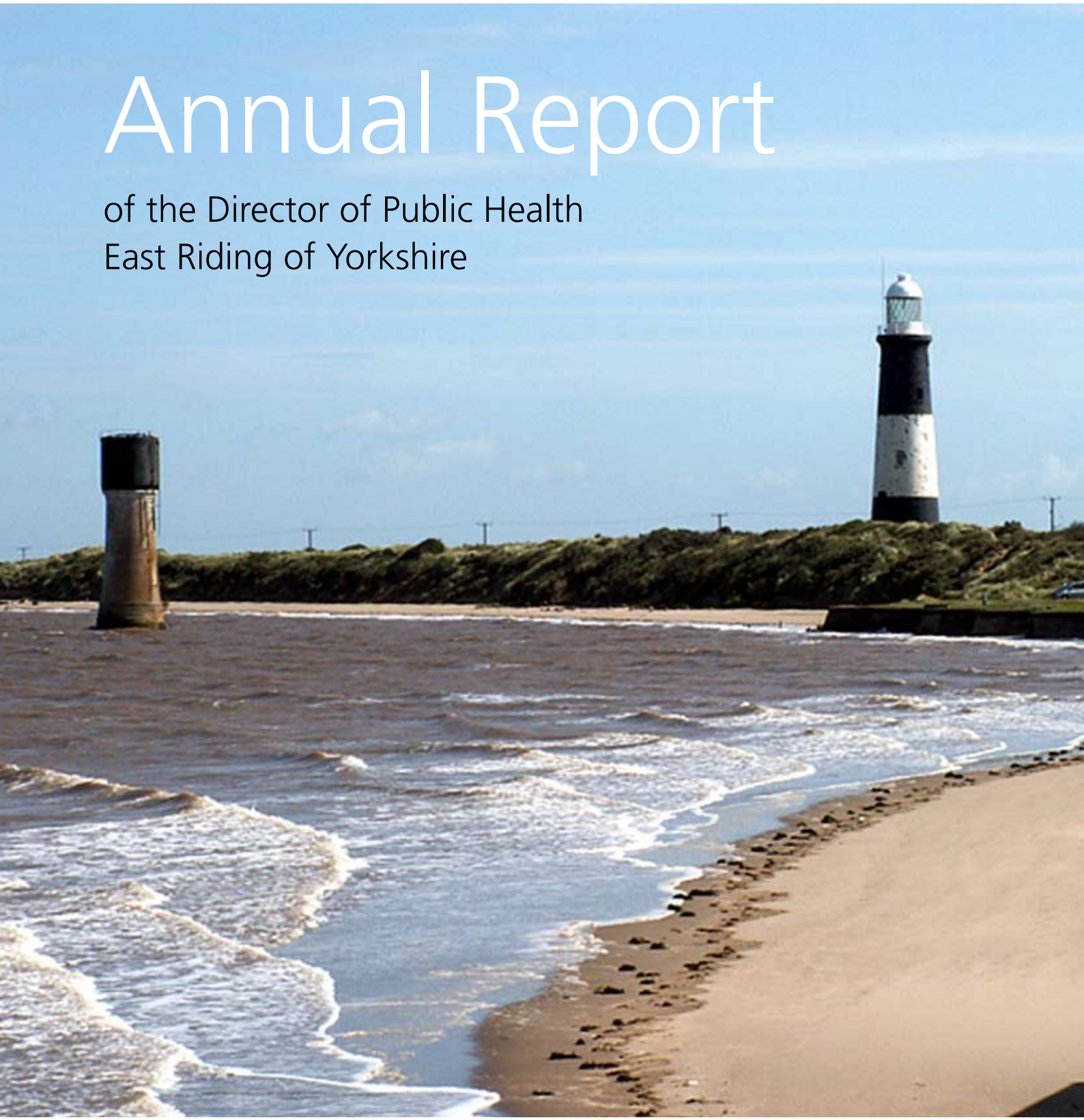
East Riding of Yorkshire NHS
Primary Care Trust

Annual Report

of the Director of Public Health
East Riding of Yorkshire



East Riding Local Strategic Partnership

2006-2007

Acknowledgements

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Contents

Executive Summary

This year's report considers priorities for improving health in the East Riding of Yorkshire and also looks at issues relating to localities and to migrant health. Health inequalities are widening within the East Riding and it is important to develop strategies to narrow the gap and improve the health of people who currently have the poorest health. The lack of a fall in the rate of people dying from lung cancer is a major concern and continued efforts to tackle smoking are vital. In other areas, such as some migrant communities, gathering further information about health needs is a major priority.

If you require the document in a different form, such as with larger print, on audiotape, or translated into a different language, please use the contact details on page 7 or telephone 01482 672145.

Recommendations

East Riding of Yorkshire PCT, East Riding of Yorkshire Council and partners should continue to take note of the local population structure in the planning and commissioning of services, particularly in the forthcoming joint health needs assessment.

East Riding of Yorkshire PCT, East Riding of Yorkshire Council and partners should continue to work to reduce local health inequalities, including work as part of the Local Area Agreement. Further specific targets should be set which would reduce inequalities if achieved. New healthcare developments should specifically consider their impact on health inequalities.

Work should continue to implement Choosing Health targets, especially in connection with diet and exercise.

Efforts to tackle lung cancer should be strengthened with consideration of new targets for smoking cessation. Potential for improvement in local lung cancer survival should also be reviewed.

Work to ensure efficient and effective delivery of the breast screening programme should continue and factors affecting breast cancer rates investigated. Bowel screening should be introduced in an efficient and effective way, ensuring appropriate public awareness.

Local health improvement campaigns such as those targeted at reducing fractured neck of femur, reducing suicide, sun safety and sexual health should continue, while additional targeted work should be considered.

Work in localities should take into account the particular needs of localities and be appropriately linked with Public Health priorities.

Further work should be undertaken to assess the health of people from migrant communities, including migrant workers, prisoners and coastal migrants and to develop plans to address those needs.

East Riding of Yorkshire PCT and its partners should continue to encourage increased immunisation uptake.

East Riding of Yorkshire PCT and its partners should continue appropriate preparations for a possible influenza pandemic, including measures to increase public understanding.

Local Strategic Partnership work aimed at improving health should continue to focus on delivery of the Public Health Strategy, reducing health inequalities and addressing the needs of marginalised groups.

1 Introduction

This is my fifth annual report as Director of Public Health. As in previous reports the principal aim of this document is to set out the health of the local population and to make recommendations aimed at improving the health of people in the East Riding of Yorkshire.

This report is my personal report on the health of the local population. It is presented to the Board of East Riding of Yorkshire Primary Care Trust (PCT), as well as in other forums, but it is not produced by the PCT. I maintain editorial control and responsibility for the content. Recommendations in the report are my recommendations to the PCT and partner organisations.

Since the publication of the last report there have been organisational changes, notably the establishment of the East Riding of Yorkshire Primary Care Trust. Its geographical boundaries are the same as those of East Riding of Yorkshire Council. At the same time there is an increased emphasis at a national level on joint working for health improvement and the reduction of health inequalities. Both these factors are reflected in this report and their effects should work to improve the health of local people through concerted and joined actions.

The structure of this report is similar to that of previous reports and some information is presented as trends over time. There is a considerable amount of information that has been presented in previous years which is still relevant today. In many cases information is not updated annually, for example the census only takes place every ten years. I may not have included such information this year, but readers may wish to consult previous reports.

This report, together with previous reports and additional detailed information about the health of local people, is available at:
http://www.erypct.nhs.uk
http://lsp.eastriding.gov.uk

The theme of migrant populations is present this year in the localities chapter. This includes not only people migrating to the East Riding from overseas, but also from elsewhere in the United Kingdom. This is intended to encourage debate and initiatives to improve the health of people who have moved to the area. On a lighter note I have included a section looking back to local health in the 1970s, a time when public health was still the domain of local authorities.

As in previous years this report considers the health of the population and efforts to improve health that are often outside the remit of general practice and hospitals. Hospital treatment is sometimes seen as the best way to improve health and resources are often concentrated there. Historically, most improvement in health has arisen from efforts such as sanitation and nutrition, outside the scope of healthcare. In more recent times healthcare has had a greater effect on health. Perhaps healthcare affects life expectancy to a similar degree now as do other factors. However, we must still concentrate on prevention and the wider determinants of health, dealing with smoking as well as lung cancer and preventing falls as well as fixing fractured hips.

I very much welcome feedback about the report. Please complete the feedback form, or if you have any comments about the report, please contact me:

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Director of Public Health
East Riding of Yorkshire Primary Care Trust


YORKSHIRE BELLE

2

People in the East Riding of Yorkshire

The population of the East Riding of Yorkshire is made up of a range of people of different ages, ethnicities and places of birth. The local population is increasing and when we consider people's health we need to be especially conscious of the growing number of older people. The majority of older people live in or near the principal towns of the East Riding.

Information about the features of the local population is collected in detail at the census every ten years. The last census was in 2001 and detailed results are available in previous reports and in an interactive format from the East Riding Data Observatory.

Population estimates by age and sex are shown by numbers in Table 1 and by chart in Figure 1.

These estimates demonstrate the relatively large number of older people in the East Riding and the relatively smaller proportion of people aged 20-34.

Recommendation

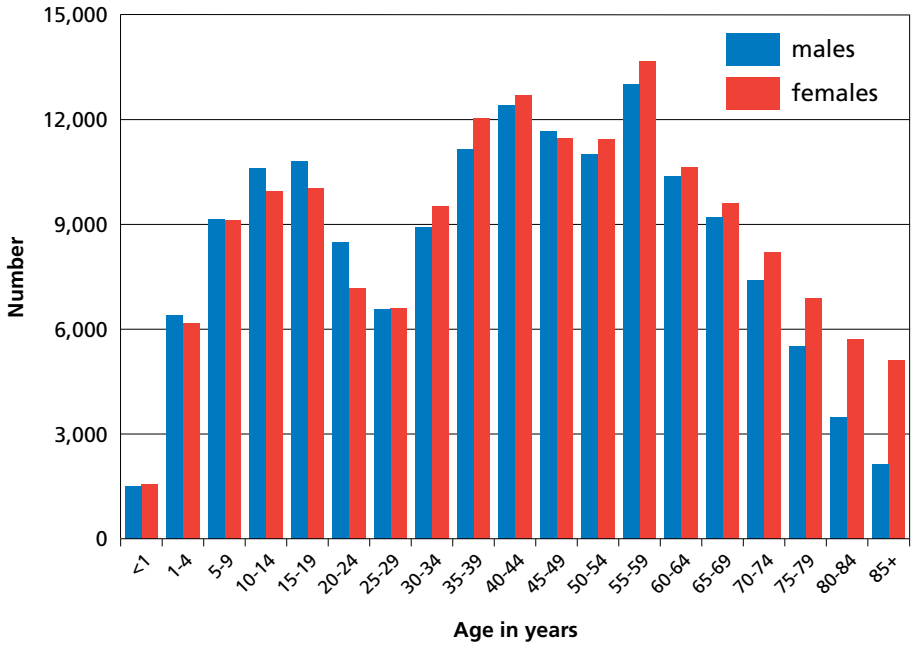
East Riding of Yorkshire PCT, East Riding of Yorkshire Council and partners should continue to take note of the local population structure in the planning and commissioning of services, particularly in the forthcoming joint health needs assessment.

