# 4. Inequalities in Wigan

The World Health Organisation (WHO) Commission on the Social Determinants of Health (2008) makes three overarching recommendations to achieve health equity (reduce health inequalities):

1. Improve daily living conditions.

2. Tackle the inequitable distribution of power, money and resources.

3. Measure and assess problems, and the impacts of actions to address them.

60 years on from the creation of the NHS, and despite considerable investment in health and social care, inequalities in health status still exist. The 1998 independent review of health inequalities, undertaken by Sir Donald Acheson, the Chief Medical Officer at the time, had 39 recommendations in how to reduce inequalities – only 3 of them referred directly to the NHS, and they were:

- More equitable allocation of resources in the NHS.

- Extending the focus of clinical governance, NICE and the National Service Frameworks to give prominence to equal access to care.

- To performance manage equity, including asking the Directors of Public Health to produce equity profiles and triennial audits of progress.

The other 36 covered economic measures (reducing poverty, up-rating benefits and pensions) education (fruit in schools and other health promoting policies) maternal and child health (included reducing smoking in pregnancy, good quality early years education, support for Looked After Children) housing, employment, mobility and transport, nutrition and the Common Agricultural Policy, making Health Impact Assessments an integrated part of policy, helping maintain older people independent and active, work with young people (sexual health services, suicide prevention), ensuring the needs of specific groups within the population are met, e.g. ethnic minorities, gender-specific work, disabled people and carers.

## 4.1 Index of Multiple Deprivation

Table 1 shows that in 2007, Wigan borough is ranked as the 67th most deprived local authority district out of the 354 local authority districts in England; this is an improvement from the ranking of 53rd most deprived in 2004 (Indices of Deprivation).

Wigan has made progress against all of the summary measures (below), except on the employment scale, which has remained persistently in the 9th worst position.

| *Table 1* | **Rank of Wigan Borough out of 354 Local Authority districts in England where 1 is most deprived** | | |
|---|---|---|---|
| | **ID 2000** | **ID 2004** | **ID 2007** |
| **Average LSOA Score** - depicts the average level of deprivation across the entire district. | N/A | 53rd | 67th |
| **Average LSOA Rank** - depicts the average level of deprivation across the entire district. | N/A | 54th | 80th |
| **Extent** - the proportion of a district's population that lives in the most deprived Super Output Areas in England. | N/A | 52nd | 63rd |
| **Local Concentration** - shows the severity of multiple deprivation in each authority, measuring 'hot-spots' of deprivation. | N/A | 48th | 53rd |
| **Income Scale** - the number of people experiencing income deprivation retrospectively. | 30th | 40th | 41st |
| **Employment Scale** - the number of people experiencing employment deprivation retrospectively. | 9th | 9th | 9th |

Figure 4 shows the IMD percentage ranking and IMD actual ranking for all of Wigan Borough's 200 Lower Super Output Areas (LSOAs) out of the 32,482 LSOAs in England. 29 of Wigan's LSOAs fall within the 10% most deprived of all LSOAs nationally and these are highlighted in dark red on the map. 10 of Wigan's LSOAs fall within the 3% most deprived of all LSOAs nationally. Worsley Hall LSOA is the most deprived LSOA in the borough and is amongst the 1% most deprived nationally (ranked 240 out of 32,482).

*Figure 4 Index of Multiple Deprivation for Wigan's 200 LSOAs*

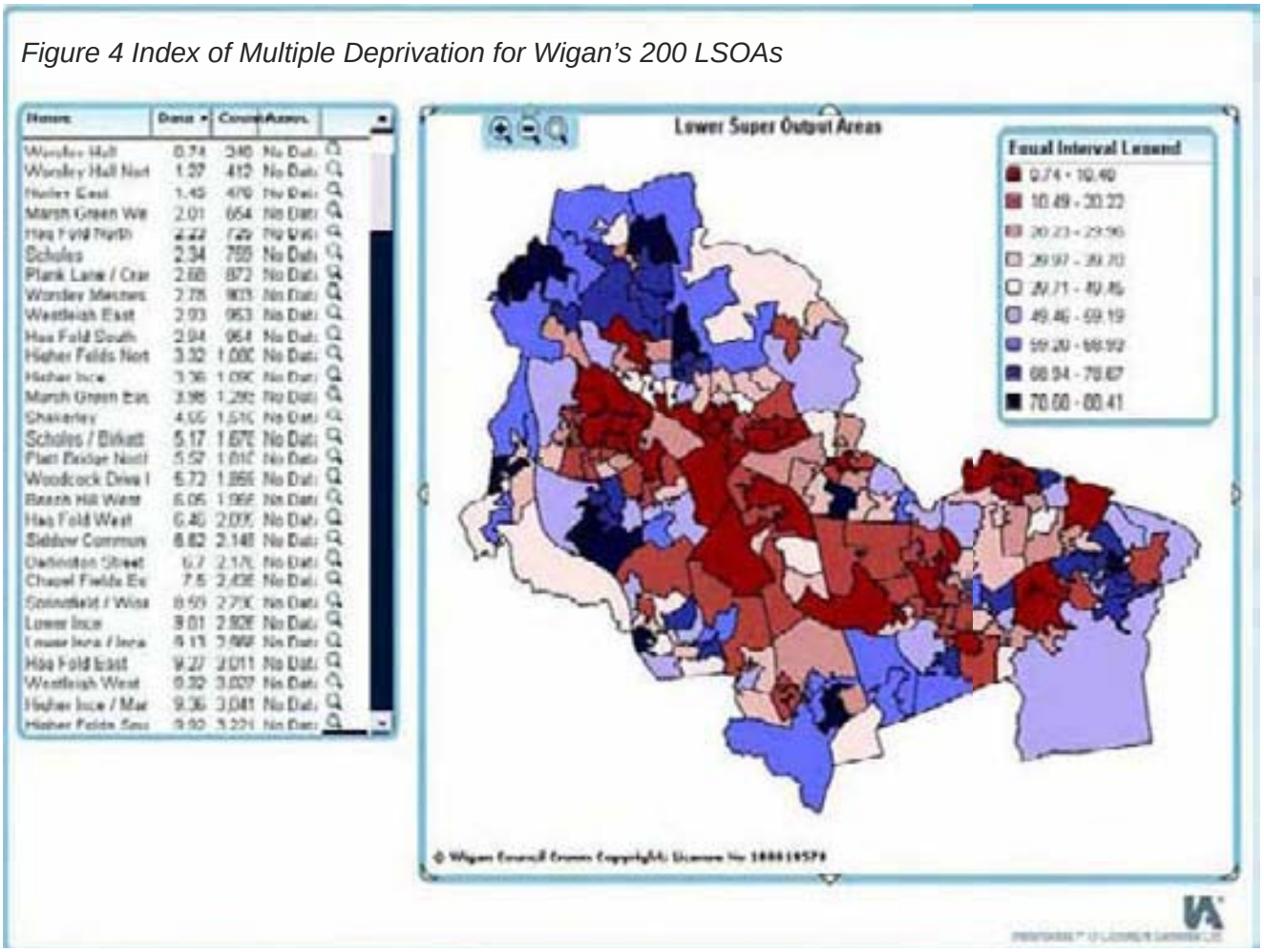



Table 2 shows the number Wigan's LSOAs which fall within the most deprived LSOAs in England for the IMD 2007 and each of its domains.

**The Health and Disability domain** is particularly high with 124 of Wigan's 200 LSOAs within the 30% most deprived nationally. In fact, Wigan ranks 20th out of 354 Local Authorities for health-related deprivation which denotes a very high level of health related deprivation.

**The Employment domain** is also high with 120 of Wigan's 200 LSOAs within the 30% most deprived nationally.

**The Income domain** reflects benefit dependence rather than levels of earned income from high quality jobs, and so the borough scores surprisingly (and probably misleadingly) well. The median weekly gross pay for a Wigan resident is £52 lower than average for England and £27 lower than the North West.

*Table 2*

| Number of Wigan's 200 LSOAs which fall within the most deprived LSOAs in England | | | | | |
|---|---|---|---|---|---|
| **Domain** | **Most deprived 10%** | **Most deprived 20%** | **Most deprived 30%** | **Most deprived 40%** | **Most deprived 50%** |
| **IMD Overall** | 29 | 64 | 85 | 110 | 129 |
| **Health & Disability** | 53 | 90 | 124 | 160 | 187 |
| **Employment** | 49 | 94 | 120 | 142 | 168 |
| **Crime** | 10 | 36 | 59 | 93 | 117 |
| **Education, Skills & Training** | 32 | 67 | 97 | 113 | 132 |
| **Living Environment** | 3 | 12 | 23 | 42 | 74 |
| **Income** | 20 | 44 | 72 | 89 | 104 |
| **Income Deprivation Affecting Children Index** | 15 | 30 | 57 | 77 | 91 |
| **Income Deprivation Affecting Older People Index** | 19 | 56 | 82 | 97 | 117 |
| **Barriers to Housing and Services** | 0 | 2 | 16 | 36 | 56 |

*Source: Indices of Multiple Deprivation 2007*

## 4.2 Targets and Progress

The government set Public Service Agreement (PSA) targets in 1999 to reduce inequalities between the fifth most deprived areas and the rest by 2010, specifically measured with the two headline indicators:

- Infant mortality
- Life expectancy

## 4.3 Infant Mortality

The rate of infant mortality (deaths under 1 year) in Wigan was 4.9/1000 live births in 2004 to 2006. This compares to 4.6/1000 in England. Wigan is within the average range, but better than the North West average of 5.4%. Child health is discussed in Section 14 of this document.

## 4.4 Health Inequalities National Support Team Review

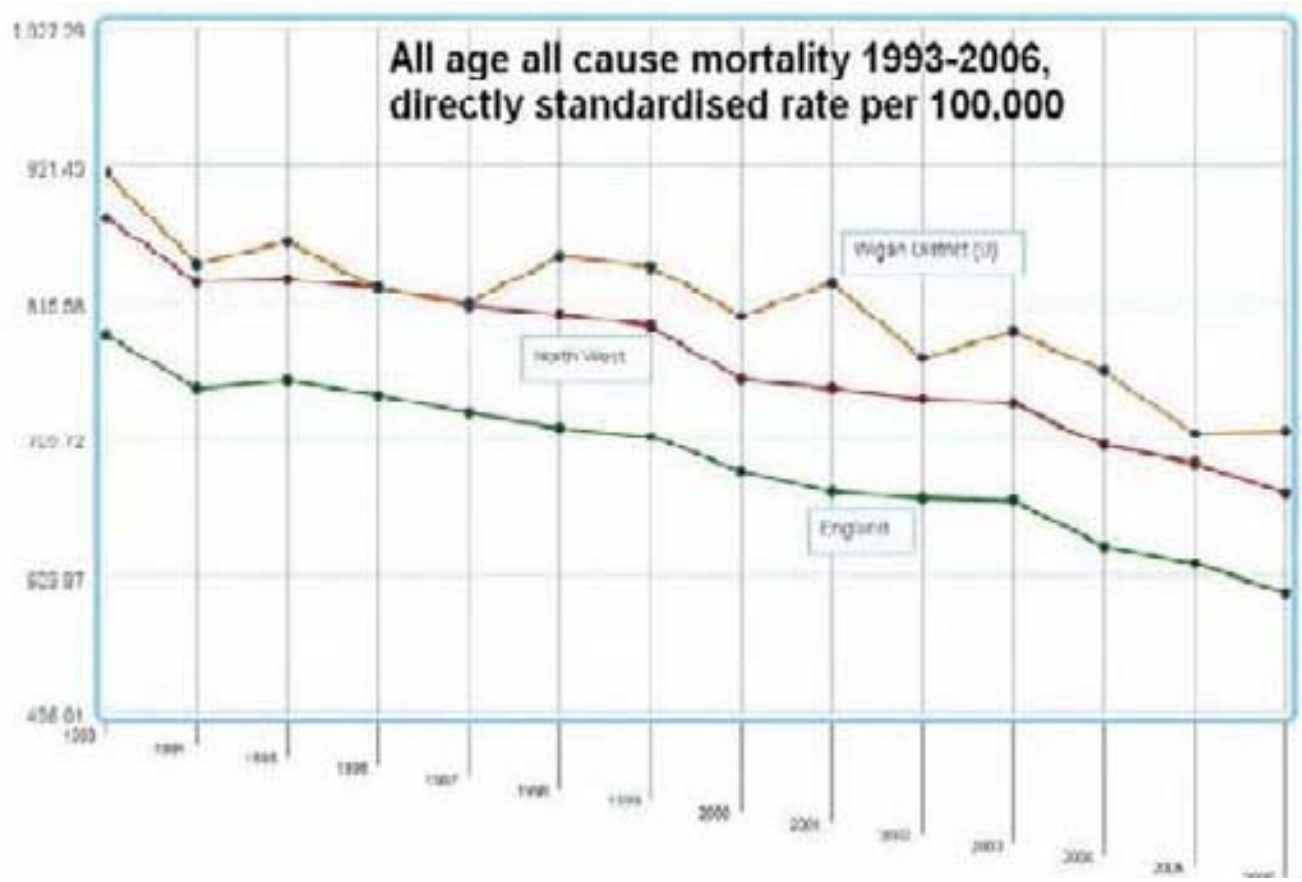
In February 2008, Wigan was reviewed by the Health Inequalities National Support Team (NST), which made significant recommendations to help the borough achieve the 2010 Life Expectancy target and sustain the improvement of healthy life expectancy beyond 2010. The NST recommendations on strategy, CVD, Cancer, Seasonal Excess Deaths, and Tobacco Control have been accepted by both the Board of Ashton Leigh and Wigan Primary Care Trust and the Wigan borough Partnership, Wigan's Local Strategic Partnership; they are at the core of the World Class Commissioning priorities for Wigan and inform the development of the initiatives for CVD, Tobacco Control, Cancer, set out in this document and the performance outcomes indicators chosen to monitor World Class Commissioning.

The PCT and key partners such as Wigan Council, Wrightington Wigan and Leigh NHS Trust (acute hospital), the Police, Fire Service and Wigan Leisure and Culture Trust are working closely with the NST on an agreed set of actions and a support programme. A progress review meeting will be held in December 2008.

# 5. Life Expectancy and mortality

The mortality rate is the number of deaths over the total population in a given time. In Wigan there are about 3000 deaths per year. The rate of all cause all age mortality has been decreasing in Wigan as elsewhere in the country since records began, as health has continued to improve. The graph below (Figure 5) compares the falling death rates for Wigan, the North West and England. It can be seen that the North West rate is higher than England, and Wigan's is higher still.

*Figure 5: All Age All Cause Mortality 1993 to 2006*



Life expectancy has been improving in England and the borough of Wigan since records began. However, Wigan's position is below that of England, and even within the North West Wigan is 30th and 31st (males and females respectively) in the list of 44 local authorities.

*Figure 6: Male life expectancy at birth in Wigan, 2000-2002 to 2004-2006*

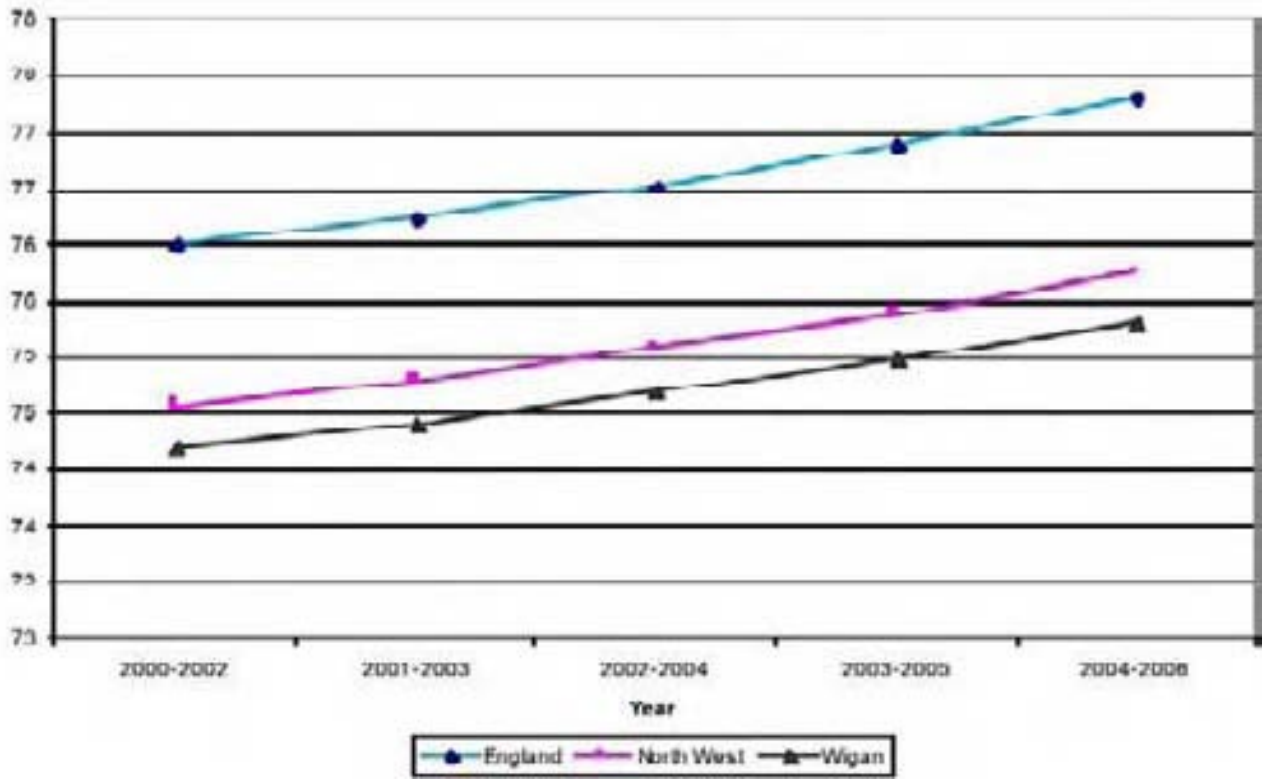
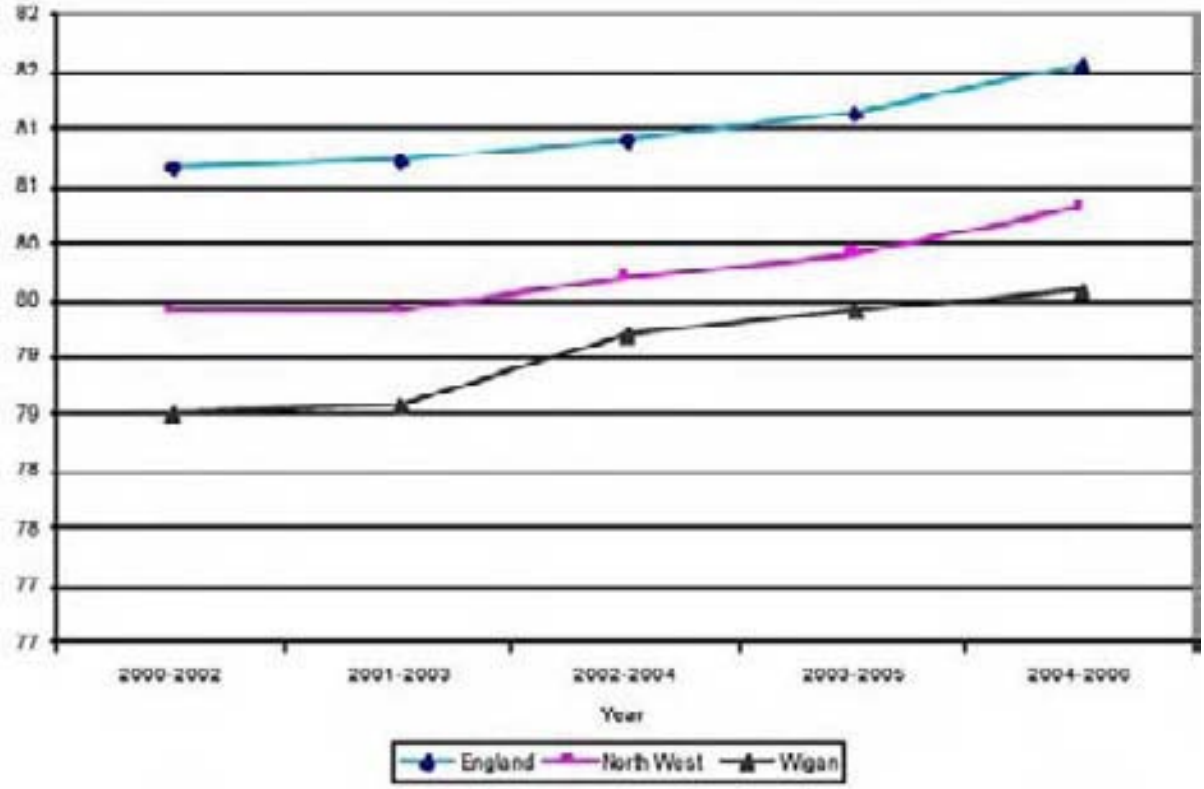
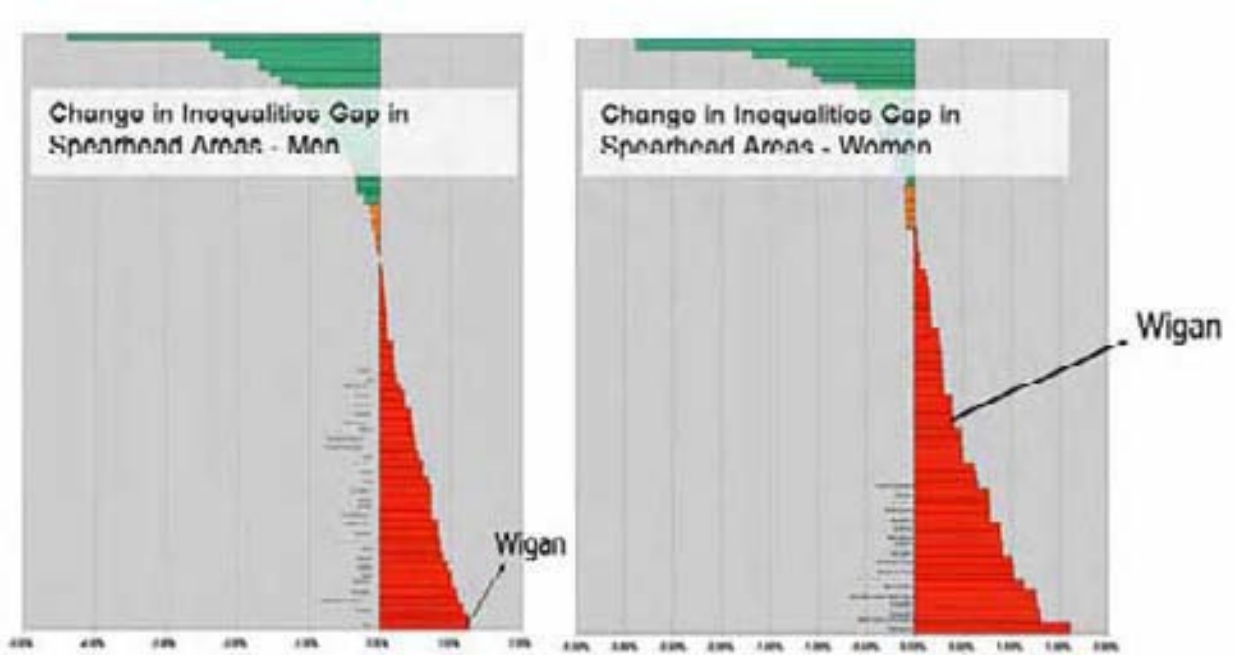



*Figure7: Female life expectancy at birth in Wigan, 2000-2002 to 2004-2006*



The average rate of improvement in life expectancy for both men and women in Wigan is 0.22 years per year. However, women and men in Wigan live on average 2 years less than the England average. Although the gap with England for females narrowed during the period 2001 to 2004 it has since begun to widen. In the early part of the 21st century the male life expectancy gap held steady at around 1.8 years and has since increased to 2 years. The Wigan gap is growing faster than elsewhere in the North West,

*Figure 8: Change in Inequalities Gap in Spearhead Areas for Men and Women.*




In order to address life expectancy, analysis has identified the major causes of the life expectancy gaps. Figures 9 and 10, therefore, show the gap between the average life expectancy in the England 'Spearhead' group as a whole and life expectancy within Wigan, which is within that Spearhead Group. In order to provide context, the Spearhead Group is based upon the Local Authority areas that are in the bottom fifth nationally for 3 or more of the following 5 indicators:

- Male life expectancy at birth
- Female life expectancy at birth
- Cancer mortality rate in under 75's
- Cardio vascular mortality rate in under 75's
- Index of Multiple Deprivation 2004 (Local Authority Summary), average score

Causes responsible for the gap between Wigan and other areas with similar levels of deprivation (the "Spearhead authorities" in England are circulatory diseases (the main contributor being cardiovascular disease), respiratory diseases and cancers.

