REPORT OF: Dr Lincoln Sargeant, Director of Public Health for North Yorkshire

SUBJECT: LIFE IN TIMES OF CHANGE – HEALTH AND HARDSHIP IN NORTH YORKSHIRE: THE 2019 DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT FOR NORTH YORKSHIRE

REASON(S) REPORT REQUESTED: To receive the report and to consider the actions that the Children and Young People’s Service Leadership Team can make to implement the recommendations

PURPOSE OF REPORT: To provide review of the health of the population focusing on the impact of poverty with recommendations to improve the issues identified

1. INTRODUCTION

There is a statutory requirement for the Director of Public Health to produce an annual report on the health of the local population.

This year my report, “Life in times of change; health and hardship in North Yorkshire” looks at poverty from a public health perspective. I identify areas and groups that are most affected by deprivation in North Yorkshire and focus on collective actions we can take to reduce the impact of poverty on population health.

Based on this work, I have made recommendations in seven categories:

1. Support deprived areas
   North Yorkshire County Council, the Borough and District Councils should lead coordinated plans focused on areas of deprivation through collaboration with local communities and residents to reflect their priorities for reducing poverty and shaping healthy places.

2. Tackle rural poverty
   Local authorities in North Yorkshire should continue to advocate for an inclusive, vibrant and sustainable rural economy as integral to the local industrial strategies being developed by Local Enterprise Partnerships and City Region deals.

   North Yorkshire County Council, the Borough and District Councils should consider developing a coordinated Rural Strategy that highlights rural-specific needs including employment, connectivity and affordable housing.

3. Reduce childhood inequalities
   All agencies working with children and families should be alert to the risk and impact of childhood poverty and ensure they take account of hidden and indirect costs that may hinder a child’s full participation in the services they offer. Plans that are drawn up to support children and families should reflect this assessment and should include actions to mitigate the impact of poverty identified.
As part of the Joint Strategic Needs Assessment, North Yorkshire County Council and Clinical Commissioning Groups in North Yorkshire should undertake specific investigation into child poverty to provide an updated picture of the scale and distribution of child poverty across North Yorkshire to inform strategies and service delivery.

4. Work with military families and veterans
Military and related agencies should ensure that service and veteran-specific issues identified in the needs assessment are addressed.

All agencies should identify and trail military service champions within their organisations to ensure that military veterans are not disadvantaged when accessing local services such as health and housing in keeping with the commitments of the Armed Forces Covenant.

5. Create safe environments for high-risk groups
All agencies working with people with multiple health and social problems should consider a ‘housing first’ approach that provides a safe and stable environment which is sensitive and flexible to the needs and individual circumstances of the person.

6. Develop priorities to mitigate the impact of changes to the benefit system
As part of the Joint Strategic Needs Assessment, North Yorkshire County Council and Clinical Commissioning Groups in North Yorkshire should undertake specific investigation to understand the impact of changes to the benefit system, cuts and sanctions on people, in terms of their mental and physical health and the use of services to set new strategic priorities in local plans to mitigate these impacts.

7. Improve community engagement
North Yorkshire County Council, the Borough and District Councils should work with voluntary and community sector partners to strengthen the involvement of local communities in shaping plans for reducing the impact of poverty in areas of deprivation.

All agencies should identify or appoint community champions and senior sponsors to promote a culture of community engagement in their organisations.

A full copy of the report and summary can be accessed here: https://www.nypartnerships.org.uk/DPHAR

District and county health profiles can be found here: https://nypartnerships.org.uk/jsna

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Outline

• Poverty – a very wicked problem
• From the workhouse to the workplace
• The extent and variation in poverty
• Progress so far
• The way forwards
Life expectancy and healthy life expectancy for men and women in North Yorkshire, 2009-13

- **Castle ward, Scarborough**
  - Life expectancy: 53.8 years
  - Healthy life expectancy: 72.4 years

- **Rudby ward, Hambleton**
  - Life expectancy: 73.3 years
  - Healthy life expectancy: 87.2 years

- **Scotton ward, Richmondshire**
  - Life expectancy: 63.6 years
  - Healthy life expectancy: 76.7 years

- **Claro ward, Harrogate**
  - Life expectancy: 75.2 years
  - Healthy life expectancy: 89.1 years
Ripon workhouse in the 1850s

- Response to poor relief
- Workhouses ensured access to
  - Secure housing
  - Food
  - Basic healthcare
  - Education for children
- Deserving v undeserving poor
- Workhouses – harsh and prison like
- Problem of vagrancy
  - Mental health and addiction not understood
- Problem of worklessness
The different levels of poverty in the UK and the value of the UK poverty line. More than one-in-five of the UK population lives in poverty - that is 14,300,000 people (21%).

- 2.5m people Living above the poverty line - within 10%.
- 2.7m people Living just below the UK poverty line - within 10%.
- 3.3m people Living between 10% and 25% of poverty line.
- 8.2m people Living in deep poverty - below 25%.

Total UK population 66.6m

14.3m People Living below the poverty line
Cycle of poverty

Based on a household with two adults and two dependent children, the current annual value of the Government’s HBAI poverty line, after housing costs have been deducted, is set at £22,100.

The deep poverty line is measured at 40% of the annual average income, which is £14,733, based on the same family structure of two adults with two dependent children.
How does poverty affect health?

Lack of money in itself does not cause someone to be poorly, but the indirect influence of poverty does have a marked effect on health.

The wider determinants of health, which include economic characteristics such as unemployment and household income, have been found to have a greater influence on population health than health care and lifestyle behaviours.

Lifestyle factors, which are inextricably linked with the wider determinants such as household income, can lead to ill health.
System map of the causes of health inequalities

- Health and Wellbeing
  - Physiological Impacts: High blood pressure, high cholesterol, anxiety/depression
  - Health behaviours: Smoking, Diet, Alcohol
- Wider determinants of health: Income and debt, employment/quality of work, education and skills, housing, natural and built environment, access to goods/services, power and discrimination
- Psycho-social factors: Isolation, social support, social networks, self-esteem and self-worth, perceived level of control, meaning/purpose of life
The Marmot Review

Set out the scale and distribution of health inequalities in England and the actions required to reduce them.

It outlined six policy objectives for reducing health inequalities:
• Give every child the best start in life
• Enable all children, young people and adults to maximise their capabilities and have control over their lives
• Create fair employment and good work for all
• Ensure healthy standard of living for all
• Create and develop healthy and sustainable places and communities
• Strengthen the role and impact of ill-health prevention.
Life expectancy in North Yorkshire

Overall, health in North Yorkshire is better than average for England. Life expectancy (LE) at birth is significantly higher for males and females, but the rate of change appears to be reducing.

Scarborough continues to have the lowest life expectancy in North Yorkshire

Healthy life expectancy in North Yorkshire - the number of years someone can expect to live in good health from birth to death - is significantly higher than the England average for females, but not significantly different for males.
Poverty in North Yorkshire

Households in poverty

Range from 8.1% (Harrogate) to 34.6% (Scarborough)

92,000 people in North Yorkshire
15% of the population
The eleven most deprived neighbourhoods in North Yorkshire, 2015

The Index of Multiple Deprivation (IMD) is an area-based, relative measure of deprivation.

All are in the most deprived decile nationally for employment deprivation.

Nine are in the most deprived 10% nationally for the Income domain.

Seven are in the most deprived decile for Health Deprivation and Disability.

Seven are in the most deprived decile for Education, Skills and Training Deprivation.
Contribution to the life expectancy gap between the most and least deprived quintiles in North Yorkshire

![Pie charts showing contribution percentages for Males and Females.]

- Males:
  - Circulatory: 25.9%
  - Cancer: 27.8%
  - Respiratory: 16.4%
  - External causes: 14.4%
  - Other: 15.5%

- Females:
  - Circulatory: 19.7%
  - Cancer: 36.6%
  - Respiratory: 6.0%
  - External causes: 22.0%
  - Other: 15.7%
Recommendation - support deprived areas

There are 11 Lower Level Super Output Areas (LSOA), out of 373 in the county, with Index of Multiple Deprivation scores (IMD 2015) amongst the most deprived 10% in England and a further 12 LSOA amongst the more deprived 10-20% in England. Many of these are located in the coastal town of Scarborough but they exist in other places as well.

The evidence indicates that interventions to increase income in these LSOAs will help to lift these away from the most deprived group. These might include supporting people into employment and better paid, more stable jobs; improving opportunities for in-work progression through skills training, and increasing uptake of benefits to which people are entitled. The changing face of work due to increased digitalisation, artificial intelligence and technology advances needs to be monitored to prevent adverse impacts on employment opportunities in the county.
Rural locations are associated with transport issues, decreased access to services and opportunities, and fuel poverty. These concerns are especially challenging in a county with a high proportion of older residents. 43% of the North Yorkshire population live either in the countryside or in small villages with less than 4,000 residents. This compares with 6% of the population of Teesside or West Yorkshire. Rural poverty may often be hidden in the statistics. The integral links between the rural economy of North Yorkshire and that of neighbouring city regions of Teesside and West Yorkshire needs greater emphasis.

**Recommendation**

Local authorities in North Yorkshire should continue to advocate for an inclusive, vibrant and sustainable rural economy as integral to the local industrial strategies being developed by Local Enterprise Partnerships and City Region deals.

North Yorkshire County Council, the Borough and District Councils should consider developing a coordinated Rural Strategy that highlights rural-specific needs including employment, connectivity and affordable housing.
Recommendation - reduce childhood inequalities

The impacts of prolonged austerity and cuts to welfare benefits have driven an increase in levels of childhood poverty. Children in workless families are especially at risk but many poor children are in families where parents work. Single parent families are particularly hit by welfare cuts.