Table 1:
Mid-year estimate of population 2005 East Riding of Yorkshire

	Males	Females	Persons
<1	1,515	1,550	3,065
1-4	6,394	6,159	12,553
5-9	9,133	9,104	18,237
10-14	10,613	9,960	20,573
15-19	10,806	10,029	20,835
20-24	8,476	7,163	15,639
25-29	6,580	6,594	13,174
30-34	8,916	9,515	18,431
35-39	11,141	12,050	23,191
40-44	12,423	12,688	25,111
45-49	11,677	11,465	23,142
50-54	11,020	11,439	22,459
55-59	12,999	13,677	26,676
60-64	10,384	10,639	21,023
65-69	9,210	9,595	18,805
70-74	7,410	8,211	15,621
75-79	5,518	6,897	12,415
80-84	3,476	5,710	9,186
85+	2,135	5,107	7,242
All ages	159,826	167,552	327,378

Source: ONS 2005 (based on 2001 Census)

Figure 1:
Mid-year estimate of population 2005 East Riding of Yorkshire



3 Health of People

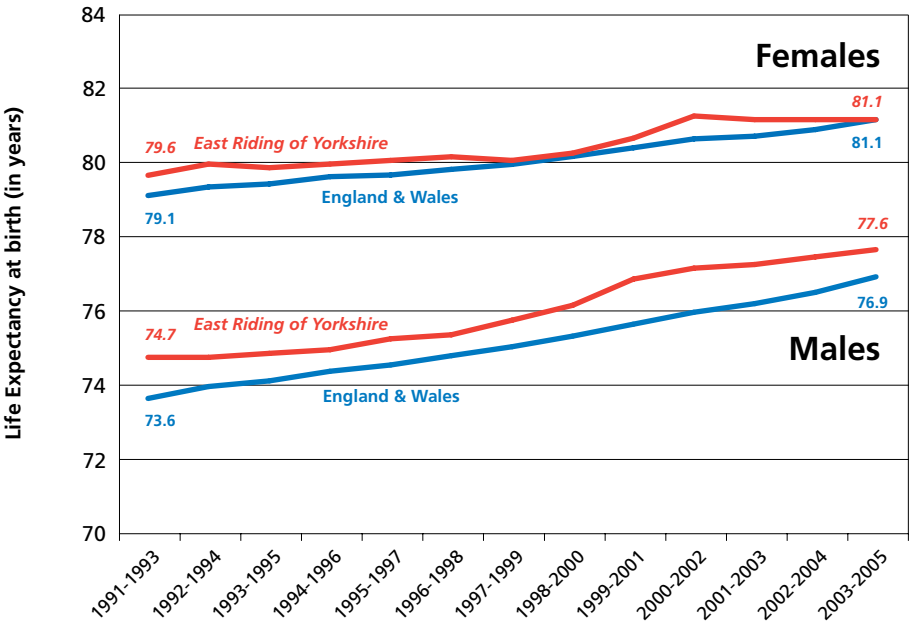
This chapter presents information about the health of people in the East Riding of Yorkshire. It begins by looking at life expectancy, then moves on to health inequalities, the difference in health between people from different groups or different areas.

Much of the information presented here and in the next chapter is based on death rates. It may seem unusual to focus on death rates when considering health. The reason that we do this is that death rates and causes of death give us some of the best information about health during life and how we can improve health and prolong life.

3.1 Life Expectancy

Life expectancy in the East Riding is improving in line with national trends as shown in Figure 2. However, while male life expectancy over the last 15 years has remained higher than national figures, female life expectancy has recently remained static. Also, as shown in last year's report, there are large variations in life expectancy from one part of the East Riding to another.

Figure 2: Life expectancy at birth (in years)



The same picture is shown when mortality rates are considered as shown in Figure 3 and Figure 4. Death rates in the East Riding are lower for men than nationally or regionally, but the difference for women is much smaller.

Figure 3: Mortality in men from all causes
Directly age-standardised rate per 100,000 males

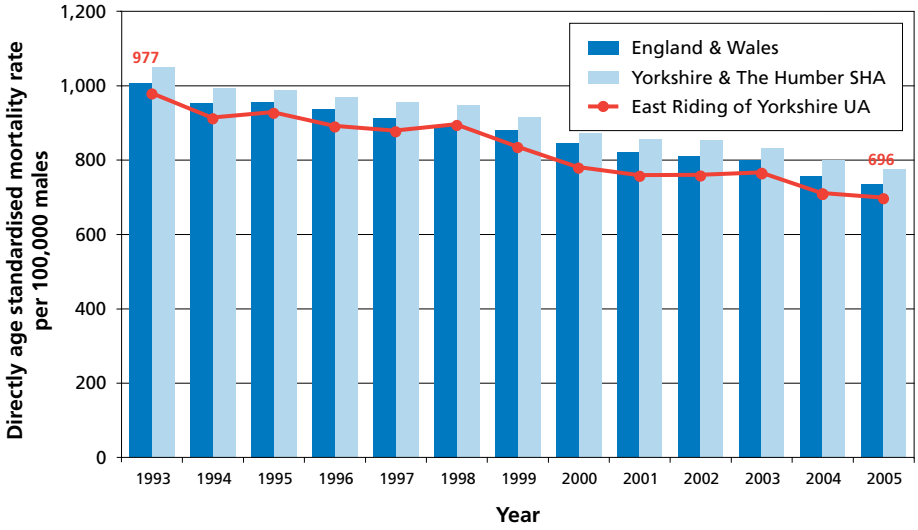
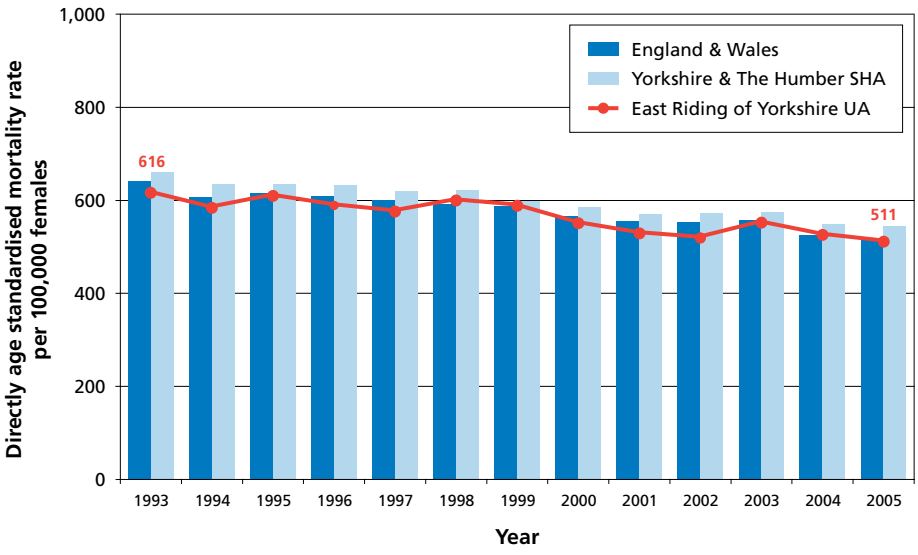


Figure 4: Mortality in women from all causes
Directly age-standardised rate per 100,000 females

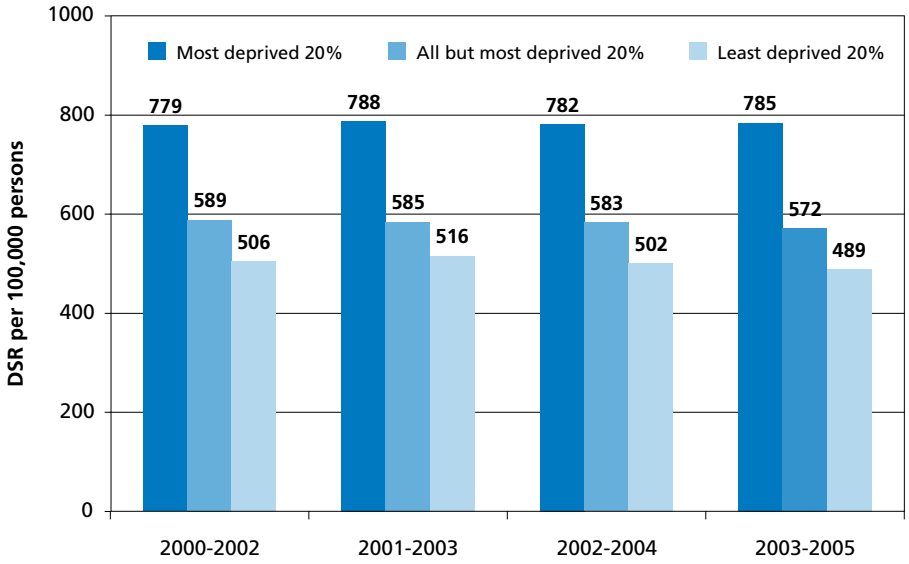


3.2 Health Inequalities

Health varies considerably across the East Riding. If we divide up the East Riding into five bands based on information about material deprivation from the 2001 census, we find differences in a range of health indicators.

For example Figure 5 shows that death rates are considerably higher in the most deprived 20% of the East Riding compared with either the remaining 80% or with the 20% least deprived.

Figure 5: Mortality from all causes and all ages
Directly age-standardised rate per 100,000 persons

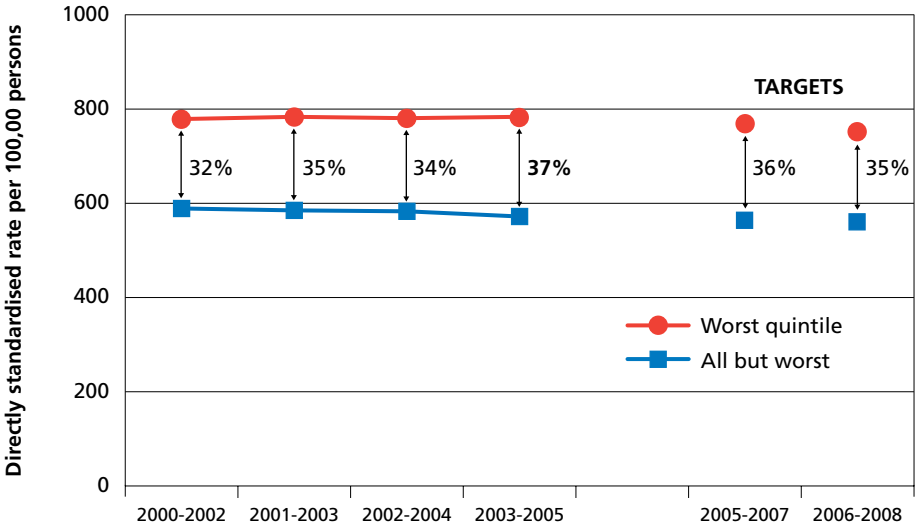


The most recent figures (2003-2005 3 year average) suggest a gap of 37% between the most deprived 20% of 2001 census Super Output Areas (SOAs) within the East Riding area compared with the remaining 80%. This gap has increased from 32% in the period 2000-2002.

To help tackle this widening gap, a Local Area Agreement target has been agreed. The Local Area Agreement is an agreement between the East Riding of Yorkshire Council and its partners and government. It sets targets designed to improve local outcomes.

This health inequalities target is to stop the widening trend and to obtain an annual reduction of 1% in the gap. This would narrow the gap to 36% in 2005-2007 and to 35% by 2006-2008 and is shown in Figure 6.

