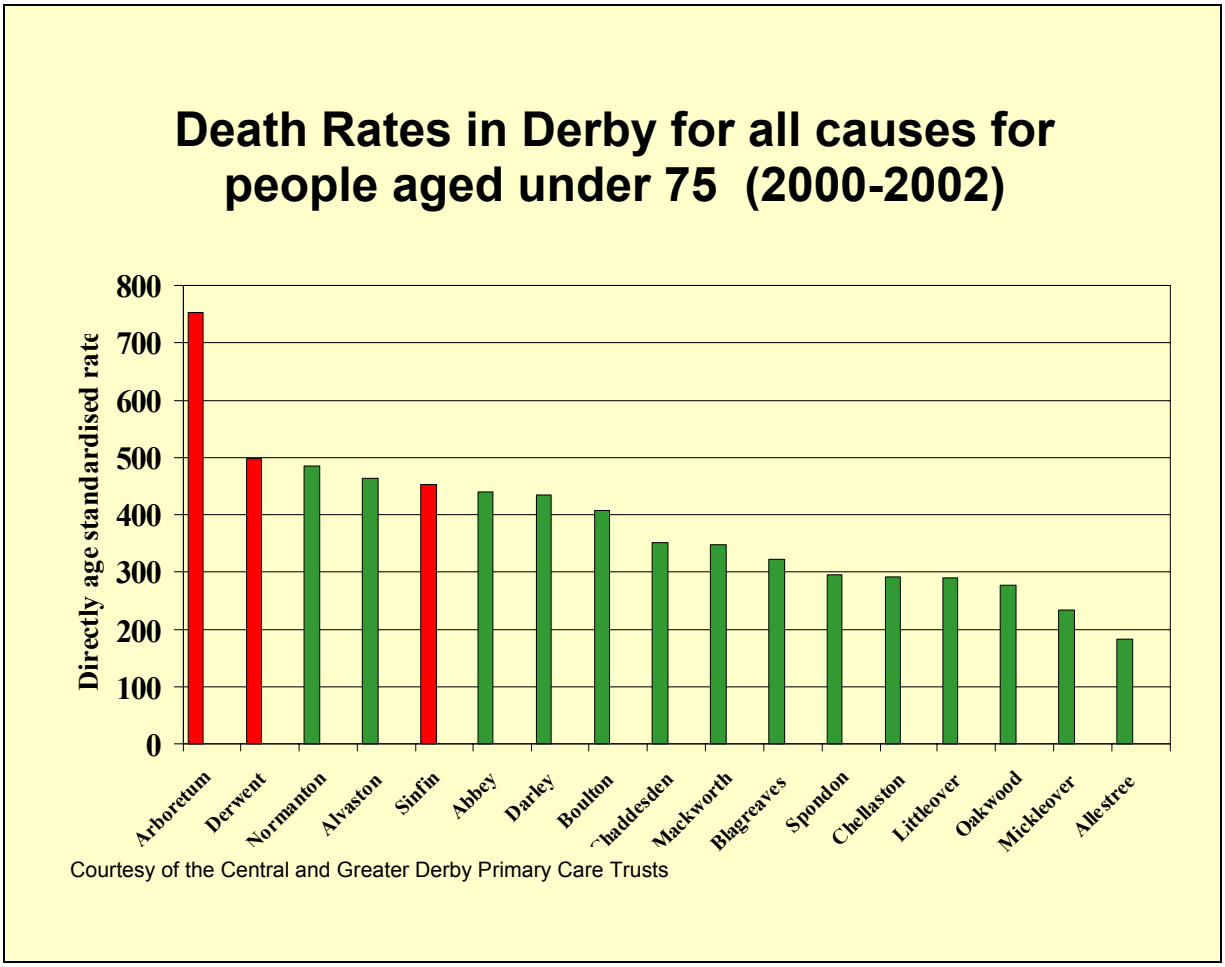
DERBY CITY COUNCIL

Reducing Health Inequalities



Final Report of the

Social Care and Health

Overview and Scrutiny Commission

July 2004

Chairman's Foreword

People living in the most deprived neighbourhoods of Derby have to contend with the worst outcomes in many spheres of life in comparison to those who live in relatively affluent areas. Health related issues paint an equally bleak picture. The gap in average life expectancy between richer and poorer parts of Derby is as much as eight years. It is hard to imagine an outcome that is more unequal than dying younger. The Health and Social Care Commission has tried to draw public attention to this unacceptable inequity. We have gathered evidence from a wide range of local and national organisations to see how Derby compares with other similar cities. We also looked at what has been done in other parts of the country to narrow the difference. The Commission found that other cities were no further forward. If anything, Derby may be the first local authority, which has attempted to grapple with the issue with a view to creating a genuine partnership framework between the Council, Primary Care Trusts and the voluntary sector in reducing inequalities.

Reducing health inequalities is one of those large and complex topics that baffle most experts when deciding how and where to begin. After debating various approaches the Commission decided to narrow its focus on the three most deprived areas of the city including Derwent, Osmaston and Normanton. The Commission received evidence from professionals on a range of issues linked to health. Members recognised that the problems cannot be addressed by one organisation in isolation and that serious inroads will only be made through a concerted effort by everyone working for the public good.

Making an impact will require developing long-term strategies and tackling the major determinants of health such as education, unemployment and crime as well as improving clinical services. There needs to be a balance between tackling the causes of ill health and treating its symptoms. Lasting change will only come about if we succeed in improving vital outcomes for communities in the greatest need.

Individuals and communities will also need to play their part. In many instances it is the lifestyle choices people make that can make the greatest difference. This includes cutting down on smoking, excessive drinking and eating a nutritional diet and taking up physical activity. The role of the agencies is to recognise and remove some of the barriers that prevent people making healthy lifestyle choices. They need to ensure that individuals have access to advice, information and appropriate services in order to adopt and maintain healthy lifestyles.

I hope that this report will generate a wider debate within the City and create better awareness amongst the public about the whole issue of inequities in civilised societies, leading to improved outcomes for all.

This has been a long and complex review carried out over many months. I would like to thank all the members of the Commission involved in this review for their dedication and hard work in completing it.

Reducing Health Inequalities

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Reducing Health Inequalities

1. Executive Summary and Recommendations

1.1 There are significant differences in health between different sections of the community. People living in some of the most deprived neighbourhoods of the city have higher death rates from cancer, coronary heart disease and generally have a shorter life expectancy than those living in the more affluent areas. There are also health inequalities amongst other groups such as minority ethnic communities, people with learning disabilities as well as between gender.

1.2 Local authorities with social services responsibilities have been given new powers under the Health and Social Care Act 2001 to scrutinise NHS health services. The Social Care and Health Overview and Scrutiny Commission, the local body charged with the responsibility for scrutinising the health function in the city, considered a number of local strategies to determine its topic for detailed investigation before resolving to review health inequalities based around three areas of the city, namely, Derwent New Deal for Communities, Normanton Neighbourhood Renewal Fund and Osmaston /Allenton Neighbourhood Renewal Fund areas. The areas were selected on the basis of them having high levels of deprivation, their size and make up of the local community and also having access to external funding to support any action that may arise from the review process. The Commission considered that taking an area based approach and investigating a broad set of issues linked to health is likely to produce better outcomes in reducing health inequalities than by reviewing a single health problem.

1.3 The key aim of the review was to identify the potential causes of health problems in deprived areas by focusing its work on the three neighbourhoods and to consider how the health gap with the rest of the city could be reduced. The Commission also aimed to raise the awareness of the differences in health outcomes amongst the local population and to disseminate its findings in the city.

1.4 The Commission followed a broad plan to guide the review process. This involved a joint brainstorming exercise between Commission Members and senior officers from local health bodies and the Council to discuss issues linked to inequalities in health. Evidence to the Review was received from a wide range of organisations. These included the Health Inequality Unit of the Department of Health, local GPs, Central and Greater Derby Primary Care Trusts (PCTs), Cancer Research UK, British Heart Foundation, Derwent New Deal for Communities, Sure Start, Fresh Start, Teenage Pregnancy Team, BBC Radio Derby and various departments of the Council. In all the Commission held 20 separate evidence gathering sessions, which were attended by 36 people.

1.5 The Commission also gathered statistical information from a variety of sources including council departments, health bodies, and also the

Internet. Where it was not possible to obtain detailed statistics on the three target areas, relevant ward data was used such as the Arboretum ward for the Normanton NRF area, Derwent ward for the Derwent NDC and Osmaston ward for the Osmaston NRF area. The Derby Pointer Panel was also used to determine the public participation in physical activities.

Conclusion

1.6 The Review has found that all three areas have lower life expectancies compared with the rest of the city. The male life expectancy in Normanton NRF area is 73.2 years, Osmaston NRF is 71.7 years and Derwent NDC is 71.3 years compared with the city average of 75.5 years. It also found that on average women live five years longer than men.

1.7 There are other differences in the health outcomes of these areas. The standardised death rate for people before their 75th birthday from all causes is up to 40% higher compared with the rest of the city. These areas also have higher standardised death rates from coronary heart disease and cancer. Evidence submitted by Lister House Surgery revealed that the death rate from circulatory diseases amongst its patients is 235.9 mortalities per 100,000 population compared with 140.3 for the city. The target areas also have greater proportion of babies born with low birthweight. This problem is particularly acute in Normanton where 12.3% of all live and stillbirths weigh less than 2500g compared with 8.9% for the city.

1.8 The full extent of the differences in health outcomes between areas of deprivation and the rest of the city has been difficult to examine not least because the issues are extremely large and complex but also due to gaps in the base line information. For example, it is nationally recognised that the level of diabetes amongst people of South Asian origin is considerably higher than the rest of the population, however data was unavailable locally at the time of the review to confirm the prevalence amongst ethnic minority groups in the city. The Commission was informed by the PCTs that a process has been started to collect this information.

1.9 The Review looked at a selection of determinants of health. These factors are considered to have a major influence on the health outcomes of the local population. The findings from the Review effectively confirm what is largely already known, that the target areas have higher rates of crime and higher levels of unemployment, lower educational attainment and a sizeable proportion of properties judged to be unfit and in need of repair compared with other parts of the city.

1.10 There will always be a gap between the high and lower value when comparing health outcomes between groups of people. The Commission is of the view that this gap shouldn't be so large. It is found that not only do these areas have a greater set of problems but also in some situations the problems have got relatively worse. For example the rate of unemployment in the Normanton area relative to the city average has got

worse since 1996. The gap has increased from approximately 2.5 times to more than 3.5 times the city average.

1.11 The Government has given the responsibility for improving the health of the local population and tackling inequalities to the Primary Care Trust under the NHS Plan and the Priorities and Planning Framework 2003-2006. However since the responsibility for addressing the determining factors lies with many separate organisations, the Commission recognises that the health bodies are unable to address health inequalities on their own. Reducing health inequalities therefore requires a multi- agency approach and has to be addressed in a partnership, not only between the statutory organisations but should also include the private and voluntary sector. The Commission therefore welcomes the lead taken by the Derby City Partnership to address health inequalities under Objective 2 of the Community Strategy Action Plan 2004/05 - City of Opportunity to 'Improve the health and well-being, and narrow the gap between deprived and more affluent communities'.

1.12 Tackling health inequalities will require taking a long-term view, joined up thinking and sharing of resources between the key agencies. It also requires individuals to play their part. They will need to consider changing their lifestyles, to stop smoking, drinking excessively, take up exercise and eat healthy foods. All these factors have strong health links.

1.13 However, making lifestyle changes is not always straightforward as it sounds. Individuals may face many barriers, which can include peer pressures and the availability of healthy foodstuffs. In many instances people know that they should adopt healthy lifestyles such as stop smoking and take up regular exercise but have problems actually putting it in practice. Agencies need to help people make informed choices and to make those choices easy by addressing the barriers.

1.14 Based on the evidence gathered through the review process, the Commission makes the following recommendations.

Recommendations

Recommendation 1

The partner organisations should seek to address the key factors (determinants) linked to ill health in addressing health inequalities

Crime and Disorder
The Crime and Disorder Partnership establishes a strategy for addressing crime linked to older people

Education

The Education Service focuses greater attention and provides more resources to improving the level of attainment amongst children in the deprived communities

Road Traffic Collisions

The Highways and Transport Division in collaboration with the Education Service provides greater level of support to schools to tackle traffic problems caused by journeys to and from school and minimise the potential health risks

Public Health

The Commission welcomes the development of the Public Health Strategy jointly by the Environmental Health Division and the Central and Greater Derby Primary Care Trusts. The Commission recommends that progress on its implementation be presented every 12 months to the Social Care and Health Commission as part of its overview role.

Housing

The Housing and Advice Service should:

- Ensure the housing allocations policy doesn't contribute to the concentration of people with multiple needs in small geographical areas
- Identify potential health hazards such as the risk of fire and accidents due to poor internal design and establishes minimum housing standards as part of licensing HMOs and private rented sector
- Lobby the Government to make a greater level of resources available for addressing the risks associated with pre- 1919 properties

The Council should consider making more land available for affordable housing to meet the increasing demand for social housing in the city

Unemployment

Derby City Council takes the lead and develops an employment strategy for the city. The strategy should include measures for addressing the high levels of unemployment in deprived communities

The Council works in partnership with key organisations and undertakes a survey to determine:

- The number and percentage of employees recruited from inner city areas with the statistics broken down by gender and ethnicity
- Whether employers have equal opportunities policies and strategies
- What steps if any are being taken to recruit people from the high unemployment areas

Sport and Leisure
The Sport and Leisure Service establishes a physical activity strategy for city and seeks to increase the level of physical activity in the local community in line with national targets

Determinants of Health

1.15 The Review examined the links between some of the key determinants of health that are recognised to have a significant effect on health outcomes. The Commission is of the view that addressing potential health problems upstream by tackling the causes of ill health and preventing certain conditions from forming can have a greater impact on the health of the local community than by solely concentrating on treating the symptoms.

Crime and Disorder

1.16 Crime can and often does damage health through physical injuries, mental health problems, increased stress and increased use of drugs and alcohol. Earlier intervention with victims of hate crimes and domestic violence could reduce mental health costs.

1.17 A considerable amount of work by the Community Safety Partnership is focused around crime around young people. However, older people can also be affected by crime. National studies show that the health of older people who are victims of crime declines faster than other people of the same age. The effect of distraction burglary or the bogus caller tends to have a greater impact on older people due to the fear crime. Although the Community Safety Partnership is addressing the issues around distraction burglary, there is a need for a wider strategy to address crime affecting older people.

1.18 Evidence from the Crime and Disorder Team stated that the Government has increased the budgets to deal with drugs problems but found that they had insufficient staffing to deal with drugs and alcohol issues. It is recommended that the Community Safety Partnership consider the staffing issues to deliver the services. It also needs to ensure that staff has the relevant training to deal with drugs problems.

Education

1.19 Education is considered to be a major determinant of health that can make a huge difference to the health and well-being of the local community.

1.20 The Review examined the attainment levels of children in the three target areas and found that their level of achievement was significantly lower than the city and national averages at all key stages. Only 17% of children attained 5A*-C GCSE's during the 2001-02 academic year in both Derwent and Osmaston compared with the city average of 44%. The figures for Normanton were better at 37%. Furthermore, the differential in the levels of attainment with rest of the city increased, as children get older.

1.21 There are a variety of factors affecting pupil performance leading to low attainment. These may include poor health of the pupil, low expectations by the school as well as the family, poor home environment, self esteem of the pupil and poor schooling. Other issues such as school exclusions will also have an impact on pupil performance.

1.22 The schools with better exam results have developed a culture of high expectations of the pupils and their families to support them. However, this may not be the case for all schools. It is recommended that the Education Service develop strategies for better and earlier involvement of families and the community to improve the attainment. Since the responsibility for developing appropriate ethos and cultures for delivering education lie with the schools, the Education Service should monitor and support schools to establish a culture of higher expectations to enable pupils to perform to the best of their ability.

1.23 Although it is easy to fall into generalisation, it is the quality of teaching that makes learning interesting and enjoyable that will make the greatest difference. Effective learning and teaching in any subject takes place when pupils' interest and curiosity are stimulated and their motivation is high. It is recommended that the Local Education Authority continue to encourage and support schools to keep teachers up to date with the best teaching techniques through their personal development plans.

1.24 Physical activity has a beneficial role to play in improving and protecting children's health. A number of witnesses commented about the low level of physical activity amongst school children. The Government wants children to participate in two hours or more of high quality sport and PE every week. This is currently being achieved in approximately 25% of schools at key stage 1 and 30% at other key stages. It is recommended that the LEA needs to:

- Encourage and work with schools to provide at least two hours per week of high quality Physical Education and sport to pupils aged 5 - 16
- Encourage and work with schools to provide a wide range of PE and sporting activities to pupils outside the core curriculum
- Encourage and work with schools to achieve The Health Promoting Schools Award
- Work with voluntary sports clubs, governing bodies of sport and other agencies to strengthen and develop the infrastructure in the city

<u>Road Traffic Collisions</u>

1.25 The Commission was pleased to learn that the number of people killed or seriously injured from road traffic collisions on Derby roads is lower than the regional figures and that Derby fares well, if not outperforms the national target for traffic accidents. The traffic calming measures installed

by the traffic engineers are considered to have prevented 270 casualties and saved £17m. The Commission was informed that social deprivation has never been a consideration for installing accident reduction schemes.

1.26 Travel to school and parking near schools was raised as significant problem affecting some schools in the city. This is a particularly sensitive issue as some parents consider driving their children to school is safer and quicker than taking them to school by other means. On the other hand some would argue that this creates congestion, increases pollution and can be potentially hazardous for young children due to a large number of vehicle competing for a relatively small amounts of space close to schools. The school run and parking close to school entrances could have health implications by reducing the opportunity for children to get exercise by walking or cycling to school and increasing dangers from accidents.

1.27 The Council operates Safe Routes to School scheme in few schools in the city. This involves providing a range of physical measures including establishing parking bays away from the school to enable parents to drop off their children. It is recommended that the Council extend the Safe Routes to School scheme, to more schools in the city. The Government is also encouraging school to produce travel plans to address the travel problems caused by parents, teachers and children with their journeys to and from school. It is recommended that the Transportation Division work with schools to help them develop travel plans for their stakeholders.

Public Health

1.28 Public Health is concerned with all aspects of community's health. The Primary Care Trusts along with the local authorities have a responsibility for improving the public health. The City Council and the Central and Greater Primary Care Trusts jointly published the annual public health report 'Improving our Health in Derby- Derby City Public Health Annual Report 2003'. This document was based on the public health survey carried out by the health bodies and identified some of the key issues affecting the health of the city. The City Council and the PCTs are currently developing a Public Health Strategy which will fill the gap for a joined up health improvement plan for the city. The Commission welcomes work on this multi-agency strategy for tackling health problems in the city.

Housing

1.29 Housing conditions have long been associated with affecting the health of the occupiers. People living in and children growing up in cold and damp housing are considered to be at risk of developing respiratory diseases. The internal design of the house may increase the risk of accidents particularly for young children and older people due to steep narrow stairs and steps on landings.

1.30 Derby Homes is carrying out a programme of improvements to its housing stock, including thermal protection and new central heating through the

additional £81m capital funding. These improvements are expected to address most of the health related issues in the public housing sector. However, the problems may still exist in the owner-occupier and the private rented sector.

1.31 It is considered that a concentration of people with multiple needs in a particular area can affect the economic viability of an area and place significant pressures on agencies to deliver local services. It could also increase the vulnerability of these communities to be exploited by drug dealers and loan sharks. The housing allocations policy which places people from the housing waiting register into social housing may impact on other local service provision in the area and lead to a downward spiral. It is recommended that the allocations policy take the need of the local community into account in allocating properties to people on its waiting register.

1.32 The new hazard rating system will provide a better assessment of the health and safety risks than the current unfitness standard which for example allows the provision of a standard power point in meeting heating requirements. The new legislation will give the Council the power to refuse granting a license to HMO's and private sector landlord who do not meet the minimum housing standards.

1.33 The continued rapid rise in the price of houses in the city is making it increasingly more difficult for people on low incomes to buy properties and couple with the increased number of people on the housing waiting list is increasing pressure on rented accommodation. The Commission also learned that there will be housing pressures on the authority over the next four or five years as the demand for rented accommodation has increased to a position not experienced in the last ten years. The Commission therefore recommends that Council consider increasing the provision of affordable housing in the city. This could include making more land available for new build and supporting housing associations to acquire existing properties to meet the growing demand in social housing.

Unemployment

1.34 Statistics show that approximately 84% of manufacturing jobs and 60 % of all jobs are located in the inner city wards. Despite the employment opportunities available in these areas, the unemployment rates remain amongst the highest in the city. The rate of unemployment in the Arboretum ward for example is approximately four times higher than the city average.

1.35 Since employment is considered to be one of the key determinants of health it is all the more reason to address high levels of unemployment in the deprived areas as unemployed people are likely to have lower incomes than those in fulltime employment.

1.36 Strategies for tackling unemployment have in the past mainly concentrated on the skills, backgrounds and aspirations of the unemployed people. This has achieved considerable success and combined with the effect of general economic improvements, the overall rate of unemployment in the city has reduced significantly. However, the level of unemployment in the deprived areas, particularly Normanton, has remained consistently high. The Commission therefore recommends that more work needs to be carried out with the local employers to determine what steps if any are being taken to recruit people from high unemployment areas and to offer support where appropriate to match the supply of labour with the demand.

1.37 The Council has the power under the Local Government Act 2000 to promote or improve social, economic and environmental well-being of its area. It also has a major role in community leadership and acts as an advocate for local regeneration partnerships. Although there are other organisations such as the Learning and Skills Council and the Job Centre Plus with an interest to tackling unemployment, it is recommended that the Council take the lead and establishes an employment strategy for the city, which includes measures to tackle the consistent high levels of unemployment in the deprived neighbourhoods.

Sport and Leisure

1.38 There is evidence that the increasing level of physical inactivity is contributing to problems of overweight and ill health. People living in deprived areas of the city are more likely to be overweight or obese and less likely to take part in physical activities than the rest of the city. Evidence by the Primary Care Trusts shows that up to a quarter of women aged 65-74 in deprived areas are obese and around half of young men aged 25-34 in deprived areas are overweight or obese. Furthermore, nearly 40% of younger men in the deprived communities do not carry out 30 minutes of moderate level of exercise even once a week.

1.39 The results of the Derby Pointer Panel survey conducted by the Commission revealed that 19.0% of the respondents describe their health as not good. The survey also broadly confirms that a large proportion of people are not physically active.

1.40 There are number of reasons why people may not be taking part in physical activity. It may be due to lack of time, disability or having medical conditions. Pricing is also likely to be a significant factor, particularly for people in deprived communities. The Commission supports the Derby's Recreation Passport to Leisure scheme, which gives free or reduced use all day during the week between 9am and 4pm and all day at the weekends and bank holidays.

1.41 The Government seeks to increase the level of participation in physical activity from current 30% to around 70% of the population. The evidence from the Sport and Leisure Service shows the emphasis being placed on the promotion and provision of sporting activity for young people inline with

the Sports Strategy for Derby adopted in 2001. However, since there is a significantly high level of physical inactivity amongst people from deprived areas, it is recommended that the Council establish a Physical Activity Strategy to complement the sports strategy. This could involve encouraging people to consider changing their lifestyles and become more physically active such as by walking to get the newspaper, or using stairs in shops rather than the lift or the escalator. It could also include establishing community based activities, promotion of physical activity amongst children and young people and greater use of cycle and walkways.

1.42 The physical activity strategy should demonstrate targeting of policies on groups least likely to have healthy levels of physical activity such as the people from deprived areas and the involvement of people for whom it is intended.

Recommendation 2

The partner organisations should continue to reduce the level of smoking in the city

a. It is recommended that the Council Cabinet examine issuing local orders for banning smoking in public places when legislation is passed and establishes structures for enforcing the ban.

b. It is recommended that health bodies consider increasing resources to Fresh Start to enable it to carryout more work with partner organisations such as schools and voluntary bodies to reduce the level of smoking amongst groups most at risk and particularly target children. The campaigns to reduce smoking could emphasise the amount of money people could save by stopping smoking.

c. It is recommended that Fresh Start undertake a specific campaign to raise the level of awareness of the dangers of smoking amongst South Asians and increase the proportion of quitters to at least reflect the make up of the local community.

Smoking

1.43 Smoking is recognised to be the biggest preventable cause of premature death. It causes many health problems including cancers, coronary heart disease and chronic obstructive lung disease. It is also a common cause of repeated infections such as colds and ear infection. Smoking during pregnancy can cause health problems for the mother and the child.

1.44 There are a variety of reasons why people smoke, including relief of stress, socialisation and general enjoyment. Due to its addictive nature, it is not always easy to give up smoking. However, all of the witnesses who

spoke about smoking said that reducing smoking is the single most important thing that can be done to reduce health inequalities.

1.45 The Government has targeted smoking cessation as a measure to tackle poor health and has set national targets for reducing smoking. The Tobacco and Smoking (Public Places and Workplaces) Bill currently going through Parliament if passed will make it unlawful for a person to smoke in public places except in designated areas. The duty to enforce this legislation will fall on local authorities.

1.46 Smoking amongst people in the three areas under review is high at around 44% compared to the city average of 30%. Also, approximately 42% of the people in 25 - 44 age group smoke in the target areas. This is of particular concern as this age group is likely to have families with young children. Smoking by this group is not only bad for the health of the smokers but will also have a direct effect on any children in the family.

1.47 Although no statistics were available on the level of smoking amongst children, the evidence from the GPs and from the Smoking Cessation Officer suggested that smoking amongst children is on the increase, particularly amongst young girls who are starting to smoke at an early age. This raises the issue of how they are getting the cigarettes. The Planning and Environment Commission on its review of 'Improving controls on the sale of age restricted goods' has recently recommended that the Council issue a nationally recognised proof of age card to all young people in Derby when they attain their 16 birthday. If this recommendation is implemented, it should help retailers to identify people over the age of 16 and also help Trading Standards to take enforcement action where this law is not observed.

1.48 Evidence from the national 2001 Health Survey found that there is less awareness of the serious health risks associated with smoking amongst South Asians. The survey also found that although the attempts at giving up smoking were high amongst South Asians, the rate of success was considerably lower compared with the general population.

1.49 It is estimated that a person smoking 20 cigarettes a day could expect to save approximately £15000 over ten years and therefore saving money can be major consideration for people to stop smoking. People in deprived communities spend a greater proportion of their household income on smoking than those in affluent areas. Lister House stated that they noticed the greatest reductions in smoking when the cost of cigarettes was increased. There is some evidence in support of this from the National Bureau of Economic Research, which estimates that a 10% increase in price of cigarettes would decrease adult consumption by 3% - 5%.

Recommendation 3

The partner organisations need to target intervention measures at the groups considered to be most at risk of developing health problems

Older People
The Housing Services should seek to improve the home environment by addressing potential health risks associated with unsuitable internal design of houses occupied by older people

The Primary Care Trusts should seek to improve the take up of screening programmes and flu vaccinations

Children
The Primary Care Trusts should continue to focus on infant mortality in line with national priority, address dental health problems and promote MMR vaccination, particularly targeting groups where the take up is low

Ethnic minorities
The Primary Care Trusts should undertake detailed research to identify the main health problems affecting ethnic minority communities and ensure that they are fully involved during the development of preventative strategies, whilst taking account of their language and cultural requirements

Areas of high deprivation
The Commission reaffirms the principle that the partnership bodies need to take account of the make-up of the local communities and develop strategies to meet specific needs rather than adopt blanket policies for all areas

At Risk Groups

1.50 Certain groups are at a greater at risk of developing health problems than the rest of the city. Targeting more resources and sharply focussed intervention measures on these groups will help to reduce the inequalities gap. These groups fall into a number of categories.

Older People

1.51 The population in the city is getting older. There was an increase of 13.6% in the number of people over the age of 65 between the 1991 and 2001 ONS Census for Derby. As people get older their risk of developing health problems naturally increases. However, there are certain measures that can be taken to reduce the risk of some conditions. Evidence from housing service suggested that older people are more likely to be living in poor housing and are more at risk of accidents due to the internal design

of the house. It was also found that the health of older people who have been victims of crime declines faster than other people of the same age.

1.52 Vaccinating people at risk against known risks from certain conditions and early screening such as for breast and cervical cancer will help to reduce some of the health problems affecting this group. The Government published the NSF for Older People in 2001 which aims to root out ageism in the provision of health and social care services, target illnesses associated with age, and treat people with respect, dignity and fairness. This is being lead by the Greater Derby PCT and is addressing some of the issues affecting older people.

Children

1.53 A child under the age of one is twice as likely to die in social class 5 than in social class 1 according to the evidence from the Health Inequalities Unit. Infant mortality rates are high amongst ethnic minority communities and are the highest for births to single mothers of all groups. The Government has therefore established tackling infant mortality as one of the national targets for reducing health inequalities.

1.54 Children experience a number of health problems. They are at a higher risk having accidents both in the home and on the roads. Children under five from deprived communities have greater number of decayed teeth, extraction and fillings than the rest of the city. They are also likely to have lower rates of immunisation. The Department of health considers immunisation to be the most effective and safest measure for protecting children against serious illness. Evidence from the GPs stated that the level of immunisation of children in the deprived areas was lower than the more affluent areas. It is therefore considered that targeting children, particularly in the deprived areas will help to reduce the health inequality gap in the city.

Ethnic Minorities

1.55 According to the 2001 Census 12.6% of Derby's population are from minority ethnic communities. Of this 66.6% are of Asian origin. The Arboretum ward, which covers most of the Normanton NRF area, has 50% of its population from ethnic minorities.

1.56 People from ethnic minority communities have a higher risk of developing certain conditions than the general population. Asian men for example have 46% higher premature death rate from CHD and are also up to five times more likely to have diabetes. These conditions may be due to their genetic disposition but also these communities live in areas of high deprivation. Specific health needs of the minority communities are being addressed through a variety of ways including through the clinic at Peartree to meet needs of the Asian community and the exclusive use of the of Fountain surgery for asylum seekers. However, it is recommended that more needs to be done to identify the causes of some the major

health problems and to support the communities on how these could be prevented. Undertaking a comprehensive survey to identify the type and extent of health problems faced by ethnic minority communities and involve the community on how these could be addressed could help with the intervention measures. Since Derby has a considerable number of asylum seekers their health problems also need to be taken into account when developing strategies aimed at ethnic minority communities.

Areas of Deprivation

1.57 All three areas under review experience a multiple set of problems that are strongly linked to ill health. However, there are some differences in the relative scale of the health outcomes between the three areas. These are not only due to differences in the size of their respective communities but are also linked to the make up of the local communities. Normanton for example has higher sets of problems associated with CHD and diabetes which may be due to a high proportion of people from minority ethnic communities and whilst the Derwent NDC area has higher mortality rates from cancer and higher levels of teenage pregnancies. It is therefore important to recognise the differences between the various sections of the community and develop intervention measures accordingly in consultation with the community.

Recommendation 4

The Primary Care Trusts should prioritise tackling health problems associated with coronary heart disease, cancer and diabetes in line with national priorities

CHD

The partnership bodies led by the Primary Care Trusts should:

- Establish a strategy to increase public awareness of the causes and prevention of heart disease in areas and communities with high levels of deprivation
- Encourage greater level of participation in physical activities including where appropriate offering exercise on prescription
- Work with employers to establish healthy work places and establish opportunities for staff to participate in exercise

Cancer

The Primary Care Trust should ensure groups most at risk from developing cancer are targeted with screening programmes, particularly amongst those where the take up is low and undertake a publicity campaign to raise awareness of how to reduce the risk of developing certain cancers

Diabetes

The Primary Care Trusts should develop strategies and ensure services are available to reduce the risk of developing diabetes particularly amongst groups that are most at risk.

The Primary Care Trusts should seek to routinely screen people who are most at risk of developing diabetes to minimise the complication that may be developed from having diabetes

Major Killer Diseases

1.58 People living in areas of high deprivation tend to have higher sets of health problems that are associated with coronary heart disease, cancer and diabetes than the rest of the city. Normanton is found to be an exception as it has lower standardised mortality rates from cancer.

1.59 The Government has prioritised tackling major killers, namely CHD and cancer in its strategy for reducing health inequalities.

CHD

1.60 Coronary Heart Disease is a major killer with more than 110,000 people dying of heart problems in England every year. At the local level, proportionately more people from deprived communities die from CHD than the average population in the city. The evidence presented by the PCTs reveals that premature mortality rates from CHD for Osmaston was 43.4% higher compared with the city, whilst the rates for Normanton was 37.9% higher and Derwent higher at 6.2%.

1.61 There are a number of risk factors associated with developing heart disease. Being male is a risk factor since almost twice as many males under the age of 75 die from CHD than females. A person whose close family member develops CHD at an early age and people from ethnic minority communities are also at a higher risk. Certain lifestyles also increase the risk. People who are overweight or obese, smoke, and don't do regular exercise significantly increase the risk of developing CHD.

1.62 Evidence by the British Heart Foundation stated that there is a need to increase public awareness of the causes and prevention of heart disease. Prevention should be on a number of levels and not just involve telling people to adopt a healthy lifestyle. It should help individuals to understand the benefits of healthy lifestyles and provide appropriate support such as providing accessible services to leisure and sport facilities at affordable prices. It should also involve educating and working with employers to establish healthy work places and to provide opportunities for staff to participate in exercise.

1.63 The PCTs have set targets for reducing death rates from CHD of at least 25% in people under 75 by 2005 compared with 1995-1997 figures and

target 20% in the areas with the highest rates. The current service provision includes specialist smoking cessation clinics, improved access to cardiac rehabilitation, joint working with Sport and Leisure Services to move phase IV cardiac rehabilitation clinics into the community and exercise on prescription scheme for some areas.

1.64 The Sport and Leisure Service confirmed close working relationships with 14 GP practices in the city to provide exercise on prescription. GPs identify and refer patients who have obesity, high blood pressure and hypertension and could benefit from exercise instead of medication. The Sports and Leisure Service provide reduced cost activities and tries to motivate people through a buddy scheme and gives a free passport to leisure after completion of 20 sessions. GPs involved in the scheme have given a positive feedback to the referral scheme. It is therefore recommended to extend opportunities for all GP surgeries to offer exercise on prescription to support rehabilitation programme.

Cancer

1.65 Cancer affects 1 in 3 people in their lifetime and mostly occurs in the over 65's. The death rates from cancer for men and women in Derby follow the national pattern. Lung cancer is the highest killer for both genders with 152 males dying from cancer during 2001-2002 and 90 females. Colon and rectum cancer is the second largest killer for men with 71 deaths where as for women it is breast cancer with 88 deaths.

1.66 There are significant variations in the death rates from cancers in the target areas. Premature mortality from malignant cancers during 1997-2000 in Derwent NDC area was 64.5% higher than the city and 38.4% higher in Osmaston whilst it was actually 16.1% lower in Normanton.

1.67 Evidence from the PCTs showed that there is lower take up of cervical screening programmes in deprived areas. The lowest area for take up was in Normanton, which is also the area with highest proportion of people from minority ethnic groups.

1.68 Lifestyles and habits can alter the risk of developing cancer. There is a need to increase awareness of how changing the lifestyle can reduce the risk of developing certain forms of cancer such as quitting smoking to reduce risk of getting lung cancer. If cancer develops, early detection and treatment is important as it can save lives. People need advice and information on how to recognise early signs of cancer. The health bodies also need to increase the promotion of the two national screening programmes of breast cancer and cervical cancer, particularly amongst groups where the take up is low. There is an argument that it is how the messages are put across that make the greatest difference. Information therefore needs to be produced in a way that people can easily understand including the use of translation in community languages where appropriate.

Diabetes

1.69 Diabetes is a common health condition affecting approximately 4% of the population in Southern Derbyshire. Over three-quarters of people with diabetes have Type 2 diabetes. Type 2 diabetes usually appears in people over the age of 40 and the risk increases as people get older.

1.70 Dr Iqbal stated that diabetes is almost endemic amongst the Asian population. National data identifies people of Pakistani and Bangladeshi origin to be up to five times more likely to have diabetes than the general population. The death rate from diabetes amongst South Asians is also more than three times greater. It is possible that diabetes is caused by genetics but it may also be due to the lifestyles adopted by the minority ethnic communities. Anecdotal evidence suggests that these groups are more likely to be overweight due to eating diets with high fat and saturates contents, smoking and doing little or no physical exercise.

1.71 A number of complications may develop as a result of having diabetes such as damage to eyes, kidney and major arteries. Early detection of diabetes can help to tackle some of these complications. It is therefore important to prevent the development of diabetes wherever possible, but also to raise awareness of detecting early signs of diabetes. There is evidence that reducing obesity and increasing physical activity could help with the primary prevention of diabetes. The National Service Framework for Diabetes recognises that a case can be made for systematic approach to screening for type2 diabetes, although it is undecided on which of the high-risk groups should be screened. The Commission is of the view that groups considered to be most at risk of developing diabetes locally should be regularly screened.

Recommendation 5

The Environmental Health Division takes the lead to establish an agreed set of local priorities and indicators to address health inequalities

Local Indicators

1.72 Establishing indicators enables organisations to measure the impact of the interventions against set objectives. Creating the right set of indicators that meet local circumstance will be a key factor for tackling health inequalities. The Priorities and Planning Framework 2003 – 2006 published by the Department of Health has listed under its objective for reducing health inequalities to agree a single set of local priorities for tackling wider determinants of health.

1.73 The Government has set two national targets to address health inequalities. It seeks to reduce inequalities in health outcomes by 10% by 2010, as measured by infant mortality and life expectancy at birth.