**Recommendation**

*All agencies working with children and families should be alert to the risk and impact of childhood poverty and ensure they take account of hidden and indirect costs that may hinder a child’s full participation in the services they offer. Plans that are drawn up to support children and families should reflect this assessment and should include actions to mitigate the impact of poverty identified.*

Actions may include support for managing household budgets, facilitating access to employment and training opportunities including provision for childcare, and signposting and making referrals to debt and benefits advice to maximise income where appropriate.

*As part of the Joint Strategic Needs Assessment, North Yorkshire County Council and Clinical Commissioning Groups in North Yorkshire should undertake specific investigation into child poverty to provide an updated picture of the scale and distribution of child poverty across North Yorkshire to inform strategies and service delivery.*
Recommendation - work with military families and veterans

Catterick Garrison is the largest military base in Western Europe, housing 8,600 service personnel in 2019. It is scheduled to expand to 9,000 service personnel from 2023. There are over 50,000 veterans in North Yorkshire. Lack of opportunities for spousal employment and the transition from military to civilian life can increase the risk of poverty. This is identified in the recent armed forces and veterans needs assessment. The new Ministry of Defence (MODs) Defence Transition Service (DTS) aims to support ex-service veterans as they transition into civilian life in North Yorkshire.

Recommendation

Military and related agencies should ensure that service and veteran-specific issues identified in the needs assessment are addressed.

All agencies should identify and train military service champions within their organisations to ensure that military veterans are not disadvantaged when accessing local services such as health and housing in keeping with the commitments of the Armed Forces Covenant.
**Recommendation - create safe environments for high-risk groups**

Deprivation and inequality can be concentrated in particular groups of people – such as those who are addicted to drugs, are homeless, have a disability, or experiencing mental ill health. Often these factors co-exist and place individuals at high risk for poverty and its negative consequences. Some families and individuals may have multiple interventions by different services which are not coordinated. Safe and stable housing is often a prerequisite for the targeted and individualised approaches that may be more beneficial for these groups compared to universal services which may not be sensitive to their multiple complex needs.

**Recommendation**

All agencies working with people with multiple health and social problems should consider a “housing first” approach that provides a safe and stable environment which is sensitive and flexible to the needs and individual circumstances of the person.
Navigating the benefits system is often challenging for people who are vulnerable. There are elements of how the system works including sanctions which causes loss of income at a time of greatest need. These sanctions appear to disproportionately target single parents, those with long-term health conditions or disabilities and keep people locked in poverty. The way in which the benefits system is operated at times has more in common with the workhouse than with the aspiration of Beveridge, that benefits should support people to live dignified lives. There appears little real evidence to support the notion that a harsh benefits regime will motivate people out of poverty. In fact, it appears to be having the opposite affect.

Recommendation

As part of the Joint Strategic Needs Assessment, North Yorkshire County Council and Clinical Commissioning Groups in North Yorkshire should undertake specific investigation to understand the impact of changes to the benefit system, cuts and sanctions on people, in terms of their mental and physical health and the use of services to set new strategic priorities in local plans to mitigate these impacts.
Recommendation - improve community engagement

Working with people and communities to create a shared future is more effective than doing things for them or to them. This principle is supported by a growing body of evidence that community participation leads to sustainable poverty reduction, especially where attention is given to training and building capacity in the community.

Poverty can undermine social networks and approaches that seek to build social capital in communities can increase the resources available to people to tackle the problems they face. The aspiration of working with communities is to design, reshape and deliver services equally with those who use them to create better outcomes.

Recommendation

North Yorkshire County Council, the Borough and District Councils should work with voluntary and community sector partners to strengthen the involvement of local communities in shaping plans for reducing the impact of poverty in areas of deprivation.

Actions may include identifying influential community members reflecting different perspectives; providing training and support for communities to develop local plans, and facilitating communities to work with relevant agencies to co-produce plans and services.

All agencies should identify or appoint community champions and senior sponsors to promote a culture of community engagement in their organisations.
Introduction

This profile provides an overview of health and social care needs in Ryedale District. Greater detail on particular topics can be found within JSNA content at www.datanorthyorkshire.org. This document is structured into four parts: population, wider determinants of health, health behaviours and diseases and death and identifies the major themes which affect health in Ryedale and links to the local response which meets those challenges.

Summary

- The population in Ryedale District is ageing. By 2025, there will be 2,000 additional people aged 65+, a 14% increase from 2018, but a static working-age population. This will lead to increased health and social care needs with no extra people available to work in health and care roles.
- There are 9 wards where about one quarter of children are growing up in poverty, located along the A64 corridor and the Kirkbymoorside, Cropton and Dales wards.
- Despite recent reductions, the rate of people being killed and seriously injured on Ryedale’s roads remains at double the England average (about 45 casualties annually).
- There are high rates of fuel poverty in parts of Ryedale, particularly in the most rural areas.
- The estimated dementia diagnosis rate is increasing but remains lower than England, with most general practices below the North Yorkshire average. There may be additional, unidentified care needs.

Overview: Population

The population pyramid shows that, overall, Ryedale district has an older population than England, with more residents between the ages of 50-89, and fewer aged under 45. The population make-up is similar to North Yorkshire. The shape of the pyramid is typical of a population with long life expectancy and low birth rate.

There are about 6,300 people aged 65+ with a limiting long term illness. Of these people, 42% (2,600) report that their daily activities are limited a lot because of their illness (POPPI, 2019).

1.7% of the population is from black, Asian and minority ethnic groups, compared with 2.8% in North Yorkshire and 15% in England.
The population of Ryedale district is estimated to be 54,920 and is set to increase to 56,700 in 2025. The birth rate in the district is 53 per 1,000 women (England= 59 per 1,000 women). Projections indicate that the population in the over-85 age group is expected to increase in Ryedale by approximately 16% by 2025. For the same age group, an increase of 23% is expected in North Yorkshire and an increase of 22% in England. An 11% increase is also anticipated for those in the retirement category in the district, compared to the 16% projected for England. Meanwhile, it is projected that the population of children and teenagers in Ryedale will increase by 6%.

Life expectancy at birth is increasing for men in Ryedale, but only gradually. For females, the life expectancy in Ryedale (85) is greater than then both England (83) and North Yorkshire (84).

By comparing the healthy life expectancy with overall life expectancy, we can get a richer picture around years spent in good health. In Ryedale, there is wide variation in the years spent in good health for both males and females between wards, indicating within district inequalities. There is a nine year difference in life expectancy for males between Norton East ward and Ampleforth ward. Men in Norton East can expect to live 62 years in good health however, men in Ampleforth spend 72 years in good health. For females, women in the district with the lowest life expectancy (Norton East) spend 68 years of their life in good health. For both sexes, the wards with the highest life expectancy exceed that seen by England and those with the lowest life expectancy are below the England figures.
Wider determinants of health

Poverty

The 2019 Index of Multiple Deprivation (IMD) identifies no Lower Super Output Areas (LSOA) out of 30 total within the district which are amongst the 20% most deprived in England. However, Pickering West, Derwent and Malton wards have higher levels of deprivation than the district average.

The IMD also calculates deprivation for specific groups based on key indicators. For children, child poverty (22%, 2379 children) is lower than that observed nationally (30%). However, this rises to over 26% in Rillington, Wolds and Sherburn ward.

Furthermore, Norton East and Pickering West wards have high levels of older people in deprivation with rates higher than the district average, indicating these areas are the most deprived areas of Ryedale.

Employment

Employment rate is higher in Ryedale (82% in the district in the period April 2018 to March 2019 compared to 76% across England and 79% in North Yorkshire); and employment rate has increased by 2.8% from 2017/18 and 2018/19 in Ryedale.

In 2018, average weekly earnings in Ryedale (£375) were significantly below England (£451) and Ryedale has one of the lowest weekly earnings when compared to the other districts in North Yorkshire.
Low school attendance is linked to lower educational attainment. The proportion of half days missed by pupils due to overall absence (both authorised and unauthorised) is 4.7%, is similar to the national (4.8%) and regional (5%) averages in 2017/18.

The proportion of pupils aged 5-15 with special educational needs in North Yorkshire has increased slowly between 2016 and 2018 and is significantly lower than England.

The chart below highlights the Ofsted judgement of overall effectiveness of primary and secondary schools in Ryedale.

Performance at primary schools is similar to county and national results. Ryedale has a higher proportion of secondary schools with a score of ‘good’ when compared to the national and county averages and does not have any secondary schools rated ‘inadequate’ or ‘requires improvement’. The small number of secondary schools (4) means that this needs to be interpreted with some caution.
Housing

Fuel poverty rates are an issue for Ryedale which is linked to deprivation. In 2017, 10% of households (2,334 households) in Ryedale were classified as fuel poor, similar to the national average (11.1%). Merely tackling poverty would not necessarily relieve the fuel poverty, as often housing type and access to affordable sources of energy are important. Tackling fuel poverty should in turn improve winter health, decreasing excess winter mortality and the pressure on the health and care system during the winter months. Further information on the North Yorkshire Winter Health Strategy 2015-20 can be found at the North Yorkshire Partnership website.

The chart to the right suggests a variable picture in the district. In 2016/17 the Excess Winter Mortality index increased from 14.5 to 31.0, above the national average of 21.6.

The rate of households who are homeless has decreased in Ryedale since 2011/12 and is below England and county averages.
Transport

Alcohol consumption is responsible for around one in seven deaths in reported road traffic accidents in Great Britain. Any amount of alcohol affects people’s ability to drive safely. The effects can include slower reactions, increased stopping distance, poorer judgement of speed and distance and reduced field of vision, all increasing the risk of having an accident or fatality.

The rate of alcohol-related road traffic accidents in Ryedale has decreased since 2011-13 and is similar to county and national rates.