Figure 6: Health inequalities gap and targets



Recommendation

East Riding of Yorkshire PCT, East Riding of Yorkshire Council and partners should continue to work to reduce local health inequalities, including work as part of the Local Area Agreement.

Further specific targets should be set which would reduce inequalities if achieved. New healthcare developments should specifically consider their impact on health inequalities.

4

Health Priorities

This section considers the main health priorities in the East Riding. Where there were recommendations about tackling these issues made in last year's report, progress is reported in Chapter 9.

4.1 Coronary Heart Disease

Deaths from coronary heart disease continue to decline in line with national trends, suggesting among other things that interventions in primary care to tackle heart disease are being effective. Reduced levels of smoking are also likely to be having an effect.

Figures 7 to 9 show the continued decline in coronary heart disease deaths for all persons aged under 75 and then for men and for women separately.

Death before the age of 75 is conventionally regarded as being premature death. Women tend to develop coronary heart disease at a later age than men and so the rate of premature death is much lower among women. However, coronary heart disease among women is still an important health challenge.

Figure 7: Mortality from coronary heart disease (CHD)
Men and women aged under years

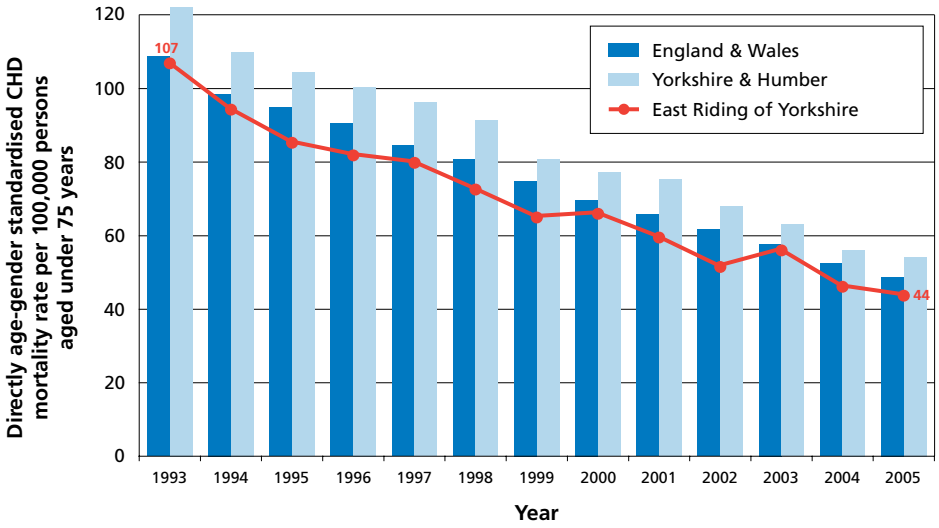


Figure 8: Mortality from coronary heart disease
Men aged under 75 years

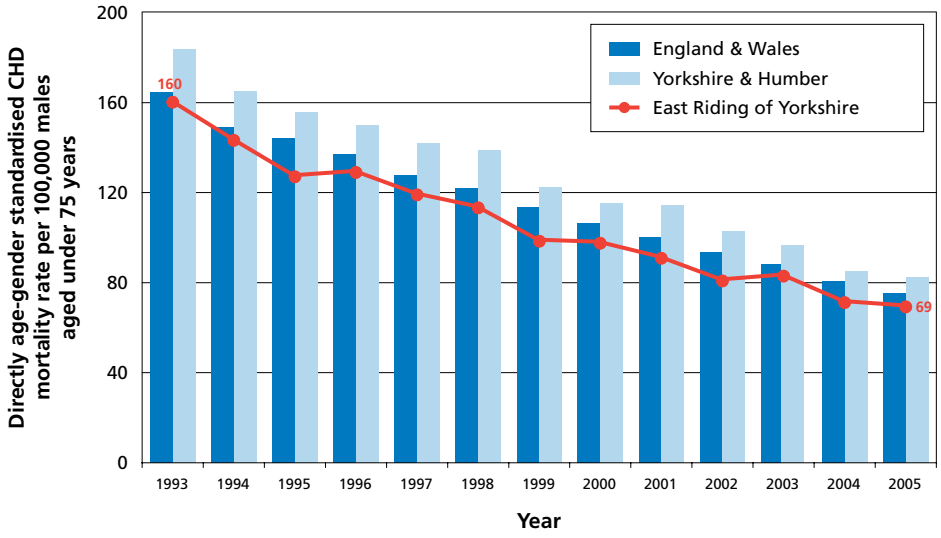
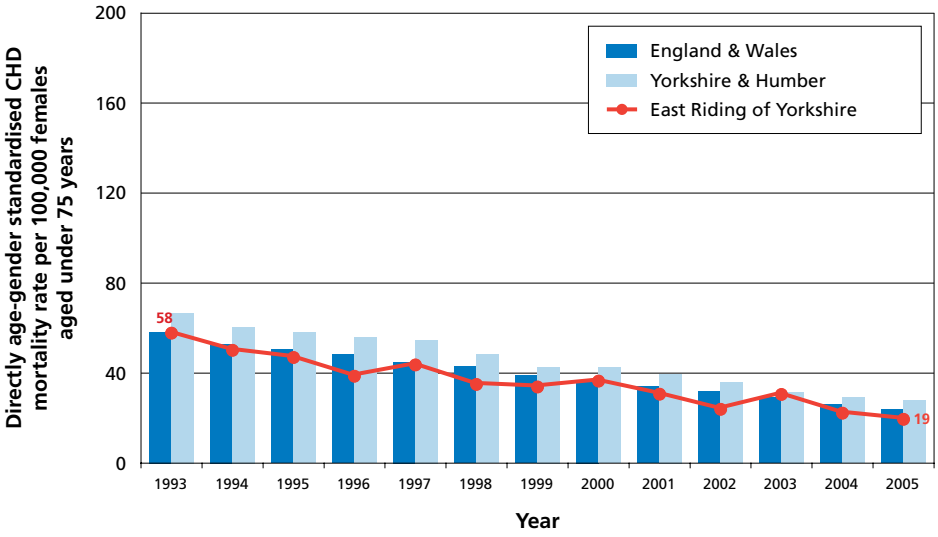


Figure 9: Mortality from coronary heart disease
Women aged under 75 years



4.2 Cancers

There is a slow decline in overall deaths from all cancers (Figure 10). This is in line with national and regional trends and the decline would not be expected to be as steep as for coronary heart disease. When deaths of people aged less than 75 are considered, the trend is similar (Figure 11). There is a slight increase for 2005 which may not be significant but this needs to be monitored.

Trends in breast cancer deaths again have largely followed the national and regional pattern as shown in Figure 12. However, for 2005 the rate has increased, with a particular increase notable for women aged 50-69 (Figure 13). There may be no specific cause behind this rise, but factors that may be related should be investigated.

Lung cancer is a major cause for concern. There has been a decline in the proportion of the population dying from lung cancer, largely due to a decline in smoking. However, for men in the East Riding, lung cancer death rate has been fairly static in recent years, not reflecting national or regional trends (Figure 14) and there is no decline in death rates for women (Figure 15).

In 2005 in the East Riding 67 men and 50 women aged under 75 died from lung cancer. Figure 16 shows that the absolute number of women in this age group dying from lung cancer is tending to increase. In 2003 there were 253 new cases of lung cancer diagnosed among East Riding patients of all ages compared with 219 ten years earlier.

Figure 10: Mortality from all cancers in all ages
Directly age-standardised rate per 100,000 persons

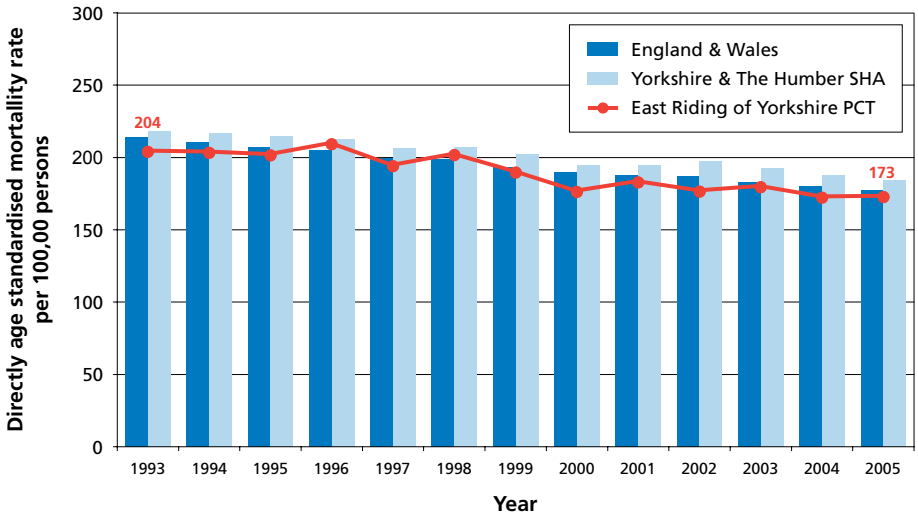


Figure 11: Mortality from all cancers in persons aged under 75 years
Directly age-standardised rate per 100,000 persons

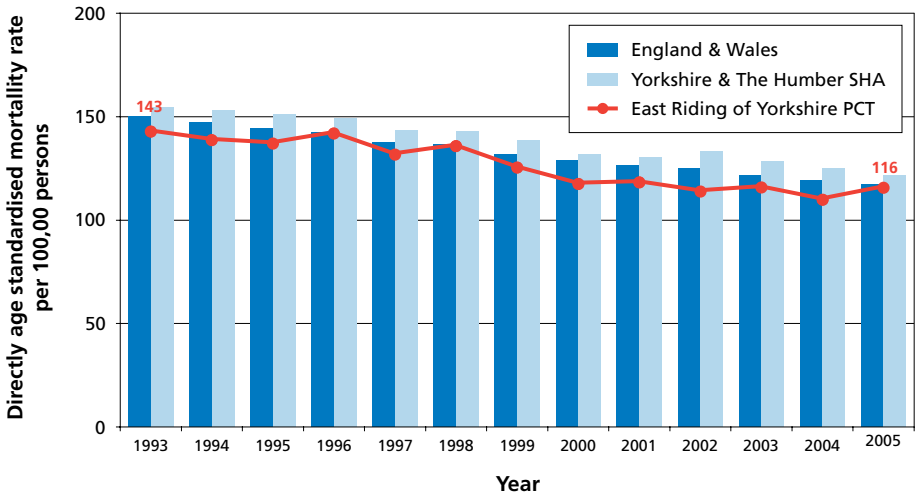


Figure 12: Mortality from breast cancer in women of all ages
Directly age-standardised rate per 100,000 women

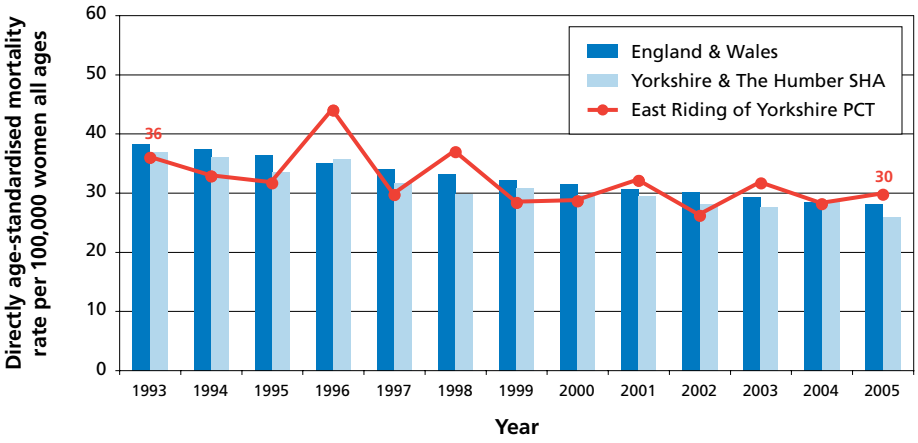


Figure 13: Mortality from breast cancer in women aged 50 to 69 years
Directly age-standardised rate per 100,000 women

