the rate of improvement for Great Yarmouth and Waveney combined to reach best performer status within 10 years time for the key local health problems identified.

1.5 How are we going to get there?
We have elaborated the interventions needed for the most remedial causes of mortality identified as priority health problems. We have made commissioning recommendations for the development of lifestyle support services, the management of risk factors (both lifestyle e.g. smoking and clinical e.g. cholesterol) for individuals, health promoting interventions, and enhanced inputs primary care. All of the recommendations are based on very good quality research evidence and the key references are given to justify them. We have quantified the extra numbers of individuals at risk of transient ischaemic attack (TIA) and/or stroke who could benefit from these interventions so as to make the scale of the task properly quantified. This will allow the PCT to set uptake targets for stroke/TIA (e.g. 50% of those with TIA referred to a TIA service within the first year and 100% in the second year). We have focused on service improvements that will make practical differences to health outcomes and the patient’s experience of the NHS. These include:

- improvements in access to NHS services, especially better risk factor management in primary care
- lifestyle support services to help people change
- partnership arrangements particularly partnerships to support lifestyle change outside a medical model
- improving clinical outcomes – particularly for chronic diseases such as heart disease, diabetes, respiratory disease, mental illness and multiple morbidity in the frail elderly
• helping people stay healthy through improved delivery of preventative care including lipid control, treatment of hypertension, smoking cessation, obesity management, dietary advice and support, physical activity promotion, lifestyle support, screening, and immunisation

• ensuring good services are in place for marginalised groups, be they areas of deprivation or demographic groups. In particular how the PCT can ensure high quality primary care is in place for these groups.

1.6 How will we know when we are there?
Measurement of progress will be against the aims, objectives and targets specified for the planning period. For the planned service developments there should be measurable indicators and targets.
2 What is this strategy about?

Great Yarmouth and Waveney PCT are committed to improving the health and well-being of local people. They are working to achieve this with partners such as Great Yarmouth and Waveney Councils. The PCT wants to improve the health and well-being of local people in the fastest possible ways. This will entail ensuring there are support services for people who wish to move away from unhealthy behaviours, as well services to support people with established diseases to prevent further ill-health. To do this the PCT needs to know where the biggest gaps are in ill-health locally. It also needs to know how to measure that progress is being made quickly. And finally it needs to know what are the best service developments based on research evidence to achieve this. This strategy spells out these elements in greater detail.
3 What is the current health and well-being of local people?

The current comparative position of health and well-being of the local people can be assessed from available information on general health and well-being, mortality, mental health, and the burden of disease.

3.1 General perceived health and well-being

3.1.1 General health question

The 2001 Census contained a question on people’s self-reported health. Figure 3.1.1 shows the analysed results of this for Great Yarmouth and Waveney. The proportions of people of Great Yarmouth and Waveney who had poor health were both greater than for East of England or England, with Great Yarmouth having the worst proportion. The bars at the top of each column show the 95% confidence interval for each area value. A 95% confidence interval shows the range of values that the true value will lie within 95% of the time.

3.1.2 Limiting long term illness

The 2001 Census also contained a question on people’s self-reported experience of limiting long-term illness. Figure 3.1.2 shows the analysed results of this for Great Yarmouth and Waveney. The proportions of people of Great Yarmouth and Waveney who had more limiting long-term illness were again both greater than for the East of England, with Great Yarmouth having the worst proportion.
### Deprivation

Deprivation is a good marker for health and well-being with the more deprived having worse health. Oxford Consultants for Social Inclusion and Roger Tym & Partners were commissioned by the Suffolk Development Agency to assess the evidence base across Suffolk and comparator areas for the next stage of the Suffolk Investing in Communities programme. This included looking at the needs of the communities including their level of deprivation. They analysed the Index of Multiple Deprivation 2004 for large settlements in the East of England. The results are shown in Table 3.1.3. Great Yarmouth and Lowestoft have the greatest levels of deprivation in Norfolk and Suffolk. The deprivation in Lowestoft can be hidden because of the relative prosperity of the other parts of Waveney.
Table 3.1.3 Deprivation in the largest settlements (>50,000) in the East of England

<table>
<thead>
<tr>
<th>Settlement name</th>
<th>Local authority</th>
<th>Population</th>
<th>IMD 2004 Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Great Yarmouth</td>
<td>Norfolk</td>
<td>66,788</td>
<td>31.89</td>
</tr>
<tr>
<td>Clacton-on-Sea</td>
<td>Essex</td>
<td>54,048</td>
<td>28.35</td>
</tr>
<tr>
<td>Basildon</td>
<td>Essex</td>
<td>101,492</td>
<td>27.97</td>
</tr>
<tr>
<td>Lowestoft</td>
<td>Suffolk</td>
<td>68,340</td>
<td>25.52</td>
</tr>
<tr>
<td>Peterborough</td>
<td>Peterborough</td>
<td>136,292</td>
<td>25.02</td>
</tr>
<tr>
<td>Grays/Tilbury</td>
<td>Thurrock</td>
<td>75,635</td>
<td>23.12</td>
</tr>
<tr>
<td>Luton/Dunstable</td>
<td>Luton/Bedfordshire</td>
<td>236,318</td>
<td>21.53</td>
</tr>
<tr>
<td>Norwich</td>
<td>Norfolk</td>
<td>194,839</td>
<td>21.21</td>
</tr>
<tr>
<td>Bedford/Kempston</td>
<td>Bedfordshire</td>
<td>101,928</td>
<td>20.69</td>
</tr>
<tr>
<td>Ipswich</td>
<td>Suffolk</td>
<td>141,658</td>
<td>20.50</td>
</tr>
<tr>
<td>Harlow</td>
<td>Essex</td>
<td>88,296</td>
<td>19.74</td>
</tr>
<tr>
<td>Colchester</td>
<td>Essex</td>
<td>104,390</td>
<td>16.70</td>
</tr>
<tr>
<td>Southend</td>
<td>Southend-on-Sea/Essex</td>
<td>269,415</td>
<td>16.35</td>
</tr>
<tr>
<td>Stevenage</td>
<td>Hertfordshire</td>
<td>81,482</td>
<td>15.40</td>
</tr>
<tr>
<td>Cambridge</td>
<td>Cambridgeshire</td>
<td>131,465</td>
<td>13.29</td>
</tr>
<tr>
<td>Welwyn</td>
<td>Hertfordshire</td>
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<td>11.65</td>
</tr>
<tr>
<td>St Albans/Hatfield</td>
<td>Hertfordshire</td>
<td>114,710</td>
<td>10.79</td>
</tr>
<tr>
<td>Chelmsford</td>
<td>Essex</td>
<td>99,962</td>
<td>8.83</td>
</tr>
</tbody>
</table>

Settlement level data is shown, developed by OCSI from ONS settlement definitions and IMD 2004 scores. Settlements are ranked against other settlements with more than 50,000 residents in the East of England. Source: OCSI 2006 (from ODPM 2004, Census 2001, ONS Settlement Definitions)

The IMD is made up of seven domain indices. Great Yarmouth and Waveney did particularly badly in the domains of Health Deprivation and Disability, Employment Deprivation, and Education, Skills and Training. Great Yarmouth also did particularly badly on the Crime domain.

### 3.2 Healthy lifestyles

#### 3.2.1 Physical activity

The Sport England Survey of sport and physical activity assessed participation in the recommended levels of physical activity. Figure 3.2.1 shows the analysed results of this for Great Yarmouth and Waveney. The proportions of people of Great Yarmouth and Waveney who participated in the recommended levels of physical activity were both lower than for the East of England or England with Waveney having the lowest proportion.
3.2.2 Smoking
The annual English Health Survey contains questions on people’s smoking habits from time-to-time. Figure 3.2.2 shows the analysed results of this for Great Yarmouth and Waveney for the most recent years for which data is available. The proportions of adult people of Great Yarmouth and Waveney who smoked were both greater than for the East of England or England, with Great Yarmouth having the worst level.

3.2.3 Childhood obesity
No up-to-date local information is available at present.
3.2.4 Adult obesity
The annual English Health Survey contains questions on people’s height and weight from time-to-time. From these two measures the Body Mass Index (BMI) can be calculated. The BMI equals the weight/height². A BMI over 30 for adults is defined as being obese. Figure 3.2.4 shows the analysed results of this for Great Yarmouth and Waveney for the most recent years for which data is available. The proportions of adult people of Great Yarmouth and Waveney who were obese were both much greater than for the East of England or England, with Great Yarmouth having the worst proportion.

Figure 3.2.4 Prevalence of adult obesity - person 16+ (Community Health Profiles 2000-2002)

3.2.5 Diet
The annual English Health Survey contains questions on people’s eating habits from time-to-time. Figure 3.2.5 shows the analysed results of this for Great Yarmouth and Waveney for the most recent years for which data is available. The proportions of adult people of Great Yarmouth and Waveney who consumed 5 or more portions of fruit and vegetables daily were less than for the East of England or England, with Waveney having the lowest level.
3.3 Mortality

3.3.1 All-causes all-ages mortality

The best overall measure of the mortality experience of a population is the all-causes all-ages directly standardised mortality rate. The standardised means that differences in the local population, such as it is more aged, are taken into account when comparative rates are calculated. The mortality experience for Great Yarmouth, Waveney, and Great Yarmouth and Waveney combined is shown in Figure 2.31. The best comparator for both Great Yarmouth and Waveney and hence the PCT area and its population is Coastal and Countryside. This is a cluster of local authorities that are most like Great Yarmouth and Waveney. Figure 3.3.1 also shows the comparative positions with the East of England and England. The mortality rate for Great Yarmouth is 8% greater than the Coastal and Countryside one. Waveney’s is about the same as the Coastal and Countryside one. The higher comparative death rate in Great Yarmouth is mainly experienced by men.
3.3.2 All-causes premature mortality

It is sometimes more useful to see what the premature mortality rate is. If we assume that everybody should live until 75 years then any death before that can be classified as premature. The premature mortality experience for Great Yarmouth, Waveney, and Great Yarmouth and Waveney combined is shown in Figure 3.3.2. The premature mortality rate for Great Yarmouth is again 8% greater than the Coastal and Countryside one. Waveney’s is about the same as the Coastal and Countryside one. The higher premature death rate in Great Yarmouth is mainly experienced by men.
3.3.3 **Years-of-life lost from all causes up to age 75 years**

Another measure of mortality experience is to measure the years of life lost up to age 75 years that each individual experiences. This is then expressed as a standardised rate to allow for differences in the age and sex structure of the population. The years-of-life lost rates for Great Yarmouth, Waveney, and Great Yarmouth and Waveney combined are shown in Figure 3.3.3. The years-of-life lost rate for Great Yarmouth was again 8% greater than the Coastal and Countryside one. Waveney’s was about the same as the Coastal and Countryside one.

![Figure 3.3.3 Mortality from all causes - Years of life lost: persons < 75 (directly standardised rate, 2003-05)](image)

3.3.4 **All-causes mortality from Coronary Heart Disease**

Coronary Heart Disease (CHD) is the commonest killer. The CHD mortality experience for people of all ages for Great Yarmouth, Waveney, and Great Yarmouth and Waveney combined is shown in Figure 3.3.4. The CHD mortality rate for Great Yarmouth is 9% greater than the Coastal and Countryside one. Waveney’s is about the same as the Coastal and Countryside one. But the premature mortality rate shows a much more marked picture. The CHD premature mortality experience for people aged under 75 years for Great Yarmouth was 29% greater than the Coastal and Countryside one. Waveney’s was about the same as the Coastal and Countryside one. The rate for women in Great Yarmouth was 51% higher than the Coastal and Countryside one; the rate for men was 21% higher. The years-of-life lost from CHD indicator shows a similar marked pattern for Great Yarmouth.
3.3.5 All-causes mortality from cancer

Cancer is also a common killer. The cancer mortality experiences for people of all ages for Great Yarmouth, Waveney, and Great Yarmouth and Waveney combined are shown in Figure 3.3.5. The cancer mortality rates for Great Yarmouth and Waveney are about the same as the Coastal and Countryside one. The cancer premature mortality rate for men aged under 75 years for Great Yarmouth was 11% greater than the Coastal and Countryside one but that for women was 14% less than its Coastal and Countryside comparator. Waveney's were about the same as the Coastal and Countryside ones. The years-of-life lost from cancer indicators showed a similar pattern to the premature mortality ones for Great Yarmouth.
3.3.6 Infant mortality
The highest chance of dying until old age is reached is in the first year of life. The infant mortality rate measures the number of deaths in the first year of life. The infant mortality experiences for Great Yarmouth, Waveney, and Great Yarmouth and Waveney combined are shown in Figure 3.3.6. The infant mortality rate for Great Yarmouth was the same as the Coastal and Countryside one. Waveney’s was 34% less than the Coastal and Countryside one.

![Figure 3.3.6 Infant Mortality (crude rate, 2003-05)](image_url)

3.3.7 Breastfeeding initiation
Breastfeeding reduces the chances of a baby dying in the first year of life. The breastfeeding initiation rates for Great Yarmouth, Waveney, and Great Yarmouth and Waveney combined are shown in Figure 3.3.7. The breastfeeding initiation rate for Great Yarmouth and Waveney PCT was much less that that for the East of England region and England (60.6% versus 73.4% and 71.6%).
3.3.8 Life expectancy of men and women

Life expectancy at birth is a similar measure to the all-age all-cause mortality one except that it is always gender-specific. The life expectancies at birth for men for Great Yarmouth, Waveney, and Great Yarmouth and Waveney combined are shown in Figure 3.3.8-a. There is no Coastal and Countryside comparator available so the East of England values are used instead as the comparator. The life expectancy of men in Great Yarmouth was nearly two years less than that for the East of England; the life expectancy of men in Waveney was about the same as that for the East of England.
The life expectancies of women in Great Yarmouth and in Waveney were slightly less than those for the East of England (Figure 3.3.8-b.)

![Life expectancy chart](image)

**3.3.9 Healthy-life expectancy**

As people live longer they want to live healthy old ages. The healthy-life expectancy at birth is a measure of how much healthy life we can expect from birth. The healthy-life expectancies at birth for men for Great Yarmouth, Waveney, and Great Yarmouth and Waveney combined are shown in Figure 3.3.9-a. There is no Coastal and Countryside comparator available so the East of England values are used instead as the comparator. The healthy-life expectancy of men in Great Yarmouth was nearly three years less than that for the East of England; the healthy-life expectancy of men in Waveney was about one year less than that for the East of England.

The healthy-life expectancies of women in Great Yarmouth was also nearly three years less than that for the East of England; the healthy-life expectancy of women in Waveney was about the same as that for the East of England (Figure 3.3.9-b).
3.4 Mental Health

3.4.1 Suicide and undetermined injury deaths

Further in-depth research has shown that nearly all those deaths classified as injury of undetermined cause are probably suicides. For that reason the category of suicide and undetermined deaths is used in the numerator of the indicator for the suicide rate. The suicide rate is not a good indicator of the overall mental health of a population. However each suicide is an immense personal tragedy and can occur in young people. That is why it is important.

The experience of suicide for Great Yarmouth, Waveney, and Great Yarmouth and Waveney combined is shown in Figure 3.4.1. The suicide and undetermined death rate for Great Yar-
mouth was 18% less than the Coastal and Countryside one. Waveney’s is 15% less than the Coastal and Countryside one. The local suicide rates were particularly low for men, especially for Great Yarmouth.

Figure 3.4.1 Mortality from suicide and undetermined injury: Persons 0 + (directly standardised rate, 2003-05)

3.4.2 Prescribing drugs for neurotic conditions

Neurotic conditions such as anxiety are those mental health problems where the individual has insight into their condition but does not know how to control it. If the prescribing of medicinal drugs for neurotic conditions is being done rationally and comprehensively then the standardised rate of prescribing them can be taken as a measure of the underlying neurotic illness level in the local population. The standardised rate of prescribing drugs for neurotic conditions is shown in Figure 3.4.2. Information is only available for PCTs and England. The standardised rate of prescribing drugs for neurotic conditions was 66% more than for England.
3.4.3 Prescribing drugs for psychotic conditions

Psychotic conditions such as manic-depression are those mental health problems where the individual does not have insight into their condition and so does not know how to control it. If the prescribing of medicinal drugs for psychotic conditions is being done rationally and comprehensively then the standardised rate of prescribing them can be taken as a measure of the underlying psychotic illness level in the local population. The standardised rate of prescribing drugs for psychotic conditions is shown in Figure 3.4.3. Information is only available for PCTs, the East of England, and England. The standardised rate of prescribing drugs for psychotic conditions was slightly less than for the East of England.
3.4.4 Alcohol-use disorders – mortality rate for chronic liver disease

From a population perspective chronic liver disease is a good marker for severe chronic alcohol misuse. It is therefore taken as a comparative measure of alcohol-use disorders in populations. The standardised mortality rates for chronic liver disease for Great Yarmouth, Waveney, and Great Yarmouth and Waveney combined are shown in Figure 3.4.4. The chronic liver disease death rate for Great Yarmouth was 11% more than the Coastal and Countryside one. Waveney’s was 11% less than the Coastal and Countryside one. The same pattern was shown for both men and women.

![Mortality from chronic liver disease: Persons 0+ (Directly standardised rate, 2003-05)](chart)

3.4.5 Alcohol-use disorders – hospital admission rate

There are specific conditions that only alcohol misuse can cause which lead to admission to hospital. The rate of hospital admission for such conditions is therefore a good comparative indicator of the level of alcohol-use disorders in a population. The hospital admission standardised rates for conditions specific to alcohol misuse for Great Yarmouth, Waveney, and Great Yarmouth and Waveney combined are shown in Figure 3.4.5. The information is not available for the coastal and countryside comparator. The hospital admission rate for Great Yarmouth was 56% more than the East of England one. Waveney’s was 16% more than the East of England one. This was a similar pattern to the one for the East of England comparisons for the chronic liver disease death rate (Figure 3.4.4).
3.4.6 Prevalence of severe mental illness

The new contract for general practices rewards them for keeping information on registers of patients with certain diseases using the Quality Outcomes Framework. One of these registers is for severe mental illness. Figure 3.4.6 shows the comparative position of Great Yarmouth and Waveney PCTs to the East of England and England averages. The estimated prevalence of severe mental illness was higher in Great Yarmouth and Waveney PCT than for the East of England and the same as that for England (0.71% versus 0.63% and 0.71%).
3.5 Burden of disease

3.5.1 Inability-to-work due to permanent sickness

The 2001 Census also contained a question on people’s inability to work due to permanent sickness. Figure 3.5.1 shows the analysed results of this for Great Yarmouth and Waveney. The proportions of people of Great Yarmouth and Waveney who were unable to work because of permanent sickness were again both greater than for the East of England and England, with Great Yarmouth having the worst level.
3.5.2 Health and disability domain of IMD 2004
The Index of Multiple Deprivation is made up of seven domains. Great Yarmouth and Waveney both did particularly badly in the domain of Health Deprivation and Disability.

3.5.3 Fractured neck of femur hospital admission rate
Fracturing the neck of the femur (hip) nearly always ends up in an emergency admission to hospital. Thus rates of admission to hospital with a fractured neck of femur are a good measure of underlying incidence of the condition. Figure 3.5.3 shows the analysed results of hospital admissions data for fractured neck of femur for Great Yarmouth and Waveney. The proportions of people of Great Yarmouth and Waveney who have fractured their hip are slightly more than for the East of England, with Great Yarmouth having the higher rate.
3.5.4 All cause cancer incidence

All cases of cancer are registered with regional cancer registries. This allows incidences of cancers to be compared. Figure 3.5.4 shows the analysed results for all cancers for Great Yarmouth and Waveney. The incidence of cancer in the people of Great Yarmouth and Waveney was slightly higher than for the East of England but less than for England, with Great Yarmouth having a higher incidence than Waveney.

3.5.5 Total period abortion rate

All terminations of pregnancy undertaken have to be reported centrally. This allows the incidences of such terminations to be compared. Figure 3.5.5 shows the analysed results of this
for Great Yarmouth and Waveney. The proportion of women aged 11 to 49 years of Waveney who had a termination of pregnancy was less than for the East of England and England. The rate for Great Yarmouth was higher than Waveney and the East of England but less than that for England.

![Figure 3.5.5 Abortion rate - women 11-49 (2004)](chart)

### 3.5.6 Low birth weight

The birth weight of each baby born is reported to the Registrar of Births and Deaths. This allows the incidences of low birth weight babies (under 2.5 kg) to be compared. Figure 3.5.6 shows the analysed results of this for Great Yarmouth and Waveney. The proportions of low birth weight babies in Great Yarmouth and Waveney was slightly higher than for the East of England but less than for England.
3.5.7 Stillbirth rate

The live birth status of each baby born is reported to the Registrar of Births and Deaths. This allows the incidences of stillborn babies to be compared. Figure 3.5.7 shows the analysed results of this for Great Yarmouth and Waveney. The proportions of stillborn babies in Great Yarmouth and Waveney were slightly less than for the East of England and England.

3.5.8 Comparative Illness and Disability Ratio

There are specific conditions that cause chronic illness and/or disability. People with these conditions are allowed to claim a range of welfare benefits. The Comparative Illness and Disability Ratio (CIDR) indicator is a directly age and sex-standardised morbid-
The disability ratio is derived from a non-overlapping count of individuals receiving any of the following benefits: Disability Living Allowance, Attendance Allowance, Incapacity Benefit, Severe Disablement Allowance and the disability premium of Income Support. It is thus a measure of the level of chronic illness and disability in a population. The CIDR for Great Yarmouth and Waveney for 2001 and 2003 are shown in Figure 3.5.8. The information is not available for the coastal and countryside comparator. The CIDR for Great Yarmouth was about 45% more than the East of England one. Waveney’s was about 30% more than the East of England one. Mid Suffolk which is the 10th percentile district based on the 2001/2003 changes was just under half of the ratio for Great Yarmouth in 2003 and much less than the Waveney ratio.