The rate of people being killed and seriously injured (KSI) casualties on roads in Ryedale is significantly higher than the national average at 85 per 100,000.

Across North Yorkshire, the rate of children killed and seriously injured on England’s roads has decreased between 2014-16 and 2015-17 (from 19 per 100,000 to 18 per 100,000) and is now similar to the England average (17 per 100,000). More information on staying safe on the road can be found in Safer Roads, Healthier Place: York and North Yorkshire Road Safety Strategy and at roadwise.co.uk.

In Ryedale, most of the population (71%) lives within a 30 minute travel time, by public transport, to a general practice. There are about 16,000 residents in Ryedale District with longer travel times.

Further information is available via the Strategic Health Asset Planning and Evaluation (SHAPE) Place Atlas online tool. This is an interactive health atlas tool available to NHS and Local Authority professionals working in public health or social care.
Lifestyle and behaviour

Smoking

Smoking prevalence for adults in Ryedale is similar to England, at 14.6% compared with 14.5% nationally. For adults in routine and manual professions, smoking rates are higher than for the general population; in Ryedale the prevalence is 37% - not statistically significantly different from the 25% estimated for England.

Maternal smoking during pregnancy is known to be detrimental for both the health of the mother and baby. In Ryedale, maternal smoking is a concern, with 15% (60) of local mothers smoking, compared to 11% nationally. This is the lowest rate of maternal smoking at time of delivery in the district since 2014/15.

Alcohol

Implementing appropriate local interventions ensures we reduce misuse and harm associated with alcohol in our communities. Overall, the rate of admission episodes for alcohol-specific conditions in Ryedale is significantly lower than England at 444 per 100,000 population compared to 569 for England. As alcohol misuse can be a contributing factor in a wide variety of diseases, and it is important to also look at broader health conditions where alcohol may have had a role, including both physical and mental health. When we look at people admitted for alcohol-related conditions, Ryedale is significantly lower compared to England (1,822 per 100,000 population compared to 2,223). This shows most alcohol-related harm is due to prolonged use, manifesting in a wide range of health problems.

Further information on the 2014-2019 North Yorkshire Alcohol Strategy can be found on North Yorkshire Partnership website via the following link http://www.nypartnerships.org.uk/
Nutrition, activity and excess weight

Childhood obesity is closely related to excess weight in adulthood. The proportion of children in Reception who are overweight or obese in Ryedale is similar to England overall (20% locally and 22% nationally). The prevalence of excess weight in year 6 children is significantly lower in Ryedale (28% locally and 34% nationally). There is an increase in the proportion of obese children from Reception to year 6 in Ryedale, demonstrating that it is important to identify children at risk for excess weight early on and minimise excessive weight gain through primary school. For overweight children, we don’t see an increase between Reception and year 6 but this could be because children change weight status (from overweight to obese) rather than indicating weight maintenance.

Details of approaches to tackle excess weight across the lifecourse are in the strategy Healthy Weight, Healthy Lives: Tackling overweight and obesity in North Yorkshire 2016-2026

Physical activity is associated with overall better health. Adults are identified as being inactive if they engage in less than 30 minutes of physical activity per week. The proportion of inactive adults in Ryedale is similar to England (23% locally and 22% at the national level). Targeting adults who are inactive will impact on the reduction of chronic disease, particularly those related to excess weight. Targeting obesity is a priority area for Government as a way to decrease premature mortality and avoidable ill health. The proportion of adults who are overweight or obese in Ryedale is 59%—similar to the proportion of adults with excess weight in England.

The Government recommends that adults eat at least five portions of fruit and vegetables per day. Self-reported fruit and vegetable consumption shows that Ryedale is below the England average in consuming the recommended fruit and vegetables, and indicates that nearly 40% of the adult population in Ryedale could improve their diet.

Breastfeeding provides benefits to the health and wellbeing of both mother and child. In Ryedale, 72% of women initiate breastfeeding within 48 hours of delivery, similar to the proportion of women in England (75%).

In order to increase breastfeeding a strategy and action plan has been developed that is focusing on:

- Increasing initiation of breastfeeding
- Increasing breastfeeding at 6-8 weeks
- Reducing the gap between breastfeeding rates in the most deprived areas/population groups and the York and North Yorkshire average.
Lifestyle and behaviour

Sexual health

It is important that we have a good understanding of local sexual health needs in order to provide the most appropriate services and interventions. In Ryedale, the rate of new Sexually Transmitted Infection (STI) diagnoses for 2018 at 360 per 100,000 population is significantly lower than the rate of 784 per 100,000 in England. This excludes chlamydia diagnoses in the under 25’s as they have their own active screening programme in place.

The STI testing rate for the same time period, shows Ryedale is significantly lower than England but similar to North Yorkshire. There are many factors which can explain a low diagnosis rate; it is not necessarily indicative of a lower prevalence of disease. When accompanied by a low rate of testing, it is important to consider if all of those who need to be tested within the population have services that are accessible and available to them.

Long-acting reversible contraception (LARC) is recommended as a cost-effective and effective form of birth control. As part of the priority to make a wide-range of contraceptive services available to all, LARC prescription measurement is often used as a proxy measure for access to wider contraceptive services. An increase in access to contraceptive services is thought to lead to a reduction in unintended pregnancies. The prescription rate for LARC in Ryedale at 63 per 1,000 women aged 15-44 is significantly higher than the rate seen in England (47).

Unplanned pregnancies at any stage of life can have an impact on women’s health and well-being. There is a great deal of attention paid to the experiences of teenagers who have an unplanned pregnancy, particularly in relation to the wider determinants of health including education, housing and poverty. The rate of teenage conception in Ryedale is similar to England (11 and 18 per 1,000 women aged 15-17, respectively); however there has been a slight increase between 2016 and 2017. However, numbers are small and should be interpreted with caution.
Diseases and Death

Major causes of death

In Ryedale, there were 615 deaths in 2017. Over half of deaths fell under just three broad causes: 199 (32%) due to circulatory diseases; 165 (27%) due to cancer and 81 (13%) due to respiratory diseases.

The rate of mortality for individuals aged under 75 from cardiovascular disease has decreased in Ryedale between 2001-03 and 2015-17 and is significantly lower than national (72 per 100,000) and Yorkshire and Humber (83 per 100,000) average.

The rate of mortality for individuals aged under 75 from cancer has increased in Ryedale between 2011-13 and 2015-17 (130) and is now similar to the national (135 per 100,000) and regional (143.4 per 100,000) average.

The rate of mortality for individuals aged under 75 from respiratory disease has decreased in Ryedale between 2013-15 and 2015-17 and is significantly lower than the national (34 per 100,000) and regional (39 per 100,000) averages.

Inequality

The following charts show causes of death which contribute towards the life expectancy gap between the most deprived and least deprived areas in Ryedale district. The biggest contributor to the life expectancy gap for both men is cancer and respiratory and women is respiratory and circulatory diseases. Targeting NHS Health Checks in deprived areas will help to narrow the inequality in life expectancy.
Diseases and Death

Dementia

Ryedale has a significantly lower rate of those estimated to have dementia being diagnosed when compared with England (53% vs 69%). There are 441 people aged 65+ with dementia diagnosed in Ryedale, with potentially another 390 cases unrecorded.

NHS Health Check works to identify people at risk of vascular diseases including vascular dementia so they can reduce risks. More information on NHS Health Checks can be found via FingerTips website.

The chart to the right shows the number of people with dementia registered at each general practice as a proportion of all people registered at each practice, for practices in the district. There are two GPs in Ryedale that have a higher proportion of practices with dementia than the national average.

Cancer Screening

In Ryedale there tends to be higher uptake of screening for breast and cervical cancer when compared with bowel cancer.

Breast and cervical cancer screening rates continue their long-term downward trend but coverage remains significantly higher than England across the district. Bowel cancer screening uptake is also significantly higher than England but with only a slight increase of uptake since 2015.

Screening for cancer leads to diagnosis at an earlier stage, leading to better outcomes and increased survival.
Diseases and Death

Diabetes

Complications from diabetes result in considerable morbidity and have a detrimental impact on quality of life. Type 2 diabetes is typically associated with excess weight can be prevented or delayed by lifestyle changes.

To implement effective interventions, it is important to identify all cases. The gap between observed prevalence (the number of diabetes cases recorded) and the actual prevalence (observed plus those who are undiagnosed) helps to quantify those who may be untreated. In Ryedale, it is estimated that only 68% of diabetes cases are diagnosed, significantly lower than England (78%).

The chart to the right highlights the prevalence of diabetes by general practice. The NHS Diabetes Prevention Programme aims to identify those at high risk of developing diabetes and the NHS Health Checks programme routinely tests for those at risk of developing diabetes.

Substance Misuse

Deaths from drug misuse data is not available for Ryedale district. The value cannot be calculated because the numbers are too small. However, deaths from drug misuse in North Yorkshire have increased slightly between 2014-16 and 2015-17 and the rate per 100,000 is similar to the England average (4.3 nationally V 4.4 locally). Between 2001-03 and 2015-17 deaths from drug misuse have remained similar to the England average; however, in 2014-16 the rate was statistically lower than the Yorkshire and Humber average.

Confidential help with drug and alcohol addiction is available through North Yorkshire Horizons.
Mental Health

The percentage of individuals reporting depression or anxiety in Ryedale is significantly lower (8.2%) when compared to the national average (13.7%). Ryedale district has the lowest proportion of depression or anxiety when compared to other districts in North Yorkshire.

Ryedale’s rate of individuals who have long-term musculoskeletal disease who are also feeling depressed or anxious is not statistically significantly different from the England average (12.6% locally compared to 24.1% nationally).

Ryedale district has a significantly lower rate of emergency hospital admissions for self-harm (137 per 100,000) than the England average (185 per 100,000). The proportion of hospital admissions for intentional self harm has increased between 2016/17 and 2017/18.

