Equity Matters in Eastbourne Downs Primary Care Trust

2004/05 REPORT OF THE DIRECTOR OF PUBLIC HEALTH
ACKNOWLEDGEMENTS

I am indebted to:

- Maurice Marchant for statistical and analytical support
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CONTENTS

EXECUTIVE SUMMARY .............................................................................................................. 1

1. HEALTH EQUITY AUDIT ........................................................................................................ 3
   BACKGROUND .......................................................................................................................... 3
   WHAT IS EQUITY? ................................................................................................................... 3
   WHAT IS A HEALTH EQUITY AUDIT? ..................................................................................... 3
   WHY DO A HEALTH EQUITY AUDIT? .................................................................................... 5
   WHAT IS THIS REPORT? ......................................................................................................... 5
   REFERENCES ........................................................................................................................... 7

2. LIFE EXPECTANCY AT BIRTH .............................................................................................. 8

3. MEASURING DEPRIVATION ................................................................................................. 9
   GEOGRAPHICAL UNITS FOR THE IMD 2004 ...................................................................... 11

4. HEALTH & LIFESTYLE ........................................................................................................... 13
   SELF-REPORTED HEALTH STATUS ..................................................................................... 13
   RISK OF MAJOR DEPRESSION ............................................................................................ 14
   FALLS ..................................................................................................................................... 15
   SMOKING ............................................................................................................................... 16
   ALCOHOL ............................................................................................................................... 17
   EXERCISE ............................................................................................................................... 18
   DIET ...................................................................................................................................... 19
   NEED FOR DENTAL TREATMENT ......................................................................................... 21
   COLD HOMES ....................................................................................................................... 22

5. CHILD HEALTH ..................................................................................................................... 24
   UPTAKE OF MEASLES, MUMPS AND RUBELLA (MMR) VACCINE .................................... 24
   ORAL HEALTH ........................................................................................................................ 25
   OVERWEIGHT AT SCHOOL ENTRY ......................................................................................... 27

6. HOSPITAL ADMISSION .......................................................................................................... 30
   CIRCULATORY DISEASES .................................................................................................... 30
   CORONARY HEART DISEASE ............................................................................................... 31
   STROKE .................................................................................................................................. 31
   DIABETES ............................................................................................................................... 32
   ASTHMA ................................................................................................................................. 33
   CHRONIC OBSTRUCTIVE PULMONARY DISEASE .............................................................. 34
   PNEUMONIA .......................................................................................................................... 35
   MENTAL ILLNESS .................................................................................................................. 35
   ACCIDENTS ............................................................................................................................. 36
   FALLS .................................................................................................................................... 37
   EMERGENCY ADMISSION (ANY CONDITION) ..................................................................... 38
   CATARACTS ............................................................................................................................. 39
   HIP AND KNEE REPLACEMENTS ............................................................................................ 39
   PERCUTANEOUS TRANSLUMINAL CORONARY ANGIOPLASTY (PTCA) AND
   CORONARY ARTERY BYPASS GRAFT (CABG) ................................................................. 40

7. MORTALITY ............................................................................................................................ 42
   ALL CAUSES .......................................................................................................................... 42
   CIRCULATORY DISEASES ...................................................................................................... 43
   CORONARY HEART DISEASE ............................................................................................... 43
   ALL CANCER .......................................................................................................................... 44
   BREAST CANCER ................................................................................................................... 45
LUNG CANCER ................................................................................................................46
COLORECTAL CANCER .................................................................................................46
SUICIDE AND INJURY OF UNDETERMINED INTENT ...................................................47
PNEUMONIA...................................................................................................................48

8. TOWARDS A HEALTH EQUITY AUDIT .................................................................. 50

UNHEALTHY LIFESTYLES ..............................................................................................50
SMOKING CESSATION SERVICES ..................................................................................56
CORONARY HEART DISEASE ..........................................................................................58
HEALTH POVERTY INDEX ..............................................................................................62
RECOMMENDATIONS .....................................................................................................66
REFERENCES ..................................................................................................................66

GLOSSARY .......................................................................................................................... 67

APPENDICES
Appendix 1: Deprivation - Electoral Ward Clusters.................................................................68
Appendix 2: Locality Electoral Wards.....................................................................................69
Appendix 3: Index of Multiple Deprivation 2004 Indicators Details........................................70
Appendix 4: Index of Multiple Deprivation 2004 Data Sources ...........................................75
Appendix 5: Index of Multiple Deprivation 2004 Scores for Super Output Areas ................77
Appendix 6: HPI Data for Eastbourne Borough Council and Lewes and Wealden District Councils ..........................................................................................................................78

LIST OF FIGURES

HEALTH EQUITY AUDIT
Figure 1: Health Equity Audit Cycle..................................................................................4

UNHEALTHY LIFESTYLES
Figure 2: Adult Unhealthy Lifestyle by Sex..........................................................................51
Figure 3: Adult Unhealthy Lifestyle by Age..........................................................................52
Figure 4: Adult Unhealthy Lifestyle by Ethnic Group...........................................................53
Figure 5: Adult Unhealthy Lifestyle by Level of Deprivation................................................53
Figure 6: Adult Unhealthy Lifestyle by Locality....................................................................54
Figure 7: Unhealthy Lifestyle in Children by Level of Deprivation..........................................55
Figure 8: Unhealthy Lifestyle in Children by Locality............................................................56

SMOKING CESSATION SERVICES
Figure 9: Smoking and Smoking Cessation by Level of Deprivation....................................57
Figure 10: Smoking and Smoking Cessation by Locality.......................................................57

CORONARY HEART DISEASE
Figure 11: Coronary Heart Disease Risk Factors, Hospital Experience and Mortality by Sex...59
Figure 12: Coronary Heart Disease Risk Factors, Hospital Experience and Mortality by Age....60
Figure 13: Coronary Heart Disease Risk Factors, Hospital Experience and Mortality by Level of Deprivation ..........................................................................................61
Figure 14: Coronary Heart Disease Risk Factors, Hospital Experience and Mortality by Locality ..................................................................................................................62

HEALTH POVERTY INDEX
Figure 15: HPI Conceptual Framework..................................................................................63
Figure 16: HPI Domains.......................................................................................................64
Figure 17: Radar Graph of HPI for Eastbourne Borough Council and Lewes and Wealden District Councils ...........................................................................................................65
LIST OF TABLES

LIFE EXPECTANCY AT BIRTH
Table 1:  Life Expectancy at Birth for Males by Level of Deprivation .................................................. 8
Table 2:  Life Expectancy at Birth for Females by Level of Deprivation .................................................. 8
Table 3:  Life Expectancy at Birth for Males by Locality ........................................................................... 8
Table 4:  Life Expectancy at Birth for Females by Locality ........................................................................ 8

MEASURING DEPRIVATION
Table 5:  IMD 2004 at Local Authority District, Primary Care Trust and Ward Level .......................... 12

HEALTH & LIFESTYLE

Self Reported Health Status
Table 6:  General Health Perception by Sex ............................................................................................... 13
Table 7:  General Health Perception by Age ................................................................................................ 13
Table 8:  General Health Perception by Ethnic Group .................................................................................. 13
Table 9:  General Health Perception by Level of Deprivation ................................................................. 13
Table 10: General Health Perception by Locality ...................................................................................... 14

Risk of Major Depression
Table 11: Risk of Major Depression by Sex ............................................................................................... 14
Table 12: Risk of Major Depression by Age ............................................................................................... 14
Table 13: Risk of Major Depression by Ethnic Group ................................................................................ 14
Table 14: Risk of Major Depression by Level of Deprivation ................................................................. 14
Table 15: Risk of Major Depression by Locality ...................................................................................... 14

Falls
Table 16: Fallen in the Past Six Months by Sex .......................................................................................... 15
Table 17: Fallen in the Past Six Months by Age ........................................................................................ 15
Table 18: Fallen in the Past Six Months by Ethnic Group ......................................................................... 15
Table 19: Fallen in the Past Six Months by Level of Deprivation ........................................................... 15
Table 20: Fallen in the Past Six Months by Locality ................................................................................. 16

Smoking
Table 21: Smokers by Sex ............................................................................................................................ 16
Table 22: Smokers by Age ............................................................................................................................ 16
Table 23: Smokers by Ethnic Group ............................................................................................................. 16
Table 24: Smokers by Level of Deprivation ................................................................................................ 16
Table 25: Smokers by Locality .................................................................................................................... 17

Alcohol
Table 26: Average Units of Alcohol Consumed Per Week and Percentage of
        Heavy Drinkers by Sex .......................................................................................................................... 17
Table 27: Average Units of Alcohol Consumed per Week and Percentage of
        Heavy Drinkers by Age ........................................................................................................................ 17
Table 28: Average Units of Alcohol Consumed per Week and Percentage of
        Heavy Drinkers by Ethnic Group ........................................................................................................ 18
Table 29: Average Units of Alcohol Consumed per Week and Percentage of
        Heavy Drinkers by Level of Deprivation ............................................................................................ 18
Table 30: Average Units of Alcohol Consumed per Week and Percentage of
        Heavy Drinkers by Locality .................................................................................................................. 18

Exercise
Table 31: Exercise by Sex ............................................................................................................................ 18
Table 32: Exercise by Age ............................................................................................................................ 19
Table 33: Exercise by Ethnic Group ............................................................................................................. 19
Table 34: Exercise by Level of Deprivation ................................................................................................ 19
Table 35: Exercise by Locality .................................................................................................................... 19
Diet
Table 36: Portions of Fruit/Vegetables a Day by Sex ......................................................... 20
Table 37: Weight Perception by Sex ................................................................................. 20
Table 38: Portions of Fruit/Vegetables a Day by Age ...................................................... 20
Table 39: Weight Perception by Age ................................................................................ 20
Table 40: Portions of Fruit/Vegetables a Day by Ethnic Group ...................................... 20
Table 41: Weight Perception by Ethnic Group ................................................................. 20
Table 42: Portions of Fruit/Vegetables a Day by Level of Deprivation ......................... 21
Table 43: Weight Perception by Level of Deprivation ....................................................... 21
Table 44: Portions of Fruit/Vegetables a Day by Locality .............................................. 21
Table 45: Weight Perception by Locality ....................................................................... 21

Need for Dental Treatment
Table 46: Need for Dental Treatment by Sex ................................................................. 21
Table 47: Need for Dental Treatment by Age ................................................................. 22
Table 48: Need for Dental Treatment by Ethnic Group .................................................. 22
Table 49: Need for Dental Treatment by Level of Deprivation ....................................... 22
Table 50: Need for Dental Treatment by Locality .......................................................... 22

Cold Homes
Table 51: Cold Homes by Sex .......................................................................................... 22
Table 52: Cold Homes by Age ........................................................................................ 23
Table 53: Cold Homes by Ethnic Group ........................................................................... 23
Table 54: Cold Homes by Level of Deprivation ............................................................... 23
Table 55: Cold Homes by Locality .................................................................................. 23

CHILD HEALTH
Uptake of Measles, Mumps and Rubella (MMR) Vaccine
Table 56: Uptake of MMR Vaccine by Age 2 Years by Sex ........................................... 24
Table 57: Uptake of MMR Vaccine by Age 2 Years by Level of Deprivation ................. 24
Table 58: Uptake of MMR Vaccine by Age 2 Years by Locality ...................................... 24
Table 59: Uptake of MMR Booster Vaccine by Age 5 Years by Sex .............................. 25
Table 60: Uptake of MMR Booster Vaccine by Age 5 Years by Level of Deprivation .... 25
Table 61: Uptake of MMR Booster Vaccine by Age 5 Years by Locality ...................... 25

Oral Health
Table 62: Median Percentage of Children Referred for Treatment by Level of Deprivation... 26
Table 63: Median Percentage of Children Referred for Treatment by Locality ............... 26
Table 64: Median DMFT Score for 5 Year Olds and 8 Year Olds by Level of Deprivation .. 26
Table 65: Median DMFT Score for 5 Year Olds and 8 Year Olds by Locality ................... 27

Overweight at School Entry
Table 66: Percentage of Children Born Between 01.09.96 and 31.08.98 Who Were
        Overweight and Obese at School Entry by Sex ....................................................... 27
Table 67: Percentage of Children Born Between 01.09.96 and 31.08.98 Who Were
        Overweight and Obese at School Entry by Level of Deprivation ............................ 28
Table 68: Percentage of Children Born Between 01.09.96 and 31.08.98 Who Were
        Overweight and Obese at School Entry by Locality ............................................... 28
Table 69: Percentage of Children Born Between 01.09.96 and 31.08.98 Whose Weight
        Was in the Top 5% at School Entry by Sex ............................................................. 28
Table 70: Percentage of Children Born Between 01.09.96 and 31.08.98 Whose Weight
        Was in the Top 5% at School Entry by Level of Deprivation ................................... 28
Table 71: Percentage of Children Born Between 01.09.96 and 31.08.98 Whose Weight
        Was in the Top 5% at School Entry by Locality ..................................................... 29

HOSPITAL ADMISSION
Circulatory Diseases
Table 72: DSAR for Circulatory Diseases by Sex ............................................................ 30
Table 73: DSAR for Circulatory Diseases by Age ............................................................. 30
Table 74: DSAR for Circulatory Diseases by Level of Deprivation .................................... 30
Table 75: DSAR for Circulatory Diseases by Locality ....................................................... 30

Coronary Heart Disease
Table 76: DSAR for Coronary Heart Disease by Sex ....................................................... 31
Table 77: DSAR for Coronary Heart Disease by Age ....................................................... 31
Table 78: DSAR for Coronary Heart Disease by Level of Deprivation ............................................ 31
Table 79: DSAR for Coronary Heart Disease by Locality .......................................................... 31

**Stroke**
Table 80: DSAR for Stroke by Sex .......................................................................................... 31
Table 81: DSAR for Stroke by Age ......................................................................................... 32
Table 82: DSAR for Stroke by Level of Deprivation ............................................................... 32
Table 83: DSAR for Stroke by Locality .................................................................................... 32

**Diabetes**
Table 84: DSAR for Diabetes by Sex ...................................................................................... 32
Table 85: DSAR for Diabetes by Age ....................................................................................... 32
Table 86: DSAR for Diabetes by Level of Deprivation ............................................................. 33
Table 87: DSAR for Diabetes by Locality .................................................................................. 33

**Asthma**
Table 88: DSAR for Asthma by Sex ......................................................................................... 33
Table 89: DSAR for Asthma by Age ........................................................................................ 33
Table 90: DSAR for Asthma by Level of Deprivation ............................................................... 33
Table 91: DSAR for Asthma by Locality .................................................................................... 34

**Chronic Obstructive Pulmonary Disease**
Table 92: DSAR for Chronic Obstructive Pulmonary Disease by Sex ...................................... 34
Table 93: DSAR for Chronic Obstructive Pulmonary Disease by Age ..................................... 34
Table 94: DSAR for Chronic Obstructive Pulmonary Disease by Level of Deprivation ........ 34
Table 95: DSAR for Chronic Obstructive Pulmonary Disease by Locality ............................... 34

**Pneumonia**
Table 96: DSAR for Pneumonia by Sex .................................................................................. 35
Table 97: DSAR for Pneumonia by Age ................................................................................... 35
Table 98: DSAR for Pneumonia by Level of Deprivation ......................................................... 35
Table 99: DSAR for Pneumonia by Locality ............................................................................. 36

**Mental Illness**
Table 100: DSAR for Mental Illness by Sex ......................................................................... 35
Table 101: DSAR for Mental Illness by Age .......................................................................... 36
Table 102: DSAR for Mental Illness by Level of Deprivation .................................................. 36
Table 103: DSAR for Mental Illness by Locality .................................................................... 36

**Accidents**
Table 104: DSAR for Accidents by Sex .................................................................................. 36
Table 105: DSAR for Accidents by Age ................................................................................... 36
Table 106: DSAR for Accidents by Level of Deprivation ......................................................... 37
Table 107: DSAR for Accidents by Locality ............................................................................ 37

**Falls**
Table 108: DSAR for Falls by Sex .......................................................................................... 37
Table 109: DSAR for Falls by Age .......................................................................................... 37
Table 110: DSAR for Falls by Level of Deprivation ................................................................. 37
Table 111: DSAR for Falls by Locality .................................................................................... 38

**Emergency Admission (Any Condition)**
Table 112: DSAR for Emergency Admissions by Sex ............................................................. 38
Table 113: DSAR for Emergency Admissions by Age .............................................................. 38
Table 114: DSAR for Emergency Admissions by Level of Deprivation .................................. 38
Table 115: DSAR for Emergency Admissions by Locality ...................................................... 38

**Cataracts**
Table 116: DSAR for Cataract Operations by Sex ................................................................. 39
Table 117: DSAR for Cataract Operations by Age ................................................................. 39
Table 118: DSAR for Cataract Operations by Level of Deprivation ........................................ 39
Table 119: DSAR for Cataract Operations by Locality ............................................................ 39

**Hip and Knee Replacements**
Table 120: DSAR for Hip and Knee Replacements by Sex ..................................................... 40
Table 121: DSAR for Hip and Knee Replacements by Age ..................................................... 40
Table 122: DSAR for Hip and Knee Replacements by Level of Deprivation ......................... 40
Table 123: DSAR for Hip and Knee Replacements by Locality .............................................. 40

**Percutaneous Transluminal Coronary Angioplasty (PTCA) and Coronary Artery Bypass Graft (CABG)**
Table 124: DSAR for PTCA and CABG by Sex ..................................................................... 41
Table 125: DSAR for PTCA and CABG by Age ................................................................. 41
Table 126: DSAR for PTCA and CABG by Level of Deprivation ............................... 41
Table 127: DSAR for PTCA and CABG by Locality ......................................................... 41

MORTALITY

All Causes
Table 128: DSMR from All Causes by Sex ..................................................................... 42
Table 129: DSMR from All Causes by Age ................................................................. 42
Table 130: DSMR from All Causes by Level of Deprivation ..................................... 42
Table 131: DSMR from All Causes by Locality ......................................................... 42

Circulatory Diseases
Table 132: DSMR from Circulatory Diseases by Sex ................................................. 43
Table 133: DSMR from Circulatory Diseases by Age .............................................. 43
Table 134: DSMR from Circulatory Diseases by Level of Deprivation ..................... 43
Table 135: DSMR from Circulatory Diseases by Locality ........................................ 43

Coronary Heart Disease
Table 136: DSMR from Coronary Heart Disease by Sex ......................................... 43
Table 137: DSMR from Coronary Heart Disease by Age ......................................... 44
Table 138: DSMR from Coronary Heart Disease by Level of Deprivation ............... 44
Table 139: DSMR from Coronary Heart Disease by Locality .................................... 44

All Cancer
Table 140: DSMR from Cancer by Sex ....................................................................... 44
Table 141: DSMR from Cancer by Age ....................................................................... 44
Table 142: DSMR from Cancer by Level of Deprivation ........................................... 45
Table 143: DSMR from Cancer by Locality ............................................................... 45

Breast Cancer
Table 144: DSMR from Breast Cancer by Age ......................................................... 45
Table 145: DSMR from Breast Cancer by Level of Deprivation ............................... 45
Table 146: DSMR from Breast Cancer by Locality ..................................................... 45

Lung Cancer
Table 147: DSMR from Lung Cancer by Sex ............................................................. 46
Table 148: DSMR from Lung Cancer by Age ............................................................. 46
Table 149: DSMR from Lung Cancer by Level of Deprivation ................................. 46
Table 150: DSMR from Lung Cancer by Locality ....................................................... 46

Colorectal Cancer
Table 151: DSMR from Colorectal Cancer by Sex .................................................... 46
Table 152: DSMR from Colorectal Cancer by Age .................................................... 47
Table 153: DSMR from Colorectal Cancer by Level of Deprivation ......................... 47
Table 154: DSMR from Colorectal Cancer by Locality ............................................. 47

Suicide and Injury of Undetermined Intent
Table 155: DSMR from Suicide & Injury of Undetermined Intent by Sex ................. 47
Table 156: DSMR from Suicide & Injury of Undetermined Intent by Age ............... 47
Table 157: DSMR from Suicide & Injury of Undetermined Intent by Level of Deprivation 48
Table 158: DSMR from Suicide & Injury of Undetermined Intent by Locality ............ 48

Pneumonia
Table 159: DSMR from Pneumonia by Sex ............................................................... 48
Table 160: DSMR from Pneumonia by Age ............................................................... 48
Table 161: DSMR from Pneumonia by Level of Deprivation .................................... 48
Table 162: DSMR from Pneumonia by Locality .......................................................... 49

TOWARDS A HEALTH EQUITY AUDIT

Unhealthy Lifestyles
Table 163: Risk Factors and Overall Disease Burden ................................................. 50
Table 164: Adult Unhealthy Lifestyle Summary ...................................................... 51
Table 165: Unhealthy Lifestyle in Children Summary ................................................ 55

Smoking Cessation
Table 166: Smoking Cessation Summary ................................................................. 56

Coronary Heart Disease
Table 167: Coronary Heart Disease Summary .......................................................... 59
EXECUTIVE SUMMARY

This report is the beginning of an equity profile of the primary care trust. Aspects of health and lifestyle, child health, hospital admission and mortality have been examined in relation to sex, age, ethnicity, level of deprivation and locality.

This reproduces the Sussex Downs and Weald Primary Care Trust Public Health Report as much as possible to try to ensure consistency across both PCTs. It has not been possible, however, to reproduce the analysis on illness (MIQUEST queries were generated to extract information on prevalence rates for a variety of conditions recorded on general practitioner computer systems) that was in the Sussex Downs and Weald PCT report. An attempt was made to use the Quality and Outcomes Framework data, but at time of writing this report the data had only just become available and was not robust enough to use.

A rough guide to the results of the analysis in this report is produced in the table on the next page.

The final chapter provides examples of how the data can be linked. It provides a picture of unhealthy lifestyles in adults and children. In terms of specific areas, it examines smoking cessation services and coronary heart disease.