![Figure 3.5.8 Comparative Illness and Disability ratio (Age standardised rate ratio)](image)

**3.5.9 Oral health – decayed, missing, and filled teeth percentage in 5 year olds**

Every few years the community dental services did surveys of school children’s teeth. This allowed the extent of diseased teeth in children to be assessed. Figure 3.5.9 shows the analysed results of this for Great Yarmouth and Waveney. The proportions of children under 5 years of Great Yarmouth and Waveney who had decayed, missing, and filled teeth were again both greater than for the East of England, with Great Yarmouth having the worst rate.
3.5.10 Teenage pregnancy rate

The government receives information on all births and all terminations of pregnancy along with the mother’s age. It can therefore calculate a pregnancy rate for 15-17 year olds for all areas. Figure 3.5.10 shows the analysed results of this for Great Yarmouth and Waveney. The rates of teenage pregnancy for Great Yarmouth and Waveney were higher than for the East of England and England, with Great Yarmouth having the worst rate.
3.6 Current health problems in Great Yarmouth and Waveney

3.6.1 Current health problems
The current health problems in Great Yarmouth and Waveney from the preceding sections are:

- The people of Great Yarmouth usually have worse health than those of Waveney
- But Waveney consist of two communities – Lowestoft and the rest of Waveney and the people of Lowestoft are more deprived
- Men in Great Yarmouth have worse health than women there but comparatively the women of Waveney have a worse health experience than the men there
- Lifestyle behaviours of smoking, eating healthily, taking physical activity, keeping a healthy weight, and drinking alcohol are poor
- Ill health and disability are comparatively more prevalent
- Mental health problems are comparatively more prevalent
- CHD
- Teenage pregnancy
- Low breastfeeding rates
- The chronic conditions of diabetes, stroke, and chronic obstructive pulmonary disease arising from the poor lifestyle behaviours and poor ill-health record

3.6.2 The impact of lifestyle risk factors on disability and premature deaths
The poor lifestyles found locally are very important causes of disability and premature deaths. The World Health Organisation uses disability adjusted life-years (DALYs) as a measure of how much disability is suffered in a life. The WHO have shown that smoking, eating unhealthily, not taking physical activity, not keeping a healthy weight, and drinking excess alcohol cause the major component (67%) of disability in our lives in the developed world.5 Figure 3.6.2-a shows this for males but the female picture is very similar. Thus tobacco and alcohol are the two most important contributors to disability causing 17% and 14% of it respectively.

Figure 3.6.2-a: Burden of disability caused by lifestyle risk factors

But these lifestyle risk factors are not only the major cause of disability in the developed world they are also the major cause (93%) of premature death. This is shown on Figure 3.6.2-b for males but again the female picture is very similar. Thus smoking and hypertension are the two most important contributors to premature mortality causing 26% and 20% of it respectively. But eating unhealthily, not taking physical activity, not keeping a healthy weight, and drinking excess alcohol are all significant contributors to premature mortality.
4 How can we measure we have the fastest-improving health?

4.1 Health and well-being
The World Health Organisation defines health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. We use the terms health and well-being together to emphasise the positive aspects of being in good health.

4.2 Measuring health
Health and well-being consist of various dimensions. There is physical health and well-being, mental or emotional or psychological health and well-being, social well-being, and well-being in the determinants of health such as education and housing. The problem with measuring health is that each of these dimensions should ideally be covered. Moreover there is often not an ideal indicator or information system for the desired measure of health. Healthy people live longer than unhealthy ones. So measures of mortality, life expectancy, and premature mortality are important proxies for the health of populations. Furthermore to understand what the current rate of change in health indicator is we need some recent data, which may be more or less available. Finally there is always a time delay between health events occurring and information systems being able to report these. This means that often the otherwise-best data on the health of populations is always one or two years out-of-date. Frustratingly information on perceived health and well-being is not regularly available at the local level. Taking all these factors into account we need population measures of mortality, sickness and illness, and mental health.

4.3 Measuring fastest improving
4.3.1 Trend time period
The best way of measuring ‘fastest improving’ is to analyse the historical trends at 3 yrs, 5 yrs and 10 yrs or longer for Great Yarmouth and Waveney districts. Longer time periods provide more accurate estimation of any underlying trend. Recent information will have more weight in predicting the next few years’ results. But health trends tend to change not so quickly. So this would suggest that 10 years or the longest period if less than 10 years may be the appropriate time periods if the data is available and this is what we have used. For each of these periods the best measure would be the slope of the trend now, especially if this was statistically significant at the 5% level or better. To measure this slope we need at least three data points, although ideally many more. These may not be available so there may be uncertainty about this slope. Or the slope may not be consistent over the period for which data is available. The statistics provided as output from regression analysis confirm the reliability of the trend (or lack of it), so these are taken into consideration. We also need
to know which other districts are doing well in improving health and well-being quickly and have assessed the best 10% and the performance of the ONS cluster of Coastal and Countryside local authorities, the East of England, and England.

### 4.3.2 Healthy migrant effect

Our preliminary analyses of all-cause all-age mortality rates for local authority areas showed that nearly all of the fastest improvers were in the London area (such as Westminster and Islington) and had started from a high rate position. We suspected that the mortality experience of the residents of these areas had been affected by the migration inwards of more healthy and wealthy people, who were less likely to die prematurely. We consulted the experts on demography and migration at the Office of National Statistics who confirmed that there was no analytical way of untangling this from current routinely available information sources. However they did point out a very germane research article that had examined\(^6\) this question with a longitudinal study of internal male migrants and their mortality experience.

*They concluded that male migration accounts for nearly all the differences in mortality rates between districts.* We did not think it rational or fair to therefore use as comparators those districts with very high mortality rate reductions achieved probably through an internal healthy migrant effect. We therefore used two statistical techniques to eliminate statistical outliers when choosing fastest-improving and 10\(^{th}\) percentile comparator districts. We used funnel plots of the relevant rate ratio for change against the average number of events (deaths) in a district. For example, the rate ratio for change over the most recent three years would be the rate in the third year divided by the rate in the first of those three years. The same principle has been applied to the 5-year and 10-year periods. An example of this is shown in Figure 4.3.2-a which shows the ratio of the age-sex directly standardised rates of improvement over 10 years (1993 to 2005) for all-ages all cause mortality per 100,000 for persons covering all local authority districts. The chart shows the limits beyond which the ratios for local authorities are unlikely to have arisen by chance. The thin dotted line shows the 95% statistical confidence interval. Local authorities lying beyond these lines were excluded as outliers. There are quite a few outlying districts.

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The remaining districts were ranked by percentile and the fastest-improving comparator was that district with the greatest improvement within the 95% confidence interval (Figure 4.3.2-b).

Similarly the 10th percentile comparator districts were chosen as those districts that were within the 95% confidence limits with the improvement that was at the boundary of the top 10%.

We then used these comparators in our tables and figures. It must be borne in mind though that even for these comparator districts there will be a mixture of health improvement effects occurring – resident lifestyle improvements, health care improvements, and the healthy migrant effect.

It is also likely that the healthy migrant effect has worked in reverse for Great Yarmouth, Lowestoft and Waveney. The more healthy residents there are likely to have migrated out.
Even here where there is an approximate straight line between the 10th to 90th percentiles there are marked upward and downward curves outside of these.

**4.3.3 The East of England Strategic Health Authority health strategy**

The East of England Strategic Health Authority health strategy called ‘Saving lives’ has also just been published for consultation. There are three key pledges in it relating to health and inequalities:

1. We will add 5 million years of life to people in the east of England by 2011.
2. We will halve the difference in life expectancy between the poorest 20% of our communities and the rest of the east of England.
3. We will ensure healthcare is as available to marginalised groups and “looked after children” as it is to the rest of us.

This health improvement strategy will clearly have to reflect our local ambitions to contribute to the regional goals. It will also have to contain indicators that measure our local performance in contributing to these goals. We will therefore always include an East of England comparator when available for each of our indicators.

**4.3.4 Health districts most like Great Yarmouth and Waveney**

After each national Census the Office of National Statistics has organised a set of analyses of the socio-economic and demographic features of each district population to identify local authority districts and unitaries that resemble one another. These districts are then allocated
to clusters. Great Yarmouth and Waveney both belong to the Coastal and Countryside cluster. We will therefore always include a Coastal and Countryside cluster comparator when available for each of our indicators.

4.3.5 Health targets for England
There are health targets for England such as reducing the geographical inequalities in mortality and infant mortality. We will therefore always include an England comparator when available for each of our indicators.

4.4 Mortality trends
We have seen the relative positions for mortality of Great Yarmouth and Waveney populations already. We now consider what changes over time have been occurring with these and how we compare to relevant others.

4.4.1 Mortality
Rates of improvement on all-ages all-causes mortality using the directly-standardised rate are shown in Table 4.4.1 and Figure 4.4.1-a.

The current rates of improvement from 1996 to 2005 are 110.4 for Great Yarmouth and 126.4 for Waveney per 100,000. That means for Great Yarmouth that over the last nine years there have been 110 fewer deaths per 100,000 population than if the mortality rate in 1996 had pertained throughout. Waveney has thus had a greater rate of improvement than Great Yarmouth in this period (126 fewer deaths per 100,000 versus 110).

The rates of improvement for Great Yarmouth and Waveney are not too different than for the East of England, Coastal and Countryside, and England comparators. But they are significantly lower than the rates of improvement for the fastest-improving and 10\textsuperscript{th} percentile districts.

Thus Great Yarmouth would have to increase its rate of improvement by more than two times its current rate to be like Berwick-upon-Tweed (fastest-improving district) and add half as much again to be like Newark & Sherwood (10\textsuperscript{th} percentile district). Waveney would have to double its rate to be greater than Berwick-upon-Tweed but would have less to do to reach the rate for Newark & Sherwood.

For the percentage improvements from their baseline rate Waveney (-18.1\%) had similar changes to the East of England (-16.6\%), Coastal and Countryside (-16.1\%), and England (-17.3\%) comparators but not Berwick-upon-Tweed (-30.8\%) or Newark & Sherwood (-21.9\%). Great Yarmouth’s percentage improvement (-14.9\%) was lower than the others.
Table 4.4.1: Rates of improvement on all-ages all-causes mortality using directly-standardised rate per 100,000 from 1996 to 2005 for persons

<table>
<thead>
<tr>
<th>Area</th>
<th>Actual rate change</th>
<th>Linear trend</th>
<th>Relative % change**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Great Yarmouth</td>
<td>- 98.3</td>
<td>- 110.4*</td>
<td>- 14.9%</td>
</tr>
<tr>
<td>Waveney</td>
<td>- 128.0</td>
<td>- 126.4*</td>
<td>- 18.1%</td>
</tr>
<tr>
<td>East of England</td>
<td>- 117.8</td>
<td>- 114.6*</td>
<td>- 16.6%</td>
</tr>
<tr>
<td>Coastal &amp; Countryside</td>
<td>- 111.7</td>
<td>- 111.8*</td>
<td>- 16.1%</td>
</tr>
<tr>
<td>England</td>
<td>- 132.2</td>
<td>- 129.1*</td>
<td>- 17.3%</td>
</tr>
<tr>
<td>Berwick-upon-Tweed***</td>
<td>- 251.8</td>
<td>- 232.5*</td>
<td>-30.8%</td>
</tr>
<tr>
<td>Newark &amp; Sherwood****</td>
<td>- 173.1</td>
<td>- 170.7*</td>
<td>-21.9%</td>
</tr>
</tbody>
</table>

* = Statistically significant (p < 0.05)
** = Based on trend
*** = Fastest improving district (excluding outliers)
**** = District at 10th percentile (excluding outliers)

The gaps in the rate of improvement with the fastest-improving district of Berwick-upon-Tweed are 122.1 and 106.1 per 100,000 for Great Yarmouth and Waveney respectively and with the 10th percentile district of Newark & Sherwood are 60.3 and 44.3 per 100,000. That means for Great Yarmouth that from 1996 to 2005 there would have been 122 fewer deaths per 100,000 population if they had had the improvement rate for Berwick-upon-Tweed and 60 fewer if they had had the rate of Newark & Sherwood.

Figure 4.4.1-a shows the rates of improvement for Great Yarmouth and Waveney plus the comparators apart from the 10th percentile one. It also shows the predicted rates for future years.

We are in the 2007 calendar year now and the latest data is for 2005. We have therefore estimated where we are now and rolled this forward five and ten years (Figure 4.4.1-a). Thus if Great Yarmouth continues on its current trend there would be a mortality rate of 544 in five years time from now (2012) and a rate of 483 in 10 years time (2017). In each of the five-year periods there would be 61 fewer deaths per 100,000 population.

For Great Yarmouth to reach the improvement rate for Waveney in 2017 its rate of improvement over ten years would have to increase by 17 (140 - 123). To reach the rate of the fastest improving district it would have to increase by 136 (259 - 123) and Waveney would have to increase its rate by 119 (259 – 140). It would seem to me that this is unachievable. Even reaching the target for the East of England would be very difficult.

Maybe a better target would be to be the fastest improving in the East of England or to be at the 10th percentile or in the top 10%?
For Great Yarmouth to reach the improvement rate of Newark and Sherwood (the 10th percentile district) in 2017 its rate of improvement over ten years would have to increase by 67 (190 - 123) and Waveney by 50 (190 - 140). This would seem to be a more manageable task.

The rates of improvement for persons shown in Figure 4.4.1-a and Table 4.4.1 do not tell the full story though. For Great Yarmouth from 2001 to 2005 the mortality rate for males worsened from 799 to 811 per 100,000 whereas for females there was a substantial lowering from 581 to 487 per 100,000. These trends are shown in Figure 4.4.1-b and Figure 4.4.1-c. However this pattern is not present for the trends from 1996 to 2005.

Thus there has been recently a marked health inequality between the men and women in Great Yarmouth from 2001 to 2005. Not only did they have a two thirds greater chance of dying than women, but this difference was increasing. In Waveney the opposite picture has been found with mortality rates for men falling much faster than for women.
4.4.2 Premature mortality
Rates of improvement on all-causes premature mortality before the age of 75 years using the directly-standardised rate are shown in Table 4.4.2 and Figure 4.4.2.
The current rates of improvement from 1996 to 2005 are 89.9 for Great Yarmouth and 71.9 for Waveney per 100,000.

That means for Great Yarmouth that over the last nine years there have been 90 fewer premature deaths per 100,000 population than if the 1996 mortality rate had pertained throughout.

Great Yarmouth has thus had a greater rate of improvement than Waveney in the nine years (90 fewer premature deaths per 100,000 versus 72). The rate of improvement for Great Yarmouth is better than for the East of England and Coastal and Countryside comparators and similar to the England comparator’s. But Waveney’s is similar to the East of England and Coastal and Countryside comparators’ and worse than for the England comparator rate. But both Waveney and Great Yarmouth have rates of improvement that are significantly lower than those for the fastest-improving and 10th percentile districts.

Thus Great Yarmouth would have to at increase its rate of improvement by two thirds to be like Teesdale (fastest-improving district) and 20% to be like Christchurch (10th percentile district). Waveney would have to double its rate to be like Teesdale but would have to increase it by half to reach the rate for Christchurch.

For the percentage improvements from their baseline rate Great Yarmouth (-22.3%) had greater changes than Waveney (-20.2%), the East of England (-20.8%), and Coastal and Countryside (-20.6%) comparators and similar to England’s (-22.3%) but not Teesdale (-35.8%) or Christchurch (-31.9%).

The gaps in the rate of improvement with the fastest-improving district of Teesdale are 58.4 and 76.4 per 100,000 for Great Yarmouth and Waveney respectively. That means for Great

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<thead>
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<td>- 90.7</td>
<td>- 89.9*</td>
<td>- 22.3%</td>
</tr>
<tr>
<td>Waveney</td>
<td>- 67.3</td>
<td>- 71.9*</td>
<td>- 20.2%</td>
</tr>
<tr>
<td>East of England</td>
<td>- 75.0</td>
<td>- 72.1*</td>
<td>- 20.8%</td>
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<tr>
<td>Coastal &amp; Countryside</td>
<td>- 72.3</td>
<td>- 74.8*</td>
<td>- 20.6%</td>
</tr>
<tr>
<td>England</td>
<td>- 88.8</td>
<td>- 88.8*</td>
<td>- 22.3%</td>
</tr>
<tr>
<td>Teesdale***</td>
<td>- 209.7</td>
<td>- 148.3*</td>
<td>- 35.8%</td>
</tr>
<tr>
<td>Christchurch****</td>
<td>- 119.5</td>
<td>- 103.4*</td>
<td>- 31.9%</td>
</tr>
</tbody>
</table>

* = Statistically significant (p < 0.05)
** = Based on trend
*** = Fastest improving district (excluding outliers)
**** = District at 10th percentile (excluding outliers)
Yarmouth that from 1996 to 2005 there would have been 58 fewer premature deaths per 100,000 population if they had had the improvement rate for Teesdale.

Figure 4.4.2 shows the rates of improvement for Great Yarmouth and Waveney plus the comparators apart from the 10th percentile one. It has the same format as Figure 4.4.1-a.

Thus if Great Yarmouth continues on its current trend there would be a premature mortality rate of 243 in five years time from now (2012) and a rate of 193 in ten years time (2017). In each of the five-year periods there would be 50 fewer premature deaths per 100,000 population. Teesdale had similar rates to Great Yarmouth’s in 1993 to 1998.

For Waveney to reach the rate for Great Yarmouth in 2017 its rate of improvement over ten years would have to increase by 20 (100 - 80). To reach the rate of the fastest improving district (Teesdale) it would have to increase by 85 (165 - 80) over those ten years to 2017 and to reach rate for the 10th percentile district (Christchurch) it would have to increase by 35 (115 - 80). Great Yarmouth would have to increase its rate by 65 (165 – 100) to reach the rate of Teesdale and by 15 (115 – 100) to reach the rate for Christchurch. The same considerations apply about achievability as discussed in Section 4.4.1.

The rates of improvement for persons shown in Figure 4.4.2 and Table 4.4.2 again do not tell the full story. The patterns of male-female inequality for premature mortality for 2001 to 2005 in Great Yarmouth and Waveney are the same as for all-ages mortality described above in Section 4.4.1.
4.4.3 Life expectancy for men and women

Men

Life expectancy is usually measured from birth for men and women separately, although it can be measured from the age of one year or 50 years or any other age. Rates of improvement on life expectancy from birth for men are shown in Table 4.4.3-a and Figure 4.4.3-a. The current rates of improvement for men from 1995 to 2004 are 2.5 years for Great Yarmouth and 3.1 years for Waveney.

That means for Great Yarmouth that over the last nine years men can now expect to live 2.5 years longer than if life expectancy for the year 1995 had pertained throughout. Waveney has thus had a greater rate of improvement than Great Yarmouth in the five years (3.1 more years versus 2.5).

The rate of improvement for Great Yarmouth is the same as that for the England comparator and better than the East of England’s but Waveney’s is better than these. But both Waveney and Great Yarmouth have rates of improvement that are significantly lower than those for the fastest-improving (Kensington & Chelsea). Waveney’s is better than the 10th percentile districts (Rushmoor) and Great Yarmouth’s is close.

Thus Great Yarmouth would have to more than triple its rate of improvement to be like Kensington & Chelsea (fastest-improving district) and increase it slightly to be like Rushmoor (10th percentile district). Waveney would have to nearly triple its rate to be like Kensington & Chelsea and has already reached the rate for Rushmoor.

For the percentage improvements from their baseline rate Waveney (+ 4.2%) had a greater change than Great Yarmouth (+ 3.4%), the East of England (+ 3.0%), England (+ 3.4%) and Rushmoor (3.7%) comparators but not Kensington & Chelsea (+ 11.6%).

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<td>Great Yarmouth</td>
<td>+ 2.3</td>
<td>+ 2.5*</td>
<td>+ 3.4%</td>
</tr>
<tr>
<td>Waveney</td>
<td>+ 2.6</td>
<td>+ 3.1*</td>
<td>+ 4.2%</td>
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<tr>
<td>East of England</td>
<td>+ 2.3</td>
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<td>+ 3.0%</td>
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<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>England</td>
<td>+ 2.5</td>
<td>+ 2.5*</td>
<td>+ 3.4%</td>
</tr>
<tr>
<td>Kensington &amp; Chelsea**</td>
<td>+ 8.9</td>
<td>+ 8.5*</td>
<td>+ 11.6%</td>
</tr>
<tr>
<td>Rushmoor****</td>
<td>+ 3.3</td>
<td>+ 2.8*</td>
<td>+ 3.7%</td>
</tr>
</tbody>
</table>

* = Statistically significant (p < 0.05)
** = Based on trend
*** = Fastest improving district (excluding outliers)
**** = District at 10th percentile (excluding outliers)
The gaps in the rate of improvement with the fastest-improving district of Kensington & Chelsea are 6.0 and 5.4 years for Great Yarmouth and Waveney respectively. That means for Great Yarmouth that from 1995 to 2004 men would have lived on average another 6 years if they had had the improvement rate for Kensington & Chelsea.

Figure 4.4.3-a shows the rates of improvement for Great Yarmouth and Waveney plus the comparators apart from the 10th percentile one. It has the same format as Figure 4.4.1-a.

Thus if Great Yarmouth continues on its current trend there would be a life expectancy of 78.25 years in five years time from now (2012) and 79.64 years in 10 years time (2017). In each of the five-year periods there would be 1.39 extra years. Kensington & Chelsea had lower life expectancies than the others in 1993 to 1997.

For Great Yarmouth to reach the rate of increase of life expectancy for men for Waveney in 2017 its rate of improvement over ten years would have to increase by 0.66 years (3.44 – 2.78). To reach the rate of the fastest improving district (Kensington & Chelsea) it would have to increase by 6.66 years (9.44 – 2.78) over those ten years to 2017 and by 0.33 years (3.11 – 2.78) for the 10th percentile district (Rushmoor). Waveney would have to maintain its increase to be better placed than 10th percentile district (Rushmoor) in 2017. The same considerations apply about achievability as discussed in Section 3.41.

