



Stevenage District Health Inequalities JSNA

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Acronyms

- **ACE** – Adverse Childhood Experience
- **APMS** – Adult Psychiatric Morbidity Survey
- **BAME** – Black and Minority Ethnic
- **BMI** – Body Mass Index
- **CBT** – Cognitive Behavioural Therapy
- **COL** – Cost of Living
- **CMD** – Common Mental Disorder
- **CVD** – Cardiovascular Disease
- **CYP** - Children and Young People
- **GP** – General Practitioner
- **JSNA** – Joint Strategic Needs Assessment
- **LGBTQ** - Lesbian, Gay, Bisexual, Transexual and/or Questioning
- **LSOA** - Lower Layer Super Output Areas
- **ONS** – the Office for National Statistics
- **PTSD** – Post-Traumatic Stress Disorder
- **QOF** – Quality Outcomes Framework
- **SMI** – Severe Mental Illness

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1.0 Purpose

- The purpose of this Joint Strategic Needs Assessment (JSNA) is to identify health needs impacted by inequality within Stevenage district across all age groups. This JSNA will focus on the following six identified key themes:
 - Long-term health conditions
 - Healthy weight
 - Mental health and wellbeing
 - Frailty and older people
 - Cancer
 - Wider determinants of health
- This JSNA aims to achieve this by exploring relevant national and local data, reviewing academic research on causes and risk factors, and providing an overview of local strategies and interventions for each of these health themes. The findings from this JSNA will be used to provide an evidence base to inform local strategies and provision aimed at tackling health inequalities within the district of Stevenage.
- This JSNA makes several recommendations based on the available evidence and guidance examined throughout this document. These recommendations are intended to inform strategic planning and local service provision in reducing health inequalities and improving health outcomes for this cohort.

2.0 Background

2.1 Overview

- Stevenage is a district located within the county of Hertfordshire in the East of England region. It is situated in the middle of the county, bordering the districts of North Hertfordshire, East Hertfordshire and Welwyn Hatfield. Stevenage is broken down into 13 wards with the town centre located within Bedwell ward. Additionally, Stevenage is located in the East and North Hertfordshire sub-ICB (Integrated Care Board) area.
- Stevenage is located alongside the A1(M) motorway and is well connected by train links into London. The Lister A&E Hospital, including Cygnet acute mental health inpatient wards, are also located within the district, with the QE2 Hospital in the neighbouring district of Welwyn Hatfield.

Figure 1: Map of Stevenage



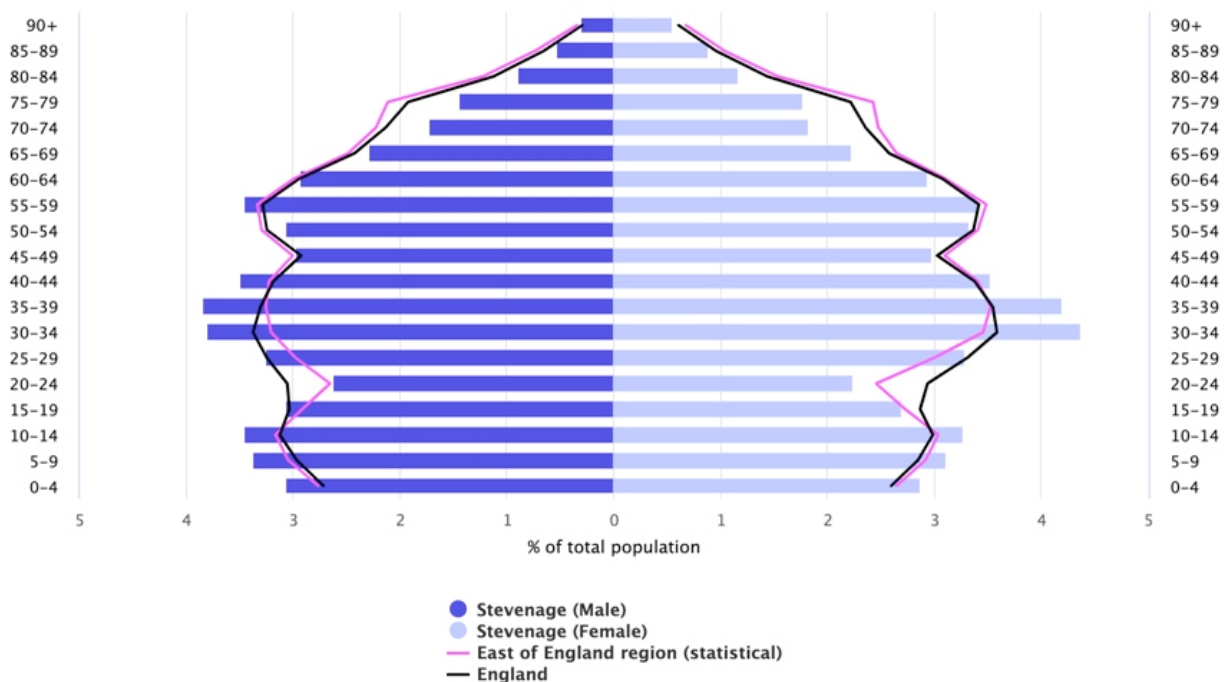
Source: [Open Source Map](#).

2.2 Population

Age and sex

- The latest national mid-year population estimates for 2023 show that the population of Stevenage is estimated to be 90,146, with a split of 51% females (n=45,603) and 49% males (n=44,543).¹
- The majority of Stevenage residents are aged 16-64 years (64%), with 20% of the population aged 0-15 years, and 16% aged 65+. According to the Office for National Statistics, it is projected that the population of Stevenage will increase by 2% over the next 20 years up to mid-2043, with the largest increase in adults aged 65+, which are expected to increase by 30%.¹
- The most common age group of Stevenage residents was 30-39 years, which was higher than the regional and national benchmarks. Stevenage also had a higher proportion of children aged 0-14. However, Stevenage had a lower proportion of males and females aged 20-24 and 65+ compared to regional and national averages (see Figure 2).

Figure 2: Sex and age population profile of Stevenage residents, compared to regional and national benchmarks (mid-2023)



Source: Office of Health Improvement and Disparities (OHID) [Fingertips website](#).

Ethnicity

- The most recent source of ethnicity data is based on the 2021 Census. As of 2021, 82.8% of residents in Stevenage identified as White and 17.2% identified as being from an ethnic minority group (see Table 1).

Table 1: Ethnic group populations for Stevenage residents, by ward (2021)

Ward	Asian	Black	Mixed	White	Other	Total BAME
Almond Hill*	7.4%	3.5%	3.8%	84.1%	1.2%	15.9%
Bandley Hill & Poplars	5.3%	4.8%	3.1%	85.7%	1.1%	14.3%
Bedwell	10.6%	5.0%	3.9%	78.9%	1.7%	21.2%
Chells	6.2%	4.2%	3.8%	85.0%	0.9%	15.1%
Longmeadow	3.3%	3.6%	3.1%	89.0%	0.9%	10.9%
Manor	5.8%	5.5%	2.8%	84.7%	1.2%	15.3%
Martins Wood	7.3%	5.8%	3.3%	82.6%	1.1%	17.5%
Old Town	9.6%	4.3%	3.9%	80.5%	1.6%	19.4%
Roebuck	6.3%	4.7%	3.7%	84.3%	1.0%	15.7%
Shephall	6.0%	5.9%	4.1%	83.2%	0.8%	16.8%
St Nicholas	9.6%	8.0%	4.1%	76.9%	1.4%	23.1%
Symonds Green	6.3%	3.0%	3.5%	85.5%	1.8%	14.6%
Woodfield	15.1%	4.1%	3.3%	75.3%	2.2%	24.7%
Stevenage (%)	7.5%	4.8%	3.6%	82.8%	1.3%	17.2%
Stevenage (count)	6,700	4,340	3,216	74,099	1,143	15,399

Source: Office for National Statistics, Census 2021.

*Almond Hill ward was previously Pin Green ward prior to 2024.

**Highlighted cells indicate areas with the highest population for each ethnic group.

- The wards with the greatest ethnic diversity include Woodfield, St Nicholas and Bedwell which had the highest non-White population (24.7%, 23.1% and 21.2% respectively) and the highest.
- Woodfield and Bedwell had the highest Asian population, whereas St Nicholas and Shephall had the highest Black and Mixed population. Woodfield also had the highest proportion of residents from Other ethnic groups.

Other population demographics

- According to the latest Census in 2021:
 - **Sexual orientation:** 90.6% of Stevenage residents identified as heterosexual, 2.8% identified as non-heterosexual, and 6.6% did not answer the question.
 - **Disability:** 17.3% of Stevenage residents (n=15,468) had a disability as defined under the Equality Act.
 - **Unpaid carers:** 2.7% of Stevenage residents (n=2,277) provided 50+ hours of unpaid care. An additional 2.0% (n=1,643) provided between 20-49 hours of unpaid care each week.
 - **Military veterans:** 3.1% of Stevenage residents (n=2,236) have served in the regular and/or reserve UK armed forces.
- Table 2 below summarises the proportion of Stevenage residents in each ward that have the above characteristics. Please note that sexual orientation is not currently available at ward level and is therefore not included within this table.

Table 2: Selected characteristics for Stevenage residents, by ward (2021)

Ward	Disabled (%)	Unpaid carers - 50+ hours (%)	Military veterans (%)
Bandley Hill	17.7%	2.5%	2.9%
Bedwell	18.2%	2.6%	3.0%
Chells	16.0%	2.9%	3.2%
Longmeadow	17.1%	3.2%	3.6%
Manor	14.6%	2.1%	3.2%
Martins Wood	19.2%	2.4%	3.5%
Old Town	17.1%	2.5%	3.3%
Pin Green	18.6%	2.9%	3.1%
Roebuck	18.1%	2.9%	2.6%
Shephall	17.6%	3.3%	3.1%
St Nicholas	16.0%	2.5%	3.1%
Symonds Green	18.6%	3.2%	2.6%
Woodfield	15.9%	2.4%	2.6%
Stevenage (%)	17.3%	2.7%	3.1%
Stevenage (count)	15,468	2,277	2,236

Source: Office for National Statistics, NOMIS, Census 2021.

Note: Dark yellow shaded boxes indicate the highest wards.

More detailed information on population demographics for Stevenage is available on the [Stevenage diversity profile](#).

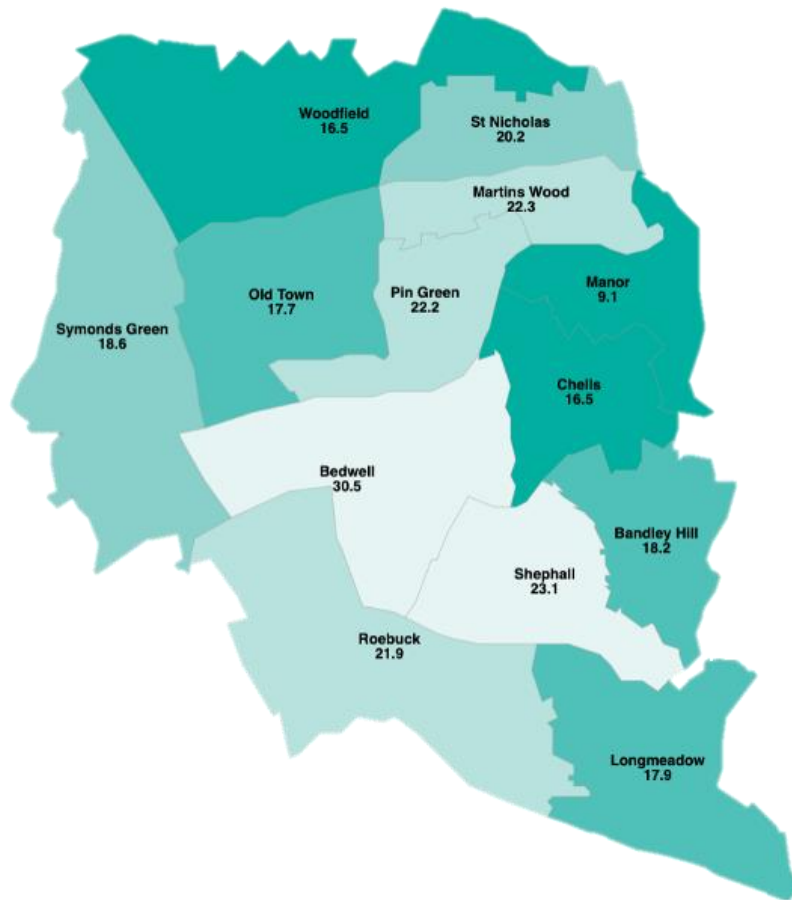
2.3 Life expectancy

- The average life expectancy at birth in Stevenage between 2020 and 2022 was 80.8 years (79.3 years for males and 82.2 years for females).² This was significantly lower than Hertfordshire for both males and females, but statistically similar to England.
- The average life expectancy at age 65 in Stevenage between 2020 and 2022 was 19.3 years (18.2 years for males and 20.4 years for females).² This was significantly lower than Hertfordshire for both males and females, but statistically similar to England.

2.4 Deprivation and inequality

- The Index of Multiple Deprivation (IMD) for 2019 is a relative measure of deprivation for small areas in England. It is calculated by combining seven domains of deprivation, which include: income, employment, education, health, crime, barriers to housing and services, and the living environment. According to the 2019 Index of Multiple Deprivation (IMD) rankings, Stevenage had a deprivation score of 19.7, making it the most deprived district in Hertfordshire.³
- The most deprived wards in Stevenage were Bedwell (30.5), Shephall (23.1) and Roebuck (21.9), all of which were significantly lower than the England average. Chells (16.5) and Manor (9.1) were the least deprived wards (see *Figure 3*).

Figure 3: Index of Multiple Deprivation score by ward, Stevenage (2019)



Source: DLUHC, Indices of Deprivation (2019)

Note: District boundaries were accurate at time of data collection. As of 2024, Pin Green ward has now been replaced by the Almond Hill ward.

2.5 Work and education

- In the year ending 2021, a higher proportion of working age adults in Stevenage had no qualifications (8.3%) compared to the Hertfordshire average (4.4%), and a lower proportion were qualified at degree level or above (35.0%) compared to the Hertfordshire average (41.6%).⁴
- In 2023/24, 84.5% of Stevenage residents were in employment, which was statistically similar to Hertfordshire (79.4%) and England (75.7%).
- At June 2024, 15.9% of Stevenage residents aged 16-64 were claiming Universal Credit, which was higher than Hertfordshire (12.3%) but lower than England (16.4%). This percentage has increased every month since September 2023.

More information on the Stevenage population can be found on the [Herts Insight website](#).

3.0 Causes and Risk Factors

This section explores some of the key risk factors identified through academic research that increase the likelihood of people developing the conditions of focus within this JSNA. More information on individual conditions is available in relevant JSNA documents on the [Hertfordshire JSNA website](#).

3.1 Long-term conditions

Cardiovascular disease

- Cardiovascular disease (CVD) is a general term for conditions affecting the heart or blood vessels, with the four main types being coronary heart disease, strokes, peripheral arterial disease, and aortic disease. CVD is a key cause of death and disability in the UK but can often be largely prevented by lifestyle modifications.⁵

Non-modifiable risk factors

- **Sex:** Men have a higher risk of CVD than women at all ages compared to women, and on average, develop CVD around 10 years earlier than women.⁶ However, research suggest that women who have heart attacks receive poorer care than males during diagnosis, treatment and aftercare which may affect health outcomes.⁷
- **Age:** The risk of developing CVD increases with age, with it being most common in individuals over the age of 50.⁶
- **Ethnicity:** In the UK, South Asian, Black African and African Caribbean ethnicities have an elevated risk of developing CVD.⁵ Specifically, South Asian groups have the highest mortality from heart disease and stroke, while Black groups in the UK have a significantly lower risk of heart disease compared to the general population but have higher incidence of and mortality from hypertension and stroke.⁸

Modifiable risk factors

- **Smoking:** Tobacco use is a leading behavioural risk factor for CVD, with it being estimated to contribute to at least 15,000 CVD-related deaths in the UK each year.⁹
- **Diet and physical activity:** A poor quality diet – i.e., excessive intake of sodium and processed foods, added sugar, and unhealthy fats – and physical inactivity increase the risk of high blood pressure, high cholesterol and being overweight, and thus are both associated with an increased risk of CVD.^{10,11}

Other risk factors

- **Socioeconomic status:** Lower socioeconomic status is associated with an increased risk of cardiovascular disease. In 2017 the mortality rate from CVD was 3.7 times higher for males and 4.5 times higher for females living in the most deprived areas compared to males and females living in the least deprived areas.¹²

- **Comorbidities:** A wide range of comorbidities exist which can increase an individual's risk of developing CVD. Hypertension is one of the most important risk factors for CVD as it can damage an individual's blood vessels. Some other important comorbidities include type 2 diabetes, dyslipidaemia, chronic kidney disease, atrial fibrillation, and serious mental health problems.⁶

More information can be found in the [Healthy Weight JSNA](#).

Stroke

- Stroke occurs when blood supply is cut off to part of the brain, which results in damage to the brain cells and affects bodily function. The effects of a stroke vary depending on which part of the brain is affected and the extent of damage. There are three different types of stroke¹³:
 - **Ischaemic stroke:** These occur when there is a blockage in the brain which cuts off blood supply to brain cells. Ischaemic strokes are the most common type of stroke and account for 85% of strokes in the UK.
 - **Haemorrhagic stroke:** These occur where there is bleeding in or around the brain. Around 15% of strokes in the UK are haemorrhagic.
 - **Transient ischaemic attack (TIA):** Also known as a 'mini-stroke', TIAs have the same causes and symptoms as a stroke, but symptoms only last a short time.

Non-modifiable risk factors

- **Sex:** Women have increased risk for stroke compared to men as they have a higher disease burden for certain conditions, including atrial fibrillation, increased risk of stroke related to diabetes, and higher prevalence of hypertension. Women also carry sex hormone-specific risk factors for stroke related to pregnancy, birth control medication and menopause.¹⁴
- **Age:** Approximately three-quarters of all strokes occur in adults aged 65+. The risk of having a stroke doubles every 10 years after the age of 55.¹⁵
- **Ethnicity:** A UK research study in 2023 shows that ethnic minority groups had earlier onset on acute stroke by around 5 years and 2-4 times higher risk of stroke-related adverse outcomes and deaths compared to Caucasian patients.¹⁶

Modifiable risk factors

- **Smoking:** Smoking is strongly associated with increased risk of stroke as it narrows blood vessels and can lead to clotting. A 2019 meta-analysis of the relationship between cigarette smoking and stroke found that smokers had a statistically significant higher risk of stroke compared to non-smokers. Passive smoking was also found to increase the risk of stroke by 45%.¹⁷

- **Diet, physical activity and obesity:** Obesity is one of the most key risk factors for developing stroke and is associated with premature mortality. It is estimated that for every 5 unit increase in BMI above 25, vascular mortality risk increases by 41%.¹⁸
- **High blood pressure:** High blood pressure can lead to blood clots and damage blood vessels in the brain. The risk of high blood pressure increases with age and certain behaviours such as poor diet, inactivity, alcohol misuse and smoking.¹⁹

Other risk factors

- **Pre-existing health conditions:** Pre-existing health conditions including heart conditions (including coronary artery disease and atrial fibrillation) and diabetes can increase the risk of stroke due to the additional risk of blood clots and/or sugars reducing oxygen flow to the brain.²⁰

Diabetes

- Diabetes is a chronic metabolic disease which affects the body's ability to produce and utilise insulin and leads to hyperglycaemia, which is linked to a plethora of complications. Diabetes has three main subtypes:
 - **Type 1 (T1DM)** is autoimmune in origin and onset usually occurs early in life. Individuals are unable to produce insulin due to the destruction of pancreatic cell.²¹
 - **Type 2 (T2DM)** is the most prevalent type which accounts for up to 90% of diagnoses and has a gradual onset due to reduced insulin synthesis and insulin resistance in cells.²² Prior to full development of type 2 diabetes, a 'prediabetes' diagnosis may be made when the patient has elevated blood glucose which has not yet reached a diagnostic value.²³
 - **Gestational diabetes mellitus (GDM)** is characterised by abnormal blood glucose in pregnancy and affects around 4-5% of pregnancies.²⁴
- Risk factors are often shared between subtypes and include:
 - **Demographics:** T2DM prevalence increases with increasing levels of deprivation.²⁵ Increasing age is associated with an increased prevalence of pre-diabetes and T2DM,^{26,27} whilst type T1DM typically peaks around puberty.²⁸ A cross-sectional analysis of the Health Improvement Network Primary Care Database found that minority ethnic groups were more likely to have a type 2 diabetes diagnosis compared to white individuals.²⁹
 - **Weight and lifestyle factors:** Being overweight or obese is associated with both prediabetes and T2DM.³⁰ The risk of T2DM may be over 7 times higher in those who have obesity compared to those with 'normal' weight.³¹ Low physical activity levels and high consumption of processed and unprocessed red meat can also increase the risk of T2DM.^{32,33}

- **Family history and genetics:** Family history is associated with an increased risk of prediabetes,³⁴ T2DM³⁵ and GDM³⁶. Genetic factors are also important in the development of T1DM, with studies indicating that the human leukocyte antigen complex is associated with susceptibility for T1DM.³⁴
- **Comorbidities:** There are many comorbidities involved in the development of prediabetes and T2DM. Polycystic ovary syndrome is linked to prediabetes,³⁷ T2DM^{38,39} and GDM.⁴⁰ Hypertension has been indicated with both prediabetes⁴¹ and T2DM, with one meta-analysis concluding that a 20mm Hg increase in systolic blood pressure and 10mmg Hg increase in diastolic blood pressure was associated with a 58% and 52% increased risk of new-onset diabetes respectively.⁴²

More information can be found in the [Diabetes JSNA](#), [Diabetes JSNA Lite Bite](#) and [Healthy Weight JSNA](#).

Musculoskeletal problems and chronic pain

- Chronic pain is defined as chronic or persistent pain that continues for more than 12 weeks despite medication or treatment.⁴³ The most common types of pain are back pain (53%), headache (48%) and joint pain (46%)⁴⁴, with low back pain being the second most leading cause of disability adjusted life years in Hertfordshire.⁴⁵ Chronic pain may be caused by an acute injury, an ongoing degenerative illness, localised or regional disease, chronic systemic conditions, or surgery or medical interventions.⁴⁴
- Arthritis is a common condition that causes pain and inflammation in a joint, affecting people of all ages, including children. Osteoarthritis and rheumatoid arthritis are the two most common types. Arthritis is most commonly caused by wear and tear of cartilage in joints, metabolic abnormalities, infection, autoimmune disease, or injury.⁴⁶ Risk factors for arthritis include:
 - **Demographic:** Osteoarthritis typically develops in individuals in 45 years older and above, while rheumatoid arthritis often starts between the age of 30 and 50. Both types of arthritis are more common in females than males.⁴⁶
 - **Obesity** is the greatest modifiable risk factor for osteoarthritis, particularly of the knee, increasing the load on weight-bearing joints and accelerating disease progression.⁴⁷
 - **Genetic:** There is some evidence that rheumatoid arthritis may have a genetic basis, with the risk of developing rheumatoid arthritis being most significantly associated with HLA-DRB1 alleles.⁴⁸

3.2 Healthy weight

- In England, obesity has been recognised as a public health issue across all age groups, with 26% of adults in 2021 and 23% of year 6 children in 2021/22 classified as obese.^{49,50} Being overweight or obese is associated with an increased risk of several major diseases, including type 2 diabetes, cancer and coronary heart disease.⁵¹
- Body mass index (BMI) is a widely used measure to determine whether somebody is a healthy weight. A BMI of under 18.5 is considered underweight, a BMI of 18.5 to 24.9 is considered to be in the healthy weight range, a BMI of 25-29.9 is considered overweight, and a BMI of 30+ is considered to be in the obese range.⁵¹

Overweight and obesity

- Although a direct lack of physical activity and poor diet (i.e., high in sugar and fat) plays a large role in obesity, there are other physiological, social, and environmental determinants that also affect the risk of obesity. For example, economic drivers and the obesogenic environment – including availability and accessibility of different food types and physical activity opportunities – can influence the prevalence of obesity across different communities.⁵² As such, no one factor should be considered alone.
- Research shows that certain groups of people are at greater risk of obesity. These include people with rare genetic conditions (e.g., Prader Willi syndrome) or endocrine disorders (e.g., hypothyroidism), and people who are on medication associated with weight gain (including corticosteroids, anti-epileptic drugs, and antipsychotics).⁵³
- Findings from the 2021 Health Survey for England highlight that both children and adults living in the most deprived areas of England are substantially more likely to be obese than those in the least deprived areas. It also found that men, people aged 45-74, people from the Black ethnic group, and disabled people are at higher risk for overweight and obesity.⁴⁹
- Obesity during pregnancy can cause health problems for both the mother and child, including increased risk of maternal death; miscarriage; gestational diabetes; blood clots; pre-eclampsia; post-partum haemorrhage; still birth; foetal abnormality and increased risk of the baby becoming obese in adulthood.^{54,55}

More information can be found in the [Healthy Weight JSNA](#).