Suicide is a significant cause of death in young adults, and is seen as an indicator of underlying rates of mental ill-health. The suicide rate in Ryedale decreased from 2015-17 to 2016-18 and is similar to England (10.1 per 100,000 locally; 9.6 per 100,000 nationally). The suicide rate for males is higher than females in Ryedale, in line with national rates. However, these are small numbers and should be interpreted with caution. Further information can be found in the Suicides Audit in North Yorkshire 2015 and on the North Yorkshire

End of Life Care

The North Yorkshire Joint Health and Wellbeing Strategy includes an ambition to increase the number of people dying either at home or place of choice that they chose by 2020. In recent years, the proportion of people dying at home in North Yorkshire has tended to increase and Ryedale has a higher proportion of people dying at home compared with county and national rates. Ryedale District has a higher proportion of people dying at hospital when compared to county averages in 2017.

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North Yorkshire Joint Strategic Needs Assessment 2019
Scarborough Borough Summary Profile

Introduction

This profile provides an overview of health and social care needs in Scarborough. Greater detail on particular topics can be found within JSNA content at www.datanorthyorkshire.org. This document is structured into four parts: population, wider determinants of health, health behaviours and diseases and death and identifies the major themes which affect health in Scarborough and links to the local response which meets those challenges.

Summary

- Scarborough Borough is the most deprived district within North Yorkshire and has three quarters of the county’s most deprived areas. Material deprivation has a significant impact on population health, with inequality in outcomes apparent. There are ten wards where more than one-third of children grow up in poverty.
- The population in Scarborough is ageing. By 2025, there will be 3,300 additional people aged 65+, an 11% increase from 2018, but a 4% decrease in the working-age population. This will lead to increased health and social care needs with fewer people available to work in health and care roles.
- Maximising efforts to reduce differences in the wider determinants of health will have prolonged, sustainable benefits for the population as a whole.
- A sustained focus on helping people to have healthy lifestyles is needed, minimising harm from smoking, alcohol and substance misuse and increasing healthy eating and physical activity.
- Circulatory diseases are the largest contributor to the gap in life expectancy between the most and least deprived areas within the borough.

Overview: Population

The population pyramid shows that, overall, Scarborough Borough has an older population than England, with more residents aged of 50-89, and fewer aged under 50. The population make-up is broadly similar to North Yorkshire, but there are noticeably fewer females aged 20-29 in Scarborough. The shape of the pyramid is typical of a population with long life expectancy and low birth rate.

There are about 14,500 people aged 65+ with a limiting long term illness. Of these people, 46% (6,700) report that their daily activities are limited a lot because of their illness (POPPI, 2019).

2.5% of the population is from black, Asian and minority ethnic groups, compared with 2.8% in North Yorkshire and 15% in England.
The population of Scarborough Borough is estimated to be 108,736 and is set to increase to 108,500 in 2025. The birth rate in the district is 59 per 1,000 women (England= 59 per 1,000 women). Projections indicate that the population aged over 85 is expected to increase in Scarborough by approximately 16% by 2025. For the same age group, in North Yorkshire an expected increase of 23% and an increase of 22% in England. A 10% increase is also anticipated for those in the retirement category in the district. Meanwhile, the working age population in Scarborough is projected to decrease across the relevant age groupings.

Life expectancy at birth is increasing for men in Scarborough, but remains lower than both North Yorkshire and England. For females, the life expectancy in Scarborough is slightly lower than England and North Yorkshire. Between 2014-16 and 2015-17 there has been a slight decrease in life expectancy for females in Scarborough.

By comparing healthy life expectancy with overall life expectancy, we can get a richer picture of years spent in good health. In Scarborough, there is wide variation in the years spent in good health for both males and females between wards, indicating within district health inequalities. There is an 11 year difference in life expectancy for males between Castle ward and Esk Valley ward. Men in Castle ward can expect to live 56 years in good health (77% of their life), but men in Esk Valley ward spend 69 years in good health (83% of their longer life). Women in Hertford ward spend 63 years in good health, while women in Derwent Valley ward spend 71 years of their life in good health. For both sexes, the wards with the highest life expectancy exceed that seen by England and those with the lowest life expectancy are below the England figures.
**Wider determinants of health**

**Poverty**

The 2019 Index of Multiple Deprivation (IMD) identifies 20 Lower Super Output Areas (LSOAs) out of 71 within the district which are amongst the 20% most deprived in England. The 20 LSOAs include parts of Eastfield, Castle and Woodlands wards. 30,827 people live in these 20 LSOAs, 29% of the borough population. Over 85% of most deprived population in North Yorkshire live in Scarborough.

The IMD also calculates deprivation for specific groups based on key indicators, including deprivation related to children and older people. The charts above highlight that, as well as experiencing high level of overall deprivation, Eastfield and Castle wards also have high levels of older people in deprivation. These rates are higher than national and district averages.

Derwent Valley and Newby wards have the lowest rate of children in poverty after housing costs and the lowest rates of older people in deprivation. Child poverty (31%, 6651 children) is higher than that observed nationally (30%).

**Employment**

The employment rate is in Scarborough (77%) is slightly higher than England’s rate (76%) but lower compared to North Yorkshire (79%). The rate has decreased by 0.7% from 2017/18 to 2018/19.

In 2018, average weekly earnings in Scarborough (£398) were significantly below England (£451) and Scarborough has one of the lowest weekly earnings compared with the other districts in North Yorkshire.
Low school attendance is linked to lower educational attainment. The proportion of half days missed by pupils due to overall absence (both authorised and unauthorised) is 5.0%, significantly higher than the national (4.8%) and Yorkshire and Humber (8%) averages in 2017/18. Scarborough has the highest rate of pupil absence compared with other districts in North Yorkshire.

The proportion of overall absence has increased steadily from 2013/14 to 2017/18 in Scarborough.

The proportion of pupils aged 5-15 with special educational needs in North Yorkshire has increased slowly between 2016 and 2018 and is significantly lower than England.

The chart below highlights the Ofsted judgement of overall effectiveness of primary and secondary schools in Scarborough.

Performance at primary schools is similar to county and national results. However, Scarborough has a higher proportion of secondary schools with a score of ‘inadequate’ when compared to the national and county averages and does not have any secondary schools rated ‘outstanding’. The small number of secondary schools (8) means that this needs to be interpreted with some caution. The North Yorkshire Coast Opportunity Area brings together leaders from schools, communities, businesses and both central and local government to raise education standards, giving children the chance to reach their full potential.
Housing

Housing affordability affects where people live and work. It also affects factors that influence health, including the quality of housing available, poverty, community cohesion, and time spent commuting. There is increasing evidence of a direct association between unaffordable housing and poor mental health, over and above the effects of general financial hardship. Type of housing tenure may be an important factor in determining how individuals experience and respond to housing affordability problems.

Scarborough has a ratio of lower quartile house price to lower quartile earnings (estimating housing affordability for lower than average earners) similar to England average. This has decreased between 2016 and 2018 highlighting that housing in Scarborough is becoming more affordable relative to earnings.

Fuel poverty rates are an issue for Scarborough which is linked to deprivation. In 2017, 12% of households (5,907 households) in Scarborough were classified as fuel poor, slightly higher than the national average (11%). Merely tackling poverty would not necessarily relieve the fuel poverty, as often housing type and access to affordable sources of energy are important. Tackling fuel poverty should in turn improve winter health, decreasing excess winter mortality and the pressure on the health and care system during the winter months. Further information on the North Yorkshire Winter Health Strategy 2015-20 can be found at the North Yorkshire Partnership website.

The chart to the right suggests a variable picture in the borough. In 2016/17 the Excess Winter Mortality index increased from 5 to 14 and is below the national average of 22.

The rate of households who are homeless has decreased in Scarborough between 2016/17 and 2017/18 and is similar to the England average.

Scarborough has the second highest rate of homelessness among all districts in North Yorkshire.
Alcohol consumption is responsible for around one in seven deaths in reported road traffic accidents in Great Britain. Any amount of alcohol affects people’s ability to drive safely. The effects can include slower reactions, increased stopping distance, poorer judgement of speed and distance and reduced field of vision, all increasing the risk of having an accident or fatality.

The rate of alcohol-related road traffic accidents in Scarborough has decreased since 2011-13 and is significantly lower than county and national rates. Scarborough is the only district in North Yorkshire with a rate is significantly lower than England.

The rate of people being killed and seriously injured (KSI) on roads in Scarborough is similar to the national average at 44 per 100,000. The trend has been consistently reducing, narrowing the gap between Scarborough and England. However these are relatively small numbers and must be interpreted with caution.

Across North Yorkshire, the rate of children killed and seriously injured on England’s roads has decreased between 2014-16 and 2015-17 (from 19 per 100,000 to 18 per 100,000) and is now similar to the England average (17 per 100,000). More information on staying safe on the road can be found in Safer Roads, Healthier Place: York and North Yorkshire Road Safety Strategy and at roadwise.co.uk.

In Scarborough, most of the population (99%) lives within a 30 minute travel time, by public transport, to a general practice. There are about 1,400 residents of Scarborough Borough with longer travel times. They are mostly resident between Scarborough town and Whitby, with some in the Glaisdale area. All of the district population is estimated to be within a 20 minutes’ drive to a general practice.

Further information is available via the Strategic Health Asset Planning and Evaluation (SHAPE) Place Atlas online tool. This is an interactive health atlas tool available to NHS and Local Authority professionals working in public health or social care.
Lifestyle and behaviour

Smoking

Smoking prevalence for adults in Scarborough is similar to England, at 13.6% compared with 14.5% nationally. For adults in routine and manual professions, smoking rates are higher than for the general population; prevalence in Scarborough is 27%, similar to England 25%. This is a decrease from the 2017 estimate, although not statistically significant, but suggesting a local reduction in the number of smokers in routine and manual professions.