1.74 The East Midlands Assembly has also adopted a set of headline indicators that cover:

- Life expectancy
- Teenage pregnancy
- Premature mortality from circulatory disease
- Premature mortality from cancer
- Deaths from accidents
- Suicide
- Smoking

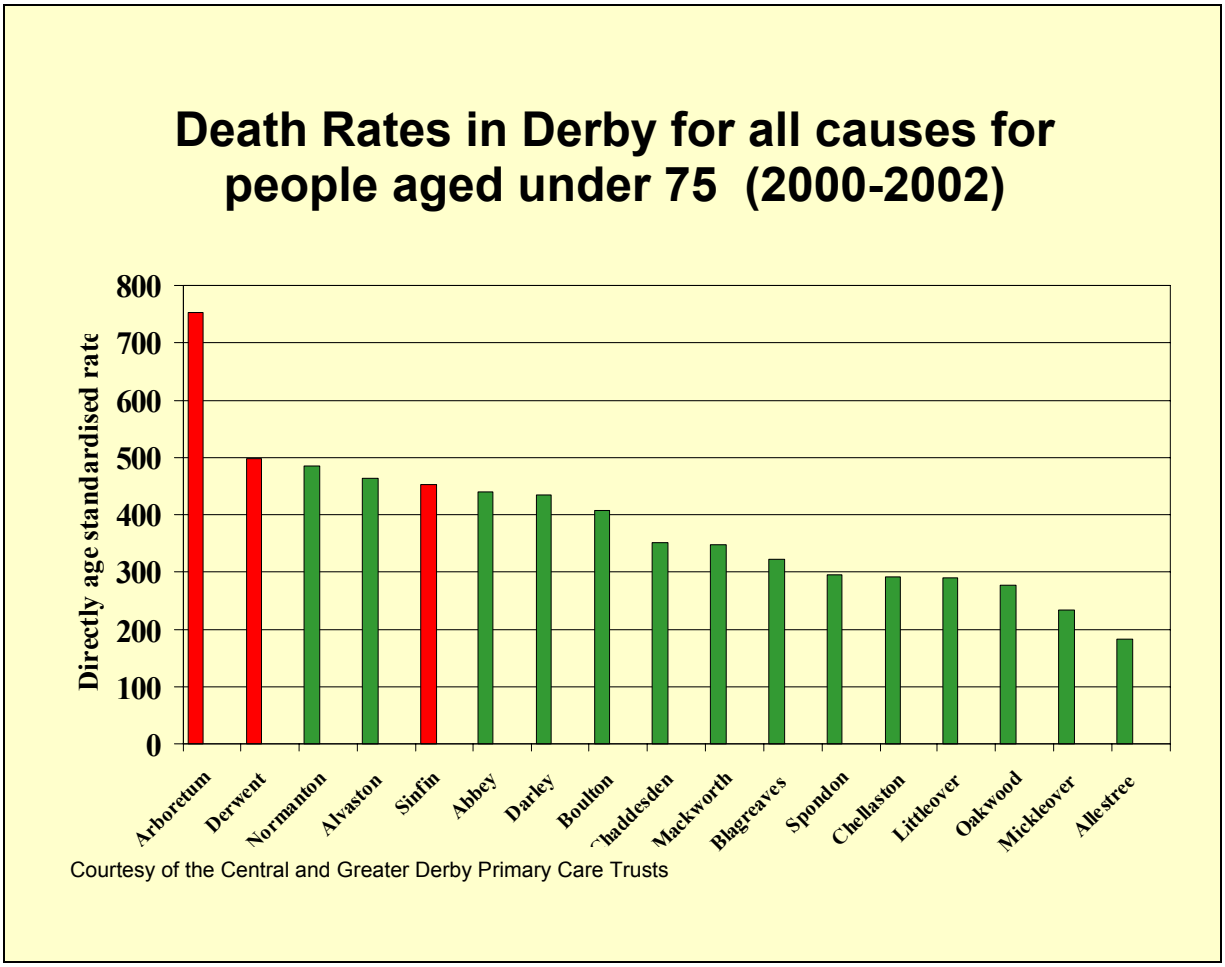
(East Midlands Health Profile- March 2003)

1.75 The main purpose of the local indicators is to help support local action to achieve the Government's national inequalities targets for life expectancy and infant mortality, by highlighting information relevant to addressing the targets and assisting local areas with monitoring progress towards reducing health inequalities. There are variations in the factors contributing to health. For example in terms of crime, Normanton has higher proportion of crime related with drugs and sex offences, Osmaston has higher proportion of crime against the person and Derwent has a higher proportion of household burglaries. Therefore indicators that reflect the local circumstances need to be established.

1.76 There are a number of sources to help establish the local indicators. The Audit Commission has a library of Performance Indicators that can be selected off the shelf to meet local circumstances. The East Midlands Public Health Observatory has also established an indicator package that brings together information on health and factors affecting health. These could be adopted to suit local needs. It is therefore recommended that Environmental Health Division establish an agreed set of local indicators in consultation with the key partners as part of the city's public health strategy.

DERBY CITY COUNCIL

Reducing Health Inequalities



Social Care and Health

Overview and Scrutiny Commission

2 Introduction

2.1 This country has seen significant improvements in its prosperity over the last 25 years with the total marketable wealth rising from £280 billion in 1976 to over £3.3 trillion in 2001. There has also been a steady increase in life expectancy at birth. The male life expectancy in the United Kingdom has increased from 70.8 years in 1980 to 75.3 years in 2000. Similarly, the life expectancy for females has also increased, from 76.8 years to 80.1 years over the same period.

2.2 However, the improvements in the life expectancies have not occurred equally across all social groups. Improvements for people in the professional classes have been much greater than the routine and manual groups with the gap between them increasing to over twofold over the sixty year period. Inequalities in health outcomes also exist between genders and people from different ethnic groups.

2.3 Health inequalities affect people at all stages of life and across different parts of the country. There are wide geographical variations in health status, reflecting the multiple problems of material disadvantage facing some communities. These differences begin at conception and continue throughout life.

2.4 There are also significant differences at the local level. Statistics published by the Trent Health Observatory in 2002, found that the life expectancy for people living in the Allestree ward was approximately 10 years greater than people living in the Osmaston ward.

2.5 There are other differences in health between various groups. The death rate from circulatory diseases in the former Babington ward for example, was five times higher than Mickleover ward and death rate from cancer in the Osmaston ward was more than twice that of Blagreaves ward.

Ward (2001)	Male Life Expectancy (Yrs)	Female Life Expectancy (Yrs)	Death Rate from Circulatory Disease for under 75s 95-99 (DSR)	Death Rate from Cancer for under 75s 95-99 (DSR)
Babington	70.7	78.8	249.4	135.4
Derwent	71.9	79.1	169.9	164.0
Osmaston	69.0	75.5	215.4	196.3
Highest	80.0 Allestree	85.7 Allestree	249.4 Babington	196.3 Osmaston
Lowest	69.0 Osmaston	75.5 Osmaston	46.0 Mickleover	87.9 Blagreaves

Source: Trent Health Observatory 2002
DSR -Directly Standardised Rates

2.6 The Independent Inquiry into Inequalities in Health commissioned by the Government and conducted by Donald Acheson in 1998 highlighted the

effects of poor living and working conditions on health. Those that experience one or more of factors such as low educational attainment, insecure employment or material disadvantages are likely to have more health problems than the rest of the population. It also recognised that social networks, location, ethnicity and gender significantly shape experiences and opportunities in life and impact directly on health of an individual or the community.

2.7 The social policy to address health inequalities has fluctuated, with the responsibility for improving health alternating between the individual and service providers.

2.8 Local authorities with social services have been granted additional powers under the Social Care and Health Act 2001 for the scrutiny of the NHS health services. In Derby this responsibility falls to the Social Care and Health Overview and Scrutiny Commission (the Commission). This new power enables the Commission to look across organisations and services and to consider how they can be improved to meet local needs. The Commission exercised this power and resolved to conduct a review on health inequalities.

2.9 The Commission selected three of the most deprived areas in the city, namely, Normanton Neighbourhood Renewal Funding (NRF), Osmaston NRF and Derwent New Deal for Communities as a focus for its review. The Commission considered that selecting the three small distinct areas would help it to identify issues affecting other deprived areas of the city and any lessons learnt from this review could be applied to other areas.

2.10 The Commission invited the Health Inequalities Unit of the Department of Health and local GPs to attend the topic review meetings and explain the factors linked to poor health in deprived neighbourhoods. This information helped the Commission to identify and invite other relevant organisations to give evidence on health inequality issues.

2.11 This report is based on the evidence collected by the Commission through evidence gathering meetings and is backed up by desk-based research.

3 The Review Process

3.1 The Government guidance published in support of the health scrutiny legislation encourages scrutiny committees to take account of local strategies and other published information in determining topics for review. The Commission looked at a number of published strategies and documents to determine its topic for policy review. These included:

- Derby's 2020 Vision - Community Strategy (draft)
- Derby City Crime and Disorder Strategy
- Southern Derbyshire Director of Public Health Annual Report 2000
- A Decade of Public Health in Southern Derbyshire
- Derby Housing Needs and Markets Study
- Derby Joint Local Plan - Annual Progress Report July 2002
- Population profile determined by 2001 Census
- Derby Poverty Profile 2001
- Derby's Neighbourhood Renewal Strategy- April 2002

3.2 The differences in the health outcomes of people from various communities in the city identified by the Decade of Public Health in Southern Derbyshire convinced Members to review health inequalities in the city.

3.3 Since many causes of health problems are interlinked, the Commission felt that taking a geographical area based approach could potentially produce better outcomes and have a greater impact to the review on health inequalities than a single issue based approach.

3.4 The Commission decided to focus the review on small geographical areas that exhibit high levels of deprivation and have the greatest sets of health problems, as a city wide approach may not adequately reveal the extent of the problems in deprived communities. In selecting the areas for review, the Commission considered Derby's Neighbourhood Renewal Strategy. This document makes the case for the allocation of Neighbourhood Renewal Funding to 12 priority areas. From the table showing the key neighbourhood characteristics and indicators the Commission selected Normanton and Osmaston since they had the most indicators of high levels of deprivation. The Commission also selected the Derwent New Deal for Communities (NDC) area since it also has indicators of multiple deprivations and a detailed strategy developed by the Derwent Community Partnership.

3.5 In selecting the areas the Commission was also mindful of the need for the target areas to have access to external resources to support any action that may be identified by the review. All three areas have access to external funding. Normanton has successfully bid for funding from Single Regeneration Budget (SRB 6) and European Social Fund URBAN II, Osmaston has access to SRB 5 and Derwent has been allocated £42m over 10 years from the New Deal for Communities programme.

Terms Of Reference

3.6 The Commission consulted health bodies and other stakeholders in the drafting terms of reference for the review before submitting them to the Scrutiny Management Commission for final approval. The adopted terms of reference for the review are:

To reduce health inequalities in three priority areas of the city namely Derwent New Deal for Communities, Normanton and Osmaston /Allenton Neighbourhood Renewal Fund areas by:

- Identifying major health problems of the residents in the priority neighbourhood areas
- Investigating the effectiveness and recommending improvements of current multi agency approach in addressing health needs
- Developing a multi agency action plan to narrow the gap between the areas of deprivation and the rest of the city, to be recommended to the appropriate agencies
- Raising awareness of the health issues throughout the city and disseminating information on the action plan
- Regularly monitoring outcomes from the action plan

3.7 Members recognised that they could benefit from having additional people on the Commission with knowledge and experience of the NHS. The Commission therefore co-opted further five members with non-voting rights to assist in the review process.

3.8 The Commission followed a broad plan to conduct the topic review and guide the process. This involved:

- Holding a joint brainstorming session with Members of the Commission and senior officers from health bodies to discuss the key factors of health inequalities
- Seeking statistical and other information from key service providers, GP's, and through desk based research to identify health problems in target areas
- Seeking evidence from statutory and voluntary sector organisations on health issues
- Inviting service departments and Primary Care Trusts to give evidence about their strategies and action plans for tackling health inequalities
- Drafting the final report with recommendations

3.9 The joint brainstorming session with the health bodies identified the need to consider clinical health issues as well as the factors that determine health. The determinants such as education, housing and employment are considered to play a major part in determining an individual's health.

3.10 The Commission established a list of indicators that it considered could help to reveal the problems associated with poor health in the three target areas. This was submitted to the key service providers in the city and asked to provide the relevant information. Senior officers from these organisations were also invited to attend evidence gathering meetings to explain their organisation's policies for delivering the services.

3.11 Organisations have their own systems for collecting and monitoring data. This is not always geared up to be presented on small geographical areas and can cause difficulties in making direct comparisons between organisations. The Commission sought information on the three target areas and where this was not possible, the relevant ward data has been used, such as the Arboretum ward for the Normanton area, Derwent ward for the Derwent NDC and Osmaston ward for the Osmaston NRF area.

3.12 In all the Commission held 20 evidence gathering sessions which were attended by 36 people from various organisations (Appendix 6).

4 Description of the Target Areas

Normanton Neighbourhood Renewal Funding Area

4.1 The Normanton Neighbourhood Renewal Funding area boundary coincides with the SRB 6 and European Social Fund URBAN II Programme Area. It has a population of 23,443 living in approximately 10,500 households. The area is made up of number of smaller neighbourhoods such as Rosehill and Peartree. Normanton is home to approximately 45% of Derby's minority ethnic community including significant numbers of asylum seekers and refugees.

4.2 The area continues to have high levels of unemployment. Even during the current relatively low levels of unemployment in the city, the levels of unemployment in Normanton is more than four times higher. Unemployment rates published for April 2003 show that the Arboretum ward, which covers most of the Normanton NRF area has an unemployment rate of 18.2% compared to the city average of 4.7 %. It is also found to be one of the four highest areas for households with incomes below £15,000 by the Derby Poverty Profile 2001.

4.3 Statistics supplied by the Crime and Disorder Team for 2002 show that Normanton has high levels of crime compared with the rest of the city. In particular, it has the highest number of drugs offences (at 6.6 per thousand population), sex offences (4.5 compared with the city of 2.7) and drugs offences of 1.6 offences per thousand population respectively.

4.4 The life expectancy for men in Normanton is 73.2 years and women 78.2 compared with city average of 75.5 and 80.1 years respectively. It has a high proportion of standardised premature mortality rates (death before the age of 75) for all causes at 466.5 deaths per 100,000 population compared to the city average of 366.1.

4.5 Normanton also has the highest proportion of babies born with low birthweight (weighing less than 2500g) in the city. Normanton had 12.3% low birthweight babies as a proportion of live and stillbirths compared with the city's rate of 8.9% during 1997 – 2000.

4.6 There is a wide range of voluntary sector activities run by the numerous minority ethnic and faith based community organisations. This can at times lead to competition for resources and/or duplication of provision while leaving some gaps in other services.

4.7 Normanton has a history of funding initiatives to address the persistent high levels of deprivation. These have ranged from the Urban Programme during the eighties, City Challenge during the mid-nineties and recently, a number of Single Regeneration Budget funding programmes. The area currently has access to approximately £13 million to be spent over a six-year period starting from 2001 through the SRB6 and URBAN II

Programme. It is also included in the Neighbourhood Renewal Funding programme that has replaced the SRB programme.

4.8 In brief, the Normanton neighbourhood area has a significant number of problems, which are compounded by its poor reputation.

Osmaston Neighbourhood Renewal Funding Area

4.9 The Osmaston NRF area comprises of two estates with a total population of 10,948 in around 4,500 households. It has a predominantly white community (86.4%) and a number of small ethnic minority communities.

4.10 The unemployment rate in the area is high at 8.4% compared with the city average of 4.7%. It has low educational attainment with 17% of children attaining 5A*-C GCSE's during the 2001-02 academic year compared with the city average of 44%. It also has high levels of crime, particularly crimes against the person. The area has the highest rates for violent crime with 59 offences per thousand population and for assault with 53.3 offences per thousand population compared with the city of 32.8 for violent crime and 28.2 for assault respectively.

4.11 Investment by SRB and Sure Start programmes, which are still continuing, are helping to bring improvements in the local facilities and services. There has been an emphasis on support for young children and families, and a marked increase in youth provision through joint working between the voluntary sector, SRB and the Youth Offending Service. A Youth Inclusion Project for the area has created an active partnership whereby a local voluntary youth project, the Police, Education, Social Services and the Youth Service work in partnership to engage the young people of Osmaston and Allenton in meaningful activities.

4.12 The nursery in the neighbourhood, Lord Street Nursery, has Early Excellence Centre status and will have a new build extension. There is a well-established local community project, the St Bartholomew's Project, which provides a variety of local projects to improve social and economic well-being of the area.

4.13 The area includes the Moorways Leisure Centre and the facilities on Osmaston Park. These are not well accessed by the local community due to a main road going through the area and acting as a barrier.

4.14 A centre providing facilities for children and families and other community activities will be built at the eastern edge of the area adjacent to the Crewton and Harvey Road neighbourhood, through Sure Start, SRB and Neighbourhood Renewal Funding.

4.15 Housing services are delivered from two local area offices at Bingham Street and Addison Road. The clearance of Council houses at Glossop Street provides an opportunity for the redevelopment of that site.

4.16 This area is reasonably well served by retail facilities. It contains Allenton District Centre, one of the larger and stronger shopping areas in the City with few vacant units, despite having some environmental and traffic problems. It contains a local market and some national multiples, including Boots, Kwik Save and Somerfield. A number of neighbourhood centres containing small shops and services are also distributed throughout the area.

Derwent New Deal for Communities Area

4.17 The Derwent New Deal for Communities (NDC) area has a population of 9355 living in 4000 households. The make up of the population is mostly white (96.1%) with a number of small ethnic minority communities.

4.18 The Derwent NDC area has a high number of people living in council houses with 45.5 % of households living in council properties compared with the city average of 19%. It has patches of poor housing with 4.3% of homes not meeting the decent homes standard against the city average of 2%.

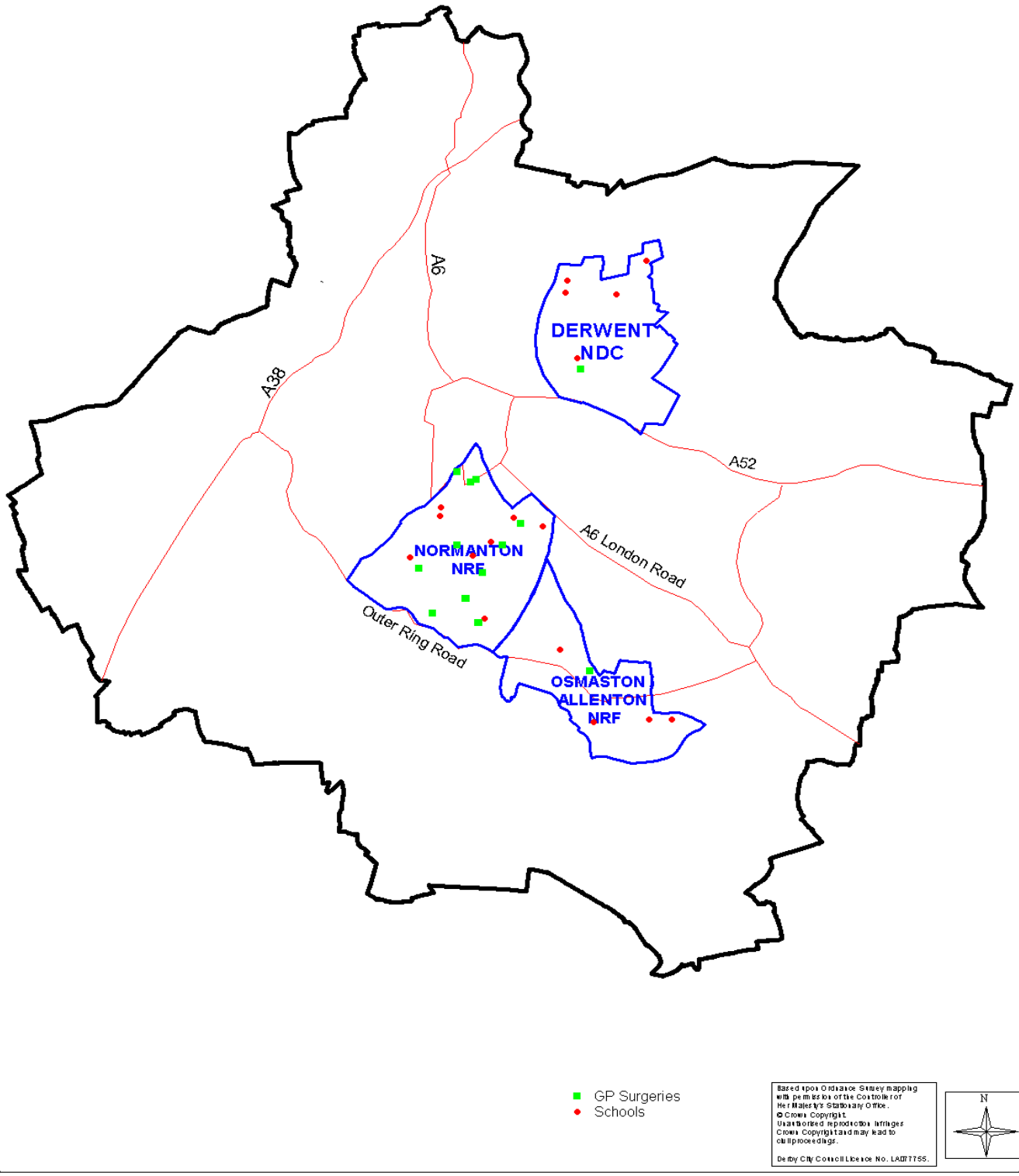
4.19 The area has unemployment rate of 6.1%, which is slightly higher than the city average. It has low educational attainment with 17% of children attaining 5A*-C GCSE's during the 2001-02 academic year compared with the city average of 44%. It has high levels of crime with household burglaries at 25.8 offences per thousand population, being the highest in the city.

4.20 It has a large public open space, the Race Course on its Western edge and a large out of town shopping centre, the Wyvern on its Southern boundary. The area has popular community nursery and number of school including a secondary school. The Derbyshire County Cricket Club has its base in the area and actively supports the local community.

4.21 A major issue in Derwent is one of isolation as two major roads surround the area. The community suffers low self-esteem. The area is poorly served by the financial services industry with residents in the area having to pay more for insurance and other financial services than in other parts of the city.

4.22 The Greater Derby PCT is working with Derwent NDC programme to establish a Healthy Living Centre to improve the provision of health services in the area.

TARGET AREAS



5 Identification of the Health Problems

5.0 The Commission received evidence from a number of organisations including the Health Inequalities Unit of the Department of the Environment, local GPs and the Primary Care Trusts to learn about the some of the common problems faced by the residents in deprived communities, which are linked to health and suggestions on how these could be addressed.

5.1 Summary of Evidence Provided by Health Inequalities Unit of the Department of Health

5.1.1 The Health Inequalities Unit was invited to give a national, regional and citywide picture of health, explain how the Government was addressing health issues and give suggestions for developing local indicators. The evidence was presented by Ms Anne Griffin, Team Leader Health Inequalities Unit

5.1.2 Ms Griffin stated that tackling health inequalities is a key Government target that has ministerial commitment with a Cabinet Sub-Committee on Health Inequalities chaired by the Deputy Prime Minister John Prescott MP.

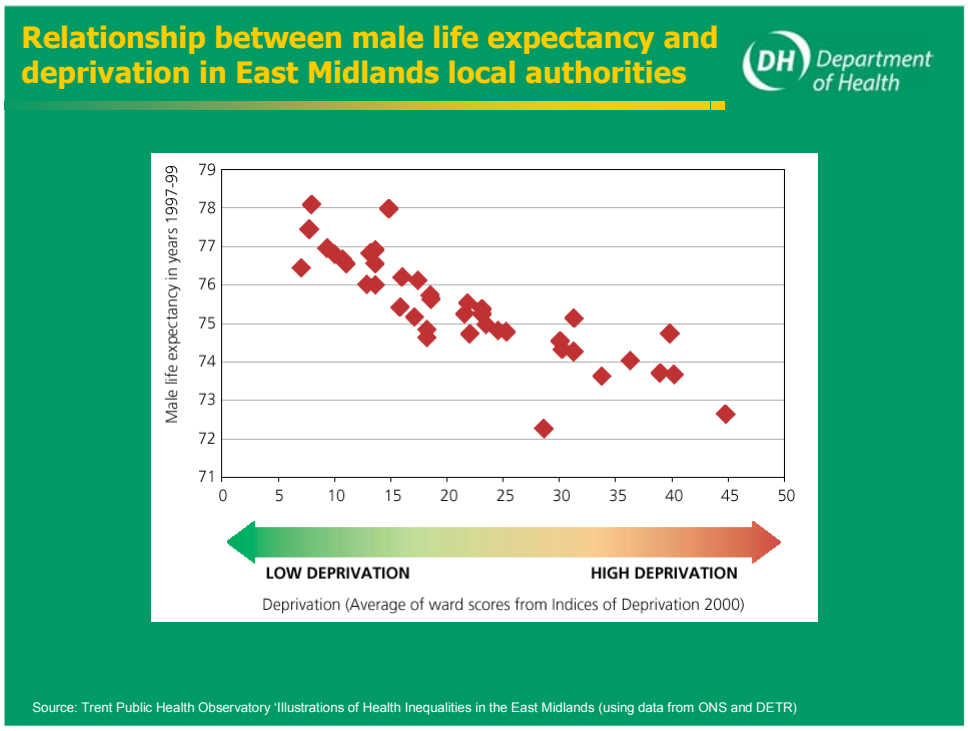
The Problems of Health Inequalities

5.1.3 Ms Griffin stated that a child under the age of one in the East Midlands is twice as likely to die in social class 5 than in social class 1. Progress has been achieved in reducing infant mortality in all social classes but there were still significant difference between manual and non-manual groups with the gap widening since early 1990s. Infant mortality rates for births to single mothers have shown a greater reduction but is still the highest of all groups. Infant mortality is also particularly high in some minority ethnic groups.

5.1.4 Improvements in premature mortality have not occurred equally. Apart from the geographical differences in the mortality rates, there is also a gap between social class groups. The professional classes have seen greater improvement than manual groups and the gap has increased twofold over the last sixty years.

5.1.5 It was stated that there is a clear association between life expectancy and deprivation in the East Midlands. Authorities with the highest levels of deprivation also have the shortest life expectancies as illustrated below. The effect of deprivation is seen across a number of health outcomes.

5.1.6 For England as a whole, the life expectancy at birth for males in 1999-2001 was 75.6 years and females 80.3 years. During the same period, the life expectancy for males in Derby was 74.9 years and 79.9 for females. This placed Derby in the lowest 30% for both male and female life expectancy tables.



5.1.7 Ms Griffin stated that the major causes of death in the East Midlands are circulatory disease and cancers. Deaths due to accidents in the region are also amongst the highest in the country.

5.1.8 It was suggested that the quality of life should also be considered when looking at health inequalities. The poorest sections of the community tend to have multiple problems and need action on a broad range of issues. People suffering from ill health are also likely to be experiencing inequalities in services.

Tackling Health Inequalities

5.1.9 The actions recommended by the Department of Health have been listed in a number of reports since 1998, which had highlighted inequalities as well as progress. These include:

- The Acheson report, and independent Inquiry into Inequalities in Health (1998)
- Saving Lives: Our Healthier Nation (1999)
- The NHS Plan (July 2000)
- Announcement of national health inequalities targets (February 2001)
- Cross Cutting Spending Review (July 2002)
- Health Inequalities: A Programme for Action (July 2003)

5.1.10 The Government has set a target to reduce inequalities in health outcomes by 10 % as measured by infant mortality and life expectancy at birth by 2010. This is supported by two specific targets:

- ❖ Starting with children under one year, by 2010 to reduce the gap in mortality by at least 10% between "routine and manual" groups and the population as a whole

- ❖ Starting with Local Authorities, by 2010 to reduce the gap by at least 10% between the fifth of areas with the lowest life expectancy at birth and the population as a whole

5.1.11 To meet these targets, the Government seeks to narrow the gap in life expectancy between the fifth of areas with the highest mortality rates and the average and in infant mortality. It also seeks to tackle the wider determinants of health, which drive inequalities including neighbourhood deprivation, poor educational attainment, sub-decent housing, worklessness, fuel poverty, poor access to services and crime.

5.1.12 The Government also identified the need to targets key activities for the over 50s in disadvantaged groups and areas at the local level. This may include:

- Smoking cessation services for manual social groups
- Quality of and access to cancer and coronary heart disease (CHD) services, targeting the areas with the highest rates
- Cancer screening
- Reducing hypertension
- Appropriate prescription of statins (drugs to reduce blood cholesterol)
- A focus on the needs of older people
- Action to reduce winter deaths
- Reducing mortality from accidents
- Promoting increased physical activity

5.1.13 The Government's policy to tackle health inequalities has a geographical area dimension, as demonstrated by the life expectancy target. Raising standards in areas that are falling below the average is inherent to this policy and to achieving its target.

5.1.14 National headline indicators have been established to give a broad picture of progress whilst allowing local discretion on issues about wider determinants. These are not intended to cover all aspects of health inequalities.

National headline indicators

- **Access to primary care**: numbers of primary care professionals
- **Accidents**: road casualties in disadvantaged communities
- **Child Poverty**: children in low income households
- **Diet** - 5 A DAY: consumption of fruit & vegetables in poorest households
- **Education**: GCSEs at grades A* to C at age 16 in deprived areas
- **Homelessness**: families with children in temporary accommodation
- **Housing**: households living in non-decent housing
- **Influenza vaccinations**: uptake by older people
- **Physical Activity**: PE and school sport
- **Smoking prevalence**: manual groups and in pregnancy
- **Teenage conception**: in worst quintile local authorities
- **Mortality from Cancer and CHD**

5.1.15 Ms Griffin explained that it is important for the NHS and local authorities to work together in partnerships to address the inequalities, as a single organisation will be unable to address the problems on its own. The big resources, both within the NHS and local Government are in mainstream programmes. Taking a mainstreaming approach means those resources should be directed towards areas of greatest need. Local Government services linked to health inequalities include housing, fuel poverty, education, transport, physical activity/leisure services and environmental services.

5.1.16 Ms Griffin stated that the single most important thing that can be done to reduce health inequalities is smoking cessation. Getting pregnant women to give up smoking for example, will improve the health of the mother and child and reduce the risk of infant mortality.

5.1.17 Ms Griffin stated that Derby is not alone in seeking to address health inequalities on a geographical area basis but other cities are also taking a similar approach. Manchester is aiming to narrow the health inequality gap amongst the worst wards and Telford and Wrekin is seeking to tackle infant mortality in areas where the rates are high.

5.2 Summary of Evidence Provided by General Practitioners

5.2.1 The Commission invited a number of GPs from the target areas to share their knowledge and experience about issues affecting the general health of their patients. Two GP practices accepted the invitation and gave evidence to the Commission, Dr Iqbal and Lister House Surgery, both with practices based in the Normanton area.

Summary of Evidence from Dr Iqbal

5.2.2 Dr Iqbal's practice has almost exclusively Asian patients. He stated in his presentation that education would make a huge difference to improving health. Looking after patients is a partnership. Patients need to understand their role and have an input in order to make a positive contribution to the health outcomes. Education will help people to understand the measures that need to be taken to prevent illnesses as well the action to take when they become ill.

5.2.3 Many people living in his surgery's catchment area feel that certain factors make them prone to diseases and that there is little that they can do about it. Although it is true that variable and modifiable risk factors could have a knock on effect, some things can be done of which the most important are diet, housing and how people manage compliance with the medication.

Health Problems

5.2.4 Dr Iqbal stated that diabetes is almost endemic amongst Asian patients but many are also prone to ischaemic heart disease and hypertension. Renal failure is more prevalent in Asians than the general public.

5.2.5 Approximately 7% of the patients at the practice have diabetes. At present the reasons for higher levels of diabetes amongst the Asian communities are not fully known. Observation from an early stage suggests that there is a genetic disposition since it is up to five times higher amongst Asians than in the rest of the population. Diet may be one of the factors.

5.2.6 Diabetes is not always obvious and could be present in various ways. Early detection could reduce complications later, however, it is difficult to determine the frequency of health checks and in any case people may develop symptoms in between checks. Carrying out regular checks at the surgeries has considerable resource implications, however it may be possible to carry out checks at local community health centres. There is a need to raise awareness of general health and for identifying early symptoms of developing diabetes.

Immunisation

5.2.7 Immunisation is an extremely important public health issue but sadly the take up is low amongst the residents in deprived areas. Although measles

has not been seen for a long time, there was a recent case of mumps in an 18 month old child. Dr Iqbal stated that he had considered going into people's homes to immunise but this also has disadvantages of raising expectations and creating a culture of dependency.

5.2.8 There is also a misconception that only the middle classes are refusing MMR vaccination, as this is not his experience. In Dr Iqbal's view the main reason for lack of immunisation in some groups is lack of motivation.

5.2.9 It was stated that most diseases are multi factorial, being affected by genetics as well as the environment. This is perhaps where the Council can help, through educating and raising awareness of immunisation amongst the local population.

Smoking

5.2.10 Smoking is a common cause of repeated infections such as cold and ear infections. Smoking is glamorised in the Asian communities and seen as a sign of success. It is a part of the Asian culture to offer a cigarette to guests when they visit Asian households. Smoking is also more common in the developing countries.

5.2.11 Dr Iqbal stated that smoking is mostly started through peer pressure at an early age. Although most people smoke for pleasure there are some who use it to suppress appetite. Smoking is an addiction but experience shows that after the first heart attack the patient's priority is often changed and they no longer want to smoke.

5.2.12 There are local smoking cessation services and GPs do refer patients to them. More resources could be provided by the PCTs to stop people from smoking. Discouraging children from smoking is also extremely important. Dr Iqbal stated that meetings to address smoking amongst children could include fun activities to encourage greater participation.

Changing Attitudes

5.2.13 There is a need to change the public's attitude to health, and the media can play an important role in this. Doctors and other medical professionals regularly state the importance of balanced diet with little effect. However, if the same issue is raised on popular TV programmes, it makes an immediate impact. It is important to involve the media in this process. The Government could consider putting conditions on licence franchises to radio stations to promote health.

5.2.14 Many people attending the surgery expect and want the doctor to prescribe antibiotics. However his experience is that many people do not always need them and has cut issuing antibiotic prescriptions in his surgery by 74%. Dr Iqbal stated that there is a misconception that high-energy drinks are good for the health, however in practice they can contain large amounts of sugar, artificial colouring and may be unhealthy.

5.2.15 The most common complaints that people attend the surgery with are those that involve pain. High blood pressure for example may be asymptomatic and although this is a serious problem that needs to be kept under control, if the patients are not experiencing any pain they do not want to visit the doctor.

5.2.16 Dr Iqbal stated that there is a need to take a holistic approach to health improvement by improving education, housing, employment and other determinants. Exercise and fitness can also improve health and should be encouraged.

Lister House Practice (including Oakwood Medical Centre and Fountain Primary Care Service)

5.2.17 The Commission received evidence from a team of people from Lister House Practice that included Dr John Spincer, Dr Richard Crowson and Chris Roome, Mental Health Nurse.

5.2.18 Dr Spincer stated that Lister House is one of the largest GP practices in the Southern Derbyshire area with approximately 15000 patients mainly resident in the city. It has two principal sites, Lister House and Oakwood. It is also responsible for the management of Fountain Primary Care Service, which provides GP services to asylum seekers.

5.2.19 The Lister House surgery is based in Normanton and covers parts of the Arboretum, Normanton, Sinfin and Littleover wards and has 9500 patients. The Oakwood surgery has 5500 patients. The surgery has a computerised recording system, which enables it to produce accurate and up to date statistics.

5.2.20 The patient profile reveals that 7.9% (1235) are under 5 years, 13.03% (1955) are elderly aged over 65 with 813 patients over 75. The female to male ratio is 1.03 to1. Overall, the practice has 13% ethnic minority patients including a significant number of asylum seekers.

5.2.21 It was stated that there are significant differences in the profile of patients between the two surgeries and the health problems they face. Compared with Lister House, patients at the Oakwood site are relatively well educated, have better community relations and live in small nuclear family units.

5.2.22 The Lister House surgery has one of the highest incidences of circulatory disease in the city with an average of 235.9 mortalities per 100,000 population compared with the Trent Region of 140.3 mortalities per 100,000 population. This is despite having one of the best provisions of care by operating a hypertension clinic and having a close working relationship with the University of Nottingham. Cancer cases are also high with 164.6 mortalities per 100,000 population compared with Oakwood

which has 119.8. Breast cancer, picked up through routine screening programme represents 20% of all PCT breast cancer cases.

5.2.23 The surgery has higher than average winter deaths with a 39% increase between December to March against a national and PCT average of 28%. Children at Lister House surgery are three times more likely to be admitted to hospital for household accidents than in Oakwood surgery. Patients of Lister House are five times more likely to be victims of crime.

5.2.24 Some of the other health problems experienced by the patients at the surgery are shown in the table below.

Disease	% Practice population
Asthma	11.1
Cardio Vascular Disease	11.1
Raised Blood Pressure	10.7
Arthritis	5.3
Diabetes	3.5
Mental Disorder	1.8
Heart Attack	1.7
Angina	1.0

5.2.25 The level of smoking amongst the patients is high at 44% compared with the average in the area of 31%. It is also high amongst children with 30% of 14 year olds smoking and 70% offered a cigarette by the age of 16. The practice is aiming to reduce smoking to at least the city average.

5.2.26 The biggest influence on smoking is the cost of cigarettes since the biggest reduction occurs when the cost of cigarettes goes up. It was stated that the NHS spends far more on treating smoking related illnesses than it receives from taxes on it. It was stated that from their experience not everyone wants to join Fresh Start, the local smoking cessation service.

5.2.27 It was stated that 56% of the 65-74 year patients have mobility problems and 25% of men have alcohol problems. Drug addiction is also high and rising although there are currently no detailed statistics available to support this. Every week the equivalent of a full surgery session lasting up to three hours at Lister House is taken up with treating drug use.

5.2.28 Obesity in 25-34 year olds is 43% for men and 31% for women whilst for 65-74 year olds it is 56% for men and 40% for women. There are no figures for children at present.

5.2.29 It was stated that housing, crime, accidents and employment issues also affect health.

5.2.30 Older people tend to have hearing, vision, continence and mobility problems, which are not complex medical conditions but still need proper

assessment and support. The practice would like to appoint a nurse practitioner who specialises in services for the elderly.

5.2.31 National statistics suggest that there are a lot of undiscovered diabetics. The surgery employs a diabetic specialist nurse to address diabetes amongst its patients.

5.2.32 The surgery expects to achieve its targets for children's vaccination. It was stated that it is much easier to encourage parents of children of Oakwood patients to take up the full range of immunisations for their children than is in the Lister House catchment area.

5.2.33 Obesity, drinking, drugs, smoking and diet, all contribute to children's health issues, poor diets being of particular concern for the Lister House patients. In general people are eating 20 times more salt than necessary. It was also stated that schools are not providing the necessary level of exercise for children.

5.2.34 Funding formulae in the past had not recognised the need for extra resources to GPs delivering services in deprived areas. However this is now reflected in the new GP contracts, which provide money based on deprivation factors.

5.2.35 The provision of local services is fragmented. The knowledge of facilities available locally and how to access them is not common amongst the patients or professionals. The Council could do more to publicise its leisure facilities and passes for leisure and GPs could be more proactive to encourage people to access them.

Mental Health

5.2.36 The Lister House team stated that everyone is potentially at risk of depression through a variety of reasons or for no reason at all. Depression may be described as a mental health or a social problem and is not just about severe mental disorder. At any one time over 10% of a GP's time can be taken up treating patients with depression and anxiety.

5.2.37 There are three sides to treating depression, medication; psychotherapy; and social and recreation. The social and recreation aspect is often the most neglected. For example exercise is considered to be therapeutic in the treatment of depression and if people are depressed they are unlikely to do much exercise. To address this, exercise could be prescribed by GPs and carried out in a controlled environment. Disempowerment can also lead to depression. Developing learning skills and encouraging greater community involvement could help individuals to access other services.