Eating disorders

- In 2019, 16% of adults aged over 16 in England screened positive for a possible eating disorder.⁵⁶ Research suggests that eating disorders such as anorexia nervosa, bulimia nervosa, and binge eating disorder are more prevalent among women than men and typically develop in people during their late teens and mid-twenties.^{57,58}

- An umbrella review of meta-analyses found evidence to support the association between appearance-related teasing victimisation for any eating disorder and childhood sexual abuse as a risk factor for bulimia nervosa.⁵⁹ Another review identified sociocultural influences (such as media exposure, pressures for thinness, and thin-ideal internalisation) and personality characteristics (such as perfectionism, negative emotionality/neuroticism, and negative urgency) as risk factors for disordered eating.⁶⁰

More information on eating disorders can be found in the [Mental Health of Children and Young People JSNA](#) and [Body Positivity JSNA Lite Bite](#).

3.3 Mental health and wellbeing

- Mental ill health may include a large variety of conditions including common mental health disorders (such as depression, anxiety and post-traumatic stress disorder), severe mental illness (including schizophrenia and bipolar disorder) and eating disorders (such as bulimia and anorexia). Poor mental health is also the most significant risk factor for self-harm and suicide among children and adults.
- Mental disorders represent the second leading cause of disability in the UK across all ages, with half of all mental health conditions beginning before age 14.^{61,62}

Children and young people

- Risk factors for mental ill health among children and young people include:
 - **Demographics:** A national survey of children and young people's (CYP) mental health found that the prevalence of mental health disorders was highest among 11- to 16-year-olds, and among children of a White British or Mixed/other ethnic background compared to those from Asian/Asian British and Black/Black British backgrounds. Mental health disorders were also found to be more common among boys aged 6 to 10 years compared to girls, but more prevalent among 17-23 year old women compared to men.⁶³
 - **Family-related:** Factors that have been found to increase the risk of CYP having a mental health disorder include having parents with poor mental health; living in unhealthy functioning families; and having lone parents.⁶³ Domestic violence and abuse, parental substance misuse, homelessness and being in social care are also linked to reduced childhood mental wellbeing.⁶⁴
 - **Socioeconomic:** Substantial evidence suggests that socioeconomically disadvantaged CYP are more likely to have poor mental health.^{63,65} Furthermore, research suggests that crisis referrals for mental health are more common among CYP in the most deprived areas, indicating a higher severity of mental health support needs.⁶⁶

More information can be found in the [Mental Health and Wellbeing in Children and Young People JSNA](#).

Adults

- Mental ill health can result from a cumulative effect of disadvantages over the life course or from new issues that may develop during adulthood.
- **Demographics:** Women are reported to have a higher rate of all types of common mental health disorders, although suicide is more common among men (particularly those aged 40-59 years).^{67,68} Research suggests that people from BAME communities are at higher risk of developing a mental health problem in adulthood, but are less likely to receive support.⁶⁷ Barriers to BAME people accessing mental health support include cultural attitudes and stigma towards mental health (particularly among males), language barriers, lack of awareness and information of services, and discrimination when accessing and interacting with mental health services.⁶⁹
- **Sexual orientation:** People who identify as non-heterosexual are more likely to develop mental health problems including depression, anxiety, eating disorders, self-harm, suicidal feelings and misuse of drugs or alcohol.⁷⁰ This is related to the fact that many LGBTQ+ people are more likely to experience stigma and/or discrimination, social isolation, exclusion, rejection and inequality.⁷⁰⁻⁷²
- **Socioeconomic:** Social disadvantage and poverty are both a consequence and cause of common and severe mental illness. Housing issues, food insecurity, and debt are frequently cited as negatively impacting mental health⁷³, which has been further exacerbated by the Cost of Living Crisis (see [Cost of Living JSNA Lite Bite](#)).
- **Lifestyle and health:** Smoking, drug and/or alcohol use, and excessive stress are all associated with poor mental health.^{74,75} Evidence suggests there is a two-way causal relationship between mental health and long-term conditions like CVD, diabetes, chronic obstructive pulmonary disease, and musculoskeletal disorders.⁷⁶
- **Adverse Childhood Experiences (ACEs):** ACEs include childhood abuse or neglect and growing up in a household where there are issues such as domestic abuse, long-term mental health conditions, criminal behaviour or imprisonment. Compared to 18% of adults with no ACEs, 25% and 35% of adults with 2-3 and 4+ ACEs respectively, report poor mental wellbeing.⁷⁷
- **Other groups:** Groups identified as being at particular risk of poor mental health include carers⁷⁸, veterans⁷⁹, refugees and asylum seekers⁸⁰, people with learning disabilities⁸¹, and women during the perinatal period⁸².

More information can be found in the [Mental Health and Wellbeing in Adults JSNA](#) and [Mental Health and Wellbeing Perinatal JSNA](#).

3.4 Frailty and older people

Frailty

- Frailty, characterised by a decline in functioning across multiple organ systems, is emerging as a global health burden, with it being associated with a greater risk of adverse outcomes including falls and fractures, admissions to long-term care, and premature mortality.⁸³
- Frailty is multidimensional, with a range of modifiable and non-modifiable risk factors covering sociodemographic, clinical, lifestyle-related, and biological domains. A systematic review of longitudinal studies identified the following risk factors for frailty:⁸⁴
 - **Sociodemographic:** Older age, female gender, and lower socioeconomic position are all positively significantly associated with frailty.
 - **Clinical:** BMI, obesity, reduced functions of extremities, and higher allostatic load (i.e., exposure to chronic stress) were all significantly positively associated with frailty.
 - **Lifestyle:** Significant positive associations have been reported between frailty and smoking and significant negative associations reported between frailty and higher consumption of fruit, vegetables and protein. However, findings were mixed.
 - **Psychological:** Significant positive associations have been found between frailty and higher levels of depression.
- Physical activity and nutrition are important modifiable risk factors that are often targeted in frailty prevention efforts. Physical activity can help to maintain mobility and muscular strength, whilst inactivity can lead to a range of health conditions, including CVD, cerebrovascular disease, T2DM, dementia, all of which can result in the development or progression of frailty. Insufficient calorie intake, inadequate protein intake, and vitamin D deficiency are all positively associated with frailty.⁸⁵

More information on frailty can be found in the [Physical Activity JSNA briefing](#).

Dementia and Alzheimer's disease

- Dementia is not a disease but a collection of symptoms which can include impairments of memory, language, thinking and problem-solving skills. Dementia is caused by several different diseases, most commonly Alzheimer's Disease. As dementia progresses it is often associated with behavioural and psychological symptoms which may be a source of distress to people with dementia and a source of strain for families and carers.⁸⁶

Non-modifiable risk factors

- **Sex:** Dementia is known to be more prevalent in females compared to males, with females accounting for around 65% of all dementia patients.⁸⁷ Some of this can be explained by females having longer life expectancy.⁸⁸
- **Age:** The risk of dementia increases exponentially with age. From the age of 70, a person's risk of dementia roughly doubles every five years.⁸⁹
- **Ethnicity:** There is evidence to suggest that the prevalence of dementia differs between different ethnic groups. A meta-analysis found that people from Black ethnic groups had around 20% higher incidence of dementia than people from White ethnic groups, but found no significant differences between people from Asian and White ethnic groups.⁹⁰

Modifiable risk factors

- **Lifestyle factors:** Lifestyle factors including obesity, physical inactivity, alcohol misuse and smoking have all been associated with increased risk of dementia.⁹¹
- **Social isolation:** It is hypothesised that lack of social contact may enhance cognitive decline. Social isolation in later life is estimated to increase dementia risk by 60%.^{91,92}
- **Mental health:** Depression in later life is estimated to increase the risk of dementia by 90%. A UK cohort study found that depressive symptoms in later life, but not in midlife, increases dementia risk.^{91,93}

More information on dementia can be found in the [Dementia JSNA](#).

3.5 Cancer

- Cancer is a condition where cells in a specific part of the body grow and reproduce uncontrollably. There are over 200 different types of cancer, all of which are diagnosed and treated in a particular way. In England, the four most common types of cancer are breast cancer, lung cancer, prostate cancer, and colorectal cancer.⁹⁴ Cancer is the cause of over 25% of all deaths in England in a typical year.^{95,96} However, according to the World Health Organization, at least 40% of all cancer cases could be prevented with effective primary prevention measures.⁹⁷

Non-modifiable risk factors

- **Age:** Increasing age is an important risk factor for cancer, with overall cancer incidence rates rising as age increases. In the UK, the peak rate of cancer cases is among people aged 85-89 years. Despite this, certain types of cancer are more common in children and young people, including brain and spinal tumours and leukaemia.⁹⁸

- **Sex:** In general, cancer incidence is higher among men than women. However, this pattern differs by age in England, with common cancers that affect women (including breast and cervical cancer) more likely to develop in younger people compared to cancers that mainly affect men (such as prostate cancer).⁹⁵
- **Sexual orientation:** LGBT people are less likely to attend for cancer screening, in part due to fear of discrimination by health care workers. Furthermore, some people identifying as transgender are less likely to access sex-specific screening such as cervical or breast cancer screening because in some cases they have been omitted from the register due to their recorded gender.^{99,100}
- **Ethnicity:** Cancer incidence rates vary by ethnic group. A recent 2022 study in England found that people of non-White ethnicity generally have lower cancer risk than the White population, with some notable exceptions. Some exceptions included prostate cancer (2 times higher in Black ethnic groups), myeloma (3 times higher in Black ethnic groups) and several gastrointestinal cancers (1.1–1.9 times higher in Black ethnic groups and 1.4–2.2 times higher in Asian ethnic groups).¹⁰¹
- **Genetic:** Between 5– 10% of cancers are linked to inherited gene mutations.^{102,103} For example, faulty BRCA1 and BRAC2 genes increase the risk of developing breast, ovarian, pancreatic and prostate cancer.¹⁰⁴

Modifiable risk factors

- A study of cancer cases in the UK found that tobacco smoking (15.1%) contributed the largest proportion of attributable cancer cases, followed by overweight/obesity (6.3%). Other common modifiable risk factors included overexposure to ultraviolet radiation, occupational risks, exposure to infections, drinking alcohol, and insufficient dietary fibre.¹⁰⁵
- The relative impact of different modifiable risk factors depends on the type of cancer. For example, lung cancer is strongly associated with tobacco-smoke exposure and workplace exposure; breast cancer is strongly associated with overweight and obesity; and melanoma skin cancer is strongly associated with exposure to UV radiation.¹⁰⁶

More information on the different types of cancer can be found in the [Cancer JSNA](#).

3.6 Wider determinants of health

- Wider determinants of health include a diverse range of social, economic and environmental factors which impact people's health and determine the extent to which individuals have access to healthcare and support services to identify and meet their needs. The [Marmot Review](#) published in 2010 showed that people with a higher socioeconomic position in society have greater life chances, better health and wellbeing.¹⁰⁷

- Health inequalities arise because of variations in society and the conditions in which people grow and live in. The Office for Health Improvement and Disparities (OHID) group these determinants into five key themes¹⁰⁸:
 1. Natural and built environment
 2. Work and the labour market
 3. Income and vulnerability
 4. Crime
 5. Education

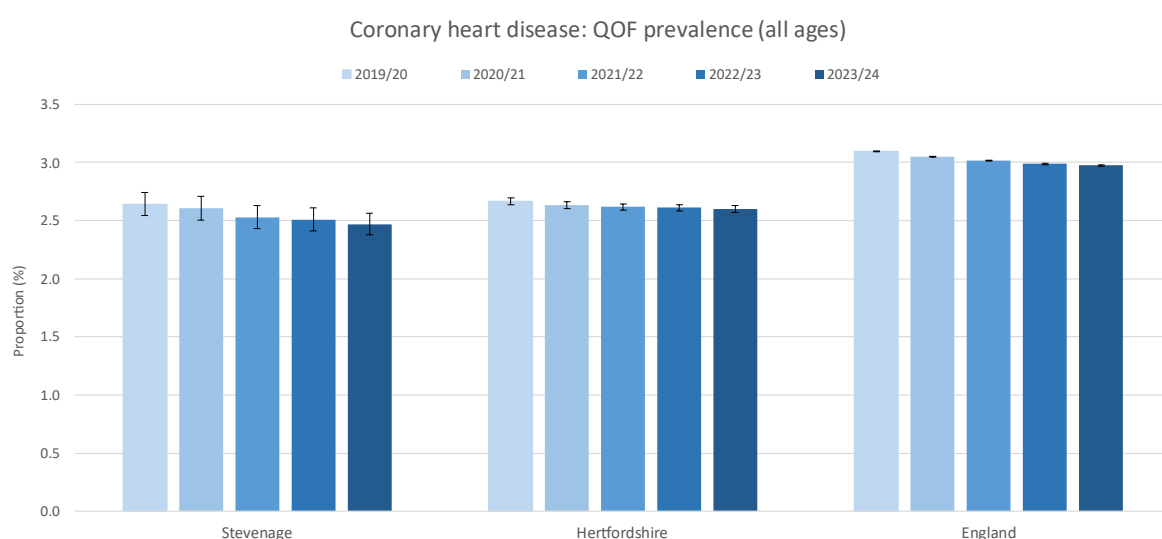
Some of the key indicators under these themes are explored further in the following data section. See [Wider determinants of health](#).

4.0 What do the statistics show?

This section explores local data for Stevenage on a range of indicators grouped by the key themes outlined at the beginning of this document. Where possible, trend data and comparator areas have been included to allow for benchmarking and trend comparisons. Confidence intervals have also been included where possible as a measure of statistical significance (see [Appendix B](#) for guidance on interpreting confidence intervals and statistical significance).

4.1 Long-term health conditions

Coronary heart disease (CHD)

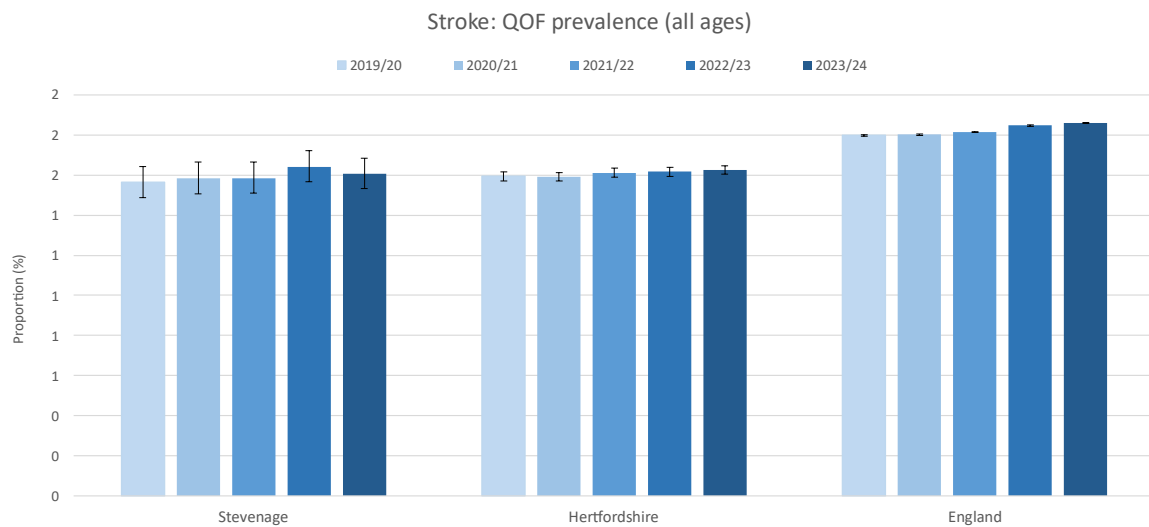


Source: NHS England.

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- In 2023/24, the QOF prevalence of coronary heart disease in Stevenage was 2.5%. This was statistically similar to Hertfordshire (2.6%) but significantly lower than England (3.0%).
- In Stevenage, the prevalence of CHD has decreased over the last 5 years, decreasing each year since 2019/20 in line with the Hertfordshire and England trend. However, this decrease was not statistically significant.
- Data on inequalities between different demographic groups was unavailable for this indicator.

Stroke

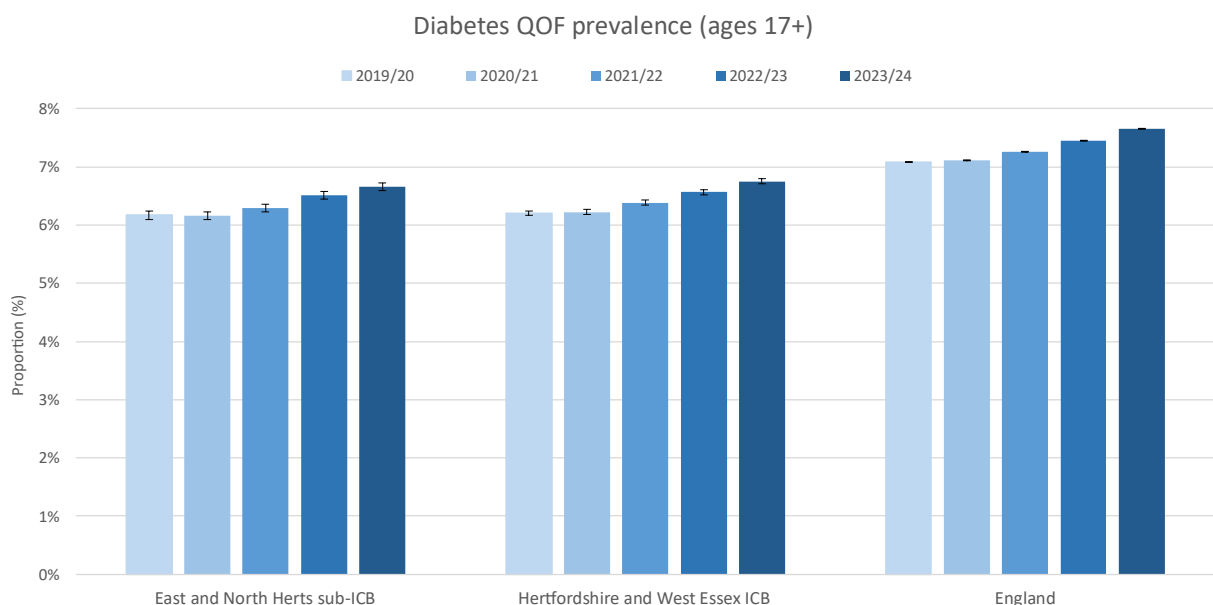


Source: NHS England.

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- In 2023/24, the QOF stroke prevalence in Stevenage was 1.6%. This was statistically similar to Hertfordshire (1.6%) but significantly lower than England (1.9%).
- In Stevenage, the prevalence of stroke has increased year-on-year between 2019/20 and 2022/23 in line with the Hertfordshire and England trend, followed by a slight decrease in 2023/24. This decrease was not statistically significant.
- Although local inequalities data was not available, data from England shows that there was no significant correlation between deprivation and stroke prevalence in the latest period (2023/24).

Diabetes

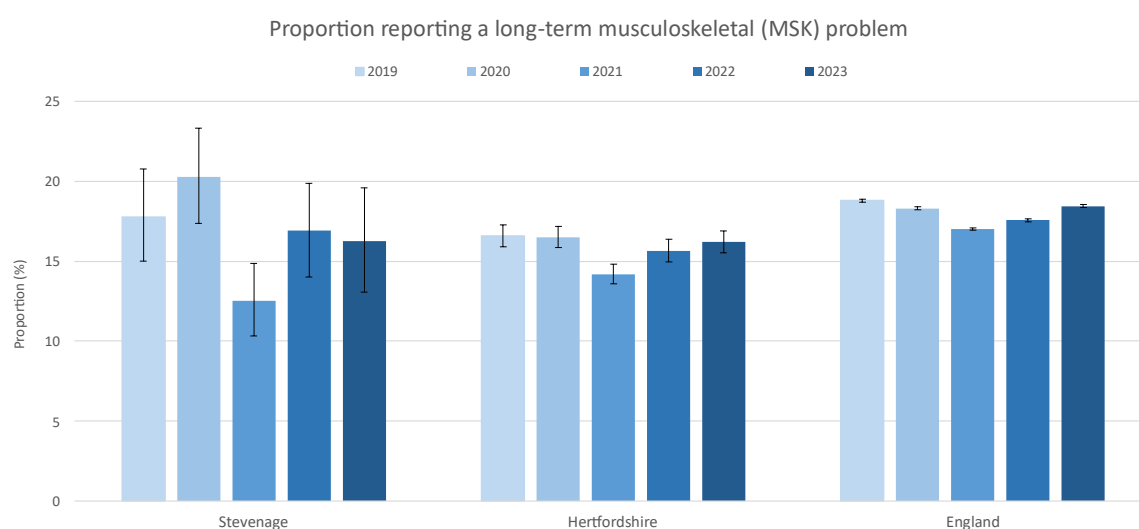


Source: NHS England

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- Data on the prevalence of diabetes is not available at district level, however it is available at sub-ICB level, therefore this indicator is compared for the East and North Hertfordshire sub-ICB area, which covers the district of Stevenage.
- In 2023/24, the prevalence of diabetes (including Type 1 and 2 diabetes) in East and North Hertfordshire was 6.7%. This was statistically significantly similar to the Hertfordshire and West Essex ICB (6.7%) but significantly lower than England (7.7%).
- In East and North Hertfordshire, the recorded prevalence of diabetes has increased significantly every year since 2020/21, from 6.2% in 2013/14 up to 6.7% in 2023/24. This equates to approximately 33,811 people in 2023/24.
- Although inequalities data was not available at sub-ICB level, data from England shows that there was no significant correlation between deprivation and diabetes prevalence in the latest period (2023/24).

Long-term musculoskeletal problems



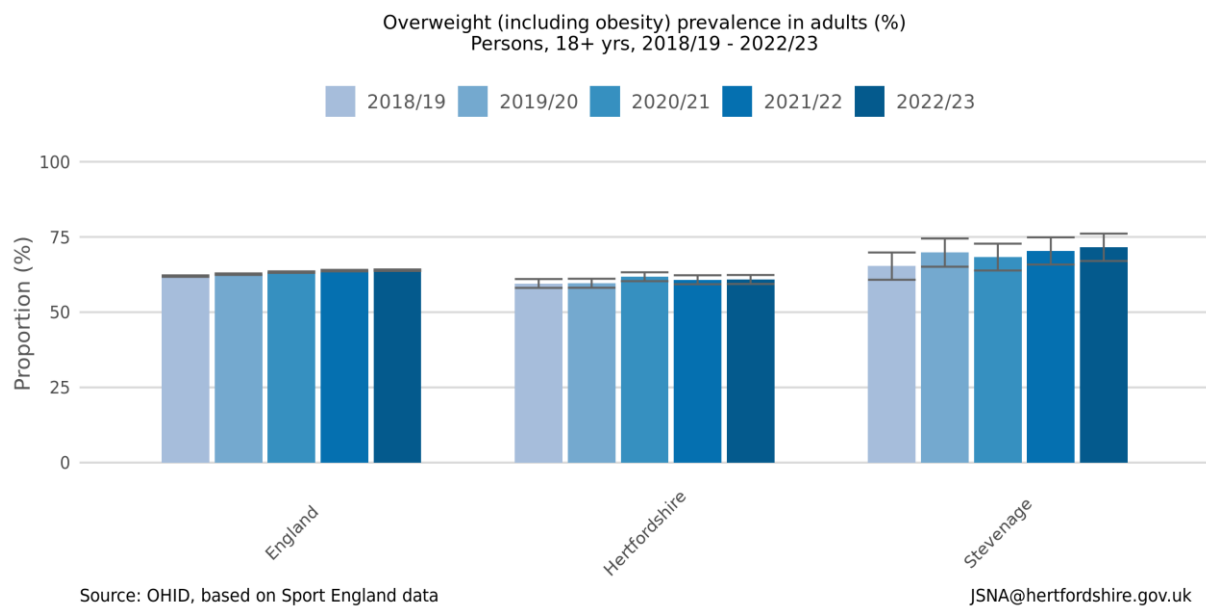
Source: NHS England, GP Patient Survey.