It includes an outline of the Health Poverty Index and provides details of the index for Eastbourne Borough Council and Lewes and Wealden District Councils.

This report is not the type of report you read from cover to cover, but one you dip in and out of according to interest.

This is a report which raises lots of questions but provides none of the answers. Results are suggestive of inequity rather than conclusive. It is not a health equity audit. The health equity audit cycle is not complete until changes which are likely to reduce inequity, e.g. resource allocation, commissioning, service provision, care outcome, occur.

Recommendations: This report has presented results suggestive of inequity across a range of areas.

1. Smoking cessation services have been examined and resources now need to be changed to complete the equity audit.

2. Coronary heart disease has also been examined but represents only the beginning of an audit to which other data should be included. It is therefore recommended that a Coronary Heart Disease Health Equity Audit be undertaken.

3. Consideration should also be given to undertaking health equity audits in other areas.
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<td>CHILD HEALTH SUMMARY</td>
<td>Uptake of MMR Vaccine by Age</td>
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<td></td>
<td>PTCA</td>
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<td></td>
<td>CABG</td>
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<tr>
<td>MORTALITY SUMMARY</td>
<td>All Causes</td>
<td></td>
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<tr>
<td></td>
<td>Circulatory Diseases</td>
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<tr>
<td></td>
<td>Coronary Heart Disease</td>
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<tr>
<td></td>
<td>All Cancer</td>
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<tr>
<td></td>
<td>Breast Cancer</td>
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<td></td>
<td>Lung Cancer</td>
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<tr>
<td></td>
<td>Colorectal Cancer</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td></td>
<td>Suicide</td>
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<td></td>
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<tr>
<td></td>
<td>Pneumonia</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

**Key**
- Green: Not applicable/not possible
- Red: Little/no difference (rates less than 1, percentages 0-3%)
- Blue: Some difference (rates 1 or more but less than 10, percentages 4-7%)
- Yellow: Big difference (rates 10 or more, percentages 8-10%)
1. HEALTH EQUITY AUDIT

BACKGROUND
The Acheson Independent Inquiry into Inequalities in Health, published in 1998, recommended that Directors of Public Health:

“Produce an equity profile for the population they serve, and undertake a triennial audit of progress towards achieving objectives to reduce inequalities in health.”

‘Tackling Health Inequalities – A Programme for Action’ identified health equity audit (HEA) as a key tool to embed evidence of inequalities into mainstream activities such as planning, commissioning and service delivery.

The Priorities and Planning Framework for 2003-06 set out a number of targets which support the Programme for Action, including the requirement for primary care trust service planning to be informed by an HEA.

WHAT IS EQUITY?
The best way to define ‘equity’ is to define ‘inequity’. ‘Inequity’ has a moral and ethical dimension. It refers to differences which are unnecessary and avoidable but, in addition, are also unfair and unjust. So, in order to describe a certain situation as inequitable, the cause has to be examined and judged to be unfair in the context of what is going on in the rest of society.

Equity should not be confused with equality. Equality is concerned with the sameness of a distribution. Equity is concerned with the fairness of distribution.

WHAT IS A HEALTH EQUITY AUDIT?
HEAs identify how fairly services or other resources are distributed in relation to the needs of different groups and areas, and the priority action to provide services relative to need. Figure 1 is a step by step guide to the HEA process.
Use data on Health Inequalities to support decision at all levels: make appropriate comparisons by area, ethnicity, socio-economic group, gender, age, etc.

1 – Agree partners and issues
   • Choose issue(s) with highest impact, e.g., cancer, CHD, primary care, over 50s, infant health
   • Relate issues to service planning and commissioning, take opportunities where changes are planned
   • Identify factors driving low life expectancy
   • Take on views of front line staff and users
   • Scope for joining up services with local government

2 – Equity profile: identify the gap
   • Use data to compare service provision with need, access, use and outcome measures including proxies for disadvantage, social class, ward in the bottom quintile, BME, gender or other population group
   • Focus on the third of population with poorest health outcomes

3 – Agree high impact local action to narrow the gap
   • Quality and quantity of primary care in disadvantaged areas
   • Address inequalities through NSF implementation
   • Commission new services, change or amend existing contracts
   • Develop LIFT projects where health need is highest
   • Holistic services through partnerships

4 – Agree priorities for action
   Identify highest impact intervention for effective local actions, for example:
   • Diet and physical activity
   • Promoting healthy lifestyles in over 50s
   • Ensure choice, responsiveness and equity for all
   • Accidents
   • Smoking prevalence
   • Screening
   • Flu vaccinations
   • Maternal and infant health
   • Statins & antihypertensives

5 – Secure changes in investment and service delivery
   • Move resources to match need
   • Develop service delivery to match need
   • Ensure changes in contracts and commissioning are reaching areas and groups with highest need
   • Assess impact on inequalities

6 – Review progress and assess impact
   • Ensure effective monitoring systems are in place using indicators etc
   • Review progress
   • Assess the impact of action – has change been made and is it fast enough?
   • Identify local areas or groups where more action is required

EQUITY MATTERS IN EASTBOURNE DOWNS PCT – 2004/5 REPORT OF THE DIRECTOR OF PUBLIC HEALTH
Health equity audit is designed to answer the following questions in a local area:

- What are the known health inequalities for a particular population group or area?
- What are the significant equity issues in relation to provision/access to services, facilities and the determinants of good health?
- Which of these are priorities for action?
- What programmes already exist which might help reduce the inequities?
- Are there any relevant national targets?
- Should a local target be set?
- What further action can be taken by existing public services or through more targeted action with key groups and areas?
- Have resources been reallocated to take the most effective action?
- Has there been any impact on the inequities targeted?

There are a number of ways in which a health equity audit can assess equity in service delivery in the NHS, local government and elsewhere. This can include a review of:

- Equal access for equal need: such as greater availability of free fruit in schools in the most deprived areas.
- Equal use for equal need: such as greater use of smoking cessation services among low-income smokers.
- Equal quality of care for all: such as culturally appropriate and relevant maternity services for black and minority ethnic communities.
- Equal outcomes for equal need: such as greater reductions in coronary heart disease mortality among lower socio-economic groups.

**WHY DO A HEALTH EQUITY AUDIT?**

The purpose of HEA is to help narrow health inequalities by using evidence of inequalities to inform decision on investment, service planning, commissioning and delivery and to review the impact of actions on inequalities. It is a way of getting health inequalities into mainstream activity. High level HEA may inform overall strategy development. More focused HEA may aid or drive action in target areas within the strategy.

A HEA programme should address the dimensions of health inequalities, aiming to narrow the gap in health outcomes between:

- social class
- geographical areas
- men and women
- ethnic groups
- age groups and the population as a whole
- the majority of the population and vulnerable groups and those with special needs

**WHAT IS THIS REPORT?**

This report is the beginnings of an equity profile of the primary care trust. Several areas have been examined but it does not include everything. These areas have been chosen as examples which may warrant further investigation. There are other areas not included here where inequities may exist.
Originally, this report attempted to examine the extent to which inequities concerned with:

- Sex;
- Age;
- Ethnicity;
- Level of Deprivation;
- Locality

exist in a whole range of areas (e.g. health, lifestyle, mortality, etc). However, due to lack of data, it was not possible to do this for all the areas.

**Sex**

It was possible to examine the extent to which inequities exist between the sexes across all the areas except smoking cessation service and childhood oral health.

**Age**

It was also possible to examine the extent to which inequities exist between those aged under 65 years of age and those 65 years of age and over across all the areas except smoking cessation services.

**Ethnicity**

There have been major problems with accessing information on ethnicity. It was only possible to analyse health and lifestyle data by ethnic group. The Public Health Mortality File, which was used for the analysis of deaths, does not record ethnicity. Additionally, ethnicity is not well recorded by general practice and hospital information systems and so it was not possible to analyse illness or hospital admission data by ethnic group.

**Level of Deprivation**

This report uses the Index of Multiple Deprivation 2004 as the measure of deprivation, and to cluster wards into three levels of deprivation:

- Most Affluent
- Intermediate
- Most Deprived

Appendix 1 explains how the wards have been clustered. It was possible to analyse all the areas (e.g. health, lifestyle, mortality, etc) by level of deprivation.

**Locality**

The PCT is divided into five localities:

- Central
- Eastern
- Northern
- Southern
- Western

The electoral wards which constitute each of the localities are presented in Appendix 2. It was possible to analyse all the areas by locality.
This report is a report which raises lots of questions but provides none of the answers. Results are suggestive of inequity rather than conclusive. It is not a HEA. The HEA cycle is not complete until something changes which is likely to reduce inequity demonstrably - that would be resource allocation, commissioning, service provision or care outcome.

REFERENCES


2. LIFE EXPECTANCY AT BIRTH

Life expectancy at birth is a way of expressing the all cause mortality for an area. It gives an estimate of how long someone is expected to live based on current mortality rates.

For England, for 2001-2003, life expectancy at birth was 76.2 years for males and 80.7 years for females. For this PCT, life expectancy for males is 8 months longer and for females 11 months longer.

However, not only does life expectancy differ by sex, it differs by level of deprivation and by locality (Tables 1-4).

### At A PCT Level, Life Expectancy at Birth for Males is 76.9 Years and for Females 81.6 Years

#### By Level of Deprivation

**Table 1: Life Expectancy at Birth for Males by Level of Deprivation**

<table>
<thead>
<tr>
<th>Level of Deprivation</th>
<th>Life Expectancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most Affluent</td>
<td>78.7 years</td>
</tr>
<tr>
<td>Intermediate</td>
<td>76.9 years</td>
</tr>
<tr>
<td>Most Deprived</td>
<td>72.5 years</td>
</tr>
</tbody>
</table>

Table 1 shows that life expectancy for males in the most deprived areas is 6.2 years less than for males in the most affluent areas. For females, it is a 0.6 year difference (Table 2).

**Table 2: Life Expectancy at Birth for Females by Level of Deprivation**

<table>
<thead>
<tr>
<th>Level of Deprivation</th>
<th>Life Expectancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most Affluent</td>
<td>81.5 years</td>
</tr>
<tr>
<td>Intermediate</td>
<td>82.1 years</td>
</tr>
<tr>
<td>Most Deprived</td>
<td>80.9 years</td>
</tr>
</tbody>
</table>

#### By Locality

**Table 3: Life Expectancy at Birth for Males by Locality**

<table>
<thead>
<tr>
<th>Locality</th>
<th>Life Expectancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central</td>
<td>76.5 years</td>
</tr>
<tr>
<td>Eastern</td>
<td>75.4 years</td>
</tr>
<tr>
<td>Northern</td>
<td>78.3 years</td>
</tr>
<tr>
<td>Southern</td>
<td>76.7 years</td>
</tr>
<tr>
<td>Western</td>
<td>78.8 years</td>
</tr>
</tbody>
</table>

Tables 3 & 4 show that life expectancy for males and females varies across the localities with a difference of 3.4 years for males between the Eastern and Western localities and 1.2 years for females between the Northern and Eastern localities.

**Table 4: Life Expectancy at Birth for Females by Locality**

<table>
<thead>
<tr>
<th>Locality</th>
<th>Life Expectancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central</td>
<td>81.3 years</td>
</tr>
<tr>
<td>Eastern</td>
<td>82.1 years</td>
</tr>
<tr>
<td>Northern</td>
<td>80.9 years</td>
</tr>
<tr>
<td>Southern</td>
<td>81.8 years</td>
</tr>
<tr>
<td>Western</td>
<td>81.7 years</td>
</tr>
</tbody>
</table>

Inequalities in life expectancy can be addressed by tackling key influencing factors such as mortality rates from the main killer diseases, access to services and lifestyle issues.
3. MEASURING DEPRIVATION

The Index of Multiple Deprivation 2004 (IMD 2004) is the measure of deprivation used throughout this report. It was published in May 2004 and is a measure of multiple deprivation at the small area level. The model of multiple deprivation which underpins the IMD 2004 is based on the idea of distinct dimensions of deprivation which can be recognised and measured separately. People may be counted as deprived in one or more of the domains depending on the number of types of deprivation that they experience.

It is important to remember that the higher the IMD 2004 score the greater the level of deprivation.

The IMD 2004 contains seven domains of deprivation:

1. **Income Deprivation**
   The purpose of this domain is to capture the proportion of the population experiencing income deprivation in an area.
   - Adults and children in Income Based Job Seekers Allowance households (2001).
   - Adults and children in Working Families Tax Credit households whose equivalised income (excluding housing benefits) is below 60% of median before housing costs (2001).
   - Adults and children in Disabled Person’s Tax Credit households whose equivalised income (excluding housing benefits) is below 60% of median before housing costs (2001).
   - National Asylum Support Service supported asylum seekers in England in receipt of subsistence only and accommodation support (2002).

2. **Employment Deprivation**
   This domain measures employment deprivation conceptualised as involuntary exclusion of the working age population from the world of work.
   - Unemployment claimant count (JUVOS) of women aged 18-59 and men aged 18-64 averaged over 4 quarters (2001).
   - Participants in New Deal for the 18-24s who are not included in the claimant count (2001).
   - Participants in New Deal for 25+ who are not included in the claimant count (2001).
   - Participants in New Deal for Lone Parents aged 18 and over (2001).

3. **Health Deprivation and Disability**
   This domain identifies areas with relatively high rates of people who die prematurely or whose quality of life is impaired by poor health or who are disabled, across the whole population.
   - Adults under 60 suffering from mood or anxiety disorders (1997-2002).

4. **Education, Skills and Training Deprivation**
   This domain captures the extent of deprivation in terms of education, skills and training in a local area. The indicators fall into two sub-domains: one relating to education
deprivation for children/young people in the area and one relating to lack of skills and qualifications among the working age adult population.

**Sub-domain: Children/Young People**
- Average points score of children at Key Stage 2 (2002).
- Average points score of children at Key Stage 3 (2002).
- Average points score of children at Key Stage 4 (2002).
- Proportion of young people *not* staying on in school or school level education above 16 (2001).

**Sub-domain: Skills**
- Proportions of working age adults (aged 25-54) in the area with no or low qualifications (2001).

5. **Barriers to Housing and Services**
The purpose of this domain is to measure barriers to housing and key local services. The indicators fall into two sub-domains: ‘geographical barriers’ and ‘wider barriers’ which also includes issues relating to access to housing, such as affordability.

**Sub-domain: Wider Barriers**
- LA level percentage of households for whom a decision on their application for assistance under the homeless provisions of housing legislation has been made, assigned to Super Output Areas (SOAs) (2002).
- Difficulty of access to owner-occupation (2002).

**Sub-domain: Geographical Barriers**
- Road distance to GP premises (2003).
- Road distance to a supermarket or convenience store (2002).
- Road distance to a primary school (2001-2002).
- Road distance to a Post Office (2003).

6. **Living Environment Deprivation**
This domain focuses on deprivation with respect to the characteristics of the living environment. It comprises two sub-domains: the ‘indoors’ living environment which measures the quality of housing and the ‘outdoors’ living environment which contains two measures about air quality and road traffic accidents.

**Sub-domain: The ‘Indoors’ Living Environment**

**Sub-domain: The ‘Outdoors’ Living Environment**
- Road traffic accidents involving injury to pedestrians and cyclists (2000-2002).

7. **Crime**
This domain measures the incidence of recorded crime for four major crime themes, representing the occurrence of personal and material victimisation at a small area level.
- Burglary (4 recorded crime offence types, April 2002-March 2003).
- Theft (5 recorded crime offence types, April 2002-March 2003, constrained to CDRP level).
- Criminal damage (10 recorded crime offence types, April 2002-March 2003).
- Violence (14 recorded crime offence types, April 2002-March 2003).

Each domain contains a number of indicators. Where possible, the indicators relate to 2001. Appendix 3 lists the indicators and Appendix 4 lists the data sources.

In addition to the overall IMD 2004 and the domain indices, there are two supplementary indices, Income Deprivation Affecting Children Index and Income Deprivation Affecting Older People. The Income Deprivation Affecting Children Index shows the percentage of children aged under 16 years in each area that live in families that are income deprived (i.e. in receipt of Income Support, Income Based Job Seekers Allowance or Working Families Tax Credit/Disabled Person’s Tax Credit below a given threshold. Income Deprivation Affecting Older People Index shows the percentage of the population aged 60 and over who are Income Support/Income Based Job Seekers claimants aged 60 and over and their partners (if also aged 60 or over).

For all the indices, the higher the number the greater the level of deprivation.

**GEOGRAPHICAL UNITS FOR THE IMD 2004**

The IMD 2004 is available for geographical units called ‘Super Output Areas’ (SOAs). These are aggregates of Census output areas and will be published by The Office for National Statistics at three levels. The lowest level is a relatively small scale unit, containing an average of 1,500 people.

Summaries of the IMD 2004 are presented over at Local Authority District, Primary Care Trust and Ward levels, in Table 5.

Appendix 5 contains details of the number of SOA by ward and the minimum and maximum SOA scores for each ward.

IMD 2004 scores at ward level range from 7.9 in Willingdon (least deprived) to 32.3 in Devonshire (most deprived). At SOA level IMD 2004 scores range from 4.3 in Seaford East to 47.7 in Devonshire.
<table>
<thead>
<tr>
<th>Area</th>
<th>Index of Multiple Deprivation 2004 *</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastbourne Borough Council</td>
<td>21.2</td>
</tr>
<tr>
<td>Lewes District Council</td>
<td>12.3</td>
</tr>
<tr>
<td>Wealden District Council</td>
<td>9.6</td>
</tr>
<tr>
<td>Eastbourne Downs PCT</td>
<td>17.1</td>
</tr>
</tbody>
</table>

**Wards (ranked most deprived to least deprived):**

1. Devonshire 32.3
2. Hailsham East 29.8
3. Hampden Park 28.6
4. Langney 26.4
5. Upperton 21.5
6. Sovereign 19.9
7. St Anthony’s 18.9
8. Meads 16.7
9. Hailsham South and West 15.1
10. Seaford Central 15.1
11. Seaford North 13.9
12. Old Town 13.5
13. Polegate South 13.3
14. Ratton 12.6
15. Polegate North 12.4
16. Pevensey and Westham 12.1
17. Chiddingly and East Hoathly 11.8
18. Ninfield & Hoee with Wartling 11.8
19. Alfriston 11.6
20. Hellingly 10.9
21. Seaford East 10.0
22. Heathfield East 9.9
23. Herstmonceux 9.9
24. Hailsham Central and North 9.4
25. Seaford South 9.4
26. Seaford West 9.1
27. East Dean 8.5
28. Willingdon 7.9

* Average SOA scores
4. HEALTH & LIFESTYLE

During the Summer of 2003, a health and lifestyle survey was carried out in the primary care trust. The results at primary care trust level were reported in the 2003/04 Public Health Report, ‘Health Counts in Eastbourne Downs Primary Care Trust’. In this chapter a few of the key variables have been re-analysed to examine the extent of any inequities.

SELF-REPORTED HEALTH STATUS

The SF-36, ‘Short Form with 36 Questions’, was designed to measure overall functional status and well-being. The instrument is composed of 36 items and covers three major health attributes and eight health concepts. Each concept scale has a range from 0-100, where 0 represents the worst state while 100 represents the best possible.

Here we are examining only one of the health concepts, ‘general health perceptions’. A ‘low’ score for this concept would indicate that personal health is poor and likely to get worse and a ‘high’ score would indicate that personal health is excellent.

AT A PCT LEVEL, GENERAL HEALTH WAS RATED AT 67

By Sex

Table 6: General Health Perception by Sex

<table>
<thead>
<tr>
<th>Sex</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>67</td>
</tr>
<tr>
<td>Female</td>
<td>68</td>
</tr>
</tbody>
</table>

Table 6 shows that there is little between the sexes, males and females rate their general health virtually the same.

By Age

Table 7: General Health Perception by Age

<table>
<thead>
<tr>
<th>Age</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 65 yrs</td>
<td>70</td>
</tr>
<tr>
<td>65 yrs &amp; over</td>
<td>62</td>
</tr>
<tr>
<td>65-74 yrs</td>
<td>67</td>
</tr>
<tr>
<td>75 yrs &amp; over</td>
<td>57</td>
</tr>
</tbody>
</table>

Table 7 shows that respondents 65 years of age and over rate their general health lower than those under 65 years old. However, when looking at those over 65 years old, it’s respondents 75 years and older who rate their health the lowest.

By Ethnic Group

Table 8: General Health Perception by Ethnic Group

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>67</td>
</tr>
<tr>
<td>Other Ethnic Group</td>
<td>68</td>
</tr>
</tbody>
</table>

Table 8 shows that respondents from other ethnic groups rated their general health perception slightly higher.

By Level of Deprivation

Table 9: General Health Perception by Level of Deprivation

<table>
<thead>
<tr>
<th>Level of Deprivation</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most Affluent</td>
<td>69</td>
</tr>
<tr>
<td>Intermediate</td>
<td>64</td>
</tr>
<tr>
<td>Most Deprived</td>
<td>65</td>
</tr>
</tbody>
</table>

Table 9 shows that those respondents in the most affluent areas rated their general health highest.
By Locality

Table 10: General Health Perception by Locality

<table>
<thead>
<tr>
<th>Locality</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central</td>
<td>69</td>
</tr>
<tr>
<td>Eastern</td>
<td>67</td>
</tr>
<tr>
<td>Northern</td>
<td>68</td>
</tr>
<tr>
<td>Southern</td>
<td>65</td>
</tr>
<tr>
<td>Western</td>
<td>68</td>
</tr>
</tbody>
</table>

Table 10 shows that respondents in the Central locality rated their general health the highest and those in the Southern locality rated their general health the lowest.

RISK OF MAJOR DEPRESSION

An optional addition to the SF-36 is a screen for depression. This indicates those considered to be at risk of suffering depression.