Women
Rates of improvement on life expectancy from birth for women are shown in Table 4.4.3-b and Figure 4.4.3-b.
The current rates of improvement for women from 1995 to 2004 are 1.2 years for Great Yarmouth and 1.5 years for Waveney. That means for Great Yarmouth that over the last nine years women could have expected to live 1.2 years longer than if life expectancy for the year 1995 had pertained throughout. Great Yarmouth has thus had a lower rate of improvement than Waveney in those nine years (1.2 more years versus 1.5).

The rate of improvement for Great Yarmouth is less than those for the East of England and England comparators and Waveney’s is about the same as these. Both Waveney and Great Yarmouth have rates of change that are significantly lower than those for the fastest-improving (Kensington & Chelsea) and 10th percentile districts (Windsor & Maidenhead).

Thus Great Yarmouth would have to more than quadruple its rate of improvement to be like Kensington & Chelsea (fastest-improving district) and more than double it to be like Windsor & Maidenhead (10th percentile district). Waveney faces similar challenges to be like Kensington & Chelsea and Windsor & Maidenhead.

For the percentage improvements from their baseline rate Waveney (1.8%) had greater changes than Great Yarmouth (+1.5%) and the East of England (+1.4%) but lower change than England (+2.0%) but not Kensington & Chelsea (+6.9%) or Windsor & Maidenhead (+3.3%).

<table>
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<th>Actual rate change</th>
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<td>+1.2</td>
<td>+1.2*</td>
<td>+1.5%</td>
</tr>
<tr>
<td>Waveney</td>
<td>+1.3</td>
<td>+1.5*</td>
<td>+1.8%</td>
</tr>
<tr>
<td>East of England</td>
<td>+1.4</td>
<td>+1.4*</td>
<td>+1.8%</td>
</tr>
<tr>
<td>Coastal &amp; Countryside</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>England</td>
<td>+1.5</td>
<td>+1.6*</td>
<td>+2.0%</td>
</tr>
<tr>
<td>Kensington &amp; Chelsea***</td>
<td>+5.1</td>
<td>+5.6*</td>
<td>+6.9%</td>
</tr>
<tr>
<td>Windsor &amp; Maidenhead****</td>
<td>+2.6</td>
<td>+2.6*</td>
<td>+3.3%</td>
</tr>
</tbody>
</table>

* = Statistically significant (p < 0.05)
** = Based on trend
*** = Fastest improving district (excluding outliers)
**** = District at 10th percentile (excluding outliers)

The gaps in the rate of improvement with the fastest-improving district of Kensington & Chelsea over 1995 to 2004 are 4.4 and 4.1 years for Great Yarmouth and Waveney respectively. That means for Great Yarmouth that over those last ten years women would have lived on average another 4.4 years if they had had the improvement rate for Kensington & Chelsea.
Figure 4.4.3-b shows the rates of improvement for Great Yarmouth and Waveney plus the comparators apart from the 10th percentile one. It has the same format as Figure 4.4.1-b. Thus if Great Yarmouth continues on its current trend there would be a life expectancy of 81.98 years in five years time from now (2012) and 82.64 years in ten years time (2017). In each of the five-year periods there would be a gain of 0.66 of an extra year.

For Great Yarmouth to reach the rate of life expectancy increase for women for Waveney in 2017 its rate of improvement over ten years would have to increase by 0.33 years (1.67 – 1.33).

To reach the rate of the fastest improving district (Kensington & Chelsea) Great Yarmouth would have to increase by 4.89 years (6.22 – 1.33) over those ten years to 2017 and Waveney by 4.55 years (6.22 – 1.67). To reach the rate of the 10th percentile district (Windsor & Maidenhead) Great Yarmouth would have to increase by 1.56 years (2.89 – 1.33) and Waveney by 1.22 years (2.89 – 1.67). The same considerations apply about achievability as discussed in Section 4.4.1.

4.4.4 Years-of-life lost

Years-of-life lost measures the number of years an individual loses compared to if they had died at some standard age such as 75 years. So someone who dies at age 50 would have lost 25 life years.
Rates of improvement on years-of-life lost before the age of 75 years using the directly-standardised rate per 10,000 population are shown in Table 4.4.4 Figure 4.4.4.

The current rates of improvement from 1997 to 2004 are 187.7 for Great Yarmouth and 141.8 for Waveney per 10,000.

That means for Great Yarmouth that over the last seven years there have been 188 fewer years of life lost per 10,000 population than if the 1997 years-of-life lost rate had pertained throughout. Great Yarmouth has thus had a greater rate of improvement than Waveney in the eight years (188 fewer years-of-life lost per 10,000 versus 142).

The rate of improvement for Great Yarmouth is better than for the East of England, Coastal and Countryside, and England comparators, but Waveney’s is only better than that for the East of England comparator.

Both Waveney and Great Yarmouth have rates of improvement that are significantly lower than those for the fastest-improving district (Southwark).

Great Yarmouth has a better rate of improvement than the 10th percentile district (Halton). Thus Waveney would have to nearly double its rate to be like Southwark (fastest-improving district) and increase it by 20% to be like Halton (10th percentile district). Great Yarmouth would have to increase its rate by just under half to be like Southwark.

For the percentage improvements from their baseline rate Great Yarmouth (-27.6%) had greater changes than Waveney (-24.1%), the East of England (-21.7%), Coastal and Countryside (-25.5%), England (-24.8%) and the 10th percentile district of Halton (-21.9%) comparators but not Southwark (-33.1%).

Table 4.4.4: Rates of improvement on years-of-life lost under 75 years using directly-standardised rate per 10,000 from 1997 to 2004 with forecasts for persons

<table>
<thead>
<tr>
<th>Area</th>
<th>Actual rate change</th>
<th>Linear trend</th>
<th>Relative % change**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Great Yarmouth</td>
<td>-157.1</td>
<td>-187.7*</td>
<td>-27.6%</td>
</tr>
<tr>
<td>Waveney</td>
<td>-124.7</td>
<td>-141.8*</td>
<td>-24.1%</td>
</tr>
<tr>
<td>East of England</td>
<td>-105.4</td>
<td>-113.0*</td>
<td>-21.7%</td>
</tr>
<tr>
<td>Coastal &amp; Countryside</td>
<td>-136.0</td>
<td>-153.7*</td>
<td>-25.5%</td>
</tr>
<tr>
<td>England</td>
<td>-134.2</td>
<td>-149.4*</td>
<td>-24.8%</td>
</tr>
<tr>
<td>Southwark***</td>
<td>-257.9</td>
<td>-267.8*</td>
<td>-33.1%</td>
</tr>
<tr>
<td>Halton****</td>
<td>-172.3</td>
<td>-167.2*</td>
<td>-21.9%</td>
</tr>
</tbody>
</table>

* = Statistically significant (p < 0.05)
** = Based on trend
*** = Fastest improving district (excluding outliers)
**** = District at 10th percentile (excluding outliers)
The gaps in the rate of improvement with the fastest-improving district of Southwark are 80.1 and 126.0 per 10,000 for Great Yarmouth and Waveney respectively. That means for Great Yarmouth that from 1997 to 2004 there would have been 80 fewer life-years lost per 10,000 population if they had had the improvement rate for Southwark.

Figure 4.4.4 shows the rates of improvement for Great Yarmouth and Waveney plus the comparators apart from the 10th percentile one. It has the same format as Figure 4.4.1.

Thus if Great Yarmouth continues on its current trend there would be a years-of-life lost rate of 304 in five years time from now (2012) and a rate of 169 in 10 years time (2017). In each of the five-year periods there would be 134 fewer years-of-life lost per 10,000 population. Southwark has had a much higher rate than the others.

Great Yarmouth will reach the rate for Waveney of 304 in the year 2012 if the current rates of improvement continue. To reach the rate of the fastest-improving district Great Yarmouth would have to increase by 114 (382 - 268) over those ten years to 2017 and Waveney by 180 (382 - 202). To reach the rate of the 10th percentile district Great Yarmouth would have to continue on its current trend over those ten years to 2017 and Waveney increase its rate by 37 (239 - 202). The same considerations apply about achievability as discussed in Section 4.4.1.

The rates of improvement for persons shown in Figure 4.4.4 and Table 4.4.4 again do not tell the full story for the last five years. The male rates of improvement were both very good
whereas the female rate for Waveney worsened (that is increased) markedly but the female rate for Great Yarmouth improved satisfactorily.

This is not the same pattern as seen for all-cause all-age mortality or premature mortality described above in Sections 4.4.1 and 4.4.2. This difference can only mean that the age-specific mortality rates of young men in Great Yarmouth are improving markedly whereas those for middle-aged and elderly men show a worse picture.

4.4.5  **Coronary Heart Disease mortality**

Rates of improvement on all-ages mortality from Coronary Heart Disease (CHD) using the directly-standardised rate are shown in Table 4.4.5 and Figure 4.4.5.

The rates of improvement from 1996 to 2005 were 58.5 for Great Yarmouth and 62.8 for Waveney per 100,000. That means for Great Yarmouth that over the last nine years there have been 59 fewer deaths from CHD per 100,000 population than if the 1996 mortality rate had pertained throughout. Waveney has thus had a greater rate of improvement than Great Yarmouth in this period (62.8 fewer CHD deaths per 100,000 versus 58.5).

The rates of improvement for Great Yarmouth and Waveney are slightly better than those for the East of England and Coastal and Countryside comparators and slightly less than for England. They are markedly lower than those for the fastest-improving and 10th percentile districts.

Thus Great Yarmouth would have to nearly double its rate of improvement to be like Teesdale (fastest-improving district) with a similar but slightly smaller improvement needed to be like Coventry (10th percentile district). Waveney would have to increase its rate of improvement by over half as much to be like Teesdale and Coventry.

For the percentage improvements from their baseline rate Waveney (- 40.6%) had greater changes than Great Yarmouth (- 36.4%). Both rates of improvement were similar to those of the comparators of East of England, Coastal and Countryside, and England but markedly less than those for Teesdale and Coventry.
Table 4.4.5: Rates of improvement on CHD mortality using directly-standardised rate per 100,000 from 1996 to 2005 for persons

<table>
<thead>
<tr>
<th>Area</th>
<th>Actual rate change</th>
<th>Linear trend</th>
<th>Relative % change**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Great Yarmouth</td>
<td>-53.2</td>
<td>-58.5*</td>
<td>-36.4%</td>
</tr>
<tr>
<td>Waveney</td>
<td>-55.5</td>
<td>-62.8*</td>
<td>-40.6%</td>
</tr>
<tr>
<td>East of England</td>
<td>-57.6</td>
<td>-57.9*</td>
<td>-38.7%</td>
</tr>
<tr>
<td>Coastal &amp; Countryside</td>
<td>-56.5</td>
<td>-56.7*</td>
<td>-37.0%</td>
</tr>
<tr>
<td>England</td>
<td>-67.7</td>
<td>-66.0*</td>
<td>-39.3%</td>
</tr>
<tr>
<td>Teesdale***</td>
<td>-128.1</td>
<td>-108.2*</td>
<td>-53.5%</td>
</tr>
<tr>
<td>Coventry****</td>
<td>-91.7</td>
<td>-98.6*</td>
<td>-51.8%</td>
</tr>
</tbody>
</table>

* = Statistically significant (p < 0.05)
** = Based on trend
*** = Fastest improving district (excluding outliers)
**** = District at 10th percentile (excluding outliers)

The gaps in the rate of improvement with the fastest-improving district of Teesdale are 49.7 and 45.4 per 100,000 for Great Yarmouth and Waveney respectively. That means for Great Yarmouth that from 1996 to 2005 there would have been 50 fewer CHD deaths per 100,000 population if they had had the improvement rate for Teesdale.

Figure 4.4.5 shows the rates of improvement for Great Yarmouth and Waveney plus the comparators apart from the 10th percentile one. It has the same format as Figure 4.4.1.

Thus if Great Yarmouth continues on its current trend there would be a CHD mortality rate of 57 in five years time from now (2012) and a rate of 24 in 10 years time (2017). In each of the five-year periods there would be 33 fewer CHD deaths per 100,000 population. This would leave Great Yarmouth with a low CHD mortality rate. It is also noteworthy that if Teesdale continues with its current trend it will eradicate CHD in less than five years. Teesdale also started with a much higher rate than the others.
Figure 4.4.5: Rates of improvement on CHD mortality using directly-standardised rate from 1996 to 2005 with forecasts for persons

For Great Yarmouth to reach the rate of the fastest improving district (Teesdale) it would have to increase by 55 (120 - 65) over the next ten years to 2017 and Waveney would have to increase by 50 (120 - 70) to do the same. For Great Yarmouth to reach the rate of the 10th percentile district (Coventry) by 2017 it would have to increase by 45 (110 – 65) and for Waveney to reach this rate it would have to increase by 40 (110 – 70). In both scenarios in so doing it would have eradicated CHD in the area. The same considerations apply about achievability as discussed in Section 4.4.1.

The rates of improvement for persons shown in Figure 4.4.5 and Table 4.4.5 again do not tell the full story. The patterns of male-female inequality for CHD mortality for 2001 to 2005 in Great Yarmouth and Waveney are the same as for all-ages all-causes mortality and premature mortality described above in Sections 4.4.1 and 4.4.2.

4.4.6 Summary of the mortality indicator findings

The rates of improvement for all the mortality indicators that were analysed for Great Yarmouth, Waveney, the fastest-improving districts, and the 10th percentile ones are shown in Table 4.4.6.

The gaps with the comparator districts to achieve the same values as them by the year 2017 for these mortality indicators are also shown. The rates of improvement for all-ages all-causes mortality show a similar picture to those for life expectancy and CHD mortality with
Waveney doing better than Great Yarmouth. However for premature mortality and life-years lost Great Yarmouth is doing better than Waveney.

The age-specific death rates for young men in Great Yarmouth must be improving at a faster rate than for Waveney. For life-years lost Great Yarmouth is already in the top ten percent of improvement nationally.

For life expectancy for men Waveney is also already in the top ten percent nationally. In general achieving the rates of improvement of the fastest-improving districts seems almost impossible given the wideness of gaps and the impact of any residual healthy migrancy effect.

**Aiming to be in the top ten percent nationally for each indicator is a much more realistic yet still challenging target. If this were achieved across all the indicators, on a balanced score card approach the people of Great Yarmouth and Waveney would have the fastest-improving health nationally.**

<table>
<thead>
<tr>
<th></th>
<th>Great Yarmouth</th>
<th>Waveney</th>
<th>Gaps with fastest-improving district to 2017</th>
<th>Gaps with 10th percentile district to 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>All-ages all causes mortality (/10^5)</td>
<td>110.4</td>
<td>126.4</td>
<td>Berwick-upon-Tweed</td>
<td>Newark &amp; Sherwood</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>136</td>
<td>119</td>
<td>67</td>
<td>50</td>
</tr>
<tr>
<td>Premature mortality (/10^5)</td>
<td>89.9</td>
<td>71.9</td>
<td>Teesdale</td>
<td>Christchurch</td>
</tr>
<tr>
<td></td>
<td>65</td>
<td>85</td>
<td>15</td>
<td>35</td>
</tr>
<tr>
<td>Life-years lost (/10^5)</td>
<td>187.7</td>
<td>141.8</td>
<td>Southwark</td>
<td>Halton</td>
</tr>
<tr>
<td></td>
<td>114</td>
<td>180</td>
<td>0’</td>
<td>37</td>
</tr>
<tr>
<td>Life expectancy (Years)</td>
<td></td>
<td></td>
<td>Kensington &amp; Chelsea</td>
<td>Rushmoor</td>
</tr>
<tr>
<td>- Men</td>
<td>2.5</td>
<td>3.1</td>
<td>6.0</td>
<td>5.4</td>
</tr>
<tr>
<td>- Women</td>
<td>1.2</td>
<td>1.5</td>
<td>4.89</td>
<td>4.55</td>
</tr>
<tr>
<td></td>
<td>1.56</td>
<td>1.22</td>
<td>Kensington &amp; Chelsea</td>
<td>Windsor &amp; Maidenhead</td>
</tr>
<tr>
<td>CHD mortality</td>
<td>58.5</td>
<td>62.8</td>
<td>Teesdale</td>
<td>Coventry</td>
</tr>
<tr>
<td></td>
<td>55</td>
<td>50</td>
<td>45</td>
<td>40</td>
</tr>
</tbody>
</table>

= is out performing the 10th percentile district currently
4.5 Mental health trends

4.5.1 Suicides and undetermined injury deaths

Rates of improvement on all-ages mortality from suicides and undetermined injury deaths using the directly-standardised rate are shown in Table 4.5.1 and Figure 4.5.1.

Because the numbers of deaths are much fewer for suicides and undetermined injury only one of the trends in Table 4.5.1 is statistically significant, that for England. Figure 4.5.1 shows the year-on-year variability. The current rate of improvement from 1996 to 2005 for Great Yarmouth is 1.8 per 100,000.

Unfortunately the rate of mortality from suicides and undetermined injury has increased in Waveney by 1.7 per 100,000. For Great Yarmouth over the last nine years there have been about 2 fewer deaths from suicides and undetermined injury per 100,000 population than if the 1996 mortality rate had pertained throughout. Waveney has had 2 more deaths from suicides and undetermined injury per 100,000 population on this basis. Great Yarmouth, the East of England, Coastal and Countryside, and England comparators have all seen a slight decline in the mortality from suicides and undetermined injury. The rate of improvement for Great Yarmouth is significantly lower than the rates of improvement for the fastest-improving percentile district. Waveney would have to increase its rate of improvement over six times to be like Oswestry (fastest-improving district) and by a third to be like the Chichester (10th percentile district). Waveney faces greater challenges than these to be like Oswestry or Chichester.

The percentage change from the baseline rate for Great Yarmouth decreased (improved) by 20% whereas that for Waveney increased (deteriorated) by 19%. Again it must be emphasised that the numbers are small so the relative effects of chance are much greater. Both rates of percentage change were significantly less than that of the fastest-improving district and Waveney’s was significantly less than that of the 10th percentile comparator.
Table 4.5.1: Rates of improvement on suicides and undetermined injury mortality using the directly-standardised rate per 100,000 from 1996 to 2005 with forecasts for persons

<table>
<thead>
<tr>
<th>Area</th>
<th>Actual rate change</th>
<th>Linear trend</th>
<th>Relative % change**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Great Yarmouth</td>
<td>- 1.0</td>
<td>- 1.8</td>
<td>- 19.6%</td>
</tr>
<tr>
<td>Waveney</td>
<td>+ 0.2</td>
<td>+ 1.7</td>
<td>+ 18.6%</td>
</tr>
<tr>
<td>East of England</td>
<td>- 0.9</td>
<td>- 0.5*</td>
<td>- 5.6%</td>
</tr>
<tr>
<td>Coastal &amp; Countryside</td>
<td>+ 0.2</td>
<td>- 0.9</td>
<td>- 7.8%</td>
</tr>
<tr>
<td>England</td>
<td>- 0.7</td>
<td>- 1.1</td>
<td>- 11.6%</td>
</tr>
<tr>
<td>Oswestry***</td>
<td>- 16.7</td>
<td>- 11.3</td>
<td>- 75.3%</td>
</tr>
<tr>
<td>Chichester****</td>
<td>- 5.6</td>
<td>- 2.4</td>
<td>- 23.3%</td>
</tr>
</tbody>
</table>

* = Statistically significant (p < 0.05)
** = Based on trend
*** = Fastest improving district (excluding outliers)
**** = District at 10th percentile (excluding outliers)

The gaps in the rate of improvement with the fastest-improving district of Oswestry are 9.5 and 13.0 per 100,000 for Great Yarmouth and Waveney respectively. That means for Great Yarmouth from 1996 to 2005 there would have been 10 fewer deaths from suicides and undetermined injury per 100,000 population if they had had the improvement rate for Oswestry.

Figure 4.5.1 shows the rates of change for Great Yarmouth and Waveney plus the comparators apart from the 10th percentile one. It has the same format as Figure 4.4.1.

The greater yearly variability because of the smaller numbers can be seen for Oswestry, Great Yarmouth and Waveney compared to the other larger areas. Because the numbers of deaths are much fewer for suicide and undetermined injury the forecasting is much more problematic. From the figure the fastest-improving district should eliminate all the mortality from suicide and undetermined injury by next year, 2008. This is clearly not very likely as the mortality rate is likely to smooth out as it reaches zero.

The model predicts two fewer deaths in Great Yarmouth in the next ten years and two extra ones in Waveney. All the forecasting should be treated circumspectly.

Thus proposing a fastest-improving rate to try to achieve with such small numbers of events and such variability poses inherent problems. As the data stand the gaps in the forecast improvement rates from 2007 to 2107 between Great Yarmouth and Oswestry (the fastest-improving district) and Chichester (the 10th percentile district) are 10.56 and 0.67 per 100,000. The gaps in the forecast improvement rate from 2007 to 2107 between Waveney and Oswestry (the fastest-improving district) and Chichester (the 10th percentile district) are 14.44 and 4.1 per 100,000. Perhaps striving for the 10th percentile improvement rate is more satisfactory.
The rates of improvement for persons shown in Figure 4.5.1 and Table 4.5.1 again do not tell the full story. Only men have seen a decline in mortality from 1996 to 2005 in Great Yarmouth. There have been rises in mortality for men and women in Waveney and for women in Great Yarmouth.

Figure 4.5.1: Rates of improvement on mortality from suicide and undetermined injury using directly-standardised rate from 1996 to 2005 with forecasts for persons

4.5.2 Alcohol-use disorders as assessed by the standardised mortality rate for chronic liver disease

Rates of improvement on all-ages mortality from chronic liver disease using the directly-standardised rate are shown in Table 4.5.2 and Figure 4.5.2. Because the numbers of deaths are much fewer for chronic liver disease none of the trends in Table 4.5.2 are statistically significant. Figure 4.5.2 shows the year-on-year variability.