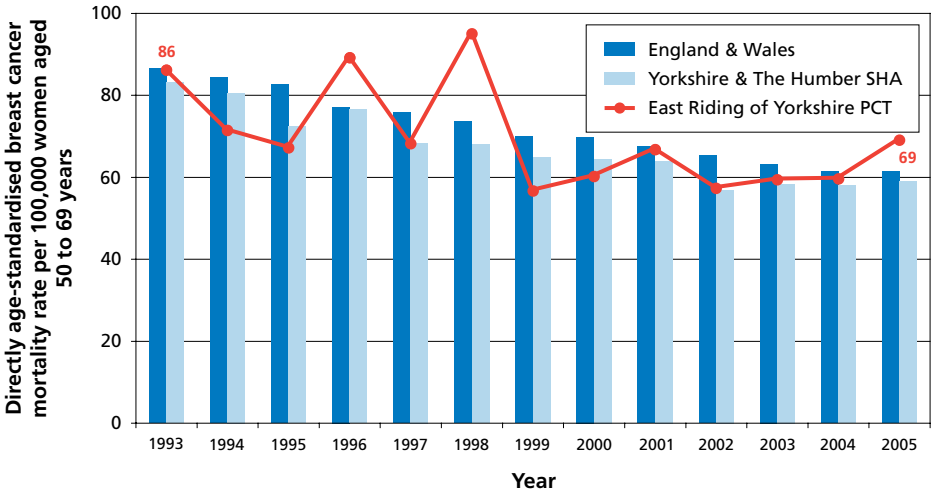


Figure 14: Mortality from lung cancer in men aged under 75 years
Directly age-standardised rate per 100,000 men

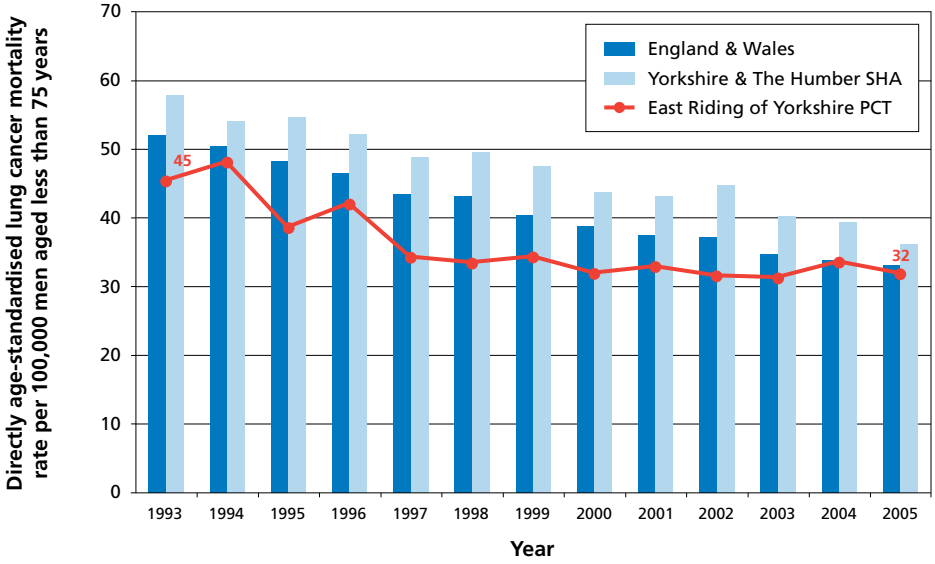


Figure 15: Mortality from lung cancer in women aged under 75 years
Directly age-standardised rate per 100,000 women

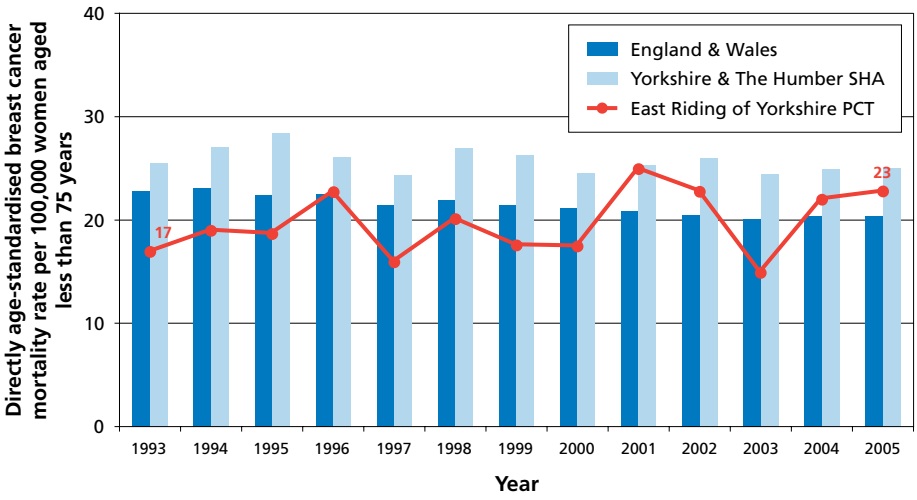
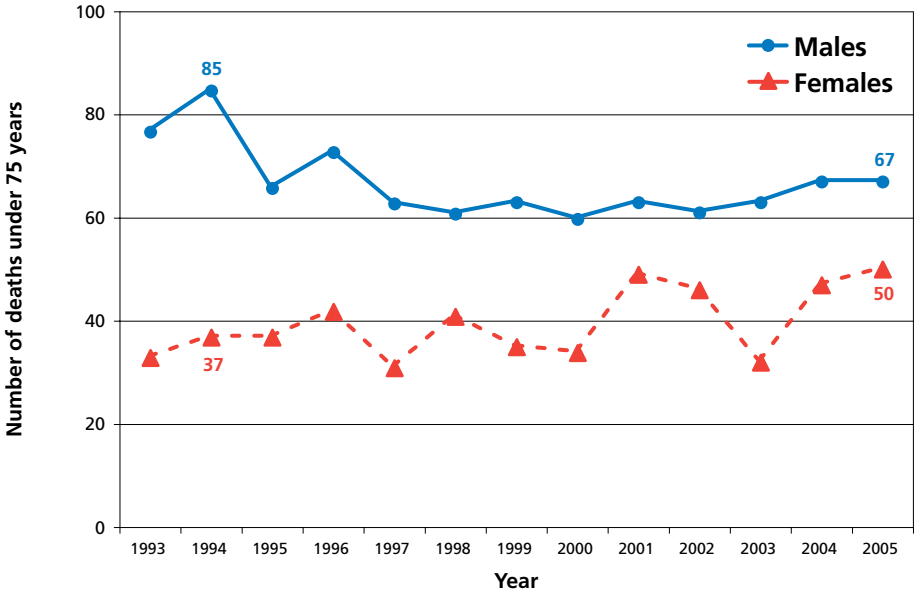


Figure 16: Number of deaths from lung cancer in people aged under 75 years within the East Riding of Yorkshire



Major preventative initiatives are aimed at both bowel cancer and at skin cancer. The number of cases of bowel cancer diagnosed among people in the East Riding is increasing, especially among men, as shown in Figure 17. In 2003, 238 people were diagnosed with bowel cancer.

Skin cancer rates are rising locally, regionally and nationally. Figure 18 shows that rates of diagnosis of skin cancer in the East Riding tend to be considerably higher than those at a regional or national level.

Figure 17: Incidence of bowel cancer within East Riding of Yorkshire
Annual number of new cases (1993 to 2003)

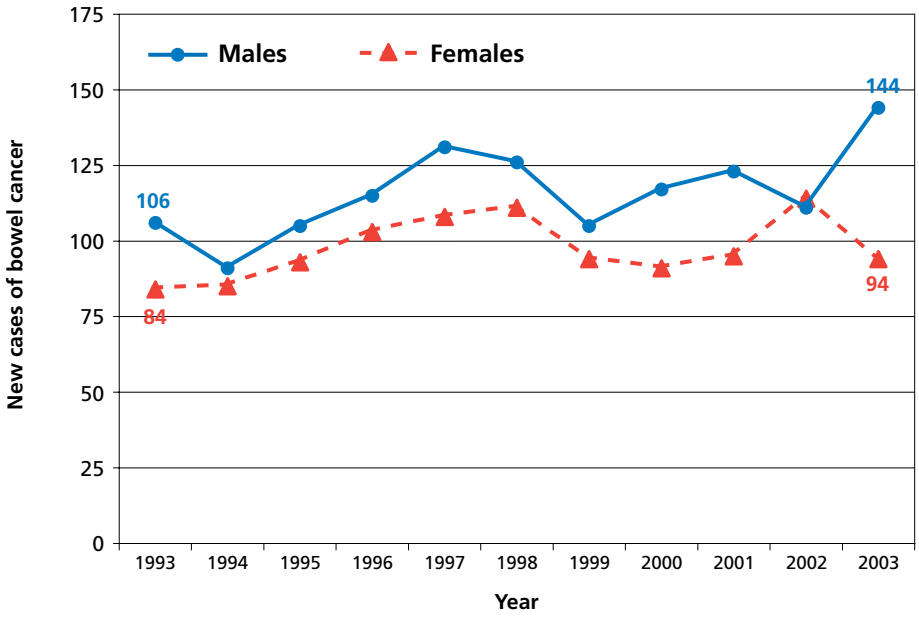
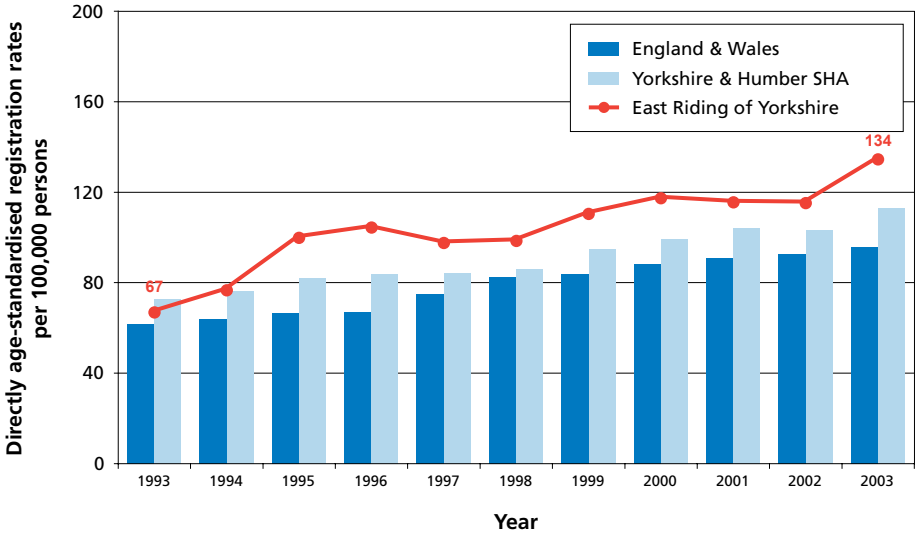


