Public health website

In the interest of reducing the carbon footprint of my Annual Report, I have continued to include the bulk of the statistical information on our public health website www.hullpublichealth.org. This website includes a wide range of information which is updated throughout the year, for example:

- Director of Public Health
  Annual Reports for 2005 and 2006
- Hull Public Health Delivery Plan
- Equity Audits (Cancer, Coronary Heart Disease and Mental Health)
- Health and Lifestyle Surveys
- Analysis of Health Needs for Hull
- Clinical Policy Documents
- Dental Health Documents

Please keep the attached bookmark as a reminder of this useful source of public health information.

Acknowledgements

Once again I would like to express thanks to the Hull Teaching Primary Care Trust and Hull City Council for their support and my appreciation to the many people who have contributed to this year’s Annual Report, in particular:

The Report Steering Group:

- Jo Stott, Public Health Lead
- Dr. Andrew Taylor, Assistant Director (Public Health Sciences)
- Ben Matthews, Graphic Designer
- Sarah Jenkins, Public Health Programmes Lead
- Jenny Farnes, Personal Assistant to the Director of Public Health for Hull

Additional assistance from:

- Peter Brown, Assistant Director (Health Improvement)
- Jim Deacon, Emergency Planning Manager
- Kate Birkenhead, Health Improvement Manager

This report is also available on CD and on the following websites:

www.hullpct.nhs.uk  
www.onehull.co.uk  
www.heros.org.uk  
www.hullcc.gov.uk  
www.hullpublichealth.org

If you would like this document in a different language or format (e.g. large print), please use the contact below:

Telephone: 01482 344812  
Email: Jenny.Farnes@hullpct.nhs.uk
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Back Page Attached to the back page of this report is a bookmark which we hope you will find useful as a reminder of the wealth of public health information that can be accessed on our website.

A CD version of this report is also attached, which includes:

▶ Full copy of this report, with hyperlinks
▶ Users’ Evaluation
▶ Hyperlinks to additional information held on the Public Health Website: www.hullpublichealth.org

I strongly recommend that you investigate the CD information and the hyperlinks included as this provides access to a constantly updated resource to ensure all our information is available to you as soon as it is published.

I have chosen to make full use of the technology available to reduce our carbon footprint. If you require assistance in accessing any of the information on the website then please do not hesitate to contact:

Public Health Library Service
Telephone: 01482 617970
E-mail: Diane.Thompson@hullpct.nhs.uk
Well here we are again and this is my third Annual Report. A great deal has happened in the City, not only in terms of health improvement, but in other significant life changing areas which have a direct impact on individuals’ health and wellbeing.

Of course I refer to the events of June 25th when the City faced one of its most widespread emergencies in living memory as significant parts of the City were flooded. The impact was felt not only by those who were unfortunate enough to have their homes flooded. There were few people in the City who have not felt some effect of the flooding. This may be in terms of the effect on schools, workplaces or social and community life. I will cover how we responded to this situation later on in my report, however I felt that the flooding has been such a significant part in the City's life that I must give this an early mention in order to recognise how the community has coped so admirably with their personal and neighbourhood situations. Furthermore, I must also thank our own health teams for supporting partner agencies in responding to the situation.

Dealing with emergencies is part of the remit of a Director of Public Health, but the big challenge that I know I still face is continuing to improve the health of Hull’s population. Where is the missing population? What do I mean by this? We know that in general terms we have poor health in the City. I also know that there are significant pockets of ill health about which, not only I don’t know, but neither do individuals who, by their health and lifestyle choices, are putting their future health at risk and may be more likely to die early from an avoidable illness. These choices are heavily influenced by the surroundings in which people live, peers who guide them in their decisions and sophisticated marketing techniques which can make it increasingly challenging for me and my team to intervene with the right sort of information to tip the balance. Tipping the balance for me means creating an environment where people are committed to investing in their respective futures by aspiring to maximise their own health and wellbeing outcomes and, in so doing, they can contribute to a safe and economically vibrant City which engenders the desire to learn and work.
Let’s get to the point, the time for prevarication is over. We now have to intervene in a systematic way to make a difference.

We need to:

- Target the right people
- Change risky behaviour
- Take individual and collective responsibility for change
- Support individuals and communities to effect change

You may think I am taking a rather unfashionable, non-inclusive, non-consultative approach. However I have to tell you now, that for the first time in the last approximate 10 years, male life expectancy in Hull has not increased and, with huge disappointment, I have to report that for the second year running, female life expectancy has decreased. Notwithstanding debates around the presentation of statistics, I cannot let this pass without adopting a particular and hard line approach to improving health. I will therefore be making no more apologies if the approach of myself and my team seems very direct and forceful. This is not about ‘target chasing’. Many of you will know that we have ambitious public sector agreement targets to achieve regarding an increase in life expectancy. For me however, the most important point to note is that, all the while that I am reporting a plateauing or drop in life expectancy, means that people are dying unnecessarily early and not only missing years from their life to be with their friends and families, but also suffering a poorer quality of life.

Our strong methods of planning and performance managing our public health activities will continue. This is not a passive process. Should we feel that our annually agreed targets are not being achieved as the year progresses, we will work with partners to develop remedial action plans in order to maintain progress. If we do not performance manage in this way and gain the support of all agencies in our approach, then we will not achieve the health gains that the City deserves. Section 2 gives an overview of my approach to public health planning.

Annual Reports are not enough in terms of providing information which influence decision making. I will commit to maintaining current data on our website www.hullpublichealth.org which I would strongly recommend you should review before making, not only directly health related decisions, but decisions about any issue which will impact on the health of the population. A brief summary of the main headlines is shown in Section 3. There is a wealth of additional information available on the website. In order to have a constant reminder of where you may easily access this information I have attached a bookmark showing the website details, which I hope you will find useful.

Section 4 describes the way that we intend to identify and tackle our health issues. Our key word is ‘systematic’. Through a targeted approach we will be identifying those people in our population who we feel may be at greatest risk from ill health either in the near or distant future. Who do we mean by this? Well let’s think about an example. We have our average 53 year old man who has been smoking since he was 16, enjoying a few pints most nights and not particularly giving much thought to the composition of his diet or how much exercise he takes each week.
When we ask him how he feels, he tells us he feels quite well and has no symptoms to report. But having engaged with this chap and checked his blood pressure, his blood cholesterol level and carried out a simple urine test we discover that this person is harbouring significant health problems which if they had not been caught at this stage may have manifested themselves in a significant life changing event in the not too distant future. This event could be, for example, the complications associated with Type II diabetes and the complications surrounding cardiovascular disease. Identifying these problems early means that our example person receives appropriate medical intervention and continued preventative support resulting in an improved quality of life and a longer life. It is as simple as that. So how do we find these missing ‘patients’ when they don’t yet know they are ‘prospective patients’? We need to use the same incisive techniques as those who market anything from food to cars, by identifying our market segment and then using the four P’s of marketing: Product, Price, Place and Promotion. In Section 4 you will see a broader description of our social marketing strategy.

Section 5 provides a progress report on last year’s recommendations and, in terms of my recommendations for the coming year, I guess bearing in mind my introduction, there will be no surprises here!

This year I was fortunate enough to be asked to chair the Yorkshire and Humber Strategic Health Authority’s Staying Healthy Clinical Pathway Group as part of Lord Darzi’s review of the NHS. I have learned a great deal from both the process and the public health input from across the region.

Bearing in mind my local plans, I was heartened to see that as part of a major NHS review, the idea of improving population health was integral to the overall plan. Furthermore, there is recognition as part of this process that health improvement will only be achieved by working across all sectors and in a holistic way.

My first experience at national policy level has shown me that we in Hull have such enthusiasm, commitment and expertise to make positive changes in the City. We are held up as examples of best practice of which I am proud, but we still have so much to do to change our health profile. Sometimes, when I report on health in Hull, people ask me, “What is the point?” There is a view held by some that we cannot change the health outcomes for the City as individuals are free to make their own choices and that I am wasting my time. However, I am also now picking up clear messages from people who live in the City which indicate that people are now ready to listen and that we need to put appropriate support mechanisms in place which will incentivise whole communities to access the services they need to live longer and healthier lives.

As a person who was born in this City, I am determined to show everyone that there is a point.