*Figure 9: The Breakdown of Life Expectancy Gap by Disease Group Between Wigan and the England Spearhead Group - Males.*

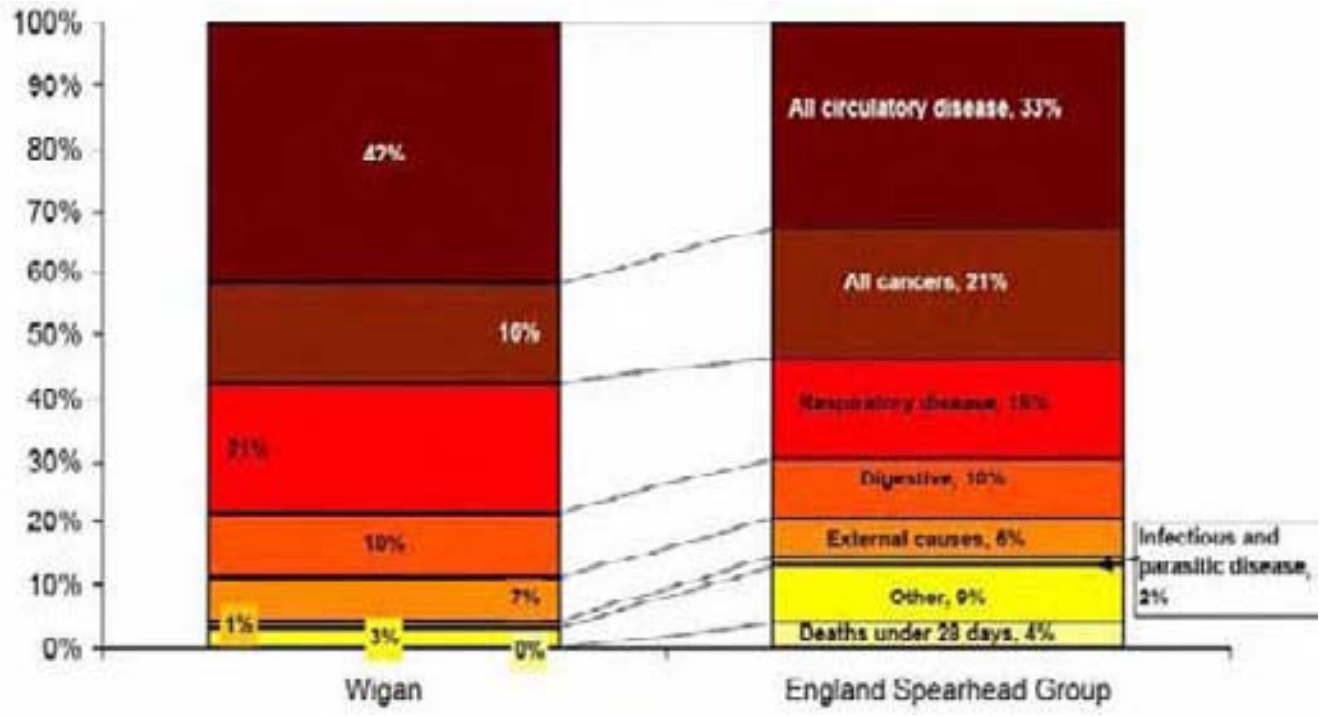
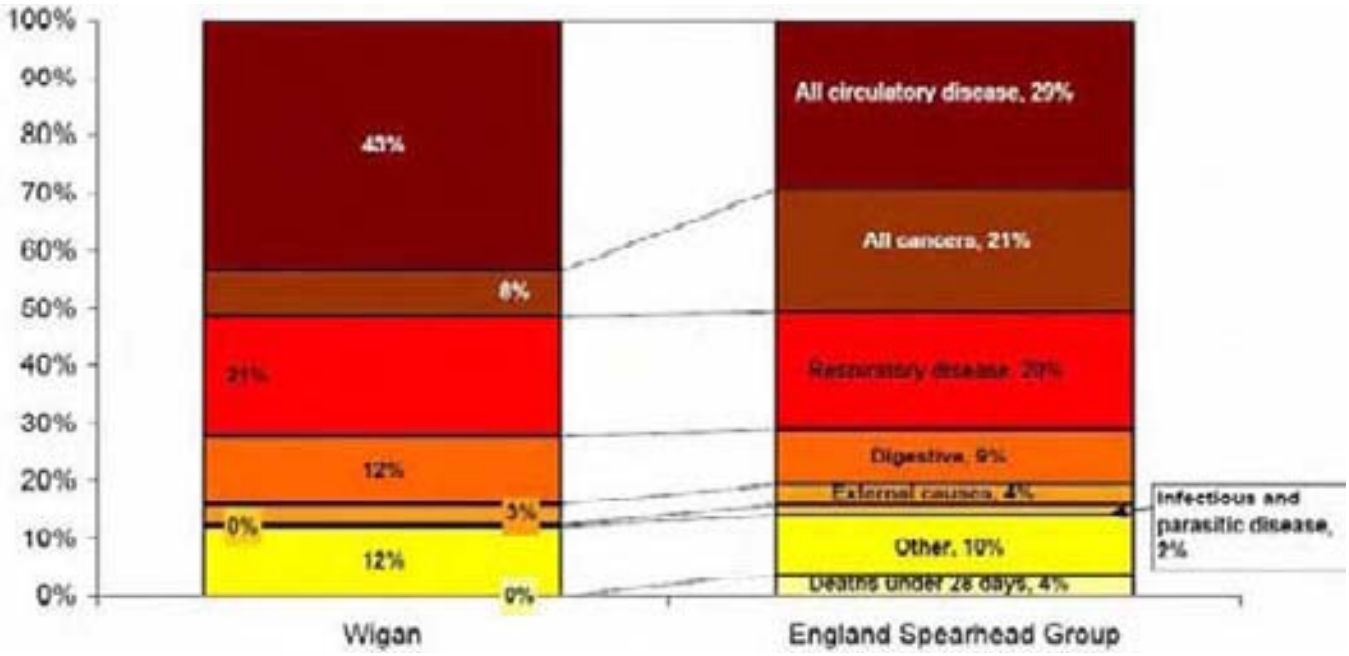



*Figure 10: The Breakdown of Life Expectancy Gap by Disease Group Between Wigan and the England Spearhead Group - Females.*




Taking this analysis down to small areas within the borough shows that the areas with highest socio-economic deprivation have the poorest life expectancy. At either end of the scale people living in parts of the borough such as Newton can expect to live 73 years on average while those living in Langtree will live, on average, to 80 years - representing a 7 year life expectancy gap within Wigan (ONS estimates 2006).

Life expectancy will only improve overall if it is improved for those living in the poorest areas. An analysis of the life expectancy gap between the most deprived 20% (quintile) of Wigan Borough against the England average (not Spearhead, but total England) is shown below, Figure 11. Circulatory disease is the biggest contributor to the life expectancy gap, reducing life by about 6 months in males and 3 months in females consistently since the mid nineties (see Fig 12).

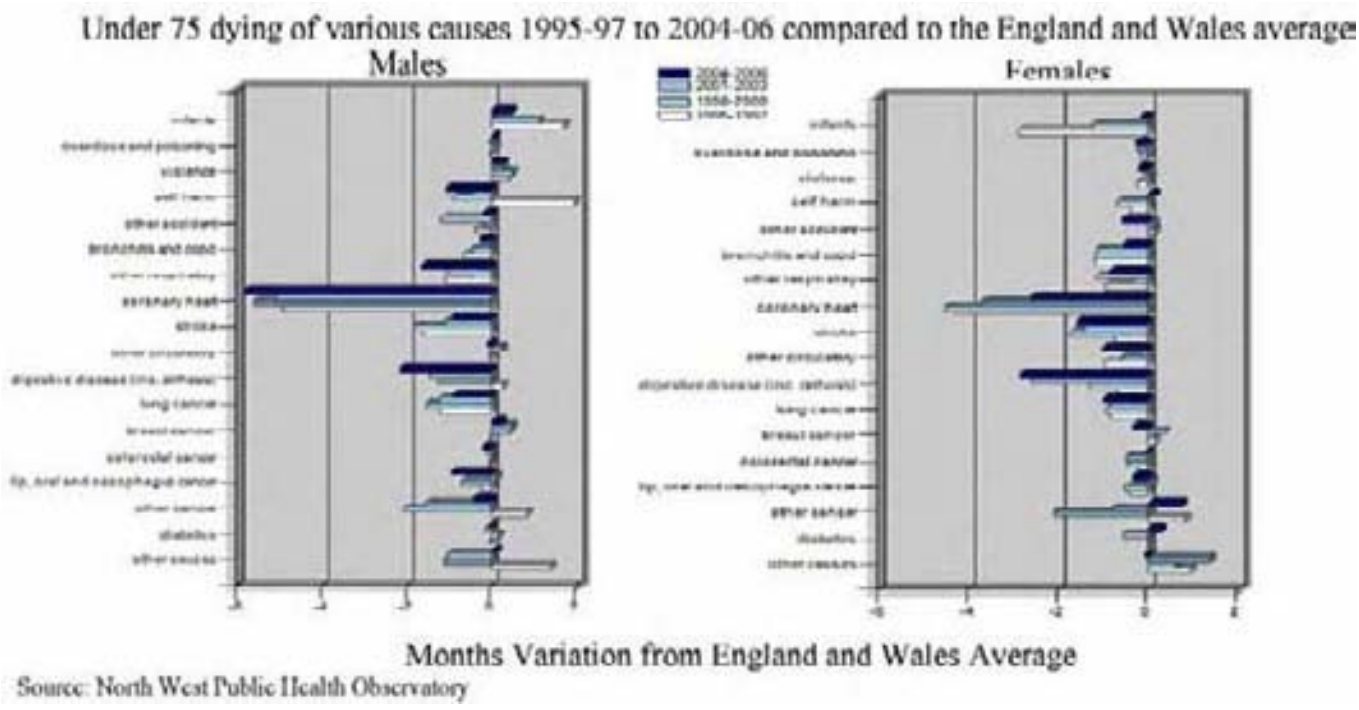
The really striking feature shown in Figure 10 is that a much larger proportion of the difference in life expectancy is down to digestive and respiratory disease in women. These causes of death are strongly related to alcohol and tobacco. In men theses causes of death are also higher than the England average, but also we see 'external causes', such as accidents, suicides and so on, accounting for 11% of the gap – these are also related to alcohol.

*Figure 11: Life Expectancy Gap Between the Most Deprived Quintile and the England Average, Male and Female.*


There is great potential to improve length and quality of life. Many of the causes of ill health are preventable (e.g. cirrhosis of the liver), and much ill health (e.g. breast cancer) can be treated, improving life expectancy. Many of the deaths which occur are from causes which are considered amenable to healthcare. This could include helping people to change their lifestyle, picking up early stages of disease sooner, managing long term conditions optimally, as well as the quality of acute care. This is estimated to account for about 20% of the deaths in Wigan (2004-06), compared to 17% in the North West, and 16% in England (Source NCHOD). This means about 600 premature deaths per year could potentially be avoided.

The breakdown by cause of death over time from the mid nineties to the mid 2000s (below) shows that Coronary Heart Disease (CHD) has consistently accounted for most of the life expectancy gap in both sexes; this is explored in greater detail in the section on Cardiovascular Disease. There has been very little significant change in the contribution the various causes of death make to Wigan's poorer life expectancy over this time period.

*Figure 12: Contribution to Life Expectancy by Cause in Wigan*



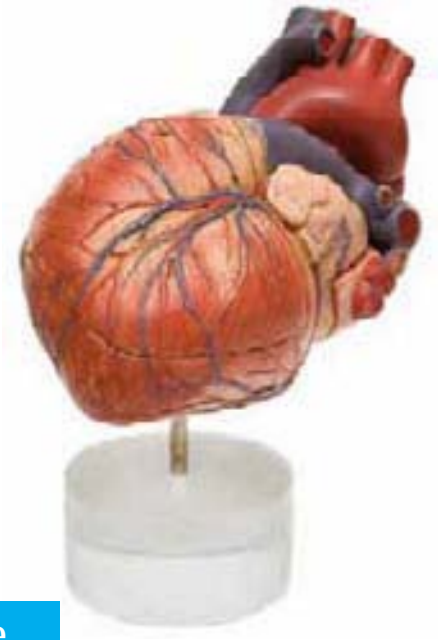

In summary, people in Wigan do not live as long as the England average. The relative position of Wigan is getting worse, in that the life expectancy gap is widening. The main cause for the poor life expectancy is premature death from circulatory or respiratory disease or cancer. These are dealt with in the sections that follow.

# 6. Cardiovascular Disease

Cardiovascular Disease (CVD) is one of the circulatory diseases, and includes Coronary Heart Disease (CHD) and Stroke, and they are often considered together as the same risk factors contribute to both.

The greatest contribution to life years (months) lost is CVD. There is potential for reducing the gap as there is a weight of good quality evidence about how to reduce the development of cardiovascular disease and how to increase survival of those with existing disease.

This section is organised in the way the disease progresses:



- Modifiable risk factors which predispose the disease
- Prevalence of early disease
- Screening for risk factors and early disease
- Later disease
- Deaths from disease

## 6.1 Risk Factors and Early Disease

Increasingly, general practices (GPs) record various risk factors for their patients, e.g. blood pressure, smoking status, a measure of obesity and cholesterol. Those already diagnosed with certain diseases are placed on 'registers'; this includes diabetes, CHD, stroke and Transient Ischaemic Attack, chronic kidney failure, and so on. Such data is routinely extracted and analysed.

Comparison of prevalence can be made according to what we would expect to see from modeling the age structure of that population with known data from other sources. Table 3 shows the most recent extract.

*Table 3: Comparison of current with recorded prevalence with predicted prevalence of Hypertension, Diabetes and Coronary Heart Disease:*

| Disease register | Recorded prevalence (%) | Number | Modeled prevalence |
|---|---|---|---|
| **Hypertension** | 12.8 | 40,075 | 75,708 |
| **Diabetes** | 3.8 | 11,983 | 13,327 |
| **Stroke & Transient Ischaemic Attack (TIA)** | 1.5 | 4,792 | N/A |
| **Coronary Heart Diseases** | 4.7 | 14,657 | 14731 |

*Source: Prevalence data QMAS (correct at September 2008, prevalence models APHO*

As can be seen it would appear that a large number of people with hypertension (high blood pressure) are not on GP registers. One would assume, therefore that they are not receiving the advice and treatment which might help reduce their risk of cardiovascular disease.

## 6.2 Screening

Given the discrepancies between recorded prevalence and predicted prevalence, systematic screening to identify early disease is appropriate. The Joint British Societies (JBS2) guidelines on prevention of cardiovascular disease in clinical practice detail how early identification of signs of vascular disease enables action to be taken. In order to systematise this identification in a population a programme of screening for the 'risk factors' is recommended.

'Find & Treat' is the CVD screening programme which has been established in Wigan Borough. This programme targets those aged 50 to 74 years, and uses data such as age, sex, smoking status and last blood pressure reading to calculate a 'risk score' – the probability of having a heart attack or stroke in the next 10 years. Probabilities above 20% are considered 'high risk'. All those people registered with GPs in the borough have their risk calculated using existing information, and if it is 20% or greater they are invited in for a full health check. If any of the required information is missing from the practice system they are invited in too. During this half hour health check they are measured and tested, and given the results there and then, with advice and referrals to any services recommended. The findings for the first 2,300 patients screened are shown in Table 4.

*Table 4*

| | Diabetes | Hypertension | CHD | Hyperlipidaemia |
|---|---|---|---|---|
| **Total** | 49 | 103 | 16 | 682 |
| **% of those screened** | 0.02% | 0.04% | <0.01% | 30% |
| **Expressed as a rate per 1000** | 21 | 44.7 | 6.9 | 296 |

Caution is required before drawing conclusions from this data – the practices which started screening first may not be representative, and the patients who were in the first wave of attendees similarly may not be representative. Nevertheless it is apparent that there is a pool of undetected disease – which is particularly of concern in terms of diabetes which can do so much harm if uncontrolled. Data on prevalence of the other risk factors of concern, smoking, obesity, physical inactivity and alcohol are also being collated. A rigorous evaluation by the University of Salford will be conducted over the next 3 years, which will enable a more accurate assessment of need, in addition to the impact of the programme.

Over the next year as the analytical capacity of NHS Ashton Leigh and Wigan increases we will be modeling the expected prevalence of CVD against the reported prevalence on the practice held risk registers. We will supplement this data with risk factor prevalence in the 50-74 year group as found in the Find & Treat programme, plus those already on CHD or diabetes registers. Comparisons will be made with local, regional and national data where available, to highlight where we might be missing data, and identify practices which are particularly of note. Estimates of the impacts of improved risk factor and disease management will also be calculated.

## 6.3 Later Disease

Once cardiovascular disease is established, it may be expressed as 'angina', a 'heart attack' (or acute myocardial infarction or "MI") or a 'stroke' (cerebrovascular accident or CVA).

Hospital admission rates for heart attack, or myocardial infarction, have declined in recent years, (as shown in Figures 13 and 14). They are higher in Wigan than in the North West, which is in turn higher than England (see table 5).

*Figure 13:*

Hospital admissions for Myocardial infarction all persons, rate per 100,000. 2001-2007 (Reverse order)

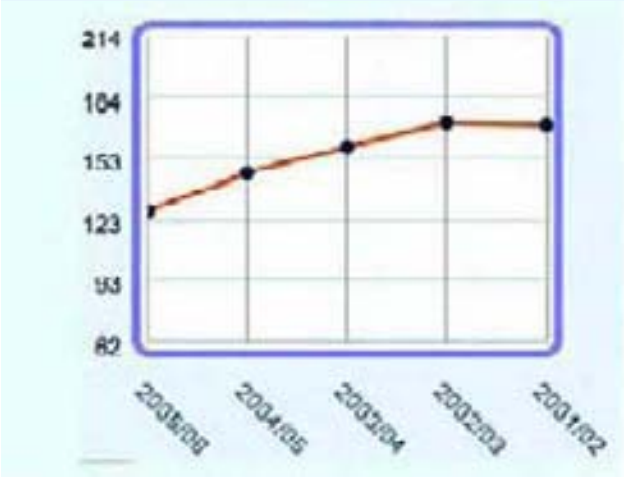



*Figure 14:*

Stroke emergency admissions, all persons, rate per 100,000. 2001-2007 (Reverse order)

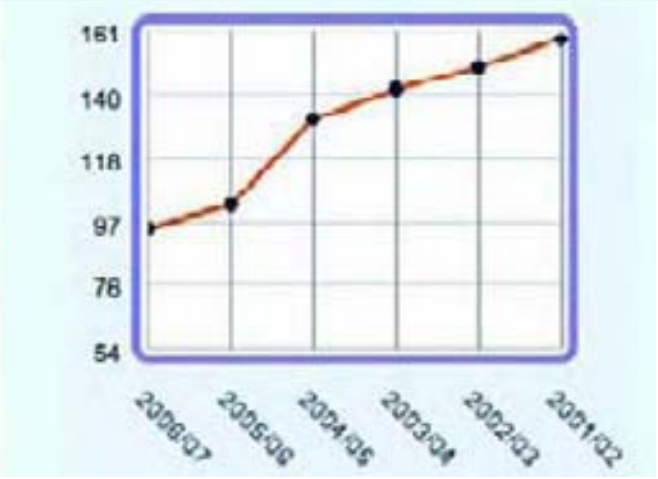



*Table 5: Hospital Admission for Myocardial Infarction, 2005/06 (rate per 100,000)*

| | England | North West | Wigan |
|---|---|---|---|
| **Male** | 148.7 | 169.4 | **185.9** |
| **Women** | 60.2 | 70.1 | **74.3** |
| **All persons** | 101.7 | 116.2 | **126.8** |

*Table 6: Stroke emergency admissions, 2005/06 (rate per 100,000)*

| | England | North West | Wigan |
|---|---|---|---|
| **Male** | 113.9 | 120.5 | **88.4** |
| **Women** | 86.1 | 94 | **99** |
| **All persons** | 99.4 | 106.5 | **94.7** |

In 2006/2007 the rate of admission for stroke for Wigan was 94.7/100,000, compared to 99.4 for England and 106.5 for the North West. Similarly the male admission rate of 88.4 per 100,000 is lower the England and North West average.