The current rates of change from 1996 to 2005 for Great Yarmouth and Waveney are +2.5 and +2.7 per 100,000 respectively. Unfortunately the rates of mortality from chronic liver disease have increased.

That means for both Great Yarmouth and Waveney that from 1996 to 2005 there have been 3 more deaths from chronic liver disease per 100,000 population than if the 1996 mortality rate had pertained throughout in each area.

The East of England, Coastal and Countryside, and England comparators have also seen a rise in the mortality from chronic liver disease like Waveney. The rates of change for Great
Yarmouth and Waveney are markedly worse than the rates of improvement for the fastest-improving and 10th percentile districts. Great Yarmouth and Waveney would both have to start to improve their rate significantly to be like Rutland (fastest-improving district) and double it to be like Huntingdonshire (10th percentile district).

The percentage change from the baseline rate for Great Yarmouth was an increase of +32.1% whereas that for Waveney was an increase of +53.7%. A similar pattern was seen in East of England, Coastal & Countryside, and England. The rates of percentage change for Great Yarmouth and Waveney were significantly worse than those of the fastest-improving and 10th percentile comparators.

<table>
<thead>
<tr>
<th>Area</th>
<th>Actual rate change</th>
<th>Linear trend</th>
<th>Relative % change**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Great Yarmouth</td>
<td>+ 1.2</td>
<td>+ 2.5</td>
<td>+ 32.1%</td>
</tr>
<tr>
<td>Waveney</td>
<td>+ 3.5</td>
<td>+ 2.7</td>
<td>+ 53.7%</td>
</tr>
<tr>
<td>East of England</td>
<td>+ 2.2</td>
<td>+ 2.4*</td>
<td>+ 50.0%</td>
</tr>
<tr>
<td>Coastal &amp; Countryside</td>
<td>+ 2.1</td>
<td>+ 2.5*</td>
<td>+ 35.3%</td>
</tr>
<tr>
<td>England</td>
<td>+ 3.1</td>
<td>+ 3.2*</td>
<td>+ 43.8%</td>
</tr>
<tr>
<td>Rutland***</td>
<td>- 6.3</td>
<td>- 4.7</td>
<td>- 62.2%</td>
</tr>
<tr>
<td>Huntingdonshire****</td>
<td>- 2.3</td>
<td>- 1.7</td>
<td>- 26.1%</td>
</tr>
</tbody>
</table>

* = Statistically significant (p < 0.05)
** = Based on trend
*** = Fastest improving districts (excluding outliers)
**** = Districts at 10th percentile (excluding outliers)

The gaps in the rate of improvement with the fastest-improving district of Rutland are 7.2 and 7.4 per 100,000 for Great Yarmouth and Waveney respectively. That means for both Great Yarmouth and Waveney over this period there would have been 7 fewer chronic liver disease deaths per 100,000 population in each area if they had had the improvement rate for Rutland.

Figure 4.5.2 shows the rate of improvement for Great Yarmouth and rate of worsening for Waveney plus the comparators apart from the 10th percentile one. It has the same format as Figure 4.4.1.

Because the numbers of deaths are much fewer for chronic liver disease the forecasting is much more problematic. From the figure the fastest-improving district should have eliminated all the mortality from chronic liver disease by 2011. This is clearly not likely as the mortality rate is likely to smooth out as it reaches zero. There is great yearly variability in all the districts’ time series. All the forecasting should be treated circumspectly. Thus proposing a fast-
est-improving rate to try to achieve with such small numbers of events and such variability poses inherent problems. Perhaps striving for the 10th or 20th percentile improvement rate is more satisfactory.

For Great Yarmouth to reach the rate of the fastest improving district (Rutland) it would have to increase its rate of improvement by 8.99 (5.22 + 2.77) over the next ten years to 2017 and by 5.32 (2.55 + 2.77) to reach the rate of the 10th percentile district (Huntingdonshire). For Waveney to reach the fastest-improving district (Rutland) it would have to increase by 8.22 (5.22 + 3.00) and to reach the 10th percentile district (Huntingdonshire) it would have to increase by 5.55 (2.55 + 3.00). In both scenarios in so doing they would have altered the upward trends markedly.

The rates of improvement for persons shown in Figure 4.5.2 and Table 4.5.2 again do not tell the full story. The patterns of male-female inequality for chronic liver disease mortality from 2001 to 2005 in Great Yarmouth and Waveney are the same as for all-ages all-causes mortality, premature mortality and CHD mortality described above in Sections 4.4.1, 4.4.2 and 4.4.5.

4.5.3 Deliberate self harm
People who deliberately harm themselves are usually suffering from a mental health problem such as a depression. The rate of admission to hospital of people who deliberately harm them-
selves sufficiently severely is thus a measure of this mental health condition. Unfortunately the data for all the PCTs were not available so we have not been able to undertake our usual 10th percentile and fastest-improving districts analyses. So for this indicator we have used as comparators those districts that are most like Great Yarmouth and Waveney from the ONS classification of areas using the 2001 Census. These are Waveney and Great Portland for Great Yarmouth and Allerdale for Waveney.

Rates of improvement (using the directly-standardised rate) on the admission to hospital of people who deliberately harm themselves are shown in Table 4.5.3 and Figure 4.5.3. The current rates of change from 2002 to 2006 for Great Yarmouth and Waveney are −19.7 and −12.0 per 100,000 respectively. Thus the rates of hospital admission for deliberate self harm have reduced unlike for all the other comparators.

That means for Great Yarmouth and Waveney that from 2002 to 2006 there have been 20 and 12 fewer admissions respectively from deliberate self harm per 100,000 population than if the 2002 admission rate had pertained throughout in each area.

The East of England and England comparators have seen a rise in the hospital admission rate from deliberate self harm. The rates of change for Great Yarmouth and Waveney are markedly better than the rates for Weymouth and Great Portland and Allerdale, both of which have seen increased rates.

The percentage changes from the baseline rate for Great Yarmouth and Waveney were decreases of 33.4% and 27.6%. Unlike the patterns seen in the other comparators which were all increases of about a third.

<table>
<thead>
<tr>
<th>Area</th>
<th>Actual rate change</th>
<th>Linear trend</th>
<th>Relative % change**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Great Yarmouth*</td>
<td>- 85.3</td>
<td>- 19.7*</td>
<td>- 34.3%</td>
</tr>
<tr>
<td>Waveney</td>
<td>- 45.2</td>
<td>- 12.0*</td>
<td>- 25.8%</td>
</tr>
<tr>
<td>East of England</td>
<td>+ 42.1</td>
<td>+ 10.3*</td>
<td>+ 33.7%</td>
</tr>
<tr>
<td>England</td>
<td>+ 60.8</td>
<td>+ 16.3*</td>
<td>+ 37.6%</td>
</tr>
<tr>
<td>Allerdale***</td>
<td>+ 104.7</td>
<td>+ 26.6*</td>
<td>+ 35.8%</td>
</tr>
<tr>
<td>Weymouth &amp; Portland****</td>
<td>+ 85.9</td>
<td>+ 17.4</td>
<td>+ 32.2%</td>
</tr>
</tbody>
</table>

* = Statistically significant (p < 0.05)
** = Based on trend
*** = Most similar district to Waveney
**** = Most similar district to Great Yarmouth

There is no information on better performers available on the rate of improvement.
Figure 4.5.3 shows the rate of change for Great Yarmouth and Waveney plus the comparators. It has the same format as Figure 4.4.1.

From the figure Great Yarmouth should have eliminated all the hospital admissions from deliberate self harm by 2013. This is clearly not likely as the hospital admission rate is likely to smooth out as it reaches zero. All the forecasting should be treated circumspectly. Waveney will have a very low rate by the year 2017 if its current rate continues.

Great Yarmouth and Waveney need to keep on improving at their current rate.

4.5.4 Alcohol-use disorders as assessed by hospital admissions for alcohol-specific conditions

***Still awaiting data for this section***

4.5.5 Summary of the mental health indicator findings

The rates of improvement for all the mental health indicators that were analysed for Great Yarmouth, Waveney, the fastest-improving districts, and the 10th percentile ones are shown in Table 4.5.5.

The gaps with the comparator districts to achieve the same values as them by the year 2017 for these mental health indicators are also shown. The ones for suicides and chronic liver
disease are based on small numbers so the forecasts are not very secure. Waveney’s suicide trend and Great Yarmouth and Waveney’s trends for chronic liver disease and deliberate self harm are all increasing.

Thus for these indicators the two districts need to reverse these trends and then catch up with the falls in the comparators. It would seem nearly impossible for the two districts to reach the trends of the fastest-improving district for the suicide and chronic liver disease mortality indicators given the performances of the Coastal and Countryside cluster, the East of England, and England and the wideness of the gaps. Aiming to be in the top ten percent nationally for each indicator is a much more realistic yet still challenging target.

### Table 4.5.5: The performance on rates of improvement for mental health indicators with gaps to target positions for 2017

<table>
<thead>
<tr>
<th></th>
<th>Great Yarmouth</th>
<th>Waveney</th>
<th>Great Yarmouth</th>
<th>Waveney</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicides (/10^5)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1.8</td>
<td>- 1.7</td>
<td>10.56</td>
<td>14.44</td>
</tr>
<tr>
<td>Alcohol-use disorders: chronic liver disease mortality (/10^5)</td>
<td>- 2.5</td>
<td>- 2.7</td>
<td>8.99</td>
<td>8.22</td>
</tr>
<tr>
<td>Deliberate self harm</td>
<td>19.7</td>
<td>12.0</td>
<td>East of England**</td>
<td>East of England**</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

* = based on most recent trend data available over ten years and improvements (falls) are all expressed as positive
** = East of England has been taken as the best comparator because of the lack of complete comparative data but the trend was rising

### 4.6 Burden of disease

#### 4.6.1 Cancer

Rates of improvement for the incidence of cancer using the directly-standardised registration rate are shown in Table 4.6.1 and Figure 4.6.1.

Unfortunately the incidence rates for cancer from 1995 to 2004 have increased in Great Yarmouth by 27.8 cases per 100,000 and in Waveney by 16.2 per 100,000. That means for Great Yarmouth over the last nine years there have been about 28 more cases of cancer occurring per 100,000 population than if the 1995 incidence rate had pertained throughout. Waveney has had 16 more cases of cancer per 100,000 population on this basis.
The Coastal and Countryside and England comparators have also seen increases in the incidence of cancer. The East of England has done particularly well with a decline of 6.5 per 1000,000. The rates of change for Great Yarmouth and Waveney are significantly worse than the rates of improvement for the fastest-improving and 10th percentile districts. Great Yarmouth and Waveney would have to reverse the increasing trends and then make very major improvements to be like the Isles of Scilly (fastest-improving district) and North Cornwall (10th percentile district).

The percentage changes from the baseline rate for Great Yarmouth and Waveney were increases of 8.2% and 4.8% respectively. The fastest-improving and 10th percentile comparators had decreases.

Table 4.6.1: Rates of improvement for cancer using the directly-standardised registration rate per 100,000 from 1995 to 2004 for persons

<table>
<thead>
<tr>
<th>Area</th>
<th>Actual rate change</th>
<th>Linear trend</th>
<th>Relative % change**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Great Yarmouth</td>
<td>+ 9.5</td>
<td>+ 27.8</td>
<td>+ 8.2%</td>
</tr>
<tr>
<td>Waveney</td>
<td>- 17.7</td>
<td>+ 16.2</td>
<td>+ 4.8%</td>
</tr>
<tr>
<td>East of England</td>
<td>- 11.1</td>
<td>- 6.5</td>
<td>- 1.9%</td>
</tr>
<tr>
<td>Coastal &amp; Countryside</td>
<td>+ 16.1</td>
<td>+ 20.5*</td>
<td>+ 5.8%</td>
</tr>
<tr>
<td>England</td>
<td>+ 8.4</td>
<td>+ 8.3</td>
<td>+ 2.3%</td>
</tr>
<tr>
<td>Isles of Scilly***</td>
<td>- 183.0</td>
<td>- 79.6</td>
<td>- 21.5%</td>
</tr>
<tr>
<td>North Cornwall****</td>
<td>- 28.7</td>
<td>- 12.1</td>
<td>- 3.4%</td>
</tr>
</tbody>
</table>

* = Statistically significant (p < 0.05)
** = Based on trend
*** = Fastest improving district (excluding outliers)
**** = District at 10th percentile (excluding outliers)

The gaps in the rate of improvement with the fastest-improving district of the Isles of Scilly are 107.4 cases and 95.8 cases per 100,000 for Great Yarmouth and Waveney respectively. That means for Great Yarmouth from 1995 to 2004 there would have been 107 fewer cases of cancer per 100,000 population if they had had the improvement rate of the Isles of Scilly. The Isles of Scilly has a small population. However the statistical techniques we used did not identify them as an outlier. Even if we had used the rate for the 10th percentile district (-28.7) in the calculation of the potential gap there would still have been 56 fewer cases of cancer in Great Yarmouth.

Figure 4.6.1 shows the rates of change for Great Yarmouth and Waveney plus the comparators apart from the 10th percentile one. It also shows the predicted rates for future years. We are in the 2007 calendar year now and the latest data is for 2004. The greater variability be-
cause of the smaller numbers can be seen for the Isles of Scilly compared to the other larger areas. All the forecasting should be treated circumspectly.

Waveney and Great Yarmouth have had similar cancer incidence rates between 1993 to 2004, which have been lower than for the Coastal and Countryside and England comparators. Recently a slight gap has opened up favouring Waveney with slight falls in the East of England as well. For Great Yarmouth to reach over the next ten years to 2017 the rate of the fastest-improving district (Isles of Scilly) it would have to reduce the incidence by 119.34 (= 30.9 + 88.44) /100,000 and to reach the rate of the 10th percentile district (North Cornwall) it would have to reduce the incidence by 44.3 (= 30.9 + 13.4) /100,000. For Waveney to reach over the next ten years to 2017 the rate of the fastest-improving district (Isles of Scilly) it would have to reduce the incidence by 106.44 (= 18.00 + 88.44) /100,000 and to reach the 10th percentile district (North Cornwall) it would have to reduce it by 31.4 (= 18.00 + 13.4) /100,000. Again here is another example of where striving for the 10th percentile improvement rate would be more satisfactory than striving for the fastest-improving one.

The rates of improvement for persons shown in Figure 4.6.1 and Table 4.6.1 again do not tell the full story. For men in Waveney there has been a decline in cancer incidence whereas for the women in Waveney there has been a marked increase. Thus the pattern seen for all-cause mortality in Section 4.4.1 is mirrored again.
4.6.2 Comparative illness and disability ratios

The Comparative Illness and Disability Ratio (CIDR) indicator is only published infrequently and when it is, it is for Lower Super Output Areas. The last two times were in 2003 and 2005 and the data was for 2001 and 2003. The CIDR for Great Yarmouth and Waveney for 2001 and 2003 are shown in Table 4.6.2 and Figure 4.6.2.

The information is not available for the coastal and countryside comparator. Most of English districts saw an increase the CIDR in this period. The CIDR for Great Yarmouth showed one of the higher increases (6.9%). But Waveney, the East of England one, and England all had increases. Mid Suffolk which is the 10th percentile district based on the 2001/2003 changes saw a slight decrease of 3.3%.

The fastest-improving district was the Isles of Scilly with a 12.8% fall. For Great Yarmouth to reach over the next ten years to 2017 the rate of the fastest-improving district (Isles of Scilly) it would have to reduce the ratio by 19.7% (= 12.8% + 6.9%) and to reach the ratio of the 10th percentile district (Mid Suffolk) it would have to reduce the ratio by 10.2% (= 3.3% + 6.9%). For Waveney to reach over the next ten years to 2017 the ratio of the fastest-improving district (Isles of Scilly) it would have to reduce the ratio by 17.1% (= 12.8% + 4.3%) and to reach the 10th percentile district (Mid Suffolk) it would have to reduce it by 7.6% (= 3.3% + 4.3%). This again may be an example of where aiming for the 10th percentile is a better target.

<table>
<thead>
<tr>
<th>Area</th>
<th>2001 Aggregate Ratio for all SOAs</th>
<th>2003 Aggregate Ratio for all SOAs</th>
<th>% Changes 2001 to 2003</th>
<th>Rank of district ('01 to '03 % change)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Great Yarmouth</td>
<td>122.9</td>
<td>131.4</td>
<td>6.9%</td>
<td>90%</td>
</tr>
<tr>
<td>Waveney</td>
<td>112.7</td>
<td>117.5</td>
<td>4.3%</td>
<td>74%</td>
</tr>
<tr>
<td>East of England</td>
<td>88.9</td>
<td>90.9</td>
<td>2.2%</td>
<td>NA*</td>
</tr>
<tr>
<td>England</td>
<td>113.1</td>
<td>117.0</td>
<td>3.5%</td>
<td>NA*</td>
</tr>
<tr>
<td>Mid Suffolk**</td>
<td>71.6</td>
<td>69.3</td>
<td>-3.3%</td>
<td>10%</td>
</tr>
</tbody>
</table>

* NA = Not Available
** = District at 10th percentile (excluding outliers)
4.6.3 Oral health of 5 year olds

Every few years the community dental services did surveys of school children’s teeth, alternating between different age groups. This allowed the extent of diseased teeth in children to be assessed. One age group chosen was five year olds since this would reflect the state of first teeth in an area or school, which could then be used to inform preventative action for second teeth. The diseased, missing or filled tooth (DMFT) in five year olds is or has been diseased with tooth decay. The DMFT indicator is only published infrequently. The last two times were for the academic years 2001/02 and 2003/04. Not all districts had the information available.

The mean DMFT situation for Great Yarmouth and Waveney PCTs for 2001 and 2003 are shown in Table 4.6.3 and Figure 4.6.3. The information is not available for the coastal and countryside comparator.

England saw an increase (+0.2) in the mean DMFT score in this period. The mean DMFT score for Great Yarmouth showed one of the higher increases (+0.44). The 95% confidence interval on the DMFT score of 1.07 in 2001/02 for Great Yarmouth is quite large though (from 0.67 to 1.47). More trend data is therefore necessary to have confidence in these figures and trends at the district level. The confidence intervals for England and the SHA area are much narrower. Waveney (-1.0) and Norfolk, Suffolk and Cambridgeshire (-0.8) had decreases. The comparator districts were chosen from those that had statistically significant changes with non-overlapping confidence intervals for the two periods.
The fastest-improving district was Westminster with a fall of -1.35. Oldham which is the 10\textsuperscript{th} percentile district saw a slight decrease of -0.91. The five year old children in the two comparator districts did have worse teeth to start with.

For Great Yarmouth to reach over the next ten years to 2017 the rate of the fastest-improving district (Westminster) it would have to reduce the mean number of DFMTs by 1.79 (= 1.35 + 0.44) and to reach the ratio of the 10\textsuperscript{th} percentile district (Mid Suffolk) it would have to reduce it by 1.35 (= 0.91 + 0.44). For Waveney to reach over the next ten years to 2017 the rate of the fastest-improving district (Isles of Scilly) it would have to reduce the mean number of DFMTs by 1.25 (= 1.35 - 0.10) and to reach the 10\textsuperscript{th} percentile district (Oldham PCT) it would have to reduce it by 0.81 (= 0.91 – 0.10).

### Table 4.6.3: Diseased, Missing, or Filled Teeth in five year olds - changes from 2001/02 to 2003/04

<table>
<thead>
<tr>
<th>Area</th>
<th>Mean number of DMFT in 2001/02</th>
<th>Mean number of DMFT in 2003/04</th>
<th>Absolute change</th>
<th>Relative percentage change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Great Yarmouth PCT</td>
<td>1.07</td>
<td>1.51</td>
<td>+ 0.44</td>
<td>+ 41.1%</td>
</tr>
<tr>
<td>Waveney PCT</td>
<td>1.26</td>
<td>1.16</td>
<td>- 0.10</td>
<td>- 7.9%</td>
</tr>
<tr>
<td>Norfolk, Suffolk and Cambridgeshire SHA</td>
<td>1.29</td>
<td>1.21</td>
<td>-0.08</td>
<td>- 6.2%</td>
</tr>
<tr>
<td>Coastal &amp; Countryside</td>
<td>NA*</td>
<td>NA*</td>
<td>NA*</td>
<td>NA*</td>
</tr>
<tr>
<td>England</td>
<td>1.47</td>
<td>1.49</td>
<td>+ 0.02</td>
<td>+ 1.4%</td>
</tr>
<tr>
<td>Westminster PCT***</td>
<td>3.04</td>
<td>1.69</td>
<td>- 1.35**</td>
<td>- 44.4%</td>
</tr>
<tr>
<td>Oldham PCT ****</td>
<td>2.96</td>
<td>2.05</td>
<td>- 0.91**</td>
<td>- 30.7%</td>
</tr>
</tbody>
</table>

* = NA - Not Available  
** = Statistically significant with p < 0.05  
*** = Fastest improving district (excluding outliers)  
**** = District at 10th percentile (excluding outliers)

Figure 4.6.3 shows the changes in the mean numbers of DMFT for Great Yarmouth, Waveney, Norfolk, Suffolk and Cambridgeshire, and Westminster but because of the paucity of data we cannot produce trends.
4.6.4 Fractured neck of femur

Fracturing the neck of the femur nearly always ends up in an emergency admission to hospital. Thus rates of admission to hospital with a fractured neck of femur are a good measure of underlying incidence of the condition. Fractured neck of femur usually occurs in the elderly and can have a devastating effect. Fortunately modern orthopaedic surgery is now producing good outcomes for this condition.

Rates of improvement for emergency admission to hospital with fractured neck of femur using the directly-standardised admission rate are shown in Table 4.6.4 and Figure 4.6.4.