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- In 2023, 16.3% of adults (aged 16+) reported a long-term musculoskeletal (MSK) problem through the GP Patient Survey. This proportion was statistically similar to Hertfordshire (16.2%) and England (18.4%).
- The proportion of the adult population reporting a long-term musculoskeletal (MSK) problem in Stevenage has decreased over the last 5 years between 2018 and 2023, from 21.5% to 16.3%, however this decrease was not found to be statistically significant.
- Although local inequalities data was not available at district level, data from England shows that a statistically significantly higher proportion of females (20.9%) reported a long-term MSK problem compared to males (15.8%) in the latest period (2023). MSK problems were also significantly correlated with age, ethnicity, and deprivation. A significantly higher proportion of adults aged 55+, from White or Black Caribbean ethnic groups, or living in the most deprived deciles reported a MSK problem.

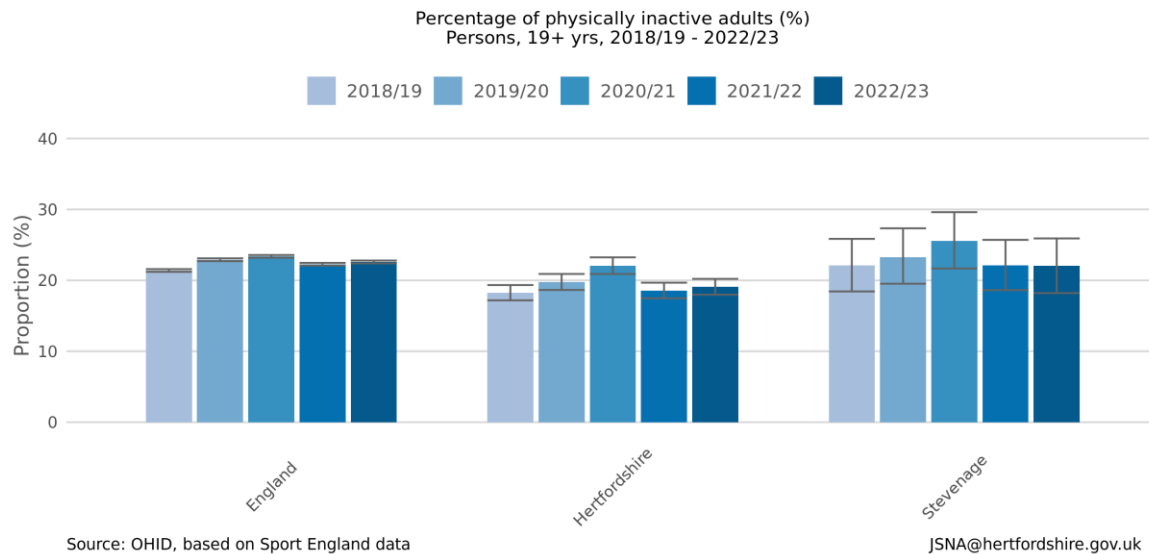
4.2 Healthy weight

Overweight or obese adults



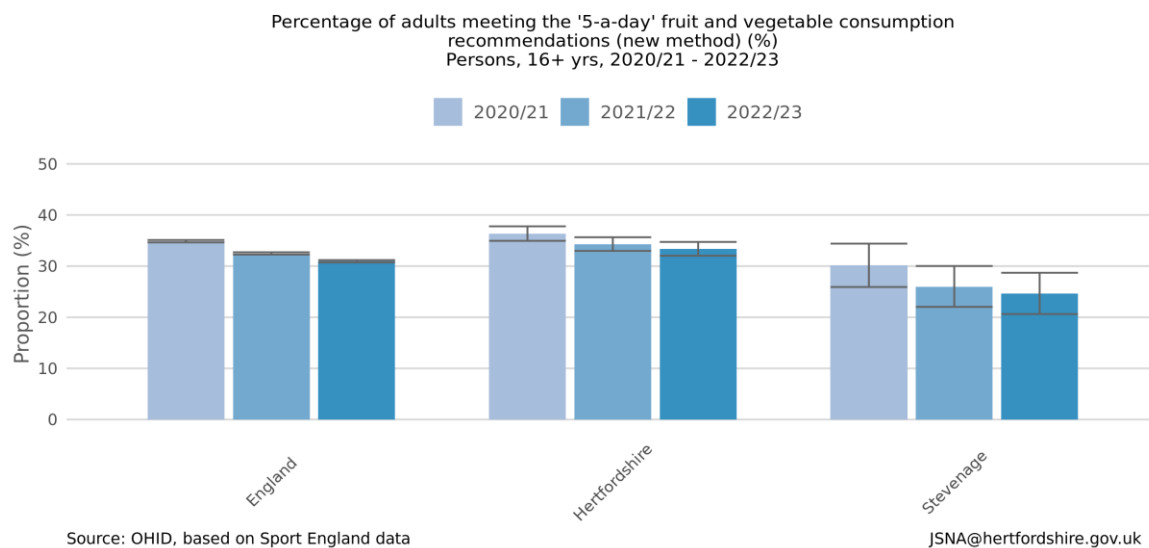
- In 2022/23, the proportion of adults (aged 18+) classified as overweight or obese in Stevenage was 71.6%. This proportion was significantly higher than Hertfordshire (60.9%) and England (64.0%).
- In the last 3 years between 2020/21 and 2022/23, the proportion of adults classified as overweight or obese in Stevenage increased from 68.3% to 71.6%, however this increase was not statistically significant.
- Nationally, the proportion of adults classified as overweight or obese in the latest year (2022/23) was significantly higher among males compared to females (69.2% compared to 58.6%). This proportion was also significantly higher among people living in the four most deprived LSOAs.

Physically inactive adults



- In 2022/23, the proportion of physically inactive adults (aged 19+) engaging in less than 30 minutes of physical exercise per week in Stevenage was 22.1%. This proportion was statistically similar to Hertfordshire (19.1%) and England (22.6%).
- In the last 3 years between 2020/21 and 2022/23, the proportion of physically inactive adults in Stevenage decreased in line with the Hertfordshire trend, however this was not a statistically significant decrease.
- Nationally, the proportion of physically inactive adults in the latest year (2022/23) was significantly higher among females compared to males (21% compared to 24%).

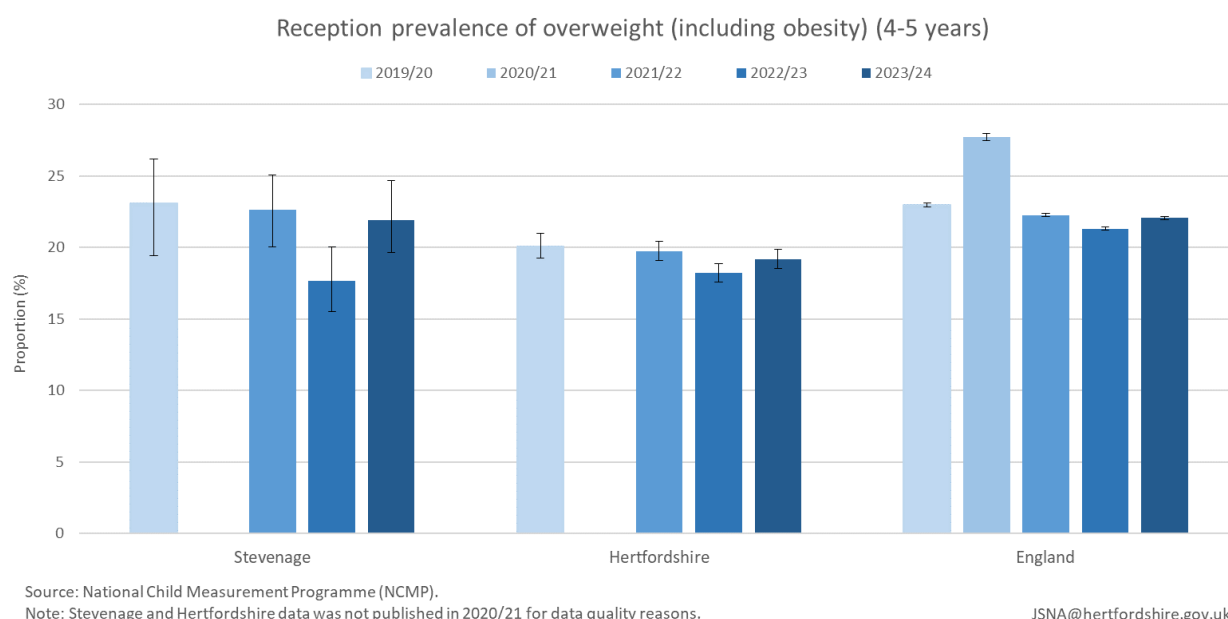
Healthy eating



- In 2022/23, the proportion of adults (aged 16+) meeting the recommended '5 a day' fruit and vegetable consumption guidelines in Stevenage was 24.6%. This proportion was significantly worse than Hertfordshire (33.4%) and England (31.0%).

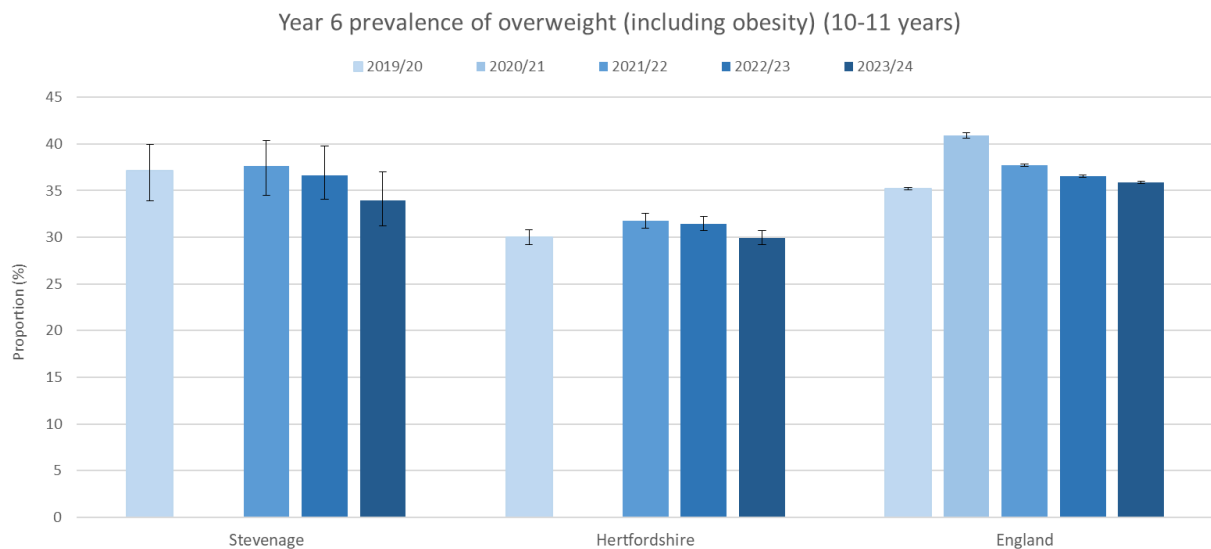
- In the last 3 years between 2020/21 and 2022/23, the proportion of adults meeting the '5 a day' recommendations in Stevenage decreased from 30.2% to 24.6% in line with the Hertfordshire trend, however this decrease was not statistically significant.
- Nationally, the proportion of adults meeting the '5 a day' recommendations in the latest year (2022/23) was significantly higher among females compared to males (34.2% compared to 27.6%).

Overweight or obese children (aged 4-5 years)



- In 2023/24, the proportion of Reception children (aged 4-5) classified as overweight or obese in Stevenage was 21.9%. This proportion was statistically similar to Hertfordshire (19.2%) but significantly lower than England (22.1%).
- Between 2021/22 and 2022/23, the proportion of Reception children classified as overweight or obese in Stevenage decreased significantly from 22.6% to 17.6% in line with the Hertfordshire trend, before increasing again in 2023/24. *Please note that data for 2020/21 is not available due to the COVID-19 pandemic.*
- Nationally, the proportion of Reception children classified as overweight or obese in the latest year (2023/24) was significantly higher among males compared to females (21.9% compared to 22.2%). Additionally, there was a strong correlation with deprivation, with children living in the most deprived areas being significantly more likely to be obese or overweight compared to the least deprived areas in England.

Overweight or obese children (aged 10-11 years)



Source: National Child Measurement Programme (NCMP).

Note: Stevenage and Hertfordshire data was not published in 2020/21 for data quality reasons.

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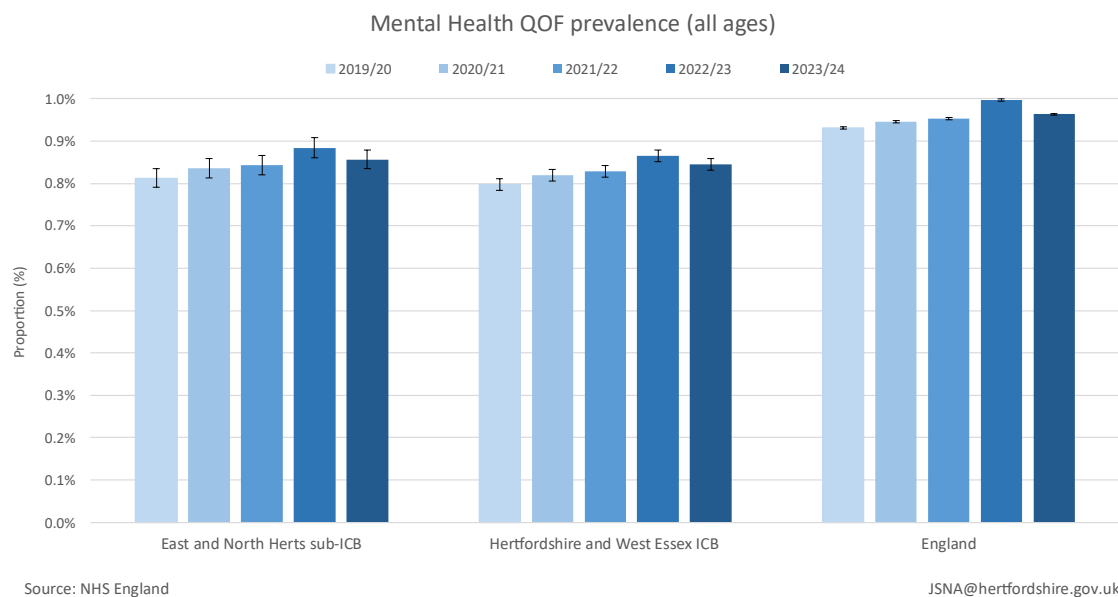
- In 2023/24, the proportion of Year 6 children (aged 10-11) classified as overweight or obese in Stevenage was 34.0%. This proportion was significantly higher than Hertfordshire (30.0%) but statistically similar to England (35.8%).
- Between 2021/22 and 2023/24, the proportion of Year 6 children classified as overweight or obese in Stevenage decreased from 37.6% to 34.0% in line with the Hertfordshire trend, however this decrease was not statistically significant. *Please note that data for 2020/21 is not available due to the COVID-19 pandemic.*
- Nationally, the proportion of Year 6 children classified as overweight or obese in the latest year (2023/24) was significantly higher among males compared to females (38.1% compared to 33.5%). Additionally, there was a strong correlation with deprivation, with children living in the most deprived areas being significantly more likely to be obese or overweight compared to the least deprived areas in England.

Eating disorders

- Between 2018/19 and 2022/23, the number of hospital admissions in Stevenage with a primary or secondary diagnosis of eating disorders remained similar at 35 admissions, however the proportion of admissions relating to children under 18 decreased during this time. Eating disorder admissions in Stevenage increased up to 55 admissions in 2020/21 during the COVID-19 pandemic, before declining year-on-year back down to 35 admissions in 2022/23. *Please note these figures are rounded to the nearest 5.*¹⁰⁹ *Due to small numbers and no comparative benchmark data, a trend graph has not been included for this indicator.*

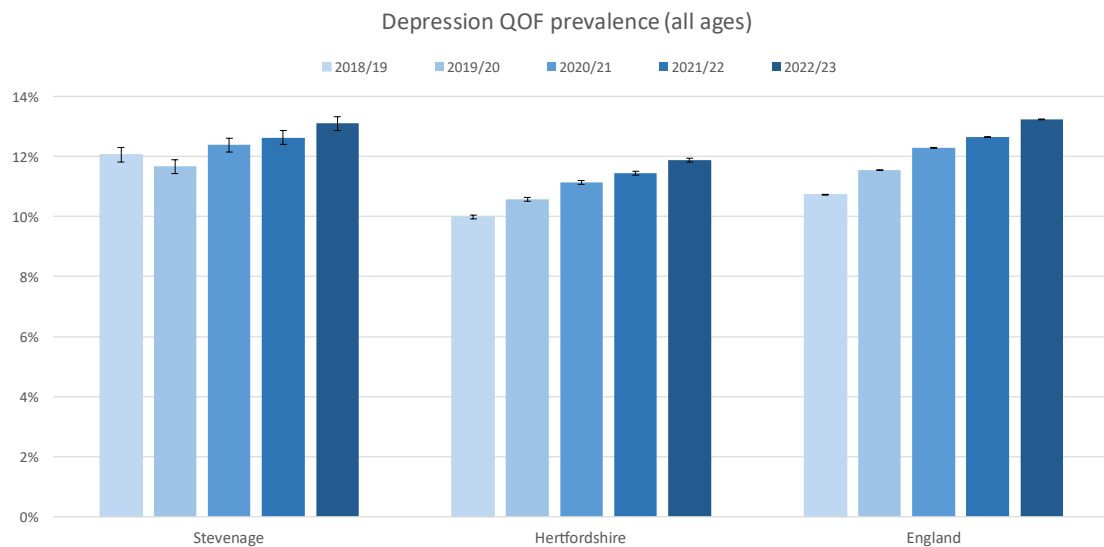
4.3 Mental health and wellbeing

Severe mental illness



- Severe mental illness (SMI) includes all patients with a diagnosis of schizophrenia, bipolar affective disorder, and other psychoses. Data on the prevalence of SMI is not available at district level, however it is available at sub-ICB level, therefore this indicator is compared for the East and North Hertfordshire sub-ICB area, which covers the district of Stevenage.
- In 2023/24, the prevalence of SMI in East and North Hertfordshire was 0.86%. This was statistically significantly similar to the Hertfordshire and West Essex ICB (0.85%) but significantly lower than England (0.96%).
- In East and North Hertfordshire, the recorded prevalence of SMI increased significantly between 2019/20 and 2022/23 up to 0.88%, followed by a slight decrease in 2023/24 down to 0.86%. This decrease was not statistically significant.
- Nationally, the prevalence of SMI was highest among people living in districts in the three most deprived deciles compared to the least deprived deciles.

Depression

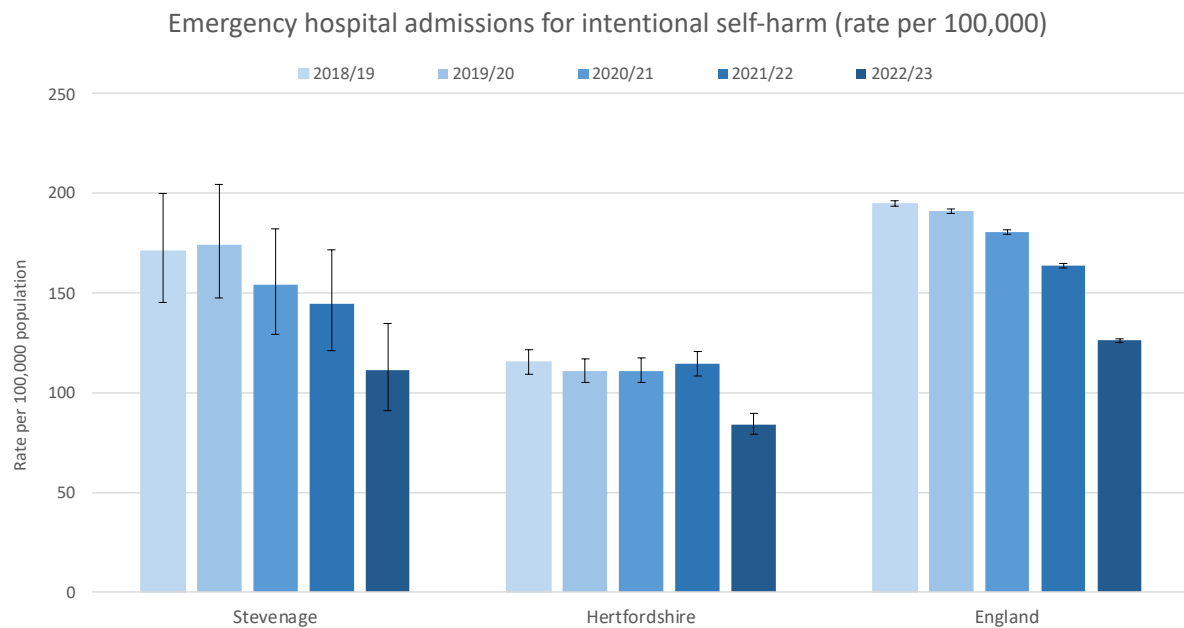


Source: NHS England

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- In 2022/23, the proportion of GP registered patients (aged 18+) with a diagnosis of depression was 13.1%. This was significantly higher than Hertfordshire (11.9%) but statistically similar to England (13.2%). *Please note this indicator has been discontinued after 2022/23.*
- The QOF prevalence of depression in Stevenage has followed a significant upward trend for the last 4 years in line with the national trend, increasing from 11.7% in 2019/20 to 13.1% in 2022/23.
- Nationally, depression was most prevalent among the most deprived areas compared to the least deprived areas, though this was not a significant difference.

Intentional self-harm

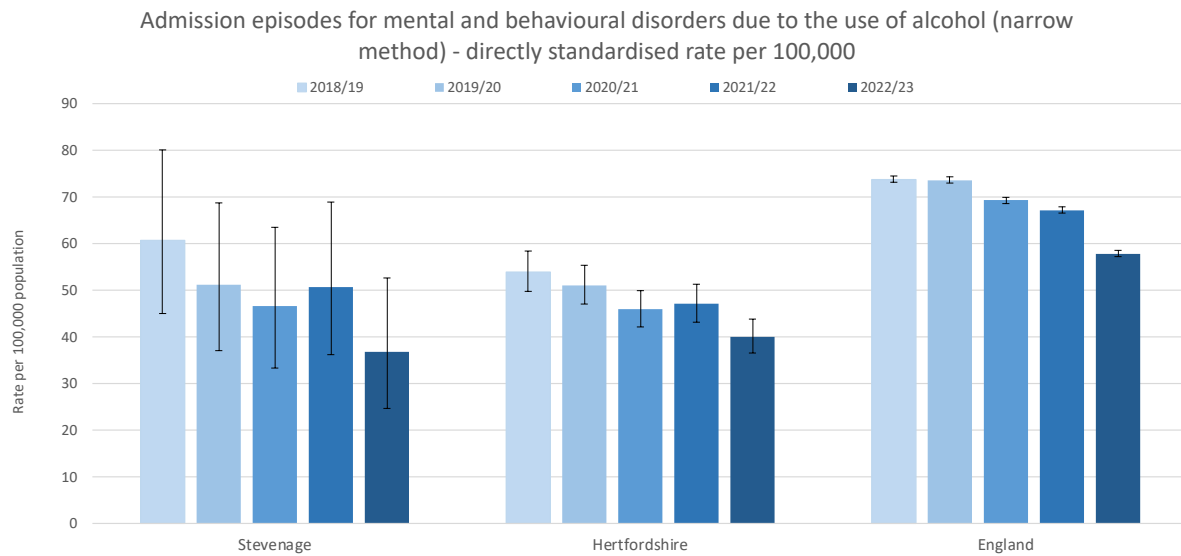


Source: Office for Health Improvement and Disparities.