Dr Wendy Richardson
Director of Public Health for Hull
Hull Teaching Primary Care Trust & Hull City Council
The Maltings, Silvester Square, Silvester Street Hull. HU1 3HA
The Floods

In June 2007, Hull was deluged with such a volume of sustained rainfall that significant parts of the City were flooded. This included the highest number of homes affected in comparison to the rest of the country as well as schools, social and community centres and workplaces.

Many reports have been written and will continue to be written about the immediate and ongoing effects of the floods. I do not therefore feel it is appropriate to go into too much detail here. However, I felt I must give a profile to the events as they took place, in order to outline our response.

The following is a bulletin which was produced to inform PCT Board Members and I think reflects our activities at the time of the floods and our ongoing work to support partner agencies and individuals in the flood recovery process.

BOARD BULLETIN

Two Events

- 15th June 2007: All Humberside, North East Lincolnshire worst hit, debrief within week
- 25th June 2007: All Humberside, Hull worst hit

Multi-agency Command — 25th June

- Multi Agency Command set up at Police HQ. Ran for seven days.
- Fire Service had primacy in first 48 hours; priority was to ensure no deaths due to floods.
- Health represented by Hull Teaching PCT, lead PCT for Emergency Planning,
  Health Protection Unit (HPU) and Ambulance Trusts.
• Priority for health was to protect critical functions:
  • Hospitals (service tunnels, etc),
  • Essential community services,
  • Maintain staffing numbers.

Health Role
• Meet health care needs in Evacuation Centres
• Provide health advice with HPU (Health Protection Unit)
  • Through Communications Managers
  • Health advice leaflet
• Continue with priority health care
  • Ensure essential work is carried out
  • Move sessions if building out of use

Staff
• Several members of staff had their own homes flooded but still came to work
• Adverse weather policy review

Communications
• Temporary failure of cell network
• Extensive use of local media (T.V., radio, print)

Recovery
• People will not be back to normal for around a year -- living in caravans, with relatives, in hotels, upstairs in own home
• Monitor Health -- and deal with any emerging issues
• Psychological Health leaflet to be distributed

Our contribution to the flood recovery process will continue. Our commitment to learn from this event and its ongoing outcomes in order to improve our response to such incidents will also continue. Of course we all hope it is a long time before the City has to deal with such an incident on such a massive scale.
Public Health Planning and Performance – Keeping to the point

It is vital we know what we need to do and whether we have done it. It is also important that we know that our work and that of our partners is contributing to reducing health inequalities.

The effective planning and performance management of public health programmes is critical with intended activity being able to demonstrate how it contributes to the overarching vision and strategic aims of the organisation.

Public health is a recognised priority for Hull Teaching PCT. The PCT’s vision is to work with partners and local people to create an affordable healthcare system that exceeds minimum standards in quality and access: ‘We will work with the citizens of Hull to improve their health and well-being as well as their healthcare.’

The Hull Teaching PCT’s vision for the 2007-08 period is represented by the following 10 strategic aims, all relating to the citizens of Hull who will:

1. Wait less than 9 weeks from seeing their GP to having elective treatment in 80% of cases, with the remainder waiting a maximum of 18 weeks
2. Increasingly have the choice of access to services in modern, high quality 21st Century healthcare facilities, which are open at a time to suit service users
3. Have rapid access to a comprehensive range of local mental health services
4. Have their care delivered by a flexible and redesigned workforce that is better able to respond to their needs and can choose services from a diverse provider market
5. Use a single point of access to a well-coordinated pathway for unscheduled care
6. Use services that are closely integrated with those of the voluntary sector and local authorities
7. Have access to a range of services which support families and children in achieving their potential
8. Enjoy services which are safe, high quality and supported by well-integrated information management systems to improve efficiency and patient safety
9. Be supported in a range of community and individual programmes to improve their health, wellbeing and life expectancy
10. Have confidence in a responsive healthcare system, which operates within financial limits
In order to ensure effective planning, the Public Health Directorate produces an annual business or delivery plan outlining intended activity for the year. The Public Health Delivery Plan for 2007-2008 presents planned public health action in support of the PCT strategic aims and is itself informed by a number of local and national drivers including:

- NHS Operating Framework 2007-08 (Annex B: National and Local Delivery Plan requirements)
- Director of Public Health for Hull Annual Report, 2006
- Hull Local Area Agreement, Local Strategic Partnership and Life Expectancy Action Plan
- Healthcare Commission Public Health Standards
- Commissioning for Health (Department of Health Consultation Document)

The Public Health Delivery Plan for 2007-2008 can be accessed via www.hullpublichealth.org and represents a detailed planning document for the period containing 38 work streams undertaken by staff within the Public Health Directorate in partnership with colleagues from a range of sectors (Local Authority, other local NHS trusts, voluntary and community sectors, etc). Examples of public health activity in support of the various PCT strategic aims* include:

**Aim 2 (access):** To undertake Health Equity Audits to influence service redesign and provision in order to contribute to reducing health/access inequalities between socio-economic, cultural, ethnic, gender or other groups

**Aim 3 (mental health):** To improve the physical health of people with schizophrenia, bipolar disorder and other psychoses and reduce health inequalities experienced by people with these conditions

**Aim 5 (unscheduled care):** To ensure delivery of the PCT Emergency Planning Programme (major incident plans, exercises, training and multi-agency planning)

**Aim 7 (1) (families and children):** To reduce smoking during pregnancy

**Aim 7 (5) (families and children):** To reduce obesity levels in children

**Aim 8 (information):** To implement a Black and Minority Ethnic health-related survey and disseminate the results

**Aim 9 (1) (health and wellbeing):** To ensure the PCT smoking cessation target of 2,439 four week quitters is achieved as well as working towards the Local Area Agreement 1 stretch target of an additional 10% increase in the number of 4 week quits achieved; a total target of 2,682

**Aim 9 (2) (health and wellbeing):** Support primary care, ensuring high risk patients for coronary heart disease are given appropriate public health advice linked to smoking, physical activity and healthy eating

**Aim 9 (9) (health and wellbeing):** To implement a local multi-agency alcohol reduction strategy

Whilst public health can contribute, to varying degrees, to all 10 PCT strategic aims, the Public Health Directorate has been given formal responsibility for delivery of action against the PCT strategic aim 9.

* Please note we have only included the aims that relate to public health activity
Each of the 38 public health activities contained in the Delivery Plan presents the objective(s) of the intervention, planned action, risks, delivery arrangements, any financial resourcing as well as key performance indicators (KPIs). The types of KPIs adopted by the various interventions will vary quite significantly but ultimately all actions contained in the Delivery Plan demonstrate their contribution and achievements in support of relevant PCT strategic aim(s).

In terms of reporting to the PCT, a number of ‘headline’ public health KPIs have been agreed with the PCT Board and with the support of the PCT Performance Directorate, including:

- Life expectancy at birth for men and women (annual reporting)
- Numbers of people quitting smoking at the 4 week stage of follow up (quarterly reporting)
- Women smoking during pregnancy (quarterly reporting)
- Mortality in infancy (annual reporting)
- Cancer mortality in men and women under 75 (annual reporting)
- Cardiovascular disease mortality in men and women under 75 (annual reporting)
- Breast screening uptake in the 53-64 age group (quarterly reporting)
- Cervical screening uptake (quarterly reporting)
- Suicide rates (annual reporting)
- Teenage pregnancy: under 18 conception rates (annual reporting)
- Immunisation rates at 24 months (quarterly reporting)
- Flu vaccinations at 65 years and over (quarterly reporting)

The monitoring and performance management of the Public Health Delivery Plan is undertaken via:

- Quarterly Public Health Directorate Delivery Plan updates
- PCT Board / Professional Executive Committee Reports as required (general updating and/or briefing on a specific public health issue)
- PCT performance management reports/presentations
- Quarterly public health reports from the Provider Services arm of the PCT
- Ad hoc public health reports from Provider Services

The Public Health Delivery Plan aims to draw together key public health challenges and targets into a single framework which is continuously reviewed and updated. It is the document through which I can report on health changes in Hull in my Annual Report. Performance and status reports are presented regularly at a number of NHS and Local Authority groups and committees. Reports are always received with interest as we have all worked hard to raise the profile of health improvement in the City. Update reports can be accessed via the website www.hullpublichealth.org

These rigorous planning and performance mechanisms ensure we’re keeping to the point, which is all about improving health in Hull.
In my first two reports, I highlighted that health in Hull was worse than the rest of England and made comparisons with Hambleton and Richmondshire, only 70 miles away and about 90 minutes drive from Hull.