At a PCT level, 35% of respondents were at risk of major depression.

By Sex

Table 11: Risk of Major Depression by Sex

<table>
<thead>
<tr>
<th>Sex</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>30%</td>
</tr>
<tr>
<td>Female</td>
<td>39%</td>
</tr>
</tbody>
</table>

Table 11 shows that a higher percentage of female respondents were at risk of major depression.

By Age

Table 12: Risk of Major Depression by Age

<table>
<thead>
<tr>
<th>Age</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 65 yrs</td>
<td>38%</td>
</tr>
<tr>
<td>65 yrs &amp; over</td>
<td>30%</td>
</tr>
<tr>
<td>65-74 yrs</td>
<td>25%</td>
</tr>
<tr>
<td>75 yrs &amp; over</td>
<td>35%</td>
</tr>
</tbody>
</table>

Table 12 shows that a greater percentage of respondents under 65 years old were at risk of major depression (38%) compared to those 65 years and over. Respondents 65-74 years old were at lowest risk of major depression.

By Ethnic Group

Table 13: Risk of Major Depression by Ethnic Group

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>35%</td>
</tr>
<tr>
<td>Other Ethnic Group</td>
<td>37%</td>
</tr>
</tbody>
</table>

Table 13 shows that respondents from other ethnic groups were at greater risk of major depression.

By Level of Deprivation

Table 14: Risk of Major Depression by Level of Deprivation

<table>
<thead>
<tr>
<th>Level of Deprivation</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most Affluent</td>
<td>33%</td>
</tr>
<tr>
<td>Intermediate</td>
<td>33%</td>
</tr>
<tr>
<td>Most Deprived</td>
<td>42%</td>
</tr>
</tbody>
</table>

Table 14 shows that 1 in 3 respondents in the most affluent areas were at risk of major depression but in the most deprived areas it was nearly 1 in 2.
By Locality

*Table 15: Risk of Major Depression by Locality*

<table>
<thead>
<tr>
<th>Locality</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central</td>
<td>35%</td>
</tr>
<tr>
<td>Eastern</td>
<td>35%</td>
</tr>
<tr>
<td>Northern</td>
<td>33%</td>
</tr>
<tr>
<td>Southern</td>
<td>35%</td>
</tr>
<tr>
<td>Western</td>
<td>35%</td>
</tr>
</tbody>
</table>

Table 15 demonstrates that respondents in the Northern locality were at less risk of major depression.

**FALLS**

People were asked if they had fallen in the past 6 months. ‘Falling’ was defined as ‘unintentionally come to rest on the ground or floor whether or not you were injured’.

**AT A PCT LEVEL, 19% OF RESPONDENTS SAID THAT THEY HAD FALLEN IN THE PAST 6 MONTHS**

By Sex

*Table 16: Fallen in the Past Six Months by Sex*

<table>
<thead>
<tr>
<th>Sex</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>19%</td>
</tr>
<tr>
<td>Female</td>
<td>19%</td>
</tr>
</tbody>
</table>

Nearly 1 in 5 male and female respondents (19%) had fallen in the last 6 months (Table 16).

By Age

*Table 17: Fallen in the Past Six Months by Age*

<table>
<thead>
<tr>
<th>Age</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 65 yrs</td>
<td>16%</td>
</tr>
<tr>
<td>65 yrs &amp; over</td>
<td>24%</td>
</tr>
<tr>
<td>65-74 yrs</td>
<td>18%</td>
</tr>
<tr>
<td>75 yrs &amp; over</td>
<td>30%</td>
</tr>
</tbody>
</table>

Table 17 shows that it is older respondents that are falling. There is only a small difference in the proportion of under 65 year olds and 65-74 year olds falling. However, of respondents 75 years and over 30% had fallen in the past 6 months.

By Ethnic Group

*Table 18: Fallen in the Past Six Months by Ethnic Group*

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>19%</td>
</tr>
<tr>
<td>Other Ethnic Group</td>
<td>13%</td>
</tr>
</tbody>
</table>

Only 13% of respondents from other ethnic groups reported that they had fallen in the past six months. (Table 18).

By Level of Deprivation

*Table 19: Fallen in the Past Six Months by Level of Deprivation*

<table>
<thead>
<tr>
<th>Level of Deprivation</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most Affluent</td>
<td>18%</td>
</tr>
<tr>
<td>Intermediate</td>
<td>24%</td>
</tr>
<tr>
<td>Most Deprived</td>
<td>18%</td>
</tr>
</tbody>
</table>

More respondents from the intermediate areas reported falling in the past 6 months (Table 19).
By Locality

Table 20: Fallen in the Past Six Months by Locality

<table>
<thead>
<tr>
<th>Locality</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central</td>
<td>18%</td>
</tr>
<tr>
<td>Eastern</td>
<td>18%</td>
</tr>
<tr>
<td>Northern</td>
<td>17%</td>
</tr>
<tr>
<td>Southern</td>
<td>25%</td>
</tr>
<tr>
<td>Western</td>
<td>19%</td>
</tr>
</tbody>
</table>

Table 20 shows that 1 in 4 respondents in the Southern locality reported falling in the past six months.

SMOKING

Smoking is the single greatest cause of preventable illness and premature death.

AT A PCT LEVEL, 22% OF RESPONDENTS SMOKED

By Sex

Table 21: Smokers by Sex

<table>
<thead>
<tr>
<th>Sex</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>25%</td>
</tr>
<tr>
<td>Female</td>
<td>19%</td>
</tr>
</tbody>
</table>

Table 21 shows that 25% of male respondents and 19% of female respondents smoked.

By Age

Table 22: Smokers by Age

<table>
<thead>
<tr>
<th>Age</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 65 yrs</td>
<td>28%</td>
</tr>
<tr>
<td>65 yrs &amp; over</td>
<td>10%</td>
</tr>
<tr>
<td>65-74 yrs</td>
<td>12%</td>
</tr>
<tr>
<td>75 yrs &amp; over</td>
<td>8%</td>
</tr>
</tbody>
</table>

Table 22 shows that over 1 in 4 of respondents under 65 years were smokers.

By Ethnic Group

Table 23: Smokers by Ethnic Group

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>21%</td>
</tr>
<tr>
<td>Other Ethnic Group</td>
<td>33%</td>
</tr>
</tbody>
</table>

Thirty three percent of respondents from other ethnic groups smoked (Table 23).

By Level of Deprivation

Table 24: Smokers by Level of Deprivation

<table>
<thead>
<tr>
<th>Level of Deprivation</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most Affluent</td>
<td>20%</td>
</tr>
<tr>
<td>Intermediate</td>
<td>18%</td>
</tr>
<tr>
<td>Most Deprived</td>
<td>33%</td>
</tr>
</tbody>
</table>

Table 24 shows that 1 in 3 of respondents in the most deprived areas smoked.
By Locality

Table 25: Smokers by Locality

<table>
<thead>
<tr>
<th>Locality</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central</td>
<td>23%</td>
</tr>
<tr>
<td>Eastern</td>
<td>22%</td>
</tr>
<tr>
<td>Northern</td>
<td>23%</td>
</tr>
<tr>
<td>Southern</td>
<td>19%</td>
</tr>
<tr>
<td>Western</td>
<td>19%</td>
</tr>
</tbody>
</table>

Table 25 shows that the highest prevalence of smoking is in the Central and Northern localities.

ALCOHOL

Alcohol consumption is generally measured in terms of units of consumption. In the UK, a unit is defined as 8 grams of alcohol, which is equivalent to half a pint of ordinary strength beer, a small glass of wine or one measure of spirit. In 1995, men were recommended to consume no more than 3-4 units per day and women 2-3, with two non-drinking days after an episode of heavy drinking. Consistent consumption at the upper limit was not advised. Heavy drinking is defined as more than 21 units a week for men and more than 14 units a week for women.

At PCT level, the average number of units of alcohol consumed per week was 9.1 units and 13% of respondents were heavy drinkers.

By Sex

Table 26: Average Units of Alcohol Consumed per Week and Percentage of Heavy Drinkers by Sex

<table>
<thead>
<tr>
<th>Sex</th>
<th>Units of Alcohol</th>
<th>Percentage Heavy Drinkers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>11.8</td>
<td>16%</td>
</tr>
<tr>
<td>Female</td>
<td>6.7</td>
<td>9%</td>
</tr>
</tbody>
</table>

Table 26 shows that male respondents consumed more alcohol per week and that a higher percentage were heavy drinkers.

By Age

Table 27: Average Units of Alcohol Consumed per Week and Percentage of Heavy Drinkers by Age

<table>
<thead>
<tr>
<th>Age</th>
<th>Units of Alcohol</th>
<th>Percentage Heavy Drinkers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 65 yrs</td>
<td>9.0</td>
<td>13%</td>
</tr>
<tr>
<td>65 yrs &amp; over</td>
<td>9.3</td>
<td>12%</td>
</tr>
<tr>
<td>65-74 yrs</td>
<td>9.4</td>
<td>13%</td>
</tr>
<tr>
<td>75 yrs &amp; over</td>
<td>9.0</td>
<td>10%</td>
</tr>
</tbody>
</table>

Across the age groups there was little difference in the units of alcohol consumed per week (Table 27).
By Ethnic Group

Table 28: Average Units of Alcohol Consumed per Week and Percentage of Heavy Drinkers by Ethnic Group

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>Units of Alcohol</th>
<th>Percentage Heavy Drinkers</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>9.1</td>
<td>13%</td>
</tr>
<tr>
<td>Other Ethnic Group</td>
<td>14.4</td>
<td>10%</td>
</tr>
</tbody>
</table>

Table 28 shows that most alcohol is consumed by respondents from other ethnic groups but that most heavy drinkers are white.

By Level of Deprivation

Table 29: Average Units of Alcohol Consumed per Week and Percentage of Heavy Drinkers by Level of Deprivation

<table>
<thead>
<tr>
<th>Level of Deprivation</th>
<th>Units of Alcohol</th>
<th>Percentage Heavy Drinkers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most Affluent</td>
<td>8.7</td>
<td>12%</td>
</tr>
<tr>
<td>Intermediate</td>
<td>10.5</td>
<td>15%</td>
</tr>
<tr>
<td>Most Deprived</td>
<td>8.9</td>
<td>12%</td>
</tr>
</tbody>
</table>

Table 29 shows that respondents living in the intermediate areas drank more alcohol. The intermediate areas also had a higher percentage of heavy drinkers.

By Locality

Table 30: Average Units of Alcohol Consumed per Week and Percentage of Heavy Drinkers by Locality

<table>
<thead>
<tr>
<th>Locality</th>
<th>Units of Alcohol</th>
<th>Percentage Heavy Drinkers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central</td>
<td>8.2</td>
<td>11%</td>
</tr>
<tr>
<td>Eastern</td>
<td>8.6</td>
<td>12%</td>
</tr>
<tr>
<td>Northern</td>
<td>9.0</td>
<td>12%</td>
</tr>
<tr>
<td>Southern</td>
<td>10.5</td>
<td>15%</td>
</tr>
<tr>
<td>Western</td>
<td>9.8</td>
<td>14%</td>
</tr>
</tbody>
</table>

Respondents in the Southern locality drank more alcohol than those in other localities (Table 30).

EXERCISE

There is strong evidence to suggest that there are many potential health benefits from being active. Current recommendations are that adults should participate in 30 minutes of moderate physical activity on at least five days per week.

AT A PCT LEVEL, 18% OF RESPONDENTS EXERCISED 5 OR MORE TIMES A WEEK

By Sex

Table 31: Exercise by Sex

<table>
<thead>
<tr>
<th>Sex</th>
<th>Exercise 5 or More Times a Week</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>21%</td>
</tr>
<tr>
<td>Female</td>
<td>16%</td>
</tr>
</tbody>
</table>

Table 31 shows that males exercise more than females.
By Age

Table 32: Exercise by Age

<table>
<thead>
<tr>
<th>Age</th>
<th>Exercise 5 or More Times a Week</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 65 yrs</td>
<td>17%</td>
</tr>
<tr>
<td>65 yrs &amp; over</td>
<td>21%</td>
</tr>
<tr>
<td>65-74 yrs</td>
<td>25%</td>
</tr>
<tr>
<td>75 yrs &amp; over</td>
<td>16%</td>
</tr>
</tbody>
</table>

Table 32 shows that respondents 65 years and over are exercising more than younger respondents. In the 65-74 year old age group, 1 in 4 respondents were meeting the current recommendation on exercise.

By Ethnic Group

Table 33: Exercise by Ethnic Group

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>Exercise 5 or More Times a Week</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>19%</td>
</tr>
<tr>
<td>Other Ethnic Group</td>
<td>9%</td>
</tr>
</tbody>
</table>

Table 33 shows that white respondents are exercising more than respondents from other ethnic groups.

By Level of Deprivation

Table 34: Exercise by Level of Deprivation

<table>
<thead>
<tr>
<th>Level of Deprivation</th>
<th>Exercise 5 or More Times a Week</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most Affluent</td>
<td>18%</td>
</tr>
<tr>
<td>Intermediate</td>
<td>20%</td>
</tr>
<tr>
<td>Most Deprived</td>
<td>17%</td>
</tr>
</tbody>
</table>

1 in 5 respondents in the intermediate areas were meeting the current recommendation on exercise, but in the other areas it is lower (Table 34).

By Locality

Table 35: Exercise by Locality

<table>
<thead>
<tr>
<th>Locality</th>
<th>Exercise 5 or More Times a Week</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central</td>
<td>16%</td>
</tr>
<tr>
<td>Eastern</td>
<td>19%</td>
</tr>
<tr>
<td>Northern</td>
<td>20%</td>
</tr>
<tr>
<td>Southern</td>
<td>18%</td>
</tr>
<tr>
<td>Western</td>
<td>19%</td>
</tr>
</tbody>
</table>

20% of respondents in the Northern locality were meeting the current recommendations, whereas in the Central locality it is 16% (Table 35).

DIET

Poor diet contributes to both coronary heart disease and cancer. Current recommendations are that a maximum of 35% of energy intake is derived from dietary fat, and no more than 11% from saturated fatty acids. Additionally, it is recommended that at least five portions of fruit or vegetables are consumed each day.

AT A PCT LEVEL, RESPONDENTS ATE AN AVERAGE 4.3 PORTIONS OF FRUIT/VEGETABLES A DAY. ACROSS THE PCT, 59% OF RESPONDENTS PERCEIVED THEMSELVES TO BE OVERWEIGHT
By Sex

**Table 36: Portions of Fruit/Vegetables a Day by Sex**

<table>
<thead>
<tr>
<th>Sex</th>
<th>Number of Portions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>4.1</td>
</tr>
<tr>
<td>Female</td>
<td>4.5</td>
</tr>
</tbody>
</table>

Female respondents ate on average more fruit/vegetables a day than males (Table 36).

**Table 37: Weight Perception by Sex**

<table>
<thead>
<tr>
<th>Sex</th>
<th>Percentage Overweight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>55%</td>
</tr>
<tr>
<td>Female</td>
<td>61%</td>
</tr>
</tbody>
</table>

Table 37 shows that more female respondents perceive themselves as overweight than male respondents.

By Age

**Table 38: Portions of Fruit/Vegetables a Day by Age**

<table>
<thead>
<tr>
<th>Age</th>
<th>Number of Portions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 65 yrs</td>
<td>4.2</td>
</tr>
<tr>
<td>65 yrs &amp; over</td>
<td>4.6</td>
</tr>
<tr>
<td>65-74 yrs</td>
<td>4.7</td>
</tr>
<tr>
<td>75 yrs &amp; over</td>
<td>4.5</td>
</tr>
</tbody>
</table>

Table 38 shows that respondents 65 years and over ate more fruit/vegetables a day than those under 65 years of age.

**Table 39: Weight Perception by Age**

<table>
<thead>
<tr>
<th>Age</th>
<th>Percentage Overweight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 65 yrs</td>
<td>60%</td>
</tr>
<tr>
<td>65 yrs &amp; over</td>
<td>56%</td>
</tr>
<tr>
<td>65-74 yrs</td>
<td>66%</td>
</tr>
<tr>
<td>75 yrs &amp; over</td>
<td>46%</td>
</tr>
</tbody>
</table>

More respondents under 65 years old perceived themselves as overweight compared to respondents 65 years old and over. Even amongst respondents 75 years old and over, nearly 1 in 2 of the respondents classified themselves as overweight (Table 39).

By Ethnic Group

**Table 40: Portions of Fruit/Vegetables a Day by Ethnic Group**

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>Number of Portions</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>4.3</td>
</tr>
<tr>
<td>Other Ethnic Group</td>
<td>3.9</td>
</tr>
</tbody>
</table>

White respondents ate on average more portions of fruit/vegetables a day (Table 40).

**Table 41: Weight Perception by Ethnic Group**

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>Percentage Overweight</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>59%</td>
</tr>
<tr>
<td>Other Ethnic Group</td>
<td>55%</td>
</tr>
</tbody>
</table>

Table 41 shows that a smaller percentage of respondents from other ethnic groups classified themselves as overweight.
By Level of Deprivation

**Table 42: Portions of Fruit/Vegetables a Day by Level of Deprivation**

<table>
<thead>
<tr>
<th>Level of Deprivation</th>
<th>Number of Portions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most Affluent</td>
<td>4.5</td>
</tr>
<tr>
<td>Intermediate</td>
<td>4.1</td>
</tr>
<tr>
<td>Most Deprived</td>
<td>4.0</td>
</tr>
</tbody>
</table>

Respondents in the most affluent areas ate on average more portions of fruit/vegetables a day (Table 42).

**Table 43: Weight Perception by Level of Deprivation**

<table>
<thead>
<tr>
<th>Level of Deprivation</th>
<th>Percentage Overweight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most Affluent</td>
<td>58%</td>
</tr>
<tr>
<td>Intermediate</td>
<td>60%</td>
</tr>
<tr>
<td>Most Deprived</td>
<td>57%</td>
</tr>
</tbody>
</table>

The percentage of respondents perceiving themselves to be overweight varies little by level of deprivation (Table 43).

By Locality

**Table 44: Portions of Fruit/Vegetables a Day by Locality**

<table>
<thead>
<tr>
<th>Locality</th>
<th>Number of Portions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central</td>
<td>4.3</td>
</tr>
<tr>
<td>Eastern</td>
<td>4.1</td>
</tr>
<tr>
<td>Northern</td>
<td>4.1</td>
</tr>
<tr>
<td>Southern</td>
<td>4.4</td>
</tr>
<tr>
<td>Western</td>
<td>4.6</td>
</tr>
</tbody>
</table>

On average respondents in the Eastern and Northern localities ate less fruit/vegetables than respondents in the other localities (Table 44).

**Table 45: Weight Perception by Locality**

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>Percentage Overweight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central</td>
<td>57%</td>
</tr>
<tr>
<td>Eastern</td>
<td>61%</td>
</tr>
<tr>
<td>Northern</td>
<td>60%</td>
</tr>
<tr>
<td>Southern</td>
<td>51%</td>
</tr>
<tr>
<td>Western</td>
<td>62%</td>
</tr>
</tbody>
</table>

More respondents in the Western locality thought they were overweight compared to residents in the other localities (Table 45).

**NEED FOR DENTAL TREATMENT**

**AT A PCT LEVEL, 28% OF RESPONDENTS THOUGHT THAT IF THEY WENT TO THE DENTIST TOMORROW THEY WOULD NEED TREATMENT**

By Sex

**Table 46: Need for Dental Treatment by Sex**

<table>
<thead>
<tr>
<th>Sex</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>30%</td>
</tr>
<tr>
<td>Female</td>
<td>26%</td>
</tr>
</tbody>
</table>

More male than female respondents thought that they were in need of dental treatment (Table 46).
By Age

Table 47: Need for Dental Treatment by Age

<table>
<thead>
<tr>
<th>Age</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 65 yrs</td>
<td>32%</td>
</tr>
<tr>
<td>65 yrs &amp; over</td>
<td>21%</td>
</tr>
<tr>
<td>65-74 yrs</td>
<td>23%</td>
</tr>
<tr>
<td>75yrs &amp; over</td>
<td>20%</td>
</tr>
</tbody>
</table>

Table 47 shows that nearly 1 in 3 of respondents under 65 years of age thought that they needed dental treatment.

By Ethnic Group

Table 48: Need for Dental Treatment by Ethnic Group

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>28%</td>
</tr>
<tr>
<td>Other Ethnic Group</td>
<td>28%</td>
</tr>
</tbody>
</table>

Table 48 shows that there was no difference between ethnic groups in the need for dental treatment.

By Level of Deprivation

Table 49: Need for Dental Treatment by Level of Deprivation

<table>
<thead>
<tr>
<th>Level of Deprivation</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most Affluent</td>
<td>26%</td>
</tr>
<tr>
<td>Intermediate</td>
<td>29%</td>
</tr>
<tr>
<td>Most Deprived</td>
<td>32%</td>
</tr>
</tbody>
</table>

A higher percentage of respondents from the most deprived areas thought they would need treatment compared to respondents from the most affluent areas (Table 49).

By Locality

Table 50: Need for Dental Treatment by Locality

<table>
<thead>
<tr>
<th>Locality</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central</td>
<td>26%</td>
</tr>
<tr>
<td>Eastern</td>
<td>30%</td>
</tr>
<tr>
<td>Northern</td>
<td>26%</td>
</tr>
<tr>
<td>Southern</td>
<td>28%</td>
</tr>
<tr>
<td>Western</td>
<td>28%</td>
</tr>
</tbody>
</table>

A higher percentage of respondents living in the Eastern locality thought that they were in need of dental treatment compared to the other localities (Table 50).