Maternal smoking during pregnancy is known to be detrimental for both the health of the mother and baby. In Scarborough, maternal smoking is a concern, with 16% (148) of local mothers smoking, compared to 11% nationally.

Alcohol

Implementing appropriate local interventions ensures we reduce misuse and harm associated with alcohol in our communities. Overall, the rate of admission episodes for alcohol-specific conditions in Scarborough is significantly higher than the England rate at 665 per 100,000 population compared to 569 for England. As alcohol misuse can be a contributing factor in a wide variety of diseases, it is important to also look at broader health conditions where alcohol may have had a role, including both physical and mental health. When we look at people admitted for alcohol-related conditions, Scarborough is similar to England (2,152 per 100,000 population compared to 2,223). This shows most alcohol-related harm is due to prolonged use, manifesting in a wide range of health problems.

Further information on the 2014-2019 North Yorkshire Alcohol Strategy can be found on North Yorkshire Partnership website via the following link http://www.nypartnerships.org.uk/. Furthermore, Scarborough Borough has a significantly higher rate (232 per 100,000) of claimants of benefits due to alcoholism than the national average (133 per 100,000) in 2016.
Lifestyle and behaviour

Nutrition, activity and excess weight

Childhood obesity is closely related to excess weight in adulthood. The proportion of children in Reception who are overweight or obese in Scarborough is significantly higher than England (28% locally, 22% nationally). However, for year 6 children Scarborough has a rate which is similar to England (35% locally, 34% nationally). There is an increase in the proportion of obese children from Reception to Year 6 in Scarborough, highlighting that it is important to identify children at risk for excess weight early on and minimise excessive weight gain through primary school. For overweight children, we only see a decrease between Reception and Year 6, but this could be because children change weight status (from overweight to obese) rather than indicating weight maintenance. Details of approaches to tackle excess weight across the life course are in the strategy Healthy Weight, Healthy Lives: Tackling overweight and obesity in North Yorkshire 2016-2026.

Physical activity is associated with overall better health. Adults are identified as being inactive if they engage in less than 30 minutes of physical activity per week. The proportion of inactive adults in Scarborough is similar to England (19% locally, 22% nationally). Targeting adults who are inactive will impact on the reduction of chronic disease, particularly those related to excess weight. Targeting obesity is a priority area for Government as a way to decrease premature mortality and avoidable ill health. The proportion of adults who are overweight or obese in Scarborough is 60%—similar to the proportion of adults with excess weight in England.

Breastfeeding provides benefits to the health and wellbeing of both mother and child. In Scarborough, there has been a general decrease in the proportion of women who initiate breastfeeding within 48 hours of delivery, from 69% in 2013/14 to 61% in 2016/17. The current proportion (61%) is significantly lower than England (75%). In order to increase breastfeeding, a strategy and action plan has been developed in partnership with York that is focussing on:

- Increasing initiation of breastfeeding
- Increasing breastfeeding at 6-8 weeks
- Reducing the gap between breastfeeding rates in the most deprived areas/population groups and the average.

Produced by: Data and Intelligence Team
Strategic Support Service.
Lifestyle and behaviour

Sexual health

It is important that we have a good understanding of local sexual health needs in order to provide the most appropriate services and interventions. In Scarborough, the rate of new Sexually Transmitted Infection (STI) diagnoses for 2018 at 402 per 100,000 population is significantly lower than the rate of 784 per 100,000 in England. This excludes chlamydia diagnoses in the under 25’s as they have their own active screening programme in place.

The STI testing rate for the same time period, shows Scarborough is significantly lower than England but similar to North Yorkshire. There are many factors which can explain a low diagnosis rate; it is not necessarily indicative of a lower prevalence of disease. When accompanied by a low rate of testing, it is important to consider if all of those who need to be tested within the population have services that are accessible and available to them.

Long-acting reversible contraception (LARC) is recommended as a cost-effective and effective form of birth control. As part of the priority to make a wide-range of contraceptive services available to all, LARC prescription measurement is often used as a proxy measure for access to wider contraceptive services. An increase in access to contraceptive services is thought to lead to a reduction in unintended pregnancies. The prescription rate for LARC in Scarborough (87 per 1,000 women aged 15-44) is significantly higher than the rate seen in England (47).

Unplanned pregnancies at any stage of life can have an impact on women’s health and well-being. There is a great deal of attention paid to the experiences of teenagers who have an unplanned pregnancy, particularly in relation to the wider determinants of health including education, housing and poverty. While the rate in Scarborough of teenage conception is similar to England (24 and 18 per 1,000 women aged 15-17, respectively) and continues an overall long-term downward trend.
Diseases and Death

Major causes of death

In Scarborough, there were 1,440 deaths in 2017. Nearly three quarters of deaths fell under just three broad causes: 455 (32%) due to circulatory diseases; 387 (27%) due to cancer and 169 (12%) due to respiratory diseases.

The rate of mortality for people aged under 75 from cardiovascular disease increased in Scarborough between 2014-16 and 2015-17 to 81 and is now higher than the national (72.5 per 100,000) and Yorkshire and Humber (82.5 per 100,000) average.

The rate of mortality for individuals aged under 75 from cancer has decreased in Scarborough between 2001-03 and 2014-16 although it has risen slightly from 2014-16 to 2015-17 (from 124-126%) however it remains significantly lower than the national (135 per 100,000) and Yorkshire and Humber (143.5 per 100,000) average.

The rate of mortality for individuals aged under 75 from respiratory disease has increased in Scarborough between 2012-14 and 2014-16 although has decreased slightly from 2014-16 to 2015-17 (from 36% to 34) however the rate is similar to the national (34 per 100,000) and Yorkshire and Humber (40 per 100,000)

Inequality

The following charts show causes of death which contribute towards the life expectancy gap between the most deprived and least deprived areas in Scarborough Borough (2015-17). The biggest contributor to the life expectancy gap for both men and women is circulatory diseases, including heart disease and stroke. Targeting NHS Health Checks in deprived areas will help to narrow the inequality in life expectancy.
Diseases and Death

Dementia

Scarborough has a significantly lower rate of those estimated to have dementia being diagnosed when compared with England (58% vs 69%). There are 1,110 people aged 65+ with dementia diagnosed in Scarborough, with potentially another 770 cases unrecorded.

Clinical Commissioning Groups (CCG) are working with NHS England to explore factors affecting diagnosis locally. NHS Health Check works to identify people at risk of vascular diseases including vascular dementia so they can reduce risks. More information on NHS Health Checks can be found via Fingertips website.

The chart to the right shows the number of people with dementia recorded on general practice registers as a proportion of all people registered at each practice, for practices in the district. There are six GPs in Scarborough that have a higher proportion of people with dementia than the county average. There is a near ten-fold difference in recorded prevalence.

Cancer Screening

In Scarborough, as for England, there tends to be higher uptake of screening for breast and cervical cancer compared with bowel cancer. Despite the lower uptake of screening for bowel cancer, in Scarborough the rate is significantly higher compared with England (62% locally; 59% nationally) in 2018.

Breast cancer screening coverage fell to 75% in 2018 down from 81% in 2012. Cervical cancer screening rates are also declining (78.6%, 2010; 75.4%, 2018). However cervical cancer screening coverage is significantly higher than England and breast screen coverage is similar to England.

Screening for cancer leads to diagnosis at an earlier stage, leading to better outcomes and increased survival.
Diseases and Death

Diabetes

Complications from diabetes result in considerable morbidity and have a detrimental impact on quality of life. Type 2 diabetes is typically associated with excess weight can be prevented or delayed by lifestyle changes.

To implement effective interventions, it is important to identify all cases. The gap between observed prevalence (the number of diabetes cases recorded) and the actual prevalence (observed plus those who are undiagnosed) helps to quantify those who may be untreated. In Scarborough, it is estimated that only 71% of diabetes cases are diagnosed, significantly lower than England (78%).

The chart to the right highlights the prevalence of diabetes by general practice. There is a more than two-fold difference in recorded diabetes prevalence between general practices in Scarborough Borough. The NHS Diabetes Prevention Programme aims to identify those at high risk of developing diabetes and the NHS Health Checks programme routinely tests for those at risk of developing diabetes.

Substance Misuse

Deaths from drug misuse have increased in Scarborough since 2010-12 and the rate is significantly higher than England. Between 2004-06 and 2010-12 deaths from drug misuse were in Scarborough were not significantly different from England. Confidential help with drug and alcohol addiction is available through North Yorkshire Horizons.

Source: PHE

Prevalence of diabetes by general practice, age 17+, 2017/18

Deaths from drug misuse

Source: PHE

North Yorkshire Horizons

Per 100,000

0.0
1.0
2.0
3.0
4.0
5.0
6.0
7.0
8.0
9.0
10.0
11.0
12.0

2004 - 06
2005 - 07
2006 - 08
2007 - 09
2008 - 10
2009 - 11
2010 - 12
2011 - 13
2012 - 14
2013 - 15
2014 - 16
2015 - 17

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n = number of people on diabetes register

North Yorkshire = 6.3%
England= 6.8%

GP1
GP2
GP3
GP4
GP5
GP6
GP7
GP8
GP9
GP10
GP11
GP12
GP13
GP14
GP15
GP16
GP17
Mental Health

The percentage of individuals reporting depression or anxiety in Scarborough is significantly higher (16%) when compared to the national average (14%). Scarborough Borough has the highest proportion of depression or anxiety when compared to other districts in North Yorkshire.

Scarborough has the same rate of individuals who have long term musculoskeletal disease who are also feeling depressed or anxious compared to the England average (both 24%).