5.2.38 It was stated that there are differences in the reasons for depression between patients at Oakwood and Lister House surgeries. Patients in Oakwood have greater expectations from the surgery whereas the Lister

House patients are more accepting of their situation and tend to self-treat by resorting to alcohol and drugs, which leads to other problems.

5.2.39 The specialist mental health nurse employed by the practice helps people to understand why they get depressed and can direct them to specialist services much quicker than otherwise would be the case.

5.2.40 It is noticeable that 20 years ago being out of work was considered stressful whereas now being in work is considered stressful. Some employers provide counselling services and have risk assessment for stress. Derby City Council for example has good policies and practices to address stress in the workplace.

5.2.41 Fatigue continues to increase and is a common symptom amongst people who work.

Asylum Seekers

5.2.42 Dr Crowson stated that the problems of the current asylum seekers are different from the previous communities who settled in this country. Some communities came to the UK in large numbers and predominantly spoke a single language such as the Polish community. Now there are many different languages and nationalities. The large numbers of different languages pose problems for the reception staff and it takes longer to deal with their queries. The Fountain Surgery has been set up to respond to asylum seekers issues' and relieve pressures on existing GP services.

5.2.43 Health experiences of the current asylum seekers are different than the main practice population in that:

- There are 14 % of patients with no health records
- 85% of the asylum seekers may not have had any medical examination in the UK before they arrived in Derby
- 25% of the asylum seekers have mental ill health with symptoms including insomnia due to stress or flash backs

5.2.44 Asylum seekers are a mixed group and in general their health problems follow the pattern of the country they have come from with the additional problem of the stress of the asylum process. They have a high degree of mental health stress and physical trauma. There are patients with scars of torture who have sensitivity to touch. There are also some women who are victims of rape.

5.2.45 Long term health needs include stress related to the fear of being returned. This can lead to developing unhealthy behaviours such as smoking and drugs and alcohol abuse.

5.2.46 The lack of activity is a significant factor affecting the health of asylum seekers. They are not allowed to work, receive only basic Income Support and do not get travel expenses to visit the doctor. They are also not allowed to enrol onto educational/training courses. Consequently a big

group of people are either stuck at home or hang around street corners with nothing to do.

5.2.47 It is the experience of the surgery that asylum seekers and refugees are desperate to work and pay for their needs but are prevented by various immigration rules.

5.2.48 It was stated that some of the health problems of the asylum seekers could be addressed by:

- Work and activity such as increasing volunteering opportunities
- Access to language tuition to aid integration and reduce isolation
- Access to interpreting services
- An integrated induction pathway- providing knowledge of services available in city
- Positive media coverage to address discrimination
- Housing – establishing a resettlement strategy

5.3 Summary of Evidence Provided by Central and Greater Derby Primary Care Trusts

5.3.1 The Primary Care Trusts have a key role to play in addressing health needs of the local community. The Commission received evidence from Dr Peter Marks, Director of Public Health at the Central Derby Primary Care Trust and Dr Anne McConville, Director of Public Health for the Greater Derby Primary Care Trust, on the key issues affecting health of residents in the targets areas and how they link to the health inequalities.

5.3.2 The evidence presented by the Trusts shows that the mortality gap between the social classes in this country has continued to widen over the last 70 years. People with higher incomes have enjoyed better health and live longer than people on low incomes.

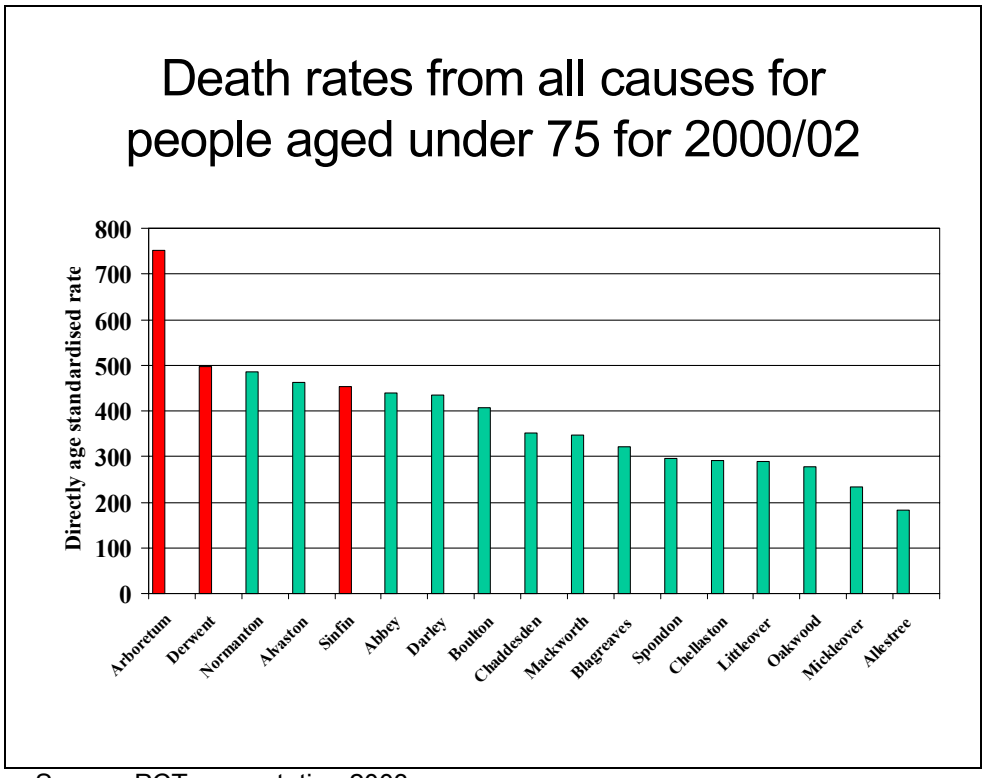
5.3.3 They supported the findings of the Health Inequality Unit about the correlation between life expectancy and level of deprivation. People living in deprived areas of the East Midlands have lower life expectancy than those living in more affluent areas. They also confirmed the Government's target to reduce mortality between the fifth of areas with the lowest life expectancy and the population as a whole areas and the gap in mortality for children under one by at least 10% between "routine and manual" groups by 2010 and the population as a whole.

5.3.4 It was stated that the Government has established a Programme for Action for delivering on these targets. The key themes for this Programme over the next five years are:

- Support families and children – addressing poverty, especially in families with children, healthy pregnancy, early childhood development through Sure Start and educational interventions to close the attainment gap
- Engaging communities and individuals: working "with the grain" of the Government's Neighbourhood Renewal and Social Exclusion Strategies to improve housing, create a safe environment, address the needs of socially excluded populations
- Preventing illness and providing effective treatment and care: a leading role for the NHS in addressing the social gradient in modifiable behavioural and physiological risks, and in primary care access
- Addressing the underlying determinants of health: tackling poverty, low basic skills, employment, low incomes

5.3.5 The Programme for Action has established a set of principles that involve working through the mainstream to target interventions and to prevent the inequalities from worsening. It is important that everyone should have access to the same level of treatment and services. However experience shows that people in deprived areas are less likely to be referred to a specialist when they have an illness than people from more affluent communities.

5.3.6 The directly age standardised mortality rates (DASR) are used to minimise effects of differences in age of the population. This is the rate that would occur in a standard population if that population had the age specific rate of the area. By using this method of standardisation it is possible to make comparisons between electoral wards with different age structures. The Commission was presented with a bar chart showing DASR premature mortality rates for 2000/02 at local ward level. The chart shows that deprived wards have significantly higher premature mortality rates than the more affluent wards. The rate for the Arboretum ward for example shows approximately 750 deaths during 2000-2002 and is more than twice the city average of approximately 350 deaths.



Source: PCT presentation 2003

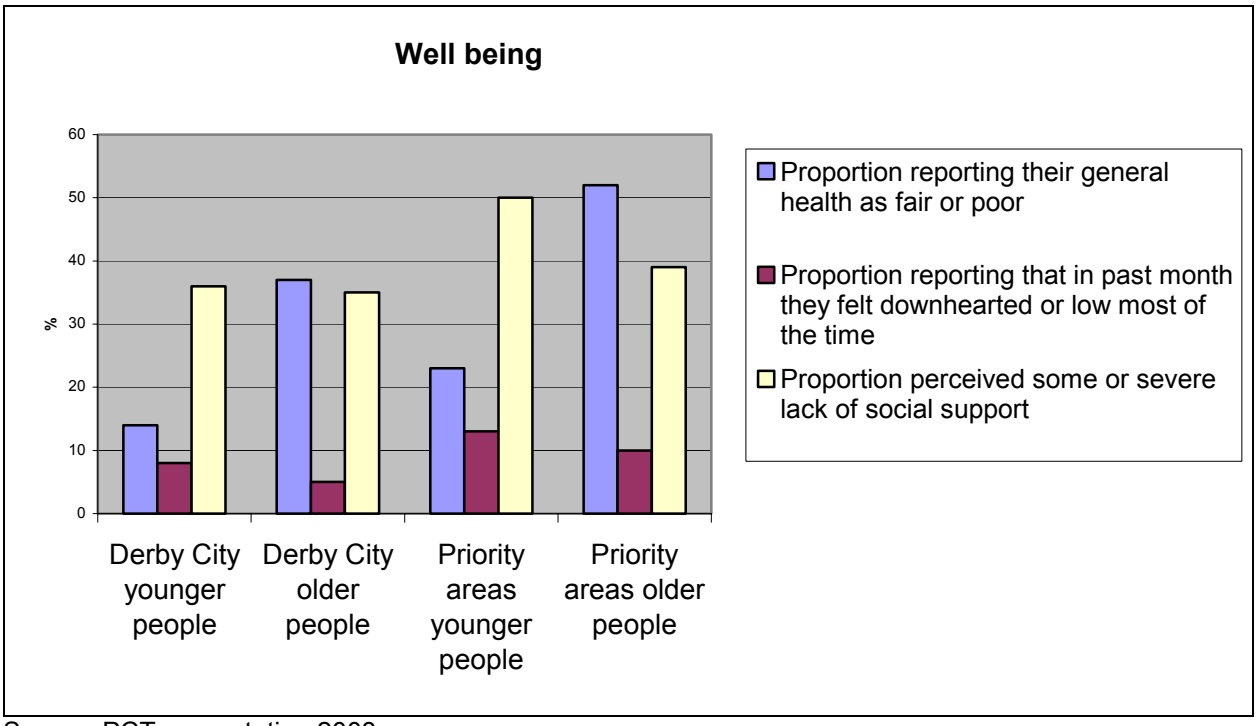
5.3.7 Households containing people with long term limiting diseases follow a similar pattern with deprived wards having greater proportion of households containing people with long term illnesses.

Well-being

5.3.8 The health bodies conducted a survey in September 2002 to determine what people perceive about their health. The graph below compares two age groups 25 – 44 (younger) and 65 – 74 (older). People were asked to report about their physical and mental health and whether they had good social support.

5.3.9 The graph shows that a significantly higher proportion of older people in the city and in the priority areas reported their health to be fair or poor. It

also shows that a greater proportion of younger people in the priority areas felt low or down hearted compared with older people.



Source: PCT presentation 2003

Dental Health

5.3.10 It was stated that there is a contrast in dental health between deprived and affluent areas. Children under five from deprived areas have greater number of decayed teeth, extraction and fillings than those living in the more affluent area.

Diabetes

5.3.11 Diabetes is a problem in some minority ethnic communities and for those living in socially deprived areas. It is up to 5 times as common in people of South Asian origin and 3 times as common in people of African-Caribbean origin than the general population. The Directors of Public Health stated that data on the incidence of diabetes in the city is currently being collected and will include information on ethnic origin of the respondent.

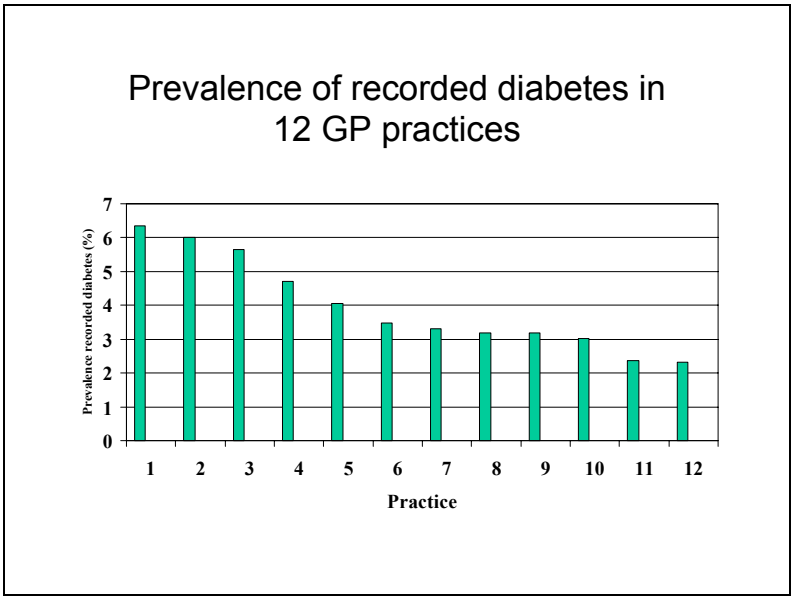
5.3.12 In response to a query why Asian people were more likely to have higher levels of diabetes, it was stated that apart from genetics it could also be due to some people changing their diets and eating foods containing high fat and saturates content.

5.3.13 It was stated that there are up to three fold variations in recorded diabetes in local GP practices and that care needs to be taken with the interpretation of the variations as a third of the people with diabetes are usually not diagnosed.

5.3.14 It is considered that people living in areas of socio-economic deprivation are less likely to get optimal treatment and the outcome may be worse.

5.3.15 There is a local strategy for tackling diabetes in the city. This includes training of staff from GP practices and community nurses, producing personal treatment plans, patient and carer education and retinopathy screening.

5.3.16 Diabetic retinopathy is complication of diabetes that affects the blood vessels of the retina and may lead to blindness. Early detection of sight-threatening diabetic retinopathy and treatment is effective in preventing visual impairment. The National Service Framework for Diabetes has set national targets for PCTs for ensuring high quality systematic retinal screening programme.



Source: PCT presentation 2003

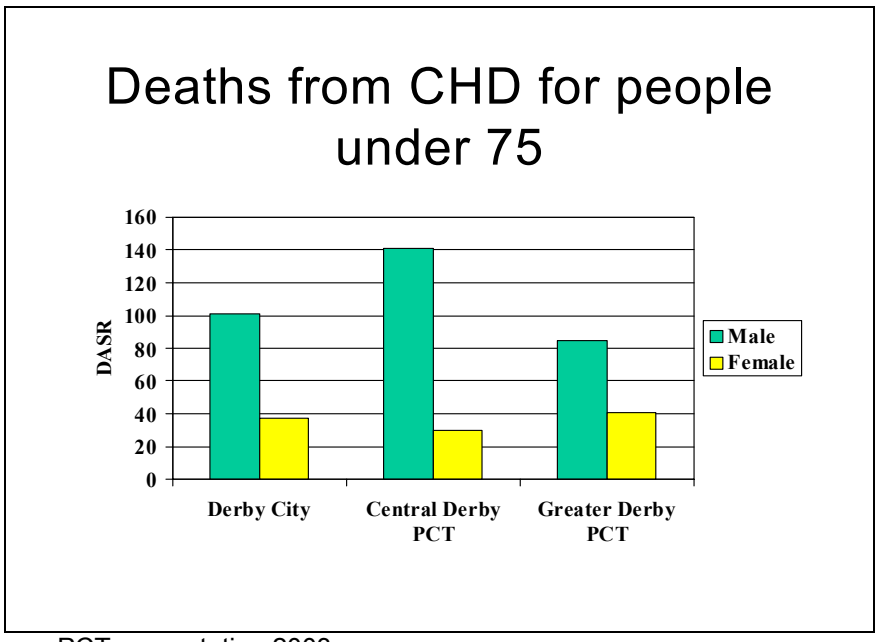
5.3.17 The Peartree Clinic in Normanton works to address the needs of Asian people. The clinic has a nurse with special expertise in diabetes, an Asian dietician and facilities for eye screening.

Coronary Heart Disease (CHD)

5.3.18 According to the information supplied by the PCTs the DASR deaths from all circulatory disease for Derby Unitary authority for the period 1998-2000 was 133.9 per 100,000 population compared with 120.4 in England and 122 in the East Midlands.

5.3.19 The graph below compares mortality rates from Coronary Heart Disease for males and females under 75 years of age in the PCT areas. It shows significant differences in gender with more than twice as many males dying from CHD than females. Differences also exist between the two

PCTs with the Central Derby PCT having a higher mortality rate than the Greater Derby PCT and for the city.



Source: PCT presentation 2003

5.3.20 The mortality rates from CHD show a reduction between 1999 and 2001 in the city although there was a small increase in the Central Derby PCT area in 2001 compared with 2000.

	Derby City (DASR)	**Central Derby PCT (DASR)**	**Greater Derby PCT (DASR)**
1999	94.92	91.24	96.42
2000	75.74	80.7	73.71
2001	68.44	83.56	62.26

Directly Age Standardised Rates of mortality for people under 75 years of from CHD (source: PCT presentation 2003)

5.3.21 The Government has issued guidelines for preventing CHD and treating heart failure. It recommends an increased use of statins (a drug to reduce cholesterol in the blood) and rapid access to chest pain clinic. The guidelines identify the need to introduce consistent levels of service for all patients across the city.

Cancer

5.3.22 Cancer deaths for males in 2001 and 2002 in Derby follow the national pattern. At the national level, prostate cancer is beginning to overtake cancer of the colon and the rectum and has become the second most common cancer in men.

5.3.23 It was stated that the number of deaths even at the citywide level are relatively small which makes looking at the differences between small geographical areas very difficult to analyse.

5.3.24 Cancer deaths for females also follow the national pattern. Due to the number of deaths involved it is necessary to monitor it over a number of years to notice any significant changes.

5.3.25 Addressing inequalities in cancer involves smoking cessation, healthy eating and tackling work place/ occupational health as some occupations can lead to health problems. The NHS Cancer plan and the Calman-Hine report (A Policy Framework for Commissioning Cancer Services report published in 1995) identified the need to improve access to screening for some cancers, improve access to treatment by organising specialists into cancer centres and units, and to provide equal access to drugs irrespective of where people live. The National Institute for Clinical Excellence (NICE) has made recommendations on standards for treatment, particularly the use of drugs.

5.3.26 Women between the age of 55 and 64 are routinely screened every three years. The Directors of Public Health stated that the breast cancer screening rates between 2001-2 for women aged 55-64 in Greater Derby PCT area are above the national average (86 per 100,000) whilst in Central Derby they are slightly below the average (82 per 100,000). The breast cancer screening programme has now been extended to women between the ages of 55 and 70 years.

5.3.27 For cervical cancer of women aged 25 to 64 the screening rates follow the socio-economic gradient with the take-up rates lower in the more deprived wards such as the former Babington and Litchurch wards. These are also the wards with the highest ethnic minority population according to the 1991 Census.

5.3.28 It was stated that smoking causes 90% of lung cancer and contributes to 40% of various other cancers. Environmental factors such as asbestos and radiation can also cause cancers. Infections including hepatitis B and C can cause liver cancer. Diets which include excessive fats, preservatives and alcohol, can also cause cancer. In addition, hormonal changes in the body are linked to ovarian and breast cancer.

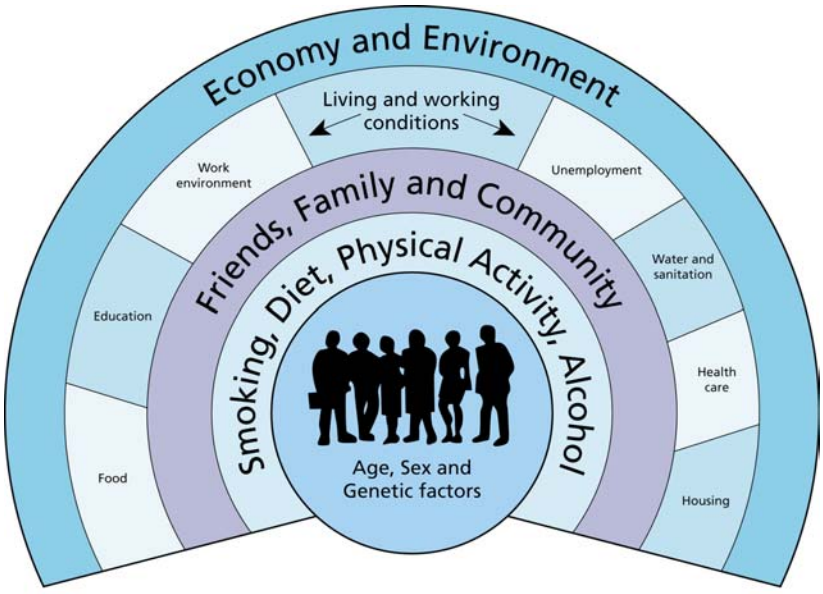
Disease Risk Factors

5.3.29 The table below shows the common risk factors for a number of diseases. It is suggested that whilst the NHS focuses on disease/ pathology for treatment services, other agencies do better to address risk factors for prevention. If people smoked, were poor and overweight they had an increased risk of a number of diseases such as cancer, heart disease and diabetes. The risk factors are similar for the determinants.

Disease risk factors

Risk factor	CHD	Cancer	Diabetes
Smoking	✓	✓	
Overweight	✓	✓	✓
Physical inactivity	✓	✓	✓
Poverty	✓	✓	✓
Ethnicity	✓	✓	✓
Genetics	✓	✓	✓

5.3.30 The Directors of Public Health presented the Dahlgren and Whitehead diagram, which shows that health is the result of complex interactions between a number of determinants. There is little that can be done about the constitutional risk factors of age, gender and genetics. It may be necessary to look at why choices are being made. Friends, family and community expectations are important. They will influence whether it is socially acceptable to smoke or to eat a particular diet. The wider economy and environment are also important factors. Access to cheap healthy food, good education, and a good work environment and leisure facilities can affect the individual's health.



after Dahlgren and Whitehead

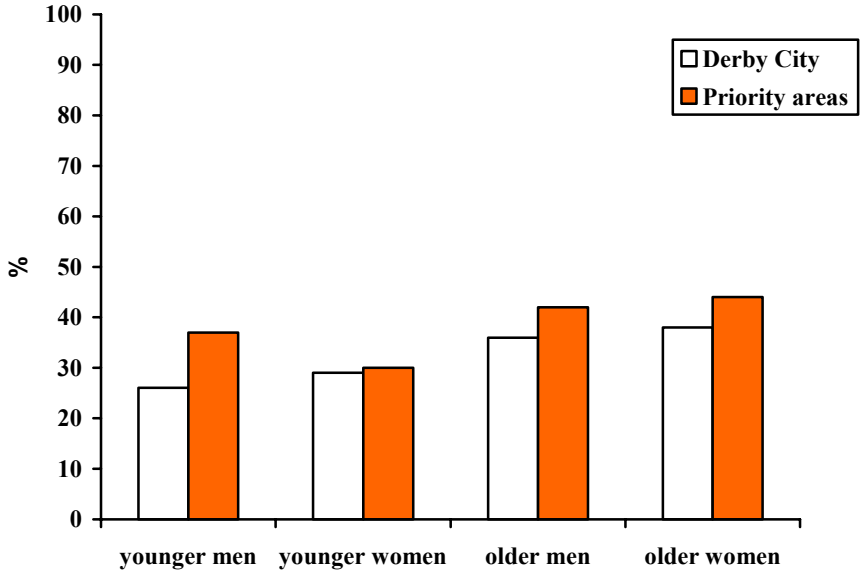
Health Survey

5.3.31 The results from a health survey carried out by the PCTs in September 2002 show that approximately a quarter of women aged 65-74 in deprived areas are obese and around half of young men aged 25-34 in deprived areas were overweight or obese.

5.3.32 It was also found that of approximately half of those who replied to a question on diets stated that they ate five or more portions of fruit and vegetables a day. It was found that more women than men ate the recommended five portions but overall less fruit and vegetables are eaten in deprived areas than the city as a whole.

5.3.33 On a question about the level of exercise the survey found that people of all age groups in the deprived areas undertook less exercise compared with the city average whilst older people undertook less exercise than younger people.

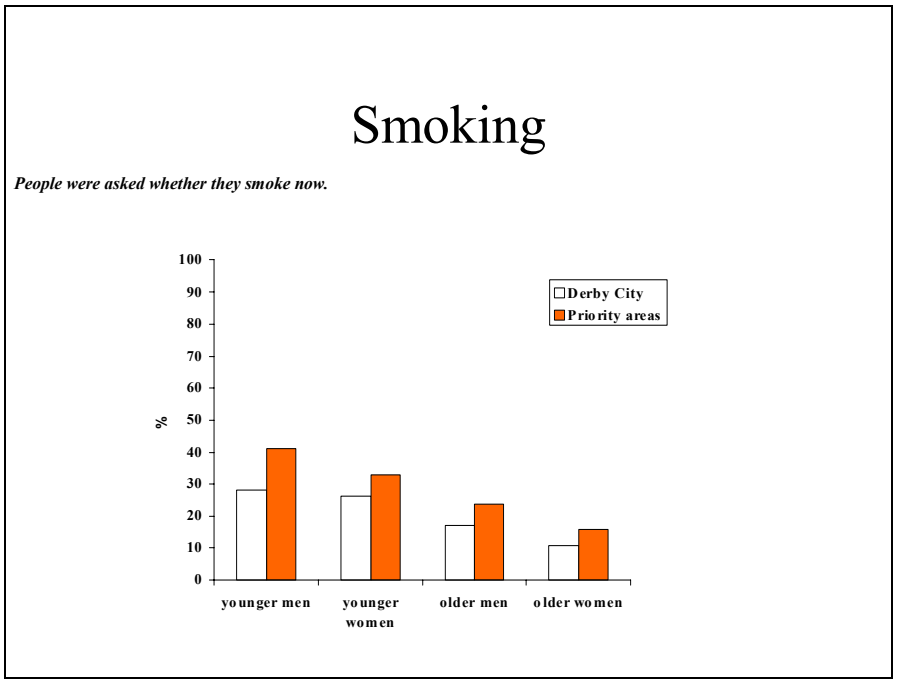
Proportion of people who carried out none or less than once a week of 30 minutes of moderate intensity exercise per week



Source: PCT presentation 2003

Smoking

5.3.34 The table below shows level of smoking between men and women in the priority areas and the rest of the city. It is found that the smoking rates in the priority areas are higher for all groups. The highest rate of smoking is amongst younger men aged 25 - 44 in the priority areas with approximately 40% of them smoking. The smoking rates for younger women are also high with approximately 30% smoking. This is a major concern as these are the age groups with young families and therefore increase the risks of smoking on children.

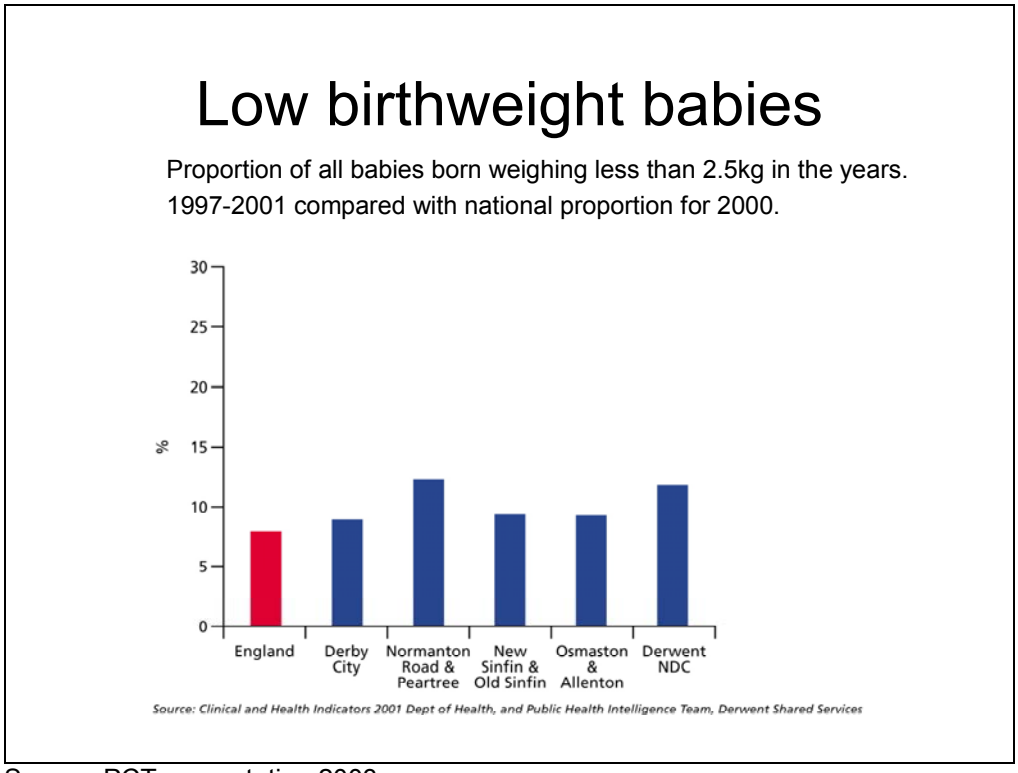


Source: PCT presentation 2003

5.3.35 It was also stated that women smoking during pregnancy can lead to low birthweight of their babies. A local smoking cessation initiative in Derby called Fresh Start has been established that aims to help smokers to give up. It specifically targets pregnant women and their partners.

Low Birthweight

5.3.36 The next graph shows that a greater proportion of babies born in the three target areas have low birthweight than the city and national rates. It was stated that Asian babies are more likely to have a low birthweight than other groups. Low birthweight is defined as babies born weighing less than 2500g. Of the three target areas, Normanton has the highest proportion of babies with low birthweight.



Source: PCT presentation 2003

Alcohol Consumption

5.3.37 Drinking above the recommended level is highest amongst younger men especially in deprived communities. A national report published recently showed that there is considerable binge drinking in both young men and young women. Professional people of both sexes are now drinking a lot and in women this may lead to an increased risk of breast cancer. Excess alcohol is also associated with cancer of the liver, mouth and oesophagus and is a major factor in domestic violence.

Damp Houses

5.3.38 The Commission was informed that people living in damp houses, especially children, are at a risk of developing respiratory diseases. In poor areas a higher percentage of the household income is spent on heating which also leads to fuel poverty. It was stated that up to 25% of young people aged 25-44 in Normanton live in damp houses compared with the approximately 12% in the city. The figures for Osmaston are around 19%.

Breastfeeding

5.3.39 Breastfeeding is recognised to give the baby the best start in life. Breast milk contains all the nutrients a baby needs in the right proportions. It also contains antibodies and other protective factors which are transferred from the mother to help the baby fight against infections. Very occasionally a mother is advised not breastfeed, for example if she is HIV positive or because of a risk of passing on a virus to the baby. It was stated that Central Derby PCT is working towards a “Baby Friendly” standard as

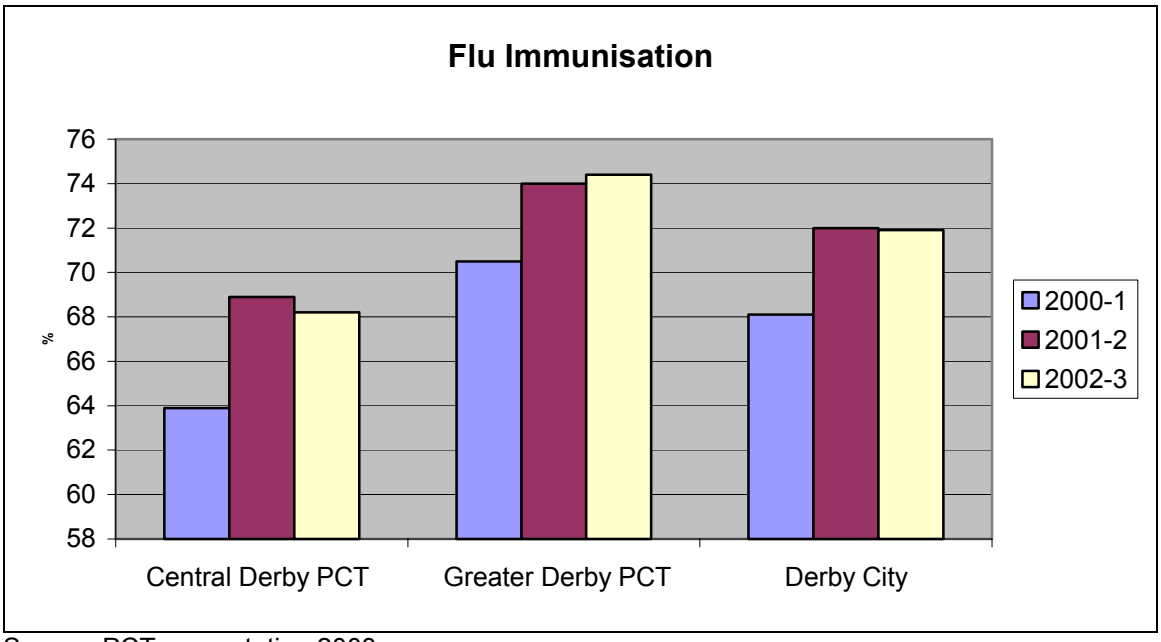
recommended by UNICEF whilst South Derbyshire Acute Hospitals Trust has already achieved this. New mothers are proactively encouraged to breastfeed with 72% of babies put to the breast in the delivery suite. It is not known how many mothers continue when they get home.

Health Promoting Schools

5.3.40 Health Promoting Schools is a national initiative delivered through a partnership between health and education. This initiative aims to promote and protect physical, mental and social well being of children. It has a greater focus on schools in the deprived areas. It seeks to address teenage pregnancy, drug and alcohol misuse, social inclusion and pupil attainment. It was stated that 104 out of 111 schools in the city have signed up to the scheme.

Flu Immunisation

5.3.41 The flu immunisation programme targets people with the highest set of risks such as the young people with illnesses, older people and those with chronic disease as they find it hard to fight the flu virus. Sometimes immunisation needs to be repeated to keep ahead of the problem as the virus may change over time.



Source: PCT presentation 2003

5.3.42 The chart above shows flu immunisation rates for three years between 2000 and 2003 for the two Primary Care Trusts and for the city. The rates show an upward trend for the Greater Derby PCT over the three years whilst there was a slight drop in the Central Derby PCT for 2002. The rates for Central Derby PCT are about 6% lower than Greater Derby PCT.

Tackling Inequalities

5.3.43 The Directors of Public Health stated that partnerships are essential for tackling health needs. The existing Derby City Partnership structures could be used to engage with organisations including the private sector. Sharply focused initiatives should ideally be funded from the mainstream. Local regeneration schemes budget could be used in tandem with health budgets.

5.3.44 It was also stated that a small number of agreed local indicators could help with addressing inequalities. These could include:

- Reduce by 10% gap in mortality by 2010
- Reduce smoking in pregnancy
- Reduce breast feeding initiation
- Reduce teenage conceptions
- Reduce deaths from cardiovascular disease
- Deaths from cancer
- Increase flu immunisation

5.3.45 The Greater Derby PCT is working with the Derwent New Deal for Communities to establish a Healthy Living Centre in the Derwent area to promote health. The Healthy Living Centre aims to improve self-esteem by training people so that they can take up local employment as well as support the community. Another local initiative was mentioned that makes use of allotments to grow food for local people, which also increases physical activity.

5.4 Derby Pointer

5.4.1 The Commission sought views from people in the city on how they feel about their health and to identify their level of participation in physical activities by including questions in the May 2003 edition of the Derby Pointer Panel. This is a quarterly survey of 1000 adults across the city conducted by the Council on a range of issues.

5.4.2 The question on health asked people how their health had been over the previous twelve months. This question was identical to the one asked in the 2001 Census to enable direct comparisons to be made. The results from the Derby Pointer show that 19.0% of the respondents describe their health to be not good compared to 10% in the 2001 Census. The difference is noticeable over a two year period. This may be explained by the smaller sample size of 523 people in the Derby Pointer compared with the 2001 Census that surveyed the whole of city's population. The Derby Pointer also has a higher proportion (22%) of people over the age of 65 compared with the 2001 Census (9.2%), which may have also affected the results.

5.4.3 The questionnaire also asked people about their participation in sports or physical activities over the previous four weeks. A separate question on walking was included as this is recognised to be an important contributor towards active and healthy lifestyle. Participation in walking is defined as "walking or hikes of at least 2 miles or more" by Sport England.

5.4.4 Of the 523 people responding to the question on walking, 27.9% had never taken part in walking two miles or more. A total of 521 people responded to the question on taking part in physical activities of which 58.5% stated that they had not taken part in any sports or physical activities in the previous 4 weeks. This suggests that a large proportion of the adult population in the city are not physically active.

5.4.5 Those people who responded positively to the sports question were asked to state which sports or physical activities they had taken part in. The top four responses to this question were swimming (32.9%), gym (32.9%), cycling (18.3%) and walking (8.9%)

5.4.6 People were asked to explain the reasons why they were not taking part in sports or physical activities. The top four reasons for not taking part in sports or physical activities included, too busy/no time (26.9%), disability (23.6%), medical condition (19.6%) and old age (12.4%). Three people (1.1%) also stated that they were unfit to take part in sport.

6 The Determinants of Health

6.0 The Dahlgren and Whitehead diagram presented by the Primary Care Trusts and the Health Inequality Unit in their evidence to the Commission identified a set of determinants for health that need to be taken into account when considering health inequalities. The Commission sought to examine these links by considering evidence on Crime and Disorder, Education, Road Traffic Collisions, Environmental Health, Social Services, Employment, Housing and Sports and Leisure Services.

6.1 Summary of Evidence on Crime and Disorder

6.1.1 Evidence to explore the links between Crime and Disorder was received from Andy Luscombe, Principal Policy Officer and Steve Spear, Drug and Alcohol Action Co-ordinator, both senior officers of the Community Safety Partnership. This is the new merged partnership between the Youth Offending Service, the Drug and Alcohol Team, the Domestic Violence Partnership and the former Crime and Disorder Partnership.

6.1.2 Mr Luscombe stated that not all of the data used in his presentation is related to Derby, however a separate annual report is being produced on Crime and Disorder in the city.

6.1.3 It was stated that crime can and often does damage health through physical injuries, mental health problems, increased stress and increased use of drugs and alcohol. Crime is also linked to increased smoking as a number of contraband cigarettes are coming into UK cities. A reduction in crime can improve public health. For example 30% of those assaulted and received NHS treatment are found to develop psychological problems. Similarly reduction in the fear of crime reduces mental health and isolation problems.

Cost of Crime

6.1.4 Crime costs the National Health Service millions of pounds every year. Violent crime represents 50% of all costs of crime, most of which falls upon the health service. Violent crime against health care staff affects about 65,000 staff, costs in the excess of £300m and reduces the effectiveness of services.