COLD HOMES

AT A PCT LEVEL, 32% OF RESPONDENTS INDICATED THAT THEY COULD NOT KEEP THEIR HOMES WARM ENOUGH IN WINTER

By Sex

Table 51: Cold Homes by Sex

<table>
<thead>
<tr>
<th>Sex</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>32%</td>
</tr>
<tr>
<td>Female</td>
<td>32%</td>
</tr>
</tbody>
</table>

Table 51 shows that the same percentage of males and females could not keep their homes warm.
By Age

**Table 52: Cold Homes by Age**

<table>
<thead>
<tr>
<th>Age</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 65 yrs</td>
<td>33%</td>
</tr>
<tr>
<td>65 yrs &amp; over</td>
<td>30%</td>
</tr>
<tr>
<td>65-74 yrs</td>
<td>29%</td>
</tr>
<tr>
<td>75 yrs &amp; over</td>
<td>32%</td>
</tr>
</tbody>
</table>

More respondents aged under 65 years indicated that they could not keep their homes warm (Table 52).

By Ethnic Group

**Table 53: Cold Homes by Ethnic Group**

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>32%</td>
</tr>
<tr>
<td>Other Ethnic Group</td>
<td>38%</td>
</tr>
</tbody>
</table>

Table 53 shows that 38% of respondents from other ethnic groups could not keep their homes warm enough compared to 32% of white respondents.

By Level of Deprivation

**Table 54: Cold Homes by Level of Deprivation**

<table>
<thead>
<tr>
<th>Level of Deprivation</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most Affluent</td>
<td>31%</td>
</tr>
<tr>
<td>Intermediate</td>
<td>32%</td>
</tr>
<tr>
<td>Most Deprived</td>
<td>37%</td>
</tr>
</tbody>
</table>

Table 54 shows a gradient. Thirty seven percent of respondents in the most deprived areas could not keep their homes warm compared to 31% of those in the most affluent areas.

By Locality

**Table 55: Cold Homes by Locality**

<table>
<thead>
<tr>
<th>Locality</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central</td>
<td>25%</td>
</tr>
<tr>
<td>Eastern</td>
<td>34%</td>
</tr>
<tr>
<td>Northern</td>
<td>35%</td>
</tr>
<tr>
<td>Southern</td>
<td>36%</td>
</tr>
<tr>
<td>Western</td>
<td>32%</td>
</tr>
</tbody>
</table>

Thirty six percent of respondents in the Southern locality indicated that they couldn’t keep their homes warm (Table 55).
5. CHILD HEALTH

UPTAKE OF MEASLES, MUMPS AND RUBELLA (MMR) VACCINE

Immunisation is a way of protecting ourselves against serious disease. Once we have been immunised, our bodies can fight those diseases if we come into contact with them. MMR is the combined vaccine against measles, mumps and rubella. Children are given two doses of MMR to give better protection. After the first dose between 5% and 10% of children are not protected against the diseases. After two doses of MMR, less than 1% are left unprotected.

UPTAKE OF MMR VACCINE BY AGE OF 2 YEARS AMONG CHILDREN BORN BETWEEN 01.09.97 & 31.08.98 AS AT JULY 2004

<table>
<thead>
<tr>
<th>Sex</th>
<th>Percentage Uptake</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>90%</td>
</tr>
<tr>
<td>Female</td>
<td>89%</td>
</tr>
</tbody>
</table>

Table 56: Uptake of MMR Vaccine by Age 2 Years by Sex

Table 56 shows that there is little difference in uptake between the sexes.

By Level of Deprivation

Table 57: Uptake of MMR Vaccine by Age 2 Years by Level of Deprivation

<table>
<thead>
<tr>
<th>Level of Deprivation</th>
<th>Percentage Uptake</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most Affluent</td>
<td>90%</td>
</tr>
<tr>
<td>Intermediate</td>
<td>89%</td>
</tr>
<tr>
<td>Most Deprived</td>
<td>89%</td>
</tr>
</tbody>
</table>

Table 57 shows that there is little difference in uptake by level of deprivation.

By Locality

Table 58: Uptake of MMR Vaccine by Age 2 Years by Locality

<table>
<thead>
<tr>
<th>Locality</th>
<th>Percentage Uptake</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central</td>
<td>90%</td>
</tr>
<tr>
<td>Eastern</td>
<td>90%</td>
</tr>
<tr>
<td>Northern</td>
<td>91%</td>
</tr>
<tr>
<td>Southern</td>
<td>85%</td>
</tr>
<tr>
<td>Western</td>
<td>89%</td>
</tr>
</tbody>
</table>

The Southern locality has the lowest uptake (Table 58).

UPTAKE OF MMR BOOSTER VACCINE BY AGE OF 5 YEARS AMONG CHILDREN BORN BETWEEN 01.09.97 & 31.08.98 AS AT JULY 2004

<table>
<thead>
<tr>
<th>Sex</th>
<th>Percentage Uptake</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>90%</td>
</tr>
<tr>
<td>Female</td>
<td>89%</td>
</tr>
</tbody>
</table>

By Level of Deprivation

Table 57: Uptake of MMR Booster Vaccine by Age 5 Years by Level of Deprivation

<table>
<thead>
<tr>
<th>Level of Deprivation</th>
<th>Percentage Uptake</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most Affluent</td>
<td>90%</td>
</tr>
<tr>
<td>Intermediate</td>
<td>89%</td>
</tr>
<tr>
<td>Most Deprived</td>
<td>89%</td>
</tr>
</tbody>
</table>

Table 57 shows that there is little difference in uptake by level of deprivation.
By Sex

Table 59: Uptake of MMR Booster Vaccine by Age 5 Years by Sex

<table>
<thead>
<tr>
<th>Sex</th>
<th>Percentage Uptake</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>81%</td>
</tr>
<tr>
<td>Female</td>
<td>81%</td>
</tr>
</tbody>
</table>

Table 59 shows that there is no difference in uptake of MMR booster vaccine between the sexes.

By Level of Deprivation

Table 60: Uptake of MMR Booster Vaccine by Age 5 Years by Level of Deprivation

<table>
<thead>
<tr>
<th>Level of Deprivation</th>
<th>Percentage Uptake</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most Affluent</td>
<td>80%</td>
</tr>
<tr>
<td>Intermediate</td>
<td>82%</td>
</tr>
<tr>
<td>Most Deprived</td>
<td>82%</td>
</tr>
</tbody>
</table>

Table 60 shows that there is a lower uptake in the most affluent areas.

By Locality

Table 61: Uptake of MMR Booster Vaccine by Age 5 Years by Locality

<table>
<thead>
<tr>
<th>Locality</th>
<th>Percentage Uptake</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central</td>
<td>83%</td>
</tr>
<tr>
<td>Eastern</td>
<td>85%</td>
</tr>
<tr>
<td>Northern</td>
<td>76%</td>
</tr>
<tr>
<td>Southern</td>
<td>79%</td>
</tr>
<tr>
<td>Western</td>
<td>76%</td>
</tr>
</tbody>
</table>

The Northern and Western localities have the lowest uptake of MMR booster vaccine (Table 61).

ORAL HEALTH

Oral health is a standard of health of the oral and related tissues which enables an individual to eat, speak and socialise without active disease, discomfort or embarrassment and which contributes to general well-being.

The oral health data presented below is not available by sex.

DENTAL INSPECTIONS IN PRIMARY SCHOOLS

School dental inspections aim to identify children in need of dental treatment. The numbers of decayed teeth, teeth missing due to decay and filled teeth are recorded. A cumulative score of dental decay experience, namely the total number of decayed, missing or filled teeth (DMFT) for each child and, hence, an average DMFT for each group may then be calculated.

PERCENTAGE OF CHILDREN REFERRED FOR TREATMENT FOLLOWING DENTAL INSPECTION IN PRIMARY SCHOOLS IN 2003/04

| AT A PCT LEVEL, 18% OF CHILDREN ARE REFERRED FOR TREATMENT |
By Level of Deprivation

Table 62: Median Percentage of Children Referred for Treatment by Level of Deprivation

<table>
<thead>
<tr>
<th>Level of Deprivation</th>
<th>Median Percentage Referred</th>
<th>Percentage Min</th>
<th>Percentage Max</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most Affluent</td>
<td>12.6%</td>
<td>3.8%</td>
<td>24.0%</td>
</tr>
<tr>
<td>Intermediate</td>
<td>21.0%</td>
<td>4.7%</td>
<td>31.0%</td>
</tr>
<tr>
<td>Most Deprived</td>
<td>25.0%</td>
<td>12.5%</td>
<td>30.5%</td>
</tr>
</tbody>
</table>

Table 62 shows that the most deprived areas have double the average percentage of children referred for treatment compared to the most affluent areas.

By Locality

Table 63: Median Percentage of Children Referred for Treatment by Locality

<table>
<thead>
<tr>
<th>Locality</th>
<th>Median Percentage Referred</th>
<th>Percentage Min</th>
<th>Percentage Max</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central</td>
<td>17.0%</td>
<td>10.5%</td>
<td>23.6%</td>
</tr>
<tr>
<td>Eastern</td>
<td>25.0%</td>
<td>15.0%</td>
<td>25.0%</td>
</tr>
<tr>
<td>Northern</td>
<td>11.8%</td>
<td>10.6%</td>
<td>15.7%</td>
</tr>
<tr>
<td>Southern</td>
<td>12.1%</td>
<td>3.8%</td>
<td>24.0%</td>
</tr>
<tr>
<td>Western</td>
<td>11.7%</td>
<td>9.1%</td>
<td>16.4%</td>
</tr>
</tbody>
</table>

The Eastern locality has the highest average percentage of children referred for treatment (Table 63).

DECAYED, MISSING OR FILLED TEETH (DMFT) SCORE FOR 5 YEAR OLDS AND 8 YEAR OLDS

AT A PCT LEVEL, 5 YEAR OLDS HAVE AN AVERAGE OF 0.8 DECAYED, MISSING OR FILLED TEETH, AND 8 YEAR OLDS AN AVERAGE OF 1.5

By Level of Deprivation

Table 64: Median DMFT Score for 5 Year Olds and 8 Year Olds by Level of Deprivation

5 Year Olds

<table>
<thead>
<tr>
<th>Level of Deprivation</th>
<th>Median DMFT</th>
<th>DMFT Min</th>
<th>DMFT Max</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most Affluent</td>
<td>0.6</td>
<td>0.1</td>
<td>1.7</td>
</tr>
<tr>
<td>Intermediate</td>
<td>0.4</td>
<td>0.2</td>
<td>1.7</td>
</tr>
<tr>
<td>Most Deprived</td>
<td>0.9</td>
<td>0.7</td>
<td>1.6</td>
</tr>
</tbody>
</table>

Table 64 shows that for 5 year olds the most deprived areas have an average DMFT score more than twice that of the intermediate areas. At age 8 years, the average DMFT scores across the levels of deprivation are nearly the same. The increase in average DMFT score between 5 and 8 year olds is interesting. In the most affluent areas it has more than doubled, in the intermediate areas it has more than trebled, and in the most deprived areas it has increased about fifty per cent.

8 Year Olds

<table>
<thead>
<tr>
<th>Level of Deprivation</th>
<th>Median DMFT</th>
<th>DMFT Min</th>
<th>DMFT Max</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most Affluent</td>
<td>1.4</td>
<td>0.6</td>
<td>2.4</td>
</tr>
<tr>
<td>Intermediate</td>
<td>1.3</td>
<td>1.0</td>
<td>1.5</td>
</tr>
<tr>
<td>Most Deprived</td>
<td>1.4</td>
<td>1.1</td>
<td>1.8</td>
</tr>
</tbody>
</table>
By Locality

Table 65: Median DMFT Score for 5 Year Olds and 8 Year Olds by Locality

<table>
<thead>
<tr>
<th>Locality</th>
<th>Median DMFT</th>
<th>DMFT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Min</td>
<td>Max</td>
</tr>
<tr>
<td>Central</td>
<td>0.8</td>
<td>0.5</td>
</tr>
<tr>
<td>Eastern</td>
<td>0.7</td>
<td>0.2</td>
</tr>
<tr>
<td>Northern</td>
<td>1.1</td>
<td>0.1</td>
</tr>
<tr>
<td>Southern</td>
<td>0.3</td>
<td>0.2</td>
</tr>
<tr>
<td>Western</td>
<td>0.7</td>
<td>0.3</td>
</tr>
</tbody>
</table>

The Northern locality has the highest average DMFT score for 5 year olds and the Western locality for 8 year olds (Table 65). At age 5 years the Northern locality has a DMFT score nearly four times greater than the lowest scoring locality score (Southern locality). At ages 5 years and 8 years, the Southern locality has the lowest DMFT score. However, the biggest increase in DMFT scores between 5 and 8 years it also is the Southern locality (more than trebled).

8 Year Olds

<table>
<thead>
<tr>
<th>Locality</th>
<th>Median DMFT</th>
<th>DMFT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Min</td>
<td>Max</td>
</tr>
<tr>
<td>Central</td>
<td>1.7</td>
<td>1.2</td>
</tr>
<tr>
<td>Eastern</td>
<td>1.3</td>
<td>0.7</td>
</tr>
<tr>
<td>Northern</td>
<td>1.4</td>
<td>0.6</td>
</tr>
<tr>
<td>Southern</td>
<td>1.0</td>
<td>1.5</td>
</tr>
<tr>
<td>Western</td>
<td>1.8</td>
<td>1.2</td>
</tr>
</tbody>
</table>

OVERWEIGHT AT SCHOOL ENTRY

Children have their health monitored throughout the pre-school and school years. Full developmental and medical screening normally takes place before the age of 4 years. Assessment of height and weight is undertaken at school entry.

SPECIFIC BODY MASS INDEX CUT OFF POINTS

AT A PCT LEVEL, 15% OF CHILDREN AT SCHOOL ENTRY MEDICAL EXAMINATION WERE OVERWEIGHT * (4% OF THOSE WERE OBESE**)

* Children whose Body Mass Index exceeds 17.45 are considered overweight.
** Children whose Body Mass index exceeds 19.47 are considered obese.

By Sex

Table 66: Percentage of Children Born Between 01.09.96 and 31.08.98 Who Were Overweight and Obese at School Entry by Sex

<table>
<thead>
<tr>
<th>Sex</th>
<th>Percentage Overweight</th>
<th>Percentage Obese</th>
<th>Percentage Overweight Includes Obese</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>10%</td>
<td>3%</td>
<td>13%</td>
</tr>
<tr>
<td>Female</td>
<td>12%</td>
<td>4%</td>
<td>16%</td>
</tr>
</tbody>
</table>

Table 66 shows that more females are overweight and obese than males.
By Level of Deprivation

**Table 67: Percentage of Children Born Between 01.09.96 and 31.08.98 Who Were Overweight and Obese at School Entry by Level of Deprivation**

<table>
<thead>
<tr>
<th>Level of Deprivation</th>
<th>Percentage Overweight</th>
<th>Percentage Obese</th>
<th>Percentage Overweight Includes Obese</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most Affluent</td>
<td>12%</td>
<td>4%</td>
<td>16%</td>
</tr>
<tr>
<td>Intermediate</td>
<td>9%</td>
<td>2%</td>
<td>11%</td>
</tr>
<tr>
<td>Most Deprived</td>
<td>11%</td>
<td>4%</td>
<td>15%</td>
</tr>
</tbody>
</table>

Table 67 shows that the highest percentage of overweight and obese children at school entry are in the most affluent areas.

By Locality

**Table 68: Percentage of Children Born Between 01.09.96 and 31.08.98 Who Were Overweight and Obese at School Entry by Locality**

<table>
<thead>
<tr>
<th>Locality</th>
<th>Percentage Overweight</th>
<th>Percentage Obese</th>
<th>Percentage Overweight Includes Obese</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central</td>
<td>11%</td>
<td>3%</td>
<td>14%</td>
</tr>
<tr>
<td>Eastern</td>
<td>10%</td>
<td>3%</td>
<td>13%</td>
</tr>
<tr>
<td>Northern</td>
<td>18%</td>
<td>4%</td>
<td>22%</td>
</tr>
<tr>
<td>Southern</td>
<td>8%</td>
<td>1%</td>
<td>9%</td>
</tr>
<tr>
<td>Western</td>
<td>10%</td>
<td>7%</td>
<td>17%</td>
</tr>
</tbody>
</table>

The Northern locality has the highest percentage of children who are overweight (includes obese), Table 68.

**BODY MASS INDEX IN THE TOP 5%**

An alternative approach is to look at those children whose weight is in the top 5% (this would equate to a Body Mass Index greater than 18.8).

**AT A PCT LEVEL, 6% CHILDREN AT SCHOOL ENTRY WERE OVERWEIGHT**

By Sex

**Table 69: Percentage of Children Born Between 01.09.96 and 31.08.98 Whose Weight Was in the Top 5% at School Entry by Sex**

<table>
<thead>
<tr>
<th>Sex</th>
<th>Percentage in Top 5%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>5%</td>
</tr>
<tr>
<td>Female</td>
<td>7%</td>
</tr>
</tbody>
</table>

Table 69 shows that more females were in the top 5% than males.

By Level of Deprivation

**Table 70: Percentage of Children Born Between 01.09.96 and 31.08.98 Whose Weight Was in the Top 5% at School Entry by Level of Deprivation**

<table>
<thead>
<tr>
<th>Level of Deprivation</th>
<th>Percentage in Top 5%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most Affluent</td>
<td>6%</td>
</tr>
<tr>
<td>Intermediate</td>
<td>4%</td>
</tr>
<tr>
<td>Most Deprived</td>
<td>6%</td>
</tr>
</tbody>
</table>

The most affluent and the most deprived areas have the same percentage of children in the top 5% (Table 70).
By Locality

Table 71: Percentage of Children Born Between 01.09.96 and 31.08.98 Whose Weight Was in the Top 5% at School Entry by Locality

<table>
<thead>
<tr>
<th>Locality</th>
<th>Percentage in Top 5%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central</td>
<td>6%</td>
</tr>
<tr>
<td>Eastern</td>
<td>4%</td>
</tr>
<tr>
<td>Northern</td>
<td>8%</td>
</tr>
<tr>
<td>Southern</td>
<td>2%</td>
</tr>
<tr>
<td>Western</td>
<td>8%</td>
</tr>
</tbody>
</table>

The Northern and Western localities have the highest percentage of children in the top 5% (Table 71).
6. HOSPITAL ADMISSION

Directly standardised admission rates (DSAR), for a variety of conditions, for the three year period 2001/2-2003/4 are presented in this chapter. Rates have been rounded up or down as appropriate. Where the rate is less than 1 per 1,000 the specific rate is given.

CIRCULATORY DISEASES

**AT A PCT LEVEL, THE DIRECTLY STANDARDISED ADMISSION RATE PER YEAR FOR CIRCULATORY DISEASES IS 20 PER 1,000 POPULATION**

By Sex

**Table 72: DSAR for Circulatory Diseases by Sex**

<table>
<thead>
<tr>
<th>Sex</th>
<th>DSAR per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>25</td>
</tr>
<tr>
<td>Female</td>
<td>15</td>
</tr>
</tbody>
</table>

Table 72 shows that males have a higher DSAR for circulatory diseases than females.

By Age

**Table 73: DSAR for Circulatory Diseases by Age**

<table>
<thead>
<tr>
<th>Age</th>
<th>DSAR per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 65 yrs</td>
<td>6</td>
</tr>
<tr>
<td>65 yrs &amp; over</td>
<td>26</td>
</tr>
<tr>
<td>65-74 yrs</td>
<td>25</td>
</tr>
<tr>
<td>75 yrs &amp; over</td>
<td>27</td>
</tr>
</tbody>
</table>

Older people have a higher DSAR for circulatory diseases than younger people, with those 75 years and over having the highest DSAR (Table 73).

By Level of Deprivation

**Table 74: DSAR for Circulatory Diseases by Level of Deprivation**

<table>
<thead>
<tr>
<th>Level of Deprivation</th>
<th>DSAR per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most Affluent</td>
<td>19</td>
</tr>
<tr>
<td>Intermediate</td>
<td>20</td>
</tr>
<tr>
<td>Most Deprived</td>
<td>22</td>
</tr>
</tbody>
</table>

Table 74 shows that the most deprived areas have the highest DSAR.

By Locality

**Table 75: DSAR for Circulatory Diseases by Locality**

<table>
<thead>
<tr>
<th>Locality</th>
<th>DSAR per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central</td>
<td>21</td>
</tr>
<tr>
<td>Eastern</td>
<td>21</td>
</tr>
<tr>
<td>Northern</td>
<td>21</td>
</tr>
<tr>
<td>Southern</td>
<td>18</td>
</tr>
<tr>
<td>Western</td>
<td>17</td>
</tr>
</tbody>
</table>

The Southern and Western localities have the lowest DSARs (Table 75).
CORONARY HEART DISEASE

AT A PCT LEVEL, THE DIRECTLY STANDARDISED ADMISSION RATE PER YEAR FOR CORONARY HEART DISEASE IS 8 PER 1,000 POPULATION

By Sex

Table 76: DSAR for Coronary Heart Disease by Sex

<table>
<thead>
<tr>
<th>Sex</th>
<th>DSAR per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>11</td>
</tr>
<tr>
<td>Female</td>
<td>5</td>
</tr>
</tbody>
</table>

Table 76 shows that males have a higher DSAR for coronary heart disease than females.

By Age

Table 77: DSAR for Coronary Heart Disease by Age

<table>
<thead>
<tr>
<th>Age</th>
<th>DSAR per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 65 yrs</td>
<td>4</td>
</tr>
<tr>
<td>65 yrs &amp; over</td>
<td>5</td>
</tr>
<tr>
<td>65-74 yrs</td>
<td>3</td>
</tr>
<tr>
<td>75 yrs &amp; over</td>
<td>6</td>
</tr>
</tbody>
</table>

Older people have a higher DSAR for coronary heart disease than younger people (Table 77).