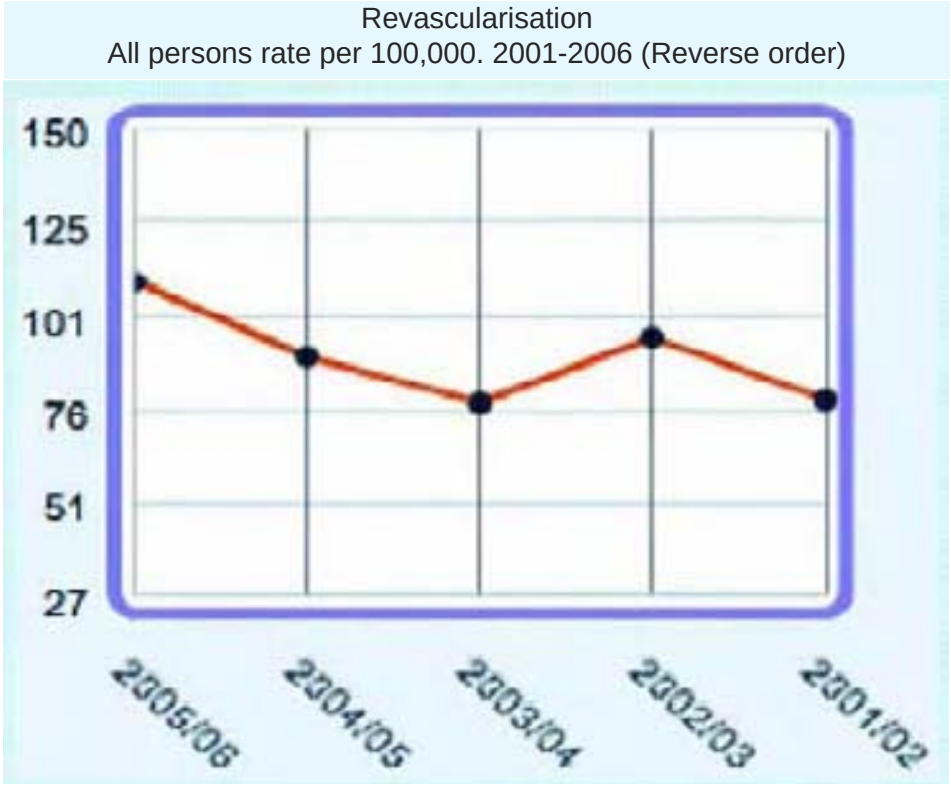
This picture is reversed for women where the rate of 99 admissions per 100,000 is higher than both the North West (94 per 100,000) and England (86.1 per 100,000).

There are twice as many admissions for MI in males than females, but with stroke, there are about 12% more admissions for stroke.

## 6.4 Revascularisations

Advanced CHD may present as angina – pain in the chest, usually brought on by exertion, which usually passes with rest. This is generally treated with drugs, and most patients can be managed quite well with drugs alone. However some people who have angina or have suffered a heart attack may be referred for further investigation including coronary angiography (x-ray of the arteries of the heart). If this shows blockage, patients may be referred for "revascularisation" – removal of the blockage by open heart surgery (by-pass graft) or a less invasive procedure - angioplasty (balloon inflated in the artery). Figure 15 shows that procedures for revascularisation have increased in the last 5 years.

*Figure 15: Revascularisation procedures undertaken on all persons 2001 to 2006*



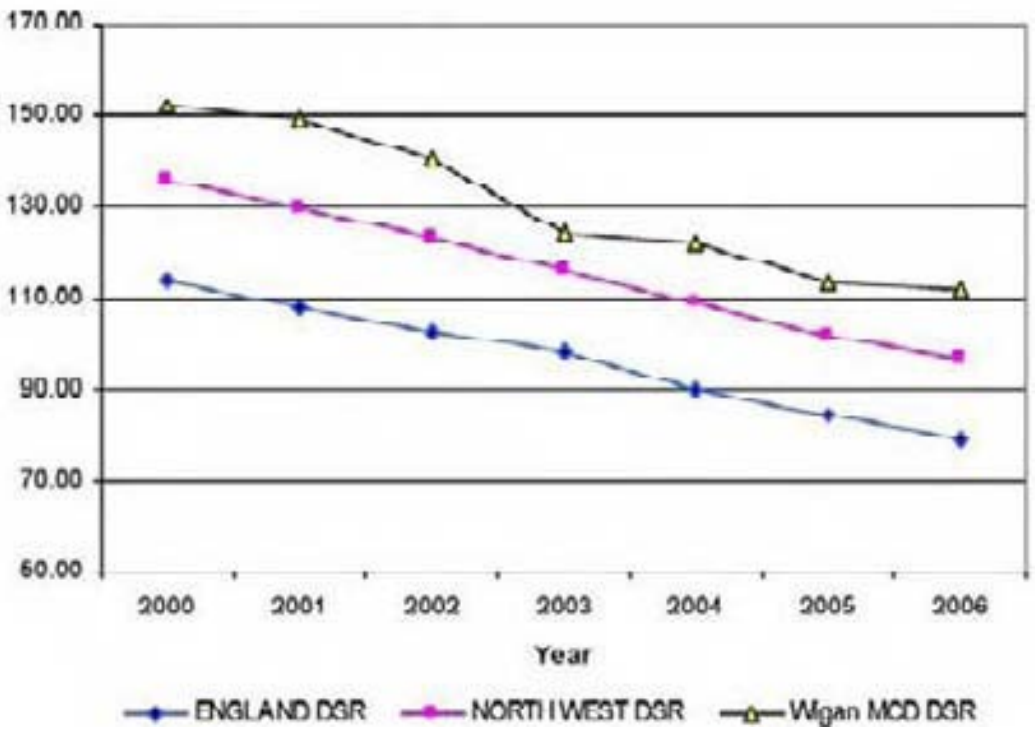

## 6.5 Gender Difference

The rate (per 100,000) for women in 2005/06 was 46.9, compared to 176.2 in men. Men have 3.7 times the rate of revascularisation than women. We know that men have a higher prevalence of CHD, and a higher death rate. CHD mortality under 75 years for men is 98 per100,000, and 34 per100,000 for women - a factor of 2.9. This shows an area that warrants further investigation, as it appears that there is inequity, with women less likely to have treatment for advanced cardiac disease. This is particularly relevant to the fact that the growing life expectancy gap in women is largely due to CVD.

## 6.6 Deaths

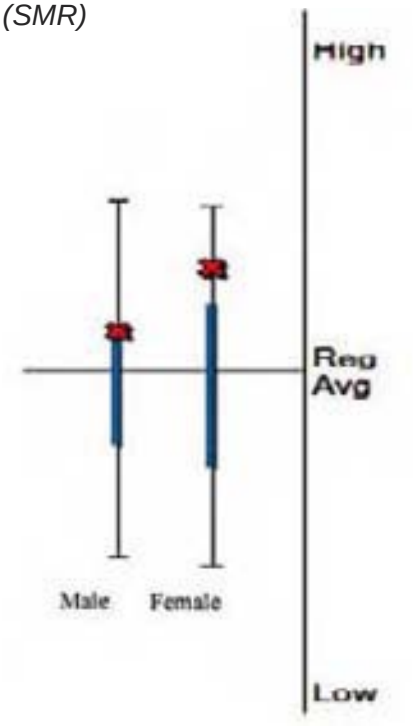
In Wigan 1130 people died of circulatory diseases in 2006 - a third (383) of them aged less than 75 years. While the mortality rate has been declining year on year it remains significantly above the England and North West average.

*Figure 16: Mortality from all Circulatory Disease, 2000 to 2006 (Directly age standardised rate.)*




## 6.7 CVD Mortality

*Figure 17: Wigan CVD Mortality compared to North West under 75 (SMR)*




CVD mortality in Wigan remains significantly above both the regional and England average.

There is a gender difference again. Men have a broadly similar experience to their counterparts in the North West. Male under 75 years standardised mortality ratio (SMR) for Wigan is 146 compared to 135 in the North West and 100 for England.

Female under 75 years SMR for Wigan is 165 compared to 136 in the North West and 100 for England.

So women in the North West have a 36% increased risk of dying of a CVD compared to the rest of England, but women in Wigan run an even worse risk than their counterparts in the rest of the North West, with a 65% increased risk of dying.

The SMR is a measure that allows comparison of mortality rates among two different populations. An SMR of 100 implies that the rates are the same; an SMR above 100 implies that the rate is greater for the population of interest compared to the standard population.

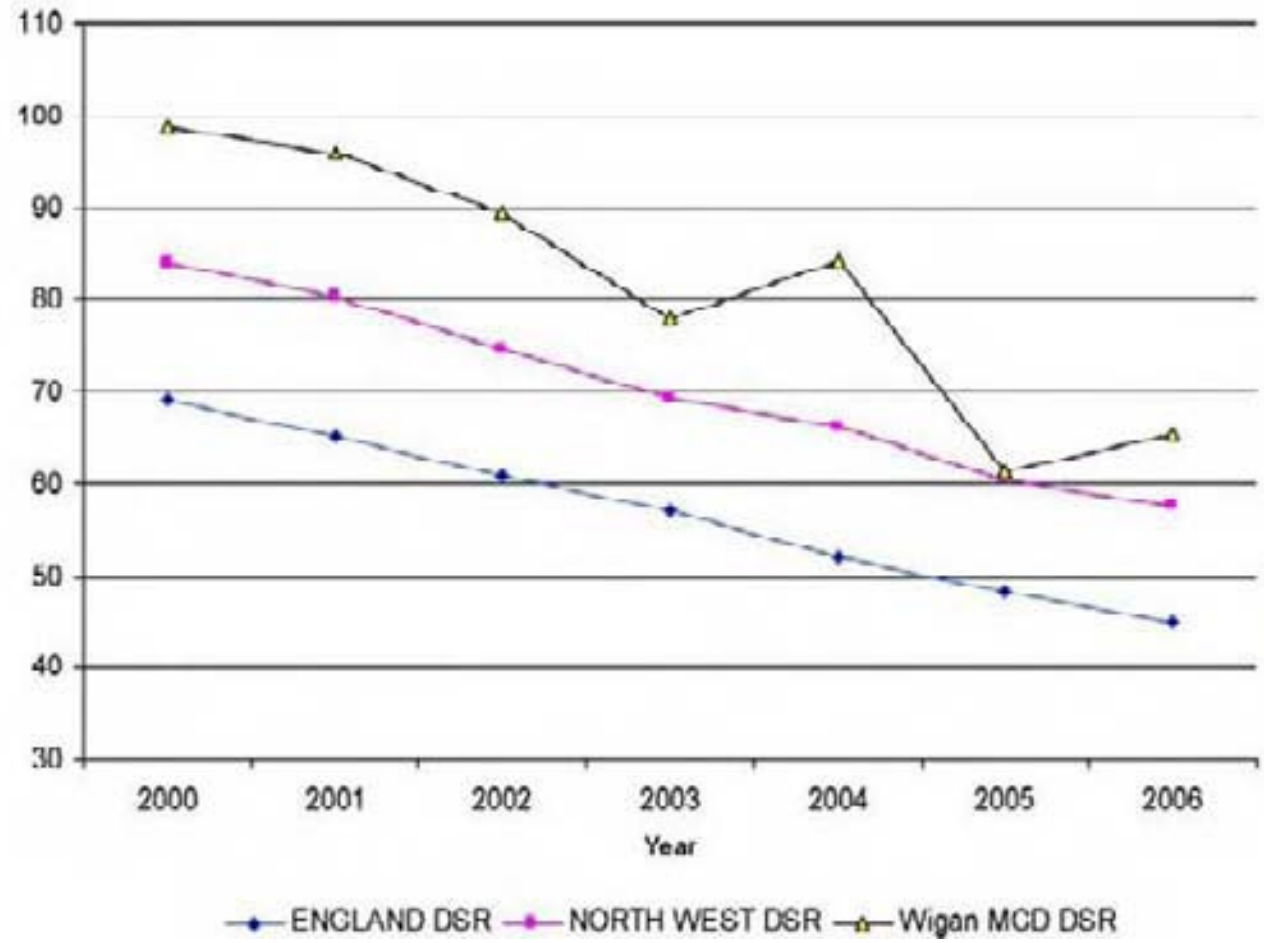
## 6.8 CHD Mortality

Cardiovascular disease death rates can be broken down by category. We have chosen to show coronary heart disease (CHD) in greater depth, and explore this by age. In 2006, 223 people under 75 died from CHD compared to 315 in 2000. Although the mortality rate from CHD has been decreasing in Wigan, the North West and England, Wigan rates remain higher. Statistically both men and women under 75 are more likely to die from CHD if they live in Wigan than either the rest of the North West or England.

*Table 7: Mortality from CHD (ICD10 I20-I25): Less than 75 Years. SMR*

| | Males | Females | Persons |
|---|---|---|---|
| **England** | 100 | 100 | 100 |
| **North West** | 126 | 128 | 126 |
| **Wigan** | **137** | **163** | **144** |

*Figure 18: Mortality from Coronary Heart Disease 2000 to 2006 less than 75 years (Directly age standardised rate.)*



Looking in greater depth at deaths in those aged under 65 reveals that the rate is nearly 50% higher in Wigan than the England average. This represents an area where much attention is needed, as arguably most of these deaths could be prevented.

*Table 8: SMRs for CHD in under 65s, Wigan 2004-2006*

| *Source: NCHOD* | **Deaths before the age of 65 which are caused by Coronary Heart Disease** |
|---|---|
| | **SMR Coronary Heart Disease** |
| **England** | 100 |
| **North West** | 130 |
| **Wigan** | **146** |

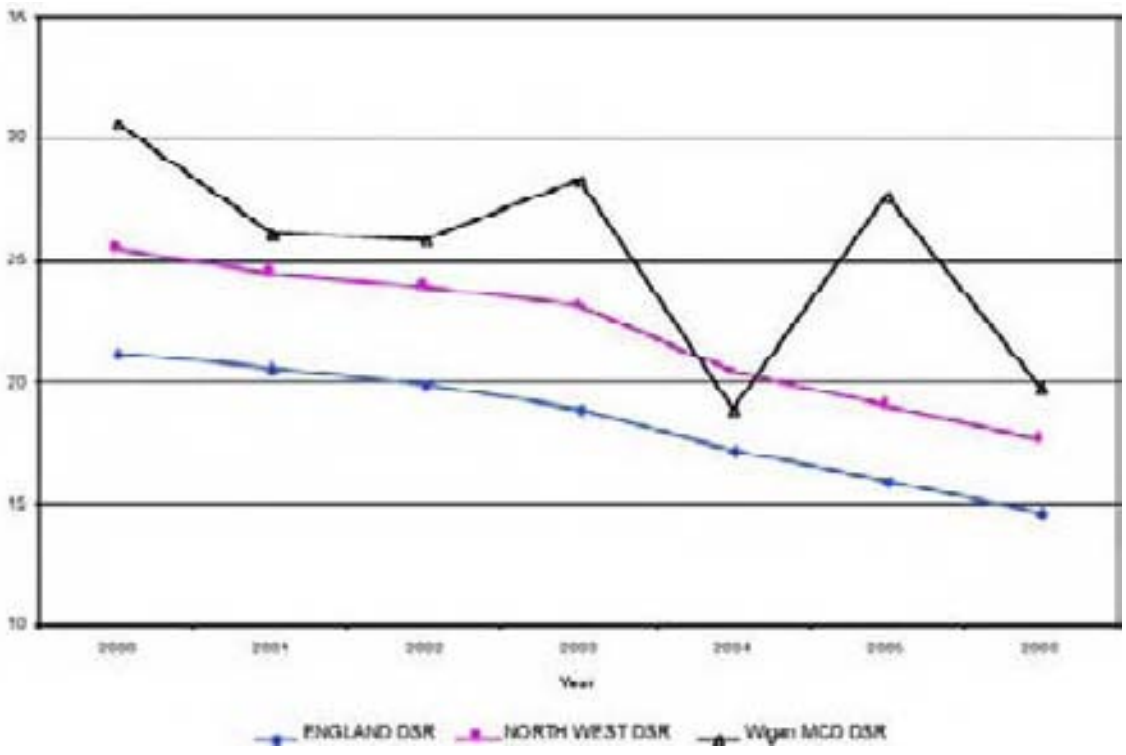
Once again women fare relatively worse than men. The Coronary Heard Disease SMR for the under 65s is 165 and 141. In other words, younger women in Wigan are at much greater risk of dying of a heart attack than women elsewhere.

Survival after Acute Myocardial Infarction (heart attack) at the local acute hospital (Wrightington, Wigan & Leigh NHS Trust) is among the lowest in the country. In April 2007 the hospital SMR for myocardial infarction was 197, and in April 2008 it was 150. This means that patients were nearly twice as likely to die while in hospital if they had a heart attack in Wigan when compared to England, and even now they are 50% more likely to die. This may be connected to either care process or factors out of the hospital's control, such as delay in ringing for help, or severity of the underlying CVD, or a combination of the two.

## 6.9 Stroke

Strokes also fall under the umbrella of Circulatory Disease. A stroke can also be called a cerebrovascular accident and can be described as the sudden death of some brain cells due to a lack of oxygen when the blood flow to the brain is impaired by a blockage or rupture of an artery to the brain. The trends in deaths from stroke are shown below. Like the other CVD there has been a large decline overall, but with quite a lot of year to year variation, and the Wigan position is again worse than North West and England.

*Figure 19: Stroke mortality from 2000 to 2006, less than 75 years (Directly age standardised rate.)*



# 7. Cancer

In a lifetime each person has a one-in-three chance of developing Cancer, and a one-in-four chance that cancer will be a significant factor in the cause of their death. However, cancer should not be seen as a single entity. Although there are similarities in the pathological mechanisms of all types of cancer, cancer is a catch-all term for many diseases each having different causes, incidence, mortality, prognosis and treatment. Cancer is strongly associated with exposure to carcinogens. The factors where there is most scope for prevention are smoking, alcohol intake, diet and obesity.

A detailed report on cancer incidence and mortality in Wigan was undertaken by NHS Ashton, Leigh and Wigan in May 2007. The main points only are presented here.

The incidence rate for all cancers in people aged 0 – 74 in Wigan borough reflects that of the North West as a whole. It has steadily increased in both males and females over the last twenty years. This apparent increase in incidence is probably not due to a real increase in the cancer burden. In the last twenty years the NHS Breast and Cervical Screening Programmes have been introduced. This has led to earlier diagnosis of these cancers. The increasing use of prostate specific antigen has resulted in the earlier diagnosis of prostate cancer. These and other measures that have led to the earlier diagnosis of cancer are probably the main reasons of this apparent rise in incidence.

Concerns about the poor cervical screening coverage in some local general practices will be explored in depth, with a detailed clinical audit programmed to take place in the coming months.

*Table 10: Incidence of all cancers 2002-2004:*
*Directly age-standardised registration rates (DSR) per 100,000 pooled.*

| | Males | Females | Persons |
|---|---|---|---|
| **England** | 401 | 343 | 364 |
| **North West** | 429 | 360 | 385 |
| **Wigan** | **435** | **345** | **377** |

*Source: The Information Centre for health and social care. © Crown Copyright.*

*Table 11: Comparison of Wigan Cancer Hospital Episodes with the North West.*

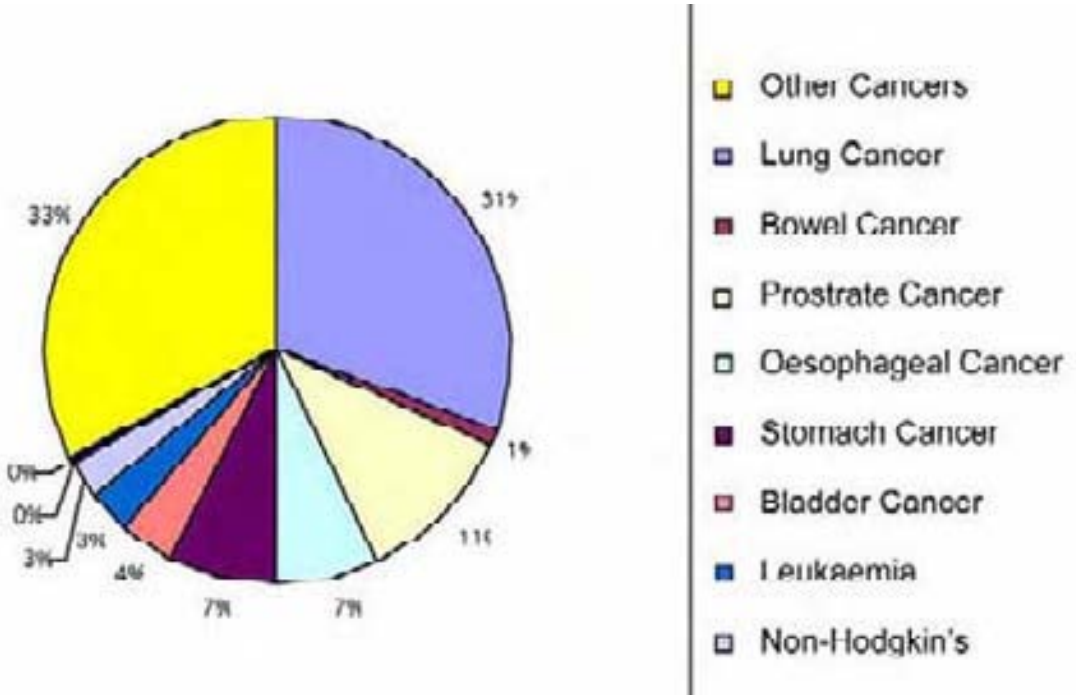
| | Bladder Cancer: HES | Bladder Cancer: HES | Cervical Cancer: HES | Colorectal Cancer: HES | Leukaemia HES | Lung Cancer: HES | Prostate Cancer: HES | Skin Cancer: HES |
|---|---|---|---|---|---|---|---|---|
| **Wigan** | 103 | 96 | 59 | 109 | 106 | 130 | 93 | 106 |
| **North West** | 103 | 93 | 97 | 98 | 100 | 122 | 111 | 92 |

## 7.1 Cancer mortality

During the three-year period from 2003 to 2005 there were, on average, 3,150 total deaths each year in the Borough. Of these, 750 a year were attributed to cancer. That is, just under a quarter (23.8%) of deaths during this period were attributable to cancer (27.6% of deaths for males, 20.4% of deaths for females).