The rate of improvement from 1998/98 to 2003/04 for Waveney was 21.7 per 100,000. Unfortunately the emergency admission rate to hospital with fractured neck of femur has increased in Great Yarmouth by 6.4 per 100,000. That means for Waveney over the last five years there have been about 22 fewer fractured necks of femur occurring per 100,000 population than if the 1998/99 incidence rate had pertained throughout. Great Yarmouth has had 6 more fractured necks of femur per 100,000 population on this basis.

The East of England, Coastal and Countryside, and England comparators have also seen declines in fractured necks of femur with the East of England doing particularly well. But the rate of improvement for Waveney is significantly lower than the rates of improvement for the fastest-improving and 10th percentile districts. Waveney would have to double its rate of improvement to be like Corby (fastest-improving district) but it is nearly at the rate for
Sedgemoor (10th percentile district). Great Yarmouth faces greater challenges than these to be like Corby or Sedgemoor.

The percentage change from the baseline rate for Waveney reduced by 20.3% whereas that for Great Yarmouth worsened (increased) by 6.7%. The rate of percentage change for Great Yarmouth was significantly less than those of the fastest-improving and 10th percentile comparators. Waveney’s rate of percentage improvement was much less than Corby’s but greater than those for the East of England, Coastal and Countryside, and England and was very close to Sedgemoor’s.

<table>
<thead>
<tr>
<th>Area</th>
<th>Actual rate change</th>
<th>Linear trend</th>
<th>Relative % change**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Great Yarmouth</td>
<td>+ 4.3</td>
<td>+ 6.4</td>
<td>+ 6.7%</td>
</tr>
<tr>
<td>Waveney</td>
<td>- 17.6</td>
<td>- 21.7</td>
<td>- 20.3%</td>
</tr>
<tr>
<td>East of England</td>
<td>- 8.6</td>
<td>- 7.9</td>
<td>- 7.9%</td>
</tr>
<tr>
<td>Coastal &amp; Countryside</td>
<td>- 3.3</td>
<td>- 2.5</td>
<td>- 2.7%</td>
</tr>
<tr>
<td>England</td>
<td>- 3.0</td>
<td>- 4.1</td>
<td>- 4.1%</td>
</tr>
<tr>
<td>Corby***</td>
<td>- 51.7</td>
<td>- 50.2*</td>
<td>- 41.7%</td>
</tr>
<tr>
<td>Sedgemoor****</td>
<td>- 21.5</td>
<td>- 23.5*</td>
<td>- 20.6%</td>
</tr>
</tbody>
</table>

* = Statistically significant (p < 0.05)  
** = Based on trend  
*** = Fastest improving district (excluding outliers)  
**** = District at 10th percentile (excluding outliers)

The gaps in the rate of improvement with the fastest-improving district of Corby are 56.6 and 28.5 per 100,000 for Great Yarmouth and Waveney respectively. That means for Great Yarmouth from 1998/99 to 2003/04 there would have been 57 fewer fractured necks of femur per 100,000 population if they had had the improvement rate of the Corby. Even if we had used the rate for the 10th percentile district (- 23.5) in the calculation of the potential gap there would still have been 30 fewer fractured necks of femur in Great Yarmouth in this period.

Figure 4.6.4 shows the rates of change for Great Yarmouth and Waveney plus the comparators apart from the 10th percentile one. It also shows the predicted rates for future years. We are in the 2007 calendar year now and the latest data is for 2003/04. The greater variability because of the smaller numbers can be seen for Great Yarmouth, Waveney, and Corby compared to the other larger areas. From the figure the fastest-improving district should eliminate all fractured necks of femur by 2012. This is most unlikely. All the forecasting should be treated circumspectly.
Great Yarmouth had high values in the last three years (2001/02, 2002/03, and 2003/04) of the period under consideration which have determined the upward trend. We have estimated where we are now in 2007-08 and rolled this forward five and eight years (Figure 4.6.4).

Thus if Great Yarmouth continues on its current trend there would be a fractured neck of femur case rate of 112 in five years time from now (2012/13) and a rate of 116 in eight years time (2015/16). In the first five-year period there would be 6 more fractured necks of femur per 100,000 population.

For Great Yarmouth to reach over the next eight years to 2015 the rate of the fastest-improving district (Corby) it would have to reduce the incidence by 90.56 (= 80.32 + 10.24) /100,000. For Waveney to reach the fastest-improving district (Corby) it would have to reduce it by 45.60 (= 80.32 – 34.72) /100,000. For Great Yarmouth to reach over the next eight years to 2015 the rate of the 10th percentile district (Sedgemoor) it would have to reduce the incidence by 47.84 (= 37.6 + 10.24) /100,000. For Waveney to reach 10th percentile district (Sedgemoor) it would have to reduce it by 2.88 (= 37.6 – 34.72) /100,000. Again here is another example of where striving for the 10th percentile improvement rate would be more satisfactory than striving for the fastest-improving one.

Figure 4.6.4: Rates of improvement of the incidence of fractured necks of femur using directly-standardised hospital emergency admission rate from 1998/98 – 2003/04 with forecasts for persons

4.6.5 Teenage pregnancy
Rates of improvement for the teenage pregnancy rate for females aged under 18 years are shown in Table 4.6.5 and Figure 4.6.5.
The rate of improvement from 1998 to 2004 for Great Yarmouth was 3 per 1,000. Unfortunately the trend (= 1) in Waveney is slightly upwards although this is not statistically significant. This means for Waveney over the last six there have been about 1 more teenage pregnancy per 1,000 population than if the 1998 incidence rate had pertained throughout. Great Yarmouth has had 3 fewer teenage pregnancies per 1,000 population on this basis.

The East of England, Coastal and Countryside, and England comparators have also seen declines in their teenage pregnancy rates with the Coastal and Countryside cluster doing particularly well. But the rate of improvement for Great Yarmouth is significantly lower than those for the fastest-improving and 10th percentile districts. Great Yarmouth would have to increase its rate of improvement by over five-fold to be like Wansbeck (fastest-improving district) and three-fold to be like Bassetlaw (10th percentile district). Waveney faces greater challenges than these to be like Wansbeck or Bassetlaw.

The actual percentage change from the baseline rate for Great Yarmouth reduced by 4.8% and that for Waveney increased by 3.3%. The rates of percentage change for Great Yarmouth and Waveney were significantly less than those of the fastest-improving and 10th percentile comparators as well as those of the East of England, Coastal and Countryside, and England.

<table>
<thead>
<tr>
<th>Area</th>
<th>Actual rate change</th>
<th>Linear trend</th>
<th>Relative % change**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Great Yarmouth</td>
<td>- 3.8</td>
<td>- 3.0</td>
<td>- 4.8%</td>
</tr>
<tr>
<td>Waveney</td>
<td>- 1.2</td>
<td>+ 1.4</td>
<td>+ 3.3%</td>
</tr>
<tr>
<td>East of England</td>
<td>- 3.5</td>
<td>- 4.2*</td>
<td>- 11.3%</td>
</tr>
<tr>
<td>Coastal &amp; Countryside</td>
<td>- 8.1</td>
<td>- 9.1*</td>
<td>- 20.3%</td>
</tr>
<tr>
<td>England</td>
<td>- 4.5</td>
<td>- 5.0*</td>
<td>- 10.8%</td>
</tr>
<tr>
<td>Wansbeck***</td>
<td>- 20.3</td>
<td>- 16.8*</td>
<td>- 22.9%</td>
</tr>
<tr>
<td>Bassetlaw****</td>
<td>- 11.4</td>
<td>- 10.6*</td>
<td>- 21.6%</td>
</tr>
</tbody>
</table>

* = Statistically significant (p < 0.05)  
** = Based on trend  
*** = Fastest improving district (excluding outliers)  
**** = District at 10th percentile (excluding outliers)

The gaps in the rate of improvement with the fastest-improving district of Wansbeck are 13.8 and 18.2 per 1,000 for Great Yarmouth and Waveney respectively. That means for Great Yarmouth from 1998 to 2004 there would have been 14 fewer teenage pregnancies per 1,000 population if they had had the improvement rate of the Wansbeck. Even if we had used the rate for the 10th percentile district (- 10.4) in the calculation of the potential gap...
there would still have been 7 fewer teenage pregnancies per 1,000 in Great Yarmouth in this period.

Figure 4.6.5 shows the rates of change for Great Yarmouth and Waveney plus the comparators apart from the fastest-improving one. It also shows the predicted rates for future years. We are in the 2007 calendar year now and the latest data is for 2004. The greater variability because of the smaller numbers can be seen for Great Yarmouth, Waveney, and Bassetlaw compared to the other larger areas. From the figure the 10th percentile district and the Coastal and Countryside cluster are improving at similar rates.

All the forecasting should be treated circumspectly. Waveney had a high value in the year 2002 of the period under consideration which has determined the upward trend. Interestingly Great Yarmouth had an upward blip here as did the other comparators but to a much lesser degree.

We have estimated where we are now in 2007 and rolled this forward four and nine years (Figure 4.6.5). Thus if Great Yarmouth continues on its current trend there would be a teenage pregnancy rate of 55 in four years time from now (2011) and a rate of 53 in nine years time (2016). In the first four-year period there would be 2 fewer teenage pregnancies per 1,000 population. For Great Yarmouth to reach over the next nine years to 2016 the rate of the fastest-improving district (Wansbeck) it would have to reduce the incidence by 20.7 (= 25.2 - 4.5) /1,000 and for Waveney to reach this it would have to reduce the incidence by 27.3 (= 25.2 + 2.1) /1,000. For Great Yarmouth to reach the 10th percentile district (Basset-
law) it would have to reduce the rate by 11.4 (= 15.9 - 4.5)/1,000 and for Waveney to reach this it would have to reduce its rate by 18 (= 15.9 + 2.1). Again here is another example of where striving for the 10th percentile improvement rate would be more satisfactory than striving for the fastest-improving one.

4.6.6 Abortion

Termination of pregnancy (abortion) can be a troubling event for women and couples. A measure of the fertility of women of child-bearing age (11 to 49 years) is the total period fertility rate (TPFR) which shows how many pregnancies an average women will have during her fertile years. A measure of the termination of pregnancy rate of women of child-bearing age (11 to 49 years) is then the total period abortion rate (TPAR) which shows which shows how many abortions an average women will have during her fertile years. We have used the average ratio of abortions to pregnancies (TPAR/TPFR) as a measure of how many pregnancies end up as abortions in an area. Figures on abortions are not available for local authority districts. They are only available for PCTs. Unfortunately, for the most recent year for which data is available (2005) there are no figures for Primary Care Organisations (PCOs) that are not co-terminous with old PCO boundaries. Great Yarmouth and Waveney PCT is one such organisation. Furthermore, PCO figures are not available before 2003, before that the figures are based on the former health authorities so the closest there is for the whole of Norfolk or Suffolk. The outcome is therefore a simple analysis based on 2003 and 2004.

England saw a small fall of - 0.2 in the TPAR/TPFR percentage from 23.6% to 23.3% between 2003 and 2004 (Figure 4.6.6 and Table 4.6.6). This means that for the whole country about one in four pregnancies are terminated. The change for Great Yarmouth was a small increase of + 0.2 with changes from 20.2% to 20.4%. The 95% confidence interval on the TPAR/TPFR percentages for Great Yarmouth is larger than the change seen though (from 19.8% to 20.6%). More trend data is therefore necessary to have confidence in the figures and trend for Great Yarmouth. The confidence intervals for larger areas are much narrower. Waveney (- 2.0), Norfolk, Suffolk and Cambridgeshire (- 0.7), and the East of England (0.6) also had statistically significant falls. Waveney’s fall was particularly large. The comparator districts were chosen from those that had statistically significant changes with non-overlapping confidence intervals for the two periods.

The fastest-improving district was Sheffield West with a fall of – 4.4. Hertsmere which is the 10th percentile district saw a decrease of – 2.4. The women in the two comparator districts did have higher percentages to start with. For Great Yarmouth to reach over the next ten years to 2017 the percentage of the fastest-improving district (Sheffield West) it would have to reduce its percentage by 4.6% (= 4.4% + 0.2%) and to reach the percentage of the 10th percentile district (Hertsmere) it would have to reduce it by 2.6% (= 2.4% + 0.2%). For
Waveney to reach over the next ten years to 2017 the percentage of the fastest-improving district (Sheffield West) it would have to reduce its percentage by 2.4% (= 4.4% - 2.0%) and to reach the 10th percentile district (Hertsmere) it would have to reduce it by 0.4% (= 2.4% - 2.0%).

Table 4.6.6: Total Period Abortion Rate as a Percentage of the Total Period Fertility Rate for females aged 11 to 49 years - changes from 2003 to 2004

<table>
<thead>
<tr>
<th>Area</th>
<th>TPAR/TPFR percentage in 2003</th>
<th>TPAR/TPFR percentage in 2004</th>
<th>Absolute change</th>
<th>Relative percentage change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Great Yarmouth</td>
<td>20.2%</td>
<td>20.4%</td>
<td>+ 0.2</td>
<td>+ 1.0%</td>
</tr>
<tr>
<td>Waveney</td>
<td>18.4%</td>
<td>16.4%</td>
<td>- 2.0**</td>
<td>- 10.9%</td>
</tr>
<tr>
<td>East of England</td>
<td>20.6%</td>
<td>20.0%</td>
<td>- 0.6**</td>
<td>- 2.9%</td>
</tr>
<tr>
<td>Norfolk, Suffolk and Cambridge SHAs</td>
<td>18.6%</td>
<td>17.9%</td>
<td>- 0.7**</td>
<td>- 3.8%</td>
</tr>
<tr>
<td>Coastal &amp; Countryside</td>
<td>NA*</td>
<td>NA*</td>
<td>NA*</td>
<td>NA*</td>
</tr>
<tr>
<td>England</td>
<td>23.6%</td>
<td>23.3%</td>
<td>- 0.3**</td>
<td>- 1.3%</td>
</tr>
<tr>
<td>Sheffield West***</td>
<td>23.6%</td>
<td>19.2%</td>
<td>- 4.4**</td>
<td>- 18.6%</td>
</tr>
<tr>
<td>Hertsmere****</td>
<td>26.0%</td>
<td>23.6%</td>
<td>- 2.4**</td>
<td>- 9.2%</td>
</tr>
</tbody>
</table>

* = NA - Not Available
** = Statistically significant with p < 0.05
*** = Fastest improving district (excluding outliers)
**** = District at 10th percentile (excluding outliers)

Figure 4.6.6 shows the changes in the TPAR/TPFR percentage but because of the paucity of data we cannot produce trends.
4.6.7 **Low birth weight**

Low birth weight babies face many more risks and hazards than do normal weight ones. It is thus a time of trouble and potential suffering for parents and baby. The cause of low birth weight is complicated and multifactorial but in part depends on the socio-economic status of the parents.

We show the data for all births and low birth weight defined as less than 2.5 kg. Babies at this weight should usually develop fairly well but as the birth weight decreases so do the risks. England saw a small rise of +0.1% in the low birth weight percentage from 7.8% to 7.9% between 1997 and 2005 (Table 3.14 and Figure 3.14). This means that for the whole country about one in thirteen babies are born with low birth weight.

The changes for Great Yarmouth were a small rise of +0.1% and for Waveney a fall of 1.8%. The change in Great Yarmouth would have made little difference to the actual numbers of low birth weight babies born (an increase of one at the most yearly) if the total birth rate had stayed the same. However the change in Waveney would have lead to about twenty fewer low birth weight babies yearly. East of England and Coastal and Countryside comparators also had small increases. Waveney’s fall was particularly large. The fastest-improving district was Newark and Sherwood with a fall of –3.6%. Penwith which is the 10th percentile district saw a fall of –1.5%. These two comparator districts did have higher percentages to start with. Only Newark and Sherwood’s change was statistically significant. This again may be another example of where aiming for the 10th percentile is a better target.
The percentage change from the baseline rate for Waveney reduced by 21.4% whereas that for Great Yarmouth worsened (increased) by 0.1%. The rate of percentage change for Great Yarmouth was significantly less than those of the fastest-improving and 10th percentile comparators. Waveney’s rate of percentage improvement was less than Newark and Sherwood’s but greater than those for the East of England, Coastal and Countryside, and England and was very close to Penwith’s.

Table 4.6.7: Rates of improvement for low birth weight babies as a percentage of all births from 1997 to 2005

<table>
<thead>
<tr>
<th>Area</th>
<th>Actual rate change</th>
<th>Linear trend</th>
<th>Relative % change**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Great Yarmouth PCT</td>
<td>- 0.7</td>
<td>+ 0.1</td>
<td>+ 1.0%</td>
</tr>
<tr>
<td>Waveney PCT</td>
<td>- 1.5</td>
<td>- 1.8</td>
<td>- 21.4%</td>
</tr>
<tr>
<td>East of England</td>
<td>+ 0.1</td>
<td>+ 0.2</td>
<td>+ 3.1%</td>
</tr>
<tr>
<td>Coastal &amp; Countryside</td>
<td>+ 0.3</td>
<td>+ 0.1</td>
<td>+ 1.9%</td>
</tr>
<tr>
<td>England</td>
<td>+ 0.1</td>
<td>+ 0.1</td>
<td>+ 1.9%</td>
</tr>
<tr>
<td>Newark &amp; Sherwood***</td>
<td>- 3.6</td>
<td>- 2.6**</td>
<td>- 29.0%</td>
</tr>
<tr>
<td>Penwith****</td>
<td>- 1.5</td>
<td>- 1.9</td>
<td>- 25.3%</td>
</tr>
</tbody>
</table>

* = NA - Not Available  
** = Statistically significant with p < 0.05  
*** = Fastest improving district (excluding outliers)  
**** = District at 10th percentile (excluding outliers)

All the forecasting should be treated circumspectly. Great Yarmouth had intermittent high values in the middle of the period under consideration which has determined the upward trend (Figure 4.6.7). We have estimated where we are now in 2007 and rolled this forward five and ten years (Figure 4.6.7).

Thus if Great Yarmouth continues on its current trend there would be a low birth weight percentage of 8.3% in five years time from now (2012) and a rate of 8.3% in ten years time (2017). In the ten-year period there would likely to be about ten more low birth weight babies born. For Great Yarmouth to reach over the next ten years to 2017 the rate of the fastest-improving district (Newark and Sherwood) it would have to reduce the forecast percentage by 3.34% (= 3.23% + 0.11%) and for Waveney to reach the fastest-improving it would have to reduce its forecast percentage by 1.23% (=3.23% - 2.00%).

For Great Yarmouth to reach 10th percentile district (Penwith) it would have to reduce the forecast percentage by 2.46% (= 2.35% + 0.11%) and for Waveney to reach this it would have to reduce it by 0.35% (=2.35% - 2.00%). Again here is another example of where striving for the 10th percentile improvement rate would be more satisfactory than striving for the fastest-improving one.
4.6.8 Summary of the burden of disease indicator findings

The rates of improvement for all the burden of disease indicators that were analysed for Great Yarmouth, Waveney, the fastest-improving districts, and the 10th percentile ones are shown in Table 4.6.8.

The gaps with the comparator districts to achieve the same values as them by the year 2017 for these indicators of the burden of disease are also shown. Great Yarmouth and Waveney’s trends for cancer incidence and comparative illness and disability ratios are all increasing, as is the number of diseased teeth in five-year olds, the fractured neck of femur rate, and the abortion rate in Great Yarmouth and the teenage pregnancy rate in Waveney. Thus for these indicators the two districts need to reverse these trends and then catch up with the reductions in the comparators. Only the cancer incidence, the fractured neck of femur rate, teenage pregnancy rate, and the low birth weight percentage trends and thus forecasts are built on significant numbers of yearly data points. The forecasts and trends for the comparative illness and disability ratio, oral health of 5 year olds, and the abortion rate are based on only two year’s worth of data that are at least four years out-of-date. For all but one of these indicators of the burden of disease Great Yarmouth trends are currently worsening. The same is true for Waveney for 3 out 7 these indicators. The PCT thus faces great challenges again. For the same reasons as before aiming to be in the top ten percent is probably the best goal to strive for.
Table 4.6.8: The performance on rates of improvement for burden of disease indicators with gaps to target positions for 2017

<table>
<thead>
<tr>
<th></th>
<th>Current rates of improvement*</th>
<th>Gaps with fastest-improving district to 2017</th>
<th>Gaps with 10th percentile district to 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Great Yarmouth</td>
<td>Waveney</td>
<td>Isles of Scilly</td>
</tr>
<tr>
<td>Cancer (/10^5)</td>
<td>- 27.8</td>
<td>- 16.2</td>
<td>119.3</td>
</tr>
<tr>
<td>Comparative illness and disability ratios (Change in ratio)</td>
<td>- 6.9%</td>
<td>- 4.3%</td>
<td>19.7%</td>
</tr>
<tr>
<td>Oral health of 5 year olds (Change in mean number)</td>
<td>- 0.44</td>
<td>+ 0.10</td>
<td>1.79</td>
</tr>
<tr>
<td>Fractured neck of femur (/10^5)</td>
<td>- 6.4</td>
<td>+ 21.7</td>
<td>90.6**</td>
</tr>
<tr>
<td>Teenage pregnancy (/10^5)</td>
<td>+ 3.0</td>
<td>- 1.4</td>
<td>20.7***</td>
</tr>
<tr>
<td>Abortion (change TAPR as a % of TPFR)</td>
<td>- 0.2%</td>
<td>+ 2.0%</td>
<td>4.6%</td>
</tr>
<tr>
<td>Low birth weight (change in %&lt;2.5kg)</td>
<td>- 0.1</td>
<td>+ 1.8</td>
<td>3.34%</td>
</tr>
</tbody>
</table>

*= based on most recent trend data available and improvements (reductions) are all expressed as positive
**= target year is 2015
***= target year is 2016

4.7 Conclusions on indicator to use

1. The improvement rates for the 10th percentile district seem to be a challenging but just about achievable set of targets. Achieving an aim such as being the top ten percent by the year 2017 for each indicator would very probably ensure that the PCT would be securing its overall fastest-improving health goal.