By Level of Deprivation

Table 78: DSAR for Coronary Heart Disease by Level of Deprivation

<table>
<thead>
<tr>
<th>Level of Deprivation</th>
<th>DSAR per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most Affluent</td>
<td>7</td>
</tr>
<tr>
<td>Intermediate</td>
<td>7</td>
</tr>
<tr>
<td>Most Deprived</td>
<td>9</td>
</tr>
</tbody>
</table>

Table 78 shows that the most deprived areas have the highest DSAR.

By Locality

Table 79: DSAR for Coronary Heart Disease by Locality

<table>
<thead>
<tr>
<th>Locality</th>
<th>DSAR per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central</td>
<td>8</td>
</tr>
<tr>
<td>Eastern</td>
<td>8</td>
</tr>
<tr>
<td>Northern</td>
<td>8</td>
</tr>
<tr>
<td>Southern</td>
<td>7</td>
</tr>
<tr>
<td>Western</td>
<td>6</td>
</tr>
</tbody>
</table>

The Southern and Western localities have the lowest DSARs (Table 79).

STROKE

AT A PCT LEVEL, THE DIRECTLY STANDARDISED ADMISSION RATE PER YEAR FOR STROKE IS 2 PER 1,000 POPULATION

By Sex

Table 80: DSAR for Stroke by Sex

<table>
<thead>
<tr>
<th>Sex</th>
<th>DSAR per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>2</td>
</tr>
<tr>
<td>Female</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 80 shows that males have a higher DSAR for stroke than females.
By Age

**Table 81: DSAR for Stroke by Age**

<table>
<thead>
<tr>
<th>Age</th>
<th>DSAR per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 65 yrs</td>
<td>0.3</td>
</tr>
<tr>
<td>65 yrs &amp; over</td>
<td>3</td>
</tr>
<tr>
<td>65-74 yrs</td>
<td>1</td>
</tr>
<tr>
<td>75 yrs &amp; over</td>
<td>4</td>
</tr>
</tbody>
</table>

Older people have a higher DSAR for stroke than younger people, with those 75 years and over having the highest DSAR (Table 81).

By Level of Deprivation

**Table 82: DSAR for Stroke by Level of Deprivation**

<table>
<thead>
<tr>
<th>Level of Deprivation</th>
<th>DSAR per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most Affluent</td>
<td>2</td>
</tr>
<tr>
<td>Intermediate</td>
<td>2</td>
</tr>
<tr>
<td>Most Deprived</td>
<td>2</td>
</tr>
</tbody>
</table>

Table 82 shows that the DSARs are the same across all levels of deprivation.

By Locality

**Table 83: DSAR for Stroke by Locality**

<table>
<thead>
<tr>
<th>Locality</th>
<th>DSAR per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central</td>
<td>2</td>
</tr>
<tr>
<td>Eastern</td>
<td>2</td>
</tr>
<tr>
<td>Northern</td>
<td>2</td>
</tr>
<tr>
<td>Southern</td>
<td>1</td>
</tr>
<tr>
<td>Western</td>
<td>2</td>
</tr>
</tbody>
</table>

The Southern locality has the lowest DSAR (Table 83).

**DIABETES**

**AT A PCT LEVEL, THE DIRECTLY STANDARDISED ADMISSION RATE PER YEAR FOR DIABETES IS 0.2 PER 1,000 POPULATION**

By Sex

**Table 84: DSAR for Diabetes by Sex**

<table>
<thead>
<tr>
<th>Sex</th>
<th>DSAR per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>0.4</td>
</tr>
<tr>
<td>Female</td>
<td>0.1</td>
</tr>
</tbody>
</table>

Table 84 shows that males have a higher DSAR for diabetes than females.

By Age

**Table 85: DSAR for Diabetes by Age**

<table>
<thead>
<tr>
<th>Age</th>
<th>DSAR per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 65 yrs</td>
<td>0.2</td>
</tr>
<tr>
<td>65 yrs &amp; over</td>
<td>0.2</td>
</tr>
<tr>
<td>65-74 yrs</td>
<td>0.1</td>
</tr>
<tr>
<td>75 yrs &amp; over</td>
<td>0.2</td>
</tr>
</tbody>
</table>

The DSAR for diabetes is the same for those under 65 years and those 65 years and over (Table 85).
By Level of Deprivation

*Table 86: DSAR for Diabetes by Level of Deprivation*

<table>
<thead>
<tr>
<th>Level of Deprivation</th>
<th>DSAR per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most Affluent</td>
<td>0.2</td>
</tr>
<tr>
<td>Intermediate</td>
<td>0.1</td>
</tr>
<tr>
<td>Most Deprived</td>
<td>0.2</td>
</tr>
</tbody>
</table>

There is little difference in the DSARs across the levels of deprivation (Table 86).

By Locality

*Table 87: DSAR for Diabetes by Locality*

<table>
<thead>
<tr>
<th>Locality</th>
<th>DSAR per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central</td>
<td>0.3</td>
</tr>
<tr>
<td>Eastern</td>
<td>0.1</td>
</tr>
<tr>
<td>Northern</td>
<td>0.2</td>
</tr>
<tr>
<td>Southern</td>
<td>0.2</td>
</tr>
<tr>
<td>Western</td>
<td>0.3</td>
</tr>
</tbody>
</table>

The Eastern locality has the lowest DSAR (Table 87).

**ASTHMA**

**AT A PCT LEVEL, THE DIRECTLY STANDARDISED ADMISSION RATE PER YEAR FOR ASTHMA IS 1 PER 1,000 POPULATION**

By Sex

*Table 88: DSAR for Asthma by Sex*

<table>
<thead>
<tr>
<th>Sex</th>
<th>DSAR per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>1</td>
</tr>
<tr>
<td>Female</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 88 shows that males and females have the same DSAR for asthma.

By Age

*Table 89: DSAR for Asthma by Age*

<table>
<thead>
<tr>
<th>Age</th>
<th>DSAR per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 65 yrs</td>
<td>0.8</td>
</tr>
<tr>
<td>65 yrs &amp; over</td>
<td>0.3</td>
</tr>
<tr>
<td>65-74 yrs</td>
<td>0.3</td>
</tr>
<tr>
<td>75 yrs &amp; over</td>
<td>0.3</td>
</tr>
</tbody>
</table>

People aged under 65 years and have the highest DSAR (Table 89).

By Level of Deprivation

*Table 90: DSAR for Asthma by Level of Deprivation*

<table>
<thead>
<tr>
<th>Level of Deprivation</th>
<th>DSAR per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most Affluent</td>
<td>1</td>
</tr>
<tr>
<td>Intermediate</td>
<td>1</td>
</tr>
<tr>
<td>Most Deprived</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 90 shows that the DSARs are the same across the levels of deprivation.
By Locality

Table 91: DSAR for Asthma by Locality

<table>
<thead>
<tr>
<th>Locality</th>
<th>DSAR per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central</td>
<td>1</td>
</tr>
<tr>
<td>Eastern</td>
<td>1</td>
</tr>
<tr>
<td>Northern</td>
<td>1</td>
</tr>
<tr>
<td>Southern</td>
<td>1</td>
</tr>
<tr>
<td>Western</td>
<td>0.7</td>
</tr>
</tbody>
</table>

The Western locality has the lowest DSAR (Table 91).

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

AT A PCT LEVEL, THE DIRECTLY STANDARDISED ADMISSION RATE PER YEAR FOR CHRONIC OBSTRUCTIVE PULMONARY DISEASE IS 2 PER 1,000 POPULATION

By Sex

Table 92: DSAR for Chronic Obstructive Pulmonary Disease by Sex

<table>
<thead>
<tr>
<th>Sex</th>
<th>DSAR per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>2</td>
</tr>
<tr>
<td>Female</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 92 shows that males have a higher DSAR for chronic obstructive pulmonary disease than females.

By Age

Table 93: DSAR for Chronic Obstructive Pulmonary Disease by Age

<table>
<thead>
<tr>
<th>Age</th>
<th>DSAR per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 65 yrs</td>
<td>0.2</td>
</tr>
<tr>
<td>65 yrs &amp; over</td>
<td>3</td>
</tr>
<tr>
<td>65-74 yrs</td>
<td>2</td>
</tr>
<tr>
<td>75 yrs &amp; over</td>
<td>3</td>
</tr>
</tbody>
</table>

Older people have a higher DSAR for chronic obstructive pulmonary disease than younger people (Table 93).

By Level of Deprivation

Table 94: DSAR for Chronic Obstructive Pulmonary Disease by Level of Deprivation

<table>
<thead>
<tr>
<th>Level of Deprivation</th>
<th>DSAR per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most Affluent</td>
<td>1</td>
</tr>
<tr>
<td>Intermediate</td>
<td>1</td>
</tr>
<tr>
<td>Most Deprived</td>
<td>3</td>
</tr>
</tbody>
</table>

Table 94 shows that the most deprived areas have the highest DSAR.

By Locality

Table 95: DSAR for Chronic Obstructive Pulmonary Disease by Locality

<table>
<thead>
<tr>
<th>Locality</th>
<th>DSAR per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central</td>
<td>2</td>
</tr>
<tr>
<td>Eastern</td>
<td>2</td>
</tr>
<tr>
<td>Northern</td>
<td>1</td>
</tr>
<tr>
<td>Southern</td>
<td>1</td>
</tr>
<tr>
<td>Western</td>
<td>0.9</td>
</tr>
</tbody>
</table>

The Western locality has the lowest DSAR (Table 95).
PNEUMONIA

AT A PCT LEVEL, THE DIRECTLY STANDARDISED ADMISSION RATE PER YEAR FOR PNEUMONIA IS 2 PER 1,000 POPULATION

By Sex

**Table 96: DSAR for Pneumonia by Sex**

<table>
<thead>
<tr>
<th>Sex</th>
<th>DSAR per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>2</td>
</tr>
<tr>
<td>Female</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 96 shows that males have a higher DSAR for pneumonia than females.

By Age

**Table 97: DSAR for Pneumonia by Age**

<table>
<thead>
<tr>
<th>Age</th>
<th>DSAR per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 65 yrs</td>
<td>0.5</td>
</tr>
<tr>
<td>65 yrs &amp; over</td>
<td>2</td>
</tr>
<tr>
<td>65-74 yrs</td>
<td>1</td>
</tr>
<tr>
<td>75 yrs &amp; over</td>
<td>4</td>
</tr>
</tbody>
</table>

Older people have a higher DSAR for pneumonia than younger people, with those 75 years and over having the highest DSAR (Table 97).

By Level of Deprivation

**Table 98: DSAR for Pneumonia by Level of Deprivation**

<table>
<thead>
<tr>
<th>Level of Deprivation</th>
<th>DSAR per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most Affluent</td>
<td>2</td>
</tr>
<tr>
<td>Intermediate</td>
<td>2</td>
</tr>
<tr>
<td>Most Deprived</td>
<td>2</td>
</tr>
</tbody>
</table>

Table 98 shows that the DSARs are the same across the levels of deprivation.

By Locality

**Table 99: DSAR for Pneumonia by Locality**

<table>
<thead>
<tr>
<th>Locality</th>
<th>DSAR per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central</td>
<td>2</td>
</tr>
<tr>
<td>Eastern</td>
<td>2</td>
</tr>
<tr>
<td>Northern</td>
<td>2</td>
</tr>
<tr>
<td>Southern</td>
<td>2</td>
</tr>
<tr>
<td>Western</td>
<td>1</td>
</tr>
</tbody>
</table>

The Western locality has the lowest DSAR (Table 99).

MENTAL ILLNESS

AT A PCT LEVEL, THE DIRECTLY STANDARDISED ADMISSION RATE PER YEAR FOR MENTAL ILLNESS IS 4 PER 1,000 POPULATION

By Sex

**Table 100: DSAR for Mental Illness by Sex**

<table>
<thead>
<tr>
<th>Sex</th>
<th>DSAR per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>4</td>
</tr>
<tr>
<td>Female</td>
<td>4</td>
</tr>
</tbody>
</table>

Table 100 shows that there is no difference in the DSARs for mental illness between males and females.
By Age

Table 101: DSAR for Mental Illness by Age

<table>
<thead>
<tr>
<th>Age</th>
<th>DSAR per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 65 yrs</td>
<td>2</td>
</tr>
<tr>
<td>65 yrs &amp; over</td>
<td>2</td>
</tr>
<tr>
<td>65-74 yrs</td>
<td>2</td>
</tr>
<tr>
<td>75 yrs &amp; over</td>
<td>2</td>
</tr>
</tbody>
</table>

The DSAR for mental illness is the same for all the age groups (Table 101).

By Level of Deprivation

Table 102: DSAR for Mental Illness by Level of Deprivation

<table>
<thead>
<tr>
<th>Level of Deprivation</th>
<th>DSAR per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most Affluent</td>
<td>3</td>
</tr>
<tr>
<td>Intermediate</td>
<td>5</td>
</tr>
<tr>
<td>Most Deprived</td>
<td>5</td>
</tr>
</tbody>
</table>

Table 102 shows that the most affluent areas have the lowest DSAR.

By Locality

Table 103: DSAR for Mental Illness by Locality

<table>
<thead>
<tr>
<th>Locality</th>
<th>DSAR per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central</td>
<td>3</td>
</tr>
<tr>
<td>Eastern</td>
<td>4</td>
</tr>
<tr>
<td>Northern</td>
<td>4</td>
</tr>
<tr>
<td>Southern</td>
<td>5</td>
</tr>
<tr>
<td>Western</td>
<td>3</td>
</tr>
</tbody>
</table>

The Southern locality has the highest DSAR (Table 103).

ACCIDENTS

At a PCT level, the directly standardised admission rate per year for accidents is 10 per 1,000 population

By Sex

Table 104: DSAR for Accidents by Sex

<table>
<thead>
<tr>
<th>Sex</th>
<th>DSAR per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>10</td>
</tr>
<tr>
<td>Female</td>
<td>9</td>
</tr>
</tbody>
</table>

Table 104 shows that males have a higher DSAR for accidents than females.

By Age

Table 105: DSAR for Accidents by Age

<table>
<thead>
<tr>
<th>Age</th>
<th>DSAR per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 65 yrs</td>
<td>5</td>
</tr>
<tr>
<td>65 yrs &amp; over</td>
<td>7</td>
</tr>
<tr>
<td>65-74 yrs</td>
<td>4</td>
</tr>
<tr>
<td>75 yrs &amp; over</td>
<td>10</td>
</tr>
</tbody>
</table>

Older people have a higher DSAR for accidents than younger people, with those 75 years and over having the highest DSAR (Table 105).
By Level of Deprivation

*Table 106: DSAR for Accidents by Level of Deprivation*

<table>
<thead>
<tr>
<th>Level of Deprivation</th>
<th>DSAR per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most Affluent</td>
<td>9</td>
</tr>
<tr>
<td>Intermediate</td>
<td>10</td>
</tr>
<tr>
<td>Most Deprived</td>
<td>12</td>
</tr>
</tbody>
</table>

Table 106 shows that the most deprived areas have the highest DSAR.

By Locality

*Table 107: DSAR for Accidents by Locality*

<table>
<thead>
<tr>
<th>Locality</th>
<th>DSAR per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central</td>
<td>9</td>
</tr>
<tr>
<td>Eastern</td>
<td>11</td>
</tr>
<tr>
<td>Northern</td>
<td>10</td>
</tr>
<tr>
<td>Southern</td>
<td>10</td>
</tr>
<tr>
<td>Western</td>
<td>9</td>
</tr>
</tbody>
</table>

The Eastern locality has the highest DSAR (Table 107).

**FALLS**

**AT A PCT LEVEL, THE DIRECTLY STANDARDISED ADMISSION RATE PER YEAR FOR FALLS IS 19 PER 1,000 POPULATION 65 YEARS AND OVER**

By Sex

*Table 108: DSAR for Falls by Sex*

<table>
<thead>
<tr>
<th>Sex</th>
<th>DSAR per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>14</td>
</tr>
<tr>
<td>Female</td>
<td>23</td>
</tr>
</tbody>
</table>

Table 108 shows that females have a higher DSAR for falls than males.

By Age

*Table 109: DSAR for Falls by Age*

<table>
<thead>
<tr>
<th>Age</th>
<th>DSAR per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>65 yrs &amp; over</td>
<td>19</td>
</tr>
<tr>
<td>65-74 yrs &amp; over</td>
<td>3</td>
</tr>
<tr>
<td>75 yrs &amp; over</td>
<td>16</td>
</tr>
</tbody>
</table>

Of those people 65 years and over, it's those 75 years and over that have the highest DSAR (Table 109).

By Level of Deprivation

*Table 110: DSAR for Falls by Level of Deprivation*

<table>
<thead>
<tr>
<th>Level of Deprivation</th>
<th>DSAR per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most Affluent</td>
<td>18</td>
</tr>
<tr>
<td>Intermediate</td>
<td>21</td>
</tr>
<tr>
<td>Most Deprived</td>
<td>22</td>
</tr>
</tbody>
</table>

Table 110 shows that the most deprived areas have the highest DSAR.
By Locality

Table 111: DSAR for Falls by Locality

<table>
<thead>
<tr>
<th>Locality</th>
<th>DSAR per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central</td>
<td>19</td>
</tr>
<tr>
<td>Eastern</td>
<td>20</td>
</tr>
<tr>
<td>Northern</td>
<td>20</td>
</tr>
<tr>
<td>Southern</td>
<td>21</td>
</tr>
<tr>
<td>Western</td>
<td>16</td>
</tr>
</tbody>
</table>

The Southern locality has the highest DSAR (Table 111).

EMERGENCY ADMISSION (ANY CONDITION)

AT A PCT LEVEL, THE DIRECTLY STANDARDISED ADMISSION RATE PER YEAR FOR EMERGENCY ADMISSIONS IS 72 PER 1,000 POPULATION

By Sex

Table 112: DSAR for Emergency Admissions by Sex

<table>
<thead>
<tr>
<th>Sex</th>
<th>DSAR per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>77</td>
</tr>
<tr>
<td>Female</td>
<td>68</td>
</tr>
</tbody>
</table>

Table 112 shows that males have a higher DSAR for emergency admissions than females.

By Age

Table 113: DSAR for Emergency Admissions by Age

<table>
<thead>
<tr>
<th>Age</th>
<th>DSAR per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 65 yrs</td>
<td>32</td>
</tr>
<tr>
<td>65 yrs &amp; over</td>
<td>67</td>
</tr>
<tr>
<td>65-74 yrs</td>
<td>47</td>
</tr>
<tr>
<td>75 yrs &amp; over</td>
<td>83</td>
</tr>
</tbody>
</table>

Older people have a higher DSAR for emergency admissions than younger people, with those 75 years and over having the highest DSAR (Table 113).

By Level of Deprivation

Table 114: DSAR for Emergency Admissions by Level of Deprivation

<table>
<thead>
<tr>
<th>Level of Deprivation</th>
<th>DSAR per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most Affluent</td>
<td>65</td>
</tr>
<tr>
<td>Intermediate</td>
<td>75</td>
</tr>
<tr>
<td>Most Deprived</td>
<td>86</td>
</tr>
</tbody>
</table>

Table 114 shows that the most deprived areas have the highest DSAR.

By Locality

Table 115: DSAR for Emergency Admissions by Locality

<table>
<thead>
<tr>
<th>Locality</th>
<th>DSAR per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central</td>
<td>73</td>
</tr>
<tr>
<td>Eastern</td>
<td>81</td>
</tr>
<tr>
<td>Northern</td>
<td>71</td>
</tr>
<tr>
<td>Southern</td>
<td>68</td>
</tr>
<tr>
<td>Western</td>
<td>58</td>
</tr>
</tbody>
</table>

The Eastern locality has the highest DSAR (Table 115).
CATARACTS

AT A PCT LEVEL, THE DIRECTLY STANDARDISED ADMISSION RATE PER YEAR FOR CATARACT OPERATIONS IS 6 PER 1,000 POPULATION

By Sex

Table 116: DSAR for Cataract Operations by Sex

<table>
<thead>
<tr>
<th>Sex</th>
<th>DSAR per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>5</td>
</tr>
<tr>
<td>Female</td>
<td>7</td>
</tr>
</tbody>
</table>

Table 116 shows that females have a higher DSAR for cataract operations than males.

By Age

Table 117: DSAR for Cataract Operations by Age

<table>
<thead>
<tr>
<th>Age</th>
<th>DSAR per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 65 yrs</td>
<td>0.7</td>
</tr>
<tr>
<td>65 yrs &amp; over</td>
<td>12</td>
</tr>
<tr>
<td>65-74 yrs</td>
<td>7</td>
</tr>
<tr>
<td>75 yrs &amp; over</td>
<td>17</td>
</tr>
</tbody>
</table>

Older people have a higher DSAR for cataract operations than younger people, with those 75 years and over having the highest DSAR (Table 117).

By Level of Deprivation

Table 118: DSAR for Cataract Operations by Level of Deprivation

<table>
<thead>
<tr>
<th>Level of Deprivation</th>
<th>DSAR per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most Affluent</td>
<td>6</td>
</tr>
<tr>
<td>Intermediate</td>
<td>6</td>
</tr>
<tr>
<td>Most Deprived</td>
<td>7</td>
</tr>
</tbody>
</table>

Table 118 shows that the most deprived areas have the highest DSAR.

By Locality

Table 119: DSAR for Cataract Operations by Locality

<table>
<thead>
<tr>
<th>Locality</th>
<th>DSAR per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central</td>
<td>7</td>
</tr>
<tr>
<td>Eastern</td>
<td>7</td>
</tr>
<tr>
<td>Northern</td>
<td>6</td>
</tr>
<tr>
<td>Southern</td>
<td>6</td>
</tr>
<tr>
<td>Western</td>
<td>5</td>
</tr>
</tbody>
</table>

The Central and Eastern localities have the highest DSARs (Table 119).