In this section of my report I am going to examine how the health gap between Hull and Hambleton and Richmondshire has progressed this year. Of course my hope would be that Hull would catch up with Hambleton and Richmondshire and that the health of the people in Hull would start to improve faster than health in other areas.

The main reason why people in Hull have worse health is that they are still smoking more than in other areas, they have a less healthy diet and they exercise less than in other areas.

We must stop this widening of the health gap but if we are to achieve this, we need to help people to change their lifestyle habits.

I hope the information in this section will help to show progress on health improvement in Hull using a summary of data available.

I also hope that some of the concerning trends described will help me to make the point as to why we need to take radical action now.

Further statistics and analyses are available on the internet at www.hullpublichealth.org
Male life expectancy

Male life expectancy has improved in Hull steadily over the last few years (Figure 1), but in the most recent period it has remained the same. Men in Hambleton and Richmondshire tend to live 4.2 years longer than in Hull, about four months more than in last year’s report. I am very concerned that the gap between Hull and the rest of England is still widening.

Figure 1: Trends in male life expectancy at birth
Female life expectancy

Female life expectancy increased substantially in the late 1990s and had remained steady in the early 2000s. However in the last two years, life expectancy for women has decreased in Hull (Figure 2). This disappointing trend was noted in my last report, and I mentioned that this could be a statistical ‘blip’. This is still possible and I hope that an increase will occur next year. But it could also mean that female life expectancy is falling in Hull as the number of women smoking in Hull is not dropping quickly enough and obesity is increasing.

Women in Hambleton and Richmondshire live on average 3.5 years longer than women in Hull, up four months from last year’s figures. This year’s figures for Hull show a drop of one month and, whilst this is relatively small, the gap is widening and we need urgently to turn around this lack of improvement in female life expectancy.

Figure 2: Trends in female life expectancy at birth

![Graph showing trends in female life expectancy at birth.](image-url)
Almost one in three people who die early in Hull (under 75 years) die from heart problems or stroke. *Figure 3* shows that the early death rate from circulatory disease has been falling in Hull. The death rate has been falling slightly more quickly in Hull than both Hambleton and Richmondshire and England, so the gap between Hull and these areas has been decreasing.

This is good news, but the gap has only been decreasing very gradually and large changes in personal lifestyle and improvements in medical care are needed to increase this trend. We have a long way to go to catch up with the rest of England and favoured areas such as Hambleton and Richmondshire.

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**Figure 3: Trends in circulatory disease death rates for under 75s (directly standardised rate – standardised to European Standard population per 100,000 population)**

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Circulatory disease (heart problems and stroke)
Coronary heart disease (CHD)

Around 60% of circulatory disease early deaths in Hull is due to CHD.

*Table 1* shows the CHD death rates.

For men aged 35-64, the death rate is 67% higher in Hull compared to Hambleton and Richmondshire and it is 41% higher for men aged 65-74. This is similar to last year. The CHD death rate is falling at a similar rate in both areas, which means that the gap between areas is not narrowing as I would hope.

For women aged 35-64, the death rate in Hull is 76% higher than Hambleton and Richmondshire, an improvement from last year. For the older age group of women aged 65-74, the death rate is more than three times as high in Hull than in Hambleton and Richmondshire, an increase on last year.

The death rate in Hull, for women aged 65-74, is similar to last year, but in Hambleton and Richmond deaths decreased by 20%.

It is very worrying that other areas are improving, but in Hull there is little change in early deaths from CHD.

The shockingly higher rate of deaths for women aged 65-74 indicates that we must not assume the CHD only affects men. Women must be prepared to look after their own health, stop smoking, eat more healthily and exercise more. In addition, continued improvements in medical care and interventions are necessary if we are to turn this trend round.

*Table 1: CHD age-specific death rates per 100,000 persons for 2003-2005*

<table>
<thead>
<tr>
<th></th>
<th>CHD death rates per 100,000 persons by age (years)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Males</td>
<td>Females</td>
</tr>
<tr>
<td></td>
<td>35-64 65-74 75+</td>
<td>35-64 65-74 75+</td>
</tr>
<tr>
<td>England</td>
<td>92.4  582 1892</td>
<td>22.5  237 1318</td>
</tr>
<tr>
<td>Hull</td>
<td>123.7 648 1904</td>
<td>36.3  407 1517</td>
</tr>
<tr>
<td>Hambleton &amp; Richmondshire</td>
<td>74.0  460 2062</td>
<td>20.6  115 1649</td>
</tr>
</tbody>
</table>
Stroke

Around 20% of circulatory disease early death is due to stroke. The death rates from stroke are given in Table 2.

Stroke death rates as a whole have decreased in Hull but have decreased even faster in Hambleton and Richmondshire, hence widening the gap once more.

This is particularly worrying, because the largest impact on this increasing gap is from deaths in women (all under 75s) and men aged 35 – 64.

The gap is widening and it is alarming to see the impact of early death from stroke in Hull, compared to other areas. Roughly a third of strokes result in death. In addition, these figures tell us that there is a great burden in Hull of disability and bad health for those people who have a stroke and who may not die but whose quality of life is severely affected.

Table 2: Stroke age-specific death rates per 100,000 persons for 2003-2005

<table>
<thead>
<tr>
<th>Stroke death rates per 100,000 persons by age (years)</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>35-64</td>
<td>65-74</td>
</tr>
<tr>
<td>England</td>
<td>19.2</td>
<td>161</td>
</tr>
<tr>
<td>Hull</td>
<td>22.7</td>
<td>224</td>
</tr>
<tr>
<td>Hambleton &amp; Richmondshire</td>
<td>10.7</td>
<td>160</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>35-64</td>
<td>65-74</td>
</tr>
<tr>
<td>England</td>
<td>14.7</td>
<td>122</td>
</tr>
<tr>
<td>Hull</td>
<td>25.9</td>
<td>166</td>
</tr>
<tr>
<td>Hambleton &amp; Richmondshire</td>
<td>12.7</td>
<td>64.9</td>
</tr>
</tbody>
</table>
Cancer

One in three people who die early in Hull die from cancer.

*Figure 4* shows that the death rate from cancer in the under 75s has been decreasing faster in Hull than the rest of England. The gap between Hull and England has therefore been gradually reducing.

Whilst this improvement is encouraging it should be said that the cancer death rate has a long way to go before it approaches the national rate or the rates in areas like Hambleton and Richmondshire.

Cancer death rates for people aged 65-74 years are 40% higher in Hull for men and almost 30% higher for women than in Hambleton and Richmondshire (*Table 3*). The gap has decreased for men, but not for women in this age group.

Cancer death rates are also higher in Hull for people 75+ years (men 33% higher and women 20% higher than Hambleton and Richmondshire).

*Figure 4: Trends in cancer death rates for under 75s (directly standardised rate – standardised to European Standard population per 100,000 population)*
The following describes the impact of the most avoidable cancer, lung cancer.

**Lung Cancer**

In Hull one in ten people who die early, die of lung cancer.

This represents 33% of all early cancer deaths, much higher than the rest of England (23%) or Hambleton and Richmondshire (21%).

Hull people over 65 are twice as likely to die from lung cancer as those who live in Hambleton and Richmondshire. *(Table 4).*

Death rates in the 35-64 age groups are also higher in Hull than Hambleton and Richmondshire (51% for men and 32% for women).

Lung cancer is the most significant avoidable cause of death in Hull. We must do everything possible to help people stop smoking.