2. Life expectancy is the best overall indicator of improvement to use. Healthy life expectancy would be better but the information to allow the healthy component to be calculated is not gathered frequently enough.

3. A basket of indicators covering mortality, mental health and burden of disease should be used.
5 Where do we want to be?

5.1 Aims, objectives and targets

This sets out the aims, objectives and local target positions that the PCT and partners will achieve over the planning period.

Armed with the data on best performer we have quantified the rate of improvement for Great Yarmouth and Waveney combined to reach best performer status within 10 years time for key local health problems in Table 4.1. We present this as absolute values as well as rates. At this stage we have not sought to redress any inequalities between the ill-health experiences of the Great Yarmouth and Waveney populations or men and women.

Thus in the next ten years for all ages all-cause mortality we are aiming to continue the decline but increase its rate by 67 per 100,000 for Great Yarmouth and 50 for Waveney so as to reach a forecast rate of 416 per 100,000 for Great Yarmouth and 355 for Waveney in 2017. Achieving these forecast absolute rate figures would mean hitting the improvement rate of the 10th percentile comparator over the next ten years.

<table>
<thead>
<tr>
<th>Health problem</th>
<th>Indicator</th>
<th>10 Year rate (and improvement) sought++</th>
<th>Value sought in 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Great Yarmouth</td>
<td>Waveney</td>
</tr>
<tr>
<td>Mortality</td>
<td>All-ages all cause DSR*</td>
<td>≥170/105 (67)</td>
<td>≥170/105 (50)</td>
</tr>
<tr>
<td>Life expectancy men</td>
<td>From birth - Years</td>
<td>≥2.8 (0.33)</td>
<td>≥ 3.1 (0.33)</td>
</tr>
<tr>
<td>Life expectancy women</td>
<td>From birth - Years</td>
<td>≥2.89 (1.56)</td>
<td>≥2.89 (1.22)</td>
</tr>
<tr>
<td>CHD mortality</td>
<td>All-ages DSR*</td>
<td>≥ 110/105 (45)</td>
<td>≥110/105 (40)</td>
</tr>
<tr>
<td>Cancer incidence</td>
<td>All ages DSI**</td>
<td>≥ 13.4/105 (44.3)</td>
<td>≥ 13.4/105 (31.4)</td>
</tr>
<tr>
<td>Alcohol-use disorders - chronic liver disease mortality</td>
<td>All ages DSR*</td>
<td>≥ 2.55/105 (5.32)</td>
<td>≥ 2.55/105 (5.55)</td>
</tr>
<tr>
<td>Fractured hip</td>
<td>All ages Hospital Admissions DSA***</td>
<td>≥ 37.6/100,000 (47.84)</td>
<td>≥ 37.6/100,000 (2.88)</td>
</tr>
<tr>
<td>Teenage pregnancy</td>
<td>15 - 17 years Crude rate</td>
<td>≥ 15.9/103 (11.4)</td>
<td>≥ 15.9/103 (18.0)</td>
</tr>
</tbody>
</table>

* = Based on a reduction in rate for undesirable conditions (Life expectancy figures are increases)
++ = Based on 10th percentile district performance
+++ = Only eight year trend data available; forecast year is 2015
The features stressing the particular local focus of Great Yarmouth and Waveney are:

- two small but coherent local coastal communities
- substantial parts of both suffer from severe socio-economic deprivation due to declines in the major industries
- surrounded by large counties in a rural area
- relatively isolated
- disadvantaged in a region of prosperity

The results of the current PCT consultation on ‘A healthier future’ support the direction chosen. The seven principles from Health Challenge England and the results of the regional workshop have been taken into account.

5.2 The most important health problems

We have already demonstrated the top causes contributing to current poor situation for indicators such as life expectancy for Great Yarmouth and Waveney. A separate health atlas will explore variation below the PCT level at electoral ward and Super Output area (SOA) levels.

5.3 The most important remediable health problems

All of the causes of ill-health elaborated here are preventable and/or treatable. We now go on to identify the remedial causes of mortality and likely extent of remediation from published sources. A recent study in Ireland investigated whether primary prevention might be more favourable than secondary prevention (risk factor reduction in patients with coronary heart disease).\(^7\) The study found that compared with secondary prevention, primary prevention achieved a two-fold larger reduction in CHD deaths. The authors recommended that future national CHD policies should therefore prioritise nationwide interventions to promote healthy diets and reduce smoking.

5.4 Contribution to the regional pledges

We will estimate our contribution to the key pledges in the East of England SHA Saving Lives Strategy. This will cover our contribution in the East of England by 2011 to:

• adding 5 million years of life to people and including 1 million extra in the unhealthiest 20%

• reducing by half the difference in premature deaths between our poorest 20% of communities and the rest of the East of England

• reducing the number of smokers by 150,000 halting the rise in the number of obese children by 2010 and then starting to reduce the numbers subsequently.
6 How are we going to get there?

6.1 Interventions for the most important remediable health problems

We have elaborated the interventions needed below for the most remedial causes of mortality identified as priority health problems. We have considered in detail the development of lifestyle support services, the management of risk factors (both lifestyle e.g. smoking and clinical e.g. cholesterol) for individuals, health promoting interventions, and enhanced inputs primary care.

We have produced quantified the extra numbers of individuals at risk of transient ischaemic attack (TIA) and/or stroke who could benefit from these interventions so as to make the scale of the task properly quantified. This will allow the PCT to set uptake targets for stroke/TIA (e.g. 50% of those with TIA referred to a TIA service within the first year and 100% in the second year). The model can be developed for CHD and other conditions if the research evidence is there.

We have focused on service improvements that will make practical differences to health outcomes and the patient’s experience of the NHS.

These include:

- improvements in access to NHS services, especially better risk factor management in primary care
- lifestyle support services to help people change
- partnership arrangements particularly partnerships to support lifestyle change outside a medical model
- improving clinical outcomes – particularly for chronic diseases such as heart disease, diabetes, respiratory disease, mental illness and multiple morbidity in the frail elderly
- helping people stay healthy through improved delivery of preventative care including lipid control, treatment of hypertension, smoking cessation, obesity management, dietary advice and support, physical activity promotion, lifestyle support, screening, and immunisation
- ensuring good services are in place for marginalised groups, be they areas of deprivation or demographic groups. In particular how the PCT can ensure high quality primary care is in place for these groups.
6.2 Coronary heart disease

6.2.1 Managing patients with cardiovascular disease in primary care

The NSF for coronary heart disease (CHD) laid great stress on the systematic identification of people at high risk of CHD\(^8\) coupled with their systematic management and review. To tackle the risk factors in such individuals there need to be systems of identification and service delivery supported by an effective administrative system. Such a system would allow people who smoke or have hypertension, high cholesterol, low activity levels, and poor diet or who are obese to be assuredly given evidence-based services that will prolong and improve their lives. We know from the Quality Outcomes Framework data that not all high risk individuals are identified and even if identified are not necessarily receiving optimum treatment. It is likely that there will be an inequality here with the more disadvantaged being less likely to receive treatment.

**Recommendation CHD 1: Identify all high risk individuals in primary care, keep good records, and treat their risk factors.**

6.2.2 Smoking cessation

Smoking remains the leading cause of preventable morbidity and premature death in England. NICE have reviewed the evidence on smoking cessation and have found that it works.\(^9\) It is also cost effective.\(^9\) About 24% of the population smoke and two thirds of these wish to stop. There is thus a very large number of smokers who can still be recruited by smoking cessation services. The priority should be to target those from the disadvantaged areas and groups (who are twice as likely to smoke) so as reduce health inequalities.

**Recommendation CHD 2: Identify all smokers through primary care in disadvantaged groups and areas and offer them smoking cessation.**

6.2.3 Promoting physical activity

The Cochrane review of interventions promoting physical activity showed that they have a positive moderate sized effect on increasing self-reported physical activity and measured cardio-respiratory fitness, at least in the short to mid-term.\(^10\) Outcomes were more consistent and better when physical activity was self-directed with some professional guidance and when there was on-going professional support. NICE have also reviewed the evidence on

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\(^8\) Chapter 2. Preventing CHD in high risk individuals. NSF CHD. London; Department of Health, 2000.


promoting physical activity.\footnote{NICE Public Health Interventions Guidance No. 1 (PH002): Physical activity; March 2006. http://guidance.nice.org.uk/PHI2/guidance/pdf/English} NICE recommend primary care practitioners should take the opportunity, whenever possible, to identify inactive adults and advise them to aim for 30 minutes of moderate activity on 5 days of the week (or more). Another recently published systematic review showed that the most successful interventions could increase walking among targeted participants by up to 30-60 minutes a week on average at least in the short term.\footnote{Ogilvie D, Foster CE, Rothnie H, Cavill N, Hamilton V, Fitzsimons CF, Muhle N. Interventions to promote walking: systematic review. BMJ | ONLINE FIRST | bmj.com. doi: 10.1136/bmj.39198.722720.BE. http://www.bmj.com/cgi/content/full/bmj.39198.722720.BEv1}

**Recommendation CHD 3:** Identify all inactive individuals through primary care in disadvantaged groups and areas and advise them to become much more active.

### 6.2.4 Promoting healthier eating

The Cochrane review of \textit{reduced or modified dietary fat for preventing cardiovascular disease} showed a small but potentially important reduction in cardiovascular risk in trials longer than two years.\footnote{Hooper L, Summerbell CD, Higgins JPT, Thompson RL, Clements G, Capps N, Davey Smith G, Reiersma RA, Ebrahim S. Reduced or modified dietary fat for preventing cardiovascular disease. Cochrane Database of Systematic Reviews 2000, Issue 2. Art. No.: CD002137. DOI: 10.1002/14651858.CD002137.} Lifestyle advice to all those at high risk of cardiovascular disease (especially where statins are unavailable or rationed), and to lower risk population groups, should continue to include permanent reduction of dietary saturated fat and partial replacement by unsaturates. The Cochrane review of dietary advice (reduction of salt and fat intake and an increase in the intake of fruits, vegetables, and fibre) for reducing cardiovascular risk showed that dietary advice appears to be effective in bringing about modest beneficial changes in diet and cardiovascular risk factors over approximately 9 months but longer term effects are not known.\footnote{Brunner EJ, Thorogood M, Rees K, Hewitt G. Dietary advice for reducing cardiovascular risk. Cochrane Database of Systematic Reviews 2005, Issue 4. Art. No.: CD002128. DOI: 10.1002/14651858.CD002128.pub2.} The Cochrane review of the effect of longer-term modest salt reduction on blood pressure showed that a modest reduction in salt intake for a duration of 4 or more weeks has a significant and, from a population viewpoint, important effect on blood pressure in both individuals with normal and elevated blood pressure.\footnote{He FJ, MacGregor GA. Effect of longer-term modest salt reduction on blood pressure. Cochrane Database of Systematic Reviews 2004, Issue 1. Art. No.: CD004937. DOI: 10.1002/14651858.CD004937.} Furthermore, their meta-analysis demonstrates a correlation between the magnitude of salt reduction and the magnitude of blood pressure reduction. Within the daily intake range of 3 to 12 g/day, the lower the salt intake achieved, the lower the blood pressure. These results support other evidence suggesting that a modest and long-term reduction in population salt intake could reduce strokes, heart attacks, and heart failure.
Recommendation CHD 4: Healthcare professionals in primary care should promote a diet reduced in salt and fat intake and with an increase in the intake of fruits, vegetables, and fibre.

6.2.5 Reducing obesity in adults

There is evidence from systematic reviews16,17,18 and the National institute of Clinical Excellence19 for losing and maintaining weight loss of 5% in adults for at least one year for:

- Low-fat diets (600 kcal/day deficit)16
- Low-calorie (1000 – 1600) kcal/day or very low-calorie diets (<1000 kcal/day)17
- Exercise programmes20
- Behaviour change strategies/programmes21
- Exercise programmes and diet16,17
- Behaviour/cognitive therapy strategies/programmes and diet16,18
- Low-fat diets and exercise with or without behaviour therapy16
- Family therapy16
- Group therapy16

Recommendation CHD 5: Primary care and community and hospital services should provide basic and specialised weight management services of multi-component interventions based on dietary, activity, and behaviour change programmes.

All the Recommendations CHD 2 to 5 will also help prevent cancer.

6.2.6 Managing hypertension

A Cochrane Systematic Review concluded that an organized system of registration, recall and regular review allied to a vigorous stepped care approach to antihypertensive drug

20 Shaw K, Gennat H, O’Rourke P, Del Mar C. Exercise for overweight or obesity. Cochrane Database of Systematic Reviews 2006;4.
treatment appears the most likely way to improve the control of high blood pressure. But salt reduction, physical activity promotion, and weight loss all also help reduce blood pressure.

**Recommendation CHD 6:** Primary care should provide systematised services to treat all people with hypertension with stepped antihypertensive drug treatment and promote salt reduction, more physical activity, and weight loss for the overweight/obese.

### 6.2.7 Reducing serum cholesterol

The CHD NSF and the new GMS contract state that GPs and primary care teams should develop a register of CHD patients, through which they can review medication, offer advice on diet and lifestyle, and maintain the necessary contact with patients most at risk of suffering renewed heart problems. Those at risk should be prescribed statins; these are drugs that reduce the levels of cholesterol (also sometimes called lipids) in the blood. But healthier eating, promoting physical activity, and weight loss all help reduce levels cholesterol.

**Recommendation CHD 7:** Primary care should through the CHD register provide statins to those at risk and promote healthier eating, more physical activity, and weight loss in the overweight/obese.

### 6.2.8 Managing a heart attack

Patients with suspected heart attack should be given pain relief, aspirin, early thrombolysis, early assessment, emergency transfer to specialised cardiac care, appropriate drug treatment, and cardiac rehabilitation when they are recovering.

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30 Wood P, Stefanick ML, Williams PT, Haskell WL. The effects on plasma lipoproteins of a prudent weight-reducing diet, with or without exercise, in overweight men and women. NEJM 1991;325(7):461-466.

Recommendation CHD 8: Patients with suspected heart attack should be given pain relief, aspirin, early thrombolysis and assessment, emergency transfer to specialised cardiac care, appropriate drug treatment, and cardiac rehabilitation when they are recovering.

6.2.9 After a heart attack

After a heart attack patients should be the appropriate advice, services, and drugs specified in the NICE Clinical Guideline CG48 MI: secondary prevention. There is evidence is that not all patients who have had a heart attack benefit from this range of evidence-based advice, services and drugs. This should cover:

- Lifestyle changes after a myocardial infarction
- Delivery of dietary advice
- Alcohol consumption
- Regular physical activity
- Smoking cessation
- Weight management
- Cardiac rehabilitation after an acute MI
- Health education and information
- Psychological and social support
- Sexual activity
- Drug therapy after an MI
- ACE inhibitors
- Antiplatelet therapy
- Beta-blockers
- Vitamin K antagonists
- Coronary revascularisation
- Selected patient subgroups
- Communication of diagnosis and advice

**Recommendation CHD 9: After a heart attack all patients should be given the advice, services and drugs covered in NICE Clinical Guideline CG48.**

### 6.2.10 Cardiac rehabilitation

After a heart attack all patients should be given a cardiac rehabilitation programme as outlined in NICE Clinical Guideline CG48 MI: Secondary prevention. This should cover:

- Dietary advice and support
- Exercise advice and support
- Health education and information
- Psychological and social support
- Recommendation CHD 10: After a heart attack all patients should be given a cardiac rehabilitation programme as covered in NICE Clinical Guideline CG48.

### 6.3 Stroke

The recommendations in this section have been extended in the recent National Stroke Strategy – to which reference should be made.

#### 6.3.1 Treating atrial fibrillation

Healthcare professionals in Trusts and primary care should practice following recommendations that have been identified as key priorities for implementation for treating atrial fibrillation (AF) by NICE in their Clinical Guideline CG36.\(^{33,34}\)

#### 6.3.2 Identification and diagnosis

An electrocardiogram (ECG) should be performed in all patients, whether symptomatic or not, in whom atrial fibrillation (AF) is suspected because an irregular pulse has been detected.

#### 6.3.3 Treatment for persistent AF

As some patients with persistent AF will satisfy criteria for either an initial rate-control or rhythm-control strategy (for example, age over 65 but also symptomatic):

- the indications for each option should not be regarded as mutually exclusive and the potential advantages and disadvantages of each strategy should be explained to patients before agreeing which to adopt

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• any comorbidities that might indicate one approach rather than the other should be taken into account
• irrespective of whether a rate-control or rhythm-control strategy is adopted in patients with persistent AF, appropriate antithrombotic therapy should be used.

6.3.4 Treatment for permanent AF
In patients with permanent AF, who need treatment for rate-control:
• beta-blockers or rate-limiting calcium antagonists should be the preferred initial monotherapy in all patients
• digoxin should only be considered as monotherapy in predominantly sedentary patients.

6.3.5 Antithrombotic therapy
In patients with newly diagnosed AF for whom antithrombotic therapy is indicated (see section 1.8.6 in CG36), such treatment should be initiated with minimal delay after the appropriate management of comorbidities.

The stroke risk stratification algorithm in CG36 should be used in patients with AF to assess their risk of stroke and thromboembolism, and appropriate thromboprophylaxis given.

Recommendation Stroke 1: People with atrial fibrillation should be immediately assessed and be offered rate control or rhythm control as appropriate and be offered anti-platelet therapy or anti-coagulation as specified in the NICE Clinical Guideline CG36.

6.3.6 Prevention of strokes
The new National Stroke Strategy recommends:
• Those at risk of stroke and those who have had a stroke are assessed for and given information about risk factors and lifestyle management issues (exercise, smoking, diet, weight and alcohol), and are advised and supported in possible strategies to modify their lifestyle and risk factors.
• Risk factors, including hypertension, obesity, high cholesterol, atrial fibrillation (irregular heartbeats) and diabetes, are managed according to clinical guidelines, and appropriate action is taken to reduce overall vascular risk.

We know that stopping smoking, treating hypertension, treating high levels of cholesterol and offering anticoagulation to suitable patients with atrial fibrillation will all prevent untimely death and disability in high risk individuals. The Department of Health has published a toolkit...
called ‘Action on stroke services: an evaluation toolkit’ (ASSET) that has been created to help health care organisations improve and transform stroke services for patients. With this commissioning tool PCTs can estimate how many lives they will save. Table 5.1 shows the impact of the four preventative interventions on premature mortality and disability from stroke. Thus if all the people with the risk factors were treated fully as indicated then 54 strokes in Great Yarmouth and 77 in Waveney yearly could be prevented.

Table 6.3: The impact of preventative interventions for stroke

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Great Yarmouth</th>
<th>Waveney</th>
<th>Cambridge</th>
<th>Ipswich</th>
</tr>
</thead>
<tbody>
<tr>
<td>Managing all individuals currently treated for hypertension to below 140mmHg systolic BP</td>
<td>23</td>
<td>33</td>
<td>19</td>
<td>30</td>
</tr>
<tr>
<td>Warfarin where indicated for patients with atrial fibrillation</td>
<td>15</td>
<td>22</td>
<td>12</td>
<td>19</td>
</tr>
<tr>
<td>Statins for all people with &gt;20% risk CVD in 10 years</td>
<td>11</td>
<td>16</td>
<td>9</td>
<td>14</td>
</tr>
<tr>
<td>Smoking cessation for all patients who have suffered a stroke or TIA</td>
<td>5</td>
<td>6</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>54</td>
<td>77</td>
<td>43</td>
<td>68</td>
</tr>
</tbody>
</table>

### 6.3.7 Managing Transient Ischaemic Attacks (TIAs)

The new National Stroke Strategy recommends:

- Immediate referral for appropriately urgent specialist assessment and investigation is considered in all patients presenting with a recent TIA or minor stroke
- A system which identifies as urgent those with early risk of potentially preventable full stroke – to be assessed within 24 hours in high-risk cases; all other cases are assessed within seven days
- Provision to enable brain imaging within 24 hours and carotid intervention, echocardiography and ECG within 48 hours where clinically indicated.

Patients who present to GPs with symptoms and/or signs suggestive of a TIA need urgent assessment. Following an evidence-based pathway saves lives. A care pathway reviewed by the Clinical Effectiveness Committee of the British Association for Emergency Medicine is recommended. They may need emergency specialist referral and will in any case need referral to a TIA clinic within 7 days. All their cardiovascular risk factors need treating, including

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AF if present. The will need anti-platelet therapy or anti-coagulation. Patients with more than one TIA in a week should be investigated in hospital immediately.\textsuperscript{37}

**Recommendation Stroke 2: After a TIA all patients should be immediately assessed and have their risk factors treated and seen in a specialised TIA clinic within 24 hours in high-risk cases - all other cases are assessed within seven days as specified by the National Stroke Strategy.**

### 6.3.8 Managing a stroke

#### Stroke units

The new National Stroke Strategy recommends:

- All patients with suspected acute stroke are immediately transferred by ambulance to a receiving hospital providing hyper-acute stroke services (where a stroke triage system, expert clinical assessment, timely imaging and the ability to deliver intravenous thrombolysis are available throughout the 24-hour period).

- Patients with suspected acute stroke receive an immediate structured clinical assessment from the right people.

- Patients requiring urgent brain imaging are scanned in the next scan slot within usual working hours, and within 60 minutes of request out-of-hours with skilled radiological and clinical interpretation being available 24 hours a day.

- Patients diagnosed with stroke receive early multidisciplinary assessment – to include swallow screening (within 24 hours) and identification of cognitive and perceptive problems.