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- In 2022/23, the directly standardised rate of emergency hospital admissions for intentional self-harm in Stevenage was 111.2 per 100,000 population, which was significantly higher than Hertfordshire (84.2 per 100,000) and statistically similar to England (126.3 per 100,000).
- Intentional self-harm hospital admissions in Stevenage have decreased significantly in the last 4 years. Admissions peaked in Stevenage in 2019/20 at a rate of 174.2 but have since significantly decreased to 111.2 per 100,000.
- The rate of hospital admissions for intentional self-harm in 2022/23 was statistically similar between males and females (102.5 and 124.3 respectively), against the national trend which shows that the rate among females is almost twice as high as males (168.0 compared to 85.8 per 100,000).
- Nationally, the rate of hospital admissions for intentional self-harm in 2022/23 was significantly higher among those living in districts in the two most deprived deciles and the second and third least deprived deciles.

Mental and behavioural disorders due to alcohol

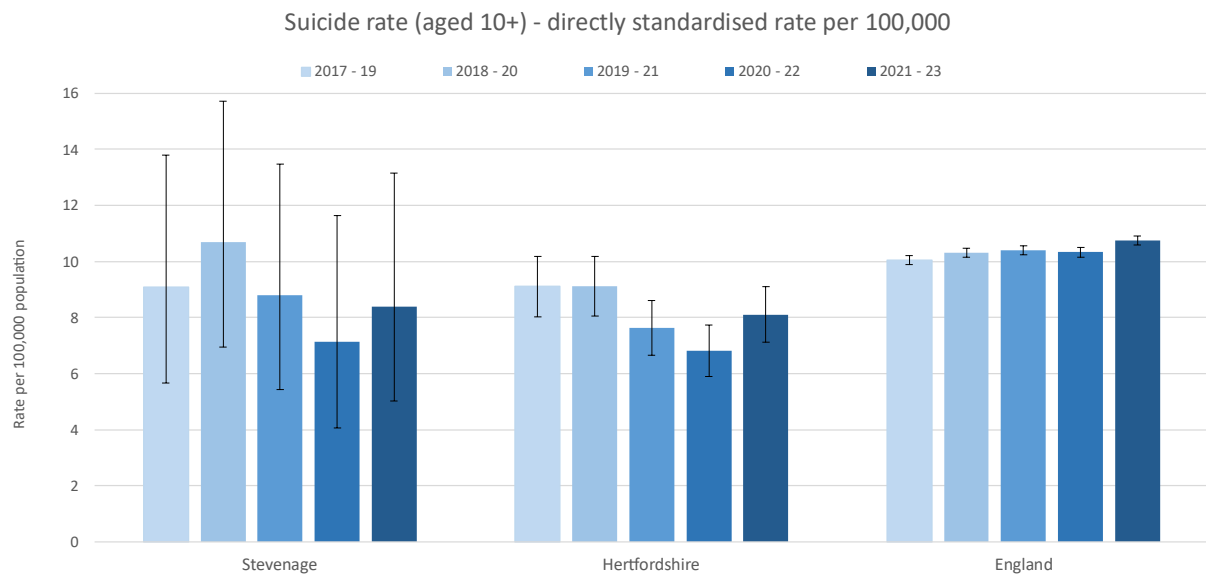


Source: Office for Health Improvement and Disparities.

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- In 2022/23, the directly standardised rate of hospital admissions for mental and behavioural disorders due to the use of alcohol (narrow method) in Stevenage was 36.7 per 100,000 population, which was statistically similar to Hertfordshire (40.0 per 100,000) but significantly lower than England (57.8 per 100,000).
- Hospital admissions for alcohol-related mental and behavioural disorders have followed a general downward trend in Stevenage following a peak of 60.7 per 100,000 in 2018/19, with a slight increase in 2021/22.
- The number of hospital admissions in Stevenage in 2022/23 were five times as high among males than females (25 compared to 5 admissions). *Please note these figures are rounded to the nearest 5, therefore a rate cannot be calculated for females.*

Suicide rate



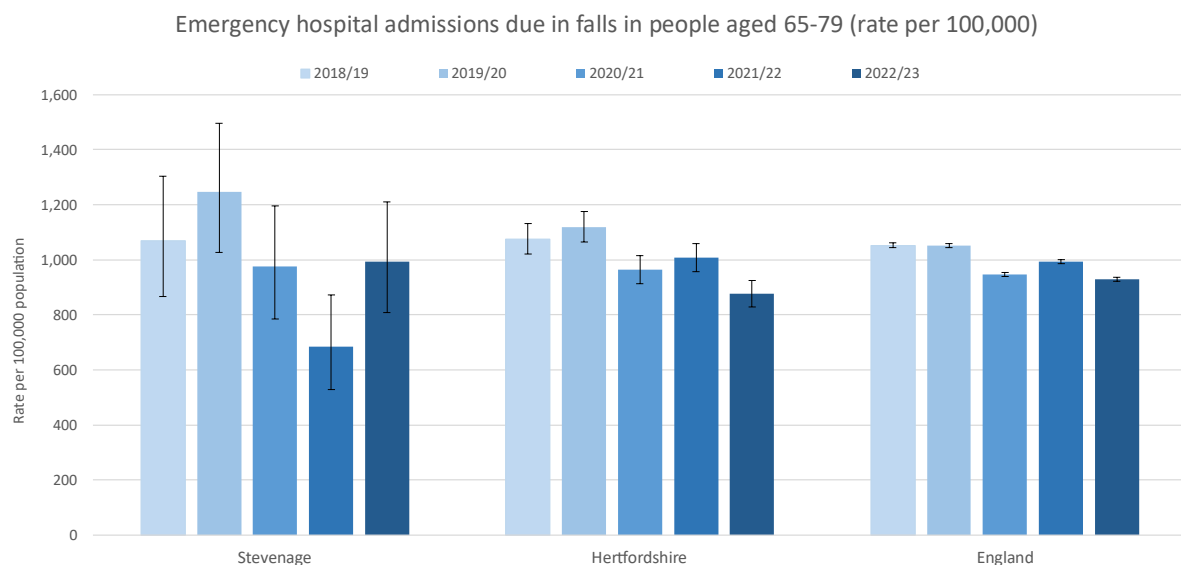
Source: Office for National Statistics.

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- In 2021-23, the suicide rate (aged 10+) in Stevenage was 8.4 per 100,000. This was statistically similar to Hertfordshire (8.1 per 100,000) and England (10.7 per 100,000).
- The suicide rate in Stevenage has fluctuated greatly over the last 5 years with an increase in the most recent year (from 7.1 to 8.4 per 100,000), although these changes have not been statistically significant.
- Findings from the [Hertfordshire Suicide Audit 2021-23](#) show that suicides were almost 3 times as high among males compared to females (73% compared to 27%). Additionally, those living in the least deprived quintile had the fewest suicides (15.3%) compared to all other IMD quintiles, but there was no significant correlation between deprivation and suicide.

4.4 Frailty and older people

Emergency hospital admissions due to falls in people aged 65-79

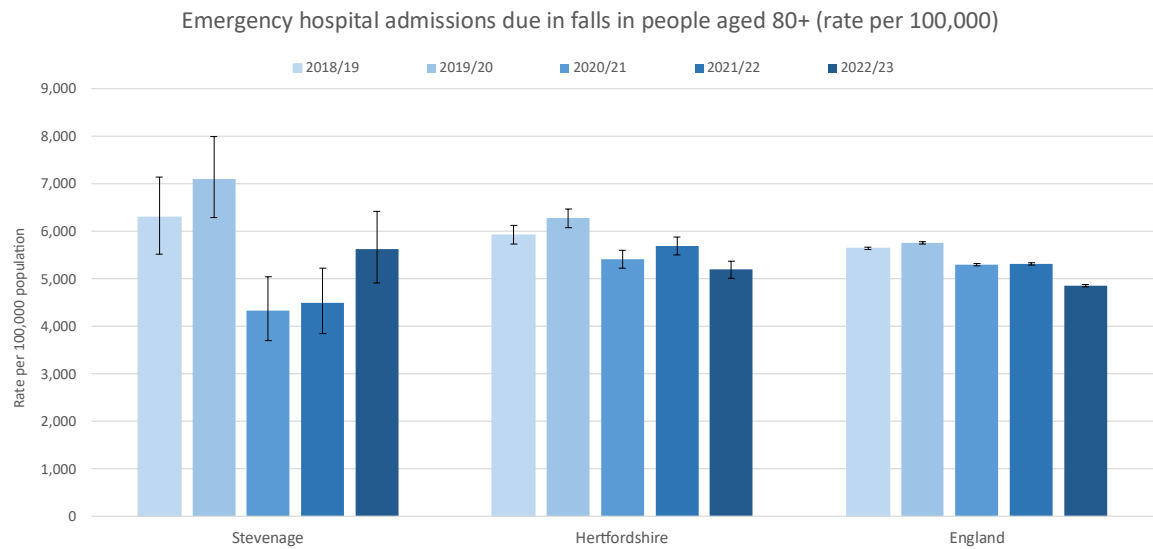


Source: Office for Health Improvement and Disparities (OHID).

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- In 2022/23, the directly standardised rate of emergency hospital admissions due to falls in people aged 65-79 years in Stevenage was 993 per 100,000. This rate was statistically similar to both Hertfordshire (877 per 100,000) and England (928 per 100,000).
- The rate of emergency hospital admissions due to falls in people aged 65-79 years in Stevenage has fluctuated considerably in the last 5 years. The rate dropped between 2019/20 and 2021/22 to a rate of 685 per 100,00 (significantly lower than England), before increasing to a rate of 993 per 100,000 in 2022/23.
- In Stevenage, the rate of falls in people aged 65-79 years in 2022/23 was statistically similar between males and females (984 and 1,006 per 100,000 respectively). This is against the national trend for the same period, where females had a significantly higher rate of falls compared to males (1,065 compared to 776 per 100,000).
- Nationally, the rate of falls in people aged 65-79 years has been significantly higher in the most deprived districts, with significantly lower rates in the least deprived districts.

Emergency hospital admissions due to falls in people aged 80+

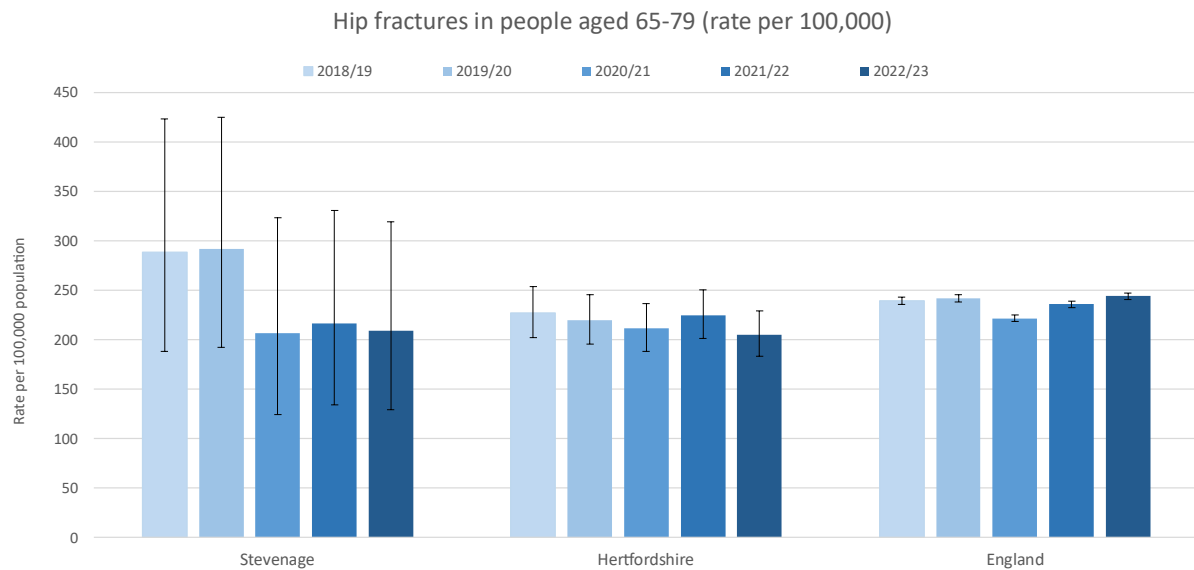


Source: Office for Health Improvement and Disparities (OHID).

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- In 2022/23, the directly standardised rate of emergency hospital admissions due to falls in people aged 80+ years in Stevenage was 5,622 per 100,000. This rate was statistically similar to Hertfordshire (5,186 per 100,000) but significantly higher than England (4,845 per 100,000).
- The rate of emergency hospital admissions due to falls in people aged 80+ years in Stevenage has fluctuated considerably in the last 5 years. The rate in Stevenage increased to 7,096 per 100,000 in 2019/20 (statistically higher than England), before reducing to 4,326 per 100,000 in 2020/21 (significantly lower than England) at the start of the COVID-19 pandemic. The rate has since increased again in 2022/23, making it statistically similar to England.
- In Stevenage, the rate of falls in people aged 80+ years in 2022/23 was statistically similar between males and females (5,135 and 5,944 per 100,000 respectively). This is against the national trend for the same period, where females had a significantly higher rate of falls compared to males (5,374 compared to 4,052 per 100,000).
- Nationally, the rate of falls in people aged 80+ years has been significantly higher in districts in the most deprived decile compared to the least deprived decile, however there is considerable variation and a weak correlation between deprivation deciles in between.

Hip fractures in people aged 65 to 79

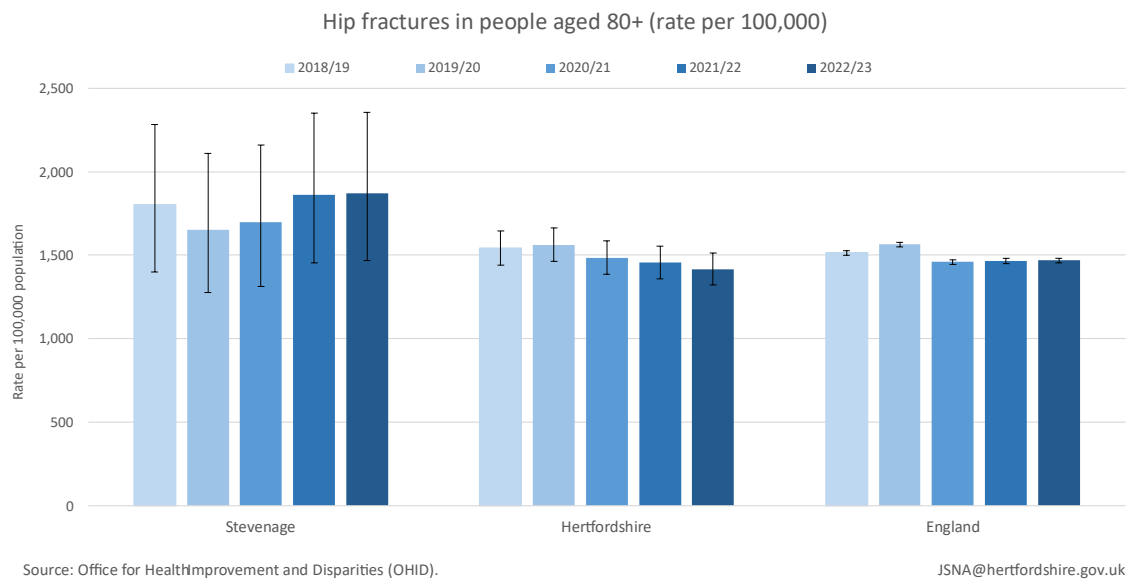


Source: Office for Health Improvement and Disparities (OHID).

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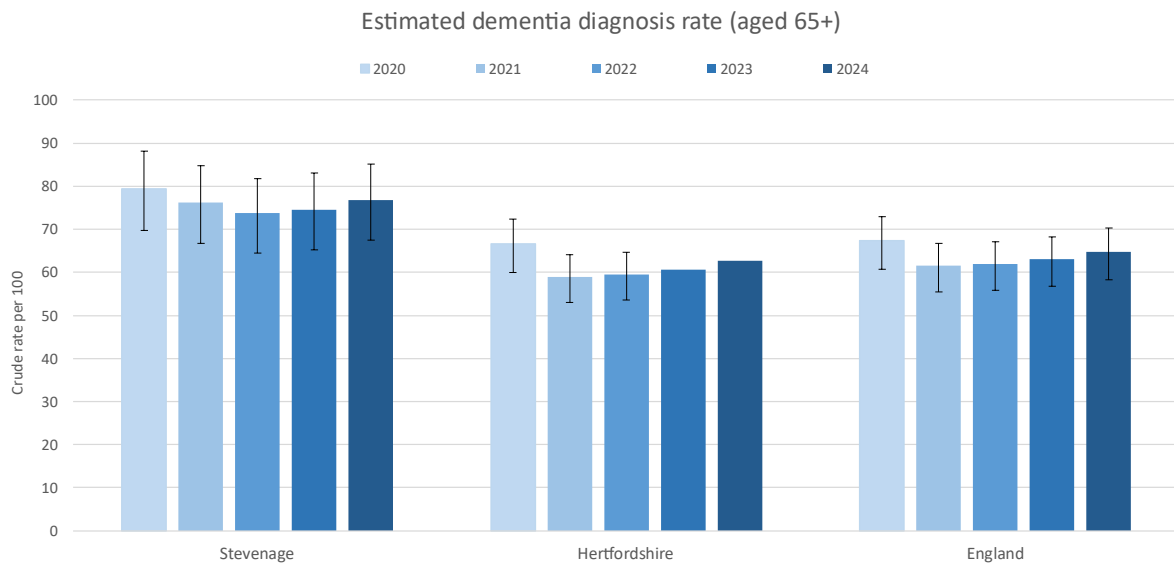
- In 2022/23, the directly standardised rate of hip fractures in people aged 65-79 years in Stevenage was 208.9 per 100,000. This rate was statistically similar to both Hertfordshire (204.8 per 100,000) and England (243.8 per 100,000).
- The rate of hip fractures in people aged 65-79 years in Stevenage has fluctuated considerably in the last 5 years. The rate dropped in 2020/21 at the start of the COVID-19 pandemic and has since remained similar, however this decrease was not found to be statistically significant.
- In Stevenage, the rate of hip fractures in people aged 65-79 years in 2022/23 was statistically similar between males and females (205.5 and 207.6 respectively). This goes against the national trend for the same period, where females had a significantly higher rate of hip fractures compared to males (309.9 compared to 170.1).
- Nationally, the rate of hip fractures in people aged 65-79 years has been significantly higher in the most deprived deciles, with the lowest rates in the least deprived areas.

Hip fractures in people aged 80+



- In 2022/23, the directly standardised rate of hip fractures in people aged 80+ years in Stevenage was 1,873 per 100,000. This rate was statistically similar to England (1,469 per 100,000) and Hertfordshire (1,415 per 100,000).
- The rate of hip fractures in people aged 80+ years in Stevenage has been increasing in the last 3 years from a rate of 1,654 to 1,873 per 100,000, however this increase was not statistically significant.
- In Stevenage, the rate of hip fractures in people aged 80+ years in 2022/23 was statistically similar between males and females (1,641 and 2,044 per 100,000 respectively). This is against the national trend for the same period, where females had a significantly higher rate of hip fractures compared to males (1,733 compared to 1,071 per 100,000).
- Nationally, the rate of hip fractures in people aged 80+ years has been significantly higher in districts in the most deprived deciles compared with the lowest deciles.

Dementia diagnosis



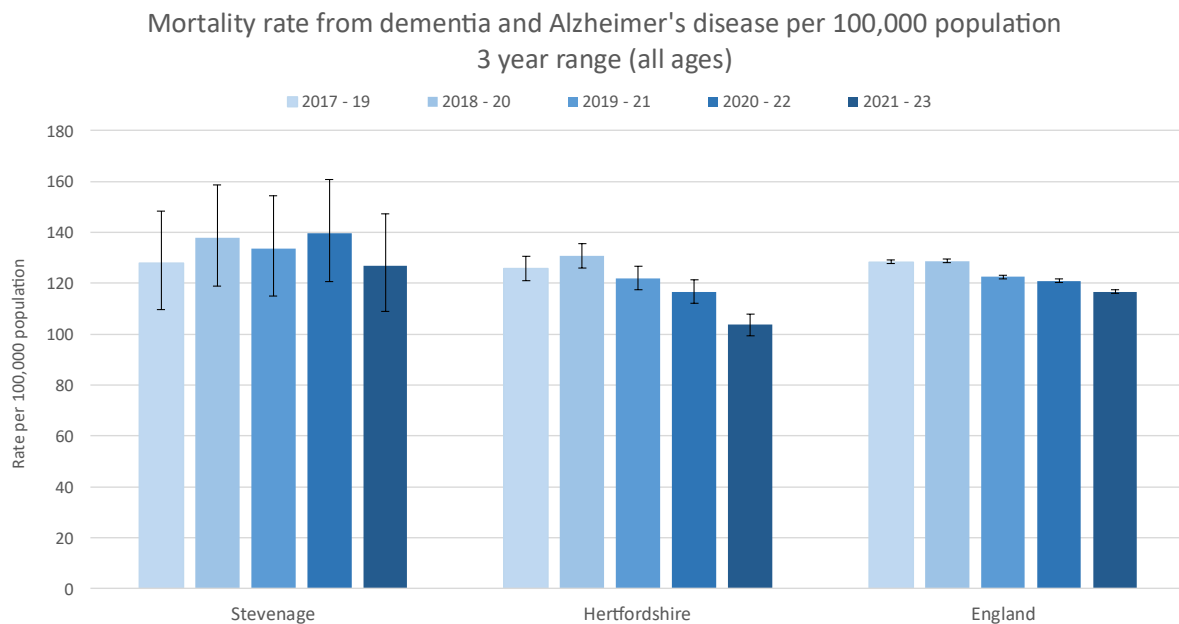
Source: Office for Health Improvement and Disparities (OHID).

Note: Confidence intervals could not be calculated for Hertfordshire in 2023 and 2024.

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- The Office for Health Improvement and Disparities (OHID) produce local estimates of the number of people aged 65+ with dementia that have a formal diagnosis recorded. In 2024, the estimated diagnosis rate for adults with dementia in Stevenage was 76.7 per 100. This rate was significantly higher than both Hertfordshire (62.7 per 100) and England (64.8 per 100).
- The estimated dementia diagnosis rate in people aged 65+ years in Stevenage has remained statistically similar for the last 5 years. The diagnosis rate has increased in the last 2 years and is now significantly better than the national rate, however this increase was not statistically significant.
- Data on inequalities (e.g. sex and deprivation) are not available for this indicator.

Mortality from dementia



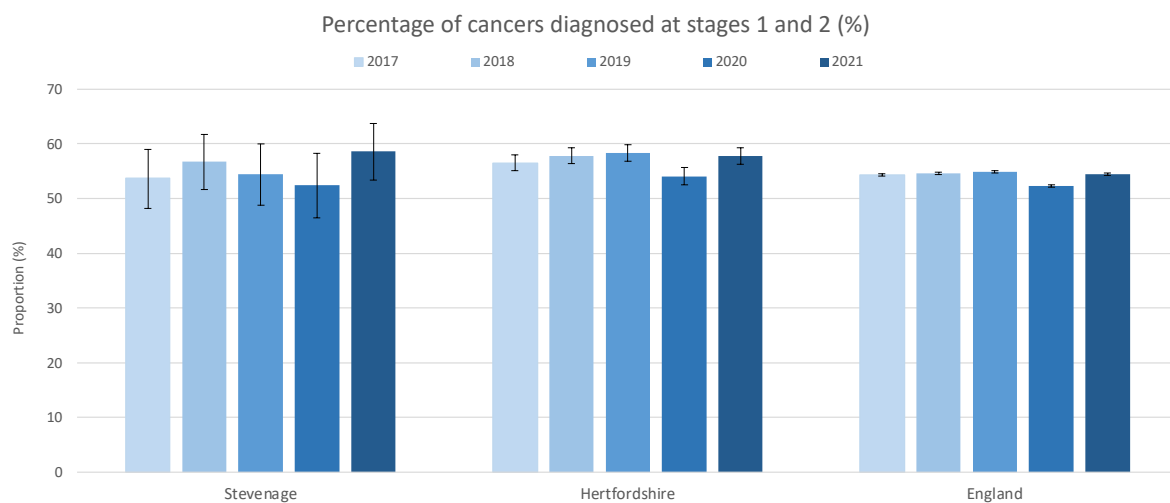
Source: Office for Health Improvement and Disparities.