6.1.5 Sometimes a cost value can be attributed to injury involving alcohol. For example a glass related injury can involve 48 different professions ranging from a nurses to plastic surgeons and cost up to £180,000.

6.1.6 Earlier intervention with victims of hate crime and domestic violence can reduce mental health costs.

Need for Information

6.1.7 The Crime and Disorder Team have attempted to get systematic data from the accident and emergency department through the Health Trust. These attempts have been unsuccessful for a variety of reasons but partly due to the manual recording systems that are in place to aid the treatment of the patient and not the criminal justice system.

6.1.8 Information about the incidents should be provided on a need to know basis. Organisations do not always need to be given specific information but just enough so some action can be taken to reduce incidents.

6.1.9 The key themes of the Community Safety Partnership are:

- Violent Crime
- Burglary
- Domestic Violence
- Drugs and Alcohol
- Audit and Analysis
- Future Local Action

6.1.10 Due to the importance attached to addressing violent crime in the city, it is included as a Best Value Performance Indicator for the City Council. Some authorities have a separate indicator for robbery but in Derby the violent crime BVPI includes assault, robbery and sexual assault. Violent crime in the city is about 18% of total crime with 25% of violent crime being domestic violence.

6.1.11 It was stated that the place of incidence and not just the place of residence should be taken into account when analysing crime in the areas of deprivation. For example, the city centre is a significant area for violent crime. In some cases it is related to the fact that it attracts visitors during the week and at the weekend and so crime should not just be attributable to people from the city centre.

Impact of Crime on the Health of Older People

6.1.12 Home Office surveys and research show that the health of elderly victims of burglary declines faster than non-victims for the same age group. Research published by the Home Office show that within 2 years of burglary an elderly victim is two times more likely to have died or gone into residential care than their non- burgled neighbours. Distraction burglary targets certain groups including those that are older, people living in remote areas, having less mobility and greater disrepair of property. A lot of this is linked to deprivation areas. It was stated that the Community Safety Partnership does a lot of work on crime around young people, however there is need to have a strategy for older people as they can be equally affected by crimes such as burglary.

Domestic Violence

6.1.13 Domestic violence can affect the victim's mental health and this could lead to depression and even suicide. Almost all domestic violence survivors come into contact with the health community at some stage. It was stated that 40% of domestic violence incidents involved injuries to the victims, 10% involved choking, strangling or suffocating and 20% of the female victims sought medical help after the most recent incident.

Drugs

6.1.14 Mr Spear stated that drugs are considered to be a deprivation issue although there is also considerable amount of middle class recreational drug use of cannabis, ecstasy and cocaine. The current drugs strategy is crime driven, as 70% of crime may be drug related. At the national level 100,000 persistent offenders are estimated to be causing 50% of all crime in the country, and 60% of these are hard drug users. Addressing drugs will have resource implications for the health community.

Alcohol and Drugs Strategy

6.1.15 Drugs and alcohol are often easily linked although in reality they are separate issues.

6.1.16 The current Government has continued with the National Alcohol and Drugs Strategy introduced by the previous administration and extended it into a ten-year plan. It has four strands all with equal importance that interact with each other.

- Prevent young people from using drugs
- Reduce the prevalence of drugs on our streets
- Reduce drug-related crime
- Reduce the demand for drugs

6.1.17 Agencies are being told by the Government to concentrate on problematic drug use since it is estimated that the 250,000 class A drug users with more severe problems account for 99% of the costs of drugs misuse.

6.1.18 Action is being taken to remove drugs from the streets with senior members already removed from four of the six drug gangs in Derby. However this didn't seem to have made much difference to the reduction in drugs on the street. Although there is little danger of gang war over dealing turf from the Derby gangs, care is taken in removing the gangs as it could make room for more hostile gangs from others areas to move in.

6.1.19 The strategy for reducing drug related crime is closely linked to the fourth strand of reducing the demand for drugs since a reduction in the demand for drugs will also reduce drug related crime. Treating the drug user through detoxification or replacing heroin with methadone reduces the demand for drugs.

6.1.20 There has been a major expansion of services within the criminal justice system. It uses every opportunity from arrest to sentence, to getting drug-misusing offenders into treatment.

6.1.21 The Government has recognised the need to increase the level of resources for addressing drugs problems. In 1998 it provided £200,000 for Southern Derbyshire to deal with drug issues, which has now been increased to £1.6 million for Derby alone. However, one problem encountered last year was having lots of money but not enough staff to deal with the issues. It was also stated that there are no standards for the training of drug related staff.

6.1.22 Unfortunately historical data was lost during the transition from operating on the Southern Derbyshire to the Derby area and as a result there was nothing to compare the impact of the funding with.

6.1.23 It is important for expansion of treatment services to stay ahead of the problem. The Government has set a target to increase the number of people in treatment by 100% by 2008. Derby has already tripled the number of people in treatment from the rates in 1998.

Targets for Crime and Disorder

6.1.24 The Council has set two Public Service Agreement targets that directly relate to the reduction of Crime and Disorder. These are:

- Increased school attendance through introduction of a Rapid Response Truancy unit, co- managed by the Education Department and Youth Offending Service.
- Reduction in the number of abandoned vehicles, managed through the Environmental Health service.

6.1.25 The Home Office has also set national targets for local authorities to reduce domestic burglary and car crime. These are to reduce:

- car crime by 30% over the period from a 1998/99 baseline through to March 2004
- domestic burglary by 25% over the period from a 1998/99 baseline year through to March 2005.

6.1.26 The Crime and Disorder Team was asked to provide crime data relating to the target areas and for the city. The next table shows that all three areas have higher crime rates than the city as measured by the proportion of offences per thousand population. The table also shows significant differences between the three areas. Normanton has the highest proportion of drugs and sex related offences, Osmaston has the highest proportion of violent crime and assaults whilst Derwent has the highest proportion of household burglaries.

	Derwent NDC	Normanton NRF (SRB6)	Osmaston NRF (SRB5)	City
Population	9355	23443	10948	221700
Households	4000	10500	4500	92400
Offences (Apr 02-Mar 03) (% per thousand population)				
Burglary dwellings	242 (25.8)	416 (17.7)	166 (15.2)	2591 (11.6)
Drugs offence	39 (4.2)	154 (6.6)	61 (5.6)	609 (2.7)
Violent crime	365 (39)	1201 (51.2)	646 (59)	7265 (32.8)
Assault	334 (35)	907 (38.7)	584 (53.3)	6244 (28.2)
Sex offence	16 (1.7)	106 (4.5)	34 (3.1)	354 (1.6)

Source: Statistical information supplied by the Crime and Disorder Team

6.2 Summary of Evidence on Education

6.2.1 Education plays a vital part in all our lives. People with high levels of education are more likely to have better paid jobs, live in a better environment, have a membership to a gym and understand the causes of ill health than people with less education. A number of people giving evidence to the Commission stated that education is also a major determinant for health and is fundamental to addressing inequalities including those in health.

6.2.2 The Commission invited Andrew Flack the Director of Education to provide evidence on the key factors affecting pupil attainment particularly in deprived areas and how these can be addressed.

6.2.3 In his evidence Mr Flack stated that the results for pupils from the target areas, at all the key stages students are tested at including GCSEs, are all below the Derby average, which is also a little below the national average. The results also show that pupils living in the deprived areas fall further behind and the gap increases at every stage.

6.2.4 There are a number reasons for these differences. The social demands on children increase as they get older. The curriculum is also more demanding and if the children are not motivated towards learning by the end of primary school they fall further behind in the secondary school. There is peer pressure on lifestyles, which needs to be considered as this also contributes to educational attainment.

6.2.5 There are other factors which can affect pupil performance.

- Poor health of pupils. This may be as a result of non take-up of screening programmes, emotional well being of the child and poor parenting, poor living conditions and other matters like drug and alcohol abuse.
- Low expectations of parents and community
- Parents' poor experience of schooling and fear of school
- Greater tendency for pupils to leave school at the age of sixteen and enter into employment
- Turbulence- moving house, for employment or due to family break up reasons
- Poor schooling itself- ethos of school, poor leadership and the general school environment
- Self esteem of the pupil

6.2.6 The factors are interrelated and impact differently on different individuals. In the past, pupil performance was linked to teacher expectations and this was considered to be the significant factor. This is still very important.

6.2.7 In response to a member query on school performance, it was stated that there were two secondary schools in special measures serving the areas

under this review. This is not unusual nationally due to challenges faced by the schools in the deprived areas.

6.2.8 In the schools with greatest challenges, it is difficult to attract good staff with right skills. People used to look for structural solutions in school management and funding but essentially it is how people interact with one another, whether within the school or beyond. It is too easy to fall into generalisation but it is the quality of teaching that makes learning interesting and enjoyable that is going to make the greatest difference.

6.2.9 Mr Flack stated that the children in the target areas are more likely to be excluded from school, which also impacts on attainment. Exclusion used to be a national priority and Derby performed very well in reducing the numbers of excluded pupils. The figures are rising again and there are tensions between the inclusion and raising achievement agendas. Less popular schools also tend to have spare places that are likely to be taken up by excluded students from other schools.

6.2.10 The Education Service has a Pupil Referral Unit, which has been very successful in supporting some excluded pupils. The Unit is expected to provide the full curriculum though relevance and motivation have particular dimensions in these circumstances.

6.2.11 The Chair observed that for Pakistani children living in the Normanton area with similar parental and economic background, it seemed to be a lottery on where the children go and how well they achieve. From his observation, it was the schools that are the biggest factor in pupil achievement. For example Pakistani children attending Littleover School on average get significantly better results, with Derby Moor also performing well whilst performance of children attending some of the other schools was significantly lower (but improving). There are several factors which affect this as stated earliar.

6.2.12 Mr Flack confirmed that in the example of Littleover School they have sustained very good exam results over a number of years. The school has very high expectations of the pupils and of their families. This provides motivation and commitment for the families to take a greater level of interest in their children's attainment. The school strongly discourages children from being absent from their class and requires a letter from parents for all absences including through illnesses and medical visits.

6.2.13 There is an argument from secondary schools about the variations in intake of children. Schools often ask for a realistic and fair assessment of their performance that shows the value added rather than just the final results. Although every Government has sought to address this issue, it has proved to be immensely difficult to achieve. Significant progress has been made this year in providing value added information.

6.2.14 Care needs to be taken when looking at the results because not all the children live in the immediate vicinity of every school. Many pupils travel

outside of their area for secondary education and therefore there is a need to be more sophisticated with the figures to determine pupil performance in the target areas.

What is causing the gap and how can it be addressed

6.2.15 In response to what can be done to eliminate the gap at an earlier age it was stated that although significant emphasis is being placed on early education, in practice more resources are provided at the older age group and they tend to have smaller class sizes. The national agenda has now moved on to improving results in secondary education. However, the Government is beginning to put significantly more resources into early education through initiatives like Sure Start and is seeking greater parental involvement. A major factor affecting attainment is low expectations and low parental support. The gap could be reduced by better and earlier involvement of the family and the community with the Education Service.

6.2.16 There are a number of inputs that can affect school performance:

- Funding - The range of funding between different areas could affect attainment. The allocation formula provides between £1800 and £3200 (primary) and £2700 and £3400 (secondary) per pupil and builds in factors on special needs, deprivation, English as an additional language and other issues. In practice, much higher levels of funding go into the deprived areas.
- Reputation of the school may create a downward spiral if the school gets stigmatised
- Identifying needs in children and focusing on vulnerable groups - children with special educational needs, in public care, under performing ethnic minority children and early years groups
- Maximising parental involvement in learning e.g. outside school
- Focus on 14-19 years olds and increasing staying-on rates
- Rapid response to get truanting children back into schools

6.2.17 There are constraints on the Education Service through national directives and greater autonomy for schools. In relation to education, the Council has few direct decision making powers on the use of resources. However, partner organisations may be able to exert some influence on how the external resources are spent. It is important to recognise and promote interagency interventions as early as possible and any lessons learned from successful initiatives should be spread more widely across to other groups and families.

6.2.18 There is a need for greater flexibility between national funding streams to contribute to educational needs. Overall the Education Service is working on the basis that targeting is needed on deprived areas because the achievement is lower.

6.2.19 In response to the query on providing extra rewards to teachers to improve performance, Mr Flack stated that it is only possible to do this to a degree

but there are also high expectations of teachers in high achieving schools. Teachers work to national pay and conditions, which make it difficult to significantly change pay scales. It could also create problems between existing staff. There is a higher degree of autonomy for governing bodies to enable them to make decisions appropriate to their circumstances.

6.2.20 There are a whole range of initiatives funded separately to improve education such as Education Action Zones and Excellence Cluster that are beginning to make a difference.

Plans and Targets

6.2.21 The Education Service has around 30 different plans to pull together each year in line with national priorities. The priorities for the Educational Development Plan (EDP) are summarised below:

- Excellence in early years and primary education
- Raising attainment in key stages 3 and 4
- Introducing innovation to support teaching and learning
- Promoting effective schools
- The use of ICT in raising attainment
- Recruitment and retention strategy

6.2.22 The Commission sought to understand the links between educational attainment and health in the three target areas. The Education Service provided details shown in the next table. Due to the current process for collecting education data based on schools rather than on a geographical area basis, it was not possible to obtain all the information for the three areas. However from the information that has been received, it shows that proportion of pupils obtaining 5 A*-C grade GCSEs in the three target areas are significantly lower than the city average. In the Osmaston and Derwent areas, only 17% of pupils achieve this grade, whilst 37% of pupils achieve it in Normanton compared with the city average of 44%.

6.2.23 The table also shows the number of permanent exclusions for the three areas. Normanton has the highest number of exclusion of the three areas, however without the information on the number of school aged children in the three areas, it is not possible to draw any firm conclusions.

Issue	Derwent NDC	Normanton NRF	Osmaston NRF	City
Population	9355	23443	10948	221700
Total number of statutory school aged children (5-16)	Not available	Not available	Not available	34383
Total primary school capacity (DfES definition - more open enrolment - moe)	951	2550	1085	22429
Total secondary school capacity (DfES definition - more open enrolment - moe)	636	1586	845	15383
% of children attaining 5 A*-C GCSE as % of entries	17%	37%	17%	44%
Total number eligible to enter for GCSE's	114	294	177	2593
Total number of entries for GCSE's	101	279	165	2545
Number of permanent Exclusions	7	10	9	83
Absence levels of pupils at primary school	Not available	Not available	Not available	6.1%
Absence levels of pupils at secondary schools	Not available	Not available	Not available	9.5%
Total formula budget (including Schools Standards Grant)/total number of pupils (FTE)				Average £2428.51 for financial year 2002/03

Source: Education Service
All data relates to 2001-02 academic year
Number of children attaining 5 A*-C GCSE for 2001-02 Academic year

6.3 Summary of Evidence on Road Traffic Collisions (Accidents)

6.3.1 The presentation by the Health Inequalities Unit stated that the accident rates in the East Midlands are significantly higher than the national average. The Commission therefore sought to explore the links between road accidents and health inequalities. It invited the Traffic and Transportation Section of the Development and Cultural Services Department to give evidence on the level of accidents in the target areas.

6.3.2 Ian Butler, Senior Engineer Accidents and Projects, and Jon Pumfrey, Accident Investigation Officer presented the evidence to the Commission.

6.3.3 In their presentation the officers stated that Derby has adopted the term collisions rather than using accidents, as accidents imply no blame. This term is suggested by the Department for Transport and is increasingly being used the agencies.

6.3.4 The categories for casualties are split into Fatal, Serious and Slight. More recently the fatal and serious figures have been combined, as they are the focus of the targets given by the Government.

6.3.5 The Government set targets in 2000, which only take into account people killed or seriously injured (KSI) in road traffic accidents and has excluded slight injuries. It was stated that except for the blip in 2001 figures, Derby is doing well against all the KSI targets set by the Government.

6.3.6 The Best Value Review carried out in 2000 compared Derby with similar sized authorities such as Coventry, Hull, Leicester, Nottingham and Stoke and found that the city has fewer casualties per 100,000 population.

	Coventry	Derby	Kingston Upon Hull	Leicester	Nottingham	Stoke on Trent
Total casualties	1610	1009	1282	1564	1743	1500
Total child casualties	276	146	314	229	373	228
Casualties per 100k Population	529	426	504	539	615	602
Child casualties per 100k Population	90	62	123	79	131	92

Source: Road Collision & Casualties in Derby 2001

6.3.7 In 2001 the target for killed or seriously injured child casualties was set at 27 but the actual number in the city was 17. It is good that the number is small but it does makes it difficult to target prevention measures on small areas. It was stated that there have been only 3 child fatalities in the last 10 years.

6.3.8 A pool of schemes are produced every year, which may include issues such as traffic calming, signal improvements, and junction improvements. Each scheme is thoroughly investigated including making use of police files to address traffic issues. A report is then produced with recommendations on any treatable factors. The schemes are then considered and included in the Local Transport Plan. These schemes tend to be given a high priority as they deal with collisions and road safety but still have to compete for the money set aside for other initiatives. The impact of the scheme is monitored generally three years before and three years after installation.

6.3.9 All collisions are given a monetary value by the Government. It ranges from £60,000 for an average collision in an urban area through to a fatal collision on the motorway costing £1.5 million. The value takes into account the cost of emergency services, compensation, loss of earnings etc. It was stated that the schemes currently in place in Derby have prevented 270 casualties and estimated to have saved £17 million, for an outlay of about £1 million.

6.3.10 Safety audits are carried out for all new schemes. A team of experienced accident investigators will assess designs for new highway schemes such as new roads developments or any junction improvements. Certain combinations of design can become unsafe and it is these people that will spot it. The idea of assessing the scheme from a safety point of view is taken all the way through to completion. Any recommendations that are made by the safety audits carry quite a lot of weight and can result in changes to schemes.

6.3.11 It was stated that Derby continues to spend significant amounts of money installing traffic calming measures across the city and as a result it has seen a downward trend in collisions.

Parking Near Schools

6.3.12 Parking near schools is a significant issue for some schools. Preventing parking near schools has been considered but it needs backing from the Police. The arrangements for enforcing parking regulations in the city centre have been taken up by the Council, which has freed up some of Police's time for other areas. The Police are willing to pay more attention to those schools from an enforcement point of view where the schools have a definite commitment through the Safe Routes to School Travel Forum. However, it was stated that encouraging people to use alternative modes of transport instead of using the car for the school run is more effective than banning parking since this is likely to move the problem to a different street and upset more people in the process.

Target Areas

6.3.13 The Traffic and Transportation Section supplied statistics on road traffic casualties in Derby during 2000 to 2003. These show that Derwent and Osmaston have a similar number of casualties whilst Normanton has substantially higher. It was stated that this was due to Normanton being twice the size of the other two areas.

6.3.14 It was stated that social deprivation has never been a consideration in how accident reduction schemes are carried out. A common sense approach is taken to install accident reduction schemes in areas of greatest collisions. There is however a correlation between deprived areas and collisions. Deprived areas may lack parking space and have small or no back gardens and consequently result in children playing in the streets which increase the chances of collisions.

6.4 Summary of Evidence on Environmental Health

6.4.1 Local authorities are responsible for developing strategies and action plans for addressing public health. Andrew Hopkin, Assistant Director, Environmental Health and Trading Standards was invited to give evidence to the Commission about the strategies and policies for improving health in the city.

6.4.2 In his presentation Mr Hopkin stated that the World Health Organisation (WHO) defines health as “A state of complete physical, social and mental well being, and not merely the absence of disease or infirmity”. Health is therefore a result of a complicated interaction between genetics, lifestyle, economic factors, the environment and the society in which a person lives. The issues impacting on health include:

- Social isolation and exclusion
- Poor working environment
- Poor diet
- Unemployment
- Poverty
- Poor housing
- Lifestyle
- Environmental pollution
- Unsafe food production
- Consumer protection

6.4.3 The national policy on health improvement is evolving and aims to lead to a healthier nation. Environmental health practitioners have a wealth of knowledge of public health and can make valuable contribution to the maintenance and improvement of public health.

6.4.4 Since the publication of the white paper Saving Lives – Our Healthier Nation (Dept of Health, 1999) and the NHS Plan (Dept of Health, 2000), the importance of the local authority contribution to improving health has increasingly been recognized.

6.4.5 The ‘new’ public health agenda and the modernization of local Government have provided:

- An emphasis on tackling wider determinants of health, recognizing that they can lie largely outside the NHS’s remit
- Tackling social exclusion
- A duty for local authorities to participate in local strategic partnerships, and to develop a community strategy with key stakeholders
- New powers for local authorities to promote and improve the economic, social and environmental well being of communities

6.4.6 The East Midlands Regional Assembly published "Investment in Health in the East Midlands" a public health strategy for the East Midlands in 2003 to add value to national health related policy and its local implementation. The strategy suggests sixteen policy objectives, five of which are identified as priorities**.** The Council has a role to play in achieving many of these objectives, including those relating to Diet, Accidents, the Workplace, Food Safety and Emergency Planning.

6.4.7 Locally a partnership between the Directors of Public Health of the Central and Greater Derby PCT's and Derby City Council produced the Derby City Public Health Annual Report 2003 – "Improving our Health in Derby".

6.4.8 The Environmental Health and Trading Standards Division aims to improve public health, quality of life and the physical environment. It has over 90 staff that includes the enforcement and licensing officers and the support staff.

6.4.9 It was stated that the Division has the responsibility to enforce the law but also to educate and give guidance to businesses and the public. The latter is perceived to be more beneficial and sustainable in the long-term.

6.4.10 Environmental Health and Trading Standards have 60,000 contacts a year. About 95% of this work involves providing advice and guidance to businesses and the public. Legal proceedings are taken in a small proportion of instances.

6.4.11 Mr Hopkin stated that it was not always possible for the Environmental Health Division to positively target geographical areas and they would struggle to meet specific reduction targets due to lack of resources, both in terms of staff and funding to set up schemes. Those schemes that had been introduced are successful.

6.4.12 The Division could undertake limited geographical targeting across the City and focus on reducing mortality. A number of projects have been set up in deprived areas of the City that directly affect health. These include:

Normanton

- SRB funded Home Safety Equipment Loan Scheme
- Women's Health Group
- Home safety training

Osmaston

- Home safety issues

Derwent

- Home safety equipment scheme bid for New Deal funding being Prepared
- Allotment scheme being looked into to promote the "5 a Day" message
- Introduction of conflict resolution

6.4.13 The Division also works on a number of city wide projects, including:

- Annual Public Health report, in conjunction with Greater and Central Derby Primary Care Trusts
- Healthy Eating on a Budget booklet
- Work with Derbyshire Action on Smoking to promote reduction in smoking. This includes initiatives to promote no smoking in the workplace and in public areas
- Work within food, alcohol and tobacco partnership on a variety of areas
- Seeking to reduce underage tobacco sales
- Promotion of responsible dog ownership by the Dog Warden Service through events held in the city parks
- Local Public Service Agreement to target abandoned vehicles and their associated problems
- Introduction of an Air Quality Strategy and Air Quality Management Areas within the city to reduce atmospheric pollution

6.4.14 The strategy document "Improving our Health in Derby" identifies stopping smoking as the single most important thing that can be done to improve local health. The Division is considering developing no smoking policies in restaurants and pubs.

6.4.15 It was stated that the Poverty Profile produced by the Council in 2001 is a useful document for identifying local issues and needs to be updated to inform the public health strategy.

6.4.16 Mr Hopkin stated that agencies should support vulnerable people in the communities and provide back up, ideally help by intervention. The Council House, St Mary's Gate and Consumer Advice buildings are all dilapidated and in need of repair. This sends out the wrong message, it is depressing rather than appearing to offer help.

6.4.17 Education and financial pressures can influence people's diet. People who are well off do not generally have to think about the cost of food whilst those with low incomes often buy food with lower nutritional values, which may contain more sugar and saturated fats. They can find it difficult to make choices about the type of food they buy due to financial constraints. People on low incomes need to have easy access to supermarkets to give them a greater choice in shopping. It was stated that better transport provision could help with this issue.

6.5 Summary of Evidence from Social Services

6.5.1 Social Services perform a key role in supporting vulnerable people who often have the highest set of needs. The Commission invited Margaret McGlade, Director of Social Services, to talk about:

- Key issues affecting the health and well being of communities
- Policies, strategies and action plans to reduce isolation of people in the community
- Department strategies and plans for providing day care and luncheon activities for people in the target area
- Actions the city partnership could take to reduce health inequalities

6.5.2 Ms McGlade stated that compared to some of the other services, Social Services is not a universal service and is not designed to provide a service to all members of the public. It is organised around specific client groups and accessed through referral and assessment. It may for example, provide intensive support to older people at home or in a residential care home.

6.5.3 Social Services seek to promote independence, enhance protection and improve quality of life for people who fall within the service criteria. Services promoting independent living include people living in their own homes and in sheltered accommodation.

6.5.4 Social Services targeted at children are designed to give them the best chance in life whether they remain at home, in adoptive or foster homes or in children's homes. The children in care are provided with services in health, education and employment to enable them to get on with their lives. Social Services also seek to minimise dependency on the state by providing support services to families of children at risk.

6.5.5 For older people the service aims to focus the right level of support through a tiered approach to enhance independence. It provides early intervention at low levels with the option to move on to higher levels if required. It also provides high level preventative services such as live at home schemes, home care and luncheon clubs, to support people to live independently. It also works with other organisations such as the Derbyshire Mental Health Trust.

6.5.6 It was stated that there is a high correlation between deprivation and ill health. The Black Report published by the Department of Health in 1980 looked at the causes of inequality linked to deprivation. This is not expected to have changed much. However, there isn't a total link between social services work and deprivation since some services such as learning difficulties are partially genetics based and can exist in affluent areas.

6.5.7 Social Services carry out a needs analysis before most services are developed. It was stated that currently there is a significant gap in the provision of child and adolescent mental health services with long waiting

lists. Equality of access is also an issue and is not just affecting deprived communities. Social Services are seeking to establish recognised criteria to make it easier for children with emotional and behavioural difficulties to obtain services.

6.5.8 Ms McGlade stated that there is a correlation between Children Looked After and/or children on the Child Protection Register and deprived wards. The Department currently doesn't have data on postcode basis but intends to collect this in future. It may be useful to collect figures on rates per population to establish a comparative base.

6.5.9 Ms McGlade stated that there is currently no joined up plan for health improvement in the city. Derby City of Opportunity Community Plan is the nearest to a multi-agency plan for improving life chances for the residents. The Service is seeking to work in partnership with other agencies and establish strategic policies and action plans to address health inequalities. There is an opportunity to establish a framework between PCTs and the Council's Environmental Health responsibilities.

6.5.10 It was also stated that the rates of teenage pregnancies in the city are high. Teenage pregnancies are likely to lead to low life chances for both the mother and the child. The Social Services Department manages the Teenage Pregnancy Project in partnership with other agencies and is working to reduce the number of teenage pregnancies in the city.

6.5.11 It was stated that social policy to address health inequalities has fluctuated with the responsibility for improving health alternating between the individual and statutory organisations.

6.5.12 Strategies to improve life chances for individuals are seen as building blocks for addressing health inequalities. Getting children off to a good start in life will improve their long-term health. This may include improving educational attainment of children in social care.

6.5.13 Social Services can offer help to older people, such as home care services to improve their quality of life and life chances. Social Services also manage a number of projects. The European Social Fund project for example seeks to get adults with physical and mental health needs into employment.

6.5.14 Looking at mental health in deprived neighbourhoods, it was stated that people often moved from having better state of affairs to worse situations. People with mental illnesses are often housed in these neighbourhoods to meet their housing needs, thus concentrating the problems in deprived areas.

6.5.15 There are three levels of issues affecting the health and well being of communities:

- Issues potentially affecting whole populations of the city and generally addressed through universal services (e.g. environmental health hazards)

- Issues affecting some user groups or localities more than others because of clusters of issues creating vulnerability (e.g. poverty, crime and poor housing)

- Issues affecting specific service user groups (e.g. diseases associated with old age, poor self esteem and the danger of developing poor mental health amongst children experiencing abuse or neglect).

6.5.16 The Commission received information from Social Services on a selection of services provided in three target areas. The table below shows that for the three target areas, in all but two cases, the figures for Normanton are significantly higher than the other target areas. This mainly due its larger size. The two exceptions are in the children services with Derwent NDC having 33 looked after children compared with 12 each for Normanton and Osmaston. Also, the total numbers of children on the child protection register are highest in Osmaston with 58 children compared with 51 in Normanton and 28 in Derwent.

Issue	**Derwent NDC**	**Normanton NRF**	**Osmaston NRF**	**City**
Population	9355	23443	10948	221700
Total number of children known to Social Services that are In Need	192	242	195	1912
Total number of looked after children	33	12	12	374
Total number on child protection register; due to • Neglect • Physical injury	28 8 5	51 27 8	58 21 4	284 115 43
Total number of children known to Social Services with disabilities	29	47	12	279
Total number of households receiving home care from the authority	143	309	157	4156
People with physical disabilities helped to live at home (18 – 64 Age Group)	33	60	31	583

Source: Social Services Department (2003)

6.6 Summary of Evidence on Unemployment

6.6.1 Employment is considered to be a significant determinant for health. The nature and type of employment can affect the level of income and thus influence lifestyles. Incomes influence housing, shopping habits for both food and clothing and the level of participation in leisure and recreation activities. All of these issues can have links to health outcomes.

6.6.2 People who are unemployed are likely to have lower incomes than those in full-time employment and will therefore have an even greater affect on these consumables. It is also considered that the long-term and youth unemployed feel increasingly isolated, which can affect their health.

6.6.3 Written evidence on unemployment issues was received from the Research and Policy Section of the Chief Executive's Department. Information was also obtained from the Internet.

6.6.4 Statistics from the Annual Business Inquiry 2002 indicate that nearly 61 per cent of all jobs in Derby were located in the four former inner city wards of Babington, Derwent, Litchurch and Osmaston. Following the boundary changes in 2002, these wards are now broadly represented by Arboretum, Derwent, Normanton and Sinfin wards. The proportion of manufacturing jobs located in these wards is even greater, rising to 84 per cent.

Wards	Manufacturing Job	Jobs from All sectors
Babington	147	2537
Derwent	2710	10617
Litchurch	8524	39361
Osmaston	10637	17053
Total	**22018**	**69568**
DERBY	**26044**	**114803**
%	**84.5**	**60.6**

Source: Annual Business Inquiry 2002, NOMIS/Office of National Statistics

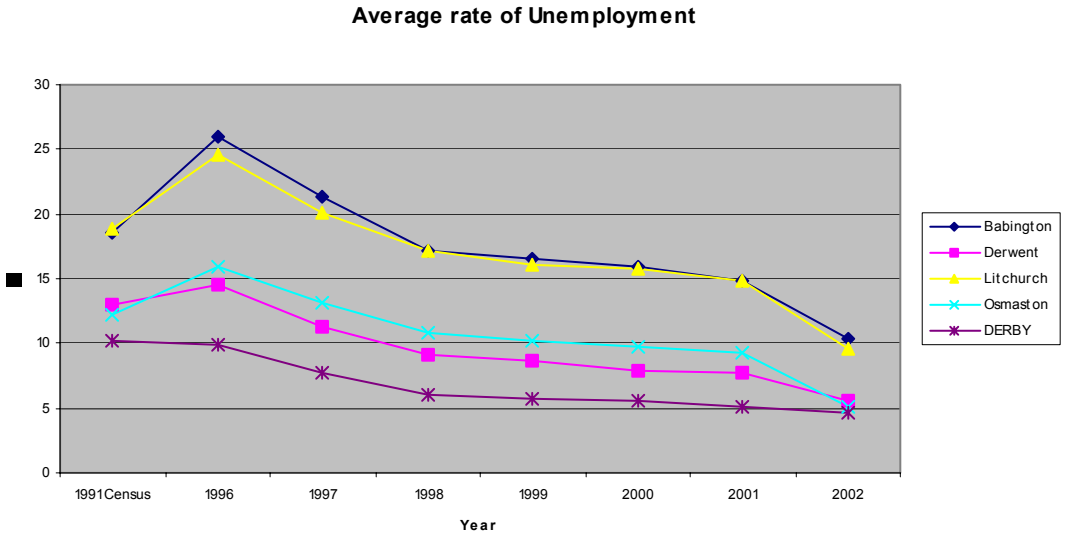
6.6.5 According to the data from the National Statistics Office, the unemployment rate in April 2003 in the Arboretum ward was 18.2%, the Derwent ward 6.1% and Normanton 10.8% compared with an average for the city of 4.7 %. The figures also show that these three wards account for 38.7% of the total number of unemployed people in the city whilst they make up 15.9% of the 16-74 economically active population.

6.6.6 When calculating the level of unemployment the Government counts those people who register as unemployed and claim benefit. People who do not register or do not claim unemployment benefit are excluded from official unemployment figures. Since the claimant count data has only just

become available for the new city wards (February 2004), the unemployment data for the new wards in the city has been based on the number of people that are economically active between the ages of 16 and 74 (Census 2001 definition).

6.6.7 The commission was informed that despite the employment opportunities available in these wards, the levels of unemployment remain high, and are consistently well above the city average.

6.6.8 Economic growth in the City since 1996 (the earliest date at which data is available from Nomis, the official labour market statistics unit) has served to reduce the unemployment rates in former Babington and Litchurch wards, which at that point were both over 25 per cent, compared with an average for the city of 10.5%. However, in 1996 these wards accounted for just over 22 per cent of all unemployment in the city. It is noticeable that the relative situation of these wards has worsened during the period of relative economic growth the city has enjoyed since 1996.



Source: Graph based on statistics supplied by research and Policy Section of the Chief Executive's Department

6.7 Summary of Evidence on Housing

6.7.1 Housing is widely considered to be a key determinant of health. The Commission sought to examine the provision of public and private sector housing in the city and the challenges it faces to improve living conditions for local residents.

Public Sector Housing

6.7.2 Phil Davies, Chief Executive of Derby Homes Ltd, presented evidence on public sector housing. Derby Homes Ltd is the arms length company established by the Council to manage its public housing stock.

6.7.3 Mr Davies stated that the origin of council housing and initiatives to improve housing were started by the Victorian reformers, who saw the link between unsanitary, unfit slum houses, diseases and the demoralisation of the industrial working people. They were the first to establish the link between health and housing. It was obvious to them at the time that they needed to address the lack of sewers, removal of waste and redesign the back-to-back houses to enable people to live in a healthy environment.

6.7.4 Derby Homes currently manages 15,000 council houses, which can still sometimes be a source of complaint for causing ill health. The emphasis for health problems has moved on from communal health problems to individual health problems. This may be in the form of asthma or other chest complaints, which could be caused by lack of central heating, wrong type of heating or the dampness of the property arising from condensation problems.

6.7.5 Dampness has been a serious problem in the past and a considerable amount of work took place in the 1980s and 1990s to address it. Houses in Osmaston and Derwent for example were offered modernisation programmes that included a thermal protection wall to reduce dampness from condensation.

6.7.6 The Government has devised a decent homes standard, which aims to set minimum standards for all homes. This requires them to be fit and weatherproof, have central heating and modern kitchens and bathrooms. In January 2003 it was estimated that 7,500 council houses failed to meet this standard.

6.7.7 With the formation of Derby Homes Ltd, the Government has offered additional an £81m funding over the next three years to be spent on council housing to address most of these problems. This money will enable the following works to be carried out:

Works	Number of Units
Rewiring	7718
Re roofing	2888
New windows	7341
Central heating	6283
Insulation	4218
New kitchens	6664
New bathrooms	5288

Source: Derby Homes Ltd

6.7.8 It is expected that the level of health complaints arising from council houses will drop dramatically once this programme of improvements is completed in 2006.

6.7.9 Derby Homes staff work closely with other partners in the city to improve the quality of life for the residents on local housing estates. Derby Homes has supported initiatives, such as the Single Regeneration Budget (SRB5) in Osmaston to improve the social support provided to that community. The Area Housing Manager has established close links with Osmaston Sure Start and also sits on its board. Mr Davies stated that there have been difficulties in developing close working relationships with health and social services agencies. For health the continuous reorganisation has seriously hindered partnership working. Also, Social Services and health agencies put a lot of their resources in council housing estates but don't manage services on a decentralised geographical area basis. There is a need to do more work with partners and particularly on elderly disabled persons issues. It could for example involve working with sheltered housing schemes and get them ready for Supporting Peoples' Assessments Programme. The Supporting People Programme offers housing and care related support to vulnerable people to live more independently.

6.7.10 Housing officers see health issues linked to poverty and deprivation. Derby Homes aims to improve local communities and areas where people want to live. It has been looking at the turnover rate of tenancies and has reduced it from 14% in 2000 to 11% in 2003. This improves the services provided to tenants, by increasing rental income, reducing wasted work for staff and also stabilises the communities. Housing in deprived areas is difficult to let. Some people regard living in these areas as a last resort and would be unwilling to live there if they had another option. Even with the improvements to the properties these areas are still likely to be difficult to let due the reputation of these areas.

6.7.11 The population of deprived areas tend to have a disproportionate number of children and older adults. They have poorer local facilities, poorer schools and generally a poorer quality of life leading to a downward spiral. The human condition seems to lead us to define ourselves by looking down on some people as well as aspiring upwards. In such deprived

communities people seek to move out of the area as their financial circumstances improve. The Housing Needs Study illustrates that people aspire to move out of council housing and into leafy suburbs of owner occupation.

6.7.12 It was stated that social housing prevents homelessness, but can pay the penalty of creating deprived communities by concentrating people with needs in particular areas. This problem is far worse in public housing areas in America.

Examples of Estates Being Transformed

6.7.13 The Old Sinfin area has been transformed from a relatively hard to let area into a popular estate with low turnover rates. The area has partly benefited from an influx of people from London who have purchased vacant hard to let properties and contributed to the stabilisation of the high turnover. Work has also been carried out to improve community safety with partners such as the Police, Burglary Reduction Team, Youth Service and the local school to improve the area. The local housing office has been a focus for service delivery and the local manager has been very active and communicates well with the tenants, police and other agencies.

6.7.14 There are also examples of blocks of flats that have been improved by evicting people causing problems for others. Using discretionary allocations combined with security improvements have made the flats more popular.

Elderly and Disabled Tenants Provision

6.7.15 Elderly or disabled people live in 40% of council houses. It was stated that Derby Homes spend £800,000 a year on over 1000 disabled persons' adaptations.

6.7.16 1700 flats and bungalows are part of the sheltered housing service. Wardens make a daily visit and are able to keep an eye on residents, contacting relatives or the GP on their behalf when necessary. This service is supported by the Council's 24 hour Carelink Intercom Service. The sheltered housing service provides warm and comfortable homes with more security. It is felt that all this adds to extending people lives.

6.7.17 There are several council sheltered housing schemes in Normanton and Osmaston/Allenton but none in the Derwent NDC area.