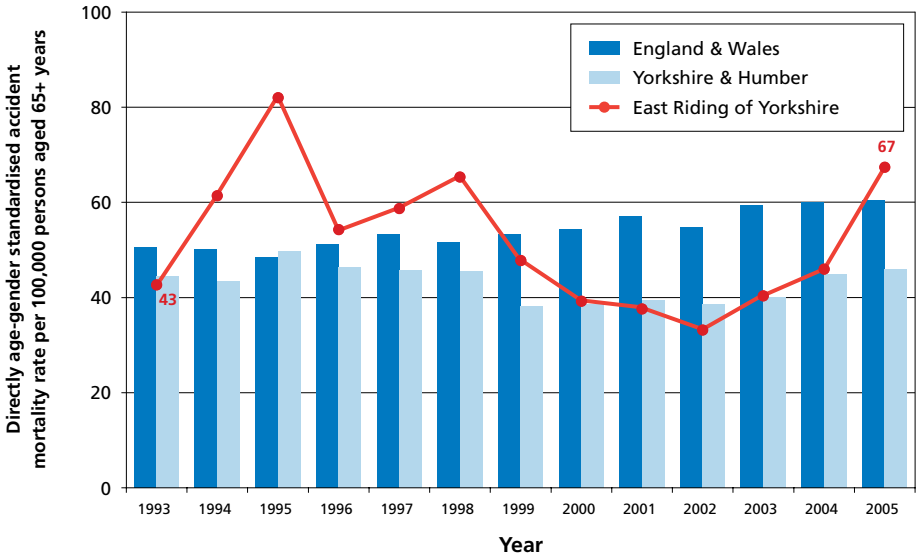
Figure 18: Incidence of all skin cancers
Directly age-standardised registration rates per 100,000 persons



4.3 Injury

Death and illness caused by injuries was highlighted in last year's report and it remains a priority. There has been a recent increase in the number of deaths of people aged more than 65 years as shown in Figure 19. There is a rising national trend and local figures were much higher in 1995, but the latest figure is still a cause for concern. In 2005, 25 people aged between 65 and 84 died from injury. This includes people who died after falls or after road traffic accidents. The term injury is often preferred to that of accident since having an accident suggests that it is something that may happen by chance and cannot be prevented.

Figure 19: Mortality from accidents in persons aged 65 years or more
Directly age-standardised rate per 100,000 persons



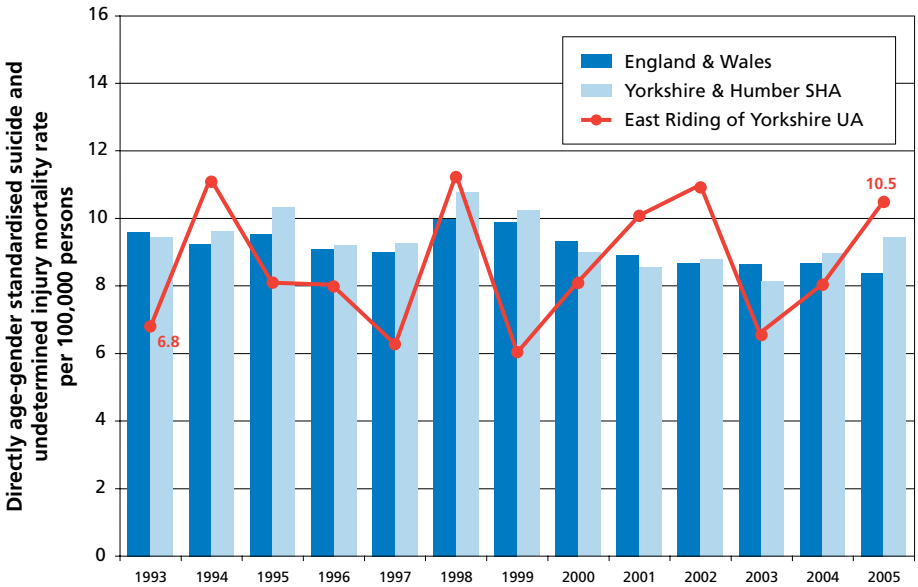
4.4 Mental Health

Establishing levels of mental health from routine statistics is a challenge and so suicide rates are often used. Suicide may relate to factors outside mental health and there is far more to considering mental health than suicide. However, the impact of suicide is considerable and reduction of suicide rates is a clear priority.

The rate of death from suicide and undetermined injury fluctuates from year to year and the smaller the area the greater the fluctuation. The latest figures available demonstrate that this rate has increased over the last two years (Figure 20). In 2005, 25 men and eight women died from suicide or undetermined injury.

A local suicide audit has been carried out. The audit found that a large percentage of the deaths occurred at home and over half of the total comprised people living alone. The most frequently identified risk factors which stand out in the audit are poor physical health and/or relationship problems. Local strategies aimed at reducing suicide need to take into consideration the large number of older people living in the East Riding.

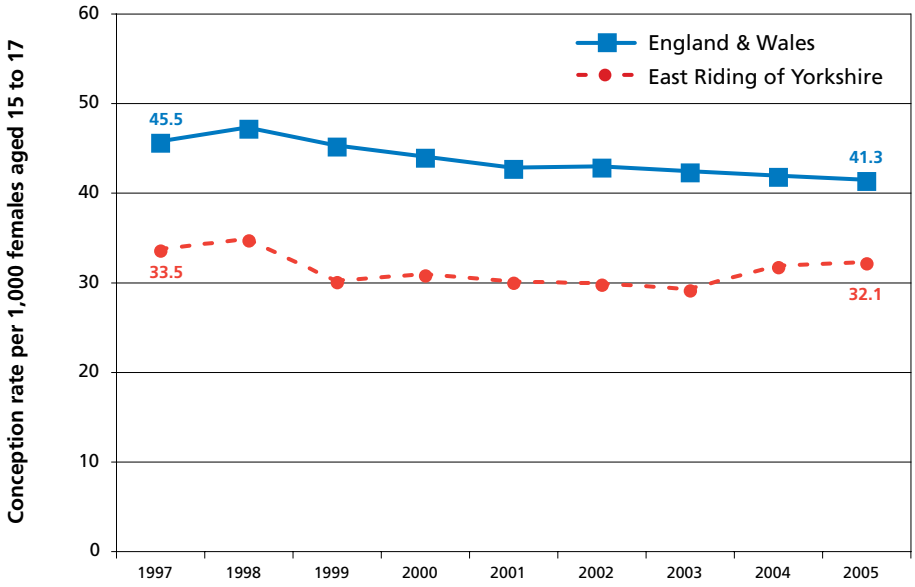
Figure 20: Mortality from suicide and undetermined injury
Directly age-standardised rate per 100,000 persons (all ages)



4.5 Sexual Health

Teenage conception is a key priority within sexual health. It also has a relationship with aspects of wider society including the desires and aspirations of young people. The East Riding of Yorkshire has traditionally experienced below average levels of teenage conceptions compared with the England average. This remains the case, although it is of concern that local numbers are increasing and the gap between local and national figures is narrowing as shown in Figure 21. In 2005 there were 195 conceptions to women aged 15-17 in the East Riding compared with 167 in 1999. There is a national target to reduce teenage conceptions by half by 2010 against a baseline from 1998, but local rates will need to reduce rapidly to meet this target.

Figure 21: Conception rate per 1,000 females aged 15 to 17 years



Conception data are also available by electoral ward, although where the number is so small that it might be possible to identify individuals, that information is not published. The figures collated by Yorkshire and Humber Public Health Observatory (Figure 22) show considerable health inequalities across the East Riding. Most wards have levels well below the national average. However, Goole South is a "hotspot" ward with a rate in the top 20% nationally. There are 4 other wards above the England average (Bridlington South, Bridlington Central & Old Town, Tranby and SE Holderness).

Recommendations

Work should continue to implement Choosing Health targets, especially in connection with diet and exercise.

Efforts to tackle lung cancer should be strengthened with consideration of new targets for smoking cessation. Potential for improvement in local lung cancer survival should also be reviewed.

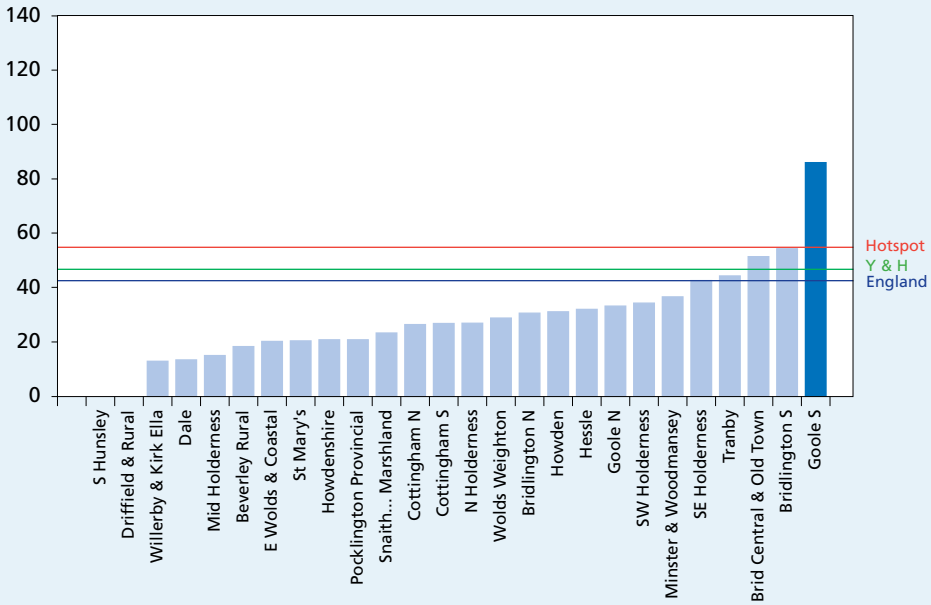
Work to ensure efficient and effective delivery of the breast screening programme should continue and factors affecting breast cancer rates investigated.

Bowel screening should be introduced in an efficient and effective way, ensuring appropriate public awareness.

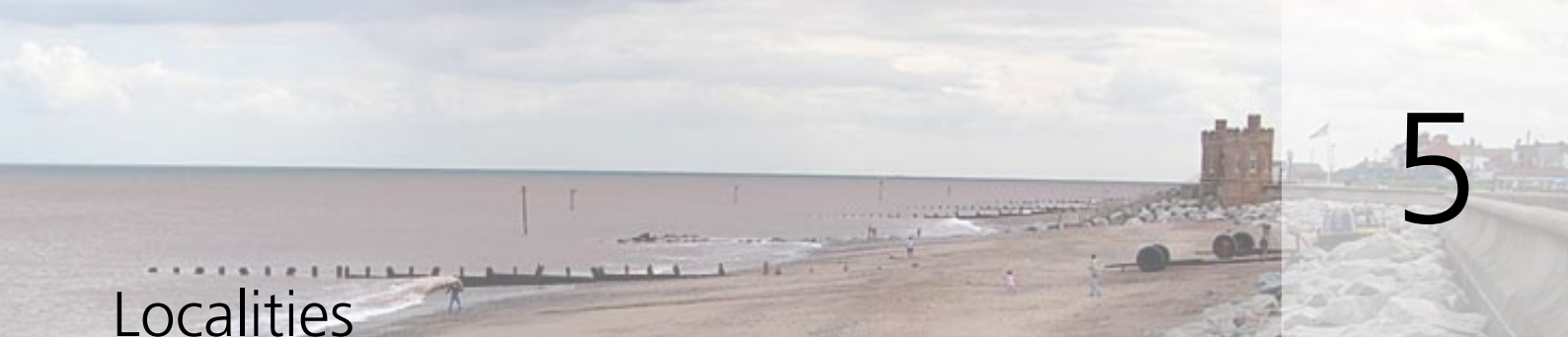
Local health improvement campaigns such as those targeted at reducing fractured neck of femur, reducing suicide, sun safety and sexual health should continue, while additional targeted work should be considered.