**Table 3: Cancer age-specific death rates per 100,000 persons for 2003-2005**

<table>
<thead>
<tr>
<th></th>
<th>Cancer death rates per 100,000 persons by age (years)</th>
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<th>Cancer death rates per 100,000 persons by age (years)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Males</td>
<td>Females</td>
<td>Males</td>
</tr>
<tr>
<td></td>
<td>15-34  35-64  65-74  75+</td>
<td></td>
<td>15-34  35-64  65-74  75+</td>
</tr>
<tr>
<td>England</td>
<td>6.8    149   947   2205</td>
<td>7.6   140   644   1337</td>
<td></td>
</tr>
<tr>
<td>Hull</td>
<td>7.1    177   1254  2743</td>
<td>11.1  140   817   1517</td>
<td></td>
</tr>
<tr>
<td>Hambleton &amp; Richmondshire</td>
<td>8.9   165   896   2055</td>
<td>8.6   145   638   1261</td>
<td></td>
</tr>
</tbody>
</table>

**Table 4: Lung cancer age-specific death rates per 100,000 persons for 2003-2005**

<table>
<thead>
<tr>
<th></th>
<th>Lung cancer death rates per 100,000 persons by age (years)</th>
<th></th>
<th>Lung cancer death rates per 100,000 persons by age (years)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Males</td>
<td>Females</td>
<td>Males</td>
</tr>
<tr>
<td></td>
<td>35-64  65-74  75+</td>
<td></td>
<td>35-64  65-74  75+</td>
</tr>
<tr>
<td>England</td>
<td>36.9   256   491</td>
<td>24.1   142   226</td>
<td>24.1   142   226</td>
</tr>
<tr>
<td>Hull</td>
<td>61.1   459   824</td>
<td>36.3   279   350</td>
<td>36.3   279   350</td>
</tr>
<tr>
<td>Hambleton &amp; Richmondshire</td>
<td>40.4   197   370</td>
<td>27.5   120   196</td>
<td>27.5   120   196</td>
</tr>
</tbody>
</table>
Diabetes

There are two main types of Diabetes, *Type I* and *Type II*.

*Type I* is usually diagnosed in children and adolescents and occurs when the pancreas is unable to produce insulin. Insulin is a hormone that ensures the body’s energy needs are met. Approximately 10% of people with diabetes have *Type I* diabetes.

The remaining 90% have *Type II* diabetes, which occurs when the pancreas does not produce enough insulin or when the body does not effectively use the insulin that is produced. *Type II* diabetes usually develops in adulthood.

People with diabetes are expected to live 15 years less for *Type I* and 7 years less for *Type II* diabetes. Eight of every ten people with diabetes die of cardiovascular disease. Scientists believe that lifestyle changes can help prevent or delay the onset of *Type II* diabetes. Healthy eating, weight control and physical activity can reduce the risk of contracting diabetes greatly.

General Practices in Hull have registers which tell us how many people there are with a particular disease. These suggest that 4.1% of Hull’s population (aged 17+) have diabetes (compared to 5.1% in the UK). In fact it is likely that the rate of undiagnosed diabetes is higher in Hull. Using statistical models we estimate in Hull the true figure is 5.8%. With increasing levels of obesity it is anticipated that the number of people with diabetes will increase.

Our analysis suggests to us that there are a number of people in Hull who don’t know that they have diabetes and therefore are unable to take steps to look after their health.

It is important, if we want to avoid this potentially dangerous disease, that we continue to encourage sensible, healthy eating and taking sufficient exercise.
Sexual health

Genital Chlamydia infection is the most common sexually transmitted infection (STI) diagnosed in clinics across the UK. In 2004, within England, rates in both males (208/100,000) and females (243/100,000) were highest in Yorkshire and Humber after London (279 and 282/100,000) respectively. The number of Chlamydia cases at Conifer House, one of our sexual health clinics, was 377 for men and 452 for women for 2002 and 380 for men and 445 for women for 2003.

Gonorrhoea is the second most common bacterial STI in the UK. Outside London, diagnostic rates in males (58/100,000) and females (31/100,000) were highest in the Yorkshire and Humber region. Incidence increased sharply between 2002 and 2003. The number of uncomplicated Gonorrhoea cases at Conifer House was 61 for men and 40 for women for 2002 which increased to 113 and 49 for men and women respectively for 2003.

At the end of 2003 an estimated 53,000 adults aged over 15 were living with HIV in the UK. In Hull the number of reported HIV/AIDS cases in 2004 was 110 (67 males and 43 females).

We must keep promoting the message that these diseases can be very serious and in the case of HIV/AIDS we need to ensure that there is an understanding that there is still no cure.

Our key ‘safe sex’ messages must continue using social marketing to target ways of delivering information to specific audiences.

Teenage conceptions

The teenage conception rate is higher in Hull than in the rest of England. In England in 2005, the rate of conceptions in under 18s was 41 per thousand girls aged 15-17 compared with 71 in Hull.

Termination of pregnancy rates in England for girls under 18 are 47% whilst in Hull it is 30%.

The conception rate in those aged under 16 years is also higher in Hull (15.1 conceptions per 1000 girls aged 13-15 years for 2003-2005) than in the rest of England (7.7) and within this age group the termination rate in Hull is much lower (46% compared to 58%).

Reducing the number of teenage conceptions is a huge priority for the City. Babies born to teenage mothers cannot expect to enjoy the same positive health and well being outcomes as those born to mature young women. We need to act to discourage young girls from believing that pregnancy is a good option and raise their aspirations to succeed as young adults before starting a family.
Infant mortality

Hull has a lower infant death rate than the rest of England. In 2005, there were 14 deaths in children aged under one year in Hull giving a death rate of 4.4 per 1000 live births and 3,078 deaths in the rest of England giving a death rate of 5.0 per 1000 live births. The death rate was also lower in Hull for 2004 (4.7 in Hull compared to 5.1 in England per 1000 live births). However, we should not be complacent and a child’s death is a life lost and we must further our efforts to reduce this rate even more.

We will continue our efforts to reduce the number of pregnant women who smoke, which is still a difficult issue to tackle in Hull.

We will also continue our support in developing parenting skills and promoting and encouraging breast feeding in order to give all children the best start in life.

Risk factors

Low life expectancy or high early deaths in Hull, however we may describe it, is largely due to deprivation and lifestyle choices. As I have pointed out in previous years, people in Hull tend to smoke more, drink more and eat less healthy diets compared to people in Hambleton and Richmondshire. Also, people in Hull tend not to go to their doctor as readily as they might with early signs and symptoms. This means for example that heart problems are not treated as early as they could be and cancer is not diagnosed as quickly. If health problems are treated earlier, then survival rates are higher.

We must therefore, coach our population in recognising changes in their own bodies which should direct them to seek advice and support. I will detail our systematic approach to this later on in the report.

During 2007 a new Health and Lifestyle Survey, funded by ONEHULL, is being undertaken. This survey will enable us to make comparisons from a similar one in 2003 to see whether people in Hull are changing their lifestyle choices to improve their health.

These results, when completed will be available on the public health website:

www.hullpublichealth.org
Smoking

The number of people who smoke in Hull is much higher than in other parts of the country.

About one in four people smoke in England, but in Hull this figure is nearer one in three people.

In Hull in the last five years, 1,800 people died of cancer before they were 75. One third of them died of lung cancer, a further 9% died of cancer of the lip, mouth, oesophagus or larynx and a further 4% died of cancer of the stomach.

Smoking is known to cause all these types of cancer. Also, smoking increases the chance of dying early from heart problems, stroke and breathing problems.

In the last five years in Hull, more than 1,500 people died early because of heart problems or stroke and a further 500 people died early because of breathing problems.

If we can reduce the number of people who smoke in Hull it will have a dramatic effect in reducing death rates and increasing life expectancy.

Obesity

Being overweight or obese are major contributors to many preventable causes of death. Higher body weights are associated with higher death rates.

In terms of quality of life, some of the illnesses associated with being overweight are as follows: high blood pressure, high cholesterol, Type II diabetes, heart disease and stroke, gallbladder disease, arthritis, sleep disturbances and problems breathing and certain types of cancers. In Hull, obesity and poor diet is a major problem. Our new Health and Lifestyle Survey, when it is published, will give updated trends on obesity and attitudes to food and exercise. I invite you to check the public health website for the latest information. The Hull and East Riding Obesity Strategy, which contains a wide range of information and the obesity pathway is also on the website.
Alcohol

Heavy drinking is harmful to individuals, families and communities.

Excessive drinking increases the risk of stroke, stomach disorders, depression and emotional disorders, cancers (particularly of the mouth, throat and oesophagus), hepatitis, cirrhosis of the liver, malnutrition, accidents, (at home, at work and on the roads) and suicide.

Based on national and regional research evidence, it is estimated that there are over 40,000 hazardous drinkers in Hull and East Riding and approximately 8,000 with an alcohol dependency.

Our surveys indicate particularly high levels of consumption for school aged girls (Year 10).

Alcohol also plays a significant part in incidents of violent crime, including domestic violence.

There is now a Hull and East Riding Alcohol Strategy which adopts a multi-sectoral approach to tackling alcohol misuse under four themes:

- Health and treatment
- Crime and disorder
- Workplace
- Families and social networks

To further identify local need for specialist services, a Needs Assessment Report has recently been produced. This report identifies local prevalence and numbers in need of treatment compared to treatment places available, as well as activity within existing alcohol services.