Accident Reduction

6.7.18 A key priority for Derby Homes is a reduction in accidents. Health and safety repairs are carried out urgently and in addition, there is a 5 yearly external repair programme that repairs paths and steps in the gardens. This is particularly important for the elderly residents.

6.7.19 Derby Homes liaises closely with the Fire and Rescue Service to develop initiatives to reduce fires and injuries from fires in council houses. Nearly all properties are fitted with smoke alarms, which are inspected and serviced each year. Currently an anti arson protocol is being developed to try and reduce the cause of fires. Chip pan fires are amongst the most common cause of fires in the home.

6.7.20 Gas supplies are scheduled for service every year. However, where there are problems with gaining access to a property, legal action is used to ensure all homes are serviced at least every 2 years.

6.7.21 Disabled adaptations such as grab rails, ramps and walk in showers all reduce the risk of falls for elderly tenants. This saves money for the health service as well as reducing problems for the elderly and disabled.

Stress, Crime and Anti Social Behaviour

6.7.22 Staff at Derby Homes deal with on average, over 200 complaints of nuisance every week. These arise from a variety of sources including children playing football in the street, loud music being played late at night, serious racial abuse and threats and harassment following a dispute between neighbours. The unhappiness this causes and the impact on the victims' health is not to be ignored. Derby Homes investigates all complaints, and will transfer tenants if the impact on their health is too great. Local offices work closely with the police to reduce such behaviour and to take legal action against the perpetrators. Providing residents with a reasonable quality of life, security in their homes and the opportunity to enjoy their home without fear must be a key contribution to their health.

6.7.23 Drugs on estates are a growing concern, although this is not as large as other parts of the East Midlands. Staff receive training in recognising the signs and litter of drug use. Derby Homes work with Addaction and the Drug and Alcohol Action Team to try to minimise the impact of drugs on deprived communities. It is a condition of tenancy that tenants must not deal in drugs. This does not include drug users as the service re-houses drug addicts. It is part of the job of the social landlord to help people when they are in trouble and give them a stable home.

6.7.24 Alcohol is also a big issue and an alcohol free zone has been established in Sinfin to tackle the problem of people drinking on streets.

Asbestos

6.7.25 Some inter war properties and most post Second World War houses built up to 1980 have some form of asbestos in them. Typically it would have bath panels and airing cupboards. Council houses are no different. In addition, several types of council houses have asbestos in their walls and ceilings. Advice from the Health and Safety Executive is that this is a low risk, so long as it is not disturbed and best dealt with by covering it with plasterboard. Derby Homes employs two Asbestos Technicians who visit

tenants and advise them on asbestos issues. Guidance is issued to tenants on an annual basis.

6.7.26 Derby Homes has a robust system of management and record keeping for each property. In order to ensure the accuracy of these records a survey of all properties is being carried out over the next three years.

Council Houses in the Target Areas

6.7.27 Normanton has a high level of demand for council houses and thus doesn't have letting difficulties. This is due to relatively low number of council properties. However, there are other areas with problems of vandalism, graffiti and poor reputation such as Derwent that have pockets of difficult to let properties. Derby Homes is working with NDC on a Futures Study in the Derwent area that looks at the layout of the estate to make it more sustainable. Although nothing has been defined, it could involve selected demolition of properties, change of tenure and open space. A similar proposal is being considered for Osmaston.

6.7.28 Clustering too many people with multiple levels of disadvantage tends to perpetuate the problems. If you have mixed communities and have people who are articulate and vociferous they will contact the agencies to ensure the service is put right. There are too many people in deprived communities who lack confidence and are passively accepting whatever comes their way without challenging it.

6.7.29 It was stated that there will be housing pressures on the authority over the next four or five years as the demand for rented accommodation has increased to a position not experienced in the last ten years. The Old Sinfin area has benefited from the increased demand in housing by reducing letting problems. It is likely that Cowsley and Osmaston will also benefit from it. This will restrict choice and could have implication for homelessness but could be good for creating stable communities.

6.7.30 In response to a question on Derby Homes' relationship with its tenants Mr Davies stated that being a council tenant doesn't make you ill. Health issues may be linked to the issues of lack of empowerment and frustration in having repair works being carried out. The level of involvement by Derby Homes and the Council with tenants is recognised nationally. There are four tenants and one leaseholder on the Derby Homes Board.

6.7.31 Derby Homes also presented statistics on the level of fitness of homes in the target areas. The table below shows that Normanton has a slightly higher proportion (45%) of non-decent properties than the city average (42%).

6.7.32 The main grounds for unfitness in the target areas are thermal comfort with 63% of properties unfit in Osmaston, 47% in Derwent and 40% in Normanton compared with 26% for the city.

Issue	Derwent NDC	Normanton NRF	Osmaston NRF	City
Population	**9355**	**23443**	**10948**	**221700**
Total number of Council residential units	**1681**	**737**	**1788**	**14891**
% of unfit (non decent) Council homes	**28%**	**45%**	**32%**	**42%**
Ground for non decent as a proportion of all unfit properties				
• Lack of Modern Facilities	**25%**	**26%**	**27%**	**30%**
• Age and Condition	**28%**	**24%**	**10%**	**44%**
• Thermal Comfort	**47%**	**40%**	**63%**	**26%**
Capital expenditure per dwelling on major repairs and improvements during the last five years	**NA**			**£3,800**

Source: Derby Homes Ltd

Private Sector Housing

6.7.33 Martin Gadsby, Private Sector Housing Manager, presented the evidence on private sector housing. Mr Gadsby stated that the basic aim and purpose of the Private Sector Housing Service is to improve housing conditions based on needs and stock condition. In doing so it seeks to improve the quality of life and protect the health and safety of all householders but particularly the most vulnerable.

6.7.34 The housing in the private sector has an ageing stock with approximately 20% of the properties built before World War 2. The greatest concentration of older housing is in the inner city areas. Derby is faced with an ageing population, in line with the rest of the country. There is a strong link between housing unfitness and the age of householder. The private rented sector in Derby also has more than 800 houses in multiple occupation (HMO's), which often exhibit the worst housing conditions

6.7.35 Living in substandard housing is not just a miserable experience for those affected but there is also increasing evidence of links between poor housing and health, especially for children and older or disabled people who spend more time than average in their homes. Poor conditions can also mean danger from faulty wiring or steep stairs.

6.7.36 It was stated that the service tackles private sector housing problems in a number of ways:

- Area based approach to renewal, targeting geographical concentrations of unfitness and disrepair. Areas are selected through the house condition surveys. It tends to follow areas with high levels of unfitness and disrepair that are tied into poor socio economic factors. This is evidenced by the Peartree Renewal Area which dealt with approximately 2000 properties.
- Property type - giving priority to particular kinds of property such as HMO's
- Types of property condition - for example empty properties
- Issue based - such as poor energy efficiency or crime prevention
- Client based - concentrating on needs of particular groups such as older or disabled people

Statutory Functions

6.7.37 There are certain functions of the housing service that are tied to the statutory framework. Local authorities have had a statutory duty to deal with unfit properties for the past 50 to 60 years. The action taken can range from advice provision through to compulsory demolition. Local authorities are also expected to take account of Public Service Agreement (PSA) targets and contribute towards its achievement, as part of their statutory duty to assess housing conditions on an annual basis.

6.7.38 The Council has a statutory duty under the housing legislation to provide grant aid for adaptations to homes occupied by disabled people in order to meet their access needs.

6.7.39 Under Home Energy Conservation requirements, the Council has a corporate duty to report annually to the Government on progress in improving energy efficiency across all tenures. Derby Home Energy Advice Service, DHEAS has been established to provide help and advice to homeowners on improving home energy efficiency. A key objective of the service is to tackle fuel poverty, which is recognised as a major contributory factor to ill health and in extreme cases, premature death. DHEAS works closely with the Government's Warm Front grant providers to ensure that vulnerable householders are brought out of fuel poverty.

6.7.40 Landlords who run HMO's with two or more households have to be registered with the Council under a local byelaw. The Council has a duty to enforce standards other than fitness. This may for example include conditions that affect tenants' comfort.

Non-Statutory Functions

6.7.41 The Private Sector Housing Service also carries out a number of non-statutory functions. It includes providing housing maintenance advice where needed, even though the basic responsibility for maintaining a home rests with the homeowner. This may include providing an advice booklet on maintenance to homeowners who have benefited from Group Repair Schemes carried out by the Council.

6.7.42 There are approximately 3000 empty properties in the city, which are recognised as a waste of resources. The Housing Service has established Council's Empty Property Strategy, which combines a mix of persuasion, legal action and compulsory purchase to bring properties back in to use.

6.7.43 The Private Sector Housing Service operates a Voluntary Registration Of Student Accommodation. Students are seen as young and vulnerable people who may be open to exploitation. Landlords are able to voluntarily register their properties for student accommodation subject to meeting set housing standards. Failure to register prevents landlords from publicising their properties at the University.

Funding the Service

6.7.44 The bulk of the money to fund the Private Sector Housing Service comes from the Council's Capital Programme, which in turn is supported by Government subsidies and borrowing approvals. This money used to be ring fenced but now it is open to competition against other priorities. At present it is running at approximately £3.5m a year. The only part that remains ring fenced is for Disabled Facilities Grants, which provides a subsidy of 60% and a top up of 40% from internal resources. Currently there are insufficient resources to service the ever-increasing demand for adaptations. This means people have to wait longer for necessary works to be carried out.

6.7.45 The Private Sector Housing Service works with a number of partners and bids into regeneration budgets through partnership funding. It also levers in around £2 million a year for the benefit of fuel poor households through the Government's Warm Front programme.

Housing Renewal Reform

6.7.46 The Government has removed the prescriptive grant framework that has been used for the past 30 years and replaced it with a general power for local authorities to provide assistance to help owners improve housing conditions.

6.7.47 The Government also published the Draft Housing Bill in 2003, which is expected to become law in 2005. This new legislation will replace the current fitness standard with a new Hazard Rating System. This will be based on assessing a house on the risks it represents in terms of danger to health and safety and establish a points band system for assessing risks. Properties in the highest risk band will require councils to take action. The next stage requires an issue of warning and the third band involves issuing an advisory notice.

6.7.48 The new legislation will also make it mandatory to licence HMO's. This should help the Council to drive up the standards in the city and impose

responsibilities on the landlords to deal with antisocial behaviour, which is harder to address in the private sector.

6.7.49 The new legislation will also modernise the Right to Buy Scheme by tackling profiteering and emphasising purchasers' responsibilities for maintaining the home.

Inadequacies in Current Statutory Housing Standards

6.7.50 There is currently no power for authorities to address fire safety in private single household dwellings. However, risk of fire is included in the proposed new hazard rating system. The Fire Service advises people that the simplest thing they can do is to have smoke alarms installed. In the Osmaston area the housing service has worked with the fire service and offered smoke alarms. Experience shows that the battery operated ones are prone to being stolen in private rented properties or batteries are often not replaced and therefore mains operated are preferred.

6.7.51 All council houses are required to have alarms. The voluntary scheme for landlords requires them to provide mains operated alarms to student accommodation.

6.7.52 It was stated that each year nationally, housing conditions are directly responsible for, on average:

- Up to 50,000 deaths; and
- Around 0.5 million injuries and illnesses requiring medical attention.

6.7.53 Under the current fitness standard a provision of a power point in the property is sufficient to meet heating requirements.

6.7.54 When set against the top ten highest risks in dwellings, as set out in the table below the current housing fitness standard has a number of shortcomings and doesn't apply to six of the risks. The top ten highest risks in dwellings are:

Top ten health risks in dwellings	**Does fitness standard apply?**
1.Low air temperatures	NO
2.Radon	NO
3.Falls on stairs	NO
4.Fire safety	NO
5.Falls on level	YES
6.Burns and scalds	YES
7.Mould and dust mites	YES
8.Falls from windows etc	NO
9.Drowning hazards	NO
10.Carbon monoxide	YES

Source: Private Sector Housing Service Presentation

Household Accidents

6.7.55 It is surprising that the same attention is not given to accidents in the home as given to accidents on the roads, given that the former result in a significantly higher number of injuries and deaths.

	Killed	**Injured**
Home (1995)	4,066	2.7 million
Road (1996)	3,598	316,704
Work (1995)	376	1.5 million

Source: Housing Health and Safety Rating System, DETR in July 2000

6.7.56 Nationally statistics show that stair related falls are highest amongst older people. Those living in pre-1919 properties were most at risk due to poor internal arrangement such as narrow steep stairs and steps to landing and bathrooms. Current Building Regulations require that stairs are no steeper than the angle of 42°. Many staircases in older properties have an angle of incline of 45° or steeper.

Falls on stairs	Stair related falls account for: • 230,000 treated injuries pa • 500 deaths pa • Vulnerable group – those 65+	Likelihood of an occurrence • All dwellings – 1 in 320 • Pre 1919 – 1 in 180 • Post 1980 – 1 in 560	Spread of outcomes* • Class I – 1% • Class II – 10% • Class III – 32% • Class IV – 57%
Falls on the level	Falls on the level account for • 108,000 treated injuries pa • 2% of all home deaths pa • Vulnerable group – those 65+	Likelihood of an occurrence • All dwellings - 1 in 180 • Pre 1919 - 1 in 100 • Post 1980 - 1 in 320	Spread of outcomes* • Class I – 0.1% • Class II – 22% • Class III – 22% • Class IV – 57%
Fire	Fires in dwellings cause: • 587 deaths a year • 10,989 injuries a year	Likelihood of an occurrence • All dwellings – 1 in 3,200 • Pre 1919 – 1 in 1,800 • Post 1980 – 1 in 5,600	Spread of outcomes* • Class I – 10% • Class II – 2% • Class III – 22% • Class IV – 66%

Source: Housing Health and Safety Rating System, DETR in July 2000

* Examples of each Class of Harm are given below

Class I Death, permanent paralysis below the neck, malignant lung tumour, regular severe pneumonia, permanent loss of consciousness, and 80% burn injuries.

Class II	Chronic confusion, mild strokes, regular severe fever, loss of hand or foot, serious fractures, very serious burns and loss of consciousness for days.
Class III	Chronic severe stress, mild heart attack, regular and persistent dermatitis, malignant but treatable skin cancer, loss of a finger, fractured skull, severe concussion, serious puncture wounds to head or body, severe burns to hands, serious strain or sprain injuries and regular and severe migraine.
Class IV	Occasional severe discomfort, chronic or regular skin irritation, and benign tumours.

6.7.57 In Derby these problems are mainly in the inner city areas such as Normanton. Although older people still experience falls in hospitals and care homes, there is a need to target pre -1919 properties under new hazard rating system to tackle poor design and minimise the risks. This is not solely confined to inner city areas as some of the older cottages in Darley Abbey village for example probably contain the steepest and most dangerously arranged staircases to be found in Derby.

6.7.58 There has been little change to the design and layout of the older properties in the City. The long-term solution is to replace these properties over time although this is at present not being addressed by the Government in any strategic way except in those areas of the North and West Midlands where housing market failure has occurred. Other European countries don't seem to have the same affinity with their properties and are more willing to replace them. In Germany for example some housing is routinely replaced every 50 to 60 years. It is considered that the cost of demolition and replacing of older housing stock, in the short term at least, is generally much higher than retention and improvement.

Private Sector House Condition Survey

6.7.59 The 1998 Private Sector House Condition Survey interim report presented to the Commission identified approximately 16,300 (17 %) pre -1919 dwellings in the city of which 39% are unfit for human habitation as defined by the Housing Act 1985. At the time of declaration in 1992 the Peartree Renewal Area had 1105 unfit dwellings where as St Marks Renewal Area was declared in 1994 and had 166 unfit dwellings. The level of unfitness has since fallen by 80% in Peartree and 90% in St Marks respectively.

6.7.60 The survey demonstrated clear links between poor housing conditions and the socio-economic circumstances of the householders. The survey revealed that:

- 39% of unfit pre-1919 dwellings are occupied by those whose head of household is unemployed
- 33% of unfit pre-1919 dwellings are occupied by those whose head of household is in receipt of Income Support
- 41% of unfit pre-1919 dwellings are occupied by households from ethnic minority communities
- 51% of unfit pre-1919 dwellings are privately rented
- 32% of unfit pre-1919 dwellings are occupied by elderly households
- 48% of unfit pre-1919 households have a registered disabled person living there.

(some properties fit more than one category)

6.7.61 A further City Wide House Condition Survey is currently being commissioned. As well as identifying how levels of unfitness have changed since the last survey it will identify the extent of vulnerable households living in non-decent homes.

6.7.62 In response to the current state of private sector housing stock in the target areas it was stated that of the three areas Normanton has the highest level of unfitness and will present the highest health risk due to a number factors. It has a considerably higher proportion of low income occupiers, high numbers of private rented properties as well as HMO's and large numbers of pre war properties. Approximately a third of the housing stock is unfit. This is due to lack of maintenance and the types of building materials used at the time of construction.

6.7.63 The NDC area has a high proportion of council housing and with most of the older private sector stock improved under the St Mark's Renewal Area programme this will present fewer problems.

6.7.64 The Osmaston area also has comparatively fewer numbers of pre-war and unfit properties than Normanton. A housing improvement zone has been set up around the Rolls Royce works on Nightingale Road which will improve properties through Group Repair Schemes, considered to be the most effective process for tackling disrepair and preventing decline in the future.

7.1.1 The Commission also received information about the level of unfitness in the target areas. The next table shows that Normanton has the highest proportion of unfit homes both in the owner-occupiers and private rented sectors. The main grounds for unfitness of all unfit properties are serious disrepair.

The table below sets out the available information on unfitness in the three areas

	¥	*	*	*
Issue	**Derwent NDC**	**Normanton NRF**	**Osmaston NRF**	**City**
Total number of units of residential accommodation per sector	**4000**	**10500**	**4500**	**92400**
• Owner occupiers				**72574**
• Council	**N/A**	**N/A**	**N/A**	**14981**
• Housing assoc				**6081**
• Private rented				**7000**
• Other				**N/A**
% of homes judged unfit to live in for each sector				
• Owner occupiers	**3.5%**	**31%**	**22%**	**11.6%**
• Council	**N/A**	**N/A**	**N/A**	**N/A**
• Housing assoc	**N/A**	**15%**	**12%**	**3%**
• Private rented	**5%**	**55%**	**42%**	**18%**
Ground for unfitness as a proportion of all unfit properties				
• Structural stability	**N/A**	**7%**	**11%**	**5%**
• Serious disrepair	**N/A**	**94%**	**84%**	**89%**
• Dampness	**N/A**	**29%**	**11%**	**23%**
• Lighting	**N/A**	**7%**	**1%**	**5%**
• Heating and ventilation	**N/A**	**10%**	**9%**	**8%**
• Satisfactory cooking	**N/A**	**29%**	**21%**	**15%**
• Washing facilities	**N/A**	**13%**	**15%**	**12%**
Number of dwellings improved as a proportion of needing renovation in the last five years	**N/A**	**N/A**	**0**	**13.4%**
Capital expenditure per dwelling on major repairs and improvements during the last five years	**N/A**	**£5k**	**0**	**£5k**

N/A = not available
* Source: 1998 House Condition Survey
¥ Source: NDC Desktop Survey 2001

NB Unfitness levels in Normanton now will be lower because of impact of Pear Tree Renewal Area and Rosehill Housing Improvement Zones

6.8 Summary of Evidence on Sport and Leisure

6.8.1 The Commission invited John Brown, Head of Sports and Leisure and Amanda Sharman, Marketing and Performance Manager of the Sports and Leisure Division to provide evidence about the level of participation in sport and leisure activities in the target areas. This would enable the Commission to examine the links between physical activity and health.

6.8.2 The Sport and Leisure Service is part of the Education Department and co-ordinates Physical Education (PE) and School Sport; Sport Development; Community Centres and Play Development. It also manages seven leisure centres in the city.

6.8.3 Mr Brown stated that the problems of inactivity are contributing to the breakdown of health and the Government is putting a lot of emphasis on sports and physical activities to address this issue. The Government wants people to exercise moderately for at least 30 minutes at least five times a week.

6.8.4 The Government has produced The Game Plan, a national strategy for sport and physical activity. This aims to increase participation in sport and physical activity and achieve similar levels of participation as experienced in Finland and Australia. By 2020, the target is to ensure 70% of the population is reasonably active; currently only 30% is achieved. In addition to this, there is a focus on improving international performance and the target for British and English teams and individuals is to sustain rankings within the top 5, particularly in more popular sports. With regard to PE in schools, the aim is to ensure that by 2005, at least 75% of children in the UK will have the chance to participate in two hours of high quality sport and PE every week both within and beyond the curriculum. Currently about a quarter of schools provide this at Key Stage 1 and a third of schools at other Key Stages.

6.8.5 The Service recognises that it can't work in isolation and needs to establish partnerships with other organisations especially due to pressure on budgets. Following consultation with partners, Sport and Leisure Services adopted the Sports Strategy for Derby and changed the way they work. In the past, the majority of effort was expended on the direct delivery of sporting activities. Now the emphasis is on partnership working and providing support to clubs and schools to develop and strengthen a sustainable infrastructure in the city.

Research

6.8.6 Research has been conducted to identify the needs of young people in order to increase their participation in sport and leisure. A participation survey was carried out that consulted with years 7 and 10 to determine their attitudes and barriers to sports.

6.8.7 The Sports and Leisure Services have used the Derby Pointer Panel on three occasions to find out what people think about sports centres and other municipal facilities available in the City. Customer surveys are carried out at each sports facility once a year as well as occasional surveys in key service areas. For example, Swim Academy customers were consulted prior to starting a review of the swimming lesson programme.

6.8.8 All the sports centres are offering a range of activities for young people to try to increase levels of participation.

6.8.9 In partnership with other agencies, a city tennis club has been established at the Sports Zone in Normanton Park and this is achieving good attendance levels. It works closely with a large new development next to the racecourse supported by New Deal For Communities.

6.8.10 Young people don't just want to participate in the traditional sports and children shouldn't be doing long sustained exercises but short bursts of activity. There is a need therefore, to look at facilities other than sports centres to encourage greater participation of young people in physical activities.

Cost

6.8.11 Pricing is a key tool to tackle activity levels. Derby's Recreation Passport to Leisure scheme is one of the most inclusive of this type of scheme in the country. It gives free or reduced use of facilities all day during the week between 9am and 4pm and all day at the weekends and bank holidays. This is available to anyone living in Derby who is claiming a low-income related benefit and to disabled people. The provision for off-peak prices is helping other people who don't qualify for the Passport.

6.8.12 The Sports and Leisure Services offer free or reduced places on holiday activities targeted at children from financially and socially disadvantaged backgrounds through the Recreation Passport to Leisure Scheme. During the summer Shaftesbury Sports Centre offered activities costing just 50p. This was made possible by securing funding from local partnerships.

6.8.13 A football camp was run during the summer. When it was advertised at £25 only 7 people showed interest but when it was advertised as free after having raised additional funding, 40 people responded. This hopefully also attracted children who aren't normally active.

6.8.14 It was stated that a free play scheme is provided for children aged between 7 and 14 during the Easter and summer breaks at community centres across the city. Last summer 14,500 children attended sessions with 2,063 different children taking part whilst attendance at Easter was 1,622 by 378 different children.

6.8.15 In relation to costs, transport is also considered to be an important issue for some groups such as older people.

6.8.16 The Service also supports exercise on prescription by working closely with a number of GPs. They identify patients who may benefit from exercise instead of or in conjunction with medication such as in cases of obesity, high blood pressure and hypertension. This scheme is currently supported by 14 GP practices.

6.8.17 The Service provides reduced cost activities and tries to motivate people through a buddy scheme by providing a free passport to leisure after completion of 20 sessions. GPs have given positive feedback to the referral scheme.

6.8.18 It was stated that an increasing number of people are having heart related illnesses, after which it is not easy to get back to normal life. Cardiac Rehabilitation classes have been introduced at Lancaster Sport Centre and Springwood Leisure Centre and plans are in hand to roll this programme out to other centres. Patients will be referred to the classes directly from the hospital. The British Association for Cardiac Rehabilitation (BACR) qualified instructors will show patients how to exercise and give them advice.

6.8.19 Children's Health related exercise is a new scheme to involve children aged 7-11 years during curriculum time. This scheme also teaches children about nutrition and is delivered over a six-week programme. Schoolteachers are involved in the scheme as then they can carry it on.

6.8.20 Research has found that once girls and young women reach the age of around 13 their interest in sports seems to diminish. Girls are also turned off by having to wear PE uniform and questioned the need to wear short skirts on cold afternoons. Research found that if they are offered aerobics or music based exercise they get interested again. The Service has therefore developed the Fit 'n' Funky scheme which is specifically aimed at older teenage girls and includes aerobics and street dance. It is carried out during lunchtime, after school or during PE lessons.

6.8.21 A scheme targeting boys will be introduced which will include things like circuit training.

6.8.22 Derby has been awarded £1.3 million by the Government to provide a school sports co-ordinator in every secondary school with support to every primary and special school in the city. The Government intends to make this mainstream funding.

6.8.23 The Service has recently been restructured and a team of sports development officers have been appointed to cover the five Area Panel areas. This geographical responsibility will enable people to receive support from the appropriate person. They will focus on traditional sports such as swimming, gymnastics, football and cricket but will work to a wider

agenda of partnership development. Their role will include signposting children to suitable clubs from schools.

6.8.24 It was stated that exercise helps older people with their balance and co-ordination and as a result could reduce accidents and falls. The Service supports community activities such as seated exercise for the over 60s. These activities also increase opportunities for people to socialise, reduce isolation and improve well-being and confidence. The demand for this is rising.

6.8.25 The Service is also trying to increase participation amongst people with disabilities by improving access and organising activities to meet their needs such as appropriately supported swimming lessons.

7 Tackling Major Killers

7.0 The Department of Health has identified tackling major killers as one of the six priorities in its strategy for tackling health inequalities. The Commission invited two national voluntary sector organisations to give evidence on coronary heart disease and cancer. The Commission also considered evidence on diabetes, which is a major health issue amongst people in deprived communities.

7.1 Summary of Evidence on Coronary Heart Disease - CHD

7.1.1 The evidence in this section is based on the presentation given by Christine Twigg of the British Heart Foundation (BHF) and other leads provided by the speaker. The statistics relating to coronary heart disease in the city have been provided by the local Primary Care Trusts.

7.1.2 Ms Twigg stated that Coronary Heart Disease is a major killer with approximately 110,000 people dying of heart problems in England every year. According to the Department of Health more than 1.4 million people suffer from angina and 250,000 have heart attacks every year across the country.

7.1.3 CHD is a condition where the blood flow through the coronary arteries of the heart muscle is reduced, most often caused by the gradual build up of a fatty substance called atheroma. The reduction in the supply of blood to the heart muscle causes severe chest pains called angina, usually occurring after exercise. A total blockage of the artery causes part of the muscle to die leading to a heart attack.

7.1.4 CHD affects many people, with certain groups specifically at risk. There are regional differences with the premature death rate from CHD for men living in Scotland 50% higher than for those living in the South-West of England. South Asian and ethnic minorities, particularly those on diets containing high intake of fat and saturates are also more at risk of getting CHD. South Asian men living in the UK have a 46% higher premature death rate from CHD than the national average.

7.1.5 It was stated that each year CHD costs 5000 lives and an equivalent of 47000 working years in men aged 20-64 years.

7.1.6 According to the BHF, between 18 and 30 patients are seen at the Derbyshire Royal Infirmary or City Hospital each week that have had Myocardial Infarction (MI) or corrective heart surgery.

7.1.7 Age can also play a part with older people developing angina if they are unable to have surgery due to the risks involved. Heart failure can lead to a debilitating disease where people feel they are suffocating and can't breathe. The prevalence of CHD amongst the elderly causes Angina and Heart failure. It can also reduce physical activity and lead to social isolation.

Risk Factors

7.1.8 BHF stated that the following factors increase the risk of developing heart disease:

- A family history of heart disease with early onset of heart disease in a near relative
- Smoking – This is one of the strongest risk factors and stopping smoking is one of the most important things that an individual can do to reduce the chance of developing heart disease
- High blood pressure - which can for example be raised by drinking too much alcohol, eating lots of salt and smoking
- Obesity
- Lack of exercise
- Having diabetes
- Being male - men are more at risk of developing heart disease than women

7.1.9 It was stated that socio-economic factors such as homelessness, low incomes, unemployment and the lifestyle people live, could increase of the risk of developing CHD. People on low incomes tend to have a diet that is high in fat and saturates which increases the onset of the disease.

Stroke

7.1.10 Cardiovascular Disease (CD) is an umbrella term that incorporates both CHD and Stroke. They both have the same risk factors. Stroke is caused by the blockage of arteries diminishing oxygen supply to the brain.

Stress

7.1.11 According to the British Heart Foundation stress and lack of physical activity is causing immense problems of heart disease. The Health and Safety Executive Commissioned research indicated that:

- Approximately half a million people in the UK experience work-related stress at a level they believe is making them ill;
- Up to 5 million people in the UK feel “very” or “extremely” stressed by their work; and
- Work-related stress costs society about £3.7 billion every year (at 1995/6 prices). HSE Information sheet: 1/03/EMSU

Prevention

7.1.12 Preventative action should be on a number of levels and not just involve telling people to adopt a healthy lifestyle. It should help them to understand the benefits of healthy lifestyles and provide support. People

also need access to leisure and sport facilities at affordable prices to help them take up regular exercise. It was suggested that there is a need to increase people's awareness and opportunities for:

- Physical activity
- Healthy eating
- Stress management
- Smoking cessation
- Safe drinking

7.1.13 The benefits of primary prevention can be measured through baseline assessments carried by GPs and practice nurses. These can include measuring blood pressure, body mass index (measuring the relationship between weight and height) and body fat density. Questions about diet can also be asked with details recorded on dietary score sheets. Some questionnaires allow a baseline assessment to be carried out. Patients embarking on healthy eating programmes can also be monitored over a period. This needs to take place commonly in GP practices.

7.1.14 The Saving Lives, Our Healthier Nation report identified the need to change lifestyles and make structural changes within communities including community capacity building.

Interventions

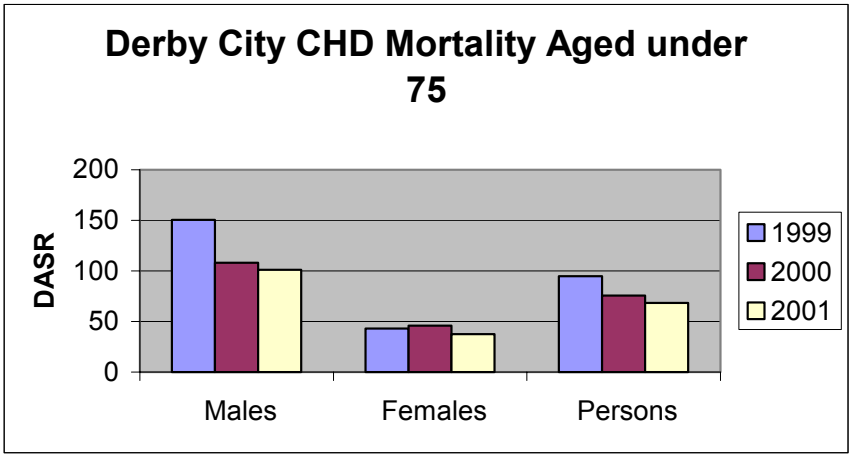
7.1.15 It was stated that people need to be consulted and should participate in the analysis of heart disease. They should be given opportunities for involvement in planning delivery and evaluation of the interventions. The Expert Patient Programme that involves training by people with a long term medical condition to other patients was mentioned as an example. This generic course run over six weeks and guides people through a structured programme initiating behavioural and motivational change.

7.1.16 Health care professionals should have cultural awareness. Cultural awareness training is provided by a number of trusts and could be promoted as good practice. It was stated that there is a shortage of people with bi-lingual skills.

7.1.17 It was stated that to tackle CHD, there is a need to:

- Undertake a mapping exercise to identify needs and numbers of people in each risk group such as the elderly and ethnic minorities.
- Develop an overall strategy for addressing CHD
- Encourage local partnerships and networks. A single organisation is unable to address the issue on its own.
- Establish what evidence there is of links between primary and secondary care
- Promote competency frameworks for health professionals

Local statistics



Source: Compendium of Clinical Health Indicators 2002

7.1.18 The graph above shows that the death rate from CHD for males under age 75 is approximately three times higher than females. The graph also shows a downward trend for both groups over the three year period between 1999 and 2002.

7.1.19 There are also differences in the premature mortality from circulatory disease (including heart attack and stroke) in people under age 75 in the three target areas. The table below shows that the three areas have a higher standardised mortality rate compared to the city average with Osmaston having higher mortality rate than all the areas.

Premature mortality from circulatory disease in those under age 75 for 1997-2001	**Derwent NDC**	**Normanton NRF**	**Osmaston NRF**	**City**
No of deaths	**53.0**	**187.0**	**76.0**	**1479.0**
DASR	**129.7**	**168.4**	**175.1**	**122.1**

Source: PCT Shared Services

Targets

7.1.20 The cardiovascular mortality targets for the United Kingdom seek to reduce the death rate from CHD, stroke and related diseases in people under 75 years by at least 20% by 2010. This is estimated to saving 200,000 lives. The Government has set a milestone for reducing death rates from CHD by at least one quarter by 2005.

7.2 CANCER

7.2.1 The Commission invited Cancer Research UK to inform members about:

- Causes and effects of cancer on local people,
- Any particular prevalence amongst certain groups of people
- People most likely to be at risk from cancer
- National targets for action
- Possible intervention measures
- Action that can be taken to raise awareness amongst people at risk
- How the impact of the intervention could be monitored

7.2.2 Diana Spall, a Community Fundraiser for the Cancer Research UK attended the evidence gathering meeting of the Commission. Ms Spall stated that there over 200 different types of cancer, the most common are those of the skin, lung, breast, bowel and prostate. Cancer affects 1 in 3 people in a lifetime and mostly occurs in people over 65.

Lung Cancer

7.2.3 Lung cancer is the most common cause of cancer deaths for both men and women nationally with smoking considered to be the main cause. It was stated that 50% of all regular smokers would eventually die from smoking related diseases. Someone who starts smoking at the age of 15 is three times more likely to die from cancer caused by smoking than someone who starts in their mid twenties. On average, 330 people die every day from a smoking-related disease in the UK.

Skin Cancer

7.2.4 Many more Britons than Australians die from malignant melanoma, the most dangerous form of skin cancer despite the fact that more cases of this form of skin cancer are diagnosed in Australia. The incidence of skin cancer is rising, due mainly to the fact that we are taking more holidays abroad, with 65,000 new cases of skin cancer reported every year. Sunburn in childhood can double the risk of developing skin cancer. Twenty five per cent of young adults in Britain use sun beds and sun lamps. It was stated that we receive 80% of our lifetime's sun exposure before age 18.

7.2.5 There are over 1,450 new cases of cancer in children in the UK each year. Although children's cancers are rare it is the most common cause of death from illness in children. The most common form of cancer amongst children (81%) is lymphoblastic leukaemia. It was stated that currently, 70% of children with cancer in the UK are cured whereas none survived in the 1960s.

Testicular Cancer

7.2.6 Testicular cancer mainly affects younger men. There are over 2,000 new cases each year. The lifetime risk of developing testicular cancer is 1 in 259. Testicular cancer is the most common cancer in men aged 15 – 44. It was

stated that although the incidence of testicular cancer has increased by more then 80% over the last 20 years, fortunately it responds very well to treatment and the number of people dying from this disease has fallen by more than 60% over the same period.

Prostate Cancer

7.2.7 Nearly 22,900 cases of prostate cancer are diagnosed each year in the UK. More than 80% of prostate cancers are diagnosed in men over 70. It is estimated that 1 in 14 men will be diagnosed with prostate cancer during their lifetime. In the last ten years, there has been a rise of nearly 40% in rates of prostate cancer in Britain, largely due to earlier diagnosis. There are 9,000 deaths each year from this cancer.

Bowel Cancer

7.2.8 Each year there are around 35,000 new cases of bowel cancer diagnosed in the UK. It is the third most common cancer in the UK. Rates of bowel cancer in men have risen by nearly 20% since the late 1970s compared with women whose rates have remained stable over the same period. More than 80% of bowel cancers occur in people over 60. Each year there are more than 16,000 deaths from bowel cancer in the UK. The number of people dying from bowel cancer has fallen to a ten year low. Ten years ago, more than 19,000 people a year were dying from the disease in the UK while today it is around 16,200. It was stated that bowel cancer seems to be predominantly associated with the high fat red meat and low fibre diet.

Breast Cancer

7.2.9 There are over 35,500 new cases of breast cancer and approximately 12,800 women in the UK die of breast cancer every year. Breast cancer is now the most commonly diagnosed cancer in the UK, with 40,945 cases diagnosed in 1999. It is considered that 1 in 9 women will develop breast cancer at some point in their lives. Men as well as women can develop breast cancer with approximately 300 male cases diagnosed each year in the UK.

7.2.10 Most breast cancers are not caused by the inheritance of a high-risk faulty gene, but by damage caused to genes during a women's lifetime. 80% of cases occur in post-menopausal women.

7.2.11 Better treatments, especially the use of Tamoxifen, early detection and prompt surgery has led to a substantial fall in the number of deaths. Deaths from breast cancer have fallen by 22% in the last ten years, which includes a 30% reduction in young and middle aged women.

7.2.12 The NHS Breast Screening Programme has detected over 80,000 cancers since 1988 and currently saves more than 300 lives per year. It is estimated that screening will save more than 1,250 lives a year by 2010.

Cervical Cancer

7.2.13 The number of new cases of cervical cancer has fallen by 36% over the last decade, largely due to the screening programme. More than 3,000 women are diagnosed and approximately 1,250 women die from cervical cancer each year in the UK. It is estimated that screening for cervical cancer prevents around 3,000 deaths annually in the UK.

Ovarian Cancer

7.2.14 Approximately 4,500 women die from ovarian cancer each year. Around 6,800 women are diagnosed with ovarian cancer each year in the UK. Half of all the cases are diagnosed in women under 65. The incidence of ovarian cancer has increased by more than 10% over the last decade.

Treatments

7.2.15 The cancer treatments of the future will be tailored to the individual patient's needs and targeted directly to the tumour. These new treatments will improve survival, reduce side effects and improve the quality of life for the individual. Investigating the causes of cancer is expensive as it often involves tracking large groups of people over long periods of time. However, developing targeted therapies requires new approaches to drug development. It was stated that Cancer Research UK has the expertise to co-ordinate these large-scale projects to develop strategies for cancer prevention.

Incidence of cancer deaths in the City

7.2.16 The evidence on cancer deaths has been provided by the Primary Care Trusts. The table shows that during 2001 and 2002, there were 593 male and 577 female deaths from all forms of cancer. Lung cancer was the biggest killer for both groups with 152 male and 90 female deaths. Colon and rectum cancer was the second largest killer for males with 71 deaths whilst for women breast cancer was the second largest with 88 deaths.