Organised specialised stroke units save lives and disability.\textsuperscript{37,38} Stroke unit care showed reductions in the odds of death or dependency (OR 0.82; 95% CI 0.73 to 0.92; P = 0.001). Stroke patients who receive organised inpatient care in a stroke unit are more likely to be alive, independent, and living at home one year after the stroke. The benefits were most apparent in units based in a discrete ward. No systematic increase was observed in the length of inpatient stay. The evidence-based Clinical Guidelines of the Royal College of Physicians should be followed.\textsuperscript{37} Notable among their recommendations are:

Stroke services should have:

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- a geographically identified unit as part of the inpatient service
- a coordinated multidisciplinary team that meets at least once a week
- staff with specialist expertise in stroke and rehabilitation
- educational programmes for staff, patients and carers
- agreed protocols for common problems
- access to brain and vascular imaging services
- Information should be freely available to patients and their families in a variety of languages and formats appropriate to patient needs and impairments.
- All patients should be referred to a specialist rehabilitation team as soon as possible after admission.
- An individualised strategy for stroke prevention should be implemented within a maximum of seven days of acute stroke.

The Department of Health has also published a guide for commissioners on improving stroke services.\(^{39}\) It has also published a tool for providers called ASSET that can predict how many people will survive stroke if evidence-based practice is followed.\(^{35}\) Early supported discharge teams can increase the proportion of people who return to independence.\(^{35}\)

**Recommendation Stroke 3: After a stroke all patients should be immediately admitted to a specialised stroke unit and receive early specialist rehabilitation as specified by the new National Stroke Strategy.**

**Alteplase for acute ischaemic stroke**

NICE have recently published technology appraisal guidance (TA122) stating that alteplase is recommended for the treatment of acute ischaemic stroke when used by physicians trained and experienced in the management of acute stroke.\(^{40}\) It should only be administered in centres with facilities that enable it to be used in full accordance with its marketing authorisation, which includes the need for 24-hour access to computed tomography scanning. Alteplase is not indicated for the treatment of acute stroke in children aged under 18 years or adults aged over 80 years.

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Recommendation Stroke 4: After an ischaemic stroke all patients should be considered for alteplase as specified in NICE Technology Appraisal Guidance TA122.

Optimum treatment of stroke
The ASSET toolkit: action on stroke services - an evaluation toolkit has also predicted the numbers of premature deaths and unnecessary disability that could be avoided by the full update of effective treatment of patients with stroke and/or TIA. ASSET shows that if all the people who suffered a stroke in Great Yarmouth were managed on a stroke unit for more than six days then 93 deaths or disabling strokes could be avoided yearly. Similarly if thrombolysis was introduced 34 patients with stroke would have better outcomes and if early supported discharge teams were introduced 51 would have better outcomes yearly. Finally if TIA clinics were introduced 19 patients with TIA would avoid having a stroke yearly. Thus in total 197 people from Great Yarmouth could each year avoid untimely death or worse disability through the uptake of the evidence-based interventions outlined in the previous sections.

6.4 Heart failure
5.1.1 Community echocardiography
The optimum clinical management of heart failure patients is not in doubt. The problems are accurately diagnosing heart failure with the aid of echocardiography and ensuring there is enough access to echocardiography. Many areas have successfully developed community echocardiography services to overcome these problems and these have been supported by the CHD NSF and a consensus statement from representatives of the British Society of Echocardiography, the British Heart Failure Society, the Coronary Heart Disease Collaborative and the Primary Care Cardiovascular Society on community echocardiography for heart failure.

Recommendation Heart Failure 1: Patients with possible heart failure should be given easier access to diagnosis with community echocardiography following the criteria and procedures stated in the consensus statement.

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43 A consensus statement from representatives of the British Society of Echocardiography, the British Heart Failure Society, the Coronary Heart Disease Collaborative and the Primary Care Cardiovascular Society. Community echocardiography for heart failure. Br J Card 2004;11(4):399-402.
6.4.1 Community heart failure service
Because of the great pressure on cardiology departments, another problem for patients with proven heart failure is making sure that their treatment is up-to-date and optimal. Again many areas have successfully developed specialised community heart failure services to overcome this and these have been supported by NICE. For such a service to work well there has to be agreement between the hospital cardiology providers, primary care and the local PCT on its organisation supported by care pathways.

**Recommendation Heart Failure 2:** Patients with heart failure should be given easier access to ongoing treatment through the development of community heart failure services that are supported by all local stakeholders.

6.5 Diabetes
The risk factors for Type II diabetes are the same as for CHD, which is a major problem in Great Yarmouth and Waveney. A recent systematic review to quantify the effectiveness of pharmacological and lifestyle interventions to prevent or delay Type 2 diabetes in people with impaired glucose tolerance has been published in the British Medical Journal online.

It found that lifestyle and pharmacological interventions reduce the rate of progression to Type 2 diabetes in people with impaired glucose tolerance. Lifestyle interventions seem to be at least as effective as drug treatment.

**Recommendation Diabetes 1:** All people with patients with impaired glucose tolerance should be given appropriate pharmacological interventions and lifestyle interventions targeted at diet, exercise, weight control, and smoking cessation.

The most recent national annual report from the diabetes national clinical director has highlighted the current range of problems. It is likely that many of these may pertain to Great Yarmouth and Waveney.

There is a need for:
- initiatives to target hard-to-reach groups such as black and minority ethnic communities, the socio-economically deprived, and those with special needs

• ensuring that all people with diabetes have received structured-education programmes appropriate to their type of diabetes such as DESMOND or DAFNE\textsuperscript{46,47,48}

• psychological support to promote behaviour change for people with diabetes to help achieve proper patient empowerment and improved self-management\textsuperscript{46}

• focusing now on the 20-40% of people who are not achieving good results and who could be at a higher risk of complications in future years\textsuperscript{46}

• offering alternative diabetes treatments for Type 1 diabetes including Continuous Subcutaneous Insulin Infusion when multi-dose insulin therapies have failed\textsuperscript{46,49}

• improving the hospital experience for all people with diabetes

• improving the range of services offered to children with diabetes\textsuperscript{46}

• improving the transitional services and arrangements offered for the changeover from adolescence to adulthood\textsuperscript{50}

• ensuring that all known people with diabetes have their complications detected early in primary care\textsuperscript{46}

• ensure that 100% of people with diabetes are offered retinal screening\textsuperscript{51}

Many of these recommendations have also been supported by the recently published guide on Diabetes in the NHS: Commissioning and providing specialist services.\textsuperscript{52}

\begin{center}
\textbf{Recommendation Diabetes 2: All patients with diabetes should be given:}
\end{center}

\begin{itemize}
  \item \textit{structured-education programmes}
  \item \textit{psychological support to promote behaviour change}
  \item \textit{a better hospital experience}
  \item \textit{regular checks in primary care to detect complications early}
\end{itemize}


\textsuperscript{49} NICE TA57 Diabetes (type 1) - insulin pump therapy. February 2003 and 2006.


• retinal screening yearly

**Recommendation Diabetes 3: Children with diabetes should have access to:**

• an improved range of services

• improved transitional services and arrangements for the changeover from adolescence to adulthood

**Recommendation Diabetes 4: Certain disadvantaged groups with diabetes should receive targeted initiatives:**

• hard-to-reach groups such as black and minority ethnic communities

• the socio-economically deprived, and those with special needs

• the 20-40% of people who are not achieving good results

• those for whom multi-dose insulin therapies have failed and who need Continuous Subcutaneous Insulin Infusion

### 6.6 Cancer

#### 6.6.1 Screening for breast cancer with mammography

Screening for breast cancer with mammography reduces mortality by about 15-20%. The Department of Health would like more than 70% of women aged 50 -69 years to be screened every three years.

**Recommendation Cancer 1: Great Yarmouth and Waveney PCT should ensure that more than 70% of women aged 50-69 years undergo breast screening every three years.**

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Great Yarmouth and Waveney PCT

Version – 16 Jan 08
6.6.2 Cervical screening
Cervical screening has prevented an epidemic that would have killed about one in 65 of all British women born since 1950 and culminated in about 6000 deaths per year in this country. The Department of Health would like more than 80% of women aged 25 to 64 years to be screened every three or five years depending on age.55

Recommendation Cancer 2: Great Yarmouth and Waveney PCT should ensure that more than 80% of women aged 25-64 years undergo cervical screening at the appropriate frequency.

6.7 Mental health

6.7.1 Treat home-based care and support as the norm for the delivery of mental health services
Hospital admission can be avoided when alternatives are in place as well as more efficient and effective use of the whole service.56 This means that inpatient services should be seen as a specialist and intensive intervention; and that there should be provision of a range of self-help and home treatment and care options, including appropriate community based support and alternatives to hospital.

Recommendation Mental Health 1: Commissioners and providers should develop home-based care and support as the norm for the delivery of mental health services

6.7.2 Exercise Interventions for Depression
There is some evidence that adjunctive exercise interventions for people with depression is effective.57 We also know that exercise is good for health and well-being more generally.

Recommendation Mental Health 2: Commissioners and providers should develop adjunctive exercise interventions for people with depression.

6.7.3 Supporting the physical needs of people with severe mental illness
People with diagnoses of severe and enduring mental illnesses such as schizophrenia and bipolar disorder are at increased risk for a range of physical illnesses and conditions, includ-

ing coronary heart disease, diabetes, infections, respiratory disease and greater levels of obesity. They are almost twice as likely to die from coronary heart disease as the general population and four times more likely to die from respiratory disease. With the launch of Choosing Health a good practice commissioning framework for supporting the physical needs of people with severe mental illness was also produced.\textsuperscript{58} This was aimed at reducing inequalities as well as providing services for a disadvantaged group with unmet needs.

**Recommendation Mental Health 3: Commissioners and providers should ensure that the physical needs of people with severe mental illness are met.**

### 6.7.4 Early support during pregnancy for mothers in difficult social and economic circumstances

Early support during pregnancy for mothers in difficult social and economic circumstances has been shown to have a positive impact on birth weight as well as family relationships.\textsuperscript{59} Professional emotional support for pregnant women caring for their existing children can decrease the rate of post-natal depression and very young mothers can also be helped to cope better, reducing the risk of depression and family problems. Support from non-professionals e.g. an experienced mother living in the community can also reduce depression and improve parenting skills. Trained lay support during childbirth also improves mental well-being and reduces anxiety/depression.

**Recommendation Mental Health 4: Commissioners and providers should ensure that early support during pregnancy for mothers in difficult social and economic circumstances is available and used.**

### 6.7.5 Follow up of people with severe adult mental illness

Recently discharged adults with severe mental illness from hospital are at increased risk of committing suicide. The Mental Health NSF stated that the follow-up for recently discharged adults with severe mental illness from hospital is a priority and that steps should be taken to improve the continuity of care and the transfer of information between hospital and community staff.\textsuperscript{60}


Recommendation Mental Health 5: Commissioners and providers should ensure that people with severe mental illness discharged from hospital are followed up within 7 days.

6.8 Alcohol-use disorders

Evidence shows very clearly that neither education nor public campaigning about alcohol generally have much effect on the way in which a society views or consumes alcohol.61

Many people with alcohol-use disorders are not identified and helped. There is a need to use a screening tool in various settings such as primary care, A&E departments, and maternity services.61

Recommendation Alcohol-Use Disorders 1: Providers should use a screening tool in various settings such as primary care, A&E departments, and maternity services to detect people with alcohol-use disorders who can be helped.

There is a need for a core assessment package to be developed in each locality to standardise and make accurate the assessment process. The outcomes of treatment also need monitoring for each client.61

Recommendation Alcohol-Use Disorders 2: Providers should use a core assessment package to standardise and make accurate the assessment process for people with alcohol-use disorders and monitor outcomes for each client validly.

A stepped-care approach to alcohol treatment is needed.61 Securing clarity of drinking goal is important before starting treatment since abstinence and moderation goals call for different treatment approaches. The type of treatment also depends on the type of alcohol-use disorder. Hazardous drinkers should be given information, advice, and counselling in primary care. Harmful drinkers should be given less intensive (than specialist) treatments in primary or specialist care. Problem drinkers should be referred to a specialist. There is no best treatment/intervention or “treatment of choice” for people with alcohol problems. Rather a range of effective treatments for different kinds of client in different settings is needed. Selection of which treatment to offer depends on clinician preference, client choice and availability of trained and enthusiastic therapists. It is also important to involve family and friends in

treatment, which will improve the chances of successful treatment. It clear that diagnosing co-morbidity alongside alcohol-use disorders is crucial, as is the provision of the range of services to tackle associated problems.

**Recommendation Alcohol-Use Disorders 3: Commissioners and providers should ensure a stepped-care approach to alcohol treatment is used with hazardous drinkers being given information, advice, and counselling in primary care; harmful drinkers should be given less intensive (than specialist) treatments in primary or specialist care such as Motivational Enhancement Therapy or Cognitive Behaviour Therapy; and problem drinkers should be referred for alcohol-focused intensive specialist treatment.**

Hazardous and harmful drinkers receiving brief interventions are twice as likely to moderate their drinking 6 to 12 months after an intervention when compared to drinkers receiving no intervention. Brief interventions also work for women, college students and attenders at Accident and Emergency Departments. For harmful drinkers there are four effective kinds of less intensive (than specialist) treatment, including Motivational Enhancement Therapy (MET). There are several effective Cognitive Behaviour Therapy modalities, including the Community Reinforcement Approach, Social Behaviour & Network Therapy, and Behavioural Self-control Training.

**Recommendation Alcohol-Use Disorders 4: GPs and staff in Emergency Departments should offer brief interventions to hazardous and harmful drinkers.**

Cognitive behavioural couple and family therapies are effective. Treatment agencies should have maintenance stage interventions, such as social skills training, within their repertoire. Client-centred counselling therapy is effective but less so than a specific structured therapy that is equally well delivered. Complementary or feelgood therapies should be part of a more comprehensive treatment package – not standalone interventions.

**Recommendation Alcohol-Use Disorders 5: Commissioners and providers should ensure that cognitive behavioural couple and family therapies and maintenance stage interventions are available for appropriate people with alcohol-use disorders.**

Detoxification is usually straightforward and possible in most settings. Preparation for detoxification with the client is crucial. Disulfiram taken supervised is an effective component of
relapse prevention strategies. Anti-craving medications show minor positive effects in relapse prevention when used in conjunction with psychosocial interventions. Service user groups, family and friends can all provide essential support for people during community-based detoxification.

Self-help manuals based on cognitive behavioural principles are an effective and cost-effective adjunct or alternative to formal treatment among alcohol misusers with mild to moderate dependence. AA appears to be effective for those alcohol misusers who are suited to it and who attend meetings regularly. AA is a highly cost-effective means of reducing alcohol-related harm. Mutual aid groups, including 12-Step and other less-spiritual approaches, are an effective means of getting support both during treatment and as aftercare. 12-Step residential treatment confers no added benefit.

**Recommendation Alcohol-Use Disorders 6: Commissioners and providers should ensure that self-help manuals based on cognitive behavioural principles are available for alcohol misusers with mild to moderate dependence.**

Commissioners and providers must understand local mutual aid groups and how to work harmoniously with them. Treatment of people with alcohol-use disorders who also have psychiatric co-morbidity, especially pharmacotherapy, is likely to be complex and there are benefits in having a single and constant treatment provider.

**Recommendation Alcohol-Use Disorders 7: Commissioners and providers should ensure that mutual aid groups, including 12-Step and other less-spiritual approaches, are available for people with alcohol-use disorders.**

Case management can effectively link people with substance abuse to community and treatment services as compared to treatment as usual or other viable treatment options, such as psycho-education or brief interventions. Community matrons work through case management and there is evidence that they can be effective. The Department of Health in England is establishing Case Management/Community Matrons everywhere. The NHS Improvement Plan: Putting People at the Heart of Public Services (2004) sets out the govern-

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ment’s intention that by 2008 there will be 3,000 community matrons using case manage-
ment techniques for planning and coordinating the care of people with high intensity needs.64

**Recommendation Alcohol-Use Disorders 8: Commissioners and providers should ensure that community matrons include people with substance abuse in their brief and they link them to community and treatment services.**

The Recommendations on Alcohol-Use Disorders will also help prevent hypertension, cardio-
dvascular disease and cancer.

### 6.9 Teenage pregnancy

#### 6.9.1 Reducing teenage pregnancies

The Government is determined to tackle poverty and reduce inequality. Reducing teenage pregnancy rates is an important part of that agenda. The Department for Education and Skills has just published ‘Teenage Pregnancy Next Steps: Guidance for Local Authorities and Primary Care Trusts on Effective Delivery of Local Strategies’.65 The key actions to be pursued from research of those areas that have successfully reduced teenage pregnancy rates against those that have not are:

Senior local sponsorship and engagement of all key partners. In high-performing areas the seniority and personal commitment of key post-holders such as the chair of the Teenage Pregnancy Partnership Board, local Teenage Pregnancy Co-ordinator and senior personnel within key partner agencies, were seen as of critical importance.

Provision of young people focused contraception/sexual health services, trusted by teenagers and well known by professionals working with them. This was the factor most commonly cited as having the biggest impact on conception rate reductions in the high performing areas. Features of successful services reflected the Best Practice guidance on the provision of effective contraception and advice services for young people, issued by the Teenage Pregnancy Unit in 2000: easy accessibility in the right location with opening hours convenient to young people; provision of the full range of contraceptive methods, including long acting methods; a strong focus on sexual health promotion (as well as reactive services) through, for example, outreach work in schools, work with professionals to improve their ability to engage with young people on sexual health issues; and through highly visible publicity. Effective services also had a strong focus on meeting the specific needs of young men. All high-

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performing areas also had condom distribution schemes involving a wide range of local agencies and/or access to emergency contraception in non-clinical settings.

Strong delivery of Sex and Relationships Education (SRE) and/or Personal Social and Health Education (PSHE) by local schools. Key features included: systematic delivery of SRE/PSHE in secondary and primary schools, driven by the LEA; a strong focus on achieving ‘healthy schools’ status; use of the DfES SRE guidance (issued in 2000) as a driver for training and support for schools, including planned programmes of training for Governors; LEA support to improve schools’ PSHE delivery, including the development of exemplar lesson plans, investment in SRE resources and consultancy support for targeted schools.

Targeted work with at-risk groups of young people, in particular Looked-After Children. All 3 high performing areas had examples of Social Services having a strong focus on sexual health issues – in one area Social Services had a local performance target that all Looked After Children (LAC) had access to advice on contraception and sexual health. In the same area, there was also mandatory SRE training for all social work managers, family support workers, foster carers and relevant social workers. And in another, Social Services delivered SRE programmes for young people in care and the LAC Nurse ran a sexual health clinic for LAC.

Workforce training on sex and relationship issues within mainstream partner agencies. An indicator of mainstream partners’ engagement in the strategy was the extent to which the professionals working within the partner agency had received training on SRE issues. Many professionals – such as Youth Workers, Connexions PAs, Social Workers – will be working intensively with young people at risk of early pregnancy, as well as other negative outcomes. This relationship offers the potential to do early preventative work to help young people delay early sex and access early advice. The most systematic approaches were: mandatory training of all relevant social workers; SRE training for youth workers to allow them to play a key role in initiatives during ‘themed weeks’ on sexual health and teenage pregnancy; and mandatory training for all Connexions PAs.

Well-resourced Youth Service, with a clear remit to tackle big social issues, such as teenage pregnancy and young people’s sexual health. Where Youth Services were well resourced, provision of positive activities for young people was strong. In addition, in high performing areas, Youth Workers had been equipped with the skills and knowledge to support young people on sex and relationship issues, and there was evidence of strategic leadership within the Youth Service, with a focus on the big social issues affecting young people, such as drugs, alcohol and sexual health.
Recommendation Teenage Pregnancy 1: Great Yarmouth and Waveney PCT and the local authorities should ensure that senior people with personal commitment are the chair of the Teenage Pregnancy Partnership Board and local Teenage Pregnancy Co-ordinator and are supported by key personnel in all agencies.

Recommendation Teenage Pregnancy 2: Great Yarmouth and Waveney PCT and the local authorities should ensure that there are young people-focused contraception/sexual health services, trusted by teenagers and well known by professionals working with them.

Recommendation Teenage Pregnancy 3: Great Yarmouth and Waveney PCT and the local authorities should ensure that there is strong delivery of Sex and Relationships Education and/or Personal Social and Health Education by local schools.

Recommendation Teenage Pregnancy 4: Great Yarmouth and Waveney PCT and the local authorities should ensure that there is targeted work with at-risk groups of young people, in particular Looked-After Children.

Recommendation Teenage Pregnancy 5: Great Yarmouth and Waveney PCT and the local authorities should ensure that there is workforce training on sex and relationship issues within mainstream partner agencies.
Recommendation Teenage Pregnancy 6: Great Yarmouth and Waveney PCT and the local authorities should ensure that there is a well-resourced Youth Service, with a clear remit to tackle big social issues, such as teenage pregnancy and young people’s sexual health.

6.9.2 Encouraging safer sex

Alongside the need to reduce teenage pregnancies is the need to reduce sexual transmitted infections in people of all ages but especially young people. Genital chlamydia is the most common sexually transmitted infection diagnosed in England, with high prevalence being documented among young men and women aged under 25 attending a variety of specialist and general health care settings. Rates of infection have remained high among 20-24 year group in men and 16-19 year olds in women.66 Tackling the prevalence of Chlamydia through the accelerated implementation of a national screening programme is one of the key commitments in the Choosing Health White Paper. A World Health Organization Report on behalf of the Observatory on Health Systems and Policy have also acknowledged that the only screening programme that they would consider appropriate in adolescence and early adulthood is the opportunistic programme for Chlamydia.67 The National Chlamydia Screening Programme (NCSP) is a control and prevention programme targeted at the highest risk group, young people under 25 who are sexually active.

Recommendation Safer Sex 1: Great Yarmouth and Waveney PCT and the local authorities should ensure that the National Chlamydia Screening Programme of control and prevention targeted at young people under 25 is fully supported in line with government direction.

A review of the evidence looking at preventing pregnancy and sexually transmitted disease found that joining-up services and interventions with other services for young people aimed at preventing pregnancy were effective.68

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Recommendation Safer Sex 2: Great Yarmouth and Waveney PCT and the local authorities should ensure that their services for young people are joined up so as to support mutual aims such as reducing teenage pregnancy and sexually-transmitted diseases, particularly for sex education and the provision of contraceptive services.