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- In the latest 3 year rolling period (2021-23), the mortality rate from dementia and Alzheimer's disease in Stevenage was 115.2 per 100,000. This rate was statistically similar to England (109.9 per 100,000) but significantly higher than Hertfordshire (96.7 per 100,000).
- The mortality rate from dementia and Alzheimer's disease in Stevenage has significantly increased over the last 10 years and has been significantly higher than England since 2012-14, however the rate has been decreasing (although not significantly) since 2018-20, making it statistically similar to England.
- In Stevenage, the mortality rate from dementia and Alzheimer's disease in 2021-23 was higher among females compared to males (127.0 compared to 96.4 per 100,000), however this was not statistically significant, and both were statistically similar to England.
- Nationally, the mortality rate from dementia and Alzheimer's disease has been significantly higher in districts in the three most deprived deciles compared with the lowest deciles.

4.5 Cancer

Early cancer diagnosis

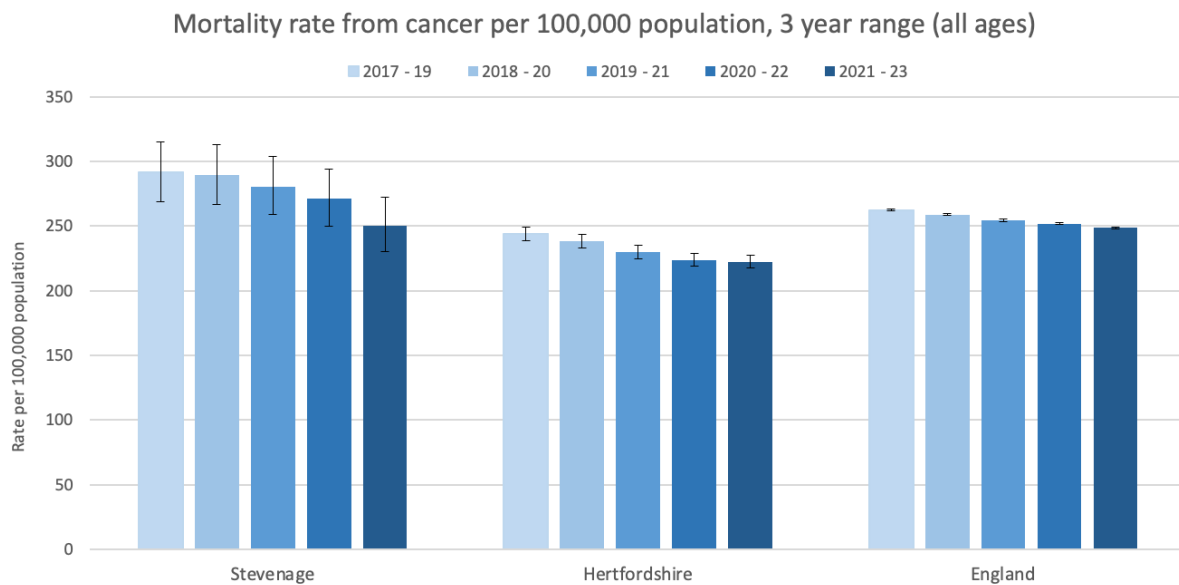


Source: NHS England, National Disease Registration Service.

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- In 2021, the proportion of cancers diagnosed at stages 1 and 2 in Stevenage was 58.7%. This proportion was statistically similar to both Hertfordshire (57.8%) and England (54.4%).
- The proportion of cancers diagnosed at an early stage decreased in Stevenage between 2018 and 2020 down to 52.4%, before increasing again up to 58.7% in 2021, however these trends were not statistically significant.
- Nationally, there was a significantly lower proportion of cancers diagnosed at an early stage in 2021 in districts in the most deprived deciles compared with the lowest deciles. Additionally, early diagnosis was significantly higher among those of Asian and Black ethnicity compared with all other ethnic groups.

Mortality rate from cancer (all ages)

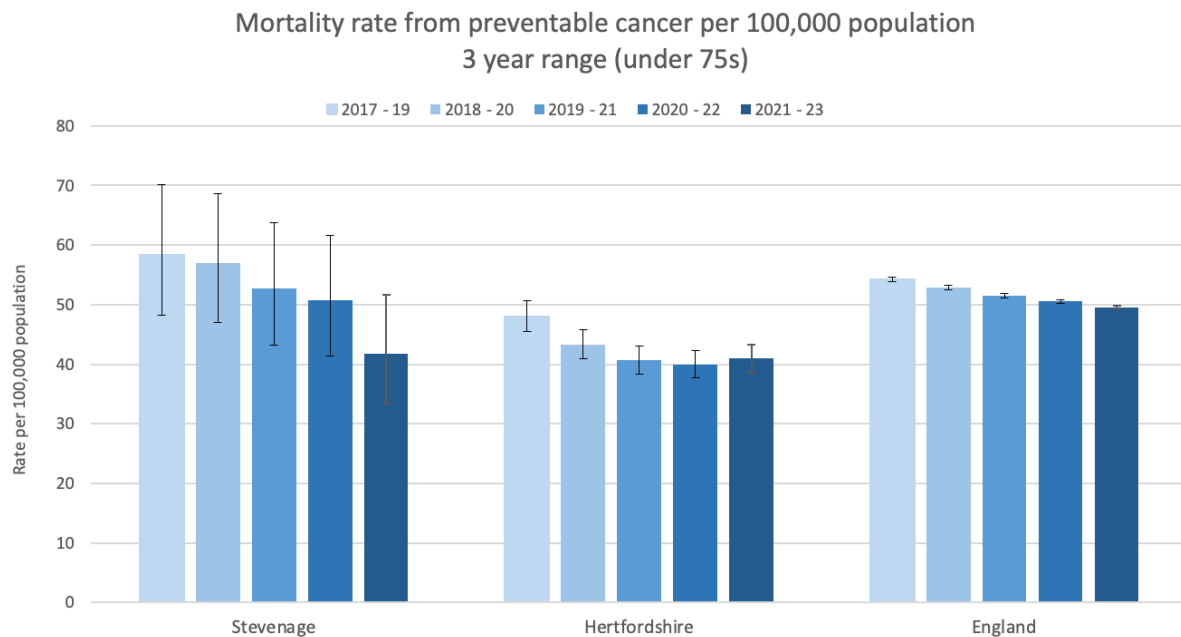


Source: Office for Health Improvement and Disparities.

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- In the latest 3 year rolling period (2021-23), the mortality rate from cancer in Stevenage was 250.4 per 100,000. This rate was statistically similar to England (248.5 per 100,000) but significantly higher than Hertfordshire (222.4 per 100,000).
- The mortality rate from cancer in Stevenage has been decreasing year-on-year since 2014-16 in line with the national trend, with the largest decrease in the most recent year (2021-23). Stevenage has previously been significantly higher than England but has been statistically similar to England in the latest two periods.
- In Stevenage, the mortality rate from cancer in 2021-23 was higher among males compared to females (286.7 compared to 226.3 per 100,000). The rates for both males and females were statistically similar to England.
- Nationally, the mortality rate from cancer in 2021-23 was significantly higher in districts in the most deprived deciles compared with the least deprived deciles.

Mortality rate from preventable cancer



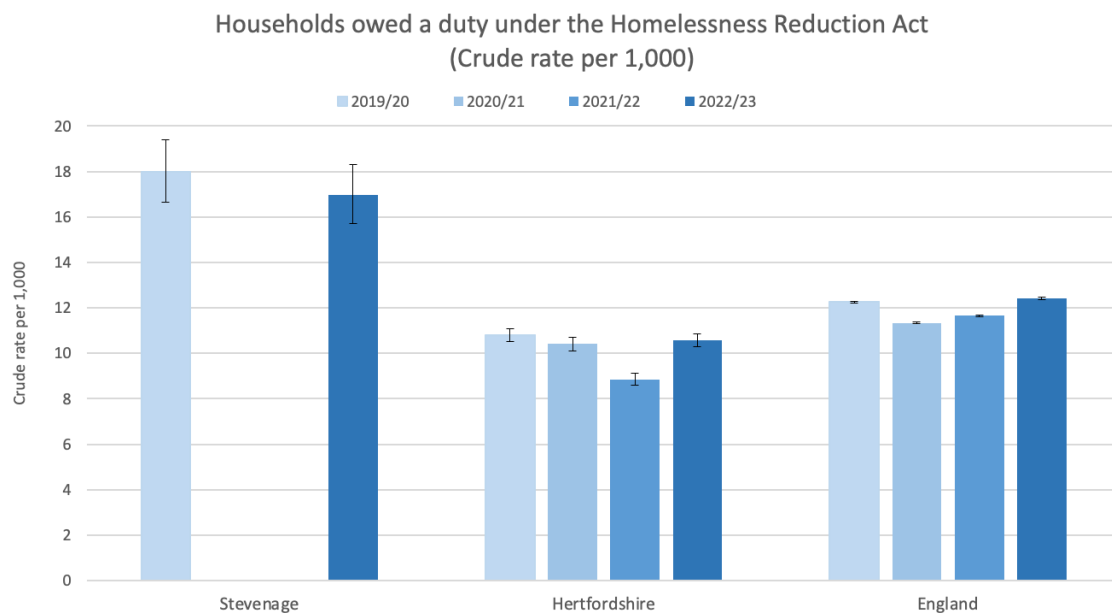
Source: Office for Health Improvement and Disparities.

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- In the latest 3 year rolling period (2021-23), the mortality rate from cancer considered preventable in under 75s in Stevenage was 41.8 per 100,000. This rate was statistically similar to Hertfordshire (40.9 per 100,000) and England (49.5 per 100,000).
- The mortality rate from preventable cancer in Stevenage has decreased in Stevenage in the last 5 years in line with the national trend. Stevenage was previously significantly higher than England, however, in 2017-19 it decreased to a rate statistically similar to England.
- In Stevenage, the mortality rate from preventable cancer in 2021-23 was higher among males compared to females (51.6 compared to 32.8 per 100,000), however both were statistically similar to England.
- Nationally, the mortality rate from preventable cancer in 2021-23 was significantly higher in districts in the most deprived deciles compared with the least deprived deciles.

4.6 Wider determinants of health

Statutory homelessness

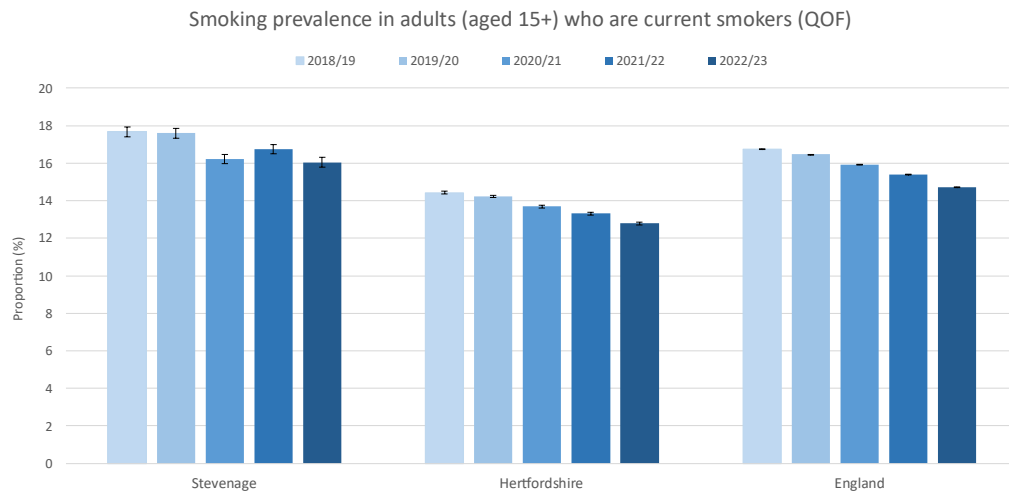


Source: Department for Levelling Up, Housing and Communities.
Note: Data was not provided for Stevenage in 2020/21 and 2021/22.

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- In 2022/23, the rate of households owed a duty under the Homelessness Reduction Act in Stevenage was 17.0 per 1,000 households. This rate was significantly higher than both Hertfordshire (10.6 per 1,000) and England (12.4 per 1,000).
- The rate of households owed a homelessness duty in Stevenage has remained statistically similar between 2019/20 and 2022/23 but has remained significantly higher than the national rate. Please note that homelessness duty data was not provided for Stevenage in 2020/21 and 2021/22.
- Nationally, the rate of households owed a homelessness duty in 2022/23 was significantly higher in districts in the three most deprived deciles compared with all other deprivation deciles.

Smoking prevalence

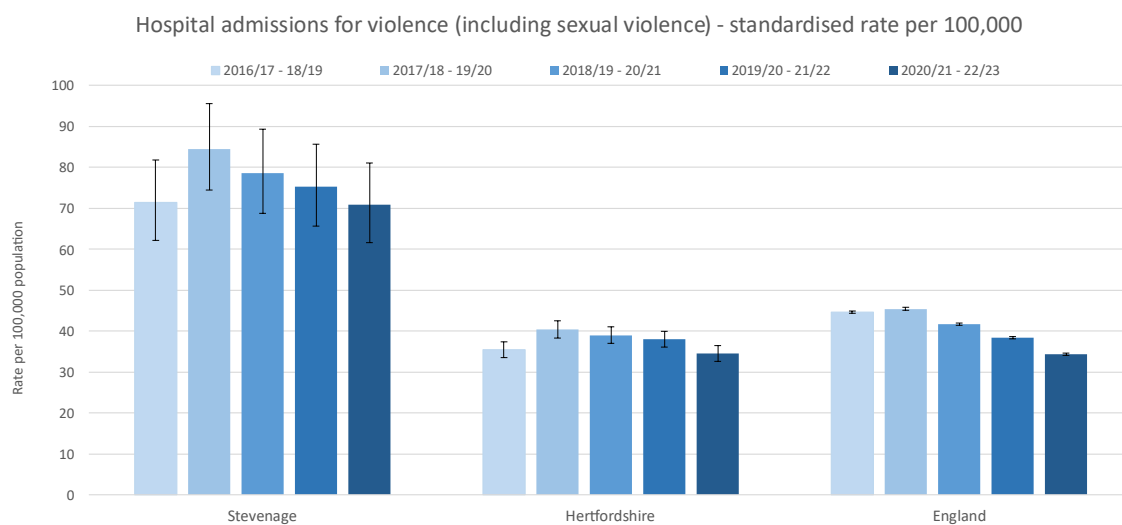


Source: NHS England.

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- In 2022/23, the proportion of GP patients (aged 15+) in Stevenage recorded as current smokers was 16.0%. This proportion was significantly higher than both Hertfordshire (12.8%) and England (14.7%).
- Smoking prevalence in Stevenage has been following a general downward trend for the last 10 years in line with the national trend. This included a statistically significant decrease in the latest year from 16.7% to 16.0%.
- Data on inequalities is not available for 2022/23, however national data from 2021/22 shows that smoking prevalence was significantly higher in districts in the five most deprived deciles compared with the five lowest deciles.

Hospital admissions for violence



Source: Office for Health Improvement and Disparities.

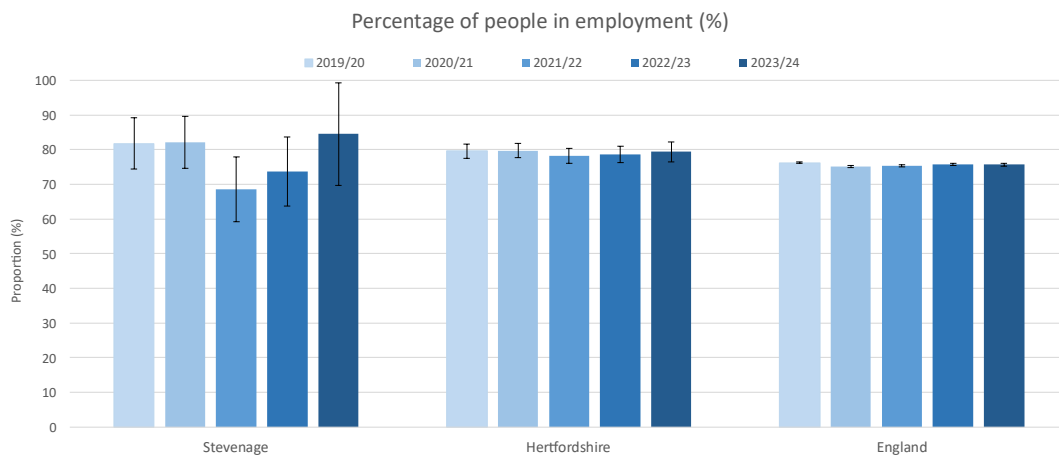
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- During the 2020/21-22/23 rolling period the directly standardised rate of hospital admissions for violence (including sexual violence) in Stevenage was 70.8 per

100,000 population. This rate was significantly higher than Hertfordshire (34.6 per 100,000) and England (34.3 per 100,000).

- The rate of hospital admissions for violence in Stevenage has been decreasing in the last 3 years since 2017/18-19/20 from a rate of 84.5 down 70.8 per 100,000. However, this decrease was not statistically significant and has remained significantly higher than England during this time.
- In Stevenage, the rate of hospital admissions for violence in 2020/21-22/23 was significantly higher among males compared to females (93.5 compared to 47.8 per 100,000).
- Nationally, the rate of hospital admissions for violence in 2020/21-22/23 has been significantly higher in districts in the three most deprived deciles compared with the lowest deprivation deciles.

Adults in employment

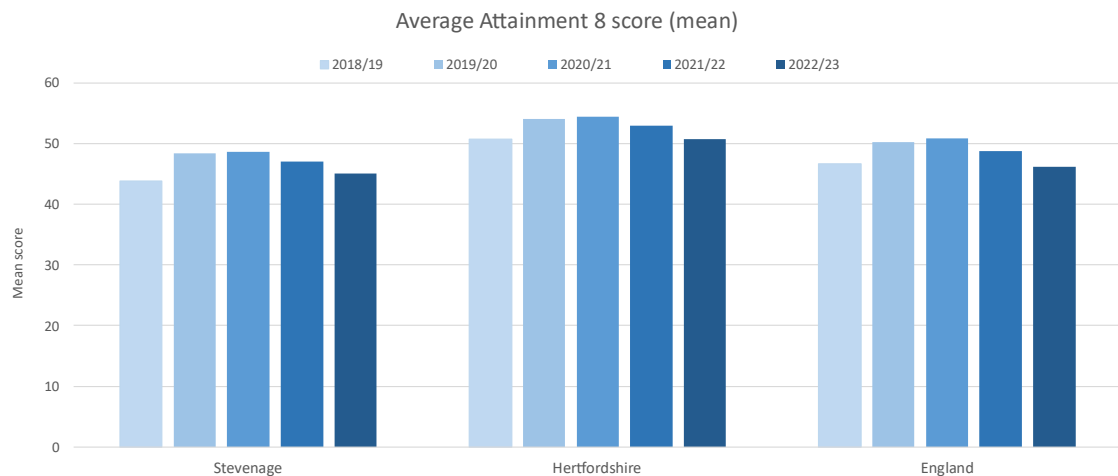


Source: NOMIS, Official Census and Labour Market Statistics.

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- In 2023/24, the proportion of adults aged 16-64 in employment in Stevenage was 84.5%. This rate was statistically similar to Hertfordshire (79.4%) and England (75.7%).
- The proportion of adults aged 16-64 in employment in Stevenage has fluctuated over recent years. Since 2016/17, the proportion of people in employment has been following an upward trend, however, this dropped to 68.6% in 2021/22 before increasing up to 84.5% in 2023/24. These changes were not found to be statistically significant.
- Nationally, the proportion of adults in employment was significantly higher among males compared to females (79.4% compared 72.0%). This proportion was also higher in the least deprived deciles compared to the most deprived.

GCSE attainment



Source: Department for Education.

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- In 2022/23, the average total GCSE Attainment 8 score for young people aged 15-16 years was 45.1. This was lower than both Hertfordshire (50.8) and England (46.2). Stevenage had the lowest score out of all Hertfordshire districts.
- The average total GCSE Attainment 8 score in Stevenage has decreased in the last 2 years from 48.6 in 2020/21 to 45.1 in 2022/23, however, trends from 2020 and 2021 should not be compared to other years due to temporary adjustments that were made during the COVID-19 pandemic for measuring student performance.
- Data on inequalities was not available at district level, however national data from 2022/23 showed that GCSE attainment was lower among:
 - Males (43.9 compared to 48.5 for females)
 - Children living in districts in the most deprived deciles (43.2 compared to 52.2 for children living in the least deprived decile)
 - Children eligible for free school meals (34.7 compared to 49.5 for non-eligible children).

5.0 Local strategies and interventions

5.1 Overarching strategies

National strategies

- [The NHS Long Term Plan](#) recognises the increasing contribution that longer-term health conditions have to the overall burden of disease in England. The NHS commits to improving upstream prevention for conditions such as CVD, cancer, and diabetes through prioritising action on smoking, poor diet, high blood pressure, obesity, and alcohol and drug use. It also outlines specific actions to improve care for major health conditions including cancer, CVD, diabetes, and mental health.
- In 2023, the UK Government launched a [Major Conditions Health Strategy](#) which aims to tackle six identified groups of major health conditions which together drive over 60% of mortality and morbidity in the UK:
 1. Cancer
 2. Cardiovascular disease (including stroke) and diabetes
 3. Chronic respiratory disease
 4. Dementia
 5. Mental ill health
 6. Musculoskeletal disorders

The strategic framework focuses on providing an integrated pathway from primary prevention through to long-term care and treatment. To maximise impact, the strategy outlines several priority areas of change, which include aligning management of multiple conditions and better integration between physical and mental health services, as well as managing personalised risk factors.

- In order to address widening health inequalities, Public Health England published guidance to taking a [whole system approach to health and wellbeing](#) and [addressing health across the life course](#). This guidance recognised the need to adopt a coordinated, collaborative approach across the life course to address complex health conditions and the wider determinants of health. The importance of focusing on health inequalities at a national, regional and local level is addressed in the [Marmot Review: Fair Society, Healthy Lives](#) and the [Marmot Review 10 Years On](#).

Local strategies

- The [Hertfordshire and West Essex Integrated Care Strategy 2023-33](#) sets out six priorities as identified for improving the health and wellbeing of local residents, based on consultation with local residents:
 1. **Give every child the best start in life** by giving families and children support at the earliest opportunity; ensuring that public and voluntary sector

organisations work together effectively; making early learning opportunities open to all; and keeping children safe from abuse and neglect.

2. **Support communities and places to be healthy and sustainable** by building more affordable housing; supporting people to get into and remain in work; creating healthy streets and improving green spaces; and putting additional support in areas with the biggest health challenges.
 3. **Support our residents to maintain healthy lifestyles** through initiatives such as developing a new physical activity offer for residents; offering all people admitted to hospital who smoke access to NHS-funded tobacco treatment services; and improving pathways and outcomes for people who have mental health issues and drug or alcohol problems.
 4. **Enable residents to age well and support people living with dementia** by promoting and encouraging take up of the NHS Health Check for people aged 40-74 to prevent the onset of disease; supporting people to reduce loneliness; and improving support for carers of people with dementia.
 5. **Improve support for people living with life-long conditions, long-term health conditions, physical disabilities, and their families** by working with the local population to lower risk factors and improve detection, diagnosis, and early intervention of long-term conditions; supporting and empowering people with long-term conditions with joined-up care; and increasing the number of residents receiving NHS health checks.
 6. **Improve residents' mental health and outcomes for those with learning disabilities and autism** through ensuring equal access to psychological therapies; improving integrated pathways to access housing, education, employment for specific groups; and working with employers to ensure they develop suitable job opportunities for people with learning disabilities.
- [Hertfordshire's Public Health Strategy 2022-27](#) outlines Hertfordshire County Council's ambitions and priorities to deliver a wide range of positive health outcomes. Key ambitions include leading prevention through partnership working and reducing health inequalities. Within the strategy, there are several proposed actions specifically targeting health behaviours (such as smoking and physical activity), excess weight, mental health, and frailty.
 - In 2022, Healthwatch Hertfordshire published a report on the [impact of the cost of living in Hertfordshire](#) which highlighted that many Hertfordshire residents are struggling with the rising cost of living. Most respondents to the consultation reported that they are reducing their energy usage (80%), going out less (62%) and reducing the amount and/or quality of food they are consuming (59%). Respondents also reported that the rising cost of living has affected their mental health and reduced their access to healthcare including dentist and/or opticians visits,

purchasing of prescriptions, purchasing of equipment to help with health and mobility, and inability to travel to appointments due to transport costs.