Cancer Deaths Males 2001 and 2002		**Cancer Deaths Females 2001 and 2002**	
Type of Cancer	Number of deaths	Type of Cancer	Number of deaths
Lung	152	Lung	90
Colon and rectum	71	Breast	88
Prostate	63	Colon and rectum	50
Oesophagus	36	Ovary	30
Stomach	32	Pancreas	30
Mesothelioma	26	Stomach	22
Pancreas	21	Oesophagus	21
Bladder	19	Non-Hodgkin's	21

		lymphoma	
Leukaemia	16	Leukaemia	19
Non-Hodgkin's lymphoma	16	Cervix	12
		Kidney	11
All malignant cancers	**593**	**All malignant cancers**	**577**

Source: PCT Shared Services

7.2.17 The table below shows Normanton has the highest number of cancer deaths from all forms of cancer of the three areas due to having the largest population. However, the Directly Age Standardised Rates show Derwent has the highest death rate for the period 1997-2000 with 194.3 mortalities. Osmaston has 163.5 mortalities whilst the rate for the city was 118.1 mortalities. Normanton is lowest number of cancer deaths of the three areas with 99.1 mortalities.

Premature mortality from malignant cancers in those under age 75 for 97-2000	**Derwent NDC**	**Normanton NRF**	**Osmaston NRF**	**City**
No of deaths	**79**	**187**	**70**	**1395**
Directly Age Standardised Rates (DASR)	**194.3**	**99.1**	**163.5**	**118.1**

Source: PCT presentation 2003

7.3 Diabetes

7.3.1 Diabetes is a major health problem that is increasingly affecting people in the deprived communities and was particularly prevalent amongst South Asians. Evidence on diabetes was collected from a number of sources including presentations by Dr Iqbal, Lister House Surgery, the Health Inequalities Unit and the Primary Care Trusts. Local data on diabetes has been provided by the Primary Care Trusts. Other information has been collected from a variety of sources using desk based research processes including information from Diabetes UK.

7.3.2 Type 1 diabetes develops if the body is unable to produce any insulin. This type of diabetes usually appears before the age of 40. It is treated by insulin injections whilst good diet and regular exercise also help.

7.3.3 Type 2 diabetes develops when the body can still make some insulin, but not enough, or when the insulin that is produced does not work properly (known as insulin resistance). This type of diabetes usually appears in people over the age of 40, though often appears before the age of 40 in South Asian and African-Caribbean people. It is also more common in people from socio-economically deprived areas. It is treated by various methods including diet and exercise, tablets and insulin injections.

7.3.4 Diabetes mellitus is a condition in which the amount of glucose in the blood is too high because the body cannot use it properly. Glucose comes from the digestion of starchy foods such as bread, rice, potatoes, chapatis, yams and plantain, from sugar and other sweet foods.

7.3.5 Diabetes is a common health condition affecting approximately 1.3 million people in the UK. It is estimated that another one million people in the UK have diabetes but don't know it. Over three-quarters of people diagnosed with diabetes have Type 2 diabetes.

7.3.6 National studies show that people of South Asian origin have very high rates of diabetes. Pakistani and Bangladeshi men and women are five times more likely than the general population to have diabetes, and Indian men and women are almost three times as likely. The death rate from diabetes amongst South Asians is more than three times greater than that for the general population. (Raleigh, 1997). (Health Survey for England, 2001).

7.3.7 The National Service Framework (NSF) for Diabetes published by the Government in December 2001 set a vision for diabetes services to reduce the number of people developing diabetes and to provide better care for those that have it.

7.3.8 The main symptoms of diabetes include:

- increased thirst
- passing urine frequently – especially at night
- extreme tiredness
- weight loss
- genital itching or regular episodes of thrush
- blurred vision.

Risk Factors

7.3.9 Risk of developing diabetes increases with age. Diabetes is known to run in families with close relatives also more at risk of developing diabetes. People from minority ethnic groups are more likely to have diabetes than the rest of the population.

7.3.10 Obesity and physical inactivity are major factors for developing Type 2 diabetes. Data from the Health Survey for England, 1994-96 shows that 38% of the population of Southern Derbyshire are overweight and 19% obese with body mass index over 30. The body mass index is calculated by measuring the weight of the person in kilograms and dividing it by the height in meters squared. The rates are increasing over time.

7.3.11 Diabetes can cause major damage to the eyes, kidneys, nerves, heart and major arteries and can lead to amputation. The main aim of treatment of both types of diabetes is to achieve blood glucose and blood pressure levels as near to normal as possible. This, together with a healthy lifestyle, will help to improve well being and protect against long-term damage.

Local Provision

7.3.12 According to the estimates from the Trent Public Health Observatory there are 2160 people in Southern Derbyshire with Type 1 diabetes and 14,000 with diagnosed Type 2 diabetes. It also estimates that there are 7100 undiagnosed Type 2 diabetics, making a total of 4.05% of the population. The presentation by the Directors of Primary Care Trust stated that Pilot PRIMIS data (April 2003) for seven practices in the Central Derby PCT area revealed prevalence of 3.9% amongst their practice population.

7.3.13 The Southern Derbyshire Diabetes NSF Local Implementation Team published a Diabetes Strategy for Southern Derbyshire in July 2003. This identified a number of areas for action by the Primary Care Trusts including identifying people with or at risk of developing diabetes and developing prevention measures.

7.3.14 The Commission was informed of the current measures to address diabetes in the city, including:

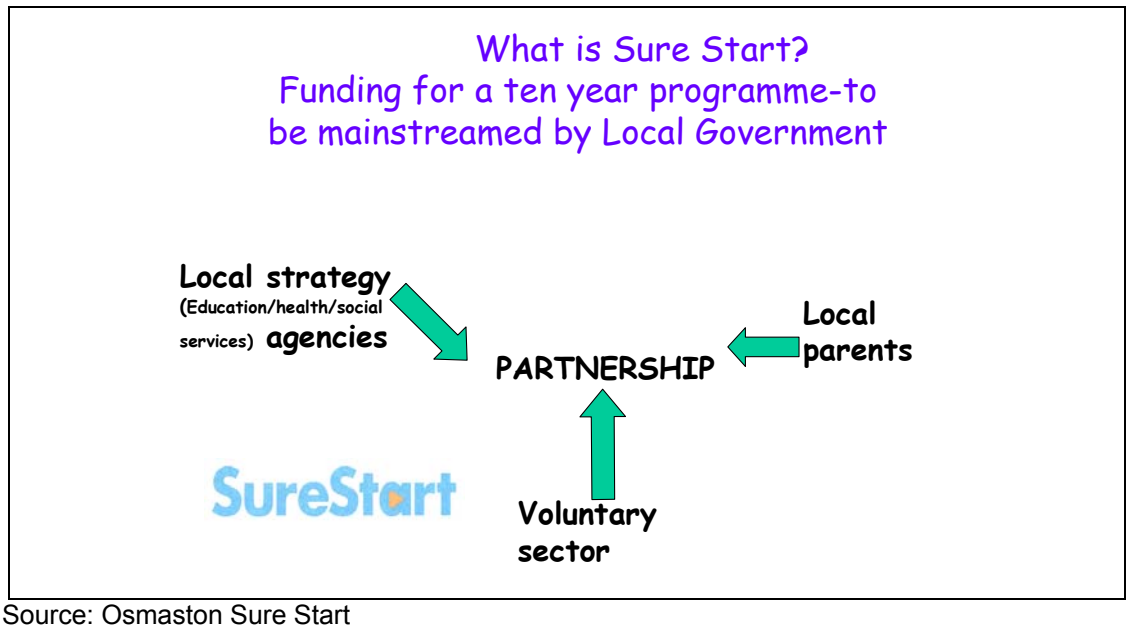
- Training of GPs and practice and community nurses
- Diabetes Strategy
- Personal treatment plans
- Patient/carer education
- Retinopathy screening
- Treatment guidelines
- Clinic at Peartree specifically addressing needs of Asian people
  - –Nurse with special expertise
  - –Eye screening
  - –Asian dietician

8 Local Action

8.1 Sure Start

8.1.1 The Commission invited Chris Tully, Programme Manager for the Osmaston Sure Start for the Commission to learn more about the programme and how it can contribute to this review.

8.1.2 Ms Tully explained that the main aim of Sure Start is to promote the physical, intellectual and social development of babies and young children, particularly those who are disadvantaged. Children from deprived communities tend to have poorer language skills and if these are improved they will have better social skills when they start nursery. Sure Start works with children under four and their parents to enable children to flourish at home and when they get to school to give them a better start in life. This will thereby break the cycle of disadvantage for the current generation of young children.



Source: Osmaston Sure Start

8.1.3 The work of Sure Start is related to national targets for reducing child protection case, accidents and hospital visits. The National Objectives for Sure Start are:

- Improve social and emotional development by supporting early bonding between parents and their children, helping families to function, and through early identification and support of children with emotional and behavioural difficulties
- Improve health by supporting parents in caring for their children and to promote healthy development before and after birth

- Improve the ability to learn by encouraging high quality environments and childcare that promote stimulating and enjoyable play, improving language skills and ensuring early identification and support of children with special needs
- Strengthen families and communities by involving families in building the community's capacity to sustain the programme and thereby create pathways out of poverty

8.1.4 A comparison of infant mortality in social classes between 1994-96 showed that 5/1000 babies died in their first year in social class I but the numbers for social class IV and V were higher with over 7/1000.

8.1.5 In response to infant mortality and other issues identified in the Black and Acheson reports, the Government established the Sure Start programme in 1999 with the aim to eliminate child poverty by 2020. There are currently over 500 Sure Start programmes across the country many of which were initially established as pilots. The short-term successes have already reached their original targets for 2006.

8.1.6 Sure Start offers a wider range of support services and requires an average funding of approximately £1,000 per child per year to operate. Families in poor areas cannot afford to pay for sessions and Sure Start needs to find finance so that these families can be helped. It seeks to strengthen facilities for families such as providing playgroups and supporting educational trips.

8.1.7 It was stated that Sure Start systematically makes contact with every child within 18 months of the start of the Sure Start programme. In Osmaston they had dealt with 1400 children over the last 18 months. Sure Start has to comply with the Data Protection Act and has to obtain consent to register details on their records. It has set up a database that will track children for 16 years.

8.1.8 Families moving into the area receive free welcome packs about local services. This tells residents about the location of dentists, doctors and other local facilities. People have found the packs to be very useful as it provides information on key local services. It was suggested that this should be made available in all areas of the city.

8.1.9 Local parents are now being trained as mentors and are offering voluntary support to other residents in the community. Sure Start provides crèche facilities to enable parents to access learning and attend meetings.

8.1.10 People from deprived communities have lower incomes and therefore need additional support. It was stated that some families send their children out to buy a sandwich from a shop even though it can be cheaper to make meals and sandwiches at home. The programme workers take families to the market to teach them how to buy food for making healthy meals.

8.1.11 In 1997 when Derby City became a Unitary Authority there were more children on the Child Protection Register than comparator authorities and Derby is still at the high end but the numbers are coming down. Social Services work closely with Sure Start to ensure services meet the best needs of the child. It was stated that child protection rates in the Derby City area are approximately 10% down in the Sure Start areas, although it is difficult to be precise due to reductions experienced across the city. In the first year Social Services received 500 referrals from Sure Start, in the second year they had 250 referrals and in the third year there were 150 referrals in Osmaston/Allenton. Referrals to Social Services are carried out as the last resort since this can reduce confidence in the community and be damaging for the programme.

8.1.12 Areas for assistance under the Sure Start Programme are selected using the indices of deprivation which include:

- factors of social exclusion
- high levels of unemployment and benefit dependency,
- little affordable child care provision;
- high density of young families with children aged 0-4 years;
- poor educational attainment,
- high levels of crime and vandalism;

8.1.13 Sure Start is managed through a local partnership body that includes parents, voluntary and statutory bodies, with the City Council Education Service being the Accountable body. Programme Managers are responsible for running each programme. A team of workers are either seconded or directly employed and support the management of the programmes. A steering group and parents forum ensure parental involvement in the local decision making process.

8.1.14 Sure Start Osmaston/Allenton serves approximately 12000 people of which 850 are children under 4 years. It directly employs 30 of its 60 staff with the remainder seconded from partner organisations. Funding from SRB, Addaction and the Children's Fund has enabled Sure Start to plan support across the whole family including helping children with behavioural problems.

8.1.15 Child protection problems in the Osmaston Sure Start area are mainly due to drug use by the parents. Special programmes have been set up with Government funding to support mothers addicted to heroin. The service works in partnership with Health, the voluntary sector and education as well as social services. There is a specialist midwife in the City General Hospital to support drug users in the antenatal and postnatal period.

8.1.16 Sure Start can't change everything in people's lives but aims to give them new opportunities. It is important that young mothers do not lose out on education by having children as they have the ability to succeed given the chance.

8.1.17 Research from America (Headstart) shows that early intervention is needed and can prevent long term problems, reduce crime and increase educational attainment.

8.1.18 Sure Start is constantly evaluated against a variety of indicators such as speech, language and accidents. At the local level Sure Start also asks the families what they think about the service and how it could be improved. Sure Start has improved breast feeding rates by 50% through giving more support to families. 10 parents are acting as mentors on breast feeding and provide local support. The Children's Hospital had indicated that there has been a drop in accidents and gastroenteritis. There is also external evaluation to assess how Sure Starts is working.

8.1.19 There are currently four Sure Starts in the city:

Osmaston/Allenton

- A trailblazer
- Approval was granted in 1999
- The Sure Start area has 840 children with a 95% white population
- £1.3 million build - First Steps - funded by 8 contributors with a 33 place day nursery.

Rosehill

- This was part of the Third Wave (2001)
- It has 800 children under 4 years
- The area has a high ethnic minority population (50%)
- The programme is taking a multi-cultural approach
- A new building under construction will provide a 44 place day nursery and is scheduled for completion in March 2004.

Austin /Sunnyhill

- This is part of the Fifth Wave (2002).
- It has 550 children.
- It is developing a former shop at Oaklands
- £1 million build-conversion of former Village School for completion March 2004 to produce a 50 place day nursery.

Mackworth/Morley

- This is also part of the Fifth Wave programme and has over 500 children. It will be based at Humbleton Drive, Mackworth. The Capital Plan is yet to be decided.

8.1.20 Each programme has grant funding of up to £750,000 a year dependent on the number of children within its catchment area. All Sure Start programmes are funded for 10 years, however funding declines after year 7. As local parents become more involved and as Sure Start proves its effectiveness the need for direct funding should decline. It is anticipated that the programmes will be mainstreamed and the best practice will be

shared across the City. However it will take many years to prove the outcomes and re-generate the areas.

8.1.22 Ms Tully was concerned about the continuation of the scheme once the 10 years funding runs out and suggested the need to consider mainstreaming of the programme very early.

8.1.23 There is a need to make sure that the objectives of Sure Start fit in with the needs of local people. Parents must want what Sure Start is providing otherwise initiatives will fail to get off the ground.

8.1.24 Basic skills are taught and it is a flagship in Derby. Parents are now accessing jobs, education and even going to University. The aim is to educate parents and all get certificates for taking part in courses.

8.1.25 In Osmaston, Social Services and other agencies all work together in specially built local community buildings where people can access them and they feel valued. A boost in individual self esteem leads to that of all of the community. The volunteers are all helping each other.

8.1.26 There are a number of short-term success stories of the programme. These include:

- Improvement to buildings
- Partnership working
- Crime decreasing in areas
- Over 100 parents have been involved in parenting courses
- Over 150 people have taken part in Basic Skills/Adult Education courses
- Reduction in accident by providing Home Safety Scheme Equipment
- Support groups for post - natal depression (sunrise group), domestic violence, teenage parents and breast feeding
- Parental involvement with over 30 volunteers
- UNICEF Baby Friendly Award 2003 and breast feeding rate improved by 50% in Osmaston/Allenton
- Over 20 parents involved in mentoring (Rosehill and Osmaston/Allenton)
- Children's self-esteem improving on entry to Nursery School
- Increase in library membership - Bookstart programme
- Special needs support- Butterfly house (Rosehill)
- Peers Early Education Programme (Speech and language)
- Parents going back to learning and work

Future Challenges

8.1.27 It was stated that Sure Start was originally not on the political agenda but due to its successes it is regularly being discussed by all the political parties. It is the first time the Government have put a significant amount of funding into pre-school and health issues. This should hopefully prevent

problems later although at this stage it is hard to prove. However, there are a number of challenges facing Sure Start:

- Mainstreaming of the services in 5 years
- Sharing good practice
- Development of Children's Centres and linking with other regeneration programmes.
- Maintaining Parental Involvement
- Partnership working
- Changing traditional ways of working
- Achievement of the milestones and national targets
- Improving mortality rates, morbidity and reducing child abuse

8.2 Fresh Start - Smoking Cessation

8.2.1 Smoking is widely considered to be a major factor affecting health. The presentations to the Commission by the Health Inequalities Unit and the GPs all stated that stopping people from smoking would make a major impact in addressing health inequalities. The Commission invited Judith Vincent, Smoking Cessation Officer from Fresh Start Core Service to inform the Members about smoking issues, its prevalence if any amongst certain groups and how smoking cessation services are being delivered in the city.

8.2.2 Ms Vincent explained that smoking is the biggest preventable cause of premature death with 50% of smokers likely to die from smoking related diseases. Thirteen people die every hour from smoking related disease in the UK. It is also an expensive habit with the total cost of smoking 20 cigarettes a day over 10 years at current prices estimated to be over £15000.

8.2.3 It causes damage to the environment with 10 trees cut to make 365 packets of cigarettes. It is estimated that 6000 fires are caused by cigarettes, lighters and matches each year in this country.

8.2.4 Tobacco is one of the few products that when used in its intended way will damage one's health. It was stated that nicotine when mixed with chemicals and tobacco causes many health problems.

8.2.5 Fresh Start Smoking Cessation Programme is a Southern Derbyshire initiative to cut down smoking. It was started in 2000 in response to the Smoking Kills document published by the Department of Health (DOH) in 1998 that identified the need for specialist cessation services in each region of the country. It covers Southern Derbyshire with each PCT having its own service. It began as an adult service dedicated to supporting people who wished to give up smoking.

8.2.6 People can find giving up smoking difficult and may take number of attempts before they finally give succeed. Fresh Start provides non-judgmental support to people wishing to give up smoking through group and one to one sessions held locally. People must want to give up smoking for it to work.

8.2.7 Fresh Start works with a wide range of community groups including pregnant mothers, young people in schools and people in temporary accommodation. Ms Vincent stated that people in the YMCA hostel respond much better as they have a more settled environment than people in other temporary accommodation for whom stopping smoking is the last thing on their minds. They have other worries such as finding a place to sleep for the night. For pregnant women, the midwives go out into their homes to try and encourage and support them to stop. Fresh Start is also developing training packages for school nurses and midwives.

8.2.8 Fresh Start can give up to 8 vouchers for nicotine replacement therapy (NRT) products which are at the same cost as prescriptions or Zyban -a drug prescribed by doctors that has the effect of depressing smoking receptors. Zyban may have some side effects such as dry mouth, headache, increased sweating, constipation, anxiety and fatigue but these affect people differently.

8.2.9 The project is working towards setting up a service at the Acute Trust as this is currently not a totally smoke free zone and still has smoke rooms.

8.2.10 The success rates of validated quitters after four weeks for 2002/03 on PCT area are:

- Greater Derby 61%
- Central Derby 58%
- Southern Derbyshire 61%

8.2.11 The Fresh Start Core Service is funded by the PCTs and has a service level agreement to:

- Manage the data base and monitor information on all clients and services
- Manage performance, produce quarterly monitoring reports and monthly breakdowns
- Administer pharmacy vouchers
- Develop core competencies training - train new advisers, midwives, school nurses and people who work with individuals
- Develop and implement strategy
- Promote the service to new groups and areas by producing leaflets and posters and hold road shows and attend events such as Liberation Day aimed at older people

8.2.12 Fresh Start is not licensed to give NRT products to people under the age of 18, who still need to go to their GPs for this. It is currently working to provide school nurses with authority to prescribe the products whilst retaining the right for GPs to be informed about it. There are no budgetary restrictions on the Core Service on how many vouchers it can give out.

8.2.13 The core service has 5 members of staff plus 1 administration officer. It covers the PCT areas in Southern Derbyshire including Greater and Central Derby, Erewash, South Derbyshire, Derbyshire Dales and Amber Valley. Additionally each PCT has approximately 4-6 advisors. Local advisers have a variety of backgrounds ranging from nursing to psychologists and are set up for Peartree, Sinfin and Sure Start areas.

8.2.14 It was stated that there is no significant difference in the level of smoking amongst the areas of high deprivation.

8.2.15 Ms Vincent stated that GPs should be routinely asking their patients whether they smoked, however she was not sure whether the data is

collected uniformly across all the GPs. Nowhere on the front sheet of patients hospital notes does it ask whether people smoke. The Commission could recommend GPs to start collecting data on smokers where this is not happening, to establish a baseline and to help to monitor interventions. This information could also be useful in assisting with diagnosis of health problems.

8.2.16 Ms Vincent stated that she has noticed increasing number of children are starting to smoke at an early age with some 9 and 10 year olds smoking an average of 9 cigarettes a day. Smoking has particularly shot up amongst girls. There is a need for campaigns to be specifically targeted at them with information developed to their level.

Smoking Prevalence Amongst South Asians

8.2.17 Data on smoking habits amongst ethnic minority communities at the local level is currently unavailable and therefore national studies are used to examine smoking amongst the largest ethnic minority group in the city, namely South Asian communities.

8.2.18 According to the Health Survey for England 2001 there are significant differences in the level of smoking between South Asian communities. In Britain, 44% of Bangladeshi, 26% of Pakistani and 23% of Indian men smoke cigarettes compared with 27% of men in the general population.

8.2.19 Smoking rates amongst South Asian women in Britain are generally low. Only 1% of Bangladeshi, 5% of Pakistani and 6% of Indian women smoke compared with 27% of women in the general population.

8.2.20 The survey also found that although attempts at giving up smoking were high amongst South Asians, the actual success rate was limited. Only a third of Indian (35%) and approximately a fifth of Pakistani (21%) and Bangladeshi (19%) men who had smoked regularly succeeded in giving up. This compares to over half (54%) of the men who have smoked regularly in the general population.

8.2.21 The survey also found that the knowledge of serious health risks associated with smoking amongst South Asians is poor with very few associating smoking with respiratory diseases.

Derbyshire Action On Smoking

8.2.22 The Commission also received information on Derbyshire Action on Smoking from Andrew Hopkin. This is a joint initiative between Derbyshire Health Services, Derbyshire County Council and the District Councils within Derbyshire. It is one of the five tobacco control alliances within the East Midlands region and is funded by the Department of Health.

8.2.23 The main aims of the alliance within Derbyshire are:

- To ensure that non-smokers are able to live and work in an environment which is not polluted by tobacco smoke.
- To help Derbyshire people who smoke break free from this costly and damaging habit.

8.2.24 Derby City Council Environmental Health and Trading Standards are actively supporting and contributing to these aims of reducing smoking by assisting a DAS project worker within the Derby area. The project worker will be based within the Food Team at Celtic House.

Smoking in the target areas

8.2.25 The PCT Shared Services provided the information contained in the table below. The table shows that more people smoke in Normanton and Osmaston compared with the city average. The number of young men smoking in Normanton was considerably higher than young women, whereas in Osmaston the rates are relatively equal.

Issue		**Normanton NRF**	**Osmaston NRF**	**City**
Prevalence of cigarette smoking-Health Survey 2000 (mean number of cigs)				
Men	Younger 25-44	41% (14)	44% (18)	28 % (17)
	Older 65-74	23% (16)	30% (17)	17% (14)
Women	Younger 25-44	24% (15)	42% (16)	26% (14)
	Older 65-74	11% (13)	22% (13)	11% (13)

Source: PCT Shared Services

8.2.26 Statistics obtained from Derwent Community Partnership annual Delivery plan 2002/03 show that 42.4% of the adults in the area smoke. (no details were available on gender)

Targets for Smoking Cessation

8.2.27 As part of the tobacco White Paper *Smoking Kills*, published in December 1998, the target for the Department of Health in England is to reduce by 1.5 million smokers by 2010 in all social classes. The target is measured by the number of people using the service who stopped smoking after four weeks.

8.3 Teenage Pregnancy

8.3.1 Teenage pregnancy is a major national concern and is also considered to have strong links with health inequalities. The Commission therefore invited the local teenage pregnancy co-ordinator and partners to provide information on the key issues surrounding teenage pregnancy and to understand how they are being addressed in the city.

8.3.2 Sheila McFarlane, the Teenage Pregnancy Co-ordinator stated that Britain has the highest teenage pregnancy rate in Europe, hence the development of local and national strategies. Tackling teenage pregnancy is a Government priority.

8.3.3 Research among teenage parents shows that there are:

- 60% higher infant mortality rates
- 50% lower breastfeeding rates
- Three times higher rates of postnatal depression
- Increased likelihood of living on low income/ benefits and in poor housing
- Higher risk of relationship breakdown between the baby's parents
- Low educational achievement/opportunities
- Higher rates amongst children looked after and care leavers

8.3.4 There are a number of reasons why rates are high, ignorance being one. Young people often lack the confidence to say no or to use contraceptives. Some young people also have low expectations of what they can achieve. Messages about sex and relationships can be confusing and misleading.

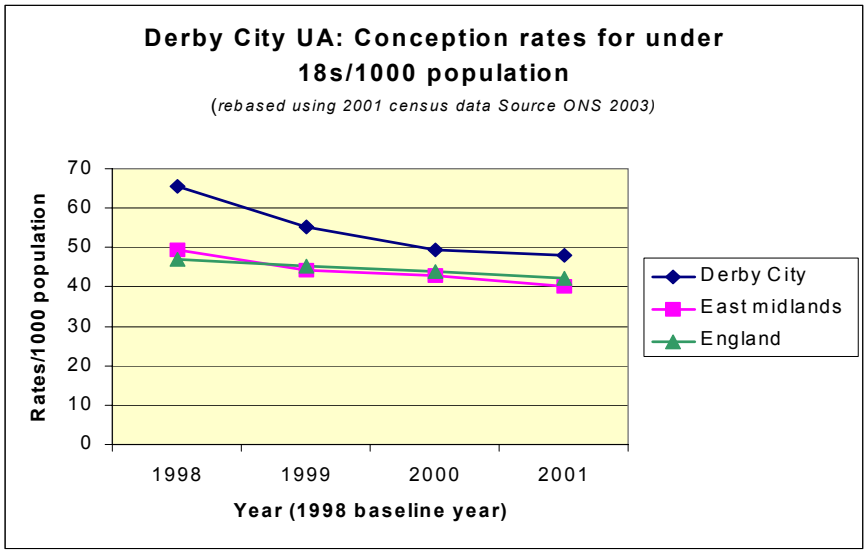
8.3.5 The Government has set challenging targets for reducing teenage pregnancies. It is seeking to reduce the rate of teenage conceptions by 50% nationally and 55% in Derby for the under 18s and establish a downward trend in the conception rates for under 16s by 2010. There is also a joint teenage pregnancy and Connexions target to reduce the long-term risk of social exclusion and increase the participation of teenage parents in education, training or work to 60% by 2010.

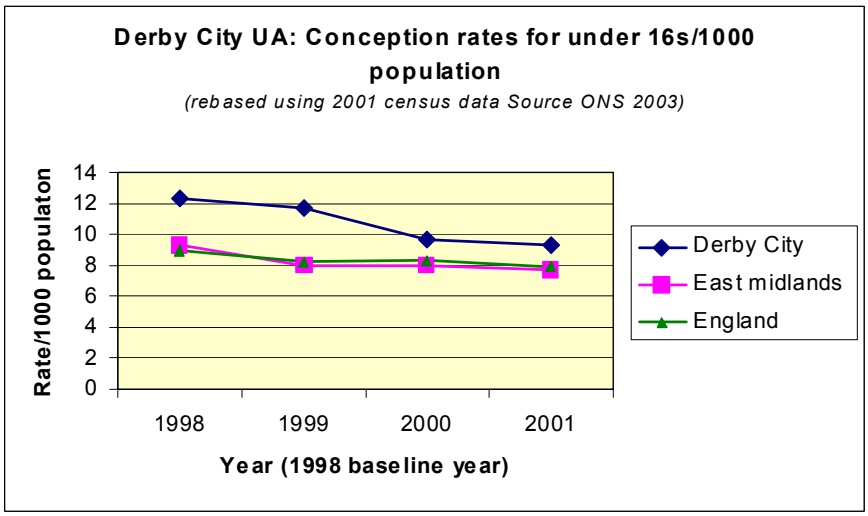
Local Performance

8.3.6 The strategy to address teenage pregnancy is based around local authority boundaries and requires joined-up working at all levels. NHS health authorities were responsible for the co-ordination of the Derby and Derbyshire teenage pregnancy strategy until 2002. In April 2002 the Social Services Department led the local teenage pregnancy coordination work and managed the grant on behalf of partners.

8.3.7 The Commission was informed that although the under 18s conception rates for the City are higher than both the regional and national levels, information for 2001 shows a reduction of 27% to the 1998 rates. The

interim target of 15% reduction by 2004 has also been overtaken. The conception rates for under 16s have also been reducing with a drop of 24% in the city since 1998 compared with the reduction in national rates of 10% over the same period. Although this is an excellent start, it is important to remain focussed as in some areas of England rates are fluctuating.





8.3.8 It was stated that the numbers of teenage pregnancies at ward level are relatively small, however, there is a strong link between teenage conceptions and areas of deprivation. In 2000, Derby had 11 wards appearing in the 'national worst 20%' (conceptions under 18yrs). These wards also have higher levels of deprivation. The list is sorted with worst first.

1. Sinfin
2. Derwent
3. Arboretum
4. Boulton
5. Normanton
6. Abbey
7. Mackworth
8. Chellaston
9. Alvaston
10. Chaddesden
11. Oakwood.

8.3.9 It was stated that although these wards should be the priority areas teenage conceptions occur in all wards in Derby so this must be taken into account. Teenage parents in wards where conception rates are lower may feel isolated or unsupported.

8.3.10 In response to a member query on the level of sexual activity, it was stated that conception rates are collected nationally and it is not known how many under 18s are sexually active or how this varies according to ethnicity. This data is not collected either at the national or local level.

8.3.11 Most teenage parents need support from a range of people including their parents and families. It is important this support is coordinated to have the maximum effect.

8.3.12 The strategy for addressing high rates of teenage pregnancy consists of providing advice and contraception, establishing local sexual health clinics, improving sex and relationships education, supporting national campaigns, targeting support to relevant groups and areas and improving support for teenage parents.

8.3.13 The aims of advice and contraception services for young people are:

- Confidentiality
- In the right locations
- Open at the right times
- Young person friendly atmosphere
- Staff with a smile
- Local publicity in places where young people meet
- Referral to services by all professionals

8.3.14 Sexual health clinics are set up locally to provide support. Local provision of advice and contraception include:

- One stop shop: The Space
- Emergency contraception in selected pharmacies
- School nurse ‘drop ins’
- 1 year pilot school nurse to provide sexual health support for children looked after and in residential care

- Participation in review of abortion services
- Established links with sexual health/HIV strategy leads

8.3.15 The uptake of sexual health clinics by young people has increased significantly over the last few years. Another area of work is related to improving sex and relationships education (SRE). This aims to link sex education to a broader framework of personal education and ensure that there is a range of provision covering the school, home, youth and the media. It also aims to provide training for workers and to help parents to talk to their children about SRE.

8.3.16 Local action to improve SRE involves delivering locality based training sessions aimed at teachers, school nurses and other partners. It provides model guidance for schools and works with specific groups such as Derby College and the Health Promoting Schools team.

8.3.17 The strategy also seeks to improve the support for teenage parents on a range of issues such as housing, training and education. It provides housing support through the Council and English Churches Housing Association for unsupported under 18s.

Key messages from the national campaign

8.3.18 The Government has established a national campaign aimed at young people and their parents to address the high rates of teenage pregnancies. Key messages of the campaign are:

For young people

- They should not feel pressurised into having sex before they are ready and that they have a choice when to have sex. They should take control, be prepared and be responsible for their actions.
- They can get free confidential advice about contraception and that it is available to all young people whatever the age
- They should use contraception to minimise the risk of pregnancy and sexually transmitted diseases
- They should be aware of the consequences of becoming a teenage parent that it is expensive and could stop them from enjoying things most teenager can enjoy

For parents

- They should talk to their children about sex and relationships rather letting them get the information and advice from other children.

Targeting support

8.3.19 Some initiatives ensure provision for all young people whereas others are targeted and strive to ensure appropriate support for:

- Vulnerable young people
- Osmaston/Allenton Sure Start, NRF

- Derwent (funded by NDC) to April 2004
    - teenage pregnancy co-ordinator works 1 day per week and full time local resident as teenage pregnancy link worker
    - school nurse for Bute Walk residential home
    - Enhanced support for 'Health Promoting Schools at High View'
    - Sexual health advice for boys and young men

Achievements

8.3.20 Local agencies are working well together in the partnerships to address the teenage pregnancy issues. It was stated that the feedback from the strategy's performance management assessment at the Government Office for the East Midlands for 2002-3 was positive.

8.3.21 There is a growing momentum in addressing teenage pregnancy issues with the expansion and strengthening of local networks. Consultation with young people is improving. There is also a process for sharing good practice both locally and nationally.

Areas for further development

8.3.22 The team providing evidence to the Commission suggested a number of areas that need further work in the future.

- Proactive work on the media and communications strategy
- Extending the range of sexual health advice/services for, young people at Derby College, ethnic minority groups and young people a disabilities
- Involving parents in SRE
- Extended school health services
- Work with young fathers
- Work with youth offenders
- Monitoring and evaluation
- Support for parents and teenage parents
- Continue multi agency training
- Mainstreaming

8.3.23 It was stated that training on a range of issues for single agency and multi agency staff is needed to support the strategy. Initial training is being carried out in 2003-4 on SRE around 'faith and values' and disability to support future work.

8.4 Derwent New Deal for Communities Programme

8.4.1 The Commission included the Derwent New Deal for Communities area for review since it has multiple indicators of deprivation. The Commission felt it could learn from the work of the project since it has a detailed strategy prepared by its local partnership and secured funding for regeneration activities. The evidence on this section of the report is based on a presentation by the Ian Smith, Director of New Deal for Communities Programme and the Ann Jones Health and Social Care and Housing Programme Development Leader.

8.4.2 The New Deal for Communities (NDC) programme is a national regeneration programme that seeks to improve social and economic well-being of communities in deprived areas. The NDC Annual Review stated "It is based on a simple objective: to bridge the gap between the most deprived neighbourhoods and the rest of the country".

8.4.3 Derby was successful in obtaining £42m grant from the Government for the Derwent area of the city spread over ten years starting in 2001. This was the one of the smaller allocation in the country when compared with the national average allocation of £50m. As mainstream services already spend approximately £30m per year in the area, this represents approximately 15% additional funding per year.

8.4.4 New Deal for Communities money can be used to match fund grants from other external sources such as ESF, Sport England and Urban Bus Challenge (funding from the Department of the transport to address the problems of public transport provision in deprived urban areas).

NDC Team

8.4.5 It was stated that the NDC team works closely with the Drug and Alcohol Action Team and has appointed a Drug Action Worker to engage with users. It has set up a number of groups - Treatment Group, Education Group, Support For Young People Group, Long Term Needs Group.

8.4.6 The main task of the NDC Team is to develop schemes and administer the programme over 10 years. The team employs 25 people of whom 10 are local residents. It also has approximately 100 local people involved in the programme.

Partnership working

8.4.7 It was stated that there is a feeling of excitement amongst the partnership with an opportunity to make a real difference through working with partners and developing local projects. Crime is being addressed through target hardening measures and one can already notice the difference e.g. fewer repeat victims. The reduction in truancy with more pupils going to school has resulted in an increase in attainment.

8.4.8 The Team seeks to work actively and support mainstream service development. It explores ways to deliver services differently, more joined up thinking to maximise collaboration and minimise overlap. The team encourages local involvement with local residents taking a lead in identifying problems and suggesting possible solutions. The Derwent Empowerment Project for example has acquired a minibus to take residents to meetings and conferences.

8.4.9 There is also a small "Can Do" grant available for local residents as part of the community capacity building programme. This seeks to improve their skills and encourage greater involvement in the area.

8.4.10 There are a number of linkages between issues. The Neighbourhood Environmental Action Team project (NEAT) involves the Police, Walbrook Housing Association, Derby Homes, environmental services and residents. The project will clean up the area and go beyond the street cleaning service specification. If the project is successful there is an understanding from the Council that this type of scheme could be rolled out to other areas of the city.

8.4.11 Teenage pregnancy is a priority for the area. It was stated that teenage girls living in Derwent are more than twice as likely to become teenage mothers compared with other parts of the city. The Teenage Pregnancy Partnership includes members from Social Services, Education, and the local community. A Teenage Pregnancy Co-ordinator is specifically working in the area and is supported by a local resident as her "shadow". They will seek to identify reasons why the pregnancy rates in the area are high and what needs to be done about it. A local project "get your kit on" works with young men to try to educate them on safe sex.

8.4.12 A Healthy Living Project has been set up in association with partners including the Greater Derby Primary Care Trust and has three main themes - smoking cessation, healthy eating and exercise. Land has been purchased to establish a healthy living centre.

Theme Groups

8.4.13 The Team operates five theme groups:

- Health, Housing Support and Social Care
- Community Safety and Physical and Built Environment
- Jobs Skills and Social Economy
- Lifelong Learning and Young People
- Community Empowerment and Capacity Building

8.4.14 A number of groups have been established to address major problems in the area. The health and social care group has been re-launched and is chaired by local resident. Key outcomes are:

- Provision of enhanced support for children in their early years

- Reduction of teenage conceptions
- Reduction in the number of people smoking in the area
- Increased levels of confidence and self esteem through the promotion of good mental health services
- Provision of quality health and social care services

Other initiatives

High View Milk Bar

8.4.15 The programme supports health promotion in schools. The High View Milk Bar is a major success in encouraging young people to drink milk instead of fizzy drinks. The Derwent Team provides 10p subsidy for every cup of milk charged at 30p.

Blue Boy

8.4.16 The NDC Team are working in partnership with the Blue Boy Pub and have leased space to target 'hard to reach' groups such as 25-40 year old males who are under represented in many activities. The pub will provide library services and provide facilities for smoking cessation work.

Grandstand

8.4.17 The NDC is working very closely with Derbyshire County Cricket Club to develop the old grandstand pub to provide coaching facilities, an affordable gym and a learning centre.

