Public Health 2013/14

The Annual Report of the Director of Public Health
Acknowledgements

I am grateful to the staff within the Department of Public Health for their hard work over the year, including the temporary staff members Kathryn Ferguson, Elaine Gilmour, Allison McAndrew and Dr Cathy Johnman. I am also grateful for their continued commitment, and the commitment of other NHS Lanarkshire and non-NHS staff, to public health in Lanarkshire.

In particular, I would like to thank all the contributors to this report and the members of the Editorial Committee (Lee Baird, David Cromie, Jennifer Darnborough, Louise Flanagan, Ashley Goodfellow, Wendy Kennedy, Fiona O’Dowd and Derek Roseburgh). Thanks also to Derek York for designing the report.

Finally, I would like to extend my thanks to all the organisations who work in partnership with NHS Lanarkshire to protect and improve the health of the public, particularly North Lanarkshire Council and South Lanarkshire Council.

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Cover photo:
The XX Commonwealth Games were held in Scotland from 23 July to 3 August 2014. It was the largest multi-sport event ever held in this country with over 4,500 athletes from 71 different nations and territories competing in 17 different sports. Triathlon events took place in Strathclyde Country Park in North Lanarkshire with nearly 50,000 people attending over two days. The cover image shows Natalie Milne leading a group of riders in the cycling leg of the triathlon mixed team relay. It is hoped that the Games will create a lasting legacy for Scotland including encouraging more people of all ages to participate in sports and physical activity. The image is used with permission from North Lanarkshire Council.
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Foreword

As in previous annual reports I want to highlight progress on issues from last year’s report.

Health Protection

• While preliminary levels of uptake of the abdominal aortic aneurysm screening programme have been favourable, efforts are continuing to raise awareness and improve understanding of the programme in the target population of 65-year-old males.
• The joint public health risk assessment in Leadhills and Wanlockhead prompted a few enquiries from local residents about local food production and consumption. SEPA is continuing to investigate local water and soil chemistry with a view to informing potential remediation measures to improve water quality in the local rivers.
• A single NHS Lanarkshire strategic Resilience Group for emergency and business continuity planning has been established to focus on delivering an optimum model for local resilience.
• The Strathclyde Loch (used for the Commonwealth Games triathlon events) revised water quality protocol is being implemented and no episodes of illness have been reported associated with recreational use of the loch.

Health Improvement

• The Best Possible Start programme was stood down in March 2014 but its key achievements are now being progressed through the Early Years Collaborative.

Oral Health

• New oral health initiatives for Pakistani and Congolese communities included the establishment of a peer education group, the development of a weaning and oral health resource, and a Shisha Smoking Educational DVD. Oral health education awareness raising sessions with prisoners and one-to-one advice is now offered routinely, which has doubled the number of prisoners benefitting from this.

Health Services

• The evaluation of the COPD Volunteer Support Service model in enhancing self-management and the web-based pulmonary rehabilitation programme is on-going. Self-management plans as part of the Anticipatory Care Project have been well received.
• The Lanarkshire Assault Injury Surveillance Programme continues to collect and analyse assault injury data, to work closely with local partners, the Violence Reduction Unit and Police Scotland, and to support assault injury surveillance in other NHS boards.
• The first year evaluation of the Detect Cancer Early programme has shown a combined increase of 9.2% (Scotland 4.2%) in the proportion of breast, colorectal and lung cancers detected at stage 1.
• Finally, staff training and development sessions were delivered to support the 27–30 month child health review implemented across Lanarkshire for all children in June 2013. Clinical pathways for children requiring additional support were developed. Uptake rates have improved by the use of personalised parent invitation letters and a poster campaign. The review has made a significant impact in relation to identifying children requiring additional support with growth and development at an earlier stage.
Turning to this year’s annual report, Lanarkshire’s population decreased slightly in 2013 but is projected to rise in future years. Life expectancy is increasing in Lanarkshire but is, on average, a year less than in Scotland as a whole and three years less than in the UK. There were 83 fewer deaths than the previous year with 5,967 deaths in Lanarkshire in 2013 but deaths rates in Lanarkshire remain well above the Scottish average. This underlines the challenge we still face in improving the health of people and decreasing health inequalities in Lanarkshire. Deaths from coronary heart disease have decreased by more than a third in the last 10 years.