6.10 Respiratory diseases

6.10.1 Chronic obstructive pulmonary disease (COPD)

Chronic obstructive pulmonary disease (COPD) is characterised by airflow obstruction. The airflow obstruction is usually progressive, not fully reversible and does not change markedly over several months. The disease is predominantly caused by smoking. NICE have published a Clinical Guideline for chronic obstructive pulmonary disease. They recommended key priorities for implementation covering the diagnosis of COPD, stopping smoking, effective inhaled therapy, pulmonary rehabilitation for all who need it, the use of non-invasive ventilation, the management of exacerbations, and the need for multidisciplinary working.

Recommendation COPD 1: Great Yarmouth and Waveney PCT and local hospital Trusts should ensure that the NICE Clinical Guideline for chronic obstructive pulmonary disease (CG12) is being followed.

Pulmonary rehabilitation should be made available to all appropriate patients with COPD. NICE have published a commissioning guide as a resource to help health professionals in England commission effective pulmonary rehabilitation services for patients with chronic obstructive pulmonary disease. Patients with COPD who benefit from pulmonary rehabilitation are those who consider themselves functionally disabled (usually MRC grade 3 and above). Pulmonary rehabilitation is not suitable for patients who are unable to walk, have unstable angina or who have had a recent myocardial infarction. The programme should be tailored to the patient’s needs, and should include physical training, disease education, nutritional, psychological and behavioural intervention.

Recommendation COPD 2: Great Yarmouth and Waveney PCT and local hospital Trusts should ensure that pulmonary rehabilitation should be made available to all appropriate patients with COPD.


Encouraging patients with COPD to stop smoking is one of the most important components of their management. All COPD patients still smoking, regardless of age, should be encouraged to stop, and offered help to do so, at every opportunity.

**Recommendation COPD 3: Great Yarmouth and Waveney PCT and local hospital Trusts should ensure that all patients with COPD still smoking, regardless of age, are encouraged to stop, and offered help to do so, at every opportunity.**

### 6.10.2 Influenza immunisation

Inactivated influenza vaccine reduces exacerbations in COPD patients. The Department of Health recommends influenza immunisation for all people with chronic respiratory disease annually between September and early November. Influenza immunisation is also recommended at this time for those aged 65 years and over and those with any chronic heart, liver, or renal disease or diabetes or who are immunosuppressed.

### 6.10.3 Pneumococcal immunisation

The overall efficacy of pneumococcal polysaccharide vaccine in preventing pneumococcal bacteraemia is probably 50 to 70%. Post-licensure surveillance, following introduction of PCV in the US in 1999 as part of a universal infant immunisation programme, has shown a large reduction in both invasive and non-invasive disease incidence due to vaccine serotypes in both vaccinated and older unvaccinated populations (‘herd immunity’). This reduction in disease has also been accompanied by a fall in the rate of penicillin-resistant pneumococcal infections. The Department of Health recommends pneumococcal immunisation for all people with chronic respiratory disease. Pneumococcal immunisation is also recommended for those aged 65 years and over and those with any chronic heart, liver, or renal disease or diabetes, or who are immunosuppressed, have cochlear implants or spinal fluid leaks, or have no or a dysfunctional spleen.

**Recommendation COPD 4: Great Yarmouth and Waveney PCT and all local GPs should ensure that all patients with COPD are immunised with influenza and pneumococcal vaccines.**

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Recommendation Immunisation 1: Great Yarmouth and Waveney PCT and all local GPs should ensure that all patients aged 65 years and over or with chronic disease as outlined in the Green Book on immunisation are immunised with influenza and pneumococcal vaccines.

6.11 Breastfeeding

NICE have published their review of the evidence on the promotion of breastfeeding initiation and duration as an ‘Evidence into practice briefing’. They recommend 8 evidence-based actions to increase breastfeeding initiation and duration:

1. UNICEF UK BFI for maternity service

   UNICEF UK BFI (baby-friendly initiative) for maternity services should be implemented as routine practice across NHS acute trusts in England. In particular all maternity hospitals should be encouraged to attain the BFI Full Accreditation Award to increase initiation rates for all women and hospitals with a BFI Certificate of Commitment should progress to the BFI Full Accreditation Award to increase breastfeeding initiation for all women.

2. Education and/or support programmes

   An appropriate mix of the following education and support programmes should be routinely delivered by both health professionals/practitioners and peer supporters in accordance with local population needs.

   • Informal, practical breastfeeding education in the antenatal period should be delivered in combination with peer support programmes to increase initiation and duration rates among women on low incomes.

   • A single session of informal, small group and discursive breastfeeding education should be delivered in the antenatal period (including topics like the prevention of nipple pain and trauma) to increase initiation and duration rates among women on low incomes.

   • Additional, breastfeeding specific, practical and problem solving support from a health professional/practitioner should be readily available in the early postnatal period to increase duration rates among all women.

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• Peer support programmes should be offered to provide information and listening support to women on low incomes in either the antenatal or both the antenatal and postnatal periods to increase initiation and duration rates.

3. Changes to policy and practice within community and hospital settings
   In order to increase duration rates of any and exclusive breastfeeding among all women, routine policy and practice for clinical care in hospital and community should:
   • support effective positioning and attachment, using a predominantly ‘hands off’ approach
   • encourage unrestricted baby led breastfeeding which helps prevent engorgement – and for women experiencing mastitis, encourage regular breast drainage and continued breastfeeding
   • encourage the combination of supportive care, teaching breastfeeding technique, sound information and reassurance for breastfeeding women with ‘insufficient milk’

4. Abandonment of practices within community and hospital settings inhibiting breastfeeding
   In order to increase the duration of any and exclusive breastfeeding among all women, routine policy and practice for clinical care in hospital and community settings should abandon or continue to abandon:
   • restriction of the timing and/or frequency of breastfeeds during immediate postnatal care
   • restriction of mother and baby contact from birth onwards during immediate postnatal care
   • supplemental feeds given routinely or without medical reason in addition to breast feeds (for example, in Baby Friendly Hospitals, the supplementation rate is usually below 10%)
   • separation of babies from their mothers for the treatment of jaundice
   • the provision of hospital discharge packs and any informational material given to mothers which contain promotion for formula feeding including the advertising of ‘follow on’ formula milks to mothers of new babies (this practice has for the most part disappeared from normal NHS care. It is important to ensure that it is not reintroduced.)

5. Complementary telephone peer support
   Peer or volunteer support should be delivered by telephone to complement face-to-face support in the early postnatal period to increase duration rates among women who want to breastfeed.

6. Education and support from one professional
Breastfeeding education and support from one professional should be targeted to women on low incomes to increase rates of exclusive breastfeeding.

7. Education and support for one year

One-to-one needs-based breastfeeding education in the antenatal period combined with postnatal support through the first year should be available to increase intention, initiation and duration rates, particularly among white, low income women.

8. Media programmes

Local media programmes should be developed to target teenagers to improve and shift attitudes towards breastfeeding.

**Recommendation Breastfeeding 1:** All local maternity services must ensure that UNICEF UK BFI is being implemented.

**Recommendation Breastfeeding 2:** All local maternity services must ensure that an appropriate mix of education and support programmes delivered by peers and professionals is available.

**Recommendation Breastfeeding 3:** All local maternity services must adopt policies and practices that promote breastfeeding among all women and abandon those that inhibit breastfeeding as detailed in the NICE Guidance.

**Recommendation Breastfeeding 4:** Great Yarmouth and Waveney PCT, all local maternity services, and local GPs must decide how to provide peer or volunteer support delivered by telephone to complement face-to-face support in the early postnatal period to increase duration rates among women who want to breastfeed and then deliver it.
**Recommendation Breastfeeding 5:** All local maternity services must ensure that breastfeeding education and support from one professional is targeted to women on low incomes to increase rates of exclusive breastfeeding and Great Yarmouth and Waveney PCT should ensure that this one-to-one needs-based breastfeeding education in the antenatal period combined with postnatal support is available throughout the first year.

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**Recommendation Breastfeeding 6:** Great Yarmouth and Waveney PCT should work with the local media so that programmes are developed to target teenagers to improve and shift attitudes towards breastfeeding.

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### 6.12 Reducing health inequalities

#### 6.12.1 Health trainers

Twelve areas have been named as the first sites for the new health trainers, an initiative announced in the Choosing Health White Paper.76 These areas will each receive £200,000 additional funding to provide personalised plans for individuals to improve their health and prevent diseases such as cancer and coronary heart disease. The initiative is targeted first at the most disadvantaged areas to make it easier for individuals in these communities to make healthier choices. It will extend to the rest of England in 2007.

A review of the evidence found:

- The programme WATCH IT using health trainers offers a model for a community-based service for obese children. The programme suggests that effective care can be delivered by health trainers supervised by health professionals, and so potentially provides a cost effective programme within children’s communities.77

- Another study in the North East of the pilots found that the Health Trainers project was one that has been constantly evolving, particularly given the fast pace of the early adopter phase and the high degree of flexibility afforded to the local sites by the centre. This has resulted in a number of discrepancies being found between the intentions outlined in the initial documentation and the picture given during interviews with stake-

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holders involved in implementing the project. In only one of the North East Primary Care Organisations did the local project fit the Choosing Health model of overall health behaviour change achieved by working on a one-to-one basis with individuals.

- An earlier review of evidence by the same team found little evidence of effectiveness. They noted that the outcomes that can be expected from community interventions, particularly in the short-term, are rarely the kind of health outcomes that can be demonstrated using clinical research.

- Another study evaluated the early adopter model in Bradford. The authors concluded that the new role of health trainer is a significant development for the public health workforce. Health trainers can offer something quite distinctive and separate from professional advice, and there is potential to help individuals to access support and services in local communities.

- Several studies have also looked at their work in mental health and migraine relief.

A recent report from the Health Evidence Network of the World Health Organisation synthesized the effectiveness of empowerment strategies to improve health and reduce health disparities. It found that health promotion should address effective empowerment strategies, such as increasing citizens’ skills and control over resources and access to information relevant to public health development, being sensitive to the health care needs defined by community members, and using community-wide participation.

Finally another recently-published review of the theoretical considerations around health trainers found that synchronized policies that tackle both individual and neighbourhood environmental barriers to improving health behaviours are essential.

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82 Kennedy A, Rogers A, Gately C. From patients to providers; prospects for self-care skills trainers in the National Health Service. Health and Social Care in the Community, Sep 2005, vol. 13, no. 5, p. 431−440, ISSN: 0966−0410.
85 World Health organisation, Health Evidence Network. What is the evidence on effectiveness of empowerment to improve health? http://www.euro.who.int/HEN/Syntheses/empowerment/20060119_10
The development of health trainers should therefore be guided by the results of the above and any emerging studies. They seem to work for obese children in disadvantaged areas. They must not be set up in isolation from overarching supportive policies and programmes.

**Recommendation Health Inequality Intervention 1: Health trainers should be developed to support obese children in disadvantaged areas.**

**Recommendation Health Inequality Intervention 2: Health trainers should only be developed along with supportive policies and programmes and following the examples of good practice that are emerging.**

### 6.12.2 Teenage pregnancy, breast feeding, and smoking cessation

Many of the developments recommended for tackling teenage pregnancy, low breastfeeding rates and smoking are based on evidence that works for disadvantaged people. These developments should be given absolute priority.

**Recommendation Health Inequality Intervention 3: The developments for teenage pregnancy, breast feeding, and smoking cessation recommended earlier should be given absolute priority for people in disadvantaged areas.**

### 6.12.3 Nutrition in women in disadvantaged groups of childbearing age

The nutrition of women in disadvantaged groups of childbearing age is likely to be poor. The government has introduced a new Healthy Start scheme to help families from low income and disadvantaged households by giving vouchers for free milk and fresh fruit and vegetables to children and mums-to-be. The scheme also encourages earlier and closer contact with health professionals who can give advice on pregnancy, breastfeeding and healthy eating.\(^87\) It is imperative that there is full uptake of Healthy Start food vouchers by pregnant women in disadvantaged areas.

**Recommendation Health Inequality Intervention 4: Great Yarmouth and Waveney PCT and community health and social care staff should ensure that there is full uptake of Healthy Start food vouchers by pregnant women in disadvantaged areas.**

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6.12.4 Routine services for maternal and child health and child development that are not taken up equally by people in disadvantaged areas

There is a great need to improve the health of children and mothers from disadvantaged groups.88

- Improve access to maternity services, focusing on early ante-natal booking and take-up rates for women from low-income backgrounds and black and minority ethnic groups. This can be done by working with communities to identify their needs and wishes, ensuring services are culturally appropriate and accessible, providing better information. This must include screening and immunisation along with particular efforts to address risk factors for sudden Infant death – parental smoking, sleeping position and adverse social circumstances. There is a key role for GPs, midwives and health visitors in identifying people in these groups and ensuring that they receive comprehensive good quality ethnically-sensitive services.88

- Increase the take up and duration of breast-feeding for new mothers, especially those in low income groups through training health professionals and encouraging peer support programmes. There is a key role for midwives health visitors and peer group networks.88 See Section 6.12 above.

Reform of the 60 year old Welfare Food Scheme by 2004 will help ensure that 800,000 women and young children from low-income families have access to a healthy diet, and provide increased support for breastfeeding mothers. There is a key role for Sure Start working with health professionals, including GPs, midwives and health visitors.88

- Promote the Brushing for Life scheme to reduce inequalities in the dental health of young children in Sure Start areas without water fluoridation.88 There is a key role for Sure Start local programmes working with health visitors and dentists.

- Develop multi-disciplinary family support teams that reflect the needs and wishes of local children and families, drawing on and developing the skills of local parents and community workers as well as those of a range of health and social care workers. Many Sure Start local programmes employ trained local volunteers to help health professionals in supporting families. There is a key role for local authority social services with Sure Start local programmes, PCTs and voluntary organisations working with for social workers, GPs, health visitors, and lay support workers, including a Black and Minority Ethnic

community development worker to improve mental health services for black and minority ethnic communities.  

Recommendation Health Inequality Intervention 5: Great Yarmouth and Waveney PCT and Great Yarmouth and Waveney councils must ensure that the routine services for maternal and child health and child development are taken up equally by people in disadvantaged areas and groups through directing mainstream services and workers to this absolute priority and the development of family support teams.

6.12.5 Cardiovascular disease in disadvantaged areas

There is much that can be learnt from innovation elsewhere in the NHS. For example the City-wide Initiative for Reducing Cardiovascular disease (CIRC) work in Sheffield which has been successful in improving outcomes in disadvantaged areas.

The Sheffield CIRC (citywide initiative for reducing cardiovascular disease) Programme aims to reduce inequalities in cardiovascular premature mortality. It delivers high quality, secondary prevention programmes to an estimated 14,000 individuals with cardiovascular disease in the areas of highest need. Fifty one Sheffield GP practices received a tailored programme of support that included: training of nurses and doctors; additional nursing time; IT support; dietetics; physical activity and psychological specialist input. A citywide programme of user support and community engagement with ethnic minority communities also linked into the practice-based activities. Additional funding of £1 million enabled the programme to be incorporated into the mainstream services of the four Sheffield Primary Care Trusts at that time. By 2003, Sheffield had seen a 23% decline in the under 75 cardiovascular mortality rate in the most deprived fifth of its population since 2000, compared to a 16% decline in the Sheffield population as a whole.

Recommendation Health Inequality Intervention 6: Great Yarmouth and Waveney PCT, its Practice-Based Commissioning Groups, local GP practices, and local community health services should consider adopting the approach of the Sheffield citywide initiative for reducing cardiovascular disease

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89 Choosing Health: Chapter 6. Example of the The Sheffield CIRC (citywide initiative for reducing cardiovascular disease).
www.dh.gov.uk/prod_consum_dh/dhldcpg/?id=115527&Rendition=Web

Great Yarmouth and Waveney PCT

Version – 16 Jan 08
6.13 Partnership interventions

6.13.1 Partnership

The PCT should be working through Local Strategic Partnerships, influencing local authorities, schools, communities and a range of other stakeholders so that they are having a positive impact on health and health inequalities. In particular by working to deliver services around the way in which people live their lives so that usage is improved, especially by those in highest need. The recent Public Health Programme Guidance on behaviour change at population, community and individual levels is the most-up-to-date evidence-based source on lifestyle change.\(^\text{90}\) The first key recommendation of this Guidance is aimed at those policy makers, commissioners, service providers, practitioners and others whose work impacts on, or who wish to change, people’s health-related behaviour. The Guidance recommends that they work in partnership with individuals, communities, organisations and populations to plan interventions and programmes to change health-related behaviour.

6.13.2 Housing improvement to tackle cold and dampness

Improving housing quality to tackle cold and dampness, particularly for the elderly, through collaborative approaches, for example between primary care, housing improvement agencies and others can be effective.\(^\text{91,92}\) Collaborative interventions addressing fuel poverty also work.\(^\text{93}\)

**Recommendation Partnership Intervention 1:** The Local Strategic Partnerships should ensure that all community services staff working with local statutory agencies should identify poor households living in cold and damp housing and that this is remedied.

6.13.3 Falls prevention in the elderly

The prevention of falls in the elderly is outlined in the Older People’s NSF and there is also respective NICE guidance:\(^\text{94}\) it requires a multi-disciplinary and multi-agency approach. Falls in older people are preventable\(^\text{94,95,96}\) and there is a wealth of advice on the Department of Health website about services to prevent them.\(^\text{97}\)

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• Single intervention prevention – some tailored home exercise programmes have been found to reduce falls in women aged 80 and over living in the community.94.

• Multi-faceted intervention prevention – programmes based on falls risk factor assessment and tailored intervention (most of which include some form of exercise), in selected groups of at-risk older people, reduce falls. Attention to postural hypotension, number of medications, balance, transfers and gait is particularly effective, and interventions should be targeted at both intrinsic and environmental risk factors for individual patients.94,96

• Home assessment – home assessment and surveillance can reduce falls in frail older people. This can be carried out by a variety of healthcare workers or volunteers. Home assessment of function, with education in risk areas, and referral to the patient’s GP, reduces falls. Identification of patients who attend A&E because they have fallen, with subsequent medical and OT assessment and with referral and follow-up, reduces falls.94,96

• Residential institutions – assessment of residents after falling with recommendations for specific preventive measures decreases falls. Assessment of residents after falling by a nurse practitioner, including laboratory test, electrocardiogram, and 24-hour Holter heart monitoring, decreases hospitalisation.94,96

Recommendation Partnership Intervention 2: The Local Strategic Partnerships should ensure that there is a falls strategy for older people covering every setting and the Great Yarmouth and Waveney PCT should commission services to work together to prevent falls in older people.

6.13.4 Childhood injury

National Service Framework for children, young people and maternity services specifies core standards that cover childhood injury.98 Primary Care Trusts and Local Authorities should ensure that childhood injuries and accidents are reduced through the development and monitoring of injury prevention strategies that target priority areas where there are marked inequalities. There should also be a named lead in each locality who develops, co-ordinates and monitors initiatives for tackling injury prevention.

There is good evidence that motor vehicle injuries in children can prevented by:94,99
• 20mph zones (leading to injury reduction and behaviour change)
• Cycle helmet education campaigns (leading to behaviour change)
• Cycle helmet legislation (leading to behaviour change)
• Child restraint loan schemes (leading to behaviour change)
• Child restraint legislation (leading to behaviour change).
• There is good evidence that injuries in children can prevented by: 94,99
• Smoke detector programmes (leading to injury reduction and behaviour change)
• Poisoning – child resistant packaging (leading to injury reduction)

**Recommendation Partnership Intervention 3: The Great Yarmouth and Waveney PCT, Waveney and Great Yarmouth Councils, and the Local Strategic Partnerships should develop and monitor an injury prevention strategy that targets priority areas where there are marked inequalities.**

**Recommendation Partnership Intervention 4: The Local Strategic Partnerships should seek to establish 20 mph zones in appropriate residential areas, develop local educational programmes for wearing cycle helmets, and make available smoke detectors and loans for child restraint systems in cars for socio-economically disadvantaged households.**

### 6.13.5 Crime and disorder related to alcohol misuse

Police-targeting initiatives of the public order and associated problems linked with alcohol occurring in and around bars and clubs have been successful.100

This seems to have better results if local community action is incorporated with coalitions formed between the licensing authorities, the local Council, police, taxi operators, security companies, and bar owners and managers.101,102,103 Such schemes have led to improved

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bar management and a decline in binge drinking, intoxication, aggression, and violence without displacement of the problems elsewhere.

The use of toughened or safety glasses in bars is helpful in reducing accidental and non-accidental glass injuries.\textsuperscript{104,105}

**Recommendation Partnership Intervention 5: The Local Strategic Partnerships, Police, licensing authorities, taxi operators, security companies, bar owners and managers should establish a partnership to reduce crime and disorder related to alcohol misuse.**

6.13.6 Town planning guides: A guide to town planning for NHS staff

It is important for there to be partnership working between National Health Service organisations (NHS) and local planning authorities (LPAs) at all levels. Having a good relationship with your LPA means that the NHS can discuss the impact of proposed developments on the health and well being of the local population as well as on existing and future healthcare provision. Consideration can be given to how best to tackle health inequality and regenerate the most deprived areas that have the poorest health. The Department of Health is helping this process by developing two new planning guides - one for the NHS to explain the town planning process and the other for LPAs to understand the NHS better.\textsuperscript{106}

**Recommendation Partnership Intervention 6: Great Yarmouth and Waveney Councils should establish a post of health policy officer who can check all the council developments for their health implications.**


\textsuperscript{105} Plant MA, Miller P, Plant ML, Nichol P. No such thing as a safe glass. British Medical Journal 1994;308:1237-1238.

7 How will we know when we are there?

Measurement of progress will be against the aims, objectives and targets specified for the planning period.

For the planned service developments there should be measurable indicators and targets. These should be as outcome focused as possible within the resources and time period available but will also include process measures such as activity changes. Any Department of Health indicators to inform local target setting being developed should be incorporated if available.