An area of sexual health that has received little attention is the sexual health of older people. Help the Aged has run a campaign highlighting the dangers of sexually transmitted infections among older people who may not practise safe sex. Figures from the Health Protection Agency show that, among women aged 45 to 64, rates of chlamydia rose by 177 per cent, between 1995 and 2003. This issue should be seen as an increasing priority in the East Riding, given the relatively large number of older people.

Figure 22: East Riding of Yorkshire wards aged under 18 years conception rate



Source: YHPHO 2006, Teenage Conceptions in Yorkshire and the Humber



5 Localities

This chapter considers each of the four localities of East Riding of Yorkshire PCT. Some statistics are presented for each locality, such as ward life expectancy and smoking cessation rates, illustrating both the health and the preventative health services of the area. Life expectancy figures are based on information from 2001-2003. Health challenges for each locality are also presented.

Specific sections follow on from each locality section, considering health issues for particular population groups or areas. They are focused on that locality, but also relate to similar groups in other localities. The general focus of these is one of migrant communities. However, this is considered in a broad context. Many groups of people are migrants, whether workers migrating to the UK for employment, people migrating to live near the coast or Gypsy and Traveller communities.

Beverley and Holderness

5.1 Beverley and Holderness

The Beverley and Holderness locality covers a significant geographical area; this poses a number of challenges in relation to improving community health and reducing health inequalities. Within the locality, pockets of deprivation exist and impact on population health. South Holderness ranks high within a number of the deprivation domains such as employment, barriers to housing and living environment. Minster and Woodmansey ward features in the 10% most deprived in the education, skills and training domain. The locality has a higher than national average older population and this trend will continue.

Key Health Challenges include:

- Preventing avoidable falls and reducing accidents
- Tackling obesity
- Work towards reducing the rise in diabetes
- Mental health and access to services
- The health and wellbeing of carers
- Living with a long term illness

Life expectancy has some variation by ward, with South East Holderness, including Withernsea having the lowest life expectancy in the locality (Table 2). Smoking cessation rates are shown in Table 3.

Table 2: Life expectancy by electoral ward; Beverley and Holderness

Ward	Life Expectancy	
	Men	Women
Beverley Rural	80	85
Mid Holderness	77	82
Minster and Woodmansey	77	80
North Holderness	76	80
St Mary's	80	83
South East Holderness	75	78
South West Holderness	77	82

Table 3: Smoking Cessation in Beverley and Holderness

Dates	Number of smokers accessing the Specialist Smoking Cessation Service and setting a quit date	Number of smokers achieving non-smoking status at the 4 week follow up	Quit rate
1/4/05 - 31/3/06	405	288	71%
1/4/06 - 30/6/06	159	112	70%

Health in Caravan Park Communities

Many people live in caravans on sites by the coast of the East Riding, often having migrated to the area from other parts of Yorkshire. However, little is known about the health of caravan park residents. In order to start gathering information, a health and lifestyle survey was carried out in 10 caravan parks around Withernsea. A presentation of the survey's findings can be found at: http://www.ukpha.org.uk/media/15thaphf/parallelC/1130%20c9.1%20zenner%20carrick2%20thurs.pdf

In addition to the information presented there, respondents were given an opportunity to articulate their main health worries in an open question (What concerns you most about your or your family's health?), and 71% of the respondents completed the question. Comments varied considerably, but financial hardship and housing problems were among the issues mentioned.

"Worries and Stress"

"I'm getting older. Where do I go if I cannot look after myself?"

"I paid and worked my life through… and my money from my life should be granted to me... Now I'm nearly homeless."

"We find our health in Jan – Feb each year is bad, owing to having to leave our caravan... We can only afford somewhere cheap, we can't afford hotels etc."

"Stress of having to leave the site for 2 months. Plus our general health"

Caravan respondents tended to be elderly and many articulated their worries about isolation, mobility, and insufficient transport links. Some added criticism of present services.

"Having another heart attack, living alone, ambulance service not up to scratch"

"I have problem with arthritis in various joints and am worried about mobility as I get older (caravan park ¼ mile from bus stop)"

"Old age – not being able to drive. Main health problems getting to surgery if unable to walk etc."

"Mobility as age advances – and of course relevant health concerns"

"Being alone in case anything happens to me as where I live is no bus service and it is 3 miles to the village so would not be able to get to the doctors."

Beverley and Holderness

Beverley and Holderness

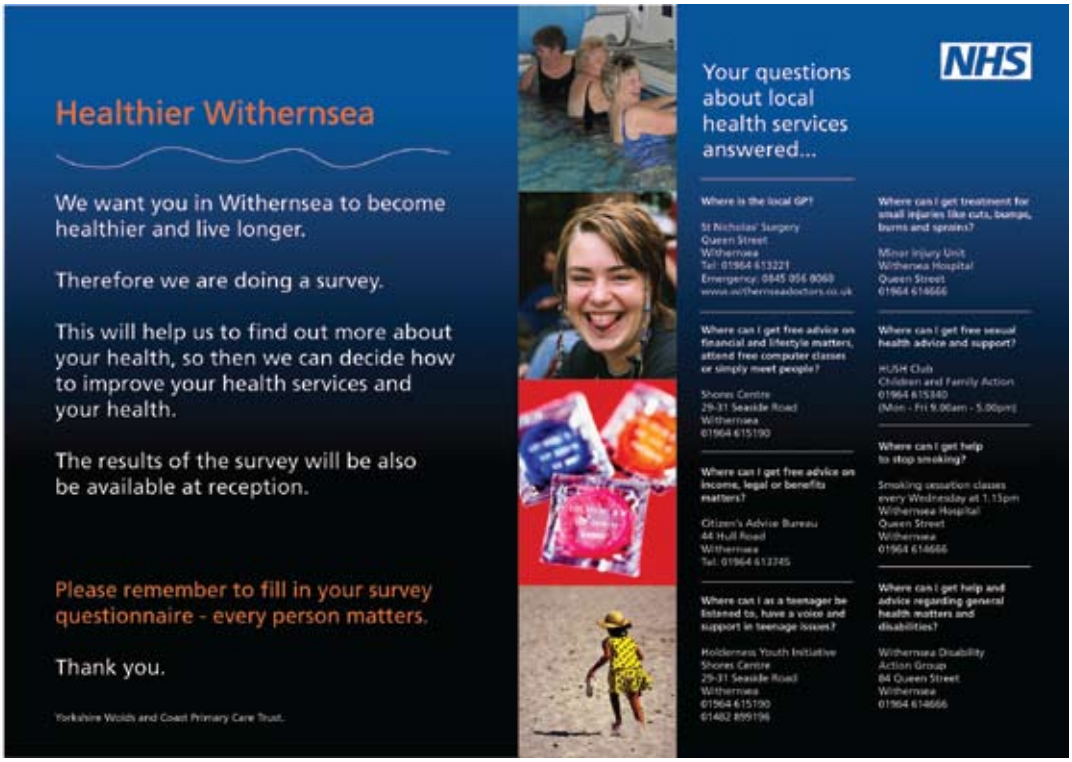
A variety of moderate to severe health conditions were described. Amongst those, heart disease, respiratory problems, musculoskeletal problems, mental health and diabetes were the most common concerns.

"General ill health, breathing and lots of pain..."

"I have problems walking due to severe pains. I have a narrow artery in my left leg. My wife has... cancer and suffers problems with her eating and pain in the lower abdomen"

"My wife has had a serious heart attack..., died but hospital saved her electronic started her heart again, plus operation over there, still has palpitations too often for my liking"

In conclusion, responses to the open health worry question illustrate substantial socioeconomic and health needs amongst caravan park residents around Withernsea and thereby add weight to the quantitative evidence gathered in the main survey.



5.2 Bridlington and Driffield

Bridlington and Driffield

The locality faces challenges common to many rural and coastal areas. Bridlington experiences large numbers of temporary residents and people migrating to the area. These can be older people retiring to the area, or younger people coming into the area to access seasonal work. This has led to specific health needs including obesity, sexual health, mental health, alcohol consumption and drug use.

Parts of Bridlington South ward show high levels of deprivation, with one area in the most deprived 2% nationally. Other parts of the locality have less material deprivation than Bridlington South but show other aspects of need. Numbers of older people are high, notably in the Bridlington North ward where 31.8% of the population are aged 65 and over, this can present issues around isolation and access to services.

Key health challenges include:

- Tackling health inequalities
- Reducing the numbers of people who smoke
- Tackling obesity
- Improving sexual health
- Improving mental health and well-being
- Reducing harm and encouraging sensible drinking
- Addressing the health of older people

Table 4: Life expectancy by electoral ward; Bridlington and Driffield

Ward	Life Expectancy	
	Men	Women
Bridlington Central and Old Town	76	82
Bridlington North	79	83
Bridlington South	74	76
Driffield and Rural	76	82
East Wolds and Coastal	78	82

Life expectancy is lowest in Bridlington South and is particularly low for women when compared with other parts of the locality where figures are reasonably consistent (Table 4).

Smoking cessation activity is particularly strong in the locality and large numbers of people have quit smoking in Bridlington (Table 5).

Table 5: Smoking Cessation in Beverley and Holderness

Dates	Number of smokers accessing the Specialist Smoking Cessation Service and setting a quit date	Number of smokers achieving non smoking status at the 4 week follow up	Quit rate
1/4/05 - 31/3/06	771	520	67%
1/4/06 - 30/6/06	248	160	65%

Health Priorities for Bridlington

Bridlington and Driffield

Bridlington has high levels of material deprivation and also has large numbers of people migrating to the town. People come for summer holidays, but may also migrate permanently perhaps because of affordable accommodation or retiring to Bridlington having been on holiday in the past. Social networks may be lost and one partner in a couple may die. Mental health and physical disability needs are also prominent. These features have created a range of health needs for the people of Bridlington. One of the principal ways of addressing the neediest parts of the town is through the Safer and Stronger Communities Initiative.

Safer and Stronger Communities

The Safer and Stronger Communities Fund programme for Bridlington was established and approved as part of the Local Area Agreement in February 2006. This included a programme for consultation and development of a neighbourhood action plan for the area.

Key health challenges for the locality include:

- Reduced crime, fear of crime, perceptions of anti-social behaviour and harm caused by illegal drugs
- Cleaner, safer and greener public spaces
- Increased capacity of local communities to participate in local decision making and influence service delivery
- Improved quality of life in the most disadvantaged neighbourhood with service providers more responsive to neighbourhood needs and improved delivery.

To date a team of community wardens have been appointed, audits of statutory, voluntary and community services have been undertaken, a quality of life survey has been carried out in the area and a small grants scheme has been set up. NHS Health Trainers for the East Riding will start in Bridlington.