HIP AND KNEE REPLACEMENTS

AT A PCT LEVEL, THE DIRECTLY STANDARDISED ADMISSION RATES PER YEAR FOR HIP AND KNEE REPLACEMENTS ARE 4 PER 1,000 POPULATION
By Sex

Table 120: DSAR for Hip and Knee Replacements by Sex

<table>
<thead>
<tr>
<th>Sex</th>
<th>DSAR per 1,000 Hip Replacement</th>
<th>DSAR per 1,000 Knee Replacement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Female</td>
<td>4</td>
<td>4</td>
</tr>
</tbody>
</table>

Table 120 shows that for hip replacements females have a higher DSAR than males, but for knee replacements males and females have the same DSAR.

By Age

Table 121: DSAR for Hip and Knee Replacements by Age

<table>
<thead>
<tr>
<th>Age</th>
<th>DSAR per 1,000 Hip Replacement</th>
<th>DSAR per 1,000 Knee Replacement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 65 yrs</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>65 yrs &amp; over</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>65-74 yrs</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>75 yrs &amp; over</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

Older people have a higher DSAR for both hip and knee replacements than younger people (Table 121).

By Level of Deprivation

Table 122: DSAR for Hip and Knee Replacements by Level of Deprivation

<table>
<thead>
<tr>
<th>Level of Deprivation</th>
<th>DSAR per 1,000 Hip Replacement</th>
<th>DSAR per 1,000 Knee Replacement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most Affluent</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Intermediate</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Most Deprived</td>
<td>4</td>
<td>4</td>
</tr>
</tbody>
</table>

Table 122 shows that intermediate areas have the lowest DSAR for hip replacements and also that the DSAR for knee replacements is the same across the levels of deprivation.

By Locality

Table 123: DSAR for Hip and Knee Replacements by Locality

<table>
<thead>
<tr>
<th>Locality</th>
<th>DSAR per 1,000 Hip Replacement</th>
<th>DSAR per 1,000 Knee Replacement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Eastern</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Northern</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Southern</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Western</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

The Southern locality has the joint lowest DSAR for hip replacements and the lowest DSAR for knee replacements (Table 123).

PERCUTANEOUS TRANSLUMINAL CORONARY ANGIOPLASTY (PTCA) AND CORONARY ARTERY BYPASS GRAFT (CABG)

AT A PCT LEVEL, THE DIRECTLY STANDARDISED ADMISSION RATES PER YEAR FOR PTCA AND CABG ARE 1 PER 1,000 POPULATION AND 0.5 PER 1,000 POPULATION RESPECTIVELY
By Sex

Table 124: DSAR for PTCA and CABG by Sex

<table>
<thead>
<tr>
<th>Sex</th>
<th>DSAR per 1,000 PTCA</th>
<th>DSAR per 1,000 CABG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Female</td>
<td>0.5</td>
<td>0.2</td>
</tr>
</tbody>
</table>

Table 124 shows that for both PTCA and CABG males have a higher DSAR than females.

By Age

Table 125: DSAR for PTCA and CABG by Age

<table>
<thead>
<tr>
<th>Age</th>
<th>DSAR per 1,000 PTCA</th>
<th>DSAR per 1,000 CABG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 65 yrs</td>
<td>2</td>
<td>0.2</td>
</tr>
<tr>
<td>65 yrs &amp; over</td>
<td>5</td>
<td>0.8</td>
</tr>
<tr>
<td>65-74 yrs</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>75 yrs &amp; over</td>
<td>6</td>
<td>0.5</td>
</tr>
</tbody>
</table>

Older people have a higher DSAR for both PTCA and CABG than younger people (Table 125).

By Level of Deprivation

Table 126: DSAR for PTCA and CABG by Level of Deprivation

<table>
<thead>
<tr>
<th>Level of Deprivation</th>
<th>DSAR per 1,000 PTCA</th>
<th>DSAR per 1,000 CABG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most Affluent</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>Intermediate</td>
<td>0.9</td>
<td>0.5</td>
</tr>
<tr>
<td>Most Deprived</td>
<td>1</td>
<td>0.7</td>
</tr>
</tbody>
</table>

Table 126 shows that the most deprived areas have the lowest DSAR for CABG.

By Locality

Table 127: DSAR for PTCA and CABG by Locality

<table>
<thead>
<tr>
<th>Locality</th>
<th>DSAR per 1,000 PTCA</th>
<th>DSAR per 1,000 CABG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>Eastern</td>
<td>1</td>
<td>0.6</td>
</tr>
<tr>
<td>Northern</td>
<td>1</td>
<td>0.6</td>
</tr>
<tr>
<td>Southern</td>
<td>0.9</td>
<td>0.5</td>
</tr>
<tr>
<td>Western</td>
<td>0.9</td>
<td>0.5</td>
</tr>
</tbody>
</table>

The Eastern and Northern localities have the highest DSARs for PTCA and CABG (Table 127).
7. MORTALITY

This chapter presents directly standardised mortality rates (DSMR) from a variety of causes for the three year period 2000-2003. Rates have been rounded up or down as appropriate except for breast cancer, lung cancer, colorectal cancer and suicide where the specific rate is given as the numbers are very small. Also where the rate is less than 1 per 1,000 the specific rate is given.

ALL CAUSES

<table>
<thead>
<tr>
<th>Sex</th>
<th>DSMR per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>18</td>
</tr>
<tr>
<td>Female</td>
<td>13</td>
</tr>
</tbody>
</table>

Table 128 shows that males have a higher DSMR from all causes than females.

By Age

Table 129: DSMR from All Causes by Age

<table>
<thead>
<tr>
<th>Age</th>
<th>DSMR per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 65 yrs</td>
<td>2</td>
</tr>
<tr>
<td>65 yrs &amp; over</td>
<td>54</td>
</tr>
<tr>
<td>65-74 yrs</td>
<td>19</td>
</tr>
<tr>
<td>75 yrs &amp; over</td>
<td>83</td>
</tr>
</tbody>
</table>

Older people have a higher DSMR from all causes than younger people, with those 75 years and over having the highest DSMR (Table 129).

By Level of Deprivation

Table 130: DSMR from All Causes by Level of Deprivation

<table>
<thead>
<tr>
<th>Level of Deprivation</th>
<th>DSMR per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most Affluent</td>
<td>14</td>
</tr>
<tr>
<td>Intermediate</td>
<td>15</td>
</tr>
<tr>
<td>Most Deprived</td>
<td>17</td>
</tr>
</tbody>
</table>

Table 130 shows that the most affluent areas have the lowest DSMR.

By Locality

Table 131: DSMR from All Causes by Locality

<table>
<thead>
<tr>
<th>Locality</th>
<th>DSMR per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central</td>
<td>14</td>
</tr>
<tr>
<td>Eastern</td>
<td>14</td>
</tr>
<tr>
<td>Northern</td>
<td>17</td>
</tr>
<tr>
<td>Southern</td>
<td>15</td>
</tr>
<tr>
<td>Western</td>
<td>14</td>
</tr>
</tbody>
</table>

The Northern locality has the highest DSMR (Table 131).
CIRCULATORY DISEASES

AT A PCT LEVEL, THE AVERAGE ANNUAL DEATH RATE FROM CIRCULATORY DISEASES IS 7 PER 1,000 POPULATION

By Sex

Table 132: DSMR from Circulatory Diseases by Sex

<table>
<thead>
<tr>
<th>Sex</th>
<th>DSMR per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>8</td>
</tr>
<tr>
<td>Female</td>
<td>6</td>
</tr>
</tbody>
</table>

Table 132 shows that males have a higher DSMR from circulatory diseases than females.

By Age

Table 133: DSMR from Circulatory Diseases by Age

<table>
<thead>
<tr>
<th>Age</th>
<th>DSMR per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 65 yrs</td>
<td>0.5</td>
</tr>
<tr>
<td>65 yrs &amp; over</td>
<td>25</td>
</tr>
<tr>
<td>65-74 yrs</td>
<td>7</td>
</tr>
<tr>
<td>75 yrs &amp; over</td>
<td>40</td>
</tr>
</tbody>
</table>

Older people have a higher DSMR from circulatory diseases than younger people, with those 75 years and over having the highest DSMR (Table 133).

By Level of Deprivation

Table 134: DSMR from Circulatory Diseases by Level of Deprivation

<table>
<thead>
<tr>
<th>Level of Deprivation</th>
<th>DSMR per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most Affluent</td>
<td>6</td>
</tr>
<tr>
<td>Intermediate</td>
<td>7</td>
</tr>
<tr>
<td>Most Deprived</td>
<td>7</td>
</tr>
</tbody>
</table>

Table 134 shows that the most affluent areas have the lowest DSMR.

By Locality

Table 135: DSMR from Circulatory Diseases by Locality

<table>
<thead>
<tr>
<th>Locality</th>
<th>DSMR per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central</td>
<td>7</td>
</tr>
<tr>
<td>Eastern</td>
<td>6</td>
</tr>
<tr>
<td>Northern</td>
<td>7</td>
</tr>
<tr>
<td>Southern</td>
<td>7</td>
</tr>
<tr>
<td>Western</td>
<td>6</td>
</tr>
</tbody>
</table>

Table 135 shows that the Central, Northern and Southern localities have the highest DSMR.

CORONARY HEART DISEASE

AT A PCT LEVEL, THE AVERAGE ANNUAL DATE RATE FROM CORONARY HEART DISEASE IS 3 PER 1,000 POPULATION

By Sex

Table 136: DSMR from Coronary Heart Disease by Sex

<table>
<thead>
<tr>
<th>Sex</th>
<th>DSMR per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>4</td>
</tr>
<tr>
<td>Female</td>
<td>2</td>
</tr>
</tbody>
</table>

Table 136 shows that males have a higher DSMR from coronary heart disease than females.
By Age

**Table 137: DSMR from Coronary Heart Disease by Age**

<table>
<thead>
<tr>
<th>Age</th>
<th>DSMR per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 65 yrs</td>
<td>0.3</td>
</tr>
<tr>
<td>65 yrs &amp; over</td>
<td>11</td>
</tr>
<tr>
<td>65-74 yrs</td>
<td>4</td>
</tr>
<tr>
<td>75 yrs &amp; over</td>
<td>16</td>
</tr>
</tbody>
</table>

Older people have a higher DSMR from coronary heart disease than younger people with those 75 years and over having the highest DSMR (Table 137).

By Level of Deprivation

**Table 138: DSMR from Coronary Heart Disease by Level of Deprivation**

<table>
<thead>
<tr>
<th>Level of Deprivation</th>
<th>DSMR per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most Affluent</td>
<td>3</td>
</tr>
<tr>
<td>Intermediate</td>
<td>3</td>
</tr>
<tr>
<td>Most Deprived</td>
<td>3</td>
</tr>
</tbody>
</table>

Table 138 shows that there is no difference in the DSMRs across the three levels of deprivation.

By Locality

**Table 139: DSMR from Coronary Heart Disease by Locality**

<table>
<thead>
<tr>
<th>Locality</th>
<th>DSMR per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central</td>
<td>3</td>
</tr>
<tr>
<td>Eastern</td>
<td>3</td>
</tr>
<tr>
<td>Northern</td>
<td>3</td>
</tr>
<tr>
<td>Southern</td>
<td>3</td>
</tr>
<tr>
<td>Western</td>
<td>3</td>
</tr>
</tbody>
</table>

Table 139 shows that there is no difference in the DSMRs across the four localities.

**ALL CANCER**

**AT A PCT LEVEL, THE AVERAGE ANNUAL DEATH RATE FROM CANCER IS 4 PER 1,000 POPULATION**

By Sex

**Table 140: DSMR from Cancer by Sex**

<table>
<thead>
<tr>
<th>Sex</th>
<th>DSMR per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>5</td>
</tr>
<tr>
<td>Female</td>
<td>3</td>
</tr>
</tbody>
</table>

Table 140 shows that males have a higher DSMR from cancer than females.

By Age

**Table 141: DSMR from Cancer by Age**

<table>
<thead>
<tr>
<th>Age</th>
<th>DSMR per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 65 yrs</td>
<td>0.8</td>
</tr>
<tr>
<td>65 yrs &amp; over</td>
<td>13</td>
</tr>
<tr>
<td>65-74 yrs</td>
<td>8</td>
</tr>
<tr>
<td>75 yrs &amp; over</td>
<td>17</td>
</tr>
</tbody>
</table>

Older people have a higher DSMR from cancer than younger people, with those 75 years and over having the highest DSMR (Table 141).
By Level of Deprivation

Table 142: DSMR from Cancer by Level of Deprivation

<table>
<thead>
<tr>
<th>Level of Deprivation</th>
<th>DSMR per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most Affluent</td>
<td>4</td>
</tr>
<tr>
<td>Intermediate</td>
<td>4</td>
</tr>
<tr>
<td>Most Deprived</td>
<td>4</td>
</tr>
</tbody>
</table>

Table 142 shows that there is no difference in the DSMRs across the three levels of deprivation.

By Locality

Table 143: DSMR from Cancer by Locality

<table>
<thead>
<tr>
<th>Locality</th>
<th>DSMR per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central</td>
<td>4</td>
</tr>
<tr>
<td>Eastern</td>
<td>4</td>
</tr>
<tr>
<td>Northern</td>
<td>4</td>
</tr>
<tr>
<td>Southern</td>
<td>3</td>
</tr>
<tr>
<td>Western</td>
<td>3</td>
</tr>
</tbody>
</table>

Southern and Western localities have the lowest DSMRs (Table 143).

BREAST CANCER

AT PCT LEVEL, THE AVERAGE ANNUAL DEATH RATE FROM BREAST CANCER IS 0.6 PER 1,000 POPULATION

By Age

Table 144: DSMR from Breast Cancer by Age

<table>
<thead>
<tr>
<th>Age</th>
<th>DSMR per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 65 yrs</td>
<td>0.2</td>
</tr>
<tr>
<td>65 yrs &amp; over</td>
<td>2</td>
</tr>
<tr>
<td>65-74 yrs</td>
<td>0.9</td>
</tr>
<tr>
<td>75 yrs &amp; over</td>
<td>2</td>
</tr>
</tbody>
</table>

Older women have a higher DSMR from breast cancer than younger women (Table 144).

By Level of Deprivation

Table 145: DSMR from Breast Cancer by Level of Deprivation

<table>
<thead>
<tr>
<th>Level of Deprivation</th>
<th>DSMR per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most Affluent</td>
<td>0.6</td>
</tr>
<tr>
<td>Intermediate</td>
<td>0.5</td>
</tr>
<tr>
<td>Most Deprived</td>
<td>0.7</td>
</tr>
</tbody>
</table>

Table 145 shows that the most deprived areas have the highest DSMR.

By Locality

Table 146: DSMR from Breast Cancer by Locality

<table>
<thead>
<tr>
<th>Locality</th>
<th>DSMR per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central</td>
<td>0.6</td>
</tr>
<tr>
<td>Eastern</td>
<td>0.6</td>
</tr>
<tr>
<td>Northern</td>
<td>0.7</td>
</tr>
<tr>
<td>Southern</td>
<td>0.5</td>
</tr>
<tr>
<td>Western</td>
<td>0.6</td>
</tr>
</tbody>
</table>

Table 146 shows that the Southern locality has the lowest DSMR.
LUNG CANCER

AT A PCT LEVEL, THE AVERAGE ANNUAL DEATH RATE FROM LUNG CANCER IS 0.6 PER 1,000 POPULATION

By Sex

Table 147: DSMR from Lung Cancer by Sex

<table>
<thead>
<tr>
<th>Sex</th>
<th>DSMR per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>0.9</td>
</tr>
<tr>
<td>Female</td>
<td>0.4</td>
</tr>
</tbody>
</table>

Table 147 shows that males have a higher DSMR from lung cancer than females.

By Age

Table 148: DSMR from Lung Cancer by Age

<table>
<thead>
<tr>
<th>Age</th>
<th>DSMR per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 65 yrs</td>
<td>0.1</td>
</tr>
<tr>
<td>65 yrs &amp; over</td>
<td>2</td>
</tr>
<tr>
<td>65-74 yrs</td>
<td>1</td>
</tr>
<tr>
<td>75 yrs &amp; over</td>
<td>2</td>
</tr>
</tbody>
</table>

Older people have a higher DSMR from lung cancer than younger people (Table 148).

By Level of Deprivation

Table 149: DSMR from Lung Cancer by Level of Deprivation

<table>
<thead>
<tr>
<th>Level of Deprivation</th>
<th>DSMR per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most Affluent</td>
<td>0.6</td>
</tr>
<tr>
<td>Intermediate</td>
<td>0.5</td>
</tr>
<tr>
<td>Most Deprived</td>
<td>0.8</td>
</tr>
</tbody>
</table>

The most deprived areas have the highest DSMR (Table 149).

By Locality

Table 150: DSMR from Lung Cancer by Locality

<table>
<thead>
<tr>
<th>Locality</th>
<th>DSMR per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central</td>
<td>0.6</td>
</tr>
<tr>
<td>Eastern</td>
<td>0.6</td>
</tr>
<tr>
<td>Northern</td>
<td>0.7</td>
</tr>
<tr>
<td>Southern</td>
<td>0.5</td>
</tr>
<tr>
<td>Western</td>
<td>0.6</td>
</tr>
</tbody>
</table>

There isn’t a great deal of difference between the DSMRs across the localities, however, the Northern locality does have the highest DSMR (Table 150).

COLORECTAL CANCER

AT A PCT LEVEL, THE AVERAGE ANNUAL DEATH RATE FROM COLORECTAL CANCER IS 0.4 PER 1,000 POPULATION

By Sex

Table 151: DSMR from Colorectal Cancer by Sex

<table>
<thead>
<tr>
<th>Sex</th>
<th>DSMR per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>0.5</td>
</tr>
<tr>
<td>Female</td>
<td>0.3</td>
</tr>
</tbody>
</table>

Table 151 shows that males have a higher DSMR from colorectal cancer than females.
By Age

Table 152: DSMR from Colorectal Cancer by Age

<table>
<thead>
<tr>
<th>Age</th>
<th>DSMR per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 65 yrs</td>
<td>0.1</td>
</tr>
<tr>
<td>65 yrs &amp; over</td>
<td>1</td>
</tr>
<tr>
<td>65-74 yrs</td>
<td>0.8</td>
</tr>
<tr>
<td>75 yrs &amp; over</td>
<td>2</td>
</tr>
</tbody>
</table>

Older people have a higher DSMR from colorectal cancer than younger people (Table 152).

By Level of Deprivation

Table 153: DSMR from Colorectal Cancer by Level of Deprivation

<table>
<thead>
<tr>
<th>Level of Deprivation</th>
<th>DSMR per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most Affluent</td>
<td>0.4</td>
</tr>
<tr>
<td>Intermediate</td>
<td>0.4</td>
</tr>
<tr>
<td>Most Deprived</td>
<td>0.4</td>
</tr>
</tbody>
</table>

Table 153 shows there is no difference in the DSMR across the levels of deprivation.

By Locality

Table 154: DSMR from Colorectal Cancer by Locality

<table>
<thead>
<tr>
<th>Locality</th>
<th>DSMR per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central</td>
<td>0.5</td>
</tr>
<tr>
<td>Eastern</td>
<td>0.4</td>
</tr>
<tr>
<td>Northern</td>
<td>0.5</td>
</tr>
<tr>
<td>Southern</td>
<td>0.4</td>
</tr>
<tr>
<td>Western</td>
<td>0.3</td>
</tr>
</tbody>
</table>

Table 154 shows that the Western locality has the lowest DSMR.

SUICIDE AND INJURY OF UNDETERMINED INTENT

At a PCT level, the average annual death rate from suicide & injury of undetermined intent is 0.1 per 1,000 population

By Sex

Table 155: DSMR from Suicide & Injury of Undetermined Intent by Sex

<table>
<thead>
<tr>
<th>Sex</th>
<th>DSMR per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>0.2</td>
</tr>
<tr>
<td>Female</td>
<td>0.1</td>
</tr>
</tbody>
</table>

Table 155 shows that males have a higher DSMR from suicide and injury of undetermined intent than females.

By Age

Table 156: DSMR from Suicide & Injury of Undetermined Intent by Age

<table>
<thead>
<tr>
<th>Age</th>
<th>DSMR per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 65 yrs</td>
<td>0.1</td>
</tr>
<tr>
<td>65 yrs &amp; over</td>
<td>0.2</td>
</tr>
<tr>
<td>65-74 yrs</td>
<td>0.1</td>
</tr>
<tr>
<td>75 yrs &amp; over</td>
<td>0.2</td>
</tr>
</tbody>
</table>

Table 156 shows that older people have a higher DSMR from suicide & injury of undetermined intent than younger people.
By Level of Deprivation

Table 157: DSMR from Suicide & Injury of Undetermined Intent by Level of Deprivation

<table>
<thead>
<tr>
<th>Level of Deprivation</th>
<th>DSMR per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most Affluent</td>
<td>0.1</td>
</tr>
<tr>
<td>Intermediate</td>
<td>0.2</td>
</tr>
<tr>
<td>Most Deprived</td>
<td>0.2</td>
</tr>
</tbody>
</table>

The most deprived areas have the lowest DSMR (Table 157).

By Locality

Table 158: DSMR from Suicide & Injury of Undetermined Intent by Locality

<table>
<thead>
<tr>
<th>Locality</th>
<th>DSMR per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central</td>
<td>0.1</td>
</tr>
<tr>
<td>Eastern</td>
<td>0.2</td>
</tr>
<tr>
<td>Northern</td>
<td>0.1</td>
</tr>
<tr>
<td>Southern</td>
<td>0.2</td>
</tr>
<tr>
<td>Western</td>
<td>0.1</td>
</tr>
</tbody>
</table>

Table 158 shows that Eastern and Southern localities have the highest DSMRs.