It also gives detailed analysis of how alcohol impacts on utilisation of local acute services. The report will assist future commissioning decisions and further development of an alcohol treatment pathway.

We are determined to work with other organisations to make an impact on alcohol use. Our Alcohol Strategy and Needs Assessment Report can be viewed on the public health website.

Sources

Compendium of Clinical and Health Indicators / Clinical and Health Outcomes Knowledge Base (www.nchod.nhs.uk).


Local Health and Lifestyle surveys (completed 2003 and 2007).
Male and female life expectancies in Hull continue to be lower than the England average and this gap shows no signs of narrowing. Premature deaths attributable to cardiovascular disease (CVD), cancer and respiratory diseases accounts for the much of the gap in life expectancy between Hull and the national average. It is no surprise therefore that the people of Hull also experience higher prevalence rates for risk factors linked with these conditions – Hull for example has a high rate of smoking which is linked to CVD, cancer and diseases of the respiratory system.

It has been repeatedly emphasised, particularly in my last two Annual Reports, that we have to put in much more effort to start to make an impression and reduce health inequalities. On current trends we will be lucky to just maintain the gap and stop it widening.

To reduce the gap in life expectancy and increase the quality of life and well-being of the people of Hull we need to engage at every level - with individuals, communities and organisations. We also need a systematic approach using every method at our disposal to target those most at risk of ill-health and a reduced life expectancy. In essence, public health needs to become more sophisticated in its approach to enabling people to make healthy lifestyle choices.

Public health has moved on from the once-dominant model of assuming that people don’t know the risks associated with certain lifestyles such as smoking, inactivity, poor diet, etc. and simply by conveying key facts expecting people to make healthy choices on the basis of rational decision making. If this model worked then public health would have ended as a profession more than a decade ago. Individual decision making is a much more complex phenomenon reflecting a combination of social and psychological material as well as other influences.

Our local intelligence on the knowledge, attitudes and behaviours of the population of Hull is improving year on year as we commission new local research surveys adding to our existing stock of knowledge.
We now need to apply concepts and approaches from other professions and sectors to make the most effective use of this information in the design and implementation of local public health programmes. We need to more actively import approaches from other disciplines, such as marketing, to sharpen up our communication and engagement methods in order to empower people to make healthy lifestyle choices and improve the City’s long-term health prospects. By embracing approaches such as social marketing, public health programmes will be developed based on a real insight into people’s needs and we will attempt to tailor our approaches in a way that will make an impact and counter the influence of competing pressures.

A Systematic Model of Tackling Health Inequalities in Hull

In order to make a significant impact on health inequalities in Hull a coherent and systematic approach is needed making full use of all the levers that we have available, applying social marketing principles wherever possible. The Hull approach will mirror that of the Yorkshire and Humber region promoting a whole system approach that has the following elements:

<table>
<thead>
<tr>
<th>Area of activity</th>
<th>Impact</th>
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</thead>
<tbody>
<tr>
<td>Improving the availability and capability of front line NHS services who work</td>
<td>Short to medium term</td>
</tr>
<tr>
<td>with the most disadvantaged</td>
<td></td>
</tr>
<tr>
<td>Supporting the work of local organisations to engage and empower the most</td>
<td>Short to medium term</td>
</tr>
<tr>
<td>disadvantaged communities in improving their own health</td>
<td></td>
</tr>
<tr>
<td>Working with local organisations to develop stronger actions that will address</td>
<td>Medium to long term</td>
</tr>
<tr>
<td>the underlying determinants of health such as housing, employment, environment,</td>
<td></td>
</tr>
<tr>
<td>transport and education</td>
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</table>

The Public Services Agreements (PSAs) on Health Inequalities require the achievement of percentage change in a health indicator (e.g. life expectancy; cancer mortality) at population level by 2010. Achievement of such measurable change will require systematic action with interventions that are known to be effective. These interventions can be delivered at three different levels to drive change at population level. They are illustrated in the following diagram:
Population health

Some interventions can be instituted directly at population level. They are sometimes referred to as health improvement or development measures. They are usually societal changes aimed at influencing behaviour or ‘making healthy choices easy choices’. They include public policy, legislation and regulation, fiscal measures e.g. taxation, media and education. The smoking legislation introduced on the 1st July 2007 is an example of this.

Personal health

Some treatments, therapies and technologies are now highly effective at the personal level. Good examples are the use of low-dose aspirin and statins to reduce the risk of heart attack. As well as being effective at the individual level, such measures can also add up to a population level effect when interventions such as use of disease registers and incentive systems to review and use population health information are used to support this systematic approach. There is an inequality of the take up of screening and preventative clinical options in Hull that needs to be addressed and this systematic approach is an attempt to do this on a large scale.

Community health

Individuals will only choose to use and benefit from certain behaviours and treatments if they fit with the cultural and belief system of their own community. Community development and engagement are ways of facilitating communities’ awareness of the factors and forces that affect their health and quality of life. The aim is to ultimately help to empower them with the skills needed for taking control and improving those conditions in the community that affect their health and wellbeing. This is where social marketing is important as a methodology for enabling a detailed understanding of the motives and drivers of specific population groups and then tailoring public health ‘offerings’ to reflect these needs.
Why Social Marketing?

Social marketing is the ‘systematic application of marketing concepts and techniques, to achieve specific behavioural goals, for a social or public good.’ When applied to health, the ‘social or public good’ is that of improving health and reducing health inequalities (National Social Marketing Centre, Social Marketing Report 2006).

Social marketing is not a new approach (it has been around since the early 1970s) but it is only in recent years that it has been developed and refined, drawing on the experiences of other sectors such as commercial marketing. These sectors spend hundreds of millions of pounds annually on marketing programmes (the advertising industry in the UK was worth over £18.4 billion in 2004).

As part of the National Health White Paper ‘Choosing Health’ (2004), an independent National Review of health-related programmes and social marketing was announced due to two concerns:

- A growing realisation that continuing with existing public health methods and approaches was not going to deliver the type of impact on key health-related behaviours that was needed and
- Other comparable countries appeared to be achieving more positive impacts by using and integrating a more dynamic customer-focused social marketing approach into their methods.

It was proposed that a National Review should be undertaken to examine the potential of social marketing approaches to contribute to national and local health priorities. The National Consumer Council was asked to lead this work as they had been key advocates for a more consumer-focused approach. It was also recognised that an independent aspect to the review would be important so that existing practice across the Department of Health could be considered and recommendations developed. The overarching objectives of the research programme were as follows:

<table>
<thead>
<tr>
<th>National Consumer Council: Research programme – overarching objectives</th>
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</thead>
<tbody>
<tr>
<td>1. To review the growing evidence-base for Social Marketing in some key priority areas.</td>
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<tr>
<td>2. To examine current government practice and effectiveness in delivering health-related programmes and campaign interventions.</td>
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<tr>
<td>3. To better understand stakeholder understanding and perceptions of Social Marketing.</td>
</tr>
<tr>
<td>4. To consider key behavioural trends and progress towards government health-related targets.</td>
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<tr>
<td>5. To consider and assess the costs to society of preventable ill-health and assess the potential of Social Marketing to contribute to reducing these costs.</td>
</tr>
<tr>
<td>6. To map current national capacity to utilise and deliver Social Marketing approaches.</td>
</tr>
<tr>
<td>7. To map key social and market research sources available to those developing health-related programmes or campaigns.</td>
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</tbody>
</table>
The National Review demonstrates the interest at a national level in the potential of adopting social marketing approaches to contribute to achieving public health goals. The National Consumer Council launched their report in 2006 “It’s our health! Realising the potential of effective social marketing”.

A number of papers have been produced reviewing different dimensions of social marketing by the Social Marketing Centre (www.nsms.org.uk) which complement the Independent Review, see below.