5.3 Goole, Howden and West Wolds

The locality of Goole, Howden and West Wolds covers a large geographical area and incorporates wide variations in populations and health need. The indices of deprivation show that the Goole South ward is in the most deprived 10% of England's population. This covers Shuffelton and the eastern parts of Goole. Goole North also has relatively high levels of income deprivation and unemployment. These factors have an adverse effect on the health of people in Goole.

Measures of deprivation are not simply connected with income. Barriers to housing and services can be measured and this shows that Wolds Weighton, Howdenshire and Snaith, Airmyn, Rawcliffe and Marshland wards fall within the most deprived 10% of England's wards for these measures.

Goole, Howden and West Wolds

Key health challenges for the locality include:

- High levels of smoking, reflected in heart disease and cancer
- High levels of teenage pregnancy, especially in Goole South
- Large numbers of female lone parent households in Goole
- Priorities included within Choosing Health such as obesity, mental health and alcohol and substance use

Table 6: Life expectancy by electoral ward in Goole, Howden & West Wolds

Ward	Life Expectancy	
	Men	Women
Goole North	76	78
Goole South	75	80
Howden	78	83
Howdenshire	77	82
Pocklington Provincial	79	84
Snaith, Airmyn, Rawcliffe and Marshland	76	79
Wolds Weighton	79	83

Life expectancy figures for the locality are shown in Table 6. The lowest life expectancy for men is in Goole South and for women in Goole North, whereas life expectancy around Pocklington and Market Weighton is higher. Smoking cessation figures in Table 7 show that when people are seen in clinics their quit rate is similar to that in other localities. However, the number of people attending clinics is relatively low compared with other localities and as has been noted before, there is a need to concentrate on smoking cessation work in Goole where rates of smoking are high.

Table 7: Smoking Cessation in Goole, Howden and West Wolds

Dates	Number of smokers accessing the Specialist Smoking Cessation Service and setting a quit date	Number of smokers achieving non smoking status at the 4 week follow up	Quit rate
1/4/05 - 31/3/06	421	284	67%
1/4/06 - 30/6/06	127	89	70%

Goole, Howden and West Wolds

Migrant Communities in Goole, Howden and West Wolds

Migrant health issues are important in Goole, Howden and West Wolds, although they may not be apparent at first sight. Many communities have had stable populations over many years, but some towns such as Pocklington and Market Weighton have housing developments attracting people to the area. Also, economic development in Goole and Howden will continue to attract new residents. Two other aspects of migrant health are migrant workers from other parts of Europe and the health of prisoners.

Many workers from overseas are employed in the East Riding. Migration has been driven by new European Union accession countries. It is difficult to be sure of the number of migrant workers, but in 2005-06 there were more than 1000 new National Insurance Numbers issued to Overseas Nationals in the East Riding. Most migrant workers are young; their health may be good and impact on health services small. However, further work needs to be done to assess the health impact of migrant workers and their dependents locally and to develop services to meet those needs. In the Goole area many migrant workers are Polish and addressing health needs with that community is a priority.

Prisoners may not appear to be a migrant community. However, prisoners have all been removed from their previous homes and may move from prison to prison. There are three prisons in the East Riding: HMP Full Sutton; HMP Everthorpe; HMP Wolds. HMP Full Sutton is a maximum security prison and prisoners come from across the country. The health of prisoners tends to be poorer than that of the general population and poor mental health and dental health for example are common. An additional issue relating to HMP Full Sutton is that the average age of prisoners is higher than in most prisons and both long term conditions and palliative care need to be addressed. It is important that there are up to date assessments of the health needs of prisoners in the local prisons so that health services and preventative measures can be designed, commissioned and provided effectively.

5.4 Haltemprice

Haltemprice

Haltemprice comprises the smallest geographical locality in East Riding while it has the second largest number of residents. Both urban and rural communities are represented within it, the overwhelming majority being urban residents. East Riding of Yorkshire PCT is responsible for most residents of Haltemprice, although many residents are registered with General Practices in Hull and so their healthcare is the responsibility of Hull Teaching PCT.

Key health challenges include:

- Choosing Health priorities such as control of obesity, increase in exercise and smoking cessation
- The health of older people, including people living in residential and nursing homes
- Health of children at school, with many children travelling from Hull to secondary schools in Haltemprice
- The health of Gypsies and Travellers
- Health of prisoners in HMP Wolds and HMP Everthorpe

Table 8: Life expectancy by electoral ward in Haltemprice

Ward	Life Expectancy	
	Men	Women
Cottingham North	80	85
Cottingham South	80	81
Dale	78	83
Hessle	77	79
South Hunsley	79	82
Tranby	79	85
Willerby and Kirk Ella	81	82

Life expectancy figures for Haltemprice wards are generally relatively high, although life expectancy in Hessle is lower than for the other wards (Table 8). Smoking cessation numbers for the locality are reasonably good. The recent quit rate is low, influenced by a low quit rate among prisoners.

Table 9: Smoking cessation in Haltemprice

Dates	Number of smokers accessing the Specialist Smoking Cessation Service and setting a quit date	Number of smokers achieving non smoking status at the 4 week follow up	Quit rate
1/4/05 - 31/3/06	705	469	66%
1/4/06 - 30/6/06	175	105	60%

Haltemprice

Recommendations

Work in localities should take into account the particular needs of localities and be appropriately linked with Public Health priorities.

Further work should be undertaken to assess the health of people from migrant communities, including migrant workers, prisoners and coastal migrants and develop plans to address those needs.

Gypsies and Travellers

"We want this [site] to be our home – more permanent, somewhere for our children to grow up."

It is estimated that there are about 250,000-300,000 Gypsies and Travellers in England. In the East Riding of Yorkshire, as of February 2007, there were 68 adults and 42 children living in the two official sites at Haltemprice (Eppleworth and Woodhill Way) and 20 adults and 9 children at the Bridlington official site (Woldgate). In addition, there are transient and highly mobile Gypsy/Traveller families passing through (roadside stopping places, transient sites, tolerated or unauthorised sites) or residing on private sites.

According to published literature, poor health among Gypsies and Travellers includes:

- Significantly poorer health and significantly more self-reported symptoms of ill health than other UK resident English-speaking Ethnic Minorities and economically disadvantaged White UK residents.
- Rate of stillbirths: 17 times the national average and smoking cessation
- Perinatal mortality: 2 times that of the settled population
- Infant mortality: 5 times the national average
- Premature death from cardiovascular disease: much higher than in the settled population
- Life expectancy: 10 years lower than that of the settled population for men and 12 years lower for women
- Road traffic accidents: very high amongst their children
- Dental health: very poor.

A variety of reasons lie behind these health issues, including living conditions on sites, cultural beliefs, societal neglect, lifestyle factors, prejudice, poor access to mainstream service provision and communication difficulties with service providers.

Local GPs, having worked with resident Gypsies and Travellers for a long time, have highlighted the prevalence of specific health conditions such as high blood pressure, diabetes, epilepsy, asthma and congenital health problems, as well as impetigo and illnesses associated with poor hygiene/sanitary conditions (East Riding Gypsy & Traveller Participation Group, 2002).

In contrast with many other migrant groups, Gypsies and Travellers have been part of the local landscape for a long period. Their insular culture, on the one hand, separates them from the majority of the local population and on the other, provides them with the means of coping with or defending themselves against the potential open hostility and ongoing prejudice of the settled community.

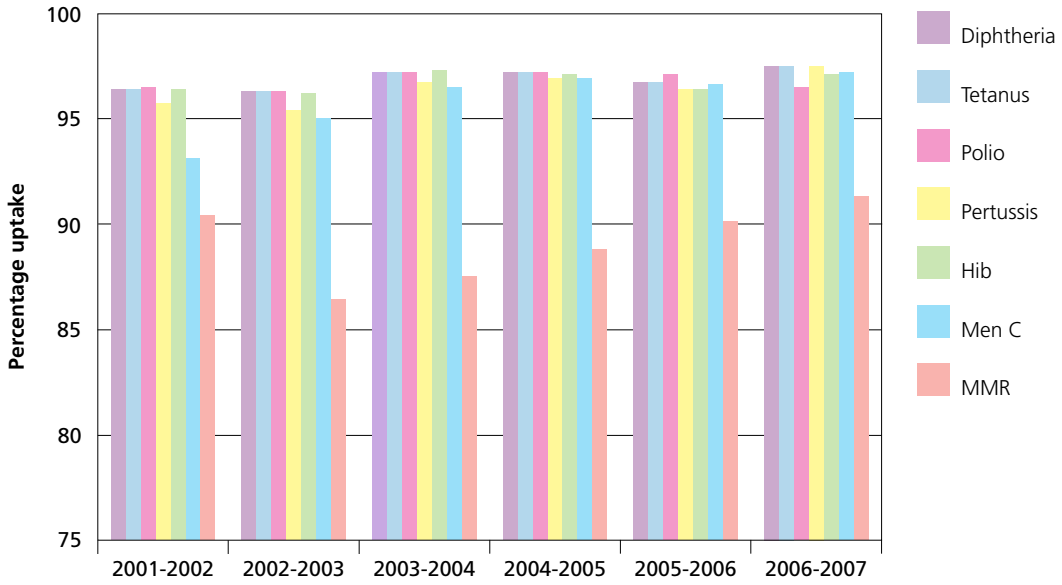
6 Health Protection

This chapter considers two elements relating to health protection. Immunisation rates are considered first followed by discussion of the background to pandemic influenza preparations.

6.1 Immunisation

Last year's report included childhood immunisation figures for 2004/05. The years included here go up to 2006/07. Figure 23 shows information relating to the combination of the two former PCTs that now constitute East Riding of Yorkshire PCT. The information demonstrates that most childhood immunisation rates are fairly stable and above the target of 95%, although there is a slow rise in coverage of measles mumps and rubella vaccine (MMR), following a return in public confidence in its safety.

Figure 23: Immunisation rates – East Riding of Yorkshire PCT 2006/07 children at their second birthday



6.2 Pandemic Influenza

The potential for pandemic influenza has received a high media profile over the past few months and there has been considerable work at a local and national level to prepare for a possible pandemic. However, there has been some confusion about the links and the dangers from different types of influenza. The aim of this section is to present information and reduce confusion.

Seasonal Influenza

Influenza is an acute, highly infectious viral illness that spreads rapidly from person to person when in close contact. It is characterised by the sudden onset of fever, chills, headache, muscle pain, severe prostration and usually cough – with or without a sore throat – or other respiratory symptoms. The acute symptoms generally last for about a week, although full recovery may take longer. In most years, seasonal influenza occurs in the UK predominantly during a six to eight week period in winter and affects some 5% to 15% of the population.

There are three broad types of influenza viruses – A, B and C. Influenza A viruses cause most winter epidemics (and pandemics) and can affect a wide range of animal species as well as humans. They have a remarkable ability to adapt and change – which is what keeps them in circulation – and the resulting viruses can have widely differing impacts. Influenza B viruses only infect people. They circulate during most winters but generally cause less severe illness and smaller outbreaks, particularly amongst children. Influenza C viruses are amongst the many causes of the common cold.

Pandemic Influenza

Pandemic influenza occurs when an influenza A virus subtype emerges or re-emerges which is:

- Markedly different from recently circulating strains
- Able to infect people
- Readily transmissible from person to person
- Capable of causing illness in a high proportion of those infected
- Able to spread widely because few – if any – people have natural or acquired immunity to it.