5.2 Long-term health conditions

Strategies

- The UK Government launched a [Major Conditions Health Strategy](#) in 2023 which included a key focus on preventing and tackling certain long-term health conditions, including cardiovascular disease (CVD), diabetes and musculoskeletal disorders.
- Public Health England's '[Health Matters – Preventing Cardiovascular Disease](#)' outlines England's CVD ambitions to improve the detection and management of atrial fibrillation (AF), high blood pressure and cholesterol, and reduce health inequalities.
- The [NHS Diabetes Rightcare Pathway](#) aims to provide resources to help diabetes services concentrate their efforts to improve population health for those at risk of developing diabetes and those who currently have T1DM or T2DM.
- NICE recommends that all people with diabetes aged 12 and over should receive nine recommended care processes at their annual diabetes review. These processes relate to blood glucose levels, blood pressure, serum cholesterol, foot examination, serum creatinine, urinary albumin, BMI, smoking history, and eye screening. Each care process has defined target levels to reduce the risk of diabetic complications.^{110,111} NICE has also published specific [guidelines for diabetes in pregnancy](#).
- The Royal College of Anaesthetist's [Four Nation Strategy for Pain Management \(2022\)](#) provides an overarching framework to deliver improved pain management across the whole healthcare sector. The strategy is patient-centred from point of first contact, including self-help signposting, personalised care and shared decision making.

Interventions

- NHS England and the National Institute for Health and Care Excellence (NICE) identified the most impactful interventions relating to the prevention and management of CVD and diabetes¹¹²:
 - **Diabetes:** Evidence-based and quality assured structured education programmes such as DAFNE and X-PERT are a cost-efficient way of reducing (a) the risk of diabetes complications, (b) the number of hospital admissions, and (c) reducing the need to refer T2DM patients to specialist services. The [NHS Diabetes Prevention Programme](#) – a nine-month, evidence-based lifestyle change programme – has shown to be effective in reducing population incidence of T2DM. Finally, evidence shows the importance of all

people with diabetes receiving the NICE recommended nine care processes on an annual basis to reduce the risk of diabetic complications.

- **CVD:** Successful interventions are based on *case finding* – namely, community pharmacy hypertension case finding, cholesterol search and risk stratification, and NHS Health Checks – and *optimising treatment*. The latter involves interventions such as preventing AF-related strokes with the use of direct-acting oral anticoagulants (DOACs); implementing cardiac rehabilitation for those diagnosed with heart failure; and the optimisation of hypertension treatment, heart failure treatment (through annual reviews), and primary care management after a high-risk CVD event (including lipid management).
- NICE recommend several evidence-based ways of managing chronic primary pain.¹¹³ These include non-pharmacological interventions such as exercise programmes and physical activity; psychological therapy such as acceptance and commitment therapy or cognitive behavioural therapy; acupuncture – but only if the course is delivered within a community setting by a band 7 healthcare professional with appropriate training; and electrical physical modalities (excluding Transcutaneous Electrical Nerve Stimulation (TENS), ultrasound or interferential therapy as there is no evidence of benefit). The only pharmacological intervention that NICE recommend is considering the use of an antidepressant for people aged 18 years and above, after a full discussion of the benefits and harms.¹¹³
- Recent evidence has shown that psychoeducational interventions are more effective in improving quality of life among fibromyalgia patients than usual treatments alone. A 2019 systematic review found that most of the examined studies found statistically significant positive results for psychoeducation compared to a control group, with specific improvements noted in functional status, management of emotions related to illness and pain, and anxiety and/or depressive symptoms. Online educational programmes were also found to be effective in increasing patients' knowledge of the disease and management of disease-related pain.¹¹⁴
- For more information on strategies and interventions relating to long-term conditions, see the [Diabetes JSNA](#), [Diabetes Lite Bite](#) and [Healthy Weight JSNA](#).

5.3 Mental health and wellbeing

Strategies

- The cross-government strategy '[No Health Without Mental Health](#)' (2011) focuses on increasing parity between physical health and mental health and improving access to quality treatment and support throughout the life course. The government is currently in the process of developing a new 10-year plan for mental health and wellbeing, extending the work of the NHS Long Term Plan to better address how local services can work together to prevent those at risk from falling into mental ill-health through earlier, targeted work.

- The [National Suicide Prevention Strategy](#) (2012) specifies key areas for action, with annual progress reports published. The [fifth progress report](#), published in 2021, set out new commitments and priorities in the context of the COVID-19 pandemic and the release of [the Cross-Government Suicide Prevention Workplan](#).
- The [Local Government Association](#) has outlined some key recommendations that councils can use to develop their mental health strategies in line with their population's specific needs identified through Joint Strategic Needs Assessments.
- The [Hertfordshire Health and Wellbeing Strategy 2022-26](#) includes a local priority to ensure that residents have good emotional and mental wellbeing throughout life. This includes support for people experiencing dementia.
- The [Hertfordshire Suicide Prevention Strategy 2020-2025](#) identified key priorities based on the national strategy, including support for men, support for those bereaved by suicide, addressing training needs, support for children and young people, reducing access to means of suicide, and support research, data collection and monitoring.
- Hertfordshire County Council are currently developing an Adult Mental Health Strategy for 2022-27 to replace the [previous 2016-21 strategy](#).

Interventions

- Within the NICE guideline [‘Common mental health problems: identification and pathways to care’](#), a stepped-care model is used to organise the provision of services for people with common mental health problems and to recommend appropriate interventions based on the severity of their disorder. In summary, effective treatments may include:
 - **Psychological:** Different forms of cognitive behavioural therapy (CBT) are effective across disorders and severity level. For depression, other effective treatments include behavioural activation, interpersonal therapy, behavioural couples therapy, and mindfulness-based cognitive therapy.
 - **Psychosocial:** Across all conditions, NICE recommends support groups, befriending and rehabilitation programmes, educational and employment support services, and referral for further assessment and interventions.
 - **Pharmacological:** A wide range of antidepressant drugs are effective in treating people with depression, and there is evidence to support the use of some antidepressants such as selective serotonin reuptake inhibitors (SSRI), for panic disorder and moderate to severe presentations of OCD.
- The Royal College of Psychiatrists published [a summary of evidence on public mental health interventions](#) across the life course. Some interventions with a strong evidence base included parenting programmes to help prevent child mental disorder and improve parental mental health; school-based bullying and violence prevention; interventions to prevent depression such as psychological interventions, physical activity, and increasing employment; and workplace interventions to reduce employee stress and/or mental disorder and increase wellbeing.

- In 2019, NICE published five quality standards to reduce the risk of suicide in the UK and help people bereaved or affected by suicide¹¹⁵:
 1. **Multi-agency suicide prevention partnerships:** Areas should have effective multi-agency partnerships where local organisations can combine their expertise and resources to implement interventions designed to prevent suicide and tackle underlying risk factors, such as self-harm.
 2. **Reducing access to methods of suicide:** reducing access to common methods of suicide and places where suicide may be more likely to occur can be an effective way of preventing suicide. A range of measures can be used to interrupt people's plans, giving them time to stop and think, or making it more difficult for them to put themselves in danger.
 3. **Media reporting:** Irresponsible reporting of suicide may have harmful effects, including potentially increasing the risk of suicide. By encouraging responsible reporting, partnerships can help prevent suicide clusters and avoid further distress being caused to those bereaved or affected by suicide.
 4. **Involving family, carers, or friends:** involving loved ones can help to support a person who is suicidal and can provide valuable input to an assessment of the person's needs in order to keep them safe. However, involving others can be complex so it is important that confidentiality is discussed.
 5. **Supporting people bereaved or affected by a suspected suicide:** People bereaved by suicide are at higher risk of suicide themselves, therefore it is important to identify people who need support as soon as possible.
- For more information on mental health strategies and interventions, see the [Mental Health and Wellbeing of Children and Young People JSNA](#), the [Mental Health and Wellbeing in Adults JSNA](#), the [Mental Health and Wellbeing Perinatal JSNA](#), and other resources on the [Hertfordshire JSNA website](#).

5.4 Healthy weight

Strategies

- [The NHS Long Term Plan](#) committed to make weight management services available to those most at risk (i.e. people living with obesity with type 2 diabetes and/or hypertension) and accelerate the NHS Diabetes Prevention Programme to provide access to high-impact weight loss services for those most at risk.
- Since 2019, Hertfordshire County Council has taken a [whole systems approach](#) to obesity. The approach aims to support and promote healthy weight by engaging with neighbourhoods and communities using 10 Pillars of Action. These include promoting a healthy environment, engaging with neighbourhoods and communities, adopting a [first 1000 critical days approach](#) for child development, improving workplaces to foster health, improving the food environment in schools and for young people, focusing on people with special needs, helping people regain a

healthier weight, learning from research and evaluation, using digital technology and using behavioural science.

Interventions

- The [NICE guidelines on preventing excess weight gain](#) makes 10 recommendations to help different population groups on how to maintain healthy weight or prevent excess weight gain. These recommendations are to:
 1. Encourage people to make changes in line with existing advice on physical activity and healthy dietary habits
 2. Encourage physical activity habits to avoid low energy expenditure
 3. Encourage dietary habits that reduce the risk of excess energy intake
 4. Further advice for parents and carers of children and young people
 5. Encourage adults to limit the amount of alcohol they drink
 6. Encourage self-monitoring
 7. Clearly communicate the benefits of maintaining a healthy weight
 8. Clearly communicate the benefits of gradual improvements to physical activity and dietary habits
 9. Tailor messages for specific groups
 10. Ensure activities are integrated with the local strategic approach to obesity.
- Evidence has suggested that media literacy interventions help to reduce weight and shape concerns; cognitive dissonance interventions help to reduce aspiring to the thin-ideal; and CBT interventions help to reduce body dissatisfaction, dieting and bulimic symptoms. Therefore, these interventions may be beneficial in the prevention of eating disorders.¹¹⁶
- The NICE guidelines for [Eating disorders: recognition and treatment](#) suggest the following:
 - **Anorexia Nervosa:** consider providing Individual Eating-disorder-focused Cognitive Behavioural Therapy (CBT); Maudsley Anorexia Nervosa Treatment for Adults; or Specialist Supportive Clinical Management for adults. For children, Anorexia-focused Family Therapy is the first-line therapy suggested.
 - **Binge-eating disorder:** offer a binge-eating-disorder focused self-help programme, or group or individual eating-disorder-focused CBT.
 - **Bulimia Nervosa:** consider bulimia-nervosa-focused self-help programmes or individual eating-disorder-focused CBT in adults. For children, offer bulimia-nervosa-focused family therapy or individual eating-disorder focused CBT.
- For more information on healthy weight strategies and interventions, see the [Healthy Weight JSNA](#), [Diabetes JSNA](#) and [Physical Activity JSNA Briefing](#).

5.5 Frailty and older people

Strategies

- [The NHS frailty framework of core capabilities](#) aims to identify and describe skills, knowledge and behaviours required to deliver high quality, holistic compassionate care and support for older people. The framework is underpinned by 14 capabilities which are grouped into 4 domains namely: understanding, identifying, and assessing frailty; person-centred collaborative working; managing frailty; and underpinning principles. These domains outline how people living with frailty, their loved ones and carers, practitioners, service providers, commissioning teams, and education and training providers can better identify frailty and understand how to support people to live well with frailty. This framework builds upon and references the priorities set in the NHS Five Year Plan.
- [The Hertfordshire Adult Care Services 15 Year Direction strategy](#) sets out ambition to make sure the right service development and transformation is available to the people that need them. Within its framework, this strategy aims to make sure that the adult social care system meets the rising expectations in society for personalised services and adequate planning for an expanding and ageing population.
- One of the six strategic priorities set by the [Hertfordshire and West Essex Integrated Care Strategy \(ICS\)](#) is to enable residents to age well and support people with dementia. In this priority, the ICS sets out to support residents to age healthily and ensure access to advice and services that enable them to live well and independently for as long as possible.

Interventions

- [A practical guide to healthy ageing](#) is an NHS information guide in partnership with Age UK that provides information to older adults from age 70 on how to manage healthy living in the later years. The guide provides practical advice on keeping active, preventing falls and overall physical and mental health in older adults.
- [The NHS practical guide to healthy caring](#) is an information guide that is designed for carers who are 65 years and older and are new to caring. The guide provides resources and support for older adults who have taken on caring roles. It also provides information on the health issues that may be associated to caring that can be harmful for older adults.
- [NICE guidelines on dementia, disability and frailty in later life](#) makes recommendations centred around promoting healthy lifestyles and service organisation and delivery to delay or prevent the onset of dementia, disability and frailty in later life. Their first recommendation is promoting healthy lifestyles by: encouraging healthy behaviours, integrating dementia risk reduction prevention policies, raising awareness of risk, and producing information on reducing the risk of dementia, disability and frailty, preventing tobacco use, improving the environment

to promote physical activity, reducing alcohol-related risk, and supporting people to eat healthily. The second recommendation is encouraging service organisation and delivery of interventions to promote behaviour change, provide accessible services, provide advice on reducing the risks of dementia, disability, and frailty, providing physical activity opportunities, provide training, lead by example in public sector, and provide support in the workplace.

- A systematic review and meta-analysis analysed the effects of physical activity intervention such as weight-based movement, outdoor walking, strength, balance, and flexibility exercises on frailty. The review concluded that physical activity is likely to help prevent frailty.¹¹⁷
- For more information on strategies and interventions for frailty and older people, see the [Physical Activity JSNA Briefing](#), [Dementia JSNA](#) and [Barriers and Enablers to Physical Activity in Older Adults JSNA Lite Bite](#).

5.6 Cancer

Strategies

- The [NHS Long Term Plan ambitions for cancer](#) aim to increase the number of people who survive cancer and those who are diagnosed early by 2028. The ambitions will be delivered by trying to improve quality of life outcomes, improving patient experience outcomes, reducing variation and inequalities. These ambitions aim to build on and accelerate the progress made through delivering recommendations made by the [Independent Cancer Taskforce](#) made in 2015. The [NHS cancer screening](#) programme encourages regular screening in an effort to help diagnose cancer or the risk of cancer earlier to improve the likelihood of successful treatment.
- The [10-Year Cancer Plan](#) (2023-2032) is a new strategy that encompasses all ambitions in the fight against cancer as identified by the Department of Health and Social Care in collaboration with other stakeholders. The new plan uses knowledge of the improvements that were undertaken during the pandemic and identifies what additional intervention might be adopted to support the delivery of the existing ambitions. Lastly, this strategy aims to look beyond the end date of the NHS Long-Term Plan to consider what more can be done to shape and improve cancer services in the next decade also through research and development.

Interventions

- [Cancel Out Cancer](#) is an initiative in East and North Hertfordshire NHS Trust aimed at improving awareness and understanding of cancer. This initiative was developed by NHS patient representatives and offers a 60-minute free online session discussing cancer screening, symptoms, and prevention.
- [Cancer Alliances](#) brings together clinical and managerial leaders from different hospital trusts and other health and social care organisations to change the diagnosis, treatment, and care for cancer patients in their local area. In collaboration

with primary care, they offer personalised care interventions to people with breast, colorectal, prostate cancer and other cancers using these four ambitions:

- **Personalised Care and Support Planning** (based on holistic needs assessments) ensures people's physical, practical, emotional, and social needs are identified and addressed at the earliest opportunity.
 - **End of Treatment Summaries** provide both the person and their GP with valuable information, including a detailed summary of treatment completed, potential side effects, signs and symptoms of recurrence and contact details to address any concerns.
 - **Primary Care Cancer Care Review** is a discussion between the person and their GP / primary care nurse about their cancer journey. This helps the person to discuss any concerns, and, if appropriate, to be referred to services or signposted to information and support that is available in their community and from charities.
 - **Health and Wellbeing Information and Support** includes the provision of accessible information about emotional support, coping with side effects, financial advice, getting back to work and making healthy lifestyle choices. This support will be available before, during and after cancer treatment.
- A systematic review exploring health promotion interventions to increase breast cancer screening uptake found that most interventions including individual, community and group-based interventions helped to increase uptake.¹¹⁸
 - Another systematic review and meta-analysis found that theory-based cervical cancer educational interventions (such as teaching about what is involved in screening and why it is important) helped to increase uptake in cervical cancer screening. Offering women the option of self-sampling for HPV testing increased screening uptake by 71%. Additionally, the study found that sending reminders to patients who are overdue for screening helped to improve uptake.¹¹⁹
 - For more information on cancer strategies and interventions, see the [Cancer JSNA](#).

6.0 Limitations

- The health conditions covered in this needs assessment are all extensive and multifaceted topics. For this reason, it was beyond the scope of this report to develop each of the individual topics in depth. More detailed information on risk factors, trends, strategies and interventions for individual health topics is available on the [JSNA website](#).
- Some indicators did not have district level data available for analysis. These included data on diabetes and severe mental illness. For these indicators, data for the East and North Hertfordshire sub-ICB area was used.
- Indicators have not been analysed at smaller geographies within Stevenage, such as at ward level or below as the vast majority of data is not available at these lower geographies. See [Appendix C](#) for more information on ward level indicators.
- There is a lack of local data regarding inequalities in the prevalence of different health conditions across various demographic groups, with the exception of sex and deprivation quintile for some of the indicators.
- The prevalence of obesity and overweight should be interpreted with caution for the following reasons:
 - BMI is a practical estimate of adiposity (body fatness) and does not distinguish between body fat mass and body lean mass or consider body composition, such as where the body fat is stored, which can pose a separate health risk.^{120,121}
 - In some ethnicities, such as some Asian groups, there may be a higher risk of certain medical conditions at a lower BMI.^{120,122} Therefore, using the cut-off points of 25kg/m² for overweight and 30kg/m² for obesity for these populations may mask potential health implications at a lower BMI.

Please see [Healthy Weight JSNA](#) for more information.

- The available data on diet and physical activity is self-reported. Self-reported data has known limitations, such as the validity of using retrospective questions, accuracy of answers and response bias.
- Data on eating disorders could not be compared to Hertfordshire or England benchmarks as this data was not available for direct comparison.
- Estimates for the prevalence of severe mental illness and depression are based on GP registered patients and therefore are not representative of people that are not registered with a GP. Furthermore, they are likely to underestimate the true scale of mental health in Stevenage as they only represent those with a registered diagnosis.
- Within this JSNA, frailty is measured using hospital admission data for falls and hip fractures in older adults, which serves as more of a proxy measure for frailty, rather than looking at measures such as the frailty index.

- Some indicators, such as those from the GP Patient Survey or Quality Outcomes Framework (QOF), only include data from individuals who are registered at GP surgeries. Therefore, certain population groups may be more likely to be excluded from the sampling framework such as those experiencing homelessness due to barriers with registering¹²³ and those exclusively using private healthcare.
- The COVID-19 pandemic affected the way that some of the indicators were measured and may mean that comparisons to previous years are misleading. For example, there was no local data collected for the National Child Measurement Programme (NCMP) in 2020/21 due to school closures during the pandemic.
- This needs assessment did not address the potential impact that the COVID-19 pandemic or Cost of Living crisis may have had on local health behaviours and outcomes. For more information, please see the [Cost of Living JSNA Lite Bite](#).

7.0 Summary

7.1 Population and inequalities

- The district of Stevenage has a diverse population compared to other districts within Hertfordshire. According to the 2021 Census, there is a balanced split of female and male residents (51% vs. 49%) and approximately 17% of residents are from ethnic minority groups.
- Compared to regional and national averages, Stevenage has a higher proportion of children and young people aged 0-14. Additionally, Stevenage has an aging population in line with regional and national trends, with the older population (aged 65+) expected to increase by 30% over the next 20 years, which is likely to increase demand on services for older people.
- Some of the most significant inequalities in Stevenage include life expectancy and deprivation. Stevenage is the most deprived district in Hertfordshire with a deprivation score of 19.7 and an average life expectancy at birth of 80.8 years, which is significantly lower than Hertfordshire but statistically similar to England.

7.2 Long-term conditions

- Over the last 5 years, Stevenage has seen a statistically significant decrease in the prevalence of coronary heart disease (CHD), as well as a decrease in adults reporting a long-term musculoskeletal (MSK) problem. On the other hand, the prevalence of stroke has increased (although not significantly) and prevalence of diabetes has increased significantly in East and North Hertfordshire sub-ICB in line with trends across the ICB and England.
- National data on inequalities showed that MSK problems were significantly higher among those who were female, aged 55+, from White or Black Caribbean ethnic groups, or living in districts in the most deprived deciles. Prevalence of stroke and diabetes showed no significant correlation with deprivation, however, data was not available for other inequalities or for coronary heart disease.

7.3 Healthy weight

- Compared to Hertfordshire and England, Stevenage has a significantly higher proportion of overweight/obese adults (72%) and a significantly lower proportion meeting the '5-a-day' fruit and vegetable consumption guidelines (25%). However, the proportion of physically inactive adults was statistically similar to Hertfordshire and England (22%).
- Latest findings from the National Child Measurement Programme (NCMP) in 2023/24 showed that 18% of Reception children and 37% of Year 6 children in Stevenage were classified as overweight or obese, both statistically similar to England.

Nationally, excess weight was significantly higher among males and was significantly correlated with areas of higher deprivation.

- Hospital admissions for eating disorders have decreased in Hertfordshire since 2020/21 during the COVID pandemic. Inequalities data was not available for this indicator.

7.4 Mental health

- The prevalence of severe mental illness (SMI) and depression has been increasing in Stevenage and the East and North Hertfordshire sub-ICB in line with national trends. However, hospital admissions for self-harm and alcohol-related mental and behavioural disorders have decreased during this time. The suicide rate has fluctuated in the last 5 periods, with an increase in the most recent period (2021-23).
- Nationally, the prevalence of SMI and depression were positively correlated with deprivation. Self-harm admissions in Stevenage were statistically similar between males and females, against the national trend of higher rates of female admissions. Conversely, alcohol-related mental and behavioural disorder admissions were 5 times as high among males compared to females.
- Findings from the Hertfordshire Suicide Audit 2021-23 showed suicides were almost 3 times as high among males compared with females, however there was no significant correlation with deprivation.

7.5 Frailty and older people

- The rate of falls and hip fractures among adults aged 65-79 in Stevenage has followed a general downward trend in the last 5 years, however, falls and hip fractures among adults aged 80+ have increased in the last 3 years. In Stevenage, the rate of falls and hip fractures has been statistically similar between males and females, against the national trend where females had a significantly higher rate. Nationally, falls and hip fractures were significantly higher among people living in the most deprived areas.
- The estimated diagnosis rate for adults with dementia in Stevenage is significantly higher than Hertfordshire and England. Dementia-related mortality has remained statistically similar over the last 5 years, against the Hertfordshire and England trend which has been decreasing. Dementia-related mortality was higher among females and those living in districts in the 3 most deprived deciles.

7.6 Cancer

- The proportion of cancers diagnosed at stages 1 and 2 in Stevenage was 58.7%, statistically similar to Hertfordshire and England. Nationally, early cancer diagnosis was significantly higher across districts in the most deprived deciles compared with the lowest deciles.

- The mortality rate from cancer (all ages) and cancer considered preventable has decreased in Stevenage in the last 5 years in line with the national trend. Cancer-related mortality in Stevenage has been significantly higher among males compared to females and, nationally, among people living in the most deprived areas.