Scarborough Borough has the second highest proportion of hospital admissions for intentional self harm in North Yorkshire (255 per 100,000) which is significantly higher than the England average (185 per 100,000). The proportion of hospital admissions for intentional self harm has increased between 2012/13 and 2017/18.

Suicide is a significant cause of death in young adults, and is seen as an indicator of underlying rates of mental ill-health.

The suicide rate in Scarborough has increased between 2015-17 and 2016-18 and the rate is significantly higher than England average (16 per 100,000 locally compared to 10 per 100,000 nationally). The suicide rate for males is higher than females in Scarborough and this is in line with national trends. However, these are small numbers and should be interpreted with caution. Further information can be found in the Suicides Audit in North Yorkshire 2015 and on the North Yorkshire Partnerships Suicide Prevention

End of Life Care

The North Yorkshire Joint Health and Wellbeing Strategy includes an ambition to increase the number of people dying either at home or place that they chose by 2020. In recent years, the proportion of people dying at home in North Yorkshire has tended to increase, however, Scarborough has a smaller proportion of people dying at home compared to county and national rates. In contrast, in 2016, Scarborough Borough has fewer people dying in hospital and a higher proportion of people dying in a care home and hospice compared with county and national averages.
North Yorkshire Joint Strategic Needs Assessment 2019
Scarborough and Ryedale CCG Profile

Introduction

This profile provides an overview of population health needs in Scarborough and Ryedale CCG (S&R CCG). Greater detail on particular topics can be found in our Joint Strategic Needs Assessment (JSNA) resource at www.datanorthyorkshire.org which is broken down by district. This document is structured into five parts: population, deprivation, disease prevalence, hospital admissions and mortality. It identifies the major themes which affect health in S&R CCG and presents the latest available data, so the dates vary between indicators.

Summary

- **Life expectancy is significantly lower than England for males and not significantly different for females.** For 2011-2015, female life expectancy in S&R CCG is 82.8 years (England: 83.1), and male life expectancy is more than four years lower than for females at 78.4 years (England: 79.4) [1].

- **There is a high proportion of older people.** In 2017, 24.2% of the population was aged 65 and over (28,900), higher than national average (17.3%). Furthermore over 3,800 (3.2%) were age 85+, compared with 2.3% in England. [2]

- **A substantial number of children grow up in relative poverty.** In 2015, there were 19.8% of children aged 0-15 years living in low income families, compared with 19.9% in England [1].

- **There are areas of deprivation.** Within the CCG area, 15 Lower Super Output Areas (LSOAs) out of a total of 69 are amongst the 20% most deprived in England, and 8 of these 15 LSOAs are amongst the 10% most deprived in England. These 8 LSOAs are in the Woodlands, Eastfield, Castle and North Bay wards in Scarborough. S&R CCG contains two-thirds of North Yorkshire’s deprived LSOAs. [3]

- **Many people have longstanding health problems.** The census in 2011 showed 23,500 people living with long-term health problem or disability (21.3% compared to 17.6% in England) [1].

- **The highest reported rates of ill health are from:** hypertension (16.9%); obesity (12.9%); depression (10.9%); asthma (7.9%); and diabetes (7%) [4].

- **Hospital admissions vary according to admissions route.** Non-elective admissions are most frequently due to respiratory problems (13.9%), and circulatory diseases (12.9%); and injury, Poisoning and other external causes (12.6%). Elective admissions are most common for neoplasms (22%); digestive disorders (14.4%) and pregnancy and childbirth (10%) [5].
Population

There are 12 general practices in S&R CCG area with 120,400 registered patients (December 2018) [6]. In contrast, the ONS mid-year resident population estimate for 2017 gave a CCG-wide population of 112,300 [7]. The GP registered population in S&R CCG is 7.2% higher than the resident population, similar to England, where the difference between registered and resident population in 7%. Such differences can be due to: over-counting in GP registers; under-counting in population estimates; people resident in one district but registered with a GP in a different district; and definitions of residency (e.g. students and other temporary residents).

The resident population is forecast to rise to 113,100 by 2025 (1% increase since 2018) and 114,300 by 2040 (2% increase since 2018) [8]. In England, the corresponding increases are 4% by 2025 and 10.3% by 2040. Local population growth is forecast to be lower than that seen nationally. For more detailed information on population growth please see the district profiles which are available at Data North Yorkshire.

There is a high proportion of people aged over 65 (24.2%) in the S&R CCG compared with England (17.3%). The proportion of people aged 5-14 (10.2%) is slightly lower than England (11.6%). The following age profile shows a lower proportion of the population in age groups 0-49 years and a higher proportion in age groups 50-95+, compared with both England and the Yorkshire & Humber region. For more detailed information on population and BME population please see the district profiles which are available at Data North Yorkshire.

Source: National General Practice Profiles, PHE
In 2015, there were 19.8% of children aged 0-15 years living in low income families, compared with 19.9% in England [1]. The 2015 Index of Multiple Deprivation (IMD) identifies 15 Lower Super Output Areas (LSOAs) out of a total of 69 across the CCG which are amongst the 20% most deprived in England, and 8 out of these 15 LSOAs are amongst the 10% most deprived in England. These 8 LSOAs are all in the Woodlands, Eastfield, Castle and North Bay areas in Scarborough. A further 7 LSOAs, in Ramshill, Central, Woodlands, Falsgrave Park, Filey and Northstead wards (all in Scarborough District) are amongst the 15 LSOAs (20% most deprived in England) [3]. A list of these 15 LSOAs can be found in Appendix 1.

These 15 LSOAs form about two-thirds (65%) of the 23 LSOAs in North Yorkshire which are amongst the 20% most deprived in England. S&R CCG has the highest concentration of deprived neighbourhoods in North Yorkshire, predominantly located in Scarborough town, but also in Eastfield and Filey.

Deprivation scores, using IMD-2015, have been estimated for general practices. They show five practices in S&R CCG have populations experiencing higher levels of deprivation than England.

Source: National General Practice Profiles, PHE
The lifestyle choices that people make and behaviours they follow in their lifetime can all have an impact on both their current and future health. Lifestyle diseases are defined as diseases linked with the way people live their life. These are commonly caused by alcohol, drug and smoking abuse as well as lack of physical activity and unhealthy eating.

Smoking

S&R CCG has highest estimated rate of smoking in 2017/18 in North Yorkshire and the rate is higher than the England average. Castle Health Centre has the highest rate of smoking prevalence in Scarborough; the rate higher than the England and CCG average.

Source: National General Practice Profiles, PHE
**Adult obesity**

There is a higher rate of adult obesity in S&R CCG compared with England, with 12,800 adults having a recorded body mass index above 30 kg/m². Ten practices have rates which are significantly higher than England, and one practice (Scarborough Medical Group) which is significantly lower.

**NHS Scarborough and Ryedale CCG: Adult Obesity Prevalence 2017/18**

![Bar chart showing prevalence of adult obesity in different practices compared to England.](chart)

Source: NHS Digital
In S&R CCG, hypertension, obesity and depression are the most common health problems, followed by asthma and diabetes.

**Disease Prevalence**

The following charts use the NHS Quality and Outcomes Framework prevalence data for 2017/18. These are expressed as crude percentages, without taking account of variation in the populations between general practices. Differences such as the proportion of elderly patients, ethnicity and levels of deprivation may affect crude prevalence rates. The charts are presented in order of recorded prevalence, from highest to lowest, within the CCG.

![Disease Prevalence Chart]

Source: NHS Digital

**Disease prevalence by general practice**

The following charts use the NHS Quality and Outcomes Framework prevalence data for 2017/18. These are expressed as crude percentages, without taking account of variation in the populations between general practices. Differences such as the proportion of elderly patients, ethnicity and levels of deprivation may affect crude prevalence rates. The charts are presented in order of recorded prevalence, from highest to lowest, within the CCG.
Hypertension

In S&R CCG, there are 20,400 people with known hypertension prevalence that is higher than England. Ten general practices have rates significantly higher than England whilst one practice (Castle Health Centre) has a significantly lower prevalence rate to England.

Source: NHS Digital
Depression

There are more than 10,700 adults with a record of depression in S&R CCG, with a higher rate than seen in England. Three practices have rates which are significantly higher than England, while three practices have significantly lower rates.

Source: NHS Digital
Asthma

In S&R CCG, asthma prevalence is significantly higher than England. There are over 9,500 people on asthma registers in S&R CCG. Almost all practices have asthma prevalence rates which are significantly higher than England.

Source: NHS Digital
Coronary heart disease

Coronary heart disease (CHD) prevalence is higher in S&R CCG compared with England and there are nearly 5,800 people with diagnosed CHD. Eight of the 12 general practices have prevalence rates significantly higher than England. Three practices that have significantly lower prevalence rates than England.

Source: NHS Digital

Consideration can be given to variation which may be due to modifiable risk factors within the population, differences in record keeping, variation in health care and access to services. NHS RightCare produces a range of intelligence products to help local health economies identify and address health inequality.

Furthermore, the NHS Health Check is a health check-up for adults in England aged 40-74, designed to spot early signs of stroke, kidney disease, heart disease, type 2 diabetes or dementia. As individuals age they have a higher risk of developing one of these conditions and an NHS Health Check helps find ways to lower this risk. The NHS Health Check report for North Yorkshire highlights performance of health checks across North Yorkshire and can be found on Data North Yorkshire.
In 2016/17, there were just over 40,000 hospital admissions of which 25,898 (63.4%) were elective admissions and 14,950 (36.6%) were non-elective admissions. In total, there were 113 providers, with York Teaching Hospitals NHS Foundation Trust being the main provider.