Almost a quarter of cancer deaths (24.6%) during 2003 to 2005 were attributed to lung cancer (27.6% of cancer deaths for males, 21.1% of cancer deaths for females). Other key causes of cancer death in males and females were bowel cancer, oesophageal cancer and stomach cancer as well as breast cancer in females and prostate cancer in males (see Figures 20 and 21).

*Figure 20: Cancer Deaths in Males of all Ages in Wigan Borough During 2003 – 2005.*

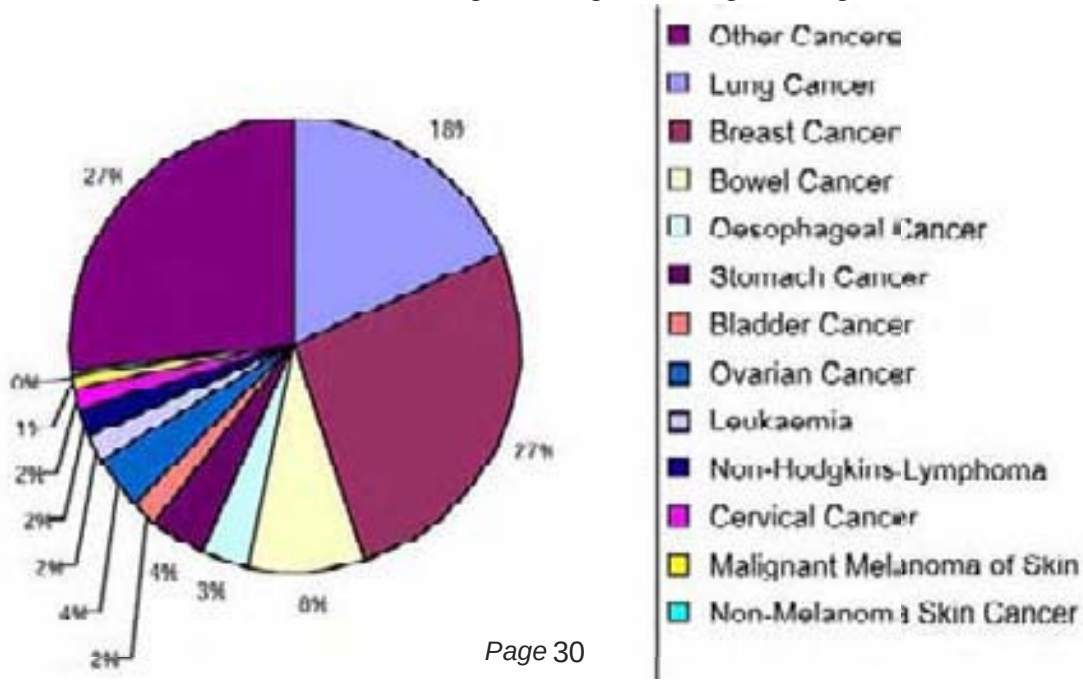



The only cause of cancer death in males for which Wigan is significantly different to the North West is stomach cancer; oesophageal cancer is also higher in Wigan than the England average.

Two rarer cancers are increasing; primary liver cancer and malignant melanoma of the skin. Liver cancer is related to alcohol intake and the prevalence of hepatitis C infection – both of which have been increasing in recent years.

Skin cancers (both melanoma, and the less invasive basal cell carcinoma) are related to UV light exposure, which has increased in many people due to sunbathing, both natural and, more recently from 'sun beds' use.

*Figure 21: Cancer Deaths in Females of all Ages in Wigan Borough During 2003 – 2005.*



Mortality rates for all cancers in Wigan Borough reflect that of the North West. The trend in mortality rates in both males and females is down. Significantly fewer people aged 0 – 74 in Wigan Borough are dying of cancer compared to 20 years ago. There is probably a variety of reasons for this, including a reduction in tobacco smoking, better diet, screening, earlier cancer diagnosis, and more effective treatment. The apparent discrepancy for males in respect of comparison with the North West and comparison with England and Wales as a whole needs further examination.

Reducing mortality from lung cancer locally will require additional measures to continue to reduce smoking prevalence. This will be a challenge, particularly as young women are adopting and sometimes exceeding the risky behaviours of young males.

The distribution of cancer incidence by electoral ward is shown for all cancers. Although there appears to be a higher incidence within more deprived wards for some of these cancers further examination is required to determine if this is statistically significant. However, this information may be helpful in targeting resources in aid Cancer prevention.

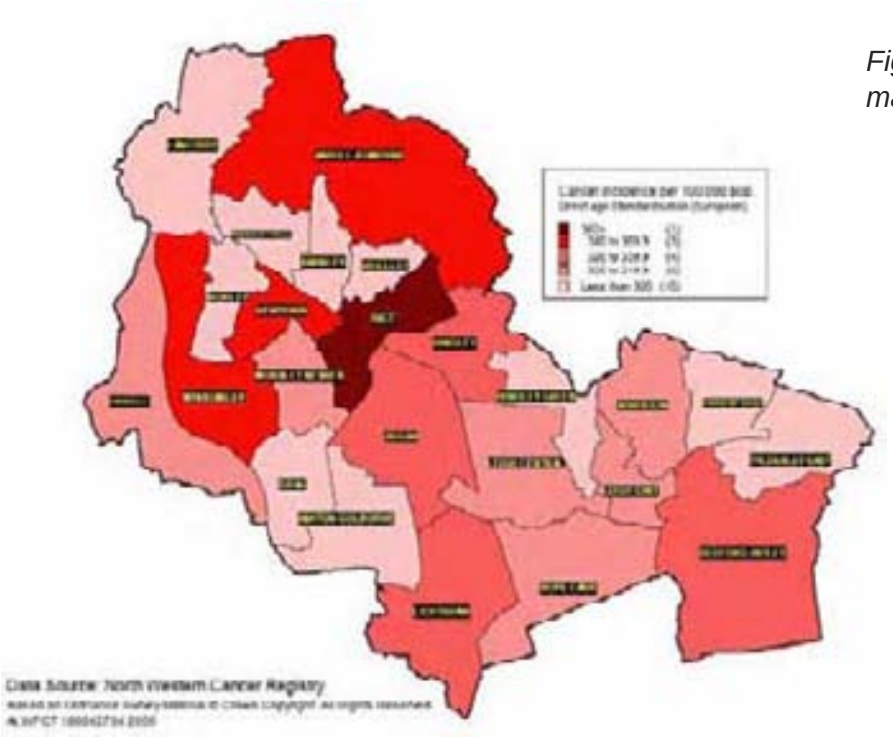


*Figure 22: Incidence of cancer in males 0-74, by ward*

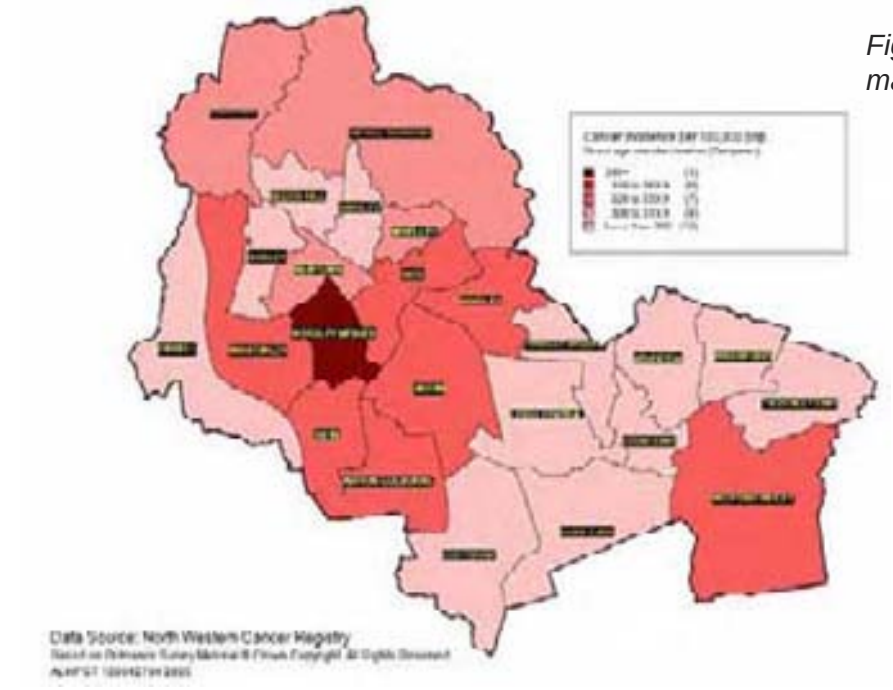



*Figure 23: Incidence of cancer in males 0-74, by ward*

This demonstrates the need for targeted resources at areas of higher cancer incidence, reducing smoking uptake and increasing quitters, weight management, diet and alcohol consumption and screening.

# 8. Chronic Obstructive Pulmonary Disease (COPD) and Smoking

Respiratory disease is a broad category, much of which is not preventable. However Chronic Obstructive Pulmonary Disease (COPD), also known as chronic obstructive airways disease (COAD), chronic bronchitis, or emphysema is a chronic condition caused by a combination of exposures, many of which are completely preventable, such as tobacco smoke exposure.

According to the General Household Survey (2005), a higher percentage of people have a history of smoking Wigan than for Britain as a whole. For example, in Britain 52% of residents claim that they have never smoked compared to 40% in Wigan.

Current population prevalence has been declining by about 1% per year. In 2001, 29.5% of Wigan borough residents smoked; by 2006 this had reduced to 24.5% according to a survey done by postal questionnaire (Wigan Borough Health and Lifestyle Survey 2006).

An estimate of the prevalence is calculated by the Office for National Statistics, and the estimated average for Wigan borough is 26.1%. The estimated smoking prevalence varies within the borough from 16% to 47% at the wards level. Smoking prevalence is very strongly correlated to deprivation and residents of more deprived areas of Wigan are more likely to smoke than those in the least deprived.

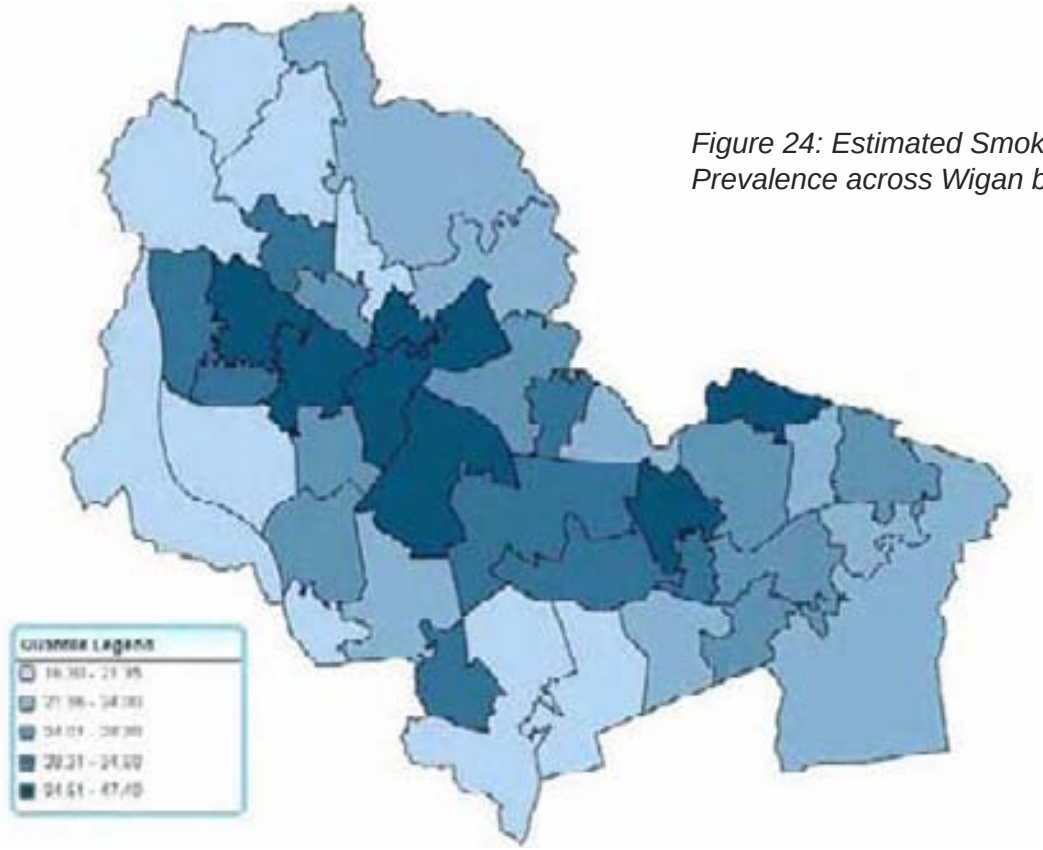


*Figure 24: Estimated Smoking Prevalence across Wigan borough.*

Smoking was once very prevalent across all the social classes, in 1960 about 60% of men smoked. However, the more affluent classes have been giving up for decades, while those most disadvantaged in our society continue to have high smoking rates - not just those in certain deprived geographic areas, but specific groups, for example. those with mental health problems, prisoners and teenage parents. These groups require targeted and tailored approaches.

Younger residents are also more likely to smoke than older residents (29% of those aged 18 to 54, compared with 14% of those aged 65 and over). Alarmingly a survey of children and young people in 2004 showed that 31% of Year 10 girls (15 year olds) smoked. The strongest factor predicting whether a young person started smoking was having a parent who smoked.

## 8.1 Effects of Smoking on Health

Wigan residents who have never smoked are more likely to be in good health than those who have smoked (71% compared with 66%). Further, those who have smoked are more likely to have a heart attack (66% compared with 30%) and are also more likely to have diabetes (64% compared with 34%). [6]

## 8.2 Stopping Smoking

There is a wealth of evidence about the effectiveness of specific stop smoking and tobacco control interventions on the Cochrane Library (41 reviews published and 9 underway). This evidence should be consulted before planning new interventions and how the existing ones may be incorporated into appropriate settings, not just the specialist Stop Smoking Service.

*Table 12: Life Years Gained After Quitting Smoking by Age Category*

| Age at stopping smoking | Years of life gained |
|---|---|
| 25-34 | 10 |
| 35-44 | 9 |
| 45-54 | 6 |
| 55-64 | 3 |

In 2006/2007, Wigan achieved a 'quit rate' of 1032 per 100,000 total population compared to 941 nationally. This is an encouraging figure, but based on the higher prevalence within Wigan of smokers, it is necessary to continue to increase the number of people quitting smoking further.

Targeting of stop smoking services at the most deprived has had some success over recent years, both in terms of contacts and number of quitters, as shown in the table below. Wigan is achieving a higher quit rate per 1,000 adult population in the 3% most deprived lower super output areas (LSOAs) at 14.36 per 1000, compared to 9.66 per 1000 borough average. These areas are where the need is as they are the areas where people are most likely to be smokers, (37.59% compared with 25% overall). [7]

It is interesting to note that the ratio of contacts to quitters increases as deprivation increases suggesting that more contacts need to be made in deprived areas to achieve the same level of quitters as the less deprived areas.

*Table 13: Wigan Smoking Cessation Service Contacts and Quit Rate by Deprivation 2006/07 by LSOA (per 1000)*

| | Contacts | Quit rate | Ratio of contacts to quitters |
|---|---|---|---|
| **3% most deprived** | 41 | 14 | 2.87 |
| **10% most deprived** | 39 | 14 | 2.82 |
| **Wigan average** | 23 | 9 | 2.39 |
| **10% least deprived** | 12 | 5 | 2.33 |

[6] Wigan Borough Health and Lifestyle Survey 2006
[7] As above

## 8.3 Smoking Deaths

Estimates suggested that 32% of deaths in the North West are attributable to smoking. The rate of attributable deaths is 277.8 per 100,000 for Wigan, compared to 225.4 for England as a whole. This equates to between 500 and 600 deaths in Wigan being attributed to smoking. Smoking contributes to many different diseases, a selection of which are presented in the table below, with estimates of how many deaths can be attributed to each.

*Table 14: Deaths Attributable to Smoking, % in England Applied to the Wigan Population*

| Disease | % | Number of equivalent deaths in Wigan (2006) |
|---|---|---|
| Lung Cancer | 87 | 152 |
| Oesophagus Cancer | 71 | 28 |
| Bladder Cancer | 40 | 12 |
| Chronic Obstructive Pulmonary disease | 86 | 118 |
| CHD less than 75 years old | 33 | 73 |
| Stroke less than 75 years old | 32 | 22 |

*Source: The Smoking Epidemic*

## 8.4 Chronic Obstructive Pulmonary Disease (COPD)

The term COPD includes conditions such as emphysema and chronic bronchitis, but most patients with COPD have characteristics of both conditions to varying degrees. The most common cause of COPD is cigarette smoking, often in combination with other aspects of social deprivation, e.g. respiratory infections in childhood, occupational exposure to dust such as in mining and some factory work, and indoor pollution such as smoke.

*Figure 25: COPD emergency admissions, all person 2003-2007, rate per 100,000.*

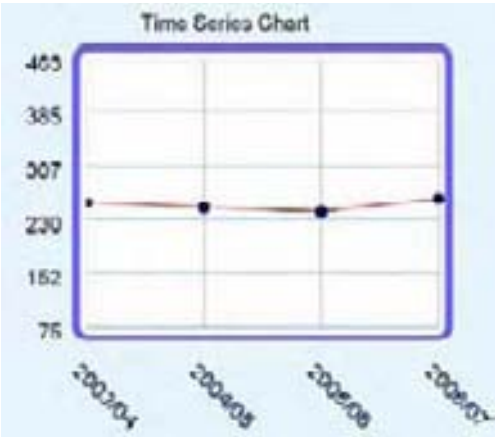



*Table 15: COPD Emergency Admissions Directly Standardised rate per 100,000 2006/07*

| | Rate per 100,000 |
|---|---|
| England | 149 |
| North West | 212 |
| **Wigan** | **260** |

Emergency admissions for COPD have been relatively static in recent years. The rates of hospitalisation are higher in Wigan than North West, and very much higher than the England average, as shown in Figure 24. However, hospital utilisation is related to many other factors such as quality of primary care, and is not necessarily a very good indicator of morbidity.

Significant mortality is associated with chronic obstructive pulmonary disease (COPD) and this is the cause of about 5% of all deaths in the Borough. However, COPD is a much more significant contributor to premature avoidable deaths in the under 75 year population (see table 16) and accounts for 21% of all preventable deaths in both men and women under the age of 75. The North West as a whole has a poor health experience in terms of COPD, but Wigan is not worse, having exactly the same death rate for women, and a slightly lower death rate for men.

*Table 16: Mortality from Bronchitis, Emphysema and other COPD less than 75 years, 2004-2006 (Directly age-standardised rates per 100,000)*

| | Males | Females | Persons |
|---|---|---|---|
| **England** | 15 | 10 | 12 |
| **North West** | 18 | 14 | 16 |
| **Wigan** | **16** | **14** | **15** |

*Source: The Information Centre for health and social care.*

*Table 17: Mortality from Bronchitis, Emphysema and other COPD less than 75 years, 2004-2006. (Indirectly standardised ratios)*

| | Males SMR | Females SMR | Persons SMR |
|---|---|---|---|
| **England** | 100 | 100 | 100 |
| **North West** | 124 | 135 | 129 |
| **Wigan** | **113** | **135** | **123** |

*Source: The Information Centre for health and social care.*

One of the major challenges lies with identifying those who are at risk of developing serious COPD. This would enable early intervention and therefore prevent future hospital admissions. There are currently 5,297 people on GP COPD patient registers. However, modeled estimates suggest that there may twice that number with COPD in the borough.

*Table 18: Disease Prevalence for Patients on GP Registers compared with Estimated Prevalence.*

| Disease register | Recorded prevalence | Number | Modeled prevalence |
|---|---|---|---|
| COPD | 1.7% | 5,297 | 11,709 |

*Source: Prevalence data QMAS*
*(correct at September 2008, prevalence models APHO)*

## 8.5 Predicted Burden of Disease

The prevalence of chronic bronchitis and emphysema by age is estimated to be 3.4% of 65-74 year old males, 2.8% of males aged 75 and over, 1.5% of 65-74 year old females and 1.4% of females aged 75. These prevalences have been used to predict the number of people with the conditions up to 2025, as shown in the table below. The reason why there are relatively fewer in the oldest age group is because people with COPD tend to die before they reach 75 years of age.

*Table 19: People Aged 65 and over Predicted to have a Longstanding Health Condition Caused by Bronchitis and Emphysema, by Gender and by Age (65-74, 75 and over), Projected to 2025.*

| | 2008 | 2010 | 2015 | 2020 | 2025 |
|---|---|---|---|---|---|
| **Males aged 65-74** | 469 | 496 | 575 | 561 | 534 |
| **Males aged 75 and over** | 218 | 232 | 288 | 364 | 451 |
| **Females aged 65-74** | 216 | 216 | 231 | 270 | 258 |
| **Females aged 75 and over** | 176 | 178 | 196 | 228 | 277 |
| **Total population aged 65 and over** | 1,080 | 1,138 | 1,331 | 1,423 | 1,520 |

*Figures may not sum due to rounding*
*Source: POPPI*

Evidence suggests that some of the deaths, and certainly a large number of hospitalisation due to COPD can be prevented by 'active case management'. We are exploring how to collect outcome data from the case managers (Community Matrons).

# 9. Alcohol

Although smoking and obesity appear to be the greatest threats to the general health of the Wigan population, alcohol related harm is increasing. Alcohol related disease such as cirrhosis of the liver and oesophageal cancer, is predicted to rise in the future (Institute of Alcohol Studies [8]). Months of life lost and mortality due to alcohol are increasing in the North West. [9]

Alcohol consumption also has a wider social impact including crime and disorder. One in three acts of partner violence is committed when the person responsible is drunk. Further, alcohol can also effect employment and therefore the economy of the Borough.

We are fortunate in Wigan in that we two distinct sources of data on alcohol, which can be used to 'triangulate' (test out by comparing a number of pieces of data) and estimate the true impact of this factor. Wigan's Health and Lifestyle surveys were conducted in 2001 and 2006 using self-completion postal questionnaires; this allows trend analysis and intra-borough variation to be explored. The North West Public Health Observatory has calculated estimates of prevalence of various behaviours based on alcohol sales, and other factors. This allows geographic comparison with other districts in the North West.