7.7 Wider determinants of health

- Stevenage has a higher rate of statutory homeless households, smoking prevalence, and hospital admissions for violence than both Hertfordshire and England benchmarks. All of these indicators were more prevalent in the most deprived areas.
- Approximately 85% of Stevenage residents were in employment in 2023/24, which was statistically similar to Hertfordshire and England and significantly higher among females and the least deprived areas.
- GCSE attainment was lower in comparison to Hertfordshire and England, with an average Attainment 8 score of 45.1. Data shows that GCSE attainment was lowest among males, children living in the most deprived areas, and children eligible for free school meals.

8.0 Recommendations

8.1 Population and inequalities

- Local services should consider any changes to Stevenage population demographics identified through the 2021 Census over the last 10 years to assess the impact on service capacity, identify gaps in service provision and inform commissioning decisions.
- Ensure that local service provision is proportionate to the age profile of Stevenage. This includes the higher proportion of children and young people (aged 0-14) within Stevenage and the predicted increase in the older population (aged 65+), which is likely to increase demand for services for older people.
- Preventative approaches aimed at overcoming health inequalities (including deprivation) are key to improving health outcomes and increasing life expectancy among Stevenage residents.

8.2 Long-term conditions

- Prioritise upstream prevention and detection of long-term health conditions, such as hypertension and type 2 diabetes, by promoting physical activity and smoking cessation initiatives, and increasing local uptake of NHS Health Checks.
- Increase referrals to structured education programmes as an evidence-based, cost-effective way of reducing risk of diabetes complications, hospital admissions and the need for referral to specialist services among patients with diabetes.
- Encourage the completion of annual care processes (e.g. blood checks, foot examination, eye screening) in those with diabetes, including specific processes for expectant mothers with diabetes in pregnancy.
- Work collaboratively with community and specialist chronic pain services to optimise patient management opportunities and support the development of advice and guidance services if referral may not be required.
- Develop targeted communications and awareness resources aimed at population groups shown to be at higher risk of developing musculoskeletal conditions, including females, adults aged 55+, those from White or Black Caribbean ethnic groups, and those living in the most deprived deciles.

8.3 Healthy weight

- Take a whole-systems approach to obesity by adopting initiatives that target the environmental, social, and physiological drivers of obesity. This approach includes:
 - increasing the availability of different food types and physical activity opportunities across the district
 - increasing nutritional education
 - promoting active travel and use of green spaces

- increasing awareness of obesity management services and management of drug-induced weight gain
- Increase physical activity in residents through strengthening partnerships across public, private and voluntary organisations to target activities in under-represented groups. This includes those living in deprived areas, women, older adults and those with long-term conditions.
- Increase the number of children and young people starting treatment for eating disorders within 4 weeks to meet the 95% target set out in the NHS Long Term Plan.
- Strengthen prevention work around disordered eating through evidence-based interventions aimed at reducing body dissatisfaction and addressing bullying behaviours, particularly those relating to appearance-related teasing.

8.4 Mental health

- Adopt a life course approach to mental health and wellbeing. This should include the promotion of mental wellbeing from early life (by reducing exposure to adverse childhood experiences and addressing harms by promoting programmes that address childhood trauma) through to older age (by addressing links with issues such as social isolation and physical health).
- Ensure that reducing inequalities and addressing wider determinants of mental health (including physical health) are at the heart of improving mental health and wellbeing in the local population. This should include support for physical health conditions and ensuring equity of access across demographic groups.
- Follow the priorities outlined in national and local strategies for suicide prevention including enabling earlier intervention, reducing access to means of suicide, and improved awareness for professionals on signposting to available services and referral routes. This should include specific consideration for higher risk demographic groups such as men, ethnic minority groups and LGBTQ individuals.

8.5 Frailty and older people

- Adopt a multidimensional approach to the prevention of frailty through the promotion of healthy lifestyle behaviours such as regular physical activity, avoidance of excess weight gain, and the prevention and cessation of smoking with a particular focus on women, older adults and those living in the most deprived areas.
- Review what services and interventions are available across the system in relation to falls prevention among older adults in Stevenage to identify current gaps in provision.
- Increase dementia screening in care homes and services for older people to improve diagnosis rates, due to diagnosis rates still not meeting the estimated prevalence of dementia.

- Increase dementia awareness training across GP surgeries, care home staff, those in support roles and families, with a focus on the recognition of the signs and symptoms of dementia.

8.6 Cancer

- Promote and increase awareness of local initiatives that focus on smoking cessation, weight management, alcohol reduction and cancer prevention behaviours such as reducing exposure to UV radiation, particularly in more deprived areas.
- Increase promotion of cancer awareness campaigns, local initiatives that assist with early detection of cancer, and cancer screening to increase the proportion of cancers diagnosed at stages 1 and 2. These should include targeted messages for population groups at higher risk of cancer, including males and those living in the most deprived areas.
- Map locations of cancer screening services in Stevenage and bordering districts and consider increasing cancer screening coverage in areas with reduced access to screening services.

8.7 Wider determinants of health

- Local health organisations should use a preventative approach to tackle wider determinants of health. This should include commissioning decisions for investment in early intervention and appropriate sharing of data to understand trends in local demand.
- Local services should give consideration to joint commissioning approaches and new ways of working together to tackle health inequalities and reduce the impact of wider determinants on the health and wellbeing of residents.
- Review and monitor the impact of the Cost of Living crisis on local residents' physical and mental health, including access to healthcare services, and increase awareness of local services available for residents struggling with the increased cost of living.

Appendix A: Information for Equality Impact Assessments



Stevenage Health Inequalities JSNA

Part A: Protected characteristics (protected under the Equality Act 2010)

Age

- The risk of developing CVD increases with age, with it being most common in individuals over the age of 50.⁶ Increasing age is associated with an increased prevalence of pre-diabetes and T2DM,^{26,27} whilst type T1DM typically peaks around puberty.²⁸
- Approximately three-quarters of all strokes occur in adults aged 65+. The risk of having a stroke doubles every 10 years after the age of 55.¹⁵
- Osteoarthritis typically develops in individuals in 45 years older and above, while rheumatoid arthritis often starts between the age of 30 and 50.⁴⁶
- A national survey of children and young people's mental health found that the prevalence of mental health disorders was highest among 11- to 16-year-olds.⁶³
- Findings from the 2021 Health Survey for England show that people aged 45-74 are at higher risk for overweight and obesity.⁴⁹ Eating disorders such as anorexia nervosa, bulimia nervosa, and binge eating disorder typically develop in people during their late teens and mid-twenties.^{57,58}
- A systematic review found that older age is significantly associated with frailty.⁸⁴
- The risk of dementia increases exponentially with age. From the age of 70, a person's risk of dementia roughly doubles every five years.⁸⁹
- Increasing age is an important risk factor for cancer, with overall cancer incidence rates rising as age increases. In the UK, the peak rate of cancer cases is among people aged 85-89 years. Despite this, certain types of cancer are more common in children and young people, including brain and spinal tumours and leukaemia.⁹⁸

Disability

- A wide range of comorbidities exist which can increase an individual's risk of developing CVD. Hypertension is one of the most important risk factors for CVD as it can damage an individual's blood vessels. Some other important comorbidities include type 2 diabetes, dyslipidaemia, chronic kidney disease, atrial fibrillation, and serious mental health problems.⁶
- Findings from the 2021 Health Survey for England show that disabled people are at higher risk for overweight and obesity.⁴⁹
- Cardiovascular disease (CVD) is a key cause of disability in the UK but can often be largely prevented by lifestyle modifications.⁵
- National data on chronic pain available from the Health Survey for England in 2017 showed that adults that were permanently unable to work because of long-term sickness or disability, and those intending to look for work but prevented by temporary sickness or injury were more likely to report having chronic pain (77% and 66% respectively) compared with those in paid employment (27%).¹²⁴
- People with learning disabilities have been identified as being at particular risk of poor mental health.⁸¹

Gender identity and reassignment

- People identifying as transgender are less likely to attend for cancer screening, in part due to fear of discrimination by health care workers, and are less likely to access sex-specific screening such as cervical or breast cancer screening because in some cases they have been omitted from the register due to their recorded gender.^{99,100}
- See also [Sexual orientation](#).

Marriage and civil partnership

No specific issues were identified through this needs assessment

Pregnancy and maternity

- Obesity during pregnancy can cause health problems for both the mother and child, including increased risk of maternal death; miscarriage; gestational diabetes; blood clots; pre-eclampsia; post-partum haemorrhage; still birth; foetal abnormality and increased risk of the baby becoming obese in adulthood.^{54,55}

- Women during the perinatal period have been identified as being at particular risk of poor mental health.⁸² See [Perinatal Mental Health and Wellbeing JSNA](#).

Race and ethnicity

- In the UK, South Asian, Black African and African Caribbean ethnicities have an elevated risk of developing CVD.⁵ Specifically, South Asian groups have the highest mortality from heart disease and stroke, while Black groups in the UK have a significantly lower risk of heart disease compared to the general population but have higher incidence of and mortality from hypertension and stroke.⁸
- A UK research study in 2023 shows that ethnic minority groups had earlier onset on acute stroke by around 5 years and 2-4 times higher risk of stroke-related adverse outcomes and deaths compared to Caucasian patients.¹⁶
- A cross-sectional analysis of the Health Improvement Network Primary Care Database found that minority ethnic groups were more likely to have a type 2 diabetes diagnosis compared to White individuals.²⁹
- A national survey of children and young people's mental health found that the prevalence of mental health disorders was highest among children of a White British or Mixed/other ethnic background compared to those from Asian/Asian British and Black/Black British backgrounds.⁶³ Research suggests that people from BAME communities are at higher risk of developing a mental health problem in adulthood, but are less likely to receive support.⁶⁷
- Findings from the 2021 Health Survey for England show that people from the Black ethnic group are at higher risk for overweight and obesity.⁴⁹
- There is evidence to suggest that the prevalence of dementia differs between different ethnic groups. A meta-analysis found that people from Black ethnic groups had around 20% higher incidence of dementia than people from White ethnic groups, but found no significant differences between people from Asian and White ethnic groups.⁹⁰
- A recent 2022 study in England found that people of non-White ethnicity generally have lower cancer risk than the White population, with some notable exceptions. Some exceptions included prostate cancer (2 times higher in Black ethnic groups), myeloma (3 times higher in Black ethnic groups) and several gastrointestinal cancers (higher in Black and Asian ethnic groups).¹⁰¹

Religion or belief

No specific issues were identified through this needs assessment

Sex

- The average life expectancy at birth for a resident in Stevenage between 2020 and 2022 was 80.8 years (79.3 years for males and 82.2 years for females).² This was significantly lower than Hertfordshire for both males and females, but statistically similar to England.
- The average life expectancy at age 65 for a resident in Stevenage between 2020 and 2022 was 19.3 years (18.2 years for males and 20.4 years for females).² This was significantly lower than Hertfordshire for both males and females, but statistically similar to England.
- Men have a higher risk of CVD than women at all ages compared to women, and on average, develop CVD around 10 years earlier than women.⁶ However, research suggest that women who have heart attacks receive poorer care than males during diagnosis, treatment and aftercare which may affect health outcomes.⁷
- Women have increased risk for stroke compared to men as they have a higher disease burden for certain conditions, including atrial fibrillation, increased risk of stroke related to diabetes, and higher prevalence of hypertension. Women also carry sex hormone-specific risk factors for stroke related to pregnancy, birth control medication and menopause.¹⁴
- Women are reported to have a higher rate of all types of common mental health disorders, although suicide is more common among men.^{67,68}
- Eating disorders such as anorexia nervosa, bulimia nervosa, and binge eating disorder are more prevalent among women than men.^{57,58}
- A systematic review found that found that the female gender is significantly associated with frailty.⁸⁴
- Dementia is known to be more prevalent in females compared to males, with females accounting for around 65% of all dementia patients.⁸⁷ Some of this can be explained by females having longer life expectancy.⁸⁸
- In general, cancer incidence is higher among men than women. However, this pattern differs by age in England, with common cancers that affect women (including breast and cervical cancer) more likely to develop in younger people compared to cancers that mainly affect men (such as prostate cancer).⁹⁵

Sexual orientation

- People who identify as non-heterosexual are more likely to develop mental health problems including depression, anxiety, eating disorders, self-harm, suicidal feelings and misuse of drugs or alcohol.⁷⁰ This is related to the fact that many LGBTQ+ people

are more likely to experience stigma and/or discrimination, social isolation, exclusion, rejection and inequality.⁷⁰⁻⁷²

- LGBT people are less likely to attend for cancer screening, in part due to fear of discrimination by health care workers.¹⁰⁰

Part B: Other Categories

Military personnel and armed forces veterans

- Veterans have been identified as being at particular risk of poor mental health.⁷⁹ In particular, military veterans are more likely to experience post-traumatic stress disorder (PTSD), anxiety, depression and alcohol problems than the general population.^{125,126}

Carers

- Carers have been identified as being at particular risk of poor mental health.⁷⁸ This is because caring responsibilities often have a significant impact on mental health, including: stress and worry; anxiety; isolation and loneliness; less personal time; money worries; lack of sleep; and guilt, frustration and anger.¹²⁷

Mental Illness/Poor Mental Health

- Evidence suggests there is a two-way causal relationship between mental health and long-term conditions like CVD, diabetes, chronic obstructive pulmonary disease, and musculoskeletal disorders.⁷⁶
- Significant positive associations have been found between frailty and higher levels of depression among older people.⁸⁴
- Depression in later life is estimated to increase the risk of dementia by 90%. A UK cohort study found that depressive symptoms in later life, but not in midlife, increases dementia risk.^{91,93}
- See also [Disability](#).

Children Looked After and Care Leavers

No specific issues were identified through this needs assessment

Appendix B: Guidance on statistical significance and interpreting confidence intervals

Statistical significance: A term used to indicate whether a difference or relationship really exists between two or more data points including two different geographic areas or time periods and/or whether the difference is just a fluke.

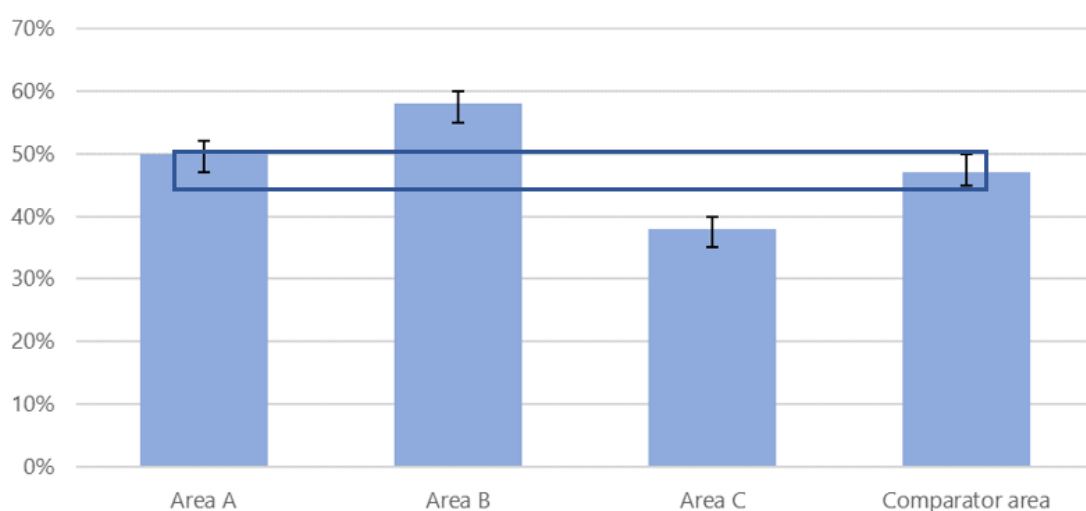
Confidence intervals: provide an easy way to look for statistically significant differences between two or more data points. There are two different methods that can be used, each with its own strengths and weaknesses.

Overlapping confidence intervals: When there are two sets of data with confidence intervals and we want to take the imprecision of both into account we compare both to see if they overlap each other. If the intervals do not overlap, there is a significant difference between the data. On the other hand, if the intervals overlap, then the data points are not statistically significant (see example below).

Example:

The graph below shows an example of how confidence intervals can be used to identify statistically significant differences between data. Applying the logic described above, the below graph shows the following:

- Area A is **statistically similar** or **not significantly different** to the comparator area because the confidence intervals overlap.
- Area B is **statistically significantly higher** than the comparator area because the confidence intervals do not overlap.
- Area C is **statistically significantly lower** than the comparator area because the confidence intervals do not overlap.



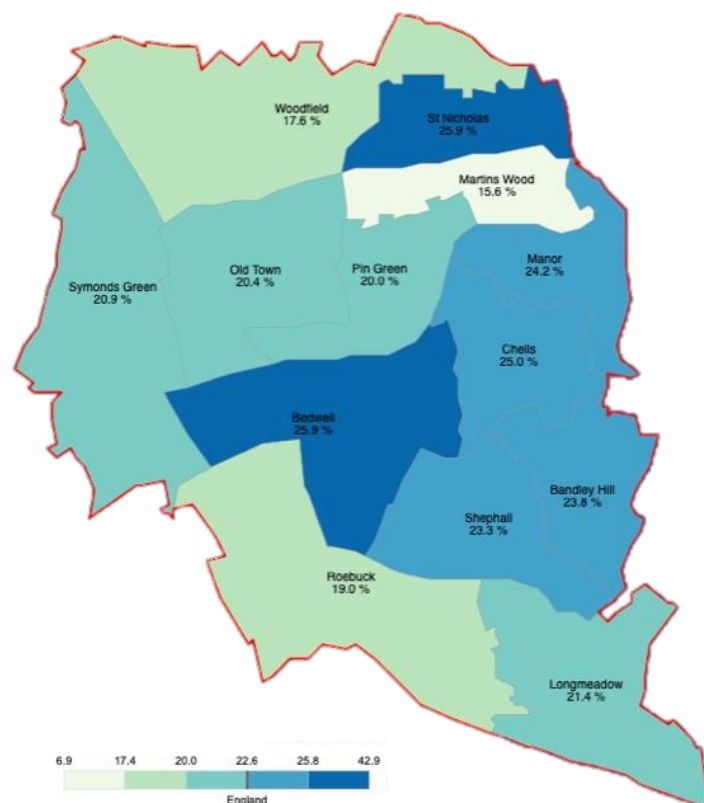
Source: *Statistics with Confidence*, Altman et al.¹²⁸

Appendix C: Ward level health indicators

Ward level data is not available for the vast majority of data contained within this JSNA. However this appendix contains ward level maps of the indicators covered within this JSNA where ward level data is available. This includes the following two indicators:

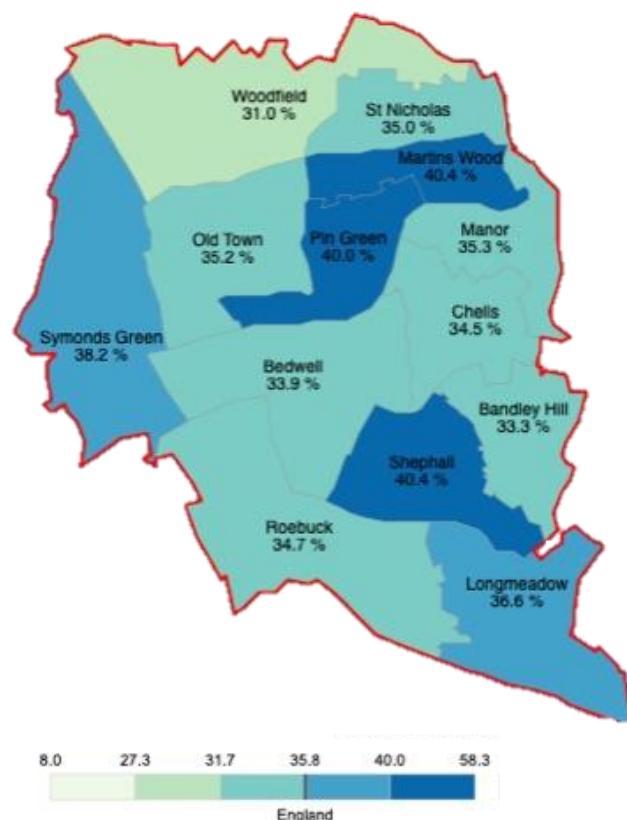
- Reception prevalence of overweight (including obesity) (4-5 years)
- Year 6 prevalence of overweight (including obesity) (10-11 years)

Map 1: Reception prevalence of overweight (including obesity) (4-5 years)



Source: National Child Measurement Programme (NCMP).

Map 2: Year 6 prevalence of overweight (including obesity) (10-11 years)



Source: National Child Measurement Programme (NCMP).