Priorities for 2003/04

8.4.18 The NDC established the following priorities for 2003/04:

- Child care study for local residents
- Best beginnings project. This is similar to Sure Start but with the age range extended to 8 instead of 4. A steering Committee has been established and a development co-ordinator is in post.
- Green Gym to be run by British Trust for Conservation Volunteers. It will provide training other structured activities whilst working on allotments to produce fruit and vegetables and encourage healthy eating
- Support for Fresh Start smoking cessation
- Review community nursing - health visitors and school nursing have been changed – an extra nurse has been appointed and will work through school holidays. They will also work with the Youth Service.
- Mental Health Audit - setting up development panels, early meetings with health professionals have been held
- Development work to support theme care groups for older people, disabled people and drugs misuse

8.5 BBC Radio Derby

8.5.1 The radio is an important medium for disseminating information to local people. Senior managers from BBC Radio Derby were invited to give evidence to the Commission on how radio could contribute to the review process and help to address health inequalities in the city. Simon Cornes, Radio Derby Station Editor, David Harvey, Producer and John Atkin - Programme Editor, attended the review meeting.

8.5.2 The Commission was informed that BBC Radio Derby is always on the lookout for all kinds of material for its broadcasts and receives information from various bodies including local authorities and NHS Trusts through their press offices. Health is probably at the top of the list of the items it deals with. There are more health stories than any other subject followed closely by education and crime. Radio Derby has a role to play but it must be a neutral reporter.

8.5.3 The information is collected by the station and assessed on how it is going to feature in programmes such as the breakfast show. If it needs a longer topic it will appear in the mid morning show e.g. GP taking calls. These longer shows lasting up to three hours could focus on single topics and invite listener responses through telephone, texts and e-mails. The station has to bear in mind that whilst a programme may be popular with some listeners it may be a turn off for others.

8.5.4 Information containing detailed figures is difficult to present and absorb over the radio whereas it is easier for newspapers because people can take time to read them.

8.5.5 The station does not want a sea of experts but prefers personal experiences such as patients' experiences with the health service. Professionals could be included in the programme to state the actions to be taken.

8.5.6 The BBC is very careful about giving opinions and as a policy obtains a source for every story. If the radio station is to cover a story on health inequalities then it must be attributed to a source. It can still deal with news in a story and may quote a GP or a Report etc.

8.5.7 A Member stated "Does he take sugar" is an excellent programme on Radio 4 that deals with disability issues and asked whether health inequalities issues such as immunisation and smoking could be dealt with in a similar way. It was stated this type of programme is very expensive and therefore difficult to achieve within the context of limited financial resources.

8.5.8 It is important for agencies to provide the information in the first place to enable the station to make their presentation. They do use most of the information given to them.

8.5.9 Dedicated programmes are useful in getting information across. In addition to the BBC Asian Network every night on medium wave providing programmes for the Asian community, there are specific programmes to meet the needs of minority ethnic groups including:

- Indian Aaj Kal – 7 – 9 p.m. on Friday night
- Afro-Caribbean ACE – 6 – 9 p.m. on Sunday night

8.5.10 BBC Radio Derby seeks to maintain a neutral image and not be seen to be too close to any one organisation otherwise it could lose its credibility. It has worked with single organisations and has carried out special programmes with single organisations such as Derbyshire County Council. They have also worked with the Acute Hospitals Trust on the Foundation Hospital issue.

8.5.11 BBC Radio Derby prefers the personal approach and asked for information to be provided at least three days in advance of the event. They can then advise on how best to present the information. They need examples of the people affected by something rather than just a politician explaining their point of view. Good personal tales are most successful in putting the information across.

9. Conclusion

9.1 The Social Care and Health Overview and Scrutiny Commission selected three of the most deprived areas in the city, namely Normanton NRF, Osmaston NRF and Derwent New Deal for Communities as the focus for it's review on health inequalities. The Review has found that all three areas have lower life expectancies compared with the rest of the city. The male life expectancy in Normanton NRF area is 73.2 years, Osmaston NRF is 71.7 years and Derwent NDC is 71.3 years compared with the city average of 75.5 years. It also found that on average women live five years longer than men.

9.2 The full extent of the differences in health outcomes between areas of deprivation and the rest of the city has been difficult to examine not least because the issues are extremely large and complex but also due to gaps in the base line information. For example, it is nationally recognised that the level of diabetes amongst people of South Asian origin is considerably higher than the rest of the population, however data was unavailable locally at the time of the review to confirm the prevalence amongst ethnic minority groups in the city.

9.3 The review looked at a selection of determinants of health. These factors are considered to have a major influence on the health outcomes of the local population. The findings from the Review effectively confirm what is largely already known, that the target areas have higher rates of crime and higher levels of unemployment, lower educational attainment and a sizeable proportion of properties judged to be unfit and in need of repair compared with other parts of the city.

9.4 The Commission accepts that addressing health inequalities will require sustained long-term commitment, joined up thinking and sharing of resources between the key agencies. It also requires individuals to play their part. They will need to consider changing their lifestyles, to stop smoking, drinking excessively, take up exercise and eat healthy foods. All these factors have strong links health. However, making lifestyle changes is not always straightforward as it sounds. Individuals may face many barriers, which may include peer pressures and the availability of healthy foodstuffs. In many instances people know that they should adopt healthy lifestyles such as stopping smoking but have problems actually putting it in practice. Agencies will need to help people make informed choices and to make those choices easy by addressing the barriers.

9.5 It is intended that this report has brought the key issues of difference in health outcomes between the different sections of the community to the fore and will generate public debate on how these could be improved.

REDUCING HEALTH INEQUALITIES TOPIC REVIEW

List of witnesses

Organisation	**Witness**
Derwent New Deal for Communities	**Ian Smith** - Director **Ann Jones** - Health Lead Officer
Neighbourhood Co-ordination Team	**Sharon Scott** - Neighbourhood Co-ordinator, Osmaston Area **Teresa Flower** - Neighbourhood Co-ordinator, Normanton Area **Isabella Stone** - Assistant Director Community Policy **Lesley Walker** - Area and Neighbourhood Manager
Dr Iqbal's Surgery	**Dr Iqbal** - General Practitioner
Lister House Surgery	**Dr John Spincer** - General Practitioner **Dr Richard Crowson** - General Practitioner **Chris Roome** - Mental Health Nurse
DOH Health Inequalities Unit	**Anne Griffin** - Team Leader Health Inequalities Unit
Fresh Start Core Services	**Judith Vincent** - Smoking Cessation Co-ordinator
Cancer – Cancer Research UK	**Diane Spall** – Community Fundraiser
British Heart Foundation	**Christine Twig**
Sure Start	**Chris Tully** - Project Manager **Christine Smith-Read** - Project Manager
Social Services	**Margaret McGlade** - Director of Social Services
Social Services- Teenage Pregnancy	**Sheila McFarlane** -Teenage Pregnancy Co-ordinator **Sarah Davies** -Head of Children's Planning, Social Services **Jackie Colley** - Project Officer Children and Family Services **Graham Falgate** - Education Officer
Education Department	**Andrew Flack** - Director of Education
Education Department	**John Brown** - Head of Sports and Leisure **Amanda Sharman** - Marketing and Performance Manager
Housing Services	**Martin Gadsby** - Private Sector Housing Manager
Derby Homes	**Phil Davis**- Chief Executive Derby Homes
Corporate Services - Environmental Health	**Andrew Hopkin** Chief Environmental Health Officer
Development & Cultural Services- Traffic Engineers	**Ian Butler** - Senior engineer accidents & projects **Jon Pumfrey** - Accident Investigation Officer

Crime & Disorder Team	**Andy Luscombe** Principle Policy Officer **Steve Spear** Drug and Alcohol Action Team Co-ordinator
Health Bodies	**Dr Peter Marks** -Director of Public Health Central Derby PCT **Dr McConville** - Director of Public Health Greater Derby PCT- Anne
BBC Radio Derby	**Simon Cornes** - Radio Derby Station Editor **David Harvey** - Producer **John Atkin** - Programme Editor

Education -

Issue	Derwent NDC	Normanton NRF	Osmaston NRF	City
Population	9355	23443	10948	221700
Households	4000	10500	4500	92400
Total number of statutory school aged children (5-16)	Not available	Not available	Not available	34383
Total number of primary age (5-11)	Not available	Not available	Not available	20372
Total number of secondary age (11-16)	Not available	Not available	Not available	14011
Total primary school capacity (DfES definition - more open enrolment - moe)	951	2550	1085	22429
Total secondary school capacity (DfES definition - more open enrolment - moe)	636	1586	845	15383
% of children attaining 5 A*-C GCSE as % of entries	17%	37%	17%	44%
Total number eligible to enter for GCSE's	114	294	177	2593
Total number of entries for GCSE's	101	279	165	2545
Number of permanent Exclusions	7	10	9	83
Absence levels of pupils at primary school	Not available	Not available	Not available	6.1%
Absence levels of pupils at secondary schools	Not available	Not available	Not available	9.5%
Total formula budget (including Schools Standards Grant)/total number of pupils (FTE)				Average £2428.51 for financial year 2002/03

All data relates to 2001-02 academic year

Number of children attaining 5 A*-C GCSE for 2001-02 Academic year

	Derwent NDC	Normanton NRF	Osmaston NRF	City
Bangladeshi	0	1	0	1
Black African	0	0	0	3
Black Caribbean heritage	0	0	0	8
Black other	0	2	0	10
Chinese	0	0	0	7
Ethnic information not sought	0	0	0	3
Indian	0	20	2	81
Other known ethnic group	0	1	1	14
Pakistani	0	53	0	66
Parent/pupil declined to say	0	0	0	1
Unknown	0	0	0	13
White European	0	1	0	10
White other (known)	0	0	0	1
White UK heritage	17	25	25	909
Boys	9	44	13	479
Girls	8	59	15	648
Total	**17**	**103**	**28**	**1127**

Environmental Health (6/5/03)

Issue	**Derwent NDC** -DE21	**Normanton NRF -**DE23	**Osmaston NRF** -DE24	**City**
Number of recorded complaints of anti-social behaviour during 12 months from 1/4/03-31/3/01 for following categories:				
• Loud music	38	60	77	314
• Noisy behaviour	13	33	12	96
• Barking noise	45	28	49	173
Air quality Nitrogen Dioxide NO_2 Fine Particles PM_{10}	Within objectives	Within objectives	Within objectives	Within objectives

Leisure & Roads

Issue 36 months 1Jan 2000-31Dec 2002	**Derwent NDC**	**Normanton NRF**	**Osmaston NRF**	**City**
Number of people killed or seriously injured in road accidents by road user in the last three years	24	55	31	370
Number of children aged 0-15 years killed or seriously injured in road accidents by road user	6	9	8	56
Slight injuries for all road users (adults and children)	182	541	191	2848
Slight injuries for children	27	69	32	360
Safety improvement schemes data (type, date, cost etc.)	6 schemes-£215500	17 Schemes £287900	6 schemes-£426500	

Social Services

Issue	**Derwent NDC**	**Normanton NRF**	**Osmaston NRF**	**City**
Total number of children known to Social Services that are In Need	192	242	195	1912
Total number of looked after children	33	12	12	374
Total number of children on child protection register due to	28	51	58	284
• Neglect	8	27	21	115

• Physical injury	5	8	4	43
Total number of children known to Social Services with disabilities	29	47	12	279
Total number of households receiving home care from the authority	143	309	157	4156
People with physical disabilities helped to live at home (18 - 64 Age Group)	33	60	31	583

Crime & Disorder

Issues	**Derwent NDC**	**Normanton NRF (SRB6)**	**Osmaston NRF(SRB5)**	**City**
Burglary dwellings (Apr 02-Mar 03)	242	416	166	2591
Drugs Offence	39	154	61	609
Violent crime (Apr 02-Mar 03)	365	1201	646	7265
Assault	334	907	584	6244
Sex Offence	16	106	34	354

Housing

	¥	*	*	*
Issue	**Derwent NDC**	**Normanton NRF**	**Osmaston NRF**	**City**
Total number of units of residential accommodation per sector				
• Owner occupiers	**N/A**	**N/A**	**N/A**	**72574**
• Council				**14981**
• Housing assoc				**6081**
• Private rented				**7000**
• Other				**N/A**
% of homes judged unfit to live in for each sector				
• Owner occupiers	**3.5%**	**31%**	**22%**	**11.6%**
• Council	**N/A**	**N/A**	**N/A**	**N/A**
• Housing assoc	**N/A**	**15%**	**12%**	**3%**
• Private	**5%**	**55%**	**42%**	**18%**
Ground for unfitness as a proportion of all unfit properties				
• Structural stability	**N/A**	**7%**	**11%**	**5%**
• Serious disrepair	**N/A**	**94%**	**84%**	**89%**
• Dampness	**N/A**	**29%**	**11%**	**23%**
• Lighting	**N/A**	**7%**	**1%**	**5%**
• Heating and ventilation	**N/A**	**10%**	**9%**	**8%**
• Satisfactory cooking	**N/A**	**29%**	**21%**	**15%**
• Washing facilities	**N/A**	**13%**	**15%**	**12%**
Number of dwellings improved as a proportion of needing renovation in the last five years	**N/A**	**N/A**	**0**	**13.4%**
Capital expenditure per dwelling on major repairs and improvements during the last five years	**N/A**	**£5k**	**0**	**£5k**

N/A = not available
* Source: 1998 House Condition Survey
¥ Source: NDC Desktop Survey 2001

NB Unfitness levels in Normanton now will be lower because of impact of Pear Tree Renewal Area and Rosehill Housing Improvement Zones

Public Sector Housing

Issue	Derwent NDC	Normanton NRF	Osmaston NRF	City
Total number of units of residential	**1681**	**737**	**1788**	**14891**
% of unfit- (non decent) homes • Council	**28%**	**45%**	**32%**	**42%**
Ground for non decent as a proportion of all unfit properties • Unfitness • Lack of Modern Facilities • Age and Condition • Thermal Comfort	 **0%** **25%** **28%** **47%**	 **0%** **26%** **24%** **40%**	 **0%** **27%** **10%** **63%**	 **0%** **30%** **44%** **26%**
Capital expenditure per dwelling on major repairs and improvements during the last five years				**£3,800**

Health Indicators

Issue	Derwent NDC	Normanton NRF	Osmaston NRF	City
Life expectancy at birth • **Men** • **Women**	 **71.3** **78.2**	 **73.2** **78.2**	 **71.7** **76.9**	 **75.5** **80.1**
Premature mortality for under 75 from all causes 97-2000 **No of deaths** **DASR** (Directly standardised rate per 100k)	 **209** **506.3**	 **532** **466.5**	 **233** **519.9**	 **4316** **366.1**
Premature mortality from circulatory disease in those under age 75 for 97-2001 **No of deaths** **DASR**	 **53** **129.7**	 **187** **168.4**	 **76** **175.1**	 **1479** **122.1**
Premature mortality from malignant cancers in those				

under age 75 for 97-2001 **No of deaths** **DASR**	**79** **194.3**	**187** **99.1**	**70** **163.5**	**1395** **118.1**
Mortality rate from accidents amongst people of all ages DASR 95-87 Number Rate 96-98 Number Rate 97-99 Number Rate 98-00 Number Rate				 **129** **15.25** **141** **16.61** **153** **17.31** **141** **15.52**
Teenage Pregnancy 1999 Number Rate 2000 Number Rate 2001 Number Rate				 **221** **54.7** **206** **50.0** **208** **47.9**
Low birth weight babies • **Number of lbw** • **All live and still births** • **Proportion**	 **102** **879** **11.6**	 **298** **2423** **12.3**	 **95** **1027** **9.3**	 **1327** **14856** **8.9**
Prevalence of cigarette smoking-Health Survey 2000 (mean number of cigs) Men Younger 25-44 Older 65-74 Women Younger 25-44 Older 65-74		 41% (14) 23% (16) 24% (15) 11% (13)	 44% (18) 30% (17) 42% (16) 22% (13)	 28 % (17) 17% (14) 26% (14) 11% (13)
Proportion of obese or overweight (BMI 25+) people Men Younger 25-44 Older 65-74 Women Younger 25-44 Older 65-74		 44% 60% 37% 63%	 56% 51% 46% 54%	 55% 53% 37% 52%
Immunisation of babies SDHA • % of children having measles, mumps and rubella • % of babies under 1 year vaccinated against				 87.2% 92.8%

whooping cough				
Number of children (under 16) admitted to hospital as an emergency over 3 years with length of stay >3 days	7 (5%)	25 (17%)	19 (13%)	150 (100%)
Access to primary care doctor within 48 hours • Central Central • Greater Derby				 91.4% 91.8%

Breast screening programme : estimated uptake by women aged 50-64 of invitations to screen, by unit, 1995-96 to 2000-01 (Percentages)

Unit	1995-96	1996-97	1997-98	1998-99	99-2000	2000-01	Change 99-00 to 00-01
Derby City & South Derbyshire	83	83	84	84	83	83	0
Nottingham	80	78	81	83	81	81	0
Leicestershire	80	82	81	81	85	81	-4
England	76	76	75	76	76	75	-1

Source: National Statistics

Derby City Profile

1: Resident population by age and gender

		All ages	0-4	5-9	10-14	15-19	20-24	25-44	45-59	60-64	65-74	75-84	85+
All people	No.	221,708	13,645	14,773	18,202	14,692	21,127	63,978	38,115	10,241	18,978	12,848	4,084
	%	104.1	6.2	6.7	8.2	6.6	9.5	28.9	17.2	4.6	8.6	5.8	1.8
	Eng.%	*103.7*	*6.0*	*6.4*	*7.8*	*6.2*	*8.4*	*29.3*	*18.9*	*4.9*	*8.4*	*5.6*	*1.9*
Male		108,240	7,060	7,591	7,703	7,397	7,381	31,593	19,118	5,080	8,870	5,295	1,148
Female		113,468	6,607	7,178	7,531	7,295	7,741	32,380	18,985	5,170	10,106	7,548	2,939

2: Marital status (people aged over 16)

	No.	%	*Eng.%*
Single (never married)	53,810	30.7	*30.2*
Married	74,759	42.7	*43.5*
Re-married	12,516	7.2	*7.4*
Separated	4,459	2.6	*2.4*
Divorced	14,339	8.2	*8.2*
Widowed	15,205	8.7	*8.3*
Population aged over 16	175,088	100.0	*100.0*

3: Resident population by religion

	No.	%	*Eng. %*
Christian	149,471	67.4	*71.7*
Buddhist	448	0.2	*0.3*
Hindu	1,354	0.6	*1.1*
Jewish	141	0.1	*0.5*
Muslim	9,958	4.5	*3.1*
Sikh	7,151	3.2	*0.7*
Other religion	550	0.3	*0.3*
None	35,207	15.9	*14.6*
Not stated	17,428	7.9	*7.7*
Total population	221,708	100.0	*100.0*

4: Resident population by ethnicity

		No.	%	*Eng.%*
White	British	187,104	84.39	*87.0*
	Irish	3,060	1.38	*1.3*
	Other white	3,717	1.68	*2.7*
All White		193,881	87.5	*90.9*
Mixed	White and Black Caribbean	2,293	1.0	*0.5*
	White and Black African	200	0.1	*0.2*
	White and Asian	980	0.4	0.4
	Other mixed	495	0.2	*0.3*
All Mixed		3,968	1.8	*1.3*
Asian or Asian British	Indian	8,505	3.8	*2.1*
	Pakistani	8,790	4.0	*1.4*
	Bangladeshi	210	0.1	*0.6*
	Other Asian	1,028	0.5	*0.5*
All Asian or Asian British		18,533	8.4	*4.6*
Black or	Caribbean	3,108	1.4	*1.1*
	African	438	0.2	*1.0*
	Other black	349	0.2	*0.2*
All Black or Black British		3,895	1.8	*2.3*
Chinese		857	0.4	*0.5*
Other ethnic group		574	0.3	*0.4*
Total population		221,708	100.0	*100.0*

5: General Health

	No.	%	*Eng. %*
Good	147,330	66.5	*68.8*
Fairly good	52,355	23.6	*22.2*
Not good	22,023	9.9	*9.0*

6: Limiting long term illness

	No.	%	*Eng. %*
Total population	221,708		
of which: people with limiting long term illness	42,862	19.3	*17.9*
All people of working age	158,156		
of which: people with limiting long term illness	19,452	14.5	*13.3*

7: Carers

	No.	%	*Eng. %*
People providing unpaid care	23,733	10.7	*9.9*

8: Highest level of qualification (people aged 16-74)

	No.	%	*Eng.%*
None	49,650	31.4	*28.85*
Level 1	26,884	17.0	*16.63*
Level 2	27,350	17.3	*19.36*
Level 3	13,230	8.4	*8.3*
Level 4/5	28,042	17.7	*19.9*
Other qualifications/ level unknown	13,000	8.2	*6.9*
Population aged 16-74	158,156	100.0	*100.0*

9: Students aged 18-74

	No.	%	*Eng. %*
Full time students aged 18-74	8,623	3.9	3.1

10: Migration in the last year

	No.	%	*Eng. %*
All migrants	27,703	12.5	*12.2*
People who moved within the area	17,095	7.7	*n/a*

Notes: (1)% is: as a percentage of the total population EXCEPT Table 8 which is a percentage of 16-74 year olds.
(2) Eng. % refers to the figure for England as a whole.
(3) Figures may not sum correctly due to rounding.

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11: Total people aged 16- 74

	Total	Males	Females
People aged 16-74	158,156	77,960	80,196

12: Economically active people aged 16-74

	All people			Males		Females	
	No.	%	*Eng. %*	No.	%	No.	%
Employees: Full time	62,822	39.7	*40.8*	40,623	52.1	22,199	27.7
Part time	19,757	12.5	*11.8*	2,730	3.5	17,027	21.2
Self employed	8,572	5.4	*8.3*	6,360	8.2	2,212	2.8
Unemployed	6,325	4.0	*3.4*	4,115	5.3	2,210	2.8
Full time student	5,060	3.2	*2.6*	2,350	3.0	2,710	3.4
Total economically active	102,536	64.8	66.9	56,178	72.1	46,358	57.8

13: Economically inactive people aged 16-74

	All people			Males		Females	
	No.	%	*Eng. %*	No.	%	No.	%
Retired (Under 75s only)	22,694	14.4	*13.5*	9,894	12.7	12,800	16.0
Full time student	8,123	5.1	*4.7*	4,018	5.2	4,105	5.1
Looking after home/family	10,474	6.6	*6.5*	816	1.1	9,658	12.0
Permanently sick/disabled	9,112	5.8	*5.3*	4,878	6.3	4,234	5.3
Other	5,217	3.3	*3.1*	2,176	2.8	3,041	3.8
Total economically inactive	55,620	35.2	33.1	21,782	27.9	33,838	42.2

14: Socio-economic classification of all people 16-74 by occupation

	All people			Males		Females	
	No.	%	*Eng. %*	No.	%	No.	%
Large employers and higher managerial	4,628	2.9	*3.5*	3,447	4.4	1,181	1.5
Higher professional	7,088	4.5	*5.1*	5,462	7.0	1,626	2.0
Lower managerial and professional	25,460	16.1	*18.7*	12,102	15.5	13,358	16.7
Intermediate	13,212	8.4	*9.5*	3,339	4.3	9,873	12.3
Small employers and own account workers	7,928	5.0	*7.0*	5,764	7.4	2,164	2.7
Lower supervisory and technical	13,304	8.4	*7.1*	9,796	12.6	3,508	4.4
Semi-routine	20,801	13.2	*11.7*	8,370	10.7	12,431	15.5
Routine	16,356	10.3	*9.0*	8,753	11.2	7,603	9.5
Never worked	5,308	3.4	*2.7*	1,482	1.9	3,826	4.8
Long-term unemployed	2,108	1.3	*1.0*	1,379	1.8	729	0.9
Full time students	12,818	8.1	*7.0*	6,203	8.0	6,615	8.3
Non-classifiable	29,145	18.4	*17.7*	11,863	15.2	17,282	21.6

15: Travel to work

		No.	%	*Eng. %*
People in employment aged 16-74 who usually travel to work by:	Train	810	0.8	*7.4*
	Bus, minibus or coach	8,916	9.3	*7.5*
	Motorcycle, scooter or moped	1,321	1.4	*1.1*
	Car or van as driver	54,329	56.9	*54.9*
	Car or van as passenger	6,901	7.2	*6.1*
	Taxi or minicab	715	0.8	*0.5*
	Bicycle	4,233	4.4	*2.8*
	Foot	11,413	12.0	*10.0*
	Work at home	6,513	6.8	*9.2*
	Other	300	0.3	*0.5*
Total 16-74 year olds in employment		95,451	100.0	*100.0*

Notes: (1) % is as a percentage of the population of the City: aged 16-74 (Table 13); economically active aged 16-74 (Table 11); economically inactive aged 16-74 (Table 12); in employment aged 16-74 (Table 14)

(2) Eng. % refers to the figure for England as a whole.

(3) Figures may not sum correctly due to rounding.

See page ? for definitions and detailed notes.

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16: Households and Dwellings

	No.	%	*Eng.%*
Total households	92,405		
Total dwellings	n/a	n/a	n/a
Occupied dwellings	n/a	n/a	n/a
Vacant dwellings	n/a	n/a	n/a
Shared dwellings	n/a	n/a	n/a

17: Household composition

	No.	%	*Eng. %*
Households with dependent children	27,544	29.8	*29.5*
Of which: lone parent with dependent children	6,754	7.3	*6.4*
Households with only pensioners	22,455	24.3	*23.8*
Of which: households with 1 pensioner living alone	13,614	14.7	*14.4*
Other 1 person households	15,232	16.48	*15.7*
Households with only students	539	0.6	*0.4*
Average number of people per household	2.35		*2.36*

18: Housing tenure

		No.	%	*Eng. %*
Households:	Owner occupied	63,979	69.2	*68.7*
	Rented from Council	13,167	14.2	*13.2*
	Rented from Housing Association or registered social landlord	5,840	6.3	*6.1*
	Rented from private landlord or letting agency	6,739	7.3	*8.8*
	Other rented or rent free	2,680	2.9	*3.2*
Total households		92,405	100.0	*100.0*

19: People in communal establishments

	No.	% of population	*Eng. %*
Residents in communal establishments	4,124	1.9	*1.8*

20: Housing conditions

		No.	%	*Eng. %*
Households:	With occupancy rating of –1 or less	4,628	5.0	*7.1*
	Without sole access to a bath/shower and toilet	260	0.3	*0.5*
	Without central heating	10,662	11.5	*8.5*
	With 1.0 or fewer persons per room	n/a	n/a	n/a
	With over 1.0 upto 1.5 persons per room	n/a	n/a	n/a
	With over 1.5 persons per room	n/a	n/a	n/a
	Not in self contained accommodation	n/a	n/a	n/a

21: Car ownership

		No.	%	*Eng. %*
Number of cars or vans owned per household:	None	28,316	30.6	*26.8*
	One	42,034	45.5	*43.7*
	Two	18,422	19.9	*23.6*
	Three or more	3,633	4.0	*5.9*
Total households		94,405	100.00	*100.0*

Notes: (1) % is: as a percentage of the number of households in the City EXCEPT in table 15 where it is: as a percentage of all dwellings and table 18 where it is: as a percentage of the total population.
(2) Eng. % refers to the figure for England as a whole.
(3) Figures may not sum correctly due to rounding.

See page 4 for definitions and detailed notes.

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Page 1: People

Resident Population	People who have their main address in the area. For the 2001 Census, students' term time addresses were taken as their main address instead of their home address as in 1991.
Age	Age at last birthday on 29th April 2001.
General Health	Person's view of their health in the last 12 months.
Limiting Long Term Illness	Any long term illness, health problem, or disability, which limits the person's daily activities or the work he or she can do.
Carers	Anyone providing unpaid care to others because of long-term physical, or mental ill-health or disability, or problems related to old age.
Highest Level of Qualification	Level 1- 1+ O level passes, 1+ CSE/ GCSE any grades, NVQ level 1, Foundation GNVQ.
	Level 2- 5+ O-level passes, 5+ CSEs grade 1, 5+ GCSEs grade A-C, School Certificate, 1+A/AS level, NVQ level 2, Intermediate GNVQ.
	Level 3- 2+ A-levels, 4+AS levels, Higher School Certificate, NVQ level 3, Advanced GNVQ.
	Level 4/5- 1st degree, higher degree, NVQ level 4 and 5, HNC, HND, qualified teacher, medical doctor, dentist, nurse, midwife, health visitor, other professional qualification.
Migrants	Anybody whose address on April 29th 2001 was different to their address twelve months previously.

Page 2: Economic Activity

Part-time Employment	For the Census, part-time employment is 30 hours per week or less.
Economically Active	People, aged 16-74, in employment, or looking for employment and available to start work.
Economically Inactive	People, aged 16-74, without a job who have not looked for one in the last four weeks or are unavailable to start work in the next two weeks.
Unemployed	People who are not in employment but were available to start work within the last two weeks and who have looked for work in the last four weeks or are waiting to start a new job.
Long Term Unemployed	People who stated they have not worked since the end of 1999 or earlier.
Students	People aged over 16 in full time education.

Page 3: Households and Housing

Household	Person living alone or people living at same address sharing a living or sitting room or sharing at least one meal per day. People are not necessarily related.
Dependent Children	Person aged 0-15 (whether in a family or not) or a person aged 16-18 who is a full time student and in a family with his or her parent(s).
Lone Parent	A lone mother or father living with their children, or, a lone grandparent with their grandchildren, but no children in the intervening generation, in the household.
Pensioners	Women aged 60 and over and men aged 65 and over.
Communal Establishments	Establishment providing managed residential accommodation. Managed means full or part-time supervision of the accommodation. E.g. prisons, hospitals, large hotels. Special rules apply to, for example, smaller hotels and sheltered housing, where the definition is less obvious.
Occupancy Rating	Relates the actual number of rooms to the number required by the household based on their ages and the relationships between them. A rating of -1 indicates there is one room too few for the people living in the household.
Shared and Unshared Dwellings	If a household space is: part of a shared or converted house; not all rooms are behind a door only the household can use and; there is at least one other such household at the same address, the dwelling is shared. If any of these conditions are not met, the dwelling is unshared. Therefore a dwelling can consist of one household space (an unshared dwelling) or two or more household spaces (a shared dwelling).
Household Space	Accommodation available for an individual household.

General Notes

1. Derby City Council believes that the figures published in the Census understate both the population of the City and the number of households in Derby. This issue is being pursued with the Office for National Statistics. It could have an impact on the numbers and percentages in this profile.

2. The 2001 Census was collected in a different way to previous censuses. A 'One Number' approach was used to estimate the number of people who had not returned the form and therefore provide more accurate figures. Also there were changes in some definitions most notably in that of the resident population (see above). This means that care should be taken when comparing the 2001 Census to previous ones. Generally, it will be more accurate to compare percentage figures than absolute values.

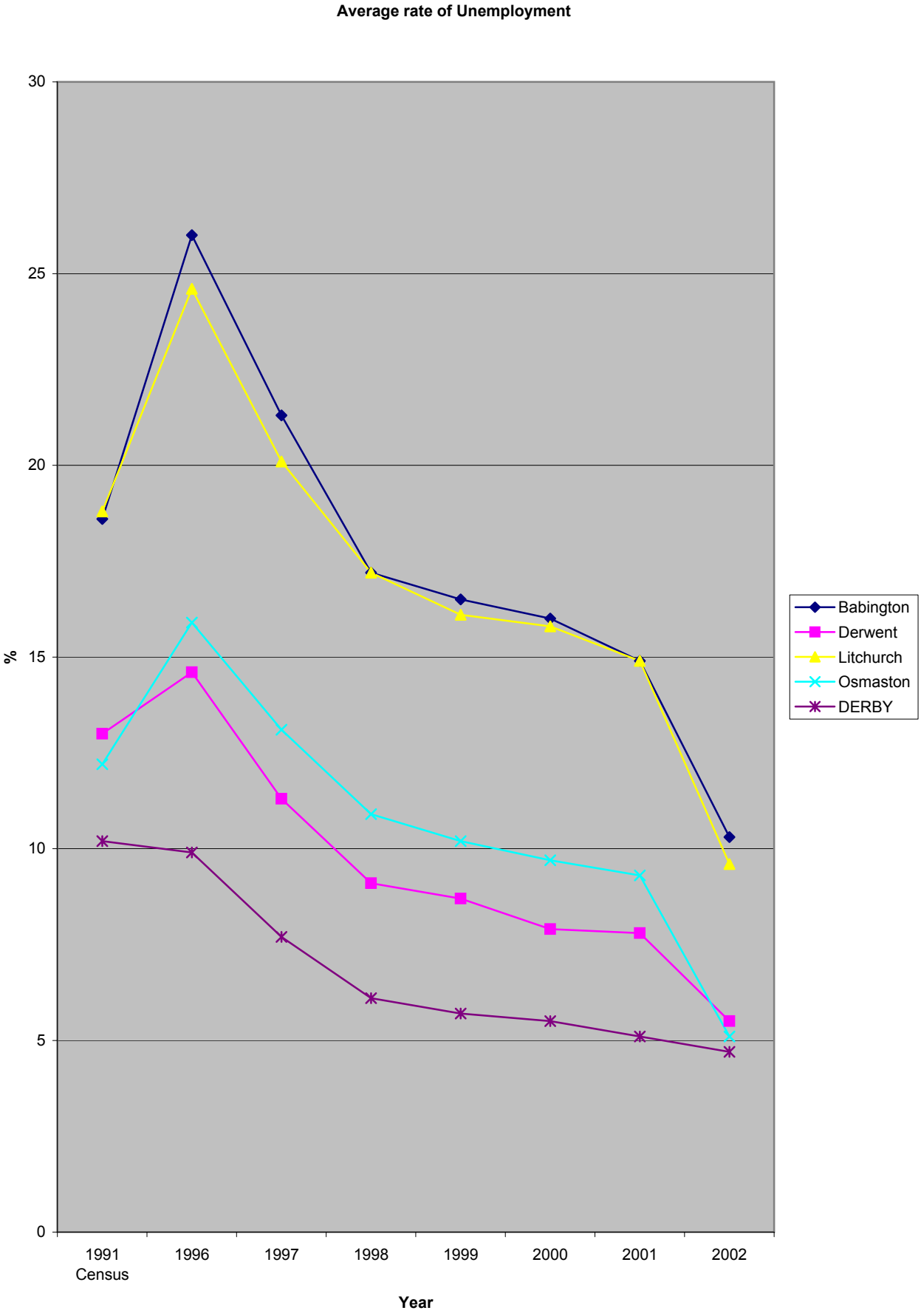
3. To prevent individuals from being identified, all very small figures have been subjected to random changes. Therefore, columns may not add up to the correct total.