PNEUMONIA

AT A PCT LEVEL, THE AVERAGE ANNUAL DEATH RATE FROM PNEUMONIA IS 0.4 PER 1,000 POPULATION

By Sex

Table 159: DSMR from Pneumonia by Sex

<table>
<thead>
<tr>
<th>Sex</th>
<th>DSMR per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>0.5</td>
</tr>
<tr>
<td>Female</td>
<td>0.3</td>
</tr>
</tbody>
</table>

Table 159 shows that males have a higher DSMR from pneumonia than females.

By Age

Table 160: DSMR from Pneumonia by Age

<table>
<thead>
<tr>
<th>Age</th>
<th>DSMR per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 65 yrs</td>
<td>0</td>
</tr>
<tr>
<td>65 yrs &amp; over</td>
<td>5</td>
</tr>
<tr>
<td>65-74 yrs</td>
<td>0.2</td>
</tr>
<tr>
<td>75 yrs &amp; over</td>
<td>8</td>
</tr>
</tbody>
</table>

Older people have a higher DSMR from pneumonia than younger people, with those 75 years and over having the highest DSMR (Table 160).

By Level of Deprivation

Table 161: DSMR from Pneumonia by Level of Deprivation

<table>
<thead>
<tr>
<th>Level of Deprivation</th>
<th>DSMR per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most Affluent</td>
<td>1</td>
</tr>
<tr>
<td>Intermediate</td>
<td>1</td>
</tr>
<tr>
<td>Most Deprived</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 161 shows there is no difference in the DSMRs across the levels of deprivation.
By Locality

*Table 162: DSMR from Pneumonia by Locality*

Table 162 shows that the Northern locality has the highest DSMR.

<table>
<thead>
<tr>
<th>Locality</th>
<th>DSMR per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central</td>
<td>1.0</td>
</tr>
<tr>
<td>Eastern</td>
<td>1.0</td>
</tr>
<tr>
<td>Northern</td>
<td>1.4</td>
</tr>
<tr>
<td>Southern</td>
<td>1.1</td>
</tr>
<tr>
<td>Western</td>
<td>1.1</td>
</tr>
</tbody>
</table>
8. **TOWARDS A HEALTH EQUITY AUDIT**

This chapter will provide examples of how the data can be linked together to provide a picture of unhealthy lifestyles in adults and in children. In terms of specific areas it examines smoking cessation services and coronary heart disease.

**UNHEALTHY LIFESTYLES**

The underlying socio-economic and environmental factors such as poverty, education and housing are of critical importance as determinants of ill health and health inequality. Lifestyle risk factors also contribute.

The World Health Organisation atlas of heart disease and stroke provides estimates of how key risk factors contribute to the burden of disease. The table below shows the percentage contribution of seven top risk factors to the overall disease burden in developed countries.

*Table 163: Risk Factors and Overall Disease Burden*

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tobacco Use</td>
<td>12.2</td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td>10.9</td>
</tr>
<tr>
<td>Alcohol Use</td>
<td>9.2</td>
</tr>
<tr>
<td>High Cholesterol</td>
<td>7.6</td>
</tr>
<tr>
<td>Obesity</td>
<td>7.4</td>
</tr>
<tr>
<td>Low Fruit and Vegetable Intake</td>
<td>3.9</td>
</tr>
<tr>
<td>Physical Inactivity</td>
<td>3.3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>54.4</strong></td>
</tr>
</tbody>
</table>

The risk factors in table 163 contribute 54% to the overall disease burden. Importantly, all these risk factors are modifiable.

**ADULTS**

The data on unhealthy lifestyles presented in this report can be summarised in the following table.
### Table 164: Adult Unhealthy Lifestyle Summary

<table>
<thead>
<tr>
<th></th>
<th>Smoking %</th>
<th>Alcohol %</th>
<th>Exercise %</th>
<th>Overweight %</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sex</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>25</td>
<td>16</td>
<td>79</td>
<td>55</td>
</tr>
<tr>
<td>Female</td>
<td>19</td>
<td>9</td>
<td>84</td>
<td>61</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 65 yrs</td>
<td>28</td>
<td>13</td>
<td>83</td>
<td>60</td>
</tr>
<tr>
<td>65 yrs &amp; over</td>
<td>10</td>
<td>12</td>
<td>79</td>
<td>56</td>
</tr>
<tr>
<td><strong>Ethnic Group</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>21</td>
<td>13</td>
<td>82</td>
<td>59</td>
</tr>
<tr>
<td>Other Ethnic Group</td>
<td>33</td>
<td>10</td>
<td>91</td>
<td>55</td>
</tr>
<tr>
<td><strong>Level of Deprivation</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Most Affluent</td>
<td>20</td>
<td>12</td>
<td>83</td>
<td>58</td>
</tr>
<tr>
<td>Intermediate</td>
<td>18</td>
<td>15</td>
<td>80</td>
<td>60</td>
</tr>
<tr>
<td>Most Deprived</td>
<td>33</td>
<td>12</td>
<td>82</td>
<td>57</td>
</tr>
<tr>
<td><strong>Locality</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Central</td>
<td>23</td>
<td>11</td>
<td>84</td>
<td>57</td>
</tr>
<tr>
<td>Northern</td>
<td>22</td>
<td>12</td>
<td>81</td>
<td>61</td>
</tr>
<tr>
<td>Southern</td>
<td>23</td>
<td>12</td>
<td>80</td>
<td>60</td>
</tr>
<tr>
<td>Western</td>
<td>19</td>
<td>15</td>
<td>82</td>
<td>51</td>
</tr>
<tr>
<td></td>
<td>19</td>
<td>14</td>
<td>81</td>
<td>62</td>
</tr>
</tbody>
</table>

**Key**
- Smoking %: Percentage who Smoke
- Alcohol %: Percentage who are heavy drinkers
- Exercise %: Percentage who do not exercise enough
- Overweight %: Percentage who perceive themselves to be overweight

**By Sex**

The data in Table 164 can be used to produce the following radar graph.

**Figure 2: Adult Unhealthy Lifestyle by Sex**

Axes as per key to Table 164
Compared to females, males are:

- more likely to smoke;
- nearly twice as likely to be heavy drinkers;
- nearly as likely not to exercise enough;
- less likely to perceive themselves as overweight.

**By Age**

Figure 3 presents the information by age.

*Figure 3: Adult Unhealthy Lifestyle by Age*

Compared to people 65 years and over, people under 65 years are:

- nearly 3 times more likely to smoke;
- as likely to be heavy drinkers;
- slightly more likely not to exercise enough;
- more likely to perceive themselves as overweight.
By Ethnic Group

Figure 4 presents the data by ethnic group.

**Figure 4: Adult Unhealthy Lifestyle by Ethnic Group**

Compared to people from white ethnic groups, people from ethnic groups other than white are:
- more likely to smoke;
- less likely to be heavy drinkers;
- less likely to exercise enough;
- less likely to perceive themselves as overweight.

By Level of Deprivation

If the same is done for level of deprivation, figure 5 is produced.

**Figure 5: Adult Unhealthy Lifestyle by Level of Deprivation**
Compared to people in the most affluent areas, people in the deprived areas are
- more than one and a half times more likely to smoke;
- as likely to be heavy drinkers;
- as likely to exercise enough;
- as likely to perceive themselves as overweight.

By Locality
The following radar graph summarises the data by locality.

*Figure 6: Adult Unhealthy Lifestyle by Locality*

Figure 6 shows how varied the picture is across the localities. The Central locality has the highest percentage of people smoking and not exercising enough. The Southern and Western localities have the lowest percentage of smokers but the highest percentage of heavy drinkers.
CHILDREN

The data on unhealthy lifestyle can be summarised in the table below.

**Table 165: Unhealthy Lifestyle in Children Summary**

<table>
<thead>
<tr>
<th>Level of Deprivation</th>
<th>Non-Uptake of MMR %</th>
<th>Non-Uptake of Booster MMR %</th>
<th>Need for Dental Treatment %</th>
<th>DMFT 5 yrs</th>
<th>Overweight %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most Affluent</td>
<td>10</td>
<td>20</td>
<td>12.6</td>
<td>0.6</td>
<td>6</td>
</tr>
<tr>
<td>Intermediate</td>
<td>11</td>
<td>18</td>
<td>21.0</td>
<td>0.4</td>
<td>4</td>
</tr>
<tr>
<td>Most Deprived</td>
<td>11</td>
<td>18</td>
<td>25.0</td>
<td>0.9</td>
<td>6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Locality</th>
<th>Non-Uptake of MMR %</th>
<th>Non-Uptake of Booster MMR %</th>
<th>Need for Dental Treatment %</th>
<th>DMFT 5 yrs</th>
<th>Overweight %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central</td>
<td>10</td>
<td>17</td>
<td>17.0</td>
<td>0.8</td>
<td>6</td>
</tr>
<tr>
<td>Eastern</td>
<td>10</td>
<td>15</td>
<td>25.0</td>
<td>0.7</td>
<td>4</td>
</tr>
<tr>
<td>Northern</td>
<td>9</td>
<td>24</td>
<td>11.8</td>
<td>1.1</td>
<td>8</td>
</tr>
<tr>
<td>Southern</td>
<td>15</td>
<td>21</td>
<td>12.1</td>
<td>0.3</td>
<td>2</td>
</tr>
<tr>
<td>Western</td>
<td>11</td>
<td>24</td>
<td>11.7</td>
<td>0.7</td>
<td>8</td>
</tr>
</tbody>
</table>

**Key**
- Non-Uptake of MMR %: Uptake of MMR vaccine by age of 2 years
- Non-Uptake of Booster MMR %: Uptake of MMR booster vaccine by age 5 years
- Need for Dental Treatment %: Percentage of children referred for treatment following school dental inspection
- DMFT 5 Yrs: Decayed, missing or filled teeth score for 5 years old
- Overweight %: Body Mass Index in the top 5% at school entry

**By Level of Deprivation**

The data in Table 165 can be used to produce the following radar graph for level of deprivation.

**Figure 7: Unhealthy Lifestyle in Children by Level of Deprivation**

Figure 7 shows how varied the picture is across the levels of deprivation. The most deprived areas have double the percentage of children requiring dental treatment and three times the DMFT score compared to the most affluent areas.
By Locality
The following radar graph summarises the data by locality.

**Figure 8: Unhealthy Lifestyle in Children by Locality**

Figure 8 shows how varied the picture is across the localities. The Southern locality, however, has the lowest percentage of children requiring dental treatment, the lowest DMFT score and the lowest percentage of overweight children.

**SMOKING CESSATION SERVICES**

Smoking is the largest preventable cause of illness and death. NHS smoking cessation services are available across the primary care trust to help smokers who want to give up.

The table below pulls together the smoking prevalence data from this report and smoking cessation service data. (The smoking cessation service data is not contained in the rest of the report but introduced here).

**Table 166: Smoking Cessation Summary**

<table>
<thead>
<tr>
<th>Level of Deprivation</th>
<th>Smoking %</th>
<th>Referrals per 1,000</th>
<th>Quitting %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most Affluent</td>
<td>20</td>
<td>25</td>
<td>63</td>
</tr>
<tr>
<td>Intermediate</td>
<td>18</td>
<td>19</td>
<td>78</td>
</tr>
<tr>
<td>Most Deprived</td>
<td>33</td>
<td>22</td>
<td>68</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Locality</th>
<th>Smoking %</th>
<th>Referrals per 1,000</th>
<th>Quitting %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central</td>
<td>23</td>
<td>17</td>
<td>71</td>
</tr>
<tr>
<td>Eastern</td>
<td>22</td>
<td>24</td>
<td>71</td>
</tr>
<tr>
<td>Northern</td>
<td>23</td>
<td>28</td>
<td>57</td>
</tr>
<tr>
<td>Southern</td>
<td>19</td>
<td>15</td>
<td>81</td>
</tr>
<tr>
<td>Western</td>
<td>19</td>
<td>36</td>
<td>61</td>
</tr>
</tbody>
</table>

**Key**
- Smoking %: Percentage who smoke
- Referrals per 1,000: Annual rate of referrals to smoking cessation services per 1,000 smokers (12 months data up to March 2004)
- Quitting %: Percent quitting after attending smoking cessation service (12 months data up to March 2004)
By Level of Deprivation
The data in Table 166 can be used to produce the following radar graph.

**Figure 9: Smoking and Smoking Cessation by Level of Deprivation**

Compared to the most affluent areas, the most deprived areas have more than one and a half times the percentage of people smoking, but lower referral rates to smoking cessation services.

By Locality
The following radar graph summaries the data by locality.

**Figure 10: Smoking and Smoking Cessation by Locality**
Figure 10 shows how varied the picture is across the localities. The Central and Northern localities have the highest percentage of people smoking but the Central locality has the lowest referral rate. The Western locality has the lowest percentage of people smoking but the highest referral rate and the lowest percentage of people quitting.

Smoking is disproportionately high among the more disadvantaged. If we are to reduce smoking overall and reduce health inequalities, we must start with the groups who smoke the most. Currently, most referrals are coming from the less deprived areas with the lowest prevalence of smoking.

CORONARY HEART DISEASE

Coronary heart disease (CHD) has a major impact on the population in terms of death, years of life lost prematurely, hospital bed-days used, major surgical procedures performed, chronic ill health and disability.

Risk factors for CHD can be sub-divided into two groups – the major non-modifiable risk factors include: age, gender, ethnicity and family history. Other potentially modifiable risk factors are: smoking, obesity, diet, lack of exercise, alcohol intake, high blood pressure and socio-economic deprivation.

The CHD National Service Framework (CHD NSF) emphasises the need for the reduction of inequalities in access to heart disease prevention, investigation and treatment for everyone irrespective of their age, gender, ethnicity or socio-economic status. The CHD NSF has set out clear national targets, which aim to secure at a local level fair access to high quality services. One of the targets is that all PCTs are to carry out a health equity audit of CHD services. The data contained in this report can be used as the beginnings of a CHD equity audit. It, however, needs to be supplemented by other data.

The following table pulls together the CHD data on risk factors, hospital admission, revascularisation and mortality.
Table 167: Coronary Heart Disease Summary

<table>
<thead>
<tr>
<th></th>
<th>Smoking %</th>
<th>Alcohol %</th>
<th>Exercise %</th>
<th>Overweight %</th>
<th>Hospital Admission per 1,000</th>
<th>CABG per 1,000</th>
<th>PTCA per 1,000</th>
<th>Mortality per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>25</td>
<td>16</td>
<td>79</td>
<td>55</td>
<td>11</td>
<td>1</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Female</td>
<td>19</td>
<td>9</td>
<td>84</td>
<td>61</td>
<td>5</td>
<td>0.2</td>
<td>0.5</td>
<td>2</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>Under 65 yrs</td>
<td>28</td>
<td>13</td>
<td>83</td>
<td>60</td>
<td>4</td>
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<td>65 yrs &amp; over</td>
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<td>79</td>
<td>56</td>
<td>5</td>
<td>0.8</td>
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<td>11</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Most Affluent</td>
<td>20</td>
<td>12</td>
<td>83</td>
<td>58</td>
<td>7</td>
<td>0.5</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Intermediate</td>
<td>18</td>
<td>15</td>
<td>80</td>
<td>60</td>
<td>7</td>
<td>0.5</td>
<td>0.9</td>
<td>3</td>
</tr>
<tr>
<td>Most Deprived</td>
<td>33</td>
<td>12</td>
<td>82</td>
<td>57</td>
<td>9</td>
<td>0.7</td>
<td>1</td>
<td>3</td>
</tr>
</tbody>
</table>

| Locality        |          |           |            |              |                             |               |                |                   |
| Central         | 23        | 11        | 84         | 57           | 8                           | 0.5           | 1              | 3                 |
| Eastern         | 22        | 12        | 81         | 61           | 8                           | 0.6           | 1              | 3                 |
| Northern        | 23        | 12        | 80         | 60           | 8                           | 0.6           | 1              | 3                 |
| Southern        | 19        | 15        | 82         | 51           | 7                           | 0.5           | 0.9            | 3                 |
| Western         | 19        | 14        | 81         | 62           | 6                           | 0.5           | 0.9            | 3                 |

Key
- Smoking %: Percentage who smoke
- Alcohol %: Percentage who are heavy drinkers
- Exercise %: Percentage who do not exercise enough
- Overweight %: Percentage perceive themselves to be overweight
- Hospital Admission per 1,000: Directly Standardised Admission Rate per year per 1,000 population
- CABG per 1,000: Directly Standardised Admission Rate per year for Coronary Artery Bypass Graft per 1,000 population
- PTCA per 1,000: Directly Standardised Admission Rate per year for Percutaneous Transluminal Coronary Angioplasty per 1,000 population
- Mortality per 1,000: Directly Standardised Mortality Rate per 1,000 population

By Sex

The data in Table 167 can be used to produce the following radar graph which clearly demonstrates the differences between the sexes (Figure 11).

Figure 11: Coronary Heart Disease Risk Factors, Hospital Experience and Mortality by Sex
Compared to females, males are:
- more likely to smoke;
- nearly twice as likely to be heavy drinkers;
- less likely not to exercise enough;
- less likely to perceive themselves as overweight;

Compared to females, males experience:
- over twice the hospital admission rate;
- five times the CABG rate;
- four times the PTCA rate;
- twice the mortality rate.

This type of analyses can also be undertaken by age, level of deprivation, and locality.

**By Age**

Figure 12 presents the information by age.

*Figure 12: Coronary Heart Disease Risk Factors, Hospital Experience and Mortality by Age*

Compared to people 65 years and over, people under 65 years are:
- nearly three times more likely to smoke;
- nearly as likely to be heavy drinkers;
- less likely not to exercise enough;
- more likely to perceive themselves as overweight;

Compared to people under 65 years old, those people 65 years and over have nearly the same admission rate, four times the CABG rate, nearly three times the PCTA rate and a much higher mortality rate.
By Level of Deprivation

If the same is done for level of deprivation, figure 13 is produced.

**Figure 13: Coronary Heart Disease Risk Factors. Hospital Experience and Mortality by Level of Deprivation**

Compared to people in the most affluent areas, people in the most deprived areas are:
- over one and a half times more likely to smoke;
- as likely to be heavy drinkers;
- nearly as likely not to exercise enough;
- slightly less likely to perceive themselves as overweight;

Compared to people in the most affluent areas, people in the most deprived areas experience:
- a higher admission rate;
- a higher PTCA rate;
- the same CABG and mortality rates.

**By Locality**

The following Figure 14 summarises the data by locality and shows how varied the picture is across the localities.
Figure 14 shows how varied the picture is across the localities. There are variations across the localities, but they are not highly significant.

What does all this say about equity? The data is suggestive that inequities exist. To investigate this further, other data should be added to the data in this report, e.g. uptake of aspirin by coronary heart disease patients, prescribing rates for Nitrate and Statins, etc. A Coronary Heart Disease Health Equity Audit should be undertaken resulting in changes that reduce inequities.

**HEALTH POVERTY INDEX**

Health equity audits can identify where new forms of integrated services are needed across health, housing, transport, leisure, education as well as social care – to provide more accessible and appropriate services for people with poorest health or access to services and facilities.

At its best, health equity audit will enable the primary care trust and its Local Strategic Partnerships (Eastbourne, Lewes and Wealden Local Strategic Partnerships) to ensure that resources, both people and money, are directed towards tackling inequalities. The ‘Health Poverty Index’ for Eastbourne Borough Council and Lewes and Wealden District Councils could help identify areas that could be the focus of a health equity audit.

The Health Poverty Index (HPI) is introduced below and the scores for Eastbourne Borough Council and Lewes and Wealden District Councils presented.

The NHS Plan (2000) proposed the production of a Health Poverty Index (HPI). Work on the HPI is funded by the Department of Health and is being carried out by the School of Geography and Geosciences, University of St Andrews, the Social Disadvantage Research Centre (SRDC) of the Department of Social Policy and Social Work at the University of Oxford and the South East Public Health Observatory (SEPHO).
The HPI tool allows groups, differentiated by geography, social or economic position and cultural identity, to be contrasted in terms of their ‘health poverty’. A group’s ‘health poverty’ is a combination of both its present state of health and its future health potential or lack of it.

A graphical representation of the conceptional framework lying behind the design of the HPI is produced below in Figure 15.

**Figure 15: HPI Conceptual Framework**

It illustrates that the situation of health, for a group, can be conceptualised as emerging from a history of intervening factors that are themselves based in a set of root causes. Each of these stages is influenced by the different contexts in which they take place. These can be seen as an immediate individual-household level, a local (intermediate) level and a wider social (macro) scale.

In order to produce an index from the conceptual framework presented in Figure 19, it is necessary to identify and measure the important elements acting at different points within the framework. It is agreed that there are nine main ‘domains’ and these are shown in Figure 16 below.
For each domain a set of indicators have been developed which aim to capture the significant aspects of the domain as they exist for different groups in society.

The indicators come from a variety of sources and have been scaled in such a way that high numbers represent a situation of high health poverty.
### SITUATIONS OF HEALTH

<table>
<thead>
<tr>
<th>Level</th>
<th>Domain</th>
<th>Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Macro</td>
<td>Resourcing for Health &amp; Social Care</td>
<td>Health Care Resourcing, Social Care Resourcing</td>
</tr>
<tr>
<td>Intermediate</td>
<td>Appropriate Care</td>
<td>Effective Primary/Secondary Care, Access to Secondary Care, Access to Social Care, Quality of Social Care</td>
</tr>
<tr>
<td>Individual</td>
<td>Health Status</td>
<td>Psychological Morbidity, Health Capital, Physical Morbidity, Premature Mortality</td>
</tr>
</tbody>
</table>

(For information on the indicators and sub-indicators from which they are made, please visit [http://www/hpi.org.uk/indicators/php](http://www/hpi.org.uk/indicators/php))

For each domain, a score of zero indicates the best situation in terms of health poverty and a score of 1 the worst situation.

The HPI for Eastbourne Borough Council and Lewes and Wealden District Councils is produced below in Figures 17 and 18. Figure 17 presents the HPI as a radar diagram, and Figure 18 presents them as a bar chart.