Binge drinkers were defined as men who drink more than 10 or more units in one session and women who drink more than 6 units in one session. [10] This study revealed that around a third of residents in Wigan are 'binge drinkers', with this behaviour declining with age, so whilst over half (55%) of those aged between 18 and 24 binge drink, this falls steadily to one in 12 (8%) of those aged 65 and over, suggesting that binge drinking is a problem with the young.

Residents who work are more than twice as likely to be binge drinkers (46% compared with 21%) among those who do not work, with those working in the skilled trade particularly likely to binge drink (55%).

The survey also revealed that there are fewer binge drinkers living in Orrell (28%) and Aspull-Standish (25%), while more than two fifths of those living in Ashton-Golborne and Swinley binge drink.

The weekly recommended alcohol consumption is 14 units for females and 21 units per week for males. Research has

shown that 26% of females and 36% of males in Wigan consume more alcohol than their recommended amount. [11] For both men and women this is more than twice the average for England of 10% and 15% respectively.

While the survey indicated that Wigan adults drink alcohol less often than people in England and the North West it has the 9th highest level of harmful drinking in the North West. The North West Public Health Observatory estimated that 23% of the adults in Wigan binge drink compared to a national average of 18%. However the estimated rate of binge drinking varies from 18% to 28% within the borough. Areas with higher binge drinking estimates tend to be associated with higher deprivation as the map below demonstrates (Figure 26).

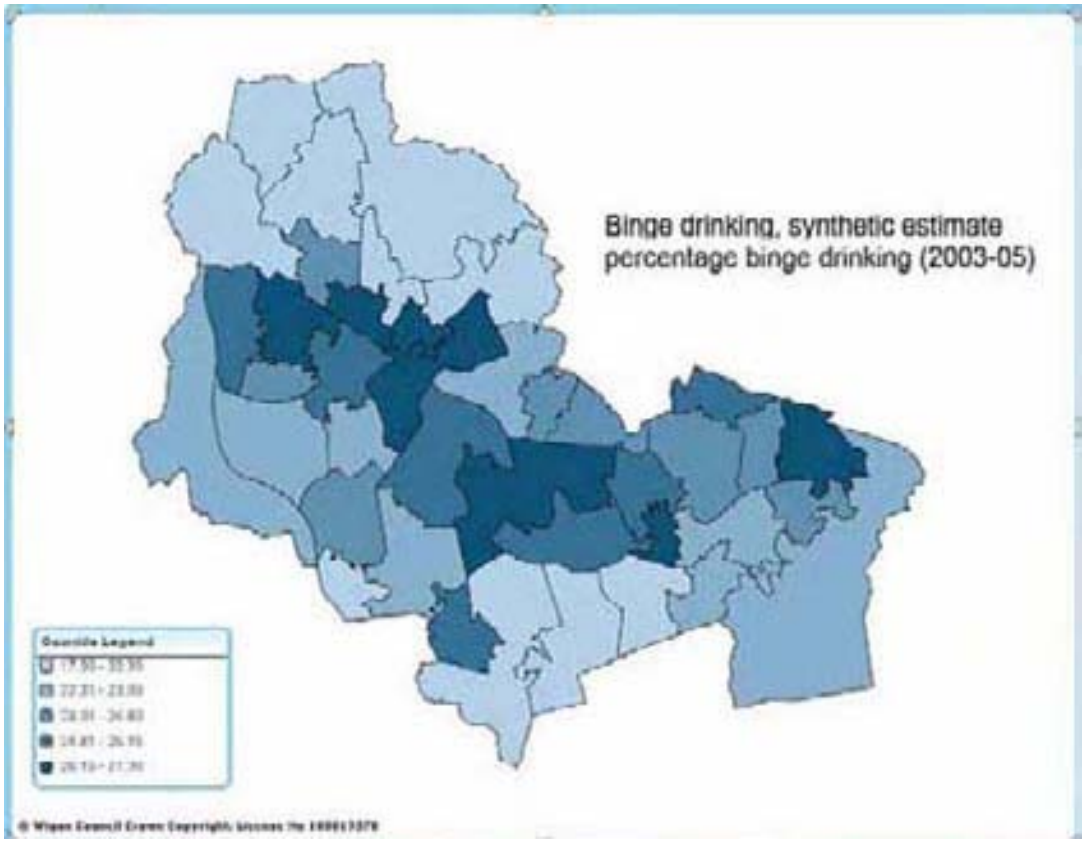
[8] *http://www.ias.org.uk/resources/factsheets/factsheets.html*

[9] *APHO, Indications of Public Health in the English Regions. 8: Alcohol*

[10] *Ipsos Mori (2006), Wigan Borough Health and Lifestyle Survey; Public Health Report 2005/2006*

[11] *The Wigan Borough Health and Lifestyle Survey 2006.*

*Figure 26: Synthetic Estimates of Binge Drinking in Wigan, 2003-05.*




*Source of data: North West Public Health Observatory*

## 9.1 Alcohol Dependence

The Health and Lifestyle Survey revealed that 6% of Wigan residents are dependent on alcohol - a problem which particularly applies to men, those aged between 18 and 54 and those working in the skilled trades occupations (10% compared with 6% overall).

# 9.2 Alcohol Related Harm

There are in the region of 3,000 alcohol-attributable hospital admissions in Wigan annually of which 1,115 are for alcohol specific conditions.

Figure 27 shows that in terms of ranking of hospital admissions nationally, Wigan's ranking for females for alcohol-specific admissions (326) is relatively worse than for males (294), although this is clearly an issue for the North West as a whole for females.

Alcohol attributable admissions are higher in Wigan for both men and women than the regional and England averages, and are amongst the worst in the country (See table 21). The under 18 admission rate for alcohol specific conditions is also cause for concern, confirming the evidence pointing to binge drinking being a particular problem for young people in the Wigan borough. (See table 20).

*Table 20: Alcohol Specific Hospital Admissions 2005-2006*

| | Wigan | | | North West |
|---|---|---|---|---|
| | No of hospital admissions | Rate per 100,000 of age related population | National Rank out of 354 | Rate |
| **Alcohol-specific hospital admission – under 18s** | 217 | 106.0 | **314** | 98.4 |
| **Alcohol-specific hospital admission – males** | 694 | 448.4 | **294** | 536.3 |
| **Alcohol-specific hospital admission – females** | 421 | 274.5 | **326** | 270.1 |

*Alcohol specific conditions are those that are wholly related to alcohol.*
*Source: NWPHO*

*Table 21: Alcohol Attributable Hospital Admissions 2005-2006*

| | Wigan | | | North West | England |
|---|---|---|---|---|---|
| | No of hospital admissions | Rate per 100,000 of age related population | National Rank out of 354 | Rate | Rate |
| **Alcohol-specific hospital admission – males** | 1,878 | 1,203.8 | **319** | 1,214.6 | 909 |
| **Alcohol-specific hospital admission – females** | 1,290 | 713.9 | **331** | 674.3 | 510.4 |

*Note: Alcohol attributable conditions are alcohol specific conditions plus the proportions of other conditions that are likely to be caused by alcohol.*
*Source: NWPHO*

## 9.3 Deaths Due to Alcohol

The average life lost per person dying from alcohol-attributable conditions in the North West is 21.2 years for males and 16.4 years for females. In terms of life expectancy for the population this equates to 11.6 months of life lost for men and 6 months for women in Wigan (See table 22). Wigan months of life lost is significantly higher than the England average, although again, this is fairly consistent with the picture for the North West generally.

*Table 22: Months of life Lost Attributable to Alcohol*

| | Wigan | North West | England |
|---|---|---|---|
| **Males** | 11.6 | 12.6 | 9.4 |
| **Females** | 6.0 | 5.8 | 4.4 |

Wigan has similar rates of mortality from alcohol-attributable and specific deaths to the North West, but significantly higher than the England average, as shown in Table 23 below.

*Table 23: Mortality from Alcohol Attributable & Alcohol Specific Conditions.*

| | Wigan | North West | England |
|---|---|---|---|
| **Male mortality from alcohol attributable conditions** | **59.4** | 58.1 | 47.2 |
| **Female mortality from alcohol attributable conditions** | **27.8** | 29.3 | 23.8 |
| **Male mortality from alcohol specific conditions** | **17.1** | 17.1 | 12.0 |
| **Female mortality from alcohol specific conditions** | **8.2** | 8.6 | 5.4 |

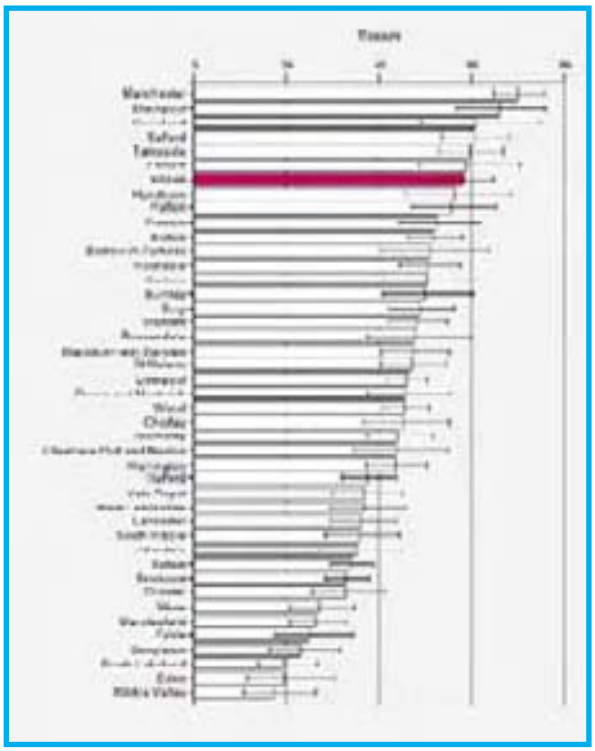
*Directly standardised rates per 100,000 of population. Source: ONS*

Evidence of effectiveness shows that brief interventions by health professionals help a significant number of people drinking over sensible limits to cut down on their drinking. Clearly further work is required to identify who specifically to target, and this will be undertaken over the coming year as part of the investment in tier one services across the Borough.

# 10. Teenage Pregnancy and Sexual Health

Teenage pregnancy is closely associated with negative social, economic and heath factors for both mother and child - principally poor life chances in terms of education, and greater likelihood of living in socio-economic deprivation, and all the poorer health outcomes related to these factors. Wigan has the seventh highest teenage pregnancy rate in the North West (Figure 27).

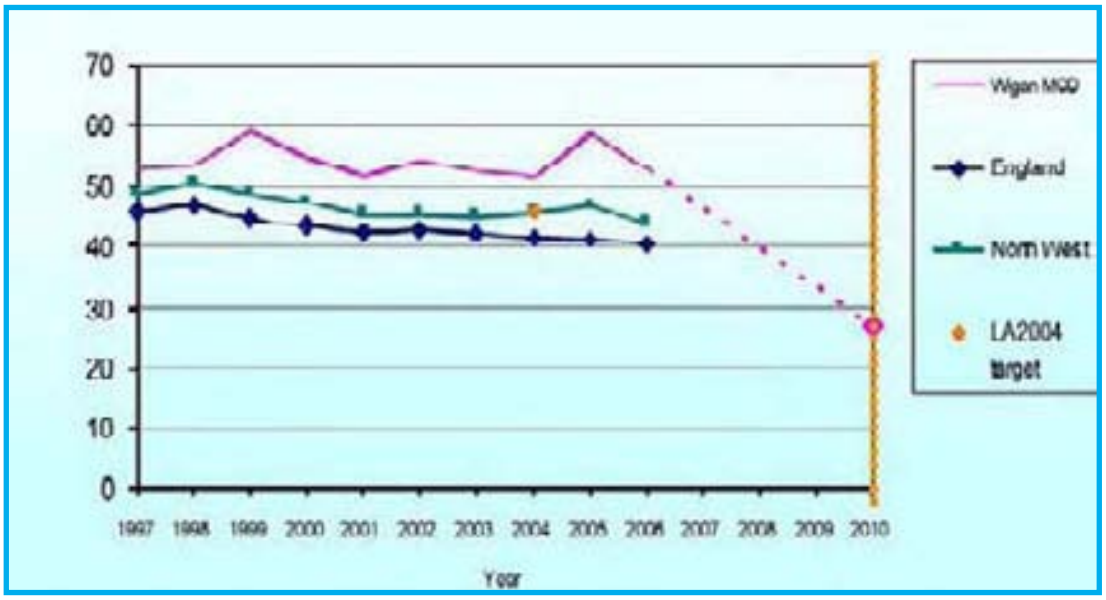
*Figure 27: Under 18 conceptions rate per 1,000 female population aged 15-17 years.*
*Source: NWPHO Office for National Statistics and Teenage Pregnancy*



Latest ONS provisional data for 2006 show the under-18 conception rate in Wigan is 52.9, which is higher than North West regional 44.0 and national 40.4 rates. In 1999, the Government set a target of a 50% reduction of teenage pregnancy by 2010. Wigan has achieved only a 1.2% reduction since 1998 baseline statistics, compared with North West regional (12.5) and national (13.3) reductions which are more favourable (figure 28).

Teenage pregnancy rates vary across the borough with some areas have a rate as high as 61 to 100 per 1000, or between 6% and 10% of 15 to 17 year old girls. Six wards have been identified as hotspot areas (i.e. with a teenage conception rate of 60 per 1,000 population or higher). These wards are amongst the most deprived areas in the borough: Norley; Newtown, Ince, Abram, Atherton and Leigh East.

*Figure 28: Teenage Conceptions 1997 projected to 2010.*




Teenage pregnancy rates vary across the borough with some areas have a rate as high as 61 to 100 per 1000, or between 6% and 10% of 15 to 17 year old girls. Six wards [12] have been identified as hotspot areas (i.e. with a teenage conception rate of 60 per 1,000 population or higher). These wards are amongst the most deprived areas in the borough: Norley; Newtown, Ince, Abram, Atherton and Leigh East.

[12] Utilising the pre 2001 ward boundaries

## 10.1 Second Pregnancies to Teenage Mothers

Wigan had fewer than 10% of second births to teenage mothers, which is half the national average and recognised as an example of good practice. Nationally, Wigan has the lowest (joint first) under-19 repeat abortion rate at 5.1%. [13]

## 10.2 Evidence Relating to Reducing Teenage Pregnancy

There is a limited evidence base to use to inform steps which may be taken to reduce the spread of sexually transmitted infections and the rate of teenage pregnancy. The NICE [14] Review of reviews published in 2003 looked at five approaches to reducing teen pregnancy:

- Education/information
- Peer-to-peer
- Approaches using parents
- Abstinence
- Skills/self esteem

The highest quality reviews concluded:

- That contraceptives were an extremely cost-effective way of preventing unplanned pregnancy.
- Some school sex education programmes, coupled with access to contraception, did increase contraceptive use. Peer-to-peer approaches seem particularly promising.
- 25 studies which aimed to delay initiation of intercourse failed to show an effect.
- 12 studies in over 8,000 young women showed that none of the interventions actually reduced the teenage pregnancy rate. One multi-faceted intervention did appear to reduce the rate, but there were methodological issues about this study, which means that the results may not be reliable.

The lack of clear evidence of the approach to take will mean that a pragmatic approach incorporating the features of effective sex education programmes, coupled with measures to increase contraception availability to young people, should be pursued. Interventions will be assessed for their impact on knowledge, attitudes and behaviour. An on-line tool for monitoring has recently been commissioned by the University of Salford, and is being rolled out to settings where young people come into contact with services. By next year we will have a snapshot of what young people know, believe and practice, which will serve as a baseline on which to assess interventions.

An audit of all contraceptive services will be undertaken over the next 12 months, looking in-depth at general practice provision, as well as the dedicated family planning and young people's sexual health service provided by Brook.

[13] ONS 2006
[14] National Institute for Clinical Excellence

# 10.3 Sexually-transmitted Infections

The picture for sexually-transmitted infections is mixed.

## 10.3.1 HIV

Prevalence and incidence of HIV infection is low in Wigan.
The number of newly diagnosed cases (the incidence) is shown in Table 24.

*Table 24: Incidence of HIV infection in Wigan residents, 2003 – 2007.*

| | 2003 | 2004 | 2005 | 2006 | 2007 |
|---|---|---|---|---|---|
| **New cases of HIV** | 10 | 16 | 18 | 18 | 18 |

*Source: North West Public Health Observatory.*

The total number of cases (the prevalence) at the end of 2007 was 105 for Wigan. The total number of HIV positive people accessing treatment and care in the North West in 2006 was at its highest ever at 4,761 - a 13% increase on 2005 (4,195). However, the 2006 data also show, for the first time in more than ten years, a down-turn in the number of new HIV cases and a 2% decrease (907 new cases) compared to 2005 (928 new cases). By comparison between 2004 and 2005 there was a 14% increase in new cases.

## 10.3.2 Chlamydia

The national screening programme for Chlamydia infection has been rolling out over the last few years, targeting people aged 15 to 24 years. The programme started in Wigan in October 2006. Despite our recent start we are now amongst the better performers for screening uptake both regionally and nationally, in the top 10%. Unfortunately, Wigan is in the top 10% in the country for prevalence of Chlamydia, too.

Data for the other sexually transmitted infections is unreliable at the district level, so is not presented here.

However rates of sexually transmitted infections in Greater Manchester are amongst the highest in the country. These two factors imply that a lot of people are having unprotected sex in the area, and so this is a priority issue.

# 11. Obesity

The national prevalence of obesity has trebled since the 1980s. In 2004, 23% of men and 24%of women were obese and almost two-thirds of all adults (approximately 31 million adults) were either overweight or obese. If current trends continue, at least one-third of adults, one-fifth of boys and one-third of girls will be obese by 2020. The average Body Mass Index (BMI - a measure weight for height) for the UK adult population has increased to the point (27 kg/m$^2$) where it is over the healthy range (18.5 – 24.9kg/m$^2$).

*Table 24: Body Mass Index Ranges.*

| | Underweight | Normal | Overweight | Obese | Very Obese |
|---|---|---|---|---|---|
| BMI | Less than 18.5 | **18.5-24.9** | 25-29.9 | **30-39.9** | 40+ |

Obesity is a condition of an excessive accumulation of body fat which usually occurs when there is an imbalance between the calories that an individual consumes and what they expend. Evidence suggests that the main reason for the rising prevalence of overweight and obesity is a combination of less active lifestyles and changes in eating patterns. Therefore, although serious illness which restricts activity can contribute to becoming overweight, the current obesity epidemic can be better understood in social, behavioural, environmental and psychological as well as physiological terms – technological advances are said to have created an 'obesogenic' environment (Foresight Report 2008) Obesity has been estimated to reduce life expectancy on average by nine years and is responsible for 9,000 premature deaths a year. Overweight or obese people have a significantly increased risk of a range of diseases, including:

| Condition | Magnitude of obesity effect |
|---|---|
| Hypertension (high blood pressure) | 5 fold increased risk. 85% of hypertension is in people with a BMI > 25 kg/m$^2$ |
| Type 2 diabetes | 90% of Type 2 diabetics have a BMI > 23 kg/m$^2$ |
| Coronary heart disease and stroke | 2.4 fold increased risk in women; 2 fold increased risk in men |
| Osteoarthritis and other joint disease | Frequent association of joint problems with obesity in older people |
| Sleep apnea and respiratory problems | |
| Cancers | 10% of all cancer deaths in non smokers; 30% in endometrial cancer |
| Gall bladder disease | 3 fold risk of gall bladder disease in women with a BMI > 32 kg/m$^2$ |
| Infertility | 6% of primary infertility attributable to obesity |
| Impotence | Frequently associated with obesity |

While obesity has a substantial human cost by contributing to the onset of disease and premature death it also has serious financial consequences for the NHS and for the economy. The economic costs of obesity are estimated at between £3.3 billion and £3.7 billion per year and the costs of obesity plus overweight at between £6.6 billion and £7.4 billion per year.

Estimates of the current obesity prevalence in Wigan vary; the local health and lifestyle survey (self-reported) indicated overall prevalence among adults at 19%. Considerable variation is shown by age. In general, younger people (those aged 18-24) tended to have healthier BMI's whereas both male and females in the 55 to 64 age group estimated at 24% obesity. This would mean that there are over 80,000 obese people in Wigan. The survey also showed large numbers of overweight individuals with some sections of the population having levels as high as 44% (see table 25).

*Table 25: Obesity prevalence in Wigan aged 18 and above.*

| Age → | | | 18 - 24 | | 25 - 34 | | 35 – 54 | | 55 - 64 | | 65+ | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Gender → | | Total | Male | Female | Male | Female | Male | Female | Male | Female | Male | Female |
| Category ↓ | Population | 224882 | 8074 | 8066 | 21920 | 22148 | 42650 | 43117 | 17899 | 17572 | 18067 | 25369 |
| | | | | | | | | | | | | |
| Underweight | Prevalence | 2991 | 267 | 432 | 271 | 359 | 257 | 262 | 200 | 133 | 184 | 627 |
| BMI<18.5 | % of pop | 1 | 3 | 5 | 1 | 2 | 1 | 1 | 1 | 1 | 1 | 2 |
| | | | | | | | | | | | | |
| Normal | Prevalence | 80051 | 4337 | 4149 | 9291 | 11023 | 10357 | 16392 | 4475 | 5757 | 5383 | 9212 |
| BMI 18.5 – 24.9 | % of pop | 36 | 54 | 51 | 42 | 50 | 24 | 38 | 25 | 33 | 30 | 36 |
| | | | | | | | | | | | | |
| Overweight | Prevalence | 78514 | 1668 | 1527 | 8299 | 5998 | 20006 | 13166 | 7791 | 5791 | 7632 | 8006 |
| BMI 25-29.9 | % of pop | 35 | 21 | 19 | 38 | 27 | 47 | 31 | 44 | 33 | 42 | 32 |
| | | | | | | | | | | | | |
| Obese | Prevalence | 41826 | 667 | 730 | 2706 | 2820 | 8749 | 8981 | 4355 | 4260 | 3282 | 4148 |
| BMI 30-39.9 | % of pop | 19 | 8 | 9 | 12 | 13 | 21 | 21 | 24 | 24 | 18 | 16 |
| | | | | | | | | | | | | |
| Very Obese | Prevalence | 4178 | 67 | 100 | 0 | 718 | 515 | 1264 | 40 | 399 | 258 | 579 |
| BMI 40+ | % of pop | 2 | 1 | 1 | 0 | 3 | 1 | 3 | 0 | 2 | 1 | 2 |

*Source: Wigan Borough Health and Lifestyle Survey 2006, and the Office National Statistics Population Projections for 2006.*

Between 2006 and 2001, residents' BMI has increased, with a fifth of people being classified as obese or very obese compared with 15% in 2001, with men more likely to be over weight (42%) compared to women (29%). Mapping obesity across the borough shows large variations between areas.