<table>
<thead>
<tr>
<th>Summary of NSM Centre papers</th>
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<tbody>
<tr>
<td>NSMC1 Effectiveness Review: Physical Activity and Social Marketing</td>
</tr>
<tr>
<td>NSMC2 Effectiveness Review: Nutrition and Social Marketing</td>
</tr>
<tr>
<td>NSMC3 Effectiveness Review: Alcohol, Tobacco and Drug Misuse and Social Marketing</td>
</tr>
<tr>
<td>NSMC4 Social Marketing Capacity in the UK: Academic Sector – initial selective review</td>
</tr>
<tr>
<td>NSMC5 Social Marketing Capacity in the UK: Commercial Sector – initial selective review</td>
</tr>
<tr>
<td>NSMC6 Social Marketing for Health in the European Union – initial selective review</td>
</tr>
<tr>
<td>NSMC7 National Health-Related Campaigns Review – selective review of 11 campaigns</td>
</tr>
<tr>
<td>NSMC8 National Stakeholder Research Findings – current understanding and views</td>
</tr>
<tr>
<td>NSMC9 Summary review of current use of Social Marketing across Government</td>
</tr>
<tr>
<td>NSMC10 Health economic analysis: Initial look at the societal costs of preventable ill-health</td>
</tr>
<tr>
<td>NSMC11 Social Marketing Research – compendium of social and market research sources</td>
</tr>
<tr>
<td>NSMC12 Overview of key behavioural trends and targets re: ‘Choosing Health’ priorities</td>
</tr>
</tbody>
</table>
Social Marketing: basic principles

Social marketing is still widely and incorrectly perceived simply as the use of advertising campaigns to convey key messages to individuals for the purpose of behaviour change. A number of key principles associated with social marketing can be identified:

- The customer/consumer is all important. The aim of social marketing is to ensure that public health interventions reflect the needs of the person rather than the other way around. At the same time social marketing strategies and programmes need to be very clear regarding what ‘behavioural goals’ represent the aim of the intervention i.e. measuring behaviours as part of the evaluation process.

- Moving beyond description of behaviours (e.g. traditional epidemiological approaches) to developing an understanding of the drivers, motives and reasons people behave as they do (i.e. from ‘what’ they do to ‘why’ they do it). Once an understanding of values has been obtained, the offering can be positioned accordingly.

- Clarity regarding the ‘offering’ from public health ensuring it reflects the value of the consumer and they consider it important (e.g. short-term versus long-term benefits). The aim is to maximise the attractiveness and value of the offer (i.e. improved health) whilst at the same time minimising the costs of adopting, maintaining or changing a particular behaviour.

The notion of exploring the competition is relevant here as this focuses upon all of the factors (positive and negative) that compete and influence people’s attention and willingness/ability to adopt certain health-related behaviours.

Segmentation is a critical feature of all marketing, including social marketing and represents a detailed understanding of consumer/population groups grouped by certain characteristics. Segmentation in public health has traditionally relied upon targeting approaches reflecting demographic and epidemiological data. In commercial marketing, more sophisticated approaches are adopted which include consideration of variables for segmenting the market (i.e. on what basis you group people together) as well as on-going examination of emerging segments.

One simple model of marketing is the ‘STP approach’:

- **Segmentation** of market based on agreed characteristics/variables
- **Targeting**, deciding on how many segments to target
- **Positioning** the offering in the mind of the consumer via the design and implementation of an appropriate marketing mix

Figure 5 summarizes a simple approach to social marketing representing movement from a current to a desired stage using a marketing mix.
The ‘Marketing Mix’ is a key planning phase and should reflect the understanding of the consumer as represented via agreed segments. In terms of public health this would consist of the traditional core ‘4 Ps’:

- **Product** (or service to act as the ‘offering’ to the consumer e.g. smoking cessation)
- **Pricing** (cost to the users/consumer)
- **Place** (location of and access to the product/service by consumer)
- **Promotion** (integrated marketing communications strategy)

Each element of the marketing mix can be further refined. For example there are five principal marketing communications tools linked to ‘promotion’:

- **Mass media campaigns** (paid advertising via TV, radio and other media)
- **Public relations** (unpaid dissemination of messages through generating news in third-party media such as newspapers, magazines, etc.)
- **Sales promotion** (paid non-personal communication targeting smaller audiences via exhibitions, displays, loop video, etc.)
- **Direct marketing** (personalised communications increasingly using technology such as emails, texts, etc.)
- **Personal selling** (inter-personal communication)

The marketing mix is a set of approaches that can be used in various combinations and at differing degrees of intensity in order to effectively communicate with identified segment(s) reflecting an understanding of their needs and goals. Effective public health strategy adopts a mixture of these approaches into programme planning and does not rely exclusively on one marketing strategy.
Applying a social marketing model in order to strengthen a systematic approach to public health

Segmentation: Getting to know more about our population

**Health & Lifestyle Survey**
This year we are repeating our major survey: the Health and Lifestyle Survey, last undertaken in 2003, in order to give us even better knowledge of the health needs of people in Hull. This year we are going to interview 5000 people from all social groups with extra focus on 1000 people who form part of the Black and Ethnic Minorities groups. We are also extending this analysis to include focused work with particular groups who are hard to reach, for example, Gypsies and Travellers. This work is funded by Hull’s Local Strategic Partnership, ONE HULL, through the Neighbourhood Renewal Fund.

**Health Profiles**
We are very committed to making an impact on inequalities in health in Hull and to targeting our approaches where there is most need and the potential for health improvement is greatest. We produce a wide range of information which is available to everyone on our website [www.hullpublichealth.org](http://www.hullpublichealth.org) and which is also at the core of planning in the PCT and partner organisations. Equity audits in cancer, coronary heart disease, mental health, diabetes and other main disease areas are regularly updated so that decision makers can have the most up to date picture of health needs in Hull.

**Attitudes to Health**
Following a refresh of the Neighbourhood Renewal Floor Target Action Plan, it was agreed to carry out a programme of qualitative study to explore the attitudes and understanding of residents aged 40-60 in targeted neighbourhood renewal wards in Hull in respect of health, health behaviours, attitudes to screening, risk taking and utilisation of health services.

The study made a number of recommendations which include further understanding of the reasons behind patients not attending appointments in primary and secondary care, improved patient education facilities within primary care and developing a community role model approach to health improvement. It is expected that the findings from the study will contribute to the social marketing agenda within our local communities.
Targeting: focussing upon those most in need

- **The mid life years (40 – 75)**
  Most people want to remain healthy and independent in later life, mid-life is a time when individuals report reassessment of their personal situations – the taking stock of where they are now and where they are going. This mid-life group have been found to be receptive to information and advice and to practical ideas and opportunities for participating in activities to improve health. People in mid-life have much to gain in terms of quality of life and the maintenance of independence and are thus key to reducing health inequalities and reducing the life expectancy gap.

- **People diagnosed with high risk factors for disease (CVD, cancer, etc)**
  Within Hull there are approximately 109,000 aged between 40 and 75 and it is estimated that approximately 23% of these will already be on a GP practice disease register, indicating medical history of the individual or a family history. These provide an easily identifiable group who could be assisted by interventions encouraging positive disease management and lifestyle choices to improve their quality of life and significantly reduce their mortality rates.

- **Black and minority ethnic communities**
  Latest estimates show that some 4% of the resident population of Hull are from ethnic minority backgrounds, an increase from 2.1% in 2002. The aim should be to ensure full participation and greater community ownership in the development of effective health and social care that promotes and improves the health and wellbeing of these communities.

- **People with mental health problems and people with learning disabilities**
  A major piece of research carried out by the Disability Rights Commission (2006) provides new evidence that people with mental health problems and people with learning disabilities are more likely to experience major illnesses, to develop them younger and die sooner than the general population. Both groups are less likely to receive some of the evidence-based treatments and checks that they need and face real barriers in accessing services.

  People with learning disabilities are particularly susceptible to obesity and respiratory diseases. People with mental health problems are more likely than the general population to experience obesity, coronary heart disease, high blood pressure, respiratory diseases, diabetes and stroke. Both groups experience ‘diagnostic overshadowing’ where physicians are likely to view physical health issues as part of the mental health problem or learning disability.
Young People
There are 64,260 children and young people under the age of 20 living in Hull – 26% of the total population (Hull Children and Young Peoples Plan 2006-08). We know that one third of these live in ‘income deprived’ households and there is a higher than average number of lone parent families. The City has more children on the child protection register than the national average but has made significant progress in reducing the number of children looked after by the Local Authority. Educational attainment remains a real challenge for the City.

Surveys and other standard sources of data paint a picture of increasing rates of obesity, excessive drinking and smoking, a high rate of teenage conceptions, low rates of breastfeeding and more women smoking during pregnancy than the national average. In response to the latter a social marketing campaign is being developed in Hull specifically targeting young mothers.