### Hospital admissions by provider, S&R CCG, 2016/17

<table>
<thead>
<tr>
<th>Provider</th>
<th>Proportion of elective admissions</th>
<th>Proportion of non-elective admissions</th>
<th>Proportion of all admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>York Teaching Hospitals NHS Foundation Trust</td>
<td>87.6%</td>
<td>93.4%</td>
<td>89.7%</td>
</tr>
<tr>
<td>Hull and East Yorkshire Hospitals NHS trust</td>
<td>6.2%</td>
<td>2.8%</td>
<td>5.0%</td>
</tr>
<tr>
<td>Leeds Teaching Hospitals NHS Trust</td>
<td>2.3%</td>
<td>1.7%</td>
<td></td>
</tr>
<tr>
<td>Ramsay Healthcare UK Operations Ltd</td>
<td>1.3%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tees, Esk and Wear Valleys NHS Foundation Trust</td>
<td></td>
<td>1.2%</td>
<td></td>
</tr>
<tr>
<td>Remaining providers</td>
<td>2.7%</td>
<td>2.7%</td>
<td>3.7%</td>
</tr>
</tbody>
</table>

Source: Public Health England SHAPE atlas

The main reasons for non-elective admissions are shown below for causes which contributed towards more than 5% of non-elective admissions. Respiratory diseases are the most common reason for non-elective admission followed by circulatory diseases and injuries & poisoning.

### Non-elective admissions by causes, S&R CCG, 2016/17

<table>
<thead>
<tr>
<th>ICD-10 chapter</th>
<th>Number of admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>X: Respiratory</td>
<td>13.9%</td>
</tr>
<tr>
<td>IX: Circulatory</td>
<td>12.9%</td>
</tr>
<tr>
<td>XIX: Injury, poisoning and certain other consequences of external causes</td>
<td>12.6%</td>
</tr>
<tr>
<td>XI: Digestive</td>
<td>9.5%</td>
</tr>
<tr>
<td>XIV: Genitourinary</td>
<td>6.4%</td>
</tr>
<tr>
<td>I: Infectious and parasitic diseases</td>
<td>6.1%</td>
</tr>
</tbody>
</table>

Source: Public Health England SHAPE atlas

Within chapter XIX: Injury, poisoning and certain other consequences of external causes, the main reasons for admission are: fracture of femur; poisoning by non-opioid drugs; open wound of head; and fracture of lower leg. This suggests falls and drug overdose (accidental or otherwise) may contribute importantly to local emergency admissions.
The main reasons for elective admission are similarly shown for causes which contributed towards more than 5% of elective admissions. Neoplasms represent the highest percentage of elective admissions, followed by digestive diseases and pregnancy & childbirth.

Source: Public Health England SHAPE atlas

For chapter XXI: Factors influencing health status, the leading reasons for admission are: live born infants according to place of birth (35% of admissions in this chapter); supervision of normal pregnancy (23%); need for other prophylactic measures (10%); follow-up examination after treatment for conditions other than cancer; and follow-up examination after treatment for malignant neoplasm.

**Under 18 hospital admissions**

S&R CCG has the lowest rate of admissions due to injury for those aged under 18 when compared to other CCGs in North Yorkshire. The rate is also lower than the England average. Around half of practices in S&R CCG have higher rates than the England and CCG average.

Source: National General Practice Profiles, PHE
S&R CCG has a higher rate of emergency hospital admissions for all causes under 18 than the England average. However, S&R CCG has the highest rate of A&E attendance under 18 compared to other CCGs in North Yorkshire and the rate is higher than the England average.

![NHS Scarborough And Ryedale CCG: A&E attendances and Emergency hospital admissions for all causes under 18, 2013/14-2015/16](image)

Source: National General Practice Profiles, PHE

Public Health England produces a summary health profile for S&R CCG (Appendix 2). This compares more than 50 indicators with national data and highlights those which are significantly different from England. This can be used to help inform topics which might be considered for focused improvement work. In particular, it highlights the following as being significantly worse than England:

- Child Development at age 5 (%)
- GCSE Achievement (SA*-C inc. Eng & Maths) (%)
- General Health - bad or very bad (%)
- General Health - very bad (%)
- Limiting long term illness or disability (%)
- Provision of 1 hour or more unpaid care per week (%)
- Provision of 50 hours or more unpaid care per week (%)
- Deliveries to teenage mothers (%)
- Emergency admissions in under 5s (Crude rate per 1,000)
- A&E attendances in under 5s (Crude rate per 1,000)
- Binge drinking adults (%)
- Emergency hospital admissions for CHD (SAR)
- Emergency hospital admissions for Myocardial Infarction (heart attack) (SAR)
- Elective hospital admissions for hip replacement (SAR)
- Elective hospital admissions for knee replacement (SAR)
- Life expectancy at birth for males, 2011-2015 (years)
- Deaths from all causes, all ages (SMR)
• Deaths from circulatory disease, all ages (SMR)
• Deaths from circulatory disease, under 75 years (SMR)
• Deaths from coronary heart disease, all ages (SMR)
• Deaths from stroke, all ages (SMR)
• Deaths from respiratory diseases, all ages (SMR)

**Mortality**

The chart below shows the directly standardised rate (DSR) of potential years of life lost (PYLL) per 100,000 registered patients and the number of observed deaths by conditions. The condition with the highest DSR (832.6) and observed deaths (177) is ischaemic heart diseases.

<table>
<thead>
<tr>
<th>Condition</th>
<th>DSR</th>
<th>Observed deaths</th>
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<tr>
<td>Ischaemic heart diseases</td>
<td>832.6</td>
<td>177</td>
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<tr>
<td>Neoplasms</td>
<td>705.2</td>
<td>105</td>
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<tr>
<td>Cerebrovascular diseases</td>
<td>427.5</td>
<td>71</td>
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<tr>
<td>Respiratory diseases</td>
<td>115.9</td>
<td>28</td>
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</table>

Source: HSCIC

**Place of death**

Within S&R CCG, 38.6% of deaths occurred in hospital, 24.9% in care homes, 22.0% at home, 12.9% in hospices and 1.6% elsewhere. Compared with England, S&R CCG has fewer people dying in hospital but more people dying in care homes and hospices.
Source: Public Health England

Additional mortality data available in the [JSNA 2018 District Profiles](https://www.jsna.org.uk/).
References

1. Public Health England. Local Health
3. Data.gov.uk
4. NHS Digital. QOF 2017/18
5. SHAPE (registration required)
6. NHS Digital. CCG outcomes tool
7. ONS. Clinical commissioning group population estimates
8. ONS. Population projections - clinical commissioning groups

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January 2019
### Appendix 1

<table>
<thead>
<tr>
<th>LSOA</th>
<th>Ward</th>
<th>District</th>
<th>Index of Multiple Deprivation (IMD) National Rank (where 1 is most deprived)</th>
<th>Index of Multiple Deprivation (IMD) Decile (where 1 is most deprived 10% of LSOAs)</th>
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## Appendix 2

### S&R CCG health profile summary

**Selection:** E38000145 - NHS Scarborough and Ryedale CCG

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Selection value</th>
<th>England value</th>
<th>England worst</th>
<th>Summary chart</th>
<th>England best</th>
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<td>2.8</td>
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<td>Child Development at age 5 (%)</td>
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<td>GCSE Achievement (%)</td>
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<td>1.8</td>
<td>4.8</td>
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<td>Long Term Unemployment (Rate/1,000 working age population)</td>
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<td>3.7</td>
<td>14.4</td>
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<td>General Health - bad or very bad (%)</td>
<td>6.3</td>
<td>5.5</td>
<td>9.5</td>
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<td>2.8</td>
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<td>General Health - very bad (%)</td>
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<td>Limiting long term illness or disability (%)</td>
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<td>17.6</td>
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<td>11.2</td>
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<td>Overcrowding (%)</td>
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<td>8.7</td>
<td>34.9</td>
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<td>Provision of 1 hour or more unpaid care per week (%)</td>
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<td>10.2</td>
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<td>Provision of 50 hours or more unpaid care per week (%)</td>
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<td>Pensioners living alone (%)</td>
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<td>Deliveries to teenage mothers (%)</td>
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<td>1.1</td>
<td>2.3</td>
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<td>0.2</td>
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<td>Emergency admissions in under 5s (Crude rate per 1000)</td>
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<td>149.2</td>
<td>369.8</td>
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<td>65.3</td>
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<td>A&amp;E attendances under 5s (Crude rate per 1000)</td>
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<td>551.6</td>
<td>1718.9</td>
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<td>138.8</td>
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<td>Admissions for injuries in under 15s (Crude rate per 10,000)</td>
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<td>Regular smoker (modelled prevalence, age 15) (%)</td>
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<td>12.7</td>
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<td>Obese adults (%)</td>
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<td>Obese Children (Reception Year) (%)</td>
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<td>Children with excess weight (Reception Year) (%)</td>
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<td>22.2</td>
<td>27.2</td>
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<td>14.6</td>
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<td>Obese Children (Year 6) (%)</td>
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<td>19.3</td>
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<td>Children with excess weight (Year 6) (%)</td>
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<td>33.6</td>
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<td>Emergency hospital admissions for CHD (SAR)</td>
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<td>59.4</td>
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<td>Emergency hospital admissions for stroke (SAR)</td>
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<td>Emergency hospital admissions for Myocardial Infarction (heart attack) (SAR)</td>
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<td>100</td>
<td>280.2</td>
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<td>53.8</td>
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<td>Emergency hospital admissions for Chronic Obstructive Pulmonary Disease (COPD) (SAR)</td>
<td>77.1</td>
<td>100</td>
<td>233.4</td>
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<td>Incidence of breast cancer (SIR)</td>
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<td>100</td>
<td>119.3</td>
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<td>76.4</td>
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<td>Incidence of colorectal cancer (SIR)</td>
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<td>120.3</td>
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<td>Life expectancy at birth for males, 2011- 2015 (years)</td>
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<td>79.4</td>
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<td>Life expectancy at birth for females, 2011- 2015 (years)</td>
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<td>83.1</td>
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<td>Deaths from all causes, under 65 years (SMR)</td>
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<td>179.1</td>
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<td>69.3</td>
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<td>Deaths from all causes, under 75 years (SMR)</td>
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<td>100</td>
<td>177</td>
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<td>72.7</td>
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<td>Deaths from all causes, over 75 years (SMR)</td>
<td>96.9</td>
<td>100</td>
<td>127.9</td>
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<td>78.3</td>
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<td>Deaths from all cancer, over 75 years (SMR)</td>
<td>90.4</td>
<td>100</td>
<td>136.5</td>
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<td>76.4</td>
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<td>Deaths from circulatory disease, all ages (SMR)</td>
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<td>73.1</td>
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<td>Deaths from circulatory disease, under 75 years (SMR)</td>
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<td>Deaths from coronary heart disease, all ages (SMR)</td>
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<td>66.3</td>
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<td>Deaths from coronary heart disease, under 75 years (SMR)</td>
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<tr>
<td>Deaths from respiratory diseases, all ages (SMR)</td>
<td>108.1</td>
<td>100</td>
<td>177.9</td>
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<td>70.5</td>
</tr>
</tbody>
</table>