*Figure 29: % of Residents who are "Obese" or very "Obese"*
*(Body Mass Index 30- 39 and > 40 respectively)*

*Source: WISDOM*

Obesity has strong associations with socio-economic status and is more common in socially disadvantaged groups and women. The Wigan Health and Lifestyle Survey (2006) revealed that, in general, those living in more deprived areas tended to have a slightly higher BMI (as highlighted in red in figure29) - a result of a higher proportion of residents being obese (22% compared with 17% overall). It was also found that the percentage of people underweight was higher in the deprived areas, so that there are fewer people in the normal weight range.

## 11.1 Obesity in Children

As can be seen from table 24, the proportions of children in reception who are overweight or obese are above both the North West and England averages. However, in Year 6, the percentage drops to below these comparator averages.

*Table 24: Percentages of Overweight and Obese Children 2006/07*

| 2006/07 | % Overweight | % Obese |
|---|---|---|
| **Reception** | | |
| **England** | 13.0 | 9.9 |
| **North West** | 13.8 | 10.2 |
| **Wigan** | **15.4** | **10.3** |
| **Year Six** | | |
| **England** | 14.2 | 17.5 |
| **North West** | 14.1 | 17.3 |
| **Wigan** | **13.8** | **16.9** |

As obesity prevalence increases it is predicted that there will be many more older people with obesity.

*Table 25: People aged 65 and Over with a Body Mass Index (BMI) above 30, by Gender and Age group (65-79, and 80 and over), Projected to 2025.*

| | 2008 | 2010 | 2015 | 2020 | 2025 |
|---|---|---|---|---|---|
| Males aged 65-79 with a BMI above 30 | 3,916 | 4,158 | 4,884 | 5,016 | 5,082 |
| Males aged 80 and over with a BMI above 30 | 760 | 800 | 1,000 | 1,340 | 1,740 |
| Females aged 65-79 with a BMI above 30 | 5,265 | 5,589 | 6,507 | 6,750 | 6,939 |
| Females aged 80 and over with a BMI above 30 | 1,950 | 1,924 | 2,080 | 2,418 | 2,938 |
| Total population aged 65 and over with a BMI above 30 | 11,891 | 12,471 | 14,471 | 15,524 | 16,699 |

*Source: Health Survey for England 2000, The Health of Older People.*

Reducing the increase in obesity and increasing the percentage of people in the normal weight range are key challenges. The Foresight Report [15] reviewed the evidence, projected data, explored different scenarios for impact and detailed how this might be achieved. Policy support is required at national and local levels, to make it easier for people to be more physically active change social norms.

The top five policy responses assessed as having the greatest average impact on levels of obesity across the scenarios were:

- Increasing 'walkability' / 'cyclability' of the built environment.
- Targeting health interventions for those at increased risk (if they can be identified and only if reinforced by interventions at the population level)
- Controlling the availability of/exposure to obesogenic foods and drinks.
- Increasing the responsibility of organisations for the health of their employees
- Early life interventions at birth or in infancy

[15] http://www.foresight.gov.uk/OurWork/ActiveProjects/Obesity/Obesity.asp

# 12. Mental Health

## 12.1 Mental Health – Adults

Official figures suggest that 20% of women and 14% of men in England have some form of 'mental illness'. This is thought to be higher in the North West region. Approximately 13,000 men and 18,500 women between the ages of 18 and 64 in Wigan have some form of mental illness.

The Wigan Borough Health Survey (2006) provides some information about the mental health status of the population, the results of which indicate that one fifth of Wigan residents claim to have suffered from nervous trouble or depression. Further, there is a higher prevalence amongst Women (23%). Those in the middle of the age spectrum (22% of those aged between 25 and 64) and those living in the more deprived areas (25%).

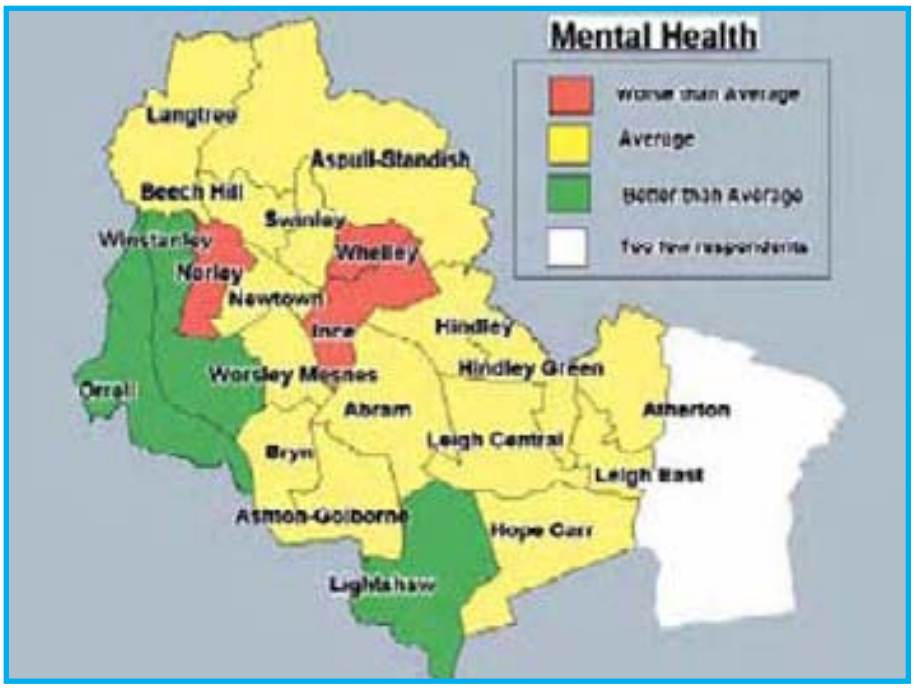
The survey also revealed that 15% of residents are distressed, with women somewhat more likely than men to be distressed (16% compared with 13%). Further, unemployment increases the likelihood of becoming distressed or having severe problems and psychological distress by 7%. It is possible that this lower level of well being may partially be a result of not working and the isolation that can be associated with that, or it may be the reason that residents cannot work. Either way, the cycle of worklessness and mental ill health needs to be broken.

On the whole, residents living in the most deprived areas are more likely to be distressed and have severe problems and psychological distress than is the case overall, (29% compared to 20% overall).

The survey also found that on the whole, social well being is higher in Winstanley and Orrell, but lower in Ince, Whelley and Norley, again highlighting that it is the more deprived areas suffering from a lack of social well being.

Perhaps of greater concern is that a Commissioning Needs Analysis [17] carried out in 2006 reported that, "Although various studies produce wildly different figures regarding mental health in the Borough, it would appear that over 90% of people with a mental health need are not accessing services." [18] If this is the case, more work will need to be carried out to identify any 'hidden' people suffering from mental health problems.

*Figure 30: Mental Health across the Borough*




*Source: Healthier Lifestyles Survey*

[17] http://boston/socs/performance/cna/cna-mh.pdf
[18] http://www.wigan.gov.uk/NR/rdonlyres/5D0B1433-1CE7-4F76-A836-3D0D6C374696/0/MentalHealth.pdf

There appears to be inequality in mental health within Wigan with more people suffering from mental health problems in the more deprived areas, and with higher prevalence amongst women. As mentioned in the Employment and Worklessness section of this document, there appears to be a link between poor mental health and worklessness - the higher the prevalence of mental health, the more likely it is that somebody will be claiming out of work benefits and are therefore 'workless'.

A joined up approach is being taken to address the levels of worklessness, employment and mental health. In order to achieve this, more support from employers is needed, and training to get people back to work, tailored to the needs of the various groups of individuals. Such initiatives need to continue to focus on areas of deprivation where mental health problems appear to be more prevalent.

In terms of social well being, more work needs to be carried out to improve peoples' happiness in the more deprived areas. In order to do this, all elements which affect quality of life will need to be considered. Investigation is also needed into identifying people with mental health needs in the borough who are not accessing services and to raise people's awareness of the services which are available to them.

## 12.2 Children's Mental Health and Wellbeing

The emphasis on Children's Mental Health Services is now moving towards an emphasis on prevention, through the promotion of healthy lifestyles.

In addition to this, the 2006 Joint Area Review (JAR) [19] recommended we take steps to avoid the admission of young people with mental health problems to adult wards. Currently, no young person under the age of 16 is admitted to an adult ward. Those aged 16-19 are occasionally admitted to adult wards, but only in line with a robust protocol for safeguarding children. This includes a joint assessment carried out with Child and Adolescent Mental Health Services (CAMHS), from which age appropriate intervention is agreed. Plans are in place to provide additional in-patient beds (including an 8 bed adolescent unit), but currently agreements are in place with neighbouring Local Authorities for us to access capacity if needed.

Finally, as a result of the needs identified in the Children's Annual Performance Assessment (APA) in 2007, a clear Mental Health Promotion strategy has been developed, which determines commissioning of work around highlighted areas: prevention of suicide, anti-bullying strategies, work to address eating disorders and support for children in care as these were the needs identified.

[19] http://www.audit-commission.gov.uk/reports/JOINT-REVIEW.asp?CategoryID=ENGLISH%5E576%5ELOCAL-VIEW%5EAUTHORITIES%5E109256&ProdID=D93FF05D-9793-44f3-87DF-94627E233D5E

# 13. Oral Health

Oral health in Wigan is poor compared to other parts of the North West and compared to England as a whole. Socio-economic factors are key determinants of oral health within the borough, and, as in other areas, a strong association is found between oral health and deprivation.

The two main oral diseases - dental caries (decay) and periodontal (gum) disease – are almost entirely preventable, yet they still affect the majority of the population at some time in their lives. Dental caries is linked to diet - particularly the amount and frequency of sugar intake (food and drinks). Fluoride has a protective effect - for example by flouridation of the water supply and tooth-brushing. Smoking is also a risk factor for periodontal disease and oral cancer.

Regular surveys of children's oral health allow for comparisons between communities within the North West and with the rest of England. Dental health is measured using the Decayed Missing Filled Tooth (DMFT) score.

## 13.1 Young People's Oral Health

Children's dental health remains poor in Wigan compared to other areas, despite the overall general improvement in children's dental health that has occurred over the past three decades (see figure 31). The last published local survey of children's dental health (2005/06) found that almost half (49%) of the borough's five year olds had some experience of tooth decay and each child had an average of 2.11 decayed, missing or filled teeth (compared to 47% and 2.00 across the north west and 38% and 1.47 in England as a whole). A similar picture is seen amongst older children as illustrated by figure 32. Because of the strong correlation between poor dental health and social and economic deprivation, children in poor families tend to experience the highest levels of dental disease.

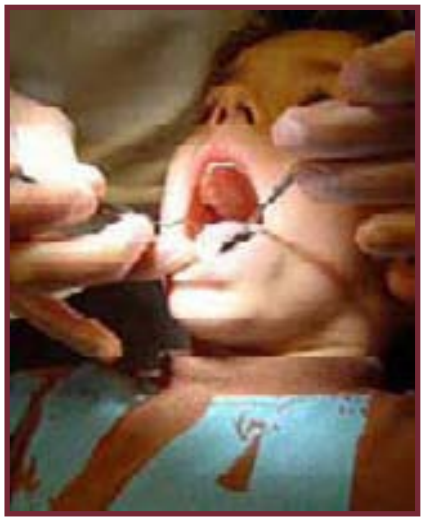
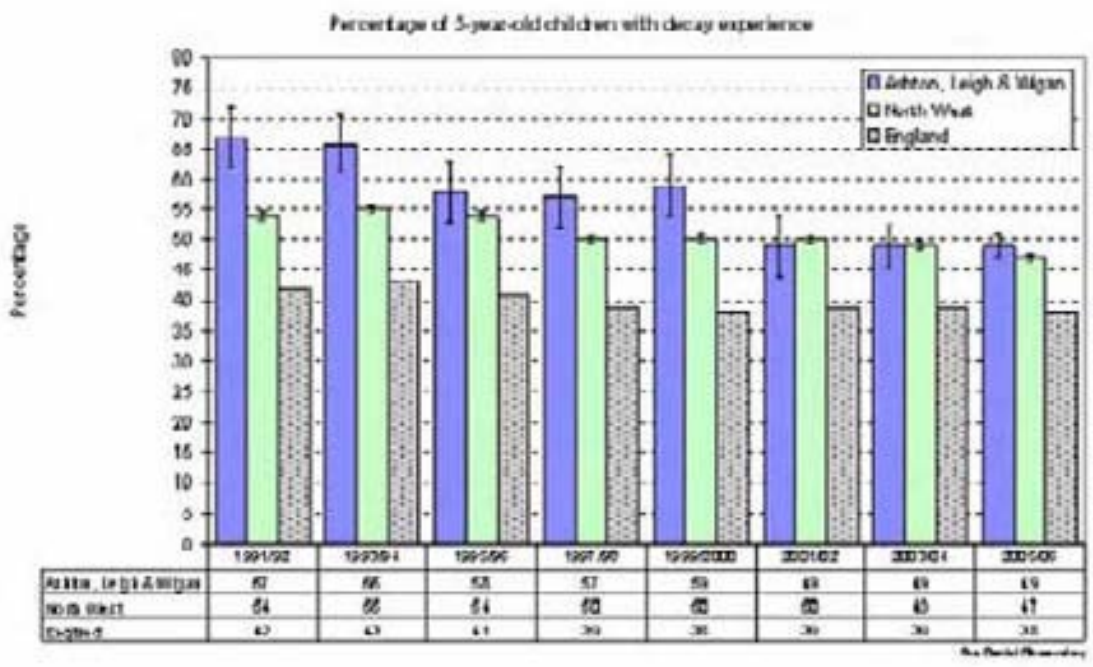
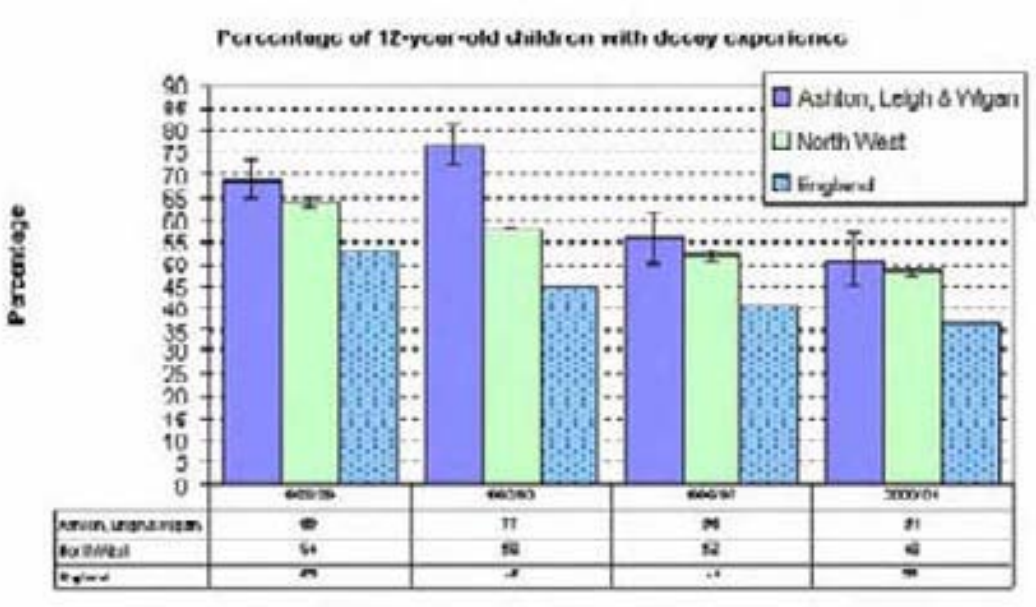


*Figure 31*




*Source: The Dental Observatory*

*Figure 32*




*Source: The Dental Observatory*

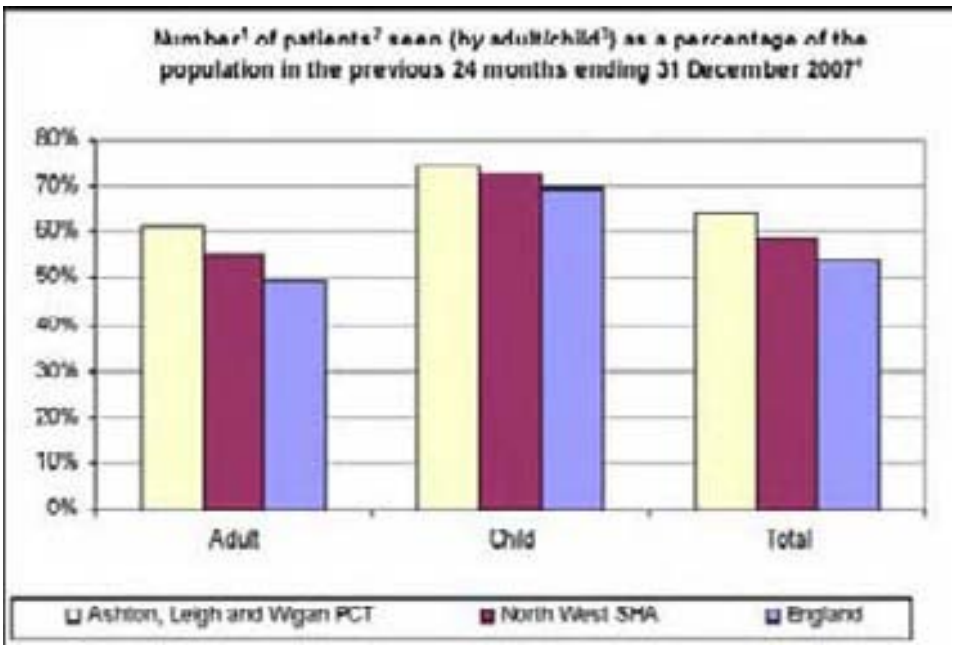
## 13.2 Adult's Oral Health

Although very little information is available regarding the oral health of adults at a local level, all of the available data points towards adults in Wigan having poor oral health compared to those in other areas.

Inequalities are also found in dental service uptake. Although Wigan compares well to other areas for the percentage of the population accessing NHS dental services (see figure 33), the Wigan Borough Health and Lifestyle Survey 2006 found that men are less likely to visit the dentist than women, as are younger residents aged between 18 and 24. This survey also differences between the more deprived and affluent areas of the borough. For example, 26% of residents in Worsley Mesnes had last visited the dentist over a year ago compared to 10% of residents in Standish.

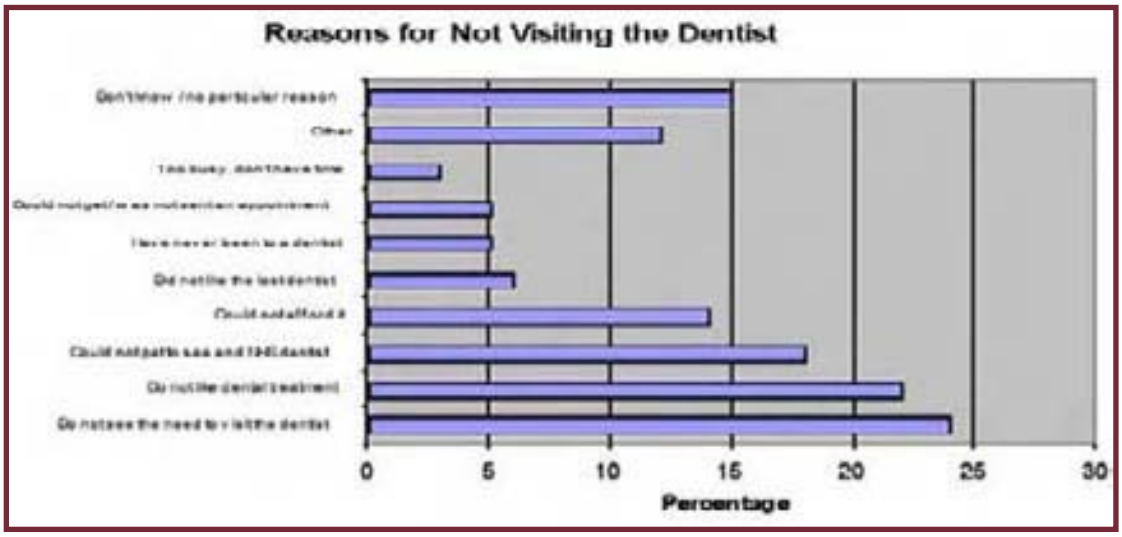
Respondents who had not visited the dentist in the last two years gave a variety of reasons for this (see figure 34).

*Figure 33*




*Source: Information Centre (http://www.ic.nhs.uk)*

*Figure 34*




*Source: Wigan Borough Health & Lifestyle Survey (2006)*

Oral health and dental services remain key priorities in Wigan and NHS Ashton Wigan and Leigh (ALW Primary Care Trust) has developed an Oral Health Strategy which aims to improve oral health, reduce oral health inequalities and improve dental services. A range of initiatives are planned and/or in progress and include increasing the amount of effective prevention delivered by dental practices through local implementation of *Delivering Better Oral Health* [20], a new scheme to support dental practices in delivering Stop Smoking interventions, the introduction of fluoride tooth-brushing schemes for young children and oral health promotion within HMP Hindley (see appendix 2). In addition, ALW PCT is commissioning new dental services in line with the needs of local people.

[20] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_078742

# 14. Young People

Outcomes for children and young people living within Wigan are good. However, there are inequalities in their health and welfare, which can be linked to the high levels of deprivation prevalent in certain areas of the borough.