**Figure 17: Radar Graph of HPI for Eastbourne Borough Council and Lewes and Wealden District Councils**

(Equity Matters in Eastbourne Downs PCT – 2004/5 Report of the Director of Public Health)
Figures 17 and 18 demonstrate the differences between Eastbourne Borough Council and Lewes and Wealden District Councils.

Health equity audits can inform local delivery plans and community strategies. Crucially, an effective health equity audit depends on cross agency agreement and commitment to action.

RECOMMENDATIONS
This report has presented results suggestive of inequity across a range of areas.

1. Smoking cessation services have been examined and resources now need to be changed to complete the equity audit.

2. Coronary heart disease has also been examined but represents only the beginning of an audit to which other data should be included. It is therefore recommended that a Coronary Heart Disease Health Equity Audit be undertaken.

3. Consideration should also be given to undertaking health equity audits in other areas.

REFERENCES


GLOSSARY

Body Mass Index (BMI): Body weight (in kilos)
(height in metres) squared.

Directly Standardised Rate: The rate of events that would occur in a standard
population if that population were to experience the age-specific rates of the subject population.

DSAR: Directly Standardised Admission Rates. The standardisation uses the PCT’s population as the reference population.

DSMR: Directly Standardised Mortality Rates. The standardisation uses the PCT’s population as the reference population.

DSPR: Directly Standardised Prevalence Rates. The standardisation uses the PCT’s population registered with those GPs providing data as the reference population.

Life Expectancy: This gives an estimate of how long someone is expected to live based on current mortality rates for an area.

Mortality: A measure of the number of people who have died in a population.

Prevalence: The proportion of a population who have a disease or condition at a given time.
APPENDIX 1: DEPRIVATION - ELECTORAL WARD CLUSTERS

Electoral wards across the PCT have been clustered according to a measure of their deprivation. The Index of Multiple Deprivation brings together measures of social and economic characteristics, based on information from the 2001 Census of Population and from a variety of other administrative sources, to score small areas (Super Output Areas) across the country. As these areas are generally smaller than electoral wards the average and range of scores of each ward were used to rank those in the PCT area.

<table>
<thead>
<tr>
<th>Level of Deprivation</th>
<th>Average Ward Score</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most Affluent</td>
<td>Less than 16</td>
<td>4.2 – 33.9</td>
</tr>
<tr>
<td>Intermediate</td>
<td>16 – 22</td>
<td>8.1 – 31.2</td>
</tr>
<tr>
<td>Most Deprived</td>
<td>Greater than 22</td>
<td>18.2 – 47.7</td>
</tr>
</tbody>
</table>

Clusters are as follows (the numbers denote their ranking by deprivation):

**Most Deprived**
1. Devonshire
2. Hailsham East
3. Hampden Park
4. Langney

**Intermediate**
5. Sovereign
6. St Anthony’s
7. Upperton
8. Meads

**Most Affluent**
9. Hailsham South and West
10. Old Town
11. Polegate South
12. Seaford Central
13. Seaford North
14. Alfriston
15. Chiddingly and East Hoathly
16. East Dean
17. Hailsham Central and North
18. Heathfield East
19. Hellingly
20. Herstmonceux
21. Ninfield & Hooe with Wartling
22. Pevensey and Westham
23. Polegate North
24. Ratton
25. Seaford East
26. Seaford South
27. Seaford West
28. Willingdon
APPENDIX 2: LOCALITY ELECTORAL WARDS

Central
Hampden Park
Polegate North
Polegate South
Ratton
Willingdon

Eastern
Devonshire
Langney
Pevensey and Westham
Sovereign
St Anthony’s

Northern
Hailsham Central and North
Hailsham East
Hailsham South and West
Heathfield East
Hellingly
Herstmonceux
Ninfield and Hooe with Wartling

Southern
Meads
Old Town
Upperton

Western
Alfriston
Chiddingly and East Hoathly
East Dean
Seaford Central
Seaford East
Seaford North
Seaford South
Seaford West
APPENDIX 3: INDEX OF MULTIPLE DEPRIVATION 2004
INDICATOR DETAILS

This Appendix provides further numerator and denominator details for each of the 37 indicators that were used in the Indices of Deprivation 2004.

1. **Adults and children in Income Support households (SOA level)**
   - **Numerator:** IS April 2001.
   - **Denominator:** Total resident population plus communal establishments minus prison establishment population (resident non-staff) from the 2001 Census, constrained to 2001 mid-year estimates (MYEs).

2. **Adults and children in Income Based Job Seekers Allowance households (SOA level)**
   - **Numerator:** JSA-IB April 2001.
   - **Denominator:** Total resident population plus communal establishments minus prison establishment population (resident non-staff) from the 2001 Census, constrained to 2001 MYEs.

3. **Adults and children in Working Families Tax Credit households whose equivalised income (excluding housing benefits) is below 60% of median before housing costs (SOA level)**
   - **Numerator:** Certain WFTC cases for April 2001 as described.
   - **Denominator:** Total resident population plus communal establishments minus prison establishment population (resident non-staff) from the 2001 Census, constrained to 2001 MYEs.

4. **Adults and children in Disabled Person’s Tax Credit households whose equivalised income (excluding housing benefits) is below 60% of median before housing costs (SOA level)**
   - **Numerator:** Certain DPTC cases for April 2001 as described.
   - **Denominator:** Total resident population plus communal establishments minus prison establishment population (resident non-staff) from the 2001 Census, constrained to 2001 MYEs.

5. **Adults and children in households in receipt of National Asylum Support Service (NASS) assistance (SOA level)**
   - **Numerator:** NASS supported asylum seekers in England in receipt of subsistence only and accommodation support for end December 2002.
   - **Denominator:** Total resident population plus communal establishments minus prison establishment population (resident non-staff) from the 2001 Census, constrained to 2001 MYEs.

6. **Unemployment claimant count (JUVOS) of women aged 18-59 and men aged 18-64 averaged over 4 quarters (SOA level)**
   - **Numerator:** As described, for October 2000, January 2001, April 2001 and July 2001.
   - **Denominator:** Resident population plus communal establishments minus prison establishment population (resident non-staff) from the 2001 Census, constrained to 2001 MYEs, for women aged 18-59 and men aged 18-64.

7. **Incacity Benefit claimants women aged 18-59 and men aged 18-64 (SOA level)**
   - **Numerator:** As described, for April 2001.
Denominator: Resident population plus communal establishments minus prison establishment population (resident non-staff) from the 2001 Census, constrained to 2001 MYEs, for women aged 18-59 and men aged 18-64.

8. **Severe Disablement Allowance claimants women aged 18-59 and men aged 18-64 (SOA level)**
   Numerator: As described, for April 2001.
   Denominator: Resident population plus communal establishments minus prison establishment population (resident non-staff) from the 2001 Census, constrained to 2001 MYEs, for women aged 18-59 and men aged 18-64.

9. **Participants in New Deal for the 18-24s who are not included in the claimant count (SOA level)**
   Numerator: As described, for 2001.
   Denominator: Resident population plus communal establishments minus prison establishment population (resident non-staff) from the 2001 Census, constrained to 2001 MYEs, for women aged 18-59 and men aged 18-64.

10. **Participants in New Deal for 25+ who are not included in the claimant count (SOA level)**
    Numerator: As described, for 2001.
    Denominator: Resident population plus communal establishments minus prison establishment population (resident non-staff) from the 2001 Census, constrained to 2001 MYEs, for women aged 18-59 and men aged 18-64.

11. **Participants in New Deal for Lone Parents aged 18 and over (SOA level)**
    Numerator: As described, for 2001.
    Denominator: Resident population plus communal establishments minus prison establishment population (resident non-staff) from the 2001 Census, constrained to 2001 MYEs, for women aged 18-59 and men aged 18-64.

12. **Years of Potential Life Lost (YPLL) (SOA level)**
    Denominator: Total resident population plus communal establishments minus prison establishment population (resident non-staff) from the 2001 Census, constrained to 2001 MYEs, in five year age-sex bands.
    Method: Blane and Drever (1998) (with shrinkage applied to age-sex rates and an upper age of 75).

13. **Comparative Illness and Disability Ratio (CIDR) (SOA level)**
    Numerator: Non-overlapping counts of people in receipt of IS Disability Premium, AA, DLA, SDA, IB, for 2001 in five year age-sex bands.
    Denominator: Total resident population plus communal establishments minus prison establishment population (resident non-staff) from the 2001 Census, constrained to 2001 MYEs, in five year age-sex bands.
    Method: Directly age-sex standardised ratio (shrinkage applied to age-sex rates).

14. **Measures of emergency admissions to hospital, derived from Hospital Episode Statistics (SOA level)**
    Denominator: Total resident population plus communal establishments minus prison establishment population (resident non-staff) from the 2001 Census, constrained to 2001 MYEs, in five year age-sex bands.
    Method: Directly age-sex standardised ratio (shrinkage applied to age-sex rates).
15. Measure of adults under 60 suffering from mood or anxiety disorders (SOA level)

16. Average points score of children at Key Stage 2 (end of primary) (SOA level)
   Numerator: All pupils in maintained schools taking KS2 in 2002 from NPD, for 2002.
   Denominator: Total population in KS2 age group in maintained schools from PLASC, for 2002.

17. Average points score of children at Key Stage 3 (SOA level)
   Numerator: All pupils in maintained schools taking KS3 in 2002 from NPD, for 2002.
   Denominator: Total population in KS3 age group in maintained schools from PLASC, for 2002.

18. Average points score of children at Key Stage 4 (GCSE/GNVG – best of eight results) (SOA level)
   Numerator: All pupils taking KS4 in maintained schools for 2002 from NPD.
   Denominator: All pupils in their final year of compulsory schooling in maintained schools for 2002 from PLASC.

19. Proportion of young people not staying on in school or school level education above 16 (SOA level)

20. Proportion of those aged under 21 not entering Higher Education (SOA level)
   Numerator: Successful entrants under 21 in UCAS data, for 1999-2002
   Denominator: Census population 14-17.

21. Secondary school absence rate (SOA level)
   Numerator: Average number of authorised and unauthorised absences from secondary school for 2001 and 2002, from the school level survey or authorised and unauthorised absences.
   Denominator: Total number of possible sessions.
   Method: The rates were attributed to all children in a school and this was assigned to areas sing PLASC home postcode.

22. Proportions of working age adults (aged 25-54) in the area with no or low qualifications (SOA level)
   Numerator: Adults aged 25-54 in the area with no qualification or with qualifications below NVQ Level 2, for 2001.
   Denominator: All adults aged 25-54.

23. Household overcrowding (SOA level)
   Numerator: Overcrowded households (as defined in Census 2001 Classifications page 15), for April 2001.
   Denominator: Number of households from the 2001 Census, for April 2001.

24. Percentage of households for whom a decision on their application for assistance under the homeless provisions of housing legislation has been made (LA level)
   Numerator: As described, for 2002/3.
   Denominator: ODPM Household estimates, for 2002.
25. **Difficulty of Access to owner-occupation (LA level)**
   Numerator: Modelled proportion of households unable to afford to enter owner occupation on the basis of their income, for 2002.
   Denominator: n/a.

26. **Road distance to GP premises (SOA level)**
   Numerator: Population weighted mean of OA road distance score. OA score is the road distance from the population weighted OA centroid to nearest GP premises, for May 2003.
   Denominator: n/a.

27. **Road distance to a supermarket or convenience store (SOA level)**
   Numerator: Population weighted mean of OA road distance score. OA score is the road distance from the populated weighted OA centroid to nearest supermarket or convenience store, for December 2002.
   Denominator: n/a.

28. **Road distance to a primary school (SOA level)**
   Numerator: Population weighted mean of OA road distance score. OA score is the road distance from the populated weighted OA centroid to nearest primary school, for 2001-02.
   Denominator: n/a.

29. **Road distance to a Post Office (SOA level)**
   Numerator: Population weighted mean of OA road distance score. OA score is the road distance from the populated weighted OA centroid to nearest open Post Office, for end of March 2003.
   Denominator: n/a.

30. **Burglary (SOA level)**
   Numerator: (4 recorded crime offence types, Police Force data for April 2002-March 2003, constrained to Crime and Disorder Reduction Partnership (CDRP) level).
   Denominator: Total dwellings from the Census plus business addresses from Address Point.

31. **Theft (SOA level)**
   Numerator: (5 recorded crime offence types, Police Force data for April 2002-March 2003, constrained to CDRP level).
   Denominator: Resident population plus non-resident working population.

32. **Criminal damage (SOA level)**
   Numerator: (10 recorded crime offence types, Police Force data for April 2002-March 2003, constrained to CDRP level).
   Denominator: Resident population plus non-resident working population.

33. **Violence (SOA level)**
   Numerator: (14 recorded crime offence types, Police Force data for April 2002-March 2003, constrained to CDRP level).
   Denominator: Resident population plus non-resident working population.

34. **Social and private housing in poor condition (SOA level)**
   Numerator: Estimate of the probability that any given dwelling in the SOA fails to meet the decent standard. Modelled primarily from the EHCS by BRE and ODPM, for 2001.
   Denominator: n/a.
35. **Houses without central heating (SOA level)**  
   Numerator: As described, for 2001.  
   Denominator: Number of households from the 2001 Census, for April 2001.

36. **Air quality (SOA level)**  
   Numerator: Modelled measure of the concentration of four pollutants (Nitrogen Dioxide, Benzene, Sulphur Dioxide and Particulates), by the Geography Department at Staffordshire University and NAEI, for 2001.  
   Denominator: n/a.

37. **Road traffic accidents (SOA level)**  
   Numerator: Injuries to pedestrians and cyclists caused by road traffic accidents from STATS19 (Road Accident Data) smoothed to SOA level, for 2000-2002.  
   Denominator: Total resident population plus communal establishments minus prison establishment population (resident non-staff) from the 2001 Census, constrained to 2001 MYEs.
APPENDIX 4: INDEX OF MULTIPLE DEPRIVATION 2004 DATA SOURCES

2001 Census, Small Area Statistics Package Version 7 (October 2003 release)
Working age adults (aged 25-59) with no or low qualifications (Education, skills and Training Deprivation Domain).
Household overcrowding (Barriers to Housing and Services Domain).
Houses without central heating (Living Environment Deprivation Domain).
Census populations and residential dwellings (denominators).

Department for Education and Skills
Pupil Level Annual School Census (PLASC) (Education, Skills and Training Deprivation Domain).
National Pupil Database (NPD) (Education, Skills and Training Deprivation Domain) School level survey or authorised and unauthorised absences (Education, Skills and Training Deprivation Domain).
Location of primary schools (Barriers to Housing and Services Domain).

Department for Transport
Road Accident Data STATS19.

Department for Work and Pensions
Income Support recipients and their partners and children (Income Deprivation Domain).
Income Based Job Seekers Allowance recipients and their partners and children (Income Deprivation Domain).
Incapacity Benefit claimants women aged 18-59 and men aged 18-64 (Employment Deprivation Domain).
Severe Disablement Allowance claimants women aged 18-59 and men aged 18-64 (Employment Deprivation Domain).
Participants in New Deal for the 18-24s who are not included in the claimant count (Employment Deprivation Domain).
Participants in New Deal for 25+ who are not included in the claimant count (Employment Deprivation Domain).
Participants in New Deal for Lone Parents aged 18 and over (Employment Deprivation Domain).
Recipients of IS Disability Premium, AA, DLA, SDA and IB (Health Deprivation and Disability Domain, CIDR).
Recipients of IB and SDA (Health Deprivation and Disability Domain, ‘adults under 60 suffering from mood or anxiety disorders or suicide’).
Child Benefit data (Education, Skills and Training Deprivation Domain, ‘not staying on in school’).

Department of Health
Hospital Episode Statistics (Health Deprivation and Disability Domain, ‘emergency admissions to hospital’ and ‘adults under 60 suffering from mood or anxiety disorders or suicide’).

Heriot-Watt University
Difficulty of Access to owner-occupation indication (Barriers to Housing and Services Domain).

Home Office
Crime and Disorder Reduction Partnership (CDRP) level recorded crime data (Crime Domain).
Police Force and CDRP boundary files (Crime Domain).

**Home Office and National Asylum Support Service**
NASS supported asylum seekers in England in receipt of subsistence only and accommodation support (Income Deprivation Domain)

**Inland Revenue**
Adults and children in Working Families Tax Credit households whose equivalised income (excluding housing benefits) is below 60% of median before housing costs (Income Deprivation Domain).
Adults and children in Disabled Person’s Tax Credit households whose equivalised income (excluding housing benefits) is below 60% of median before housing costs (Income Deprivation Domain).

**MapInfo Ltd**
Location of general stores or supermarkets (Barriers to Housing and Services Domain).

**National Health Service Information Authority**
Location of GP premises (Barriers to Housing and Services Domain).

**Office of the Deputy Prime Minister**
LA level number of households for whom a decision on their application for assistance under the homeless provisions of housing legislation has been made (Barriers to Housing and Services Domain).
LA level household estimates (Barriers to Housing and Services Domain).
Social and private housing in poor condition, modelled primarily from the English House Condition Survey by the Building Research Establishment and ODPM (Living Environment Deprivation Domain).

**Office of National Statistics**
Unemployment claimant count (JUVOS) of women aged 18-59 and men aged 18-64 averaged over 4 quarters (Employment Deprivation Domain).
Mortality data (Health Deprivation and Disability Domain, YPLL).

**Post Office Ltd**
Location of open post offices (Barriers to Housing and Services Domain).

**Prescription Pricing Authority**
Prescribing data (Health Deprivation and Disability Domain, ‘adults under 60 suffering from mood or anxiety disorders or suicide’).

**Staffordshire University**
Air quality indicator (Living Environment Deprivation Domain).

**Universities and Colleges Admissions Service**
University Admissions data (Education, Skills and Training Deprivation Domain).

**39 Regional Police Forces in England**
Recorded crime data for April 2002-March 2003 (Crime Domain).
## APPENDIX 5: INDEX OF MULTIPLE DEPRIVATION 2004 SCORES FOR SUPER OUTPUT AREAS

<table>
<thead>
<tr>
<th>Ward Name</th>
<th>Average SOAL Score by Ward</th>
<th>Min SOAL Score by Ward</th>
<th>Max SOAL Score by Ward</th>
<th>No of SOALs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aflriston</td>
<td>11.6</td>
<td>10.2</td>
<td>13.0</td>
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<td>4.5</td>
<td>12.9</td>
<td>5</td>
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</table>

**Average SOAL Score for ED PCT** 17.1

*Note: * The ward is made up of 2 SOALs, but the PCT encompasses only one of the SOALs (the other being in a neighbouring PCT).*
APPENDIX 6: HPI DATA FOR EASTBOURNE BOROUGH COUNCIL AND LEWES AND WEALDEN DISTRICT COUNCILS

The data behind Figures 21 and 22 is copied below:

<table>
<thead>
<tr>
<th>Root Cause</th>
<th>Eastbourne</th>
<th>Lewes</th>
<th>Wealden</th>
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<td>Education Quality</td>
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<td>Household Conditions</td>
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<td>Wealth</td>
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<td>Intervening Factors</td>
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<td>Resourcing to Support Health</td>
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<td>Local Government Resourcing</td>
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<td>Lifestyle</td>
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<td>Home Environments</td>
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<td>Work &amp; Local Environments</td>
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<td>Resourcing for Health &amp; Social Care</td>
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<td>Social Care Resourcing</td>
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<tr>
<td>Physical Morbidity</td>
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<tr>
<td>Premature Mortality</td>
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(Note: Data relates to 2001)
APPENDIX 7: HEALTH COUNTS IN EASTBOURNE DOWNS PRIMARY CARE TRUST. 2003/04 REPORT OF THE DIRECTOR OF PUBLIC HEALTH.

PROGRESS AGAINST RECOMMENDATIONS

Recommendations

Recommendation 1:
The PCT has the highest mortality rate for male colorectal cancer (second highest mortality rate for males and females combined). It is recommended that the Health Development Department run specific campaigns focused on this area.

Progress
• The new national screening will assist the PCT in early identification of this cancer.

Recommendation 2:
Significant inequalities exist at ward level. This report should be used to help identify the needs of the population at ward level and be used to help plan the provision of services. The PCT should focus health promotion and community development activity in the ten wards identified in Table 1. Other wards, for very specific interventions, should be targeted according to the rates/ratios/scores in Table 2 and the Census results presented in the next report.

Progress
• The report helped to confirm the locality priorities and The Devonshire Ward Project was the result. This project is mapping the needs of the community and has multiagency commitment.
• The development of a falls service.
• A strategy is underway to reduce prescribing dependency.

Recommendation 3:
There should be a commitment to explore the use of health and well-being impact assessment as part of the approach to improving the health of the population. Agencies should work together to develop joint capacity to undertake health and well-being impact assessment. As a minimum agencies should consider developing a common Health & Well-Being Impact Assessment Checklist, such as the one presented here, to be used to screen projects/policies/programmes for their impact upon health and particular groups within the population.

Progress
• A presentation on Health Impact Assessment was made to SLAV Eastbourne as part of awareness raising and to gain commitment. This work will continue to develop.

Recommendation 4:
The 2003 (health & lifestyle) survey has provided some very useful information. It has generated some comparison with 1992 data to identify significant changes and has established baseline data in areas where there had previously not been any. This data should feed into all the appropriate PCT working groups to inform programmes of action. The data has been presented at PCT level, but it could be reanalysed at local authority level. It is recommended that Local Strategic Partnerships consider exploring the possibilities of using this data in the development of indicators to support local action.

Progress
• The Annual Public Health Report was used to illustrate the sexual health needs within our population when planning further services.
• The date on depression was used as an evidence base for developing a positive mental health project entitled ‘Other Side of Blue’.
• The evidence helped to inform the Great Eastbourne Weight Loss challenge.
• The Healthy Eastbourne Board used the findings to inform the development of its sub-groups and programmes of health improvement.