Positioning: Reaching out to our population via a social marketing mix

Localities and local action plans
A key feature of public health activity in Hull is providing health improvement services and activities as close to people as possible. Each of the three PCT Localities has developed a public health plan outlining key local priorities such as smoking cessation, sensible drinking, etc. and is working with the PCT Public Health Directorate and Local Authority Area Teams to implement community-focused activities in support of the plan. Applying the marketing mix, in essence, the aim is to encourage people to use financially free (price) local health improvement services (product) in places where people live and work (place) via publicity and the use of community networks (promotion). One example is that of NHS Health Trainers who are drawn from local communities and are trained to provide support and advice on a range of health and lifestyle issues to people in a range of community settings.

Table 5 presents a summary of how the marketing mix can be applied to a range of current public health programmes and activities.

Table 6 presents a more detailed public health case study highlighting the application of social marketing principles into programme planning.
Table 5: A summary of the application of the marketing mix to selected public health programmes

<table>
<thead>
<tr>
<th>Segment</th>
<th>Product</th>
<th>Place</th>
<th>Price</th>
<th>Promotion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Trainers</td>
<td>1-1 personal advice and support to make appropriate client’ driven health and lifestyle changes.</td>
<td>A range of community venues and specialist settings (e.g. hospital, prison, etc.).</td>
<td>Free</td>
<td>Word of mouth, community networks, paid advertising, website, etc.</td>
</tr>
<tr>
<td>Social Prescribing</td>
<td>1-1 advice to enable people to access appropriate help and support to improve mental health and social inclusion.</td>
<td>Health centres and community venues.</td>
<td>Free</td>
<td>Through targeted GP practices and related community networks.</td>
</tr>
<tr>
<td>Cardiovascular Disease - Local Enhanced Service</td>
<td>Heart disease risk factor screening followed by appropriate lifestyle support/drug therapies for those in the high risk categories.</td>
<td>Community settings, GP surgeries and pharmacists.</td>
<td>Free</td>
<td>Letters to patients, aged 40-65 (direct marketing) as well as local media activity, outreach to local communities with high risk profiles (Healthy Hearts booth) and personal communication via local community workers focussing on hard to reach groups.</td>
</tr>
<tr>
<td>Choices – young people pilot</td>
<td>Animated health messages on key topics, e.g. tobacco, sexual health, alcohol.</td>
<td>Pushed out to mobile via Bluetooth and text messaging service. Also under 18s nights, colleges and university.</td>
<td>Free</td>
<td>‘Viral marketing’ uses pre-existing social networks to pass on the message voluntarily. For the NHS Choices pilot, the message will be ‘seeded’ at key events which attract our target audience.</td>
</tr>
</tbody>
</table>
Table 6: Smoking cessation and the marketing mix

<table>
<thead>
<tr>
<th>Segment</th>
<th>Product</th>
<th>Place</th>
<th>Price</th>
<th>Promotion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults</td>
<td>Provision of a network of smoking cessation clinics offering a support programme to people wishing to quit smoking. Variety of support is available including a 6 week group programme or 1-1 advice within a community setting, whistle stop sessions, drop-in sessions and telephone support.</td>
<td>Health centres and GP practices. Community and leisure centres. Workplaces. Local hospitals. Pharmacies. Mental health settings. HM Prison Hull. Mobile Clinic.</td>
<td>Free</td>
<td>Paid media campaigns and the generation of unpaid publicity, for example: radio, television, newspapers e.g. Trash The Ash, Commit to Quit. Distribution of poster, leaflets and credit cards advertising the service. Roadside billboards. Awareness raising events with health and non health professionals.</td>
</tr>
<tr>
<td>Young People</td>
<td>‘Chuck it’ Service 1-1 and group support for young people.</td>
<td>Schools. Youth settings. GP practices.</td>
<td>Free</td>
<td>A network of ‘Chuck it’ advisors. Distribution of poster, leaflets and credit cards advertising the Service. Awareness raising events with health and non health professionals.</td>
</tr>
</tbody>
</table>
Community Engagement and Patient and Public Involvement

In addition to our systematic and social marketing approach to achieving health improvement targets, as part of the Hull Teaching PCT, the Public Health Directorate take the duty of community engagement and patient and public involvement seriously. Our vision is to take this further and to always work in partnership with the people of Hull in planning, developing and evaluating services and programmes. We aim to do so much more than ‘putting a tick in the box’; we want meaningful partnership working and community engagement and are moving towards being able to commission the delivery of a selection of health programmes from the community and voluntary sectors.

We have been working in partnership with the Patient and Public Involvement Forums since they came into being and will continue to work closely with them until they are replaced by Local Involvement Networks (LINks) in April 2008.

We already work closely with groups in the voluntary and community sector, groups such as the North Bank Forum, Hull Community Network and the Hull Carers Centre. Working in this way with individuals, patients, the general public, voluntary and community groups enables the PCT to achieve its targets as set down by the Department of Health and places the people of Hull in the centre of health services development and public health programmes.

To summarise, the overall aim is to strengthen our social marketing skills in order to be even more effective in the design of our local public health programmes. In order to achieve this goal, we are in dialogue with the Department of Health and the National Social Marketing Centre to explore the following areas:

1. Good practice - exploring and importing examples from other sectors (public and private) who have successfully applied social marketing methods

2. Developing a local model of social marketing - reviewing conceptual models/frameworks of social marketing and developing an appropriate model for Hull

3. Social Marketing Mapping - reviewing current and planned information gathering and potential use (e.g. strengthening links to general commissioning as well as practice-based commissioning)

4. High Risk groups (40-60 age group) - examining examples of effective social marketing elsewhere and applying these to Hull

With this approach, my intention is to point us in the right direction to reduce the health inequalities gap.
Progress and Recommendations – Getting to the point

This section gives me the opportunity to report on progress with last year’s recommendations.

**Recommendation 1**

To give immediate priority to supporting the Hull City Council smoking ban and, in conjunction with Humber Alliance on Tobacco, develop and introduce support for local employers in complying with the Smoke-Free Legislation.

In conjunction with Hull City Council, all workplaces were sent information regarding the Smoke Free Legislation and also offered stop smoking support for their employees. A dedicated e-mail address and telephone line were established at the PCT to provide information and support regarding the legislation to local businesses and residents of Hull. Additional smoking cessation clinics were facilitated in workplaces and community venues to support local people to quit smoking.

**Recommendation 2**

The implementation of the Alcohol Strategy for Hull and East Riding of Yorkshire including the development of appropriate services to support a range of people of all ages living in local communities and encouragement of appropriate consumption of alcohol. Action should ensure that services are developed to meeting all the needs of both hazardous and dependent drinkers.

The Hull and the East Riding Alcohol Strategy with its Action Plan has been implemented around the four key themes:

- Health and treatment
- Crime and disorder
- Workplace
- Families and social networks
Partnership working has been the key and examples of work currently underway include research around Understanding Alcohol Misuse Needs in Hull and East Riding, recently published, with the aim of informing the commissioning of specialist alcohol services. This information will guide service planning and commissioning through the further development of alcohol care pathways. Much work has been done in an attempt to reduce the impact of alcohol on crime and disorder, through projects with Hull City Council and Humberside Police/CitySafe. High profile media campaigns have been successful in supporting this work.

With the recent appointment of an Alcohol Strategy Coordinator the NHS will continue to play a key role in the development of the alcohol strategy and the many opportunities for multi-agency work will continue.

**Recommendation 3**

To ensure the operational delivery of key areas of the Obesity Strategy including the development of an Obesity Strategy Implementation Plan and the development of a monitoring framework to ensure that we fully capture progress. This will include the adoption of an integrated pathway for the treatment of obesity across the full range of primary and secondary care services.

During this year we have undertaken evaluation of current schemes which focus on obesity and we have developed the framework for a monitoring protocol to meet the performance management needs of our Local Area Agreements. We have introduced an integrated pathway for the management of obesity across the full range of primary and secondary care services. This work continues with further education to clinical teams and dissemination of the pathway and will lead to modernisation of provision of services.

**Recommendation 4**

Working with local screening partnership groups to develop and implement plans to maximise the uptake of breast, cervical and colorectal screening. These plans to be informed by the cultural qualitative research study: Attitudes to Health.