Needs assessment activities undertaken on behalf of the Children, Young People and their Families Strategic Partnership, have identified the following key issues facing children and young people within Wigan:

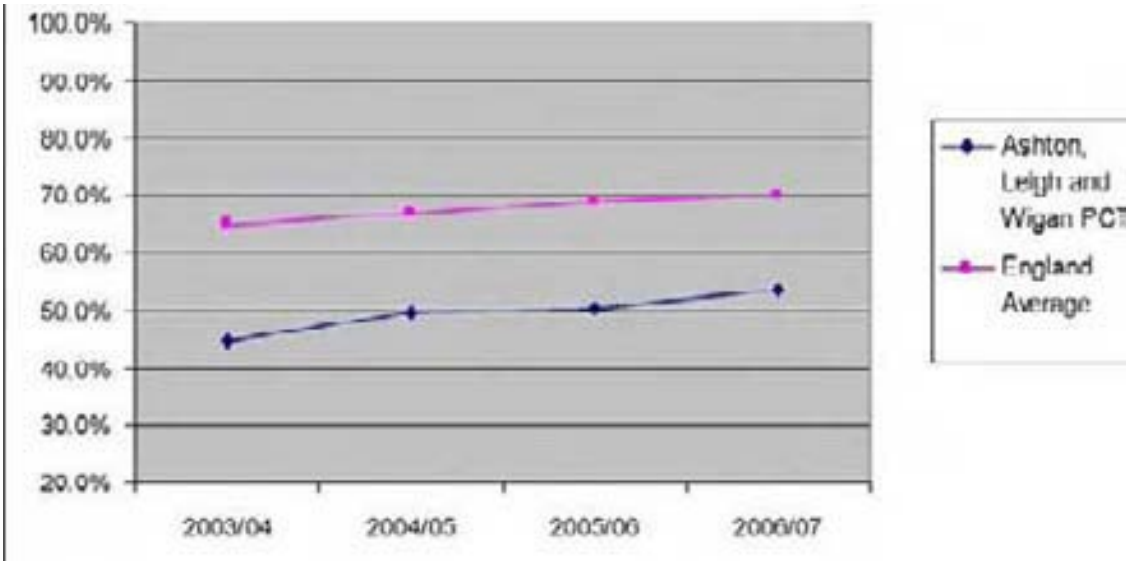
- High levels of teenage conceptions, including a need to improve access to sexual health services.
- Low levels of breastfeeding initiation, along with a requirement to tackle obesity, alcohol/substance abuse and improve dental health and emotional resilience.
- A need to safeguard children and young people though improved prevention, early intervention and community engagement.
- Significant inequalities in attainment between our most disadvantaged communities and the population as a whole.
- A need to improve the range and accessibility of positive activities for all children and young people and reduce offending / anti-social behaviour.
- Above average numbers of young people aged 16 to 19 not in education, employment or training.

Through consultation, children and young people have said that they feel generally healthy, but that they would like information and support around issues such as healthy eating, alcohol, smoking and drugs. The 2006 Health and Lifestyle Survey highlighted that binge drinking and under age drinking was a main area of concern for young people. Children and young people have also identified a need for more confidential support when stressed or worried; sexual health education to be taught at school by non-teaching staff such as youth workers and, more information about sexually transmitted diseases and where to go to get tested.

## 14.1 Breastfeeding

Breastfeeding, especially in the first six months, is generally accepted to have health benefits for the child. However, Wigan's local breastfeeding initiation rate of 53.2% (2006/07) is considerably below the national average (69.6%).

*Figure 35: Proportion of Mothers Initiating Breast Feeding*



There is an improving trajectory, assisted by a number of partnership initiatives - for example the recruitment of peer volunteers from vulnerable groups to provide assistance within the maternity unit and breastfeeding support groups and within mothers' homes. However, in order to try to significantly increase and maintain breast feeding rates and close the gap between Wigan and England, a bespoke specialist breast feeding service is being commissioned. This will commence in 2009.

## 14.2 Children in Need

Children in Need are defined as 'vulnerable children, who are unlikely to reach a satisfactory level of health and development without the use of services'. The definition includes Children with a Protection Plan, Children in Care and those with a high level of needs where parenting may be compromised. Outcomes for Children in Need are worse than for the general population, including for example, higher levels of substance misuse, increased likelihood of becoming a teenage parent, poor educational achievement and greater risk of developing a limiting long-term illness in later life.

*Table 26: Breakdown of Children in Need in Wigan.*

| Group | Definition | Numbers | | |
|---|---|---|---|---|
| **Children in Care** | Children who are looked after by the local authority (data relates to 31st March 2007). | **Age** | | **Number** |
| | | 0-4 | | 100 |
| | | 5-9 | | 78 |
| | | 10-14 | | 128 |
| | | 15-18 | | 94 |
| | | **Total** | | **400** |
| **Children with a Protection Plan** | Children with significant needs and compromised parenting/caring and in need of protection from harm. | **Year** | **Number** | **Number per 10,000 population aged under 18** |
| | | 2005 | 117 | 17.2 |
| | | 2006 | 92 | 13.6 |
| | | 2007 | 95 | 14.2 |
| **Children with disabilities** | Data has also been obtained from the Children's Disability Register, a voluntary database (as at December 2007). | **Type of Disability** | | **Number** |
| | | Physical disability | | 95 |
| | | Learning disability | | 162 |
| | | Sensory disability | | 8 |
| | | Behavioural/Emotional disability | | 52 |
| | | Multi-disability | | 184 |
| | | **Total on Record** | | **501** |
| **Young Carers** | The NSPCC estimates that 4% of children will be young carers at some point in their lives, which equates to 3,000 potential young carers within Wigan. There are approximately 320 young carers presently known to the Young Carers Team. | | | |

*Source: Local Data (Wigan Council).*

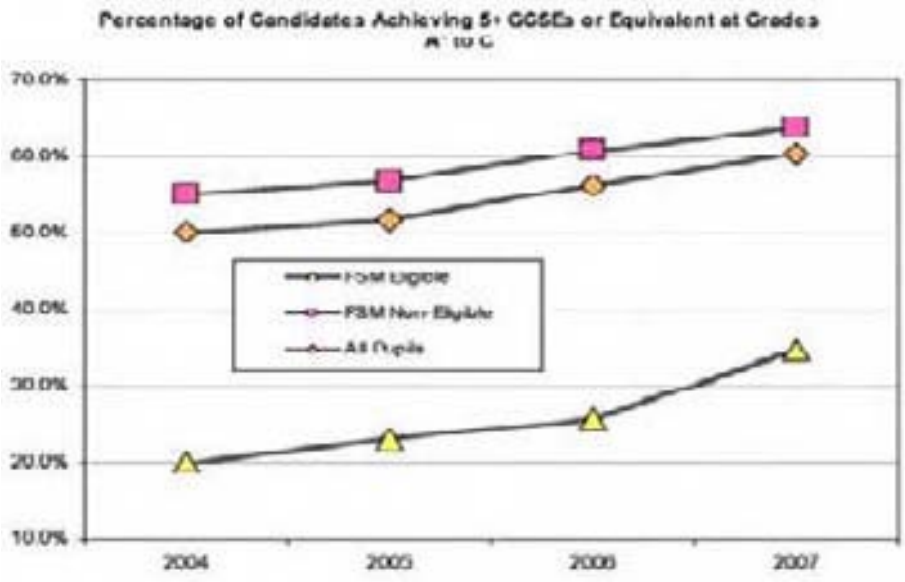
Children in Need are defined as vulnerable children who are unlikely to reach a satisfactory level of health and development without the use of services.

A snap shot taken in January 2008 showed that there were 2,030 Children in Need within Wigan. The most common reasons for social care involvement were linked to family dysfunction and abuse, or neglect.

## 14.3 Educational Attainment

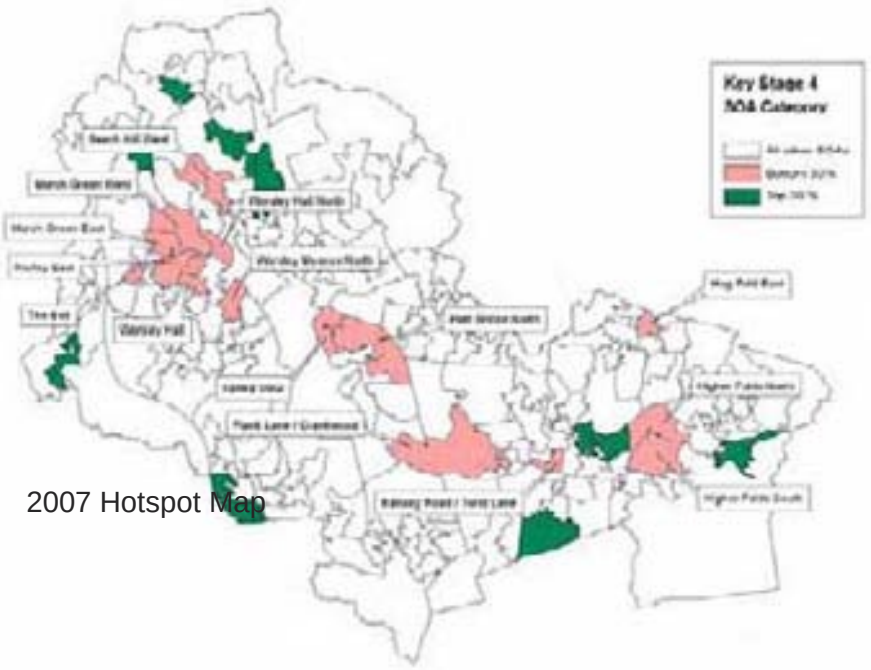
Attainment levels for pupils attending Wigan schools are broadly in line with, or better than our statistical neighbours and the England average. However, there is an attainment gap between the 3% most deprived lower super output areas and the Borough average, although this seems to be narrowing. This is demonstrated in the figure below, which compares Key Stage 4 (GCSE) performance within Wigan between those who are and are not eligible for free school meals (FSM).

*Figure 36: 2007 Attainment Hotspot Areas*




The Foundation Stage Profile (FSP) is a statutory stage of the National Curriculum and measures the achievement of children in the summer term preceding a child's transition to a Key Stage 1 programme of study. The child will usually have reached the age of 5 by this time. The assessment measures the progress of children against a range of criteria including personal, social and emotional development and communication, language and literacy.

*Figure 37: Super Output Areas within the borough that consistently had the 30% Lowest (and highest) Attainment Results in 2007*




2007 Hotspot Map

The map illustrates the super output areas within the borough that consistently had the 30% lowest (and highest) attainment results in 2007, from the Foundation Stage Profile, through to GCSEs.

Educational achievement is directly linked to long-term health outcomes [21]. Inequalities in attainment, therefore, need to be tackled to ensure that all young people have the best start in life.

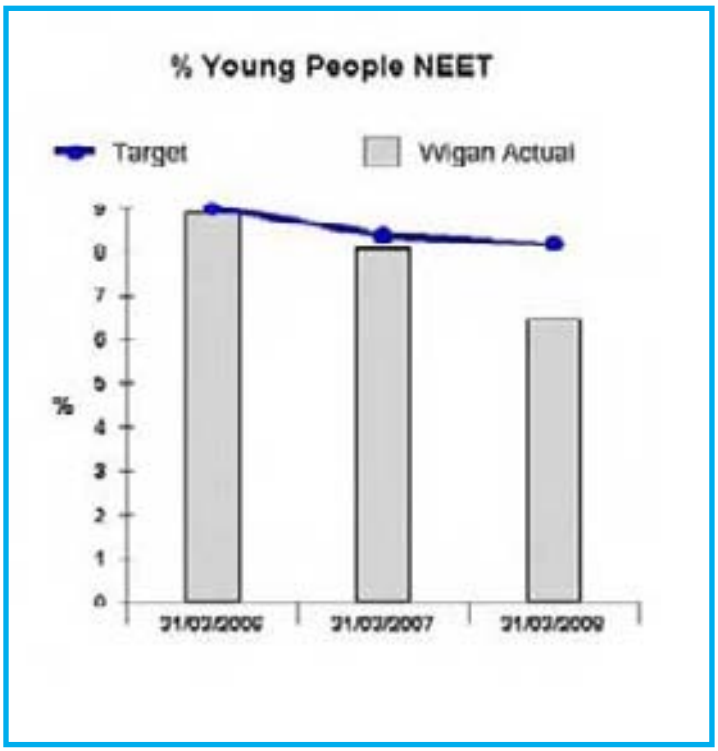
[21] Wiggins, R., Scofield, P., Sacker, A., Heald, J., and Bartley, M. (2004) Social position and minor psychiatric morbidity over time in British Household panel survey 1991-1998: J Epidemiol Community Health, 58(12).

## 14.4 Education, Employment and Training for Young People

Supporting young people upon leaving schools to enter in to either further education, employment or training ensures better outcomes.

As can be seen from the graph below, the numbers of young people not in education, employment or training (NEET) are reducing, with better than average (and improving) performance in re-engaging young people who have been NEET in learning and employment. This has been achieved through a range of interventions, including targeted work with those at risk of being NEET from Year 9 onwards and the September Guarantee (ensuring that all Year 11 school leavers have the offer of a learning place).

*Figure 38: % of Young People Not in Education, Employment or Training*




*Source: Connexions Customer Information Systems 2008*

# 15. Social Care

Social care covers a whole range of services which support people in a variety of ways. Such support ranges from care homes and meals on wheels to community services for a range of service user groups, which include older people, people with physical disabilities, people with mental health problems and those with learning disabilities. Social care also covers support for carers.

The full extent of social care need in the borough is difficult to determine. Some inferences can be made from the data relating to the proportion of people who have a long term debilitating illness or disability. Wigan has high levels of long term disability and illness. At 22.9% the borough is ranked 44th (out of 376) nationally and 9th (out of 43) regionally. In other words, reliable records in each local authority area relate only to provision of services rather than to need.

Every local council in England uses a national framework from the Department of Health to decide what are known as 'eligibility criteria' for the adult social care services it provides. The aim is to have greater consistency across the country on how decisions are made about whether people have services or not.

An assessment is completed for any person with a presenting need, and the assessment identifies and evaluates the individual's presenting needs and associated risks to independence. The seriousness of the risk to independence is then graded into four bands: 'Critical'; 'Substantial'; 'Moderate' and 'Low'. Like most local councils, Wigan Council provides services only to those with 'critical' and 'substantial' levels of need, and signposts all others to a range of agencies providing 'preventative services', some of which it also funds.

Hence, figures given below relating to the total number of adults receiving social care services does not represent data about all need, but only about 'critical' and 'substantial' need.

The total number of adult service users of all age groups receiving social care services during the period 2006/07 was 10,165. Of these 3,621 (35.6%) were aged 18-64 years and 6544 (66.4%) were aged 65 and over. Of those aged 18 to 64 years of age who received services, 39% fall under the category of physical disability, frailty or sensory impairment, 24% have learning disabilities and 37% have mental health needs.

Currently there are in excess of 13,000 contacts per year made to the Council and of these around 2,800 people make a self-referral.

## 15.1 Timeliness of Assessment and Provision of Care

The Council is judged on the timeliness of providing an assessment to new clients and also on the length of time before care is provided.

Expectations are that an assessment will be completed within 28 days of contact being made to the Department of Adult Services. Once a client is assessed as having substantial or critical needs, the aim is to provide a care package within 28 days of the assessment.

## 15.2 Direct Payments

Direct payments are made by councils to people who have been assessed as needing help from social services, and who would like to arrange and pay for their own care and support services instead of receiving them directly.

Improvement in the take up of Direct Payments has been a focus for the Council and figures for January 2008 show that there are 293 people in Wigan receiving Direct Payments. This is an increase of 61% on the figure reported for 31/03/2007. Of these 210 are under 65 years of age and 83 people are aged 65 and over.

## 15.3 Carers

A carer is someone who looks after a relative, friend, or neighbour who needs support because of a physical disability, a learning disability, a physical illness, a mental illness, substance misuse problem or limiting illness.

There are currently 5,354 people aged 65 and over providing unpaid care to a partner, family member or other person, projected to rise to 7,117 in 2025. Of these, 171 are aged 85 and over.

There are 1,641 people aged 65-74 and 688 people aged 75-84 providing care for 50 or more hours per week. 95 of people aged 85 and over are currently providing care for 50 or more hours per week. All of these figures are projected to rise steadily to 2025. It is estimated that three in five of all carers receive no regular visitor support services at all, and that between a quarter and a half of all carers have health problems of either an emotional or physical nature (ONS 2001).

Whilst a GP Registration Scheme is currently in place to identify 'hidden carers', with the aim of improving and maintaining the health of carers, such schemes will need to continue to develop to meet the needs of an ageing carer population. For more information see the Carers Strategy at: http://www.wigan.gov.uk/Services/HealthSocialCare/Carers/

## 15.4 Self Care

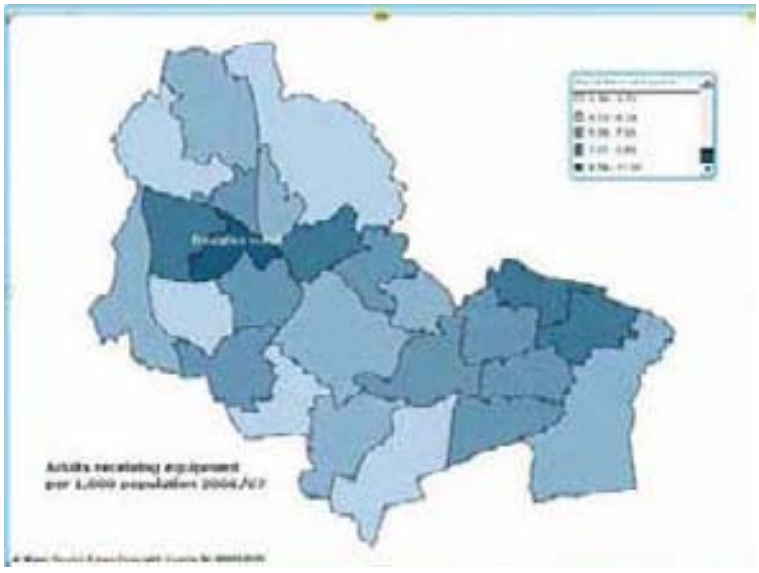
There are currently 16,464 people aged 65 or over in Wigan who are unable to carry out at least one domestic task on their own. Such tasks include household shopping, washing and drying dishes, cleaning windows inside, and jobs involving climbing. Also it is estimated that 15,092 people over the age of 64 years are unable to manage one self-care activity. Examples of self-care activities include bathing, dressing, feeding or cutting toenails. These figures are expected to rise significantly to 23,034 by 2025.

## 15.5 Occupational Therapy

In the year ending 31 March 2007, a total of 3,417 items were supplied. These included 998 small adaptations and 2419 pieces of equipment. These items were provided to 1592 clients who were assessed as requiring equipment and small adaptations, 28% were in the age range of 18 to 64 years, 24% were aged 65 to 74, 32% were aged 75 to 84 and 16% were aged 85 and over. (Figures obtained from local information: Wigan Council).

Douglas ward had the highest proportion of people receiving equipment during 2006/07 in both age bandings of 18-64 years and 65 years and over. Winstanley ward had the lowest proportion of all adults who received equipment.

*Figure 39: Adults receiving equipment per 1,000 population by Ward in 2006/2007*



## 15.6 Learning Disabilities

It is estimated that 2% [23] of the population have a learning disability, which equates to 6101 people in Wigan (based on the 2006 mid year population estimates), with 81% of adults with learning disabilities being aged 20 or over.

Research suggests that just 20% of adults with learning disabilities are known to learning disability services.[24] Given that the table below shows that there are 950 adults with learning disabilities and their carers who use social care services in Wigan, it may be assumed that that there are a remaining 4750 adults in the Borough who are not. This is partly because social care agencies deliver services to those who need them and many people who have a disability still do not require support of this kind or actively choose not to sustain their status as 'learning disabled' into adulthood.[25] However, the number is still high - indicating that there may also be people who need support who are unintentionally 'slipping through the net'.

There are a higher number of people with learning disabilities between the age of 18 and 64 being helped to live at home compared to the North West and England. This is encouraging and reflects a move towards alternative provision to residential care for people with Learning Disabilities to enable independence. Further, the percentage of all service users aged 18 and over receiving services that are 65 and over is noticeably higher within Wigan when compared to the North West and England (see table 27 over page).

Within the borough a higher proportion of people with learning disabilities aged between 18 and 64 are helped to live at home when compared to the England and North West average. In the future we will need to continue to help people with learning disabilities to remain living at home if we are to promote independence and provide personalised services.

*Table 28: Helped to Live at Home*

| People with learning disabilities aged 18-64 years who are helped to live at home per 1,000 population age 18-64 years | **England** | **North West** | **Wigan** |
|---|---|---|---|
| | 2.9 | 3.5 | **4.0** |

*Source: DH Information Centre*

Recent findings of an Independent Inquiry into access to healthcare concluded that people with learning disabilities have worse health and receive a lower quality health care. The Inquiry found convincing evidence that people with learning disabilities have higher levels of unmet need and receive less effective treatment.

[23] Estimating Future Need/Demand for Supports for Adults with Learning Disabilities in England, Institute of Health Research, Lancaster University (2004).
[24] National Statistics & NHS Health and Social Care Information Centre (2004).
[25] http://www.arts.gla.ac.uk/History/Medicine/shh2003simpson.doc
[26] http://www.iahpld.org.uk/

*Table 27: Clients with Learning Disabilities Receiving Services by Age and Service Type during 2006/07*

| Age | All | | | 18-64 | | | 65+ | | |
|---|---|---|---|---|---|---|---|---|---|
| England | 137,000 | Community Based Services | 106,000 | 125,000 | Community Based Services | 99,000 | 13,000 | Community Based Services | 7,800 |
| | | LA Residential Care | 3,000 | | LA Residential Care | 2,500 | | LA Residential Care | 500 |
| | | Independent Sector Residential Care | 36,000 | | Independent Sector Residential Care | 32,000 | | Independent Sector Residential Care | 4,700 |
| | | Nursing Care | 3,400 | | Nursing Care | 2,400 | | Nursing Care | 1,000 |
| North West | 20,000 | Community Based Services | 17,000 | 18,000 | Community Based Services | 16,000 | 1,700 | Community Based Services | 1,300 |
| | | LA Residential Care | 400 | | LA Residential Care | 300 | | LA Residential Care | 60 |
| | | Independent Sector Residential Care | 2,700 | | Independent Sector Residential Care | 2,300 | | Independent Sector Residential Care | 400 |
| | | Nursing Care | 400 | | Nursing Care | 300 | | Nursing Care | 100 |
| Wigan | 950 | Community Based Services | **930** | 855 | Community Based Services | **845** | 95 | Community Based Services | **87** |
| | | LA Residential Care | **30** | | LA Residential Care | **29** | | LA Residential Care | **3** |
| | | Independent Sector Residential Care | **10** | | Independent Sector Residential Care | **4** | | Independent Sector Residential Care | **6** |
| | | Nursing Care | **10** | | Nursing Care | **8** | | Nursing Care | **2** |

| | England | North West | Wigan |
|---|---|---|---|
| ***% of all clients 18 & over receiving services who are 65 and over*** | 9.5% | 8.6% | 10.0% |

*Source: DH Information Centre (figures may not sum due to roundings)*

Using national population projections and incidence rate data, it is predicted that the number of adults aged over 65 will increase by 17.3% between 2008 and 2015, and by 40% by 2025.