Ward level profiles

Ward level data for indicators similar to those explored in this JSNA is available through local ward profiles on the [Local Health](#) website, all of which are linked below:

- [Bandley Hill](#)
- [Bedwell](#)
- [Chells](#)
- [Longmeadow](#)
- [Manor](#)
- [Martins Wood](#)
- [Old Town](#)
- [Pin Green](#)
- [Roebuck](#)
- [Shephall](#)
- [St Nicholas](#)
- [Symonds Green](#)
- [Woodfield](#)

**Please note that the ward geographies above are based on 2021 ward boundaries, therefore these wards may alter slightly to the most recent ward geographies.*

References

1. Population estimates for England and Wales - Office for National Statistics. Accessed November 22, 2024. <https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/bulletins/populationestimatesforenglandandwales/mid2023>
2. Fingertips | Department of Health and Social Care. Accessed November 22, 2024. <https://fingertips.phe.org.uk/search/life%20expectancy#page/1/gid/1/pat/502/par/E10000015/ati/501/iid/90362/age/1/sex/1/cat/-1/ctp/-1/yr/3/cid/4/tbm/1>
3. OHID Fingertips. Public health profiles - Index of Multiple Deprivation Score. PHE. Accessed March 3, 2023. <https://fingertips.phe.org.uk/search/deprivation#page/4/gid/1/pat/159/par/K02000001/ati/15/are/E92000001/iid/93275/age/1/sex/4/cat/-1/ctp/-1/yr/1/cid/4/tbm/1>
4. Education and Lifelong Learning Profile - County | Hertfordshire | Report Builder for ArcGIS. Accessed November 22, 2024. <https://www.reports.esriuk.com/view-report/37e3ccb70620456296ae169a360fedc8/E10000015?clear=true#adultquals>
5. NHS. Cardiovascular disease . April 2022. Accessed April 5, 2023. <https://www.nhs.uk/conditions/cardiovascular-disease/>
6. NICE. Risk factors for CVD . February 2023. Accessed April 5, 2023. <https://cks.nice.org.uk/topics/cvd-risk-assessment-management/background-information/risk-factors-for-cvd/>
7. British Heart Foundation. Bias and Biology. How the gender gap in heart disease is costing women's lives. 2019. Accessed April 5, 2023. <https://www.bhf.org.uk/-/media/files/heart-matters/bias-and-biology-briefing.pdf?rev=cd26147a45f9444098aa2949551f3803&hash=7C4225981A8554B921502F609C42C7F9>
8. The King's Fund. The health of people from ethnic minority groups in England. September 17, 2021. Accessed April 5, 2023. <https://www.kingsfund.org.uk/publications/health-people-ethnic-minority-groups-england#CVD>
9. British Heart Foundation. CVD Factsheet. Published online February 2023.
10. Lichtenstein AH, Appel LJ, Vadiveloo M, et al. 2021 Dietary Guidance to Improve Cardiovascular Health: A Scientific Statement From the American Heart Association. *Circulation*. 2021;144(23):e472-e487. doi:10.1161/CIR.0000000000001031
11. Dobrosielski DA. How can exercise reduce cardiovascular disease risk? A primer for the clinician. *Pol Arch Intern Med*. 2021;131(10). doi:10.20452/PAMW.16122
12. Socioeconomic inequalities in avoidable mortality, England and Wales - Office for National Statistics. Accessed March 6, 2023. <https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/articles/measuring socioeconomicinequalitiesinavoidablemortalityinenglandandwales/2001to2017>
13. Stroke: Causes and types. Accessed November 22, 2024. <https://www.stroke.org.uk/stroke/types>
14. Hanna M, Wabnitz A, Grewal P. Sex and stroke risk factors: A review of differences and impact. *J Stroke Cerebrovasc Dis Off J Natl Stroke Assoc*. 2024;33(4):107624. doi:10.1016/j.jstrokecerebrovasdis.2024.107624
15. Yousufuddin M, Young N. Aging and ischemic stroke. *Aging*. 2019;11(9):2542. doi:10.18632/aging.101931
16. Fluck D, Fry CH, Gulli G, et al. Adverse stroke outcomes amongst UK ethnic minorities: a multi-centre registry-based cohort study of acute stroke. *Neurol Sci*. 2023;44(6):2071. doi:10.1007/s10072-023-06640-z
17. Pan B, Jin X, Jun L, Qiu S, Zheng Q, Pan M. The relationship between smoking and stroke: A meta-analysis. *Medicine (Baltimore)*. 2019;98(12):e14872. doi:10.1097/MD.00000000000014872
18. Letra L, Sena C. Cerebrovascular Disease: Consequences of Obesity-Induced Endothelial Dysfunction. *Adv Neurobiol*. 2017;19:163-189. doi:10.1007/978-3-319-63260-5_7
19. High blood pressure | Stroke Association. Accessed November 22, 2024. <https://www.stroke.org.uk/stroke/managing-risk/high-blood-pressure>
20. Stroke: Challenges, Progress, and Promise.
21. Incidence and prevalence | Background information | Diabetes - type 1 | CKS | NICE. Accessed March 6, 2023. <https://cks.nice.org.uk/topics/diabetes-type-1/background-information/incidence-prevalence/>
22. Health matters: preventing Type 2 Diabetes - GOV.UK. Accessed March 6, 2023. <https://www.gov.uk/government/publications/health-matters-preventing-type-2-diabetes/health-matters-preventing-type-2-diabetes>
23. Tabák AG, Herder C, Rathmann W, Brunner EJ, Kivimäki M. Prediabetes: A high-risk state for developing diabetes. *Lancet*. 2012;379(9833):2279. doi:10.1016/S0140-6736(12)60283-9
24. Gestational diabetes | Causes and symptoms | Diabetes UK. Accessed March 6, 2023. <https://www.diabetes.org.uk/diabetes-the-basics/gestational-diabetes>
25. Health Survey for England 2019 [NS] - NDRS. Accessed March 6, 2023. <https://digital.nhs.uk/data-and-information/publications/statistical/health-survey-for-england/2019>
26. Menke A, Casagrande S, Geiss L, Cowie CC. Prevalence of and Trends in Diabetes Among Adults in the United States, 1988-2012. *JAMA*. 2015;314(10):1021-1029. doi:10.1001/JAMA.2015.10029
27. Fazeli PK, Lee H, Steinhäuser ML. Aging Is a Powerful Risk Factor for Type 2 Diabetes Mellitus Independent of Body Mass Index. *Gerontology*. 2020;66(2):209-210. doi:10.1159/000501745

28. Frommer L, Kahaly GJ. Type 1 Diabetes and Autoimmune Thyroid Disease—The Genetic Link. *Front Endocrinol.* 2021;12. doi:10.3389/FENDO.2021.618213
29. Pham TM, Carpenter JR, Morris TP, Sharma M, Petersen I. Ethnic Differences in the Prevalence of Type 2 Diabetes Diagnoses in the UK: Cross-Sectional Analysis of the Health Improvement Network Primary Care Database. *Clin Epidemiol.* 2019;11:1081. doi:10.2147/CLEP.S227621
30. Khaodh L, Cummings S, Apovian CM. Treating diabetes and prediabetes by focusing on obesity management. *Curr Diab Rep.* 2009;9(5):348-354. doi:10.1007/S11892-009-0055-0
31. Abdullah A, Peeters A, de Courten M, Stoelwinder J. The magnitude of association between overweight and obesity and the risk of diabetes: a meta-analysis of prospective cohort studies. *Diabetes Res Clin Pract.* 2010;89(3):309-319. doi:10.1016/J.DIABRES.2010.04.012
32. Aune D, Norat T, Leitzmann M, Tonstad S, Vatten LJ. Physical activity and the risk of type 2 diabetes: a systematic review and dose-response meta-analysis. *Eur J Epidemiol.* 2015;30(7):529-542. doi:10.1007/S10654-015-0056-Z
33. Zhang R, Fu J, Moore JB, Stoner L, Li R. Processed and Unprocessed Red Meat Consumption and Risk for Type 2 Diabetes Mellitus: An Updated Meta-Analysis of Cohort Studies. *Int J Environ Res Public Health.* 2021;18(20). doi:10.3390/IJERPH182010788
34. Wagner R, Thorand B, Osterhoff MA, et al. Family history of diabetes is associated with higher risk for prediabetes: a multicentre analysis from the German Center for Diabetes Research. *Diabetologia.* 2013;56(10):2176-2180. doi:10.1007/S00125-013-3002-1
35. Florez JC, Udler MS, Hanson RL. Genetics of Type 2 Diabetes. In: *Diabetes in America*. 3rd ed. National Institute of Diabetes and Digestive and Kidney Diseases (US); 2018:1-25.
36. Zhang Y, Xiao CM, Zhang Y, et al. Factors Associated with Gestational Diabetes Mellitus: A Meta-Analysis. *J Diabetes Res.* 2021;2021. doi:10.1155/2021/6692695
37. Rojas J, Chávez M, Olivar L, et al. Polycystic Ovary Syndrome, Insulin Resistance, and Obesity: Navigating the Pathophysiologic Labyrinth. *Int J Reprod Med.* 2014;2014:1-17. doi:10.1155/2014/719050
38. Gambineri A, Patton L, Altieri P, et al. Polycystic ovary syndrome is a risk factor for type 2 diabetes: results from a long-term prospective study. *Diabetes.* 2012;61(9):2369-2374. doi:10.2337/DB11-1360
39. Cassar S, Misso ML, Hopkins WG, Shaw CS, Teede HJ, Stepto NK. Insulin resistance in polycystic ovary syndrome: a systematic review and meta-analysis of euglycaemic-hyperinsulinaemic clamp studies. *Hum Reprod Oxf Engl.* 2016;31(11):2619-2631. doi:10.1093/HUMREP/DEW243
40. Lee KW, Ching SM, Ramachandran V, et al. Prevalence and risk factors of gestational diabetes mellitus in Asia: a systematic review and meta-analysis. *BMC Pregnancy Childbirth* 2018 181. 2018;18(1):1-20. doi:10.1186/S12884-018-2131-4
41. Okada R, Yasuda Y, Tsushita K, Wakai K, Hamajima N, Matsuo S. Within-visit blood pressure variability is associated with prediabetes and diabetes. *Sci Rep.* 2015;5. doi:10.1038/SREP07964
42. Emdin CA, Anderson SG, Woodward M, Rahimi K. Usual Blood Pressure and Risk of New-Onset Diabetes: Evidence From 4.1 Million Adults and a Meta-Analysis of Prospective Studies. *J Am Coll Cardiol.* 2015;66(14):1552-1562. doi:10.1016/J.JACC.2015.07.059
43. Chronic pain - Illnesses and conditions | NHS inform. Accessed March 15, 2023. <https://www.nhsinform.scot/illnesses-and-conditions/brain-nerves-and-spinal-cord/chronic-pain>
44. NICE. Chronic pain | Health topics A to Z | CKS . April 2021. Accessed April 6, 2023. <https://cks.nice.org.uk/topics/chronic-pain/>
45. Hertfordshire County Council. JSNA Briefing: Hertfordshire's Health & Wellbeing Priorities. April 2022. Accessed April 6, 2023. <https://www.hertfordshire.gov.uk/microsites/jsna/jsna-documents/health-wellbeing-supplement-jsna-briefing-2022.pdf>
46. Arthritis - NHS. Accessed March 15, 2023. <https://www.nhs.uk/conditions/arthritis/>
47. King LK, March L, Anandacoomarasamy A. Obesity & osteoarthritis. *Indian J Med Res.* 2013;138(2):185.
48. Chauhan K, Jandu JS, Brent LH, Al-Dhahir MA. Rheumatoid Arthritis. In: *Rosen and Barkin's 5-Minute Emergency Medicine Consult*. Fifth Edit. StatPearls Publishing; 2023. doi:10.1017/cho19780521332866.074
49. NHS Digital. Health Survey for England, 2021: Data tables. December 15, 2022. Accessed March 2, 2023. <https://digital.nhs.uk/data-and-information/publications/statistical/health-survey-for-england/2021/health-survey-for-england-2021-data-tables>
50. NHS Digital. National Child Measurement Programme, England, 2021/22 school year . November 3, 2022. Accessed March 23, 2023. <https://digital.nhs.uk/data-and-information/publications/statistical/national-child-measurement-programme/2021-22-school-year>
51. NHS. Obesity . February 15, 2023. Accessed March 16, 2023. <https://www.nhs.uk/conditions/obesity/>
52. Jones A, Bentham G, Hillsdon M, Panter J. *Tackling Obesities: Future Choices - Obesogenic Environments*. Evidence Review.; 2007.
53. NICE. Causes and risk factors | Background information | Obesity . September 2022. Accessed March 1, 2023. <https://cks.nice.org.uk/topics/obesity/background-information/causes-risk-factors/>

54. Centre for Maternal and Child Enquiries and the Royal College of Obstetricians and Gynaecologists. *Management of Women with Obesity in Pregnancy*.; 2010. doi:10.1111/j.1467-789X.2007.00397.x
55. Norman JE, Reynolds R. Symposium I: Consequences of obesity and overweight during pregnancy: The consequences of obesity and excess weight gain in pregnancy. *Proc Nutr Soc*. 2011;70(4):450-456. doi:10.1017/S0029665111003077
56. NHS Digital. Health Survey for England 2019 Adults' health. December 15, 2020. Accessed August 9, 2022. <https://files.digital.nhs.uk/D4/93337C/HSE19-Adult-health-behaviours-rep.pdf>
57. Wood S, Marchant A, Allsopp M, et al. Epidemiology of eating disorders in primary care in children and young people: a Clinical Practice Research Datalink study in England. *BMJ Open*. 2019;9(8). doi:10.1136/BMJOPEN-2018-026691
58. Micali N, Hagberg KW, Petersen I, Treasure JL. The incidence of eating disorders in the UK in 2000-2009: Findings from the General Practice Research Database. *BMJ Open*. 2013;3(5):e002646. doi:10.1136/bmjopen-2013-002646
59. Solmi M, Radua J, Stubbs B, et al. Risk factors for eating disorders: an umbrella review of published meta-analyses. *Braz J Psychiatry*. 2021;43(3):323. doi:10.1590/1516-4446-2020-1099
60. Culbert KM, Racine SE, Klump KL. Research Review: What we have learned about the causes of eating disorders – a synthesis of sociocultural, psychological, and biological research. *J Child Psychol Psychiatry*. 2015;56(11):1141-1164. doi:10.1111/JCPP.12441
61. Institute for Health Metrics and Evaluation. GBD Compare | IHME Viz Hub. Global Burden of Disease. 2015. <http://vizhub.healthdata.org/gbd-compare/>
62. Kolappa K, Henderson DC, Kishore SP. No physical health without mental health: Lessons unlearned? *Bull World Health Organ*. 2013;91(1):12-15. doi:10.2471/BLT.12.115063
63. Newlove-Delgado T, Williams T, Robertson K, et al. *Mental Health of Children and Young People in England, 2021*.; 2021.
64. Public Health England. Mental health and wellbeing: JSNA toolkit. Children and young people.
65. Reiss F. Socioeconomic inequalities and mental health problems in children and adolescents: a systematic review. *Soc Sci Med*. 2013;90:24-31. doi:10.1016/J.SOCSCIMED.2013.04.026
66. Grimm F, Alcock B, Butler J, et al. *Improving Children and Young People's Mental Health Services*.; 2022. doi:10.37829/HF-2022-NDL1)
67. Appleby L, Asherson P, Ashtarikiani A, et al. *Mental Health and Wellbeing in England: Adult Psychiatric Morbidity Survey* .; 2014.
68. Samaritans. *Preventing Suicide among Less Well-off, Middle-Aged Men Out of Sight, out of Mind: Why Less-Well off, Middle-Aged Men Don't Get the Support They Need*.; 2020.
69. Bignall T, Jeraj S, Helsby E, Butt J. *Racial Disparities in Mental Health: Literature and Evidence Review*.; 2019.
70. Mind. About LGBTIQ+ mental health | Mind, the mental health charity - help for mental health problems.
71. Hudson-Sharp N, Metcalf H. *Inequality among LGB&T Groups in the UK: A Review of Evidence*.; 2016.
72. Rees SN, Crowe M, Harris S. The lesbian, gay, bisexual and transgender communities' mental health care needs and experiences of mental health services: An integrative review of qualitative studies. *J Psychiatr Ment Health Nurs*. Published online December 2020:jpm.12720. doi:10.1111/jpm.12720
73. Marmot M, Allen J, Boyce T, Goldblatt P, Morrison J. *Health Equity in England: The Marmot Review 10 Years On*.; 2020.
74. Taylor G, McNeill A, Girling A, Farley A, Lindson-Hawley N, Aveyard P. Change in mental health after smoking cessation: Systematic review and meta-analysis. *BMJ Online*. 2014;348. doi:10.1136/bmj.g1151
75. Garfin DR, Thompson RR, Holman EA. Acute stress and subsequent health outcomes: A systematic review. *J Psychosom Res*. 2018;112:107-113. doi:10.1016/J.JPSYCHORES.2018.05.017
76. Naylor C, Parsonage M, McDaid D, Knapp M, Fossey M, Galea A. *Long-Term Conditions and Mental Health*.; 2012.
77. Bellis MA, Lowey H, Leckenby N, Hughes K, Harrison D. Adverse childhood experiences: retrospective study to determine their impact on adult health behaviours and health outcomes in a UK population. *J Public Health*. 2014;36(1):81-91. doi:10.1093/pubmed/fdt038
78. Carers UK. *State of Caring 2022 | A Snapshot of Unpaid Care in the UK* .; 2022.
79. Community Innovations Enterprise. *Call to Mind: A Framework for Action - Findings from the Review of Veterans and Family Members Mental and Related Health Needs Assessments Final Report October 2015*.; 2015.
80. Royal College of Psychiatrists. *Mental Health of Asylum Seekers and Refugees*.; 2022.
81. Royal College of Nursing. *Mental Health Nursing of Adults with Learning Disabilities*.; 2010.
82. Public Health England. *Mental Health and Wellbeing: JSNA Toolkit. Perinatal Mental Health*.; 2019.
83. Hoogendijk EO, Afilalo J, Ensrud KE, Kowal P, Onder G, Fried LP. Frailty: implications for clinical practice and public health. *The Lancet*. 2019;394(10206):1365-1375. doi:10.1016/S0140-6736(19)31786-6
84. Feng Z, Lugtenberg M, Franse C, et al. Risk factors and protective factors associated with incident or increase of frailty among community-dwelling older adults: A systematic review of longitudinal studies. *PloS One*. 2017;12(6). doi:10.1371/JOURNAL.PONE.0178383
85. Woolford SJ, Sohan O, Dennison EM, Cooper C, Patel HP. Approaches to the diagnosis and prevention of frailty. *Aging Clin Exp Res*. 2020;32(9):1629. doi:10.1007/S40520-020-01559-3
86. (PDF) Dementia: definitions and types. *ResearchGate*. Published online October 22, 2024. doi:10.7748/ns.29.37.37.e9405
87. *dementia_uk_update.pdf*. Accessed November 25, 2024. https://www.alzheimers.org.uk/sites/default/files/migrate/downloads/dementia_uk_update.pdf

88. Podcasy JL, Epperson CN. Considering sex and gender in Alzheimer disease and other dementias. *Dialogues Clin Neurosci*. 2016;18(4):437-446. doi:10.31887/DCNS.2016.18.4/cepperson
89. factsheet_risk_factors_for_dementia.pdf. Accessed November 25, 2024. https://www.alzheimers.org.uk/sites/default/files/pdf/factsheet_risk_factors_for_dementia.pdf
90. Shiekh SI, Cadogan SL, Lin LY, Mathur R, Smeeth L, Warren-Gash C. Ethnic Differences in Dementia Risk: A Systematic Review and Meta-Analysis. *J Alzheimers Dis JAD*. 2021;80(1):337-355. doi:10.3233/JAD-201209
91. Livingston G, Huntley J, Sommerlad A, et al. Dementia prevention, intervention, and care: 2020 report of the Lancet Commission. *Lancet Lond Engl*. 2020;396(10248):413-446. doi:10.1016/S0140-6736(20)30367-6
92. Sommerlad A, Sabia S, Singh-Manoux A, Lewis G, Livingston G. Association of social contact with dementia and cognition: 28-year follow-up of the Whitehall II cohort study. *PLoS Med*. 2019;16(8):e1002862. doi:10.1371/journal.pmed.1002862
93. Singh-Manoux A, Dugravot A, Fournier A, et al. Trajectories of Depressive Symptoms Before Diagnosis of Dementia: A 28-Year Follow-up Study. *JAMA Psychiatry*. 2017;74(7):712-718. doi:10.1001/jamapsychiatry.2017.0660
94. NHS. Cancer . October 13, 2022. Accessed March 2, 2023. <https://www.nhs.uk/conditions/cancer/>
95. Baker C, Mansfield Z. *Cancer Statistics for England* .; 2023.
96. Nomis. Mortality statistics - underlying cause, sex and age. ONS. 2022. Accessed March 16, 2023. <https://www.nomisweb.co.uk/query/construct/summary.asp?mode=construct&version=0&dataset=161>
97. WHO. *IARC Launches the World Code Against Cancer Framework* .; 2022.
98. Cancer Research UK. Cancer incidence by age . Accessed March 2, 2023. <https://www.cancerresearchuk.org/health-professional/cancer-statistics/incidence/age#heading-One>
99. The Lancet Oncology. Cancer risk in the transgender community. *Lancet Oncol*. 2015;16(9):999. doi:10.1016/S1470-2045(15)00249-1
100. Public Health England. Addressing inequalities in LGBT cancer screening coverage. 2019. Accessed April 12, 2023. <https://phescreening.blog.gov.uk/2019/03/15/addressing-inequalities-in-lgbt-cancer-screening-coverage/>
101. Delon C, Brown KF, Payne NWS, Kotrotsios Y, Vernon S, Shelton J. Differences in cancer incidence by broad ethnic group in England, 2013–2017. *Br J Cancer*. 2022;126(12):1765-1773. doi:10.1038/s41416-022-01718-5
102. Anand P, Kunnumakara AB, Sundaram C, et al. Cancer is a Preventable Disease that Requires Major Lifestyle Changes. *Pharm Res*. 2008;25(9):2116. doi:10.1007/S11095-008-9661-9
103. C T, Hodgson S. Genetic predisposition to cancer. *Clin Med*. 2005;5:491-498.
104. Cancer Research UK. Inherited genes and cancer types . November 2021. Accessed March 2, 2023. <https://www.cancerresearchuk.org/about-cancer/causes-of-cancer/inherited-cancer-genes-and-increased-cancer-risk/inherited-genes-and-cancer-types>
105. Brown KF, Rumgay H, Dunlop C, et al. The fraction of cancer attributable to modifiable risk factors in England, Wales, Scotland, Northern Ireland, and the United Kingdom in 2015. *Br J Cancer*. 2018;118(8):1130-1141. doi:10.1038/s41416-018-0029-6
106. Cancer Research UK. Statistics on preventable cancers . March 23, 2018. Accessed March 2, 2023. <https://www.cancerresearchuk.org/health-professional/cancer-statistics/risk/preventable-cancers#heading-One>
107. Review TM. Fair Society, Healthy Lives.
108. Wider Determinants of Health | Fingertips | Department of Health and Social Care. Accessed November 25, 2024. <https://fingertips.phe.org.uk/profile/wider-determinants>
109. Hospital admissions for eating disorders, broken down by age and local authority. NHS England Digital. Accessed November 25, 2024. <https://digital.nhs.uk/supplementary-information/2023/hospital-admissions-for-eating-disorders-broken-down-by-age-and-local-authority>
110. NICE. Quality statement 6: 9 key care processes | Type 2 diabetes in adults | Quality standards. March 2, 2023. Accessed March 29, 2023. <https://www.nice.org.uk/guidance/QS209/chapter/quality-statement-6-9-key-care-processes>
111. NICE. Quality statement 4: 9 key care processes | Type 1 diabetes in adults | Quality standards. March 2, 2023. Accessed March 29, 2023. <https://www.nice.org.uk/guidance/qs208/chapter/Quality-statement-4-9-key-care-processes>
112. NHS England. Secondary prevention: reducing disparities and improving life expectancy. Accessed March 29, 2023. <https://www.england.nhs.uk/ourwork/prevention/secondary-prevention/>
113. NICE. Recommendations | Chronic pain (primary and secondary) in over 16s: assessment of all chronic pain and management of chronic primary pain | Guidance | NICE. April 2021. Accessed March 24, 2023. <https://www.nice.org.uk/guidance/ng193/chapter/Recommendations#managing-chronic-primary-pain>
114. Conversano C, Poli A, Ciacchini R, Hitchcott P, Bazzichi L, Gemignani A. A psychoeducational intervention is a treatment for fibromyalgia syndrome. *Clin Exp Rheumatol*. 2019;37(1):S98-S104.
115. Quality statement 1: Multi-agency suicide prevention partnerships | Suicide prevention | Quality standards | NICE. September 10, 2019. Accessed November 25, 2024. <https://www.nice.org.uk/guidance/qs189/chapter/Quality-statement-1-Multi-agency-suicide-prevention-partnerships>
116. Le LKD, Barendregt JJ, Hay P, Mihalopoulos C. Prevention of eating disorders: A systematic review and meta-analysis. *Clin Psychol Rev*. 2017;53:46-58. doi:10.1016/J.CPR.2017.02.001

117. Oliveira JS, Pinheiro MB, Fairhall N, et al. Evidence on Physical Activity and the Prevention of Frailty and Sarcopenia Among Older People: A Systematic Review to Inform the World Health Organization Physical Activity Guidelines. *J Phys Act Health*. 2020;17(12):1247-1258. doi:10.1123/JPAH.2020-0323
118. Agide FD, Sadeghi R, Garmaroudi G, Tigabu BM. A systematic review of health promotion interventions to increase breast cancer screening uptake: from the last 12 years. *Eur J Public Health*. 2018;28(6):1149-1155. doi:10.1093/EURPUB/CKX231
119. Musa J, Achenbach CJ, O'Dwyer LC, et al. Effect of cervical cancer education and provider recommendation for screening on screening rates: A systematic review and meta-analysis. *PLOS ONE*. 2017;12(9):e0183924. doi:10.1371/JOURNAL.PONE.0183924
120. Overview | Obesity: identification, assessment and management | Guidance | NICE. Accessed July 4, 2022. <https://www.nice.org.uk/guidance/cg189>
121. Kok P, Seidell J, Meinders A. The value and limitations of the body mass index (BMI) in the assessment of the health risks of overweight and obesity. *Ned Tijdschr Geneesk*. 2004;27(148):2379-2382.
122. Nishida C, Barba C, Cavalli-Sforza T, et al. Appropriate body-mass index for Asian populations and its implications for policy and intervention strategies. *The Lancet*. 2004;363(9403):157-163. doi:10.1016/S0140-6736(03)15268-3
123. Doctors of the World. *Registration Refused: A Study on Access to GP Registration in England, 2016.*; 2016.
124. Public Health England. *Chronic Pain in Adults 2017: Health Survey for England.*; 2020.
125. Stevelink SAM, Jones M, Hull L, et al. Mental health outcomes at the end of the British involvement in the Iraq and Afghanistan conflicts: A cohort study. *Br J Psychiatry*. 2018;213(6):690-697. doi:10.1192/bjp.2018.175
126. Community Innovations Enterprise on behalf of the Forces in Mind Trust and NHS England. *Call to Mind: A Framework for Action. Findings from the Review of Veterans and Family Members Mental and Related Health Needs Assessments.*; 2015.
127. MIND. Supporting yourself while caring for someone.
128. Altman D, Machin D, Bryant T, Gardener M. *Statistics with Confidence*. British Medical Journal; 2000.