**Breast screening - our local Breast Screening Service continues to strive to provide a high quality service to local women.** The PCT has participated alongside local partners in a review of the local Breast Screening Service to identify actions needed to achieve all standards required for the programme. Work also continues with local primary care providers to identify areas in need of additional targeted support to ensure that all eligible women can benefit by accessing this service.

**Cervical screening – in partnership with the local acute trust and primary care partners, the PCT has worked to ensure early implementation of liquid-based cytology.** This innovation will improve the quality of the service for local women. Work continues with local primary care providers to identify areas in need of additional targeted support to ensure that all eligible women can benefit by accessing this service.
Recommendation 5

Public health programmes to be developed reflecting the needs of specific groups and communities.

_Hull is a relatively homogenous City with similar health profiles in each of our three localities. However, I do recognise that there are specific groups in the City on whom we may need to focus our activities in order to support them in improving their health. For example we have developed our systematic approach to improving health for those in their middle years of life. Our Black and Ethnic Minority survey has given us key pointers in how we can support these groups with health improvement. Older people, children and young people also have specific needs to which we have responded and our social marketing strategy will help us to best use our resources to target our work with these groups to best effect. We have shown that by recognising the needs of specific groups we can develop needs-based plans with much more effective outcomes._

Recommendation 6

Refining of the Public Health Business Plan, the role of Hull City Council in public health and support of the public health workforce development programme.

_The local Public Health Workforce Group has overseen a number of key work areas including:_

- Undertaking local research to identify the public health support needs of the wider workforce (January 07);
- On-going development of public health nationally recognised qualifications for NHS Health Trainers and people from all sectors who, as part of their work role, are involved in health improvement activity and wish to gain recognition as a ‘third party’ Health Trainer;
- Coordinating a city-wide public health learning and sharing event for the public health wider workforce (October 29th, KC Stadium).

Public health is now central to workforce planning in our PCT. This is as it should be as it promotes a needs-centred model in providing services to our communities.

Recommendation 7

Implementation of the next Health & Lifestyle Survey of Hull and cultural research study including focus on health of black and minority ethnic groups.

_During this year we have successfully commissioned and executed two major surveys in Hull. The Adult Health and Lifestyle Survey has received input from over 4000 Hull people and the Black and Ethnic Minority Survey from over 1000. These surveys tell us a great deal about the health needs of different groups in Hull and will enable the commissioning of services which are focussed at reducing inequalities in health. The findings from these surveys can be accessed via our website www.hullpublichealth.org_
After a busy and challenging year I can report that my team and I, along with partners, have been able to move forward on all of my recommendations from 2006. There is still much work to do though and so I would now like to outline my recommendations for the coming year. Detailed action on delivery will appear in my 2008/2009 Public Health Delivery Plan.

**Recommendations for 2007**

**Recommendation 1**

Using our systematic inequalities reduction model we will develop a focussed approach, using the principles of social marketing, in order to scale up our impact on specific target groups in our communities. These groups may be those in their middle years who, if we intervene now, might enjoy rewarding and extended life years which will benefit them as individuals, their close social network and the community and city in which they live. This approach must be across all sectors and agencies and to an ‘industrial scale’.


**Recommendation 2**

We know that ‘broad brush’ information leaflets don’t work in changing the most entrenched, high risk behaviour. We therefore need to use similar techniques as those used by our ‘competitors’ which encourage people to embark on a risky lifestyles. We will develop our social marketing skills. This will enable us to reach resistant sectors in our population and to address risk taking behaviours around our three key risks: smoking, obesity and alcohol. In terms of increasing the skills base, my team and I will extend our own learning in this field, by the practical application of social marketing techniques to our public health plans.
Recommendation 3

The NHS is now looking towards a plurality of provision for its services which extends beyond the NHS into local government, the voluntary/community sector and the private sector. The PCT and the Local Authority should contribute to the role of good corporate citizenship in developing local provision of services as long as this provision meets financial probity, quality, safety and governance standards. The philosophy of the public sector should be local investment with a ‘grow your own’ mentality with the ultimate aim that such an ‘earning culture’ within the City can only support the improvement of physical and mental health.

Recommendation 4

My personal involvement in Lord Darzi’s Review of the NHS has been an incredible learning opportunity. Having been part of this process I will be more than happy to incorporate Lord Darzi’s ‘Staying Healthy’ recommendations into my own team’s plans. However having led the Yorkshire and Humber Strategic Health Authority’s Staying Healthy Clinical Pathway Group, I am also committed to using the knowledge from this wide ranging group to influence my plans for the coming year.

My clear recommendation is that although this is a NHS Review, partner organisations must take on board the responsibilities that will be identified for them and which clearly demonstrate their respective roles in reducing health inequalities and improving health.

Recommendation 5

I am committed to continuing to learn the lessons from the June 2007 floods. There will be ongoing health surveillance both locally and through my place on the national health surveillance steering group. Our experiences will be built in to future plans and future ‘live exercises’ so that our inter-agency response to any emergency can be strengthened to ensure an effective and focussed response. We need to continually review and adapt our emergency plans and our joint emergency planning procedures to ensure we have absolute cognisance of the impact of unexpected events on individual members of our populations.
Having said in my introduction that I would not apologise again for my interventionist approach I will take this opportunity to say I do hope you understand the need for my direct way of describing how we are going to work.

As I have said in my previous reports it is not only health services which can make a significant impact on individuals’ health. All of us can and should play a part in developing a City where earning, learning, healthy and safe are our watch words in terms of an individual’s life expectations. The old adage that health follows wealth is still true and in order to earn people must have been brought up in a learning culture where they feel safe. All of this might sound like old platitudes, but I genuinely believe that job creation and economic development is just as important a plank in a health improvement strategy as is having ready access to a blood pressure clinic. All of our plans therefore need to reflect this holistic approach whilst also looking at direct interventions.

This time next year if I am once more reporting on a static or indeed a drop in the life expectancy of our population then I will expect, as a priority, the support from all partners to implement an even more direct interventionist approach. However I am confident that the systematic inequalities reduction programme to address our health inequalities will be starting to have an impact on individuals that we will be able to report on for the whole population by 2010.

Your comments on my report have been invaluable in previous years and I would ask you again to please complete and return the evaluation form enclosed.

I hope you find the bookmark a handy memory jogger regarding where you can find up to date information on the population’s health. Do keep it handy and feel free to use the data in making plans for your own organisation.

Lets get to the point, if we don’t do this now, what is the point? Everyone in the City deserves to be healthy, able to learn, able to earn and to feel safe. I continue my comparisons with Hambleton and Richmondshire, an area that I am fully aware does not have many similarities with my own city in terms of geography, urbanisation and key industries, etc., but I shall continue with my theme that there is no reason why our citizens cannot enjoy similar life outcomes to those in Hambleton and Richmondshire in the future.

Dr Wendy Richardson
Director of Public Health for Hull
Further Reading and Websites

As part of our commitment to reduce the carbon footprint of printing this report whilst ensuring that our audience has the widest possible access to information on the health needs of the population of Hull, this section can now be found on our website www.hullpublichealth.org

This website includes a wide range of information which is updated throughout the year, for example:

- Director of Public Health Annual Reports for 2005 and 2006
- Hull Public Health Delivery Plan
- Equity Audits (Cancer, Coronary Heart Disease and Mental Health)
- Health and Lifestyle Surveys
- Analysis of Health Needs for Hull
- Clinical Policy Documents
- Dental Health Documents

We have attached a bookmark to this year’s report as a reminder of this useful source of public health information, please keep it handy for reference.

If you have any difficulties accessing or using the links on the website please contact:

Public Health Library Service
Telephone: 01482 617970
E-mail: Diane.Thompson@hullpct.nhs.uk
USERS’ EVALUATION

This report is my independent, professional statement about the health of local communities based on epidemiological evidence and objective interpretation. It is aimed at mainly local service providers and other interested parties. I hope that it will prove to be a useful resource for local inter-agency action.

Please will you take a few minutes to answer the following questions. Your views are valued and will contribute to the planning for my report in 2008.

1. Did you find this report informative and interesting?

2. How will you be able to use the information contained in this report to benefit people in Hull?

3. What was the most significant, memorable or useful information you have learned from this report?

4. The report is available in both printed and CD format. Did you find this format easy to use? If not, how could we improve it in the future?

5. Have you explored the information available on the public health website www.hullpublichealth.org? If so, how useful was this?

6. I would welcome any further comments you would like to make about this report.
Please return to:

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