Therefore, with people with learning disabilities living longer, a project to explore the needs and service responses for older people with learning disabilities is currently underway. The aim is to gain an understanding of the health and social care needs of this group of people and to make recommendations for the future development of and commissioning of services.

Previous needs assessments have revealed that agencies have struggled to match levels of support following the transition of children with learning disabilities into adulthood. Recent additional resources have the aim of earlier assessment of children at the age of 14 to enable timely identification of need as well as commissioning outside of the budgeting cycle.

Nationally, evidence suggests that there is a higher prevalence of people with Learning Disabilities within BME groups, particularly for the Asian community. Observational studies in the North East of England have suggested that between the ages of 5 and 34, the prevalence of severe intellectual disability is three times higher among the Asian community compared to the non-Asian community (Emerson et al 1997)[27]. An audit of the BME population within the borough is due to start which will be used to inform future commissioning of services. It is likely that the findings will be available early next year.

Research is also currently being conducted to investigate the current service provision for people with Autistic Spectrum Disorder (ASD). This will serve to identify any gaps in service provision across all age groups. The results of this study will be available in December 2008, and will inform commissioning in the future for high quality and integrated services for children and adults with ASD.

The number of people with learning difficulties is predicted to increase by 11% between 2001 and 2021. This applies particularly for older people because people with Learning Disabilities are living longer. Consideration will need to be given to the way that services are provided in terms of capacity, and where appropriate, alternative ways of providing services to enable people to remain independent and in their own home.

We are aware that there may be a gap between the actual number of people with Learning Difficulties and those known to services. We will need to identify how many people fall into this gap as part of our ongoing work.

We need to continue to improve our transition process to further develop age appropriate and value for money services for young people leaving school.

## 15.7 Physical Disability, Frailty and Sensory Impairment

The majority of people accessing services with a physical disability, frailty or sensory impairment are 65 years and over. Therefore with an ageing population, services will need to develop along side the increase in the older population.

*Table 29: Physical Disability, Frailty and Sensory Impairment 2006/07.*

| Age Band | England | North West | Wigan |
|---|---|---|---|
| **18-64 years** | 212,000 | 30,000 | **1,405** |
| **65 years and over** | 1,065,000 | 150,000 | **5,120** |
| **All 18 and over** | 1,277,000 | 180,000 | **6,525** |
| **% of all clients 18 & over receiving services who are 65 and over** | 83.4 | 83.0 | **78.5** |

*Source: DH Information Centre*

Within the borough a higher proportion of people with learning disabilities aged between 18 and 64 are helped to live at home when compared to the England and North West average. In the future we will need to continue to help people with physical disabilities to live at home if we are to promote independence and provide personalised services.

*Table 30: People with Physical Disabilities Helped to Live at Home.*

| People with physical disabilities aged 18-64 years who are helped to live at home per 1,000 population age 18-64 years | England | North West | Wigan |
|---|---|---|---|
| | 4.5 | 4.7 | **5.0** |

***Source: : Local Information – Wigan Council***

There is a high proportion of take up of direct payments by people with physical disabilities aged 18 to 64 years. Figures for January 2008 show 117 people in this client group were receiving direct payments; this is approximately 13% of those people age 18-64 with physical disabilities who were being helped to live in the community.

[27] http://www.library.nhs.uk/learningdisabilities/ViewResource.aspx?resID=34865

# 16. Older People

Table 31 below shows a summary of current social care provision for older people in Wigan; these are based on current figures with projections through to 2025. There is an expectation that demand for traditional social care services in the borough is set to rise significantly by 2025. However, developments in 'personalisation' and choice mean that the type of service and the method of delivery is likely to be very different. People will be allocated a set amount of money, known as a 'personalised budget', and will be able to purchase services which best meet their needs. Although a number of people are expected to purchase traditional services, more and more people are likely to want more scope to be innovative in how they want their support needs to be met.

*Table 31: Social care provision for Older People in Wigan, 2008-2025*

| | 2008 | 2010 | 2015 | 2020 | 2025 |
|---|---|---|---|---|---|
| Number of Older People helped to live at home | 3,678 | 3,884 | 4,514 | 4,856 | 5,229 |
| Number of households receiving intensive home care for people aged 65 and over (see note 1) | 293 | 309 | 359 | 386 | 416 |
| Number of older people receiving community-based services provided or commissioned by the CSSR* | 5,509 | 5,816 | 6,761 | 7,273 | 7,831 |
| Total number of older people admitted to permanent residential and nursing care and financially supported by CSSR* | 474 | 501 | 582 | 626 | 674 |
| Number of carers aged 65 or over receiving services | 612 | 646 | 751 | 807 | 869 |

*Source: POPPI (note 1 – figures in POPPI are all adults, data shown is for age 65 and over)*
**CSSR = Council with Social Services Responsibility.*

## 16.1 Older People Living Alone

The number of older people who will be living alone by 2025 is predicted to increase. As mentioned in the housing section of this document (section 18), these older people will have support needs which will affect the types of housing that they require and the level of services they require will increase. In addition to this, older people prefer to access support enabling them to remain independent in their own home rather than in more traditional methods of providing care such as residential care homes. This will be achieved through providing more care in the community and by using more innovative ways of providing services which are centred on the needs of individuals. Providing services in this way will enable older people to remain as independent as possible for as long as possible.

*Table 32: Living arrangements - Older People Living Alone in Wigan – Projections to 2025.*

| | 2008 | 2010 | 2015 | 2020 | 2025 |
|---|---|---|---|---|---|
| Males aged 65-74 predicted to live alone | 2,346 | 2,482 | 2,873 | 2,805 | 2,669 |
| Males aged 75 and over predicted to live alone | 2,184 | 2,324 | 2,884 | 3,640 | 4,508 |
| Females aged 65-74 predicted to live alone | 4,752 | 5,082 | 5,973 | 5,940 | 5,676 |
| Females aged 75 and over predicted to live alone | 7,434 | 7,493 | 8,260 | 9,617 | 11,682 |
| Total population aged 65-74 predicted to live alone | 7,098 | 7,564 | 8,846 | 8,745 | 8,345 |
| Total population aged 75 and over predicted to live alone | 9,618 | 9,817 | 11,144 | 13,257 | 16,190 |

*Source: POPPI*

## 16.2 Social Isolation

Another consideration for the older population is social isolation. With the number of older people living on their own set to rise, this will also expose more older people to the risk of becoming socially isolated, This may be due to combinations of factors such as loss of partners and friends, deteriorating health and mobility, income and social housing as well as poor access to transport.

## 16.3 Life Expectancy in Older People

People in Wigan Borough are living longer, but these extra years are not necessarily being lived in good health. Life expectancy and healthy life expectancy (expected years of life in good or fairly good health) both increased between 1981 and 2001, with life expectancy increasing at a faster rate of healthy life expectancy. [28] The NHS Ashton, Leigh and Wigan World Class Commissioning Strategic Plan (2008-2013) refers to our ambition to 'add life to years and years to life' in the borough.

## 16.4 Dementia

Dementia is a term used to describe various different brain disorders that have in common a loss of brain function that is usually progressive and eventually severe (Alzheimer's Society 2008). It can lead to a decline in memory, communication and, therefore, can affect ability to carry out routine tasks.
With an increasingly ageing population, the prevalence of dementia is set to rise. For example based on projections for 2025, the prevalence of dementia in over 65's is set to increase by 63.5% - or in the case of Wigan, by 1931 people.

*Table 33: Estimates of prevalence of Dementia in Wigan.*

| Predictions of prevalence of dementia | 2008 | 2010 | 2015 | 2020 | 2025 |
|---|---|---|---|---|---|
| Population aged 65-74 | 536 | 569 | 664 | 697 | 635 |
| Population aged 75-84 | 1,276 | 1,301 | 1,521 | 1,836 | 2,201 |
| Population aged 85 & over | 1,228 | 1,247 | 1,357 | 1,641 | 2,135 |
| Total 65 & over | 3,040 | 3,117 | 3,542 | 4,174 | 4,971 |

*Source: POPPI*

Given that the prevalence of dementia is set to rise, and that some of the causes of dementia may be treatable or manageable, those at risk should be offered interventions at the earliest stage possible. In addition to this, for those cases which cannot be prevented, adequate forward planning will be required in order to allocate resources to care for the growing number of elderly people with dementia. In addition to providing support to people who are suffering from dementia, support for carers who are caring for those suffering with dementia will also need to be considered within the planning process.

[28] Care Services Improvement Plan 2003

## 16.5 Falls

A fall may be the result of tripping or slipping which may be caused by environmental factors such as wet floors, poor footwear, loose carpets or poor lighting. Additionally, a fall may be caused by a combination of several factors. For example, a condition may present itself in an unusual way in an older person - for instance infection or transient ischemic attack may manifest themselves by way of a fall. Interestingly, the Wigan Borough Health and Lifestyle Survey revealed that almost half (47%) of accidents suffered among those aged 65 and over occur in the home compared with 27% overall, suggesting that the focus should perhaps be on adaptations and Assistive Technology in the home.[29]

Elderly people are more prone than younger people to unpredictable and unexpected falls. Falls affect a third of those aged 65 years and over rising to over 40% in those aged 80 years and above. Therefore with an ageing population, prevalence of falls is set to rise with an expected increase of 63% from 2008 to 2025.

*Table 34: Falls in Older people, Wigan Projections to 2025.*

| | 2008 | 2010 | 2015 | 2020 | 2025 |
|---|---|---|---|---|---|
| People aged 65-69 predicted to attend hospital A&E departments as a result of falls | 457 | 486 | 566 | 474 | 509 |
| People aged 70-74 predicted to attend hospital A&E departments as a result of falls | 453 | 482 | 563 | 662 | 559 |
| People aged 75 and over predicted to attend hospital A&E departments as a result of falls | 1,910 | 1,995 | 2,307 | 2,779 | 3,394 |
| Total population aged 65 and over predicted to attend hospital A&E departments as a result of falls | 2,819 | 2,962 | 3,435 | 3,915 | 4,461 |

*Source: POPPI*

## 16.6 Seasonal Excess Deaths

Seasonal Excess Deaths are more likely to be observed in older people. For example, a study carried out after the extreme heatwave of 2003 found excess mortality was 33% in those aged over 75 compared to 13.5% in the under 75 age group.[30] Further, it was found that amongst those aged over 75, deaths at home increased by 33%.

Mortality is also generally higher in winter. Although this can vary year to year as the winter weather varies, the fact remains that winter increases mortality rates in the UK. This phenomenon is not so marked in continental Europe or Scandinavia even though they have more extreme weather.

Excess winter mortality is calculated as winter deaths (deaths occurring in December to March) minus the average of non-winter deaths (April to July of the current year and August to November of the previous year) (ONS).

As can be seen from the table on the next page, although, on the whole, winter deaths within the North West are in line with the figures for England, excess winter deaths in the 85 and over age band are higher by 17% for the North West in comparison to England. This will therefore need to be considered when addressing fuel poverty issues (please refer to section 15.7 for more information), with initiatives or assistance targeted at this age group.

[29] http://www.atdementia.org.uk/editorial.asp?page_id=25

[30] Kovats, S.R., Johnson, H., & Griffiths, C. (2006). Mortality in Southern England During 2003 Heatwave by place of death. Health Statistics Quarterly: 29

*Table 35: Excess Winter Deaths Index 2006/07.*

| Age band | England and Wales | North West |
|---|---|---|
| 0-64 | 6.2 | 5.7 |
| 65-74 | 11.8 | 12.4 |
| 75-84 | 15.0 | 15.0 |
| 85 and over | 21.7 | **25.3** |
| All ages | 15.2 | 15.9 |

*Source: ONS*

The latest figure available for Wigan in relation to the Excess Winter Deaths Index is for 2005/06 which was 9.3. This figure compares well to the North West (9.3) and England (15.8) overall. However, this figure needs to be interpreted with caution as the figure is not available by age group, making it difficult to assess Excess Winter Deaths in the 85 and over age group which is the age group which appears to be most at risk as shown in table 35.

## 16.7 Fuel Poverty

Fuel poverty exists when 'there is inability to afford adequate warmth because of the energy inefficiency of the home.[31]' Fuel poverty has been defined as 'a situation in which a household has to spend more than 10% of its net income on providing the warmth it needs, when it needs it, in a house no bigger than it requires', However, this definition is does not consider that expenditure on heating depends on type of property, efficiency of heating system, insulation characteristics and property size.

Research on estimates of expenditure on various items by households in the bottom income quintile [32] shows that fuel and power constitutes 10% of the expenditure of single adult with children households whilst retired households spend a slightly lower percentage.

Evidence suggests that respiratory and circulatory diseases are responsible for most of the increases in deaths in the winter months. Given the fact that one of the greatest challenges for the borough is mortality from Circulatory and Respiratory disease, weight is added to the argument for focusing resources in this area.

## 16.8 Long Term Conditions

The impact of Wigan's longstanding problem of limiting long term illness is starting to catch up with us. By 2015, there will be over 6000 more older people who have had a long term, limiting illness, and by 2025 there will be an additional 12,000.
It is important to promote self care and self management to manage the increased numbers of older people and people in general. As long term conditions can often involve complex care, integration in the way that services are delivered will become more important if we are to cope with the increased care needs of the borough effectively.

[31] Boardman B (1991). Fuel Poverty: From Cold Homes to Affordable Warmth, London Belhaven Press.
[32] Ballard S, Harmer M, Kemm J and Samuel F. Health Impact Assessment report on New Home Energy Efficiency Scheme in Wales for the National Assembly of Wales. 2000.

## 16.9 Older People Accessing Services

The Wigan Partnership for Older People Project [33] (POPP) programme aims to support and help older people by providing them with services such as counselling, gardening, handyperson and home maintenance scheme, crime prevention awareness and support with Assistive Technology.

Analysis of the uptake of POPP schemes show that access to services is evenly distributed throughout the Borough and that living in a SOA with a higher level of deprivation is not a barrier to accessing services. People from the 10% most deprived SOAs in the Borough accounted for 10.59% of the overall people using the services.

Two of the POPP schemes were specifically aimed at members of the BME population. BME groups generally, but more so groups of BME older people, have been identified as an isolated group. Overall, 94.7% of referrals to POPP schemes described their ethnicity as British. This representation of ethnic groups does not reflect the demographic profile in the 2001 Census, which indicated 97.6% of Wigan's population was 'White British'. It is now suspected that there are considerably higher volumes of people from BME backgrounds within the Borough.

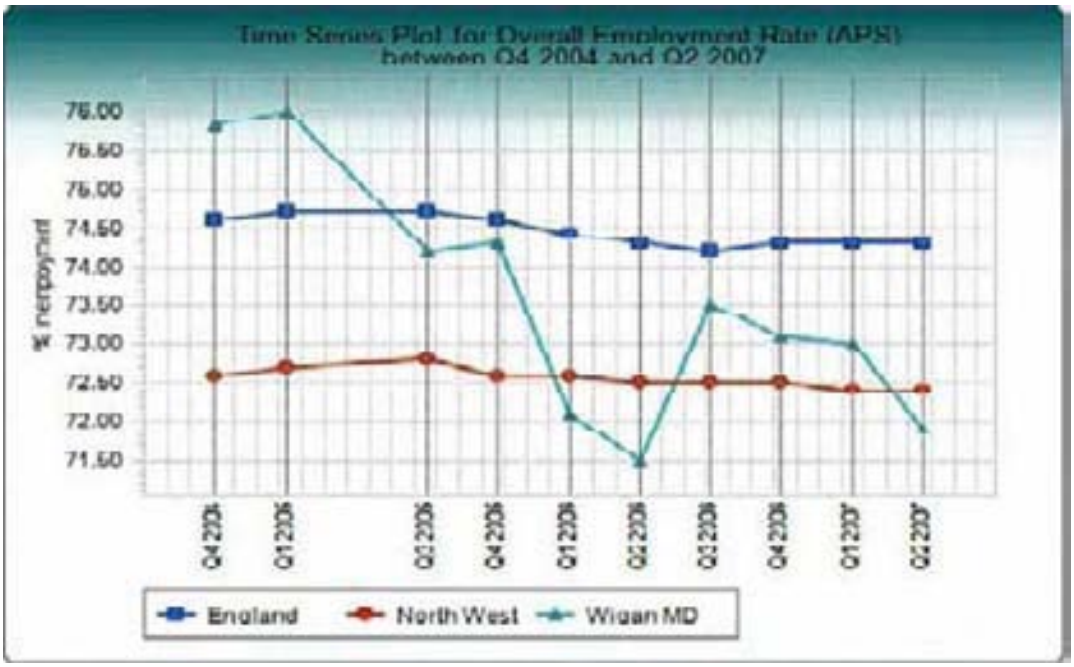
[31] Boardman B (1991). Fuel Poverty: From Cold Homes to Affordable Warmth, London Belhaven Press.
[32] Ballard S, Harmer M, Kemm J and Samuel F. Health Impact Assessment report on New Home Energy Efficiency Scheme in Wales for the National Assembly of Wales. 2000.

# 17. Employment and Worklessness

Worklessness and ill health are closely related (DH 2008). While unemployment and economic inactivity are associated with higher rates of poor health, premature deaths and mental illness, poor health can itself lead to difficulties in both securing and retaining employment. It is possible that these two factors can become entwined, which can lead to a spiral of decline, especially in disadvantaged populations.

According to the Indices of Deprivation 2007, 49 of Wigan's 200 LSOAs are within the 10% most deprived of all LSOAs in England for employment deprivation, which although an improvement on the 2004 position when there were 53, is still an issue of concern.

*Figure 40: Overall Employment Rate*




*Source: Floor Targets Interactive*

Figure 40, above, illustrates that 71.9% of Wigan's working age population is in employment - slightly lower than the North West (72.4%) and England (74.3%).

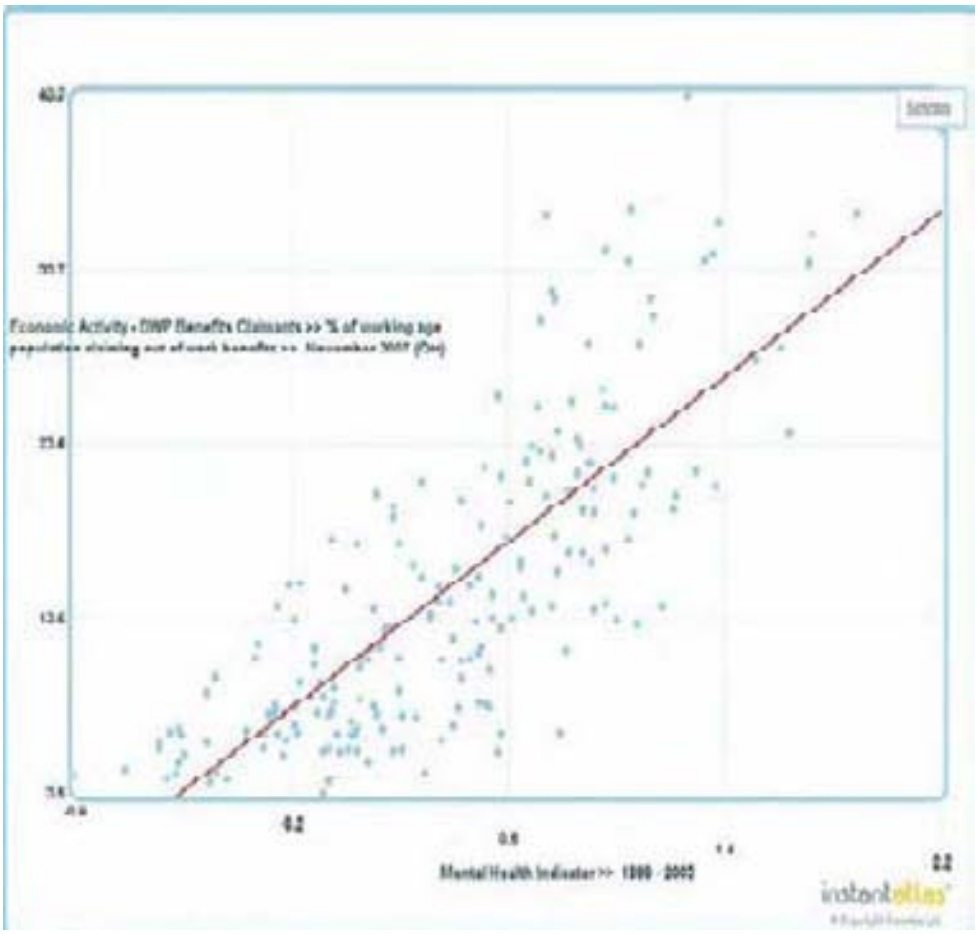
The Department of Work and Pensions (DWP) estimates the overall number of workless people in Wigan at 34,670 (2007). Although reductions in worklessness in Wigan have been observed, these reductions are reflective of national and regional trends rather than any specific localised interventions. It is also apparent that Wigan has not closed the gap compared to the North West and UK averages.

Within the deprived areas (as defined by the Department of Work and Pensions) there has been virtually no reduction in the overall figure for worklessness since 1999. Recent figures show that the percentage of the working age population claiming out of work benefits in the 3% most deprived LSOAs was 36.47% and 31.64 for the 10% most deprived LSOAs.

Links between worklessness and ill health are most acutely felt in terms of mental ill-health in Wigan, with 7045 Incapacity Benefit claimants stating mental health as their primary condition.

Figure 41 plots 'out of work benefits' LSOA data against mental health LSOA. The graph shows that the higher the prevalence of mental health, the more likely it is that somebody will be claiming out of work benefits. (Note that the graph is comparing 1999-2003 mental health data against 2007 DWP data. As more data becomes available, comparisons across the same time periods will be carried out in order to provide a more accurate comparison).

*Figure 41: % of Working Age Population Claiming our of Work Benefits Plotted Against Mental Health Indicator.*



*Note: Mental Health indicator focuses on adults under 60 years of age suffering from mood (affective) disorders and neurotic, stress-related and somatoform (anxiety) disorders. This group is believed to represent a large proportion of the total population suffering from mental ill health*