4. Cells labelled 'n/a' require data which is currently unavailable but will be added at a later date

5. Detailed definitions and explanations are available from the Office for National Statistics website.
http://www.statistics.gov.uk/census2001/outputclassifications.asp

Ward Unemployment

Wards	1991 Census		1996 Average		1997 Average		1998Average		1999 Average		2000 Average		2001 Average		2002 Average		Jan-Sept 2003 Average	
	No	%	No	%	No	%	No	%	No	%	No	%	No	%	No	%	No	%
Abbey	822	13.9	823	15.4	646	11.8	520	9.5	498	9.2	486	8.9	471	8.0	439	7.4	419	7.1
Allestree	185	3.1	161	3.7	108	2.6	76	1.8	74	1.8	80	1.9	76	1.6	72	1.2	60	1.3
Alvaston	522	8.8	588	12.8	497	10.3	392	8.2	349	7.2	303	6.3	307	5.9	287	4.9	279	5.4
Babington	1,102	18.6	1,102	26.0	876	21.3	709	17.2	672	16.5	654	16.0	663	14.9	612	10.3	646	14.5
Blagreaves	301	5.1	285	6.0	210	4.3	158	3.3	154	3.2	144	3.0	161	3.1	154	2.6	134	2.6
Boulton	461	7.8	274	5.2	161	3.1	116	2.2	104	2.0	104	2.0	106	1.9	92	1.6	82	1.4
Breadsall	611	10.3	519	6.2	372	4.1	297	3.3	281	3.1	259	2.9	269	2.8	262	4.4	244	2.5
Chaddesden	438	7.4	365	7.3	282	5.7	211	4.2	210	4.3	202	4.1	199	3.7	185	3.1	177	3.3
Chellaston	357	6.0	337	6.6	254	4.7	203	3.8	199	3.7	187	3.5	185	3.2	179	3.0	161	2.8
Darley	392	6.6	424	8.7	312	6.4	230	4.8	206	4.2	185	3.8	178	3.4	178	3.0	158	3.0
Derwent	766	13.0	605	14.6	471	11.3	373	9.1	360	8.7	325	7.9	351	7.8	328	5.5	316	7.0
Kingsway	285	4.8	221	5.3	174	4.3	138	3.5	119	2.9	121	3.0	127	2.9	109	1.8	118	2.7
Litchurch	1,113	18.8	996	24.6	814	20.1	683	17.2	649	16.1	635	15.8	652	14.9	571	9.6	598	13.7
Littleover	296	5.0	251	6.5	191	4.9	153	4.0	148	3.8	133	3.4	122	2.9	124	2.1	118	2.8
Mackworth	351	5.9	262	7.6	189	5.8	144	4.5	123	3.8	132	4.1	131	3.7	112	1.9	95	2.7
Mickleover	194	3.3	180	3.4	128	2.4	100	1.9	85	1.6	88	1.6	93	1.6	89	1.5	88	1.5
Normanton	621	10.5	515	13.5	397	10.2	322	8.3	302	7.8	304	7.9	309	7.3	295	5.0	299	7.1
Osmaston	722	12.2	524	15.9	418	13.1	348	10.9	325	10.2	309	9.7	322	9.3	300	5.1	295	8.5
Sinfin	659	11.1	605	12.8	471	9.7	374	7.8	365	7.5	364	7.6	353	6.8	334	5.6	346	6.6
Spondon	388	6.6	354	5.7	257	4.1	193	3.2	181	2.9	173	2.7	161	2.4	151	2.6	149	2.2
DERBY	**10,584**	**10.2**	**9,392**	**9.9**	**7,226**	**7.5**	**5,742**	**6.1**	**5,403**	**5.7**	**5,189**	**5.5**	**5,235**	**5.1**	**4,871**	**4.7**	**4,782**	**4.6**


Average rate of Unemployment
30
25
20
15
10
5
0
%
1991 Census
1996
1997
1998
1999
2000
2001
2002
Year
Babington
Derwent
Litchurch
Osmaston
DERBY

Wards	1991 Census		1996 Average		1997 Average		1998Av
	No	%	No	%	No	%	No
Babington	1,102	18.6	1,102	26.0	876	21.3	709
Derwent	766	13.0	605	14.6	471	11.3	373
Litchurch	1,113	18.8	996	24.6	814	20.1	683
Osmaston	722	12.2	524	15.9	418	13.1	348
DERBY	**10,584**	**10.2**	**9,392**	**9.9**	**7,226**	**7.5**	**5,742**

	1991 Cens	1996	1997	1998	1999	2000	2001
Babington	18.6	26	21.3	17.2	16.5	16	14.9
Derwent	13	14.6	11.3	9.1	8.7	7.9	7.8
Litchurch	18.8	24.6	20.1	17.2	16.1	15.8	14.9
Osmaston	12.2	15.9	13.1	10.9	10.2	9.7	9.3
DERBY	10.2	9.9	7.7	6.1	5.7	5.5	5.1

verage	1999 Average		2000 Average		2001 Average		2002 Average	
%	No	%	No	%	No	%	No	%
17.2	672	16.5	654	16.0	663	14.9	612	10.3
9.1	360	8.7	325	7.9	351	7.8	328	5.5
17.2	649	16.1	635	15.8	652	14.9	571	9.6
10.9	325	10.2	309	9.7	322	9.3	300	5.1
6.1	**5,403**	**5.7**	**5,189**	**5.5**	**5,235**	**5.1**	**4,871**	**4.7**

2002
10.3
5.5
9.6
5.1
4.7

Jan-Sept 2003 Average	
No	**%**
646	14.5
316	7.0
598	13.7
295	8.5
4,782	**4.6**

UNEMPLOYMENT BY NEW WARDS

Wards	Econ. Act 16-74	MAY-DEC 2002		JANUARY 2003		FEBRUARY 2003		MARCH 2003		APRIL 2003		MAY 2003		JUNE 2003		JULY 2003		AUGUST 2003		SEPTEMBER 2003	
		no	%	no	%	no	%	no	%	no	%	no	%	no	%	no	%	no	%	no	%
Abbey	5,682	317	5.6	322	5.7	319	5.6	329	5.8	331	5.8	319	5.6	298	5.2	304	5.4	305	5.4	284	5.0
Allestree	5,925	82	1.4	78	1.3	80	1.4	69	1.2	68	1.1	63	1.1	65	1.1	82	1.4	81	1.4	83	1.4
Alvaston	6,362	376	5.9	384	6.0	412	6.5	393	6.2	383	6.0	365	5.7	340	5.3	349	5.5	356	5.6	364	5.7
Arboretum	5,178	875	16.9	973	18.8	941	18.2	929	17.9	942	18.2	941	18.2	940	18.2	951	18.4	964	18.6	943	18.2
Blagreaves	5,953	132	2.2	136	2.3	150	2.5	139	2.3	126	2.1	116	1.9	115	1.9	92	1.5	103	1.7	116	1.9
Boulton	5,994	244	4.1	255	4.3	265	4.4	247	4.1	227	3.8	228	3.8	208	3.5	203	3.4	205	3.4	198	3.3
Chaddesden	6,224	229	3.7	238	3.8	248	4.0	235	3.8	240	3.9	235	3.8	222	3.6	197	3.2	201	3.2	192	3.1
Chellaston	5,938	128	2.1	126	2.1	140	2.4	132	2.2	129	2.2	118	2.0	120	2.0	112	1.9	122	2.1	120	2.0
Darley	5,929	269	4.5	267	4.5	281	4.7	271	4.6	256	4.3	239	4.0	245	4.1	256	4.3	257	4.3	251	4.2
Derwent	5,921	356	6.0	393	6.6	404	6.8	383	6.5	359	6.1	358	6.0	324	5.5	319	5.4	336	5.7	312	5.3
Littleover	6,192	111	1.8	112	1.8	123	2.0	106	1.7	114	1.8	103	1.7	103	1.7	99	1.6	95	1.5	106	1.7
Mackworth	5,585	241	4.3	251	4.5	260	4.7	236	4.2	224	4.0	225	4.0	198	3.5	214	3.8	225	4.0	219	3.9
Mickleover	6,899	90	1.3	91	1.3	93	1.3	90	1.3	82	1.2	81	1.2	87	1.3	89	1.3	96	1.4	90	1.3
Normanton	5,285	544	10.3	583	11.0	566	10.7	566	10.7	571	10.8	564	10.7	577	10.9	545	10.3	559	10.6	558	10.6
Oakwood	7,604	127	1.7	130	1.7	130	1.7	126	1.7	126	1.7	123	1.6	109	1.4	112	1.5	118	1.6	111	1.5
Sinfin	5,949	489	8.2	522	8.8	542	9.1	521	8.8	494	8.3	509	8.6	502	8.4	451	7.6	447	7.5	472	7.9
Spondon	5,916	139	2.3	165	2.8	169	2.9	161	2.7	162	2.7	145	2.5	139	2.3	127	2.1	121	2.0	130	2.2
Derby	**102,536**	**4,750**	**4.6**	**5,026**	**4.9**	**5,123**	**5.0**	**4,933**	**4.8**	**4,834**	**4.7**	**4,732**	**4.6**	**4,592**	**4.5**	**4,502**	**4.4**	**4,591**	**4.5**	**4,549**	**4.4**
Derby old wards (CC)	**105,826**	**4,832**	**4.6**	**5,039**	**4.8**	**5,133**	**4.9**	**4,950**	**4.7**	**4,856**	**4.6**	**4,751**	**4.5**	**4,604**	**4.4**	**4,525**	**4.3**	**4,613**	**4.4**	**4,566**	**4.3**

UNEMPLOYMENT BY NEW WARDS

Wards	All 16-74	MAY-DEC 2002		JANUARY 2003		FEBRUARY 2003		MARCH 2003		APRIL 2003		MAY 2003		JUNE 2003		JULY 2003		AUGUST 2003		SEPTEMBER 2003	
		no	%	no	%	no	%	no	%	no	%	no	%	no	%	no	%	no	%	no	%
Abbey	9,281	317	3.4	322	3.5	319	3.4	329	3.5	331	3.6	319	3.4	298	3.2	304	3.3	305	3.3	284	3.1
Allestree	9,357	82	0.9	78	0.8	80	0.9	69	0.7	68	0.7	63	0.7	65	0.7	82	0.9	81	0.9	83	0.9
Alvaston	9,634	376	3.9	384	4.0	412	4.3	393	4.1	383	4.0	365	3.8	340	3.5	349	3.6	356	3.7	364	3.8
Arboretum	9,825	875	8.9	973	9.9	941	9.6	929	9.5	942	9.6	941	9.6	940	9.6	951	9.7	964	9.8	943	9.6
Blagreaves	8,954	132	1.5	136	1.5	150	1.7	139	1.6	126	1.4	116	1.3	115	1.3	92	1.0	103	1.2	116	1.3
Boulton	9,446	244	2.6	255	2.7	265	2.8	247	2.6	227	2.4	228	2.4	208	2.2	203	2.1	205	2.2	198	2.1
Chaddesden	9,299	229	2.5	238	2.6	248	2.7	235	2.5	240	2.6	235	2.5	222	2.4	197	2.1	201	2.2	192	2.1
Chellaston	8,520	128	1.5	126	1.5	140	1.6	132	1.5	129	1.5	118	1.4	120	1.4	112	1.3	122	1.4	120	1.4
Darley	9,385	269	2.9	267	2.8	281	3.0	271	2.9	256	2.7	239	2.5	245	2.6	256	2.7	257	2.7	251	2.7
Derwent	9,373	356	3.8	393	4.2	404	4.3	383	4.1	359	3.8	358	3.8	324	3.5	319	3.4	336	3.6	312	3.3
Littleover	8,728	111	1.3	112	1.3	123	1.4	106	1.2	114	1.3	103	1.2	103	1.2	99	1.1	95	1.1	106	1.2
Mackworth	9,319	241	2.6	251	2.7	260	2.8	236	2.5	224	2.4	225	2.4	198	2.1	214	2.3	225	2.4	219	2.4
Mickleover	9,881	90	0.9	91	0.9	93	0.9	90	0.9	82	0.8	81	0.8	87	0.9	89	0.9	96	1.0	90	0.9
Normanton	9,132	544	6.0	583	6.4	566	6.2	566	6.2	571	6.3	564	6.2	577	6.3	545	6.0	559	6.1	558	6.1
Oakwood	9,935	127	1.3	130	1.3	130	1.3	126	1.3	126	1.3	123	1.2	109	1.1	112	1.1	118	1.2	111	1.1
Sinfin	9,333	489	5.2	522	5.6	542	5.8	521	5.6	494	5.3	509	5.5	502	5.4	451	4.8	447	4.8	472	5.1
Spondon	8,754	139	1.6	165	1.9	169	1.9	161	1.8	162	1.9	145	1.7	139	1.6	127	1.5	121	1.4	130	1.5
Derby	**158,156**	**4,750**	**3.0**	**5,026**	**3.2**	**5,123**	**3.2**	**4,933**	**3.1**	**4,834**	**3.1**	**4,732**	**3.0**	**4,592**	**2.9**	**4,502**	**2.8**	**4,591**	**2.9**	**4,549**	**2.9**
Derby old wards (CC)	**157,935**	**4,832**	**3.1**	**5,039**	**3.2**	**5,133**	**3.3**	**4,950**	**3.1**	**4,856**	**3.1**	**4,751**	**3.0**	**4,604**	**2.9**	**4,525**	**2.9**	**4,613**	**2.9**	**4,566**	**2.9**

In these tables the rates for the old ward totals in the bottom line have been converted respectively to 1991 Census figures for the economically active population aged 16-74, and the total 16-74 to enable direct comparisons. The rates cited here will differ from the claimant count tables for the old wards sent out each month which are still based on the 1991 economically active populations for males (16-64) and females (16-59).

CASUALTIES IN DERBY - 01/01/2000 TO 31/12/2002 (36 months)

Derwent NDC							
	Pedestrian	Cyclist	TWMV	Car/Taxi user	PCV	Other	Total
All KSI	11	3	4	5	0	1	**24**
Child KSI	5	1	0	0	0	0	**6**
All Slight	13	17	16	127	4	5	**182**
Child Slight	6	5	0	15	1	0	**27**

Normanton NRF							
	Pedestrian	Cyclist	TWMV	Car/Taxi user	PCV	Other	Total
All KSI	29	4	9	12	1	0	**55**
Child KSI	7	1	0	1	0	0	**9**
All Slight	93	48	31	343	10	16	**541**
Child Slight	30	4	1	31	3	0	**69**

Osmaston NRF							
	Pedestrian	Cyclist	TWMV	Car/Taxi user	PCV	Other	Total
All KSI	10	4	10	7	0	0	**31**
Child KSI	6	0	0	2	0	0	**8**
All Slight	28	29	23	105	0	6	**191**
Child Slight	16	7	1	8	0	0	**32**

All City							
	Pedestrian	Cyclist	TWMV	Car/Taxi user	PCV	Other	Total
All KSI	119	53	80	111	3	4	**370**
Child KSI	42	8	2	3	1	0	**56**
All Slight	371	261	219	1840	65	92	**2848**
Child Slight	134	64	5	141	13	3	**360**

SCHEME NAME	DESCRIPTION	DATE IMPLEMENTED	COST	COLLISIONS DURING 36 MONTHS BEFORE IMPLEMENTATION DATE	COLLISIONS UPTO 36 MONTHS AFTER IMPLEMENTATION DATE	MONTHS SINCE IMPLEMENTATION DATE	COLLISIONS FACTORED UPTO 36 MONTH EQUIVALENT	COLLISION SAVING (ACTUAL OR PROJECTED)
DERWENT NEW DEAL AREA								
Sir Frank Whittle Road Pentagon Approach	Anti-skid surfacing	April-95	£6,000	11	8	36	**8**	3
Chaddesden West Phase 1	traffic calming	December-95	£40,000	33	18	36	**18**	15
Chaddesden Park Road/Nottingham Road	junction improvement	April-96	£22,000	8	8	36	**8**	0
Nottingham Road	traffic signs and markings	March-97	£6,500	18	14	36	**14**	4
A61 Pentagon to Croft Lane	traffic signs and markings	April-98	£41,000	40	29	36	**29**	11
Pentagon Signalisation	traffic signals	June-02	£100,000	47	7	8	**32**	16
OSMASTON NEIGHBOURHOOD RENEWAL FUND AREA								
Osmaston Road - Litchurch Lane to Ascot Drive	junction build outs and lining	April-97	£47,000	25	22	36	**22**	3
Osmaston Triangle Phase 1	traffic calming	March-98	£65,000	30	10	36	**10**	20
Osmaston Triangle Phase 3	traffic calming	March-99	£45,000	13	13	36	**13**	0
Chellaston Road/Merrill Way junction	signals improvement	May-99	£42,000	14	6	36	**6**	8
Boulton Area Traffic Calming Scheme	traffic calming	May-00	£224,000	61	39	33	**43**	18
Osmaston Road/Chellaston Road Mobile safety Cameras	mobile safety cameras	January-01	£3,500	109	59	25	**85**	24
NORMANTON NEIGHBOURHOOD RENEWAL FUND AREA								
Douglas St/A514	junction improvement	May-95	£10,000	9	10	36	**10**	-1
St Chads Rd Phase 1	signing and lining	April-96	£3,000	11	4	36	**4**	7
Dairyhouse Rd area	traffic calming	April-96	£50,000	42	17	36	**17**	25
Osmaston Road/Ivy Sq Pelican	pelican crossing	December-96	£18,000	6	6	36	**6**	0
London Road/Hulland Street	junction improvement	March-97	£3,800	7	2	36	**2**	5
Green Ln/Burton Road	junction improvement	March-97	£20,000	11	10	36	**10**	1
St Chads Rd Phase 2	priority change and road closure	March-97	£18,000	5	4	36	**4**	1
London Road Traffic St to Oxford St	junction improvement and signing ar	April-99	£67,000	36	18	36	**18**	18
Hartington St	junction improvement	September-99	£6,800	5	0	36	**0**	5
Douglas St/A514	junction improvement	November-99	£3,000	9	4	36	**4**	5
Normanton Rd/Mill Hill Ln	junction improvement	November-99	£4,800	5	3	36	**3**	2
Clarence Rd area traffic calming	traffic calming	March-00	£46,000	28	17	35	**17**	11
Upperdale Rd/Stanhope St	traffic calming	March-00	£12,000	22	10	35	**10**	12
Burton Rd (mobile cameras)	mobile safety cameras	January-01	£3,500	26	13	25	**19**	7
London Road (mobile cameras)	mobile safety cameras	January-01	£3,500	50	33	25	**48**	2
Osmaston Road/Chellaston Road Mobile safety Cameras	mobile safety cameras	January-01	£3,500	109	59	25	**85**	24
Peartree Rd	pelican crossing	December-01	£15,000	7	1	14	**3**	4

Derby Pointer Panel May 2003– Responses to the survey on self assessment of health and participation in sports and physical activities

		Count	Col %
Over the last 12 months would you say your health has on the whole been...?	good	215	41.2
	fairly good	208	39.8
	not good	99	19.0
Total		522	100.0

		Count	Col %
How often do you take part in walking or hikes of two miles or more?	more than once a week	139	26.6
	about once a week	60	11.5
	about once a month	72	13.8
	less often	68	13.0
	never	146	27.9
	can't say/it varies	38	7.3
Total		523	100.0

		Count	Col %
Excluding walking or hiking, have you taken part in any sports or physical activities on at least one occasion in the previous 4 weeks?	yes	216	41.5
	no	305	58.5
Total		521	100.0

		Cases	Col Response %
If no, please tell us why	too busy/no time	74	26.9
	disabled/limited mobility	65	23.6
	have a medical condition	54	19.6
	old age	34	12.4
	don't like sport/not interested	30	10.9
	walking is sufficient	16	5.8
	get exercise at work/working	10	3.6
	too expensive	9	3.3
	too tired	7	2.5
	no local facilities	7	2.5
	get exercise doing housework	4	1.5
	unfit	3	1.1
	no childcare provision	3	1.1
	no reason	2	.7
	no one to go with	2	.7
	new to area	1	.4
	no confidence	1	.4
	not safe to go out	1	.4
	no transport	1	.4
	don't know	1	.4
Total		275	118.2

		Cases	Col Response %
If yes, which sports or physical activities have you undertaken in the previous 4 weeks?	swimming	70	32.9
	gymnasium workout	70	32.9
	cycling	39	18.3
	(dog) walking	19	8.9
	exercise at home	15	7.0
	golf	15	7.0
	football	15	7.0
	jogging	14	6.6
	gardening	11	5.2
	badminton	7	3.3
	dancing (unspecified)	7	3.3
	lawn bowls	6	2.8
	martial arts	6	2.8
	horse riding	4	1.9
	yoga	4	1.9
	netball/basketball	4	1.9
	DIY	3	1.4
	squash/racketball	3	1.4
	voluntary (construction) project	2	.9
	tennis	2	.9
	housework	2	.9
	sailing	2	.9
	snooker/pool	2	.9
	paint balling	1	.5
	line dancing	1	.5
	indoor cricket	1	.5
	shooting	1	.5
	tap dancing	1	.5
	salsa dancing	1	.5
	sword fencing	1	.5
	climbing	1	.5
	fishing	1	.5
Total		213	155.4

Directly standardised mortality rates

The tables Circulatory Disease and Cancer give, for each ward in Trent and Northamptonshire, the death rate per 100,000 population, directly standardised for age, from all circulatory diseases and from all cancers, for persons aged under 75. They also give 95% confidence limits for these figures.

These figures are based on deaths for the years 1995–99 and population estimates for mid-1998. The standard population used is the European standard population.

Sources

The figures in this spreadsheet have been calculated using data from the following sources:

Mortality data obtained from the ONS mortality file for the years 1995–99, based on year of registration.

Population estimates for mid-1998, prepared from:
1991 Census ward populations and Estimating With Confidence enumeration district populations;
Oxford University 1998 estimates for ward populations;
ONS 1998 mid-year estimates for local authority populations;
1998 births data from ONS births file.

These various data sets were combined to give estimates of the 1998 ward populations in age-sex groups.

Illustrations of Health Inequalities: Life Expectancy
Trent Public Health Observatory 2002

Ward	Code	Male Life Expectancy at (years)	95% Conf. Limits	Female Life Expectancy (years)	95% Conf. Limits
Trent and Northamptonshire		**75.4**	**(75.3, 75.4)**	**80.3**	**(80.2, 80.4)**
Derby UA					
Abbey	00FKMA	72.7	(71.2, 74.3)	80.4	(78.9, 81.9)
Allestree	00FKMB	80.0	(78.2, 81.8)	85.7	(83.4, 88.0)
Alvaston	00FKMC	73.7	(71.8, 75.5)	81.0	(79.0, 82.9)
Babington	00FKMD	70.7	(69.2, 72.3)	78.8	(76.9, 80.8)
Blagreaves	00FKME	75.9	(74.2, 77.6)	85.0	(83.3, 86.8)
Boulton	00FKMF	74.4	(72.9, 75.9)	78.8	(77.3, 80.4)
Breadsall	00FKMG	76.7	(75.3, 78.1)	81.9	(80.3, 83.4)
Chaddesden	00FKMH	75.8	(74.2, 77.5)	81.4	(79.3, 83.4)
Chellaston	00FKMJ	75.7	(74.4, 77.1)	81.4	(80.2, 82.7)
Darley	00FKMK	74.2	(72.7, 75.8)	78.7	(77.1, 80.3)
Derwent	00FKML	71.9	(70.1, 73.7)	79.1	(77.2, 80.9)
Kingsway	00FKMM	76.6	(75.3, 77.8)	77.6	(75.4, 79.8)
Litchurch	00FKMN	69.9	(68.1, 71.7)	76.5	(74.7, 78.2)
Littleover	00FKMP	76.5	(74.7, 78.3)	82.1	(80.4, 83.7)
Mackworth	00FKMQ	75.0	(73.1, 77.0)	80.4	(78.6, 82.2)
Mickleover	00FKMR	75.7	(73.7, 77.7)	82.2	(80.5, 83.9)
Normanton	00FKMS	72.2	(70.4, 74.0)	78.2	(76.6, 79.9)
Osmaston	00FKMT	69.0	(67.0, 71.0)	75.5	(73.6, 77.4)
Sinfin	00FKMU	74.8	(72.7, 76.9)	80.0	(77.8, 82.3)
Spondon	00FKMW	76.2	(74.7, 77.8)	80.7	(79.4, 81.9)

Illustrations of Health Inequalities:Deaths from Circulatory Disease
Trent Public Health Observatory 2002

Ward	Code	Deaths from circulatory disease Deaths	DSR	95% Conf. Limits
Trent and Northamptonshire		**44247**	**140.3**	**(139.0, 141.7)**
Derby UA				
Abbey	00FKMA	101	174.6	(141.1, 213.5)
Allestree	00FKMB	69	89.9	(68.6, 115.4)
Alvaston	00FKMC	89	182.2	(145.4, 225.2)
Babington	00FKMD	103	249.4	(202.8, 303.4)
Blagreaves	00FKME	86	110.4	(87.6, 137.1)
Boulton	00FKMF	110	159.2	(130.0, 192.7)
Breadsall	00FKMG	134	126.8	(106.1, 150.4)
Chaddesden	00FKMH	80	123.3	(96.9, 154.4)
Chellaston	00FKMJ	112	148.4	(121.2, 179.6)
Darley	00FKMK	94	124.1	(99.4, 152.9)
Derwent	00FKML	79	169.9	(133.5, 212.9)
Kingsway	00FKMM	69	110.1	(85.3, 139.9)
Litchurch	00FKMN	108	242.9	(197.9, 294.8)
Littleover	00FKMP	62	128.9	(98.2, 166.0)
Mackworth	00FKMQ	90	146.9	(116.0, 183.1)
Mickleover	00FKMR	46	86.4	(62.8, 115.8)
Normanton	00FKMS	81	200.9	(158.4, 251.0)
Osmaston	00FKMT	80	215.4	(170.0, 269.1)
Sinfin	00FKMU	70	162.8	(126.4, 206.2)
Spondon	00FKMW	82	110.6	(87.1, 138.2)

Illustrations of Health Inequalities: Deaths from Cancer
Trent Public Health Observatory 2002

Ward	Code	Deaths from cancer aged Deaths	DSR	95% Conf. Limits
Trent and Northamptonshire		**42076**	**138.2**	**(136.9, 139.6)**
Derby UA				
Abbey	00FKMA	71	135.7	(104.9, 172.5)
Allestree	00FKMB	67	94.2	(71.9, 121.0)
Alvaston	00FKMC	73	160.9	(125.3, 203.2)
Babington	00FKMD	58	135.4	(102.2, 175.8)
Blagreaves	00FKME	67	87.9	(67.5, 112.3)
Boulton	00FKMF	112	177.4	(145.1, 214.6)
Breadsall	00FKMG	123	119.8	(99.3, 143.2)
Chaddesden	00FKMH	62	103.7	(78.5, 134.2)
Chellaston	00FKMJ	94	128.0	(102.4, 157.8)
Darley	00FKMK	94	131.4	(105.4, 161.8)
Derwent	00FKML	78	164.0	(128.7, 205.7)
Kingsway	00FKMM	62	107.9	(82.2, 138.8)
Litchurch	00FKMN	72	162.0	(125.9, 205.1)
Littleover	00FKMP	52	118.9	(88.3, 156.4)
Mackworth	00FKMQ	79	125.5	(97.7, 158.3)
Mickleover	00FKMR	65	123.7	(94.9, 158.4)
Normanton	00FKMS	49	122.6	(90.0, 163.0)
Osmaston	00FKMT	68	196.3	(151.6, 249.7)
Sinfin	00FKMU	59	133.7	(101.3, 173.1)
Spondon	00FKMW	103	144.3	(117.0, 175.9)

Index of Multiple Deprivation-2000

Ward	Ward Name (2001)	Index of Multiple Deprivation Score	Rank of Index of Multiple Deprivation
FKMN	Litchurch	66.84	130
FKMT	Osmaston	62.66	218
FKMD	Babington	59.00	287
FKML	Derwent	53.89	437
FKMS	Normanton	44.70	840
FKMU	Sinfin	39.68	1142
FKMF	Boulton	33.85	1590
FKMC	Alvaston	33.43	1628
FKMQ	Mackworth	32.62	1708
FKMA	Abbey	28.17	2208
FKMH	Chaddesden	25.22	2622
FKMJ	Chellaston	22.15	3151
FKMG	Breadsall	20.41	3476
FKME	Blagreaves	19.68	3623
FKMP	Littleover	17.94	3981
FKMW	Spondon	16.22	4372
FKMK	Darley	14.42	4885
FKMM	Kingsway	14.26	4931
FKMR	Mickleover	5.95	7804
FKMB	Allestree	5.53	7914

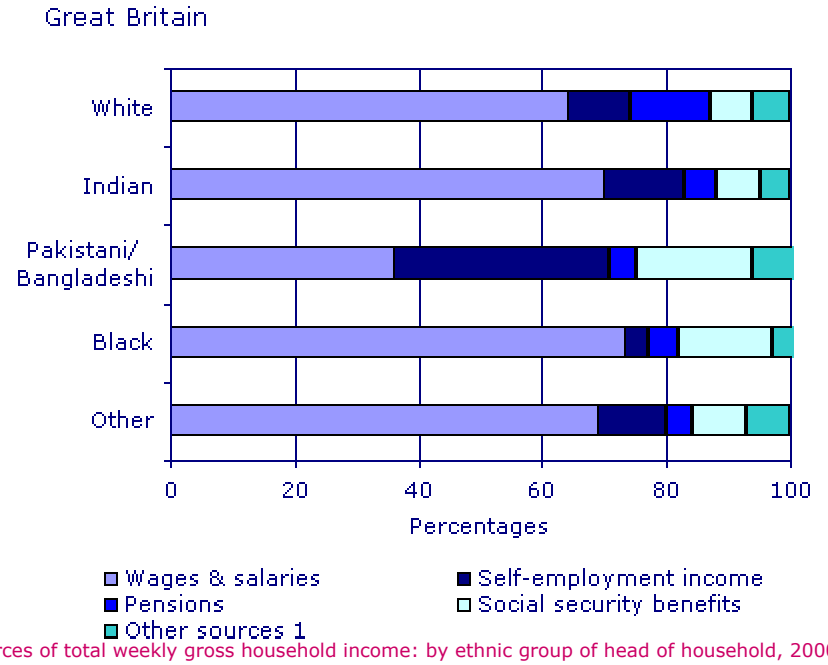
Table 6.1 Deaths: age and sex

England and Wales — Numbers (thousands) and rates

Year and quarter	All ages	Age group: Under 1*	1–4	5–9	10–14	15–19	20–24	25–34	35–44	45–54	55–64	65–74	75–84	85 and over
Numbers (thousands)														
Males														
1976	300.1	4.88	0.88	0.68	0.64	1.66	1.66	3.24	5.93	20.4	52.0	98.7	80.3	29.0
1981	289.0	4.12	0.65	0.45	0.57	1.73	1.58	3.18	5.54	16.9	46.9	92.2	86.8	28.5
1986	287.9	3.72	0.57	0.33	0.38	1.43	1.75	3.10	5.77	14.4	43.6	84.4	96.2	32.2
1991	277.6	2.97	0.55	0.34	0.35	1.21	1.76	3.69	6.16	13.3	34.9	77.2	95.8	39.3
1996	268.7	2.27	0.44	0.24	0.29	0.93	1.41	4.06	5.84	13.6	30.1	71.0	90.7	47.8
1998	264.7	2.07	0.41	0.24	0.29	0.88	1.29	4.01	5.90	13.6	29.1	66.1	90.5	50.4
1999	264.3	2.08	0.41	0.22	0.28	0.90	1.27	3.85	5.93	13.6	28.7	64.3	90.4	52.3
2000	255.5	1.89	0.34	0.22	0.28	0.87	1.22	3.76	6.05	13.4	27.9	60.6	87.1	51.9
2001	252.4	1.81	0.32	0.19	0.28	0.88	1.27	3.63	6.07	13.3	27.5	57.5	87.0	52.7
2002	253.2	1.81	0.32	0.20	0.28	0.84	1.24	3.47	6.20	12.9	27.7	56.3	88.3	53.6
Females														
1976	298.5	3.46	0.59	0.45	0.42	0.62	0.67	1.94	4.04	12.8	29.6	67.1	104.7	72.1
1981	288.9	2.90	0.53	0.30	0.37	0.65	0.64	1.82	3.74	10.5	27.2	62.8	103.6	73.9
1986	293.3	2.59	0.49	0.25	0.27	0.56	0.67	1.65	3.83	8.8	25.8	58.4	106.5	83.6
1991	292.5	2.19	0.44	0.25	0.22	0.46	0.64	1.73	3.70	8.4	21.3	54.2	103.3	95.7
1996	291.5	1.69	0.32	0.18	0.20	0.43	0.51	1.85	3.66	8.9	18.2	50.2	96.7	108.7
1998	290.3	1.56	0.31	0.18	0.19	0.41	0.48	1.72	3.68	9.1	17.9	46.9	94.7	113.2
1999	291.8	1.55	0.30	0.17	0.22	0.39	0.47	1.67	3.79	9.0	18.0	45.1	93.9	117.2
2000	280.1	1.49	0.25	0.16	0.18	0.38	0.47	1.69	3.87	9.1	17.6	42.2	89.3	113.4
2001	277.9	1.43	0.27	0.19	0.18	0.38	0.47	1.59	3.77	8.9	17.6	40.5	88.8	113.9
2002	280.4	1.32	0.24	0.16	0.19	0.39	0.43	1.61	3.77	8.7	17.7	39.6	90.0	116.3
Rates (deaths per 1,000 population in each age group)														
Males														
1976	12.5	16.2	0.65	0.34	0.31	0.88	0.96	0.92	2.09	6.97	19.6	50.3	116.4	243.2
1981	12.0	12.6	0.53	0.27	0.29	0.82	0.83	0.89	1.83	6.11	17.7	45.6	105.2	226.5
1986	11.8	11.0	0.44	0.21	0.23	0.72	0.83	0.88	1.68	5.27	16.6	42.8	101.2	215.4
1991	11.2	8.3	0.40	0.21	0.23	0.72	0.89	0.94	1.76	4.56	13.9	38.1	93.1	205.6
1996	10.8	6.8	0.32	0.14	0.18	0.60	0.87	1.02	1.67	4.06	11.9	34.5	85.0	199.0
1998	10.6	6.4	0.31	0.14	0.17	0.55	0.87	1.04	1.63	4.00	11.3	32.4	81.1	193.9
1999	10.5	6.5	0.31	0.12	0.16	0.56	0.85	1.02	1.60	4.00	10.9	31.6	80.0	194.7
2000	10.1	6.1	0.26	0.13	0.16	0.54	0.81	1.01	1.60	3.93	10.4	29.8	76.0	187.7
2001	9.9	5.9	0.25	0.11	0.16	0.53	0.81	0.96	1.57	3.89	10.0	28.1	74.2	186.6
2002	9.9	5.9	0.25	0.12	0.16	0.49	0.78	0.94	1.58	3.86	9.7	27.2	73.6	188.1
2001 Sept	9.1	5.8	0.22	0.14	0.13	0.54	0.83	0.96	1.59	3.72	9.6	26.3	67.5	166.0
Dec	9.9	6.0	0.24	0.08	0.17	0.57	0.77	0.93	1.55	3.88	10.0	28.1	74.7	190.9
2002 March	10.8	6.7	0.35	0.14	0.19	0.52	0.78	0.94	1.60	4.05	10.1	29.5	81.1	217.0
June	9.5	5.7	0.23	0.13	0.14	0.50	0.79	0.96	1.52	3.78	9.4	26.7	70.4	178.3
Sept	9.1	5.3	0.22	0.10	0.15	0.49	0.81	1.00	1.61	3.73	9.3	25.1	66.9	163.9
Dec	10.1	6.0	0.22	0.10	0.15	0.47	0.75	0.88	1.57	3.87	10.0	27.7	76.1	193.8
2003** Marchp	10.6	6.0	0.25	0.11	0.18	0.51	0.82	0.96	1.67	3.90	10.3	28.1	79.9	213.7
Junep	9.6	5.7	0.23	0.11	0.13	0.45	0.79	0.90	1.65	3.73	9.6	26.0	72.4	180.0
Females														
1976	11.8	12.2	0.46	0.24	0.21	0.35	0.40	0.56	1.46	4.30	10.1	26.0	74.6	196.6
1981	11.3	9.4	0.46	0.19	0.19	0.32	0.35	0.52	1.26	3.80	9.5	24.1	66.2	178.2
1986	11.4	8.0	0.40	0.17	0.17	0.29	0.33	0.47	1.12	3.24	9.2	23.4	62.5	169.4
1991	11.2	6.4	0.33	0.16	0.15	0.29	0.33	0.44	1.05	2.87	8.2	21.8	58.7	161.6
1996	11.1	5.3	0.25	0.10	0.13	0.29	0.31	0.46	1.04	2.63	7.1	20.6	55.8	159.1
1998	11.0	5.0	0.24	0.11	0.12	0.26	0.32	0.43	1.00	2.64	6.8	19.8	53.9	159.3
1999	11.0	5.1	0.24	0.10	0.13	0.25	0.31	0.43	1.01	2.62	6.7	19.3	53.4	162.8
2000	10.5	5.1	0.20	0.10	0.11	0.25	0.30	0.44	1.01	2.63	6.4	18.1	50.9	155.4
2001	10.4	4.9	0.22	0.12	0.11	0.24	0.30	0.42	0.96	2.57	6.3	17.4	50.2	155.3
2002	10.5	4.5	0.20	0.10	0.11	0.24	0.27	0.44	0.94	2.55	6.0	17.0	50.5	159.8
2001 Sept	9.4	4.9	0.15	0.11	0.08	0.22	0.25	0.41	0.97	2.47	5.9	15.9	45.5	137.3
Dec	10.5	5.2	0.22	0.11	0.14	0.22	0.35	0.41	0.93	2.57	6.3	17.7	50.7	157.2
2002 March	11.7	4.7	0.21	0.11	0.12	0.30	0.26	0.44	1.01	2.60	6.2	18.5	55.9	185.6
June	9.9	4.4	0.18	0.07	0.14	0.20	0.31	0.44	0.91	2.54	5.9	16.7	47.9	147.5
Sept	9.5	4.1	0.19	0.10	0.12	0.22	0.23	0.47	0.91	2.41	5.9	16.0	45.7	140.6
Dec	10.8	4.9	0.21	0.12	0.08	0.25	0.28	0.40	0.94	2.63	6.2	17.0	52.5	166.0
2003**Marchp	11.5	5.3	0.25	0.08	0.08	0.22	0.36	0.46	1.01	2.59	6.3	17.7	55.6	181.2
Junep	10.1	4.6	0.23	0.11	0.16	0.25	0.28	0.44	0.92	2.53	6.0	16.3	50.3	151.2

Note: Figures represent the numbers of deaths registered in each year up to 1992 and the numbers of deaths occurring in each year from 1993.
* Rates per 1,000 live births.
** The rates for 2003 are based on the mid-2002 population estimates.
p Provisional registrations.

Sources of Income
Earnings, pensions and benefits



Sources of total weekly gross household income: by ethnic group of head of household, 2000/01

Minority ethnic groups have lower levels of household income than the White population. This pattern reflects considerable variation in the main sources of income.

Pakistani and Bangladeshi households were heavily reliant on social security benefits – which made up nearly a fifth (19 per cent) of their income. Benefits were also a considerable source of income for the Black group (15 per cent).

Pakistani and Bangladeshi households were the least likely to obtain income from earnings, reflecting their higher unemployment rates. Wages and salaries made up only around a third (36 per cent) of their total household income, whereas for other groups this proportion was around two-thirds.

Pakistani and Bangladeshi households were much more reliant on earnings from self-employment than other groups. Over a third of their total income came from this source compared with 13 per cent for Indians and around a tenth or less for other groups.

Pensions accounted for around 5 per cent of household income for each of the minority ethnic groups compared with 13 per cent for White people. This reflects the older age structure of the White population.

The "other sources" bar in the chart also includes investments and tax credits.

Source: Family Resources Survey, Department for Work and Pensions 2000/01.

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Glossary of Terms

Directly Standardised Rate Calculation
Direct standardisation is used to calculate the mortality rates for each electoral ward. Using the method of standardisation enables comparisons to be made between electoral wards with different age structures. The directly age-standardised mortality rate, is the rate that would occur in a standard population if that population had the age-specific rate of a given area. The European Standard Population rates are used.

Routine and Manual groups
The Office of National Statistics has revised the social classifications with the "routine and manual" now the correct term. It does not equate just to the old Social Classification V but, in broad terms, equates to the old SC V, IV and IIIM [i.e. the old "manual" grouping].

There are differences between the old and the new classifications - this is to take account of structural changes in employment such as the invention of call centres. So there is not exact equivalence.

Public Service Agreements
These are a new way for councils and the Government to work together to improve public services and tackle local and national priorities. Under the PSA the council promises to achieve better performance than it would have done in the absence of the agreement and the Government provides 'pump-priming' money to invest in service improvement and will pay performance reward grant if the targets are achieved.

Body mass index (BMI)
This uses a mathematical formula that takes into account both a person's height and weight. BMI equals a person's weight in kilograms divided by height in meters squared. (BMI=kg/m2)

Interpreting the Data

Risk of Associated Disease According to BMI and Waist Size			
BMI	Weight Category	Waist less than or equal to 40 in. (men) or 35 in. (women)	Waist greater than 40 in. (men) or 35 in. (women)
18.5 or less	Underweight	--	N/A
18.5 - 24.9	Normal	--	N/A
25.0 - 29.9	Overweight	Increased	High
30.0 - 34.9	Obese	High	Very High
35.0 - 39.9	Obese	Very High	Very High
40 or greater	Extremely Obese	Extremely High	Extremely High

Malignant melanoma is the most dangerous form of skin cancer. It affects more women than men. The disease is rare in children under 14 but its incidence increases with age.

Life Expectancy Definition (ONS)
This indicator shows the average life expectancy at birth, in years. The life expectancy at birth in an area is an estimate of the number of years a newborn would survive, were he/she to experience the particular area's age specific mortality rates for that time period throughout his/her life.

Primary Care Trusts
They are local NHS organisations responsible for planning and securing health services and improving the health of the local population.

HMOs- Houses in Multiple Occupation

Fitness Standard- Set of conditions established by the Housing Act 1985. These include: structurally stable; free from serious disrepair; free from dampness; have adequate provision for lighting, heating and ventilation; have adequate pipe supply of wholesome water supply; have satisfactory facilities for preparing and cooking food, have suitably located water closet for exclusive use of the occupants; have fixed bath or shower and hand wash basin; effective drainage system; and have adequate size and number of rooms for the level of occupancy.

Housing Health and Safety Rating System – A principle behind this is that the dwelling should provide a safe and healthy environment for the occupants and any visitors

ONS - Office of National Statistics

CHD - Coronary Heart Disease

Single Regeneration Budget- Government fund allocated through competitive bidding process to regenerate areas of deprivation

Premature Mortality Rate – death rate before age 75

European Social Fund URBAN II- European funding focusing on disadvantaged urban areas

Fresh Start – Local Cessation Service managed