**Key:**
- **Significantly worse**
- **Significantly better**
- **Not significantly different from average**

18
## Appendix 3

### S&R CCG Outcomes Framework

#### Indicator Name | Value
--- | ---
1. Potential years of life lost (PYLL) from causes considered amenable to healthcare - Female (2014) | 1,757
2. Potential years of life lost (PYLL) from causes considered amenable to healthcare - Male (2014) | 2,342
3. Under 75 mortality rates from cardiovascular disease (2016) | 71.6
4. 1.3.4 Mortality within 30 days of hospital admission for stroke (2014/15) | 0.9
5. 1.5 Mortality within 30 days of hospital admission for stroke (2014/15) | 0.2
6. Under 75 mortality rates from respiratory disease (2016) | 27.2
7. Under 75 mortality rates from liver disease (2016) | 20.0
8. Emergency admissions for alcohol related liver disease (2016) | 3.9
9. Under 75 mortality rates from cancer (2016) | 1.1
10. One-year survival from all cancers (Diagnosed 2015) | 72.0
11. One-year survival from breast, lung and colorectal cancers (Diagnosed 2015) | 68.3
12. People with Severe Mental Illness (SMI) who have received the complete list of physical checks (2014/15) | 39.5
13. Maternal smoking at delivery (2017/18 Q2) | 14.0
14. Cancer at diagnosis (2016) | 81.8
15. Percentage of cancers detected at stage 1 and 2 (2016) | 48.6
16. 19. Record of lung cancer stage at diagnosis (2016) | 93.8
17. Mortality from breast cancer in females (2014 - 2016) | 25.0
18. All-cause mortality - 12 months following a first emergency admission to hospital for heart failure in people aged 16 and over (April 2013 to March 2015) | 150.6
19. In-hospital mortality: incidence (2017 - 2018 Jan - Dec) | 42.2
20. Smoking rates in people with severe mental illness (SMI) (2014/15) | 37.2
21. Referrals to cardiac rehabilitation within 5 days of an admission for coronary heart disease (2014/16) | 8.8
22. Neonatal mortality and stillbirths (2016) | 6.8
23. Low birth weight full-term infants (2016) | 3.2

#### Domain 2

| Indicator Name | Value |
--- | --- |
2.1 Health-related quality of life for people with long-term conditions (2016/17) | 0.72 |
2.2 Proportion of people who are feeling supported to manage their condition (2016/17) | 61.4 |
2.3 The percentage of people with Chronic Obstructive Pulmonary Disease (COPD) and Medical Research Council (MRC) Dyspnoea Scale ≥3, identified on GP systems, referred for a pulmonary rehabilitation (2016/17) | 38.1 |
2.4 Percentage of people with diabetes who have received nine care processes (2016/17) | 33.5 |
2.5 People with diabetes diagnosed less than a year referred to specialist diabetes care (2016/17) | 68.2 |
2.6 Hospitalisation for chronic ambulatory care sensitive conditions (2017 - 2018 Jan - Dec) | 95.5 |
2.7 Hospitalisation for asthma, diabetes and sepsis in under 16s (2017 - 2018 Jan - Dec) | 87.4 |
2.8 Complications associated with diabetes (2016/17) | 63.9 |
2.9 Access to community mental health services by people from Black and Minority Ethnic (BME) groups (2016/17) | 63.8 |
2.10 Access to psychological therapies services by people from Black and Minority Ethnic (BME) groups (2016/17) | 245.7 |
2.11 Percentage of referrals to Improving Access to Psychological Therapies (IAPT) services which indicated a clinically significant improvement following completion of treatment (2015 - 2016 Jan - Dec) | 41.8 |
2.12 Percentage of referrals to Improving Access to Psychological Therapies (IAPT) services which indicated a clinically significant improvement following completion of treatment (2015 - 2016 Jan - Dec) | 38.2 |
2.13 Percentage of referrals to Improving Access to Psychological Therapies (IAPT) services which indicated a clinically significant improvement following completion of treatment (2015 - 2016 Jan - Dec) | 13.0 |
2.14 Percentage of referrals to Improving Access to Psychological Therapies (IAPT) services which indicated a clinically significant improvement following completion of treatment (2015 - 2016 Jan - Dec) | 6.7 |
2.15 Health-related quality of life for carers, aged 18 and above (2016/17) | 0.6 |
2.16 Health-related quality of life for people with a long-term mental health condition (2016/17) | 0.6 |
<table>
<thead>
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<th>Indicator Description</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
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<td>3.1 Emergency admissions for acute conditions that should not usually require hospital admission (2017 - 2017)</td>
<td>1497</td>
<td>225</td>
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<td>3.2 Emergency readmissions within 30 days of discharge from hospital (2018)</td>
<td>168</td>
<td>8.9</td>
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<tr>
<td>3.3 Elective Hip replacement (primary) procedures - patient reported outcomes measures (PROMIS) (2019)</td>
<td>0.47</td>
<td>0.35</td>
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<td>3.4 Elective knee replacement (primary) procedures - patient reported outcomes measures (PROMIS) (2019/20)</td>
<td>0.33</td>
<td>0.19</td>
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<tr>
<td>3.5 Elective gross hemia procedures - patient reported outcomes measures (PROMIS) (2019/20)</td>
<td>0.15</td>
<td>0.04</td>
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<td>3.6 Elective varicose vein procedures - patient reported outcomes measures (PROMIS) (2019/20)</td>
<td>No Data</td>
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<tr>
<td>5.4 Emergency admissions for children under 18 years of age (2017 - 2017)</td>
<td>664</td>
<td>39</td>
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<tr>
<td>5.5 People who had a stroke who died within 30 days of discharge (2018)</td>
<td>34.2</td>
<td>17.6</td>
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<tr>
<td>5.6 People who had an acute stroke who receive thrombolysis (2019/20)</td>
<td>19.5</td>
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<tr>
<td>5.7 People with stroke who are discharged from hospital with a stroke specific care plan (2019/20)</td>
<td>5.15</td>
<td>34.3</td>
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<tr>
<td>5.8 People who have a follow-up assessment between 4 and 8 weeks after initial admission for stroke (2019/20)</td>
<td>4.19</td>
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<tr>
<td>5.9 People who had an acute stroke who spend 90% or more of their stay on a stroke unit (2019/20)</td>
<td>86.4</td>
<td>57.7</td>
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<tr>
<td>5.10 Hip fracture: proportion of patients recovering to their previous level of mobility/walking ability at 36 months (2015)</td>
<td>No Data</td>
<td>0</td>
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<tr>
<td>5.11 Hip fracture: proportion of patients recovering to their previous level of mobility/walking ability at 36 months (2019)</td>
<td>62.5</td>
<td>41.1</td>
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<tr>
<td>5.12 Hip fracture: early surgery (2016)</td>
<td>106.6</td>
<td>55.1</td>
<td></td>
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</tr>
<tr>
<td>5.13 Hip fracture: early discharge (2016)</td>
<td>75.6</td>
<td>50.1</td>
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<tr>
<td>5.14 Hip fracture: comprehensive care (2018)</td>
<td>108.5</td>
<td>75.9</td>
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<tr>
<td>5.15 Alcohol-specific hospital admissions (2017 - 2017)</td>
<td>131.0</td>
<td>39.3</td>
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<tr>
<td>5.16 Alcohol-specific hospital admissions (2017 - 2017)</td>
<td>131.0</td>
<td>39.3</td>
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<tr>
<td>5.17 Percentage of adults in contact with secondary mental health services in employment (2016 - 2017)</td>
<td>31.7</td>
<td>24</td>
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<tr>
<td>5.18 Hip fracture: care process composite indicator (2016)</td>
<td>73.3</td>
<td>25.5</td>
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<tr>
<td>4.4 Patient experience of GP out-of-hours services (2014/15)</td>
<td>57.7</td>
<td>43</td>
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<tr>
<td>4.5 Length of hospital stay (2015)</td>
<td>78.2</td>
<td>68.3</td>
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<tr>
<td>4.6 Hospital length of stay (2015)</td>
<td>0.7</td>
<td>0.5</td>
<td></td>
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<tr>
<td>4.7 Hospital length of stay (2015)</td>
<td>70.5</td>
<td>68.1</td>
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<td>4.8 Hospital length of stay (2015)</td>
<td>12.0</td>
<td>2.23</td>
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<tr>
<td>4.9 Hospital length of stay (2015)</td>
<td>150.0</td>
<td>46</td>
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</table>