Whilst such a virus could first emerge anywhere in the world – including the UK – East or South East Asia is widely considered to be the most likely potential source. It would initially spread to cause outbreaks and epidemics within the country of origin and its immediate neighbours before spreading globally to cause a pandemic. The conditions that allow a new virus to develop and spread continue to exist, and some features of modern society, such as air travel, could accelerate the rate of spread.

Avian Influenza

Avian influenza ('bird flu') is an infectious disease of birds caused by influenza A virus that spreads mainly through contact with contaminated faeces (droppings) but also via respiratory secretions. It does not readily infect species other than birds and pigs.

A highly pathogenic A/H5N1 avian influenza virus – which is extremely contagious and rapidly fatal in domestic poultry species – has prompted particular concerns in recent years. There has been rapid spread within and from the Far East, with incursions into Europe and Africa caused by movement of infected poultry and poultry products, and possibly via migratory birds. Whilst the virus has also infected humans, such infections have only been recognised in a small proportion of those who have been exposed to infected birds, and to date there has only been limited evidence of person-to-person transmission. Even if that has occurred, it has been with difficulty and has not been sustained.

Preparations for Pandemic Influenza

Pandemic influenza is known to occur periodically and there were several outbreaks during the twentieth century. We cannot be certain when the next pandemic will happen, but concern has been heightened by the emergence of avian influenza and the risk that it could change into a form of virus that could spread easily from person to person. It is important that appropriate preparations are made to tackle the risk of a new pandemic.

Recommendations

East Riding of Yorkshire PCT and its partners should continue to encourage increased immunisation uptake.

East Riding of Yorkshire PCT and its partners should continue appropriate preparations for a possible influenza pandemic, including measures to increase public understanding.

7

Local Strategic Partnership and Health

Background

During 2006 the East Riding of Yorkshire Local Strategic Partnership (LSP) has undertaken two major pieces of work to re-fresh the LSP. Firstly, the overall LSP has been re-structured to reflect the framework and local priorities contained within the Local Area Agreement and secondly, a new Community Plan has been developed covering the years 2006 - 2016.

The New Structure of the LSP

The LSP, following wide consultation in 2006, has adopted the four themed areas of the Local Area Agreement replacing the former five Community Aims. The four themes are: Healthier Communities and Older People (HC&OP); Safer and Stronger Communities; Children and Young People; Sustainable Communities and Transport.

The HC&OP Action Group replaces the former Improved Health Action Group and has adopted a revised purpose which is summarised below:

The Healthier Communities and Older People Action Group will seek to facilitate improvement in the health of the people of the East Riding of Yorkshire and improvement in the quality of life of older people. It will seek to ensure that a wider public health perspective influences all aspects of the Local Strategic Partnership and will maintain an overview of delivery of the public health and inequalities agenda across the East Riding of Yorkshire.

The Community Plan 2006 – 2016

A new Community Plan has also been developed during 2006 and the new priority outcomes for the Healthier Communities and Older People Action Group are outlined below:

LSP Partners work together to promote public health, enhance life expectation and reduce health inequalities.

Service quality for older people is raised, access is improved, information is shared and older people have increased choice and control in the services they use.

Residents are able to make informed decisions about their own health and have freedom from discrimination in both the management of their personal health and access to health care.

Residents participate in affordable recreational, educational and cultural opportunities across the East Riding as part of a healthy lifestyle.

The lifestyles of children and young people are healthy and their parents are well informed on how to encourage and enable them to participate in all forms of sport, recreation and cultural opportunities.

Employers recognise the aspirations and the employability of people with mental health problems, disabilities and older people.

A skilled workforce is delivering a diverse range of health and care services for older people.

Partners ensure that ageing is recognised as a positive process and the contributions that older people make are valued with dignity.

Healthier Communities and Older People Work Programme

Whilst the former Improved Health Action Group has transformed into the Healthier Communities and Older People Action Group, much of the public health work programme has been retained with the addition of new areas of work, most notably relating to older people.

Key highlights in the work programme have included work in the following areas:

- Public Health Strategy 2006 – 2009 Action Plans
- Local Area Agreement and Local Public Service Agreement
- Older people's health and wellbeing
- Coastal issues
- Gypsies and Travellers
- People with a learning disability

Recommendation

Local Strategic Partnership work aimed at improving health should continue to focus on delivery of the Public Health Strategy, reducing health inequalities and addressing the needs of marginalised groups.

8

Health on Mars?

The popular television series BBC One's Life on Mars pitched a modern policeman into the world of 1973. Would comparison of health today and in the early 1970s give rise to such shocks? How would a Director of Public Health react if transplanted into the world of the Medical Officer of Health? Review of the Annual Report of the County Medical Officer and Principal School Medical Officer 1972, East Riding of Yorkshire County Council, provided some answers.

Before 1974, public and community health services were operated through local authorities. Just as today where local authorities are working more closely with health issues, there was a desire in 1972 for joined up working:

"In the various management documents that have been published strong emphasis is placed on planning by multi-disciplinary terms within an overall cost limit"

The population of the East Riding at 263,980 was somewhat lower than today, although the boundaries were not the same. Causes of death and illness have changed little, with the list of causes of death in 1972 led by heart and circulatory disease, cancer then respiratory disease. Lung cancer deaths had risen from 42 in 1950 to 155 in 1971 with the importance of smoking noted. There were 45 deaths from motor vehicle accidents and one death from measles. Inequalities in health could be seen, both between the East Riding and England and also within the East Riding. Local death rates were lower than national rates, while deaths among certain groups or in certain areas of the East Riding were high, for example infant deaths following what was classed as illegitimate birth and the adjusted death rate in Hedon.

The general approach to health improvement and health promotion appeared less extensive and less systematic than today. For example only 1114 cervical screening tests were carried out annually. However, immunisation rates were excellent at 93% for whooping cough, 94% for diphtheria and 96% for poliomyelitis.

Overall, life expectancy is better and death rates lower than in 1972, but health issues today are similar and we all have the same issues such as smoking and injury to tackle.

9

Progress on recommendations from the 2005 Report

This chapter contains the recommendations from the 2005 Report and comments on progress in answering the recommendations from organisations working in the East Riding.

East Yorkshire and Yorkshire Wolds and Coast PCTs and their partners should continue to take the characteristics of the local population into account in their planning and be particularly conscious of the predictions for large increases in the population of older people.

Planning systems continue to take account of the local population. For example the East Riding Health and Social Care Alliance focuses much of its work on older people. The recent joint review of older people's services will comment on arrangements.

East Yorkshire and Yorkshire Wolds and Coast PCTs and partners should prioritise efforts to improve the health of people living in areas with the worst health and lowest life expectancy.

Two health inequalities indicators have been agreed as part of the Local Area Agreement with targets to narrow the health inequalities gap. Work in the Bridlington Safer and Stronger Communities area is aimed at the area with the worst health and lowest life expectancy in the East Riding.

Attention should also be given to addressing priority health areas, especially where challenges still exist. These areas include smoking in pregnancy, breastfeeding and efforts to tackle the major killers of coronary heart disease and cancers. Tackling smoking would contribute considerably to a reduction in cancer and heart disease deaths.

Work towards overall smoking cessation progresses well with targets met, although more work is needed to tackle smoking in pregnancy and reach those targets. Tobacco control in general was assessed by the Healthcare Commission; Yorkshire Wolds and Coast PCT was rated as the best performing PCT in England.

Breastfeeding is a key priority for improving nutrition; women who are younger and who are from more deprived areas are less likely to breastfeed. More than a third of local women bottle feed from birth and this is higher than national rates. We have a target to deliver an annual 2% increase in breastfeeding initiation rates. Also, as part of the Local Area Agreement we are making good progress towards increasing the number of Breastfeeding Friendly award holding places by 25% in the East Riding up to 63 premises by 2009.

The award is open to all public premises and requires them to:

- Welcome breastfeeding mothers and babies in public areas
- Have a breastfeeding policy which is publicised to staff and the public
- Provide staff awareness training
- If possible provide a degree of privacy for mothers who prefer it.

Implementation of Choosing Health should continue as part of the implementation of the East Riding Public Health Strategy.

The Public Health Strategy has been approved and implementation of its Action Plan continues. One example of the continuing work promoting areas of Choosing Health is the work on Public Health Training and Development Programmes. The aim is to support and enable a range of agencies, organisation and community members to promote health improvement initiatives. Programmes include:

- Active in Age (mentor training programme)
- Nutrition and Weight Management course
- Suicide Awareness Training

Attention should be paid to the various priorities of Choosing Health, including obesity and exercise.

Obesity and exercise are key themes of the Local Area Agreement with targets and associated work programmes aiming to increase exercise and reduce obesity among both children and adults. For example the aim and objectives of one of the targets are as follows:

Aim
To improve the health of children aged less than 11 with a special focus on those attending 13 primary schools in the Bridlington School Improvement Area.

Objectives
1. To reduce Body Mass Index (BMI) of those children in the cohort above considered to be overweight or obese
2. All schools to achieve National Healthy School Status

Specific work in local areas is likely to be needed to tackle challenges, for example work in South East Holderness relating to smoking and the prevention of fractured femurs.

Both smoking cessation and reducing the number of fractured necks of femur feature as Local Area Agreement targets and programmes of work are in place to meet the targets.

Locality work should take into account the specific demographic characteristics and health needs of each locality and their constituent parts

Public Health Leads have been appointed within the PCT to link with each locality, lead on health improvement and to contribute to commissioning. Initiatives are progressing in each locality. For example, in the Beverley and Holderness locality a health needs assessment is underway focusing on the midlife population (45-65). The information gained from this activity will help us to support people's health and well-being, and promote positive approaches to growing older.

Locality profiles should be developed further during 2006, building in particular on information from local residents and staff.

Focused work has been undertaken, but in general information for locality profiles still needs to be strengthened through further contact with residents and staff. Work with locality forums should be part of this.

Priority should be given to the control and prevention of sexually transmitted infections in the East Riding. This should include further measures to control the spread of HIV and full introduction of the national Chlamydia screening programme.

Targeted work has started in connection with HIV. The Chlamydia screening programme was not fully introduced during 2006-07, but should be in place early in 2007-08.

Uptake levels of childhood immunisation should be maintained or enhanced, with particular attention paid to improving uptake of MMR.

Uptake of MMR vaccine is slowly improving, as shown in Chapter 7.

East Yorkshire and Yorkshire Wolds and Coast PCTs should continue to have full engagement with partners around issues of community safety.

East Riding of Yorkshire PCT has created a post which includes a specific remit around community safety.

Agencies across the East Riding of Yorkshire should adopt and implement the Public Health Strategy. This is likely to require increasing levels of partnership working and joint working.

Joint working and partnership working continue at both a formal and an informal level. Further work would be helpful to maximise the benefits and efficiency of partnership working and may include more formal arrangements.

East Yorkshire PCT, Yorkshire Wolds and Coast PCT and partners should continue to build on the recommendations from previous reports.

Partners in the East Riding continue to build on previous report recommendations, especially those which are part of the Public Health Strategy. One example of continued work is the Sun Awareness Campaign, where materials went to every primary school again last year within the East Riding. Around 25,000 of the purse/wallet cards and stickers were distributed so that every primary school age child received their own information on how to keep safe from the sun. Over 600 entries were received for the colouring competition. A range of other events was held including a stand at Driffield Show and participation in an event for people with a learning disability.