Most older people (aged 65 and over) in Lanarkshire report fair, good or very good health, but 17% have bad or very bad health (compared to 13% in Scotland). Twelve per cent of older people (numbering 10,000 people) report they provide unpaid care.

In each of the other chapters I wish to highlight one contribution to give you a flavour of the annual report:

- The health protection chapter has a section on the Wishaw tyre fire risk, highlighting the potential risks to the surrounding area and to the population of a tyre fire.
- The chapter on health improvement features the Healthy Weight Strategy and the challenge of obesity we face in Lanarkshire and Scotland.
- Oral health has a section on modernising dental services to help improve the oral health of people in Lanarkshire.
- Finally, the chapter on health services describes crucial work in responding to a rise in syphilis cases in Lanarkshire.

I welcome any comments you have on the report or requests for further information.

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This section provides information on the current population of Lanarkshire and looks at how the population is projected to change over the next twenty years. The number of births in Lanarkshire during 2013 is reported in addition to information on life expectancy, including trends. Finally, mortality information for 2013 is presented, both overall and specifically for the diseases that cause the most deaths. Readers are also referred to the appropriate sections in the Statistical Appendix for further detailed information.

Population estimates and projections
The estimated population of the NHS Lanarkshire area on 30 June 2013 was 572,300, a slight decrease of 220 on the previous year’s figure. This is the first reduction in Lanarkshire’s population since 2001, reversing a trend that has seen the number of people increasing by 17,000 (3.1%) over the period.

The median age of the population was 41, the same as Scotland as a whole. Eighteen per cent of people in Lanarkshire were aged under 16, 63% were working age and 19% were pensionable age – again, similar to the Scotland average. There were 19,000 (6.9%) more females than males.

The latest projections of Lanarkshire’s future population are based on estimates for 2012 and show that, despite the slight reduction in 2013, the population will rise at a gradual rate over the next 20 years with significant increases in the number of older people. The projected change in the age structure of Lanarkshire’s population between 2013 and 2033 is shown in Figure 1.1.1.

Figure 1.1.1
Projected change in the age structure of Lanarkshire’s population, 2013–2033

Source: National Records of Scotland
Key components in the changing Lanarkshire population are as follows:

- An increase of 34% in the population aged 75 and over is projected by 2023 and a further increase of 38% by 2033. Overall this means a projected increase of 72% over the next twenty years, resulting in over 30,000 more people aged 75 and over.
- The largest fall in population will be in age range 45–59, with a projected decrease of 20% by 2033. It is projected that there will be 25,000 fewer people aged 45–59 in twenty years.

More details on population estimates and projections for Lanarkshire are provided in tables A2 and A3 in the Statistical Appendix.

**Births**

There were 6,068 live births in Lanarkshire in 2013, a small decrease of 77 (1.3%) compared to 2013, making it the lowest number registered since 2003. The birth rate is 55.4 births per 1,000 women of child-bearing age, higher than the Scottish rate of 53.7. The number of stillbirths in Lanarkshire continues to decrease, with a reduction from 24 in 2012 to 20 in 2013, the lowest number ever recorded.

Over the three-year period 2011–2013, 99.6% of all babies born alive in Lanarkshire survived their first year, continuing the very gradual increase from 99.3% 20 years ago. There were 21 infant deaths under the age of one in Lanarkshire in 2013: 12 in the first week, four in the next three weeks and five in the next 11 months. Given the small numbers, these figures fluctuate from one year to the next.

Further information on births is shown in tables A4 and A5 in the Statistical Appendix.

**Life expectancy**

Life expectancy continues to increase in Lanarkshire. In the 10 years between 2000–2002 and 2010–2012, average life expectancy increased by 2.7 years for males (from 72.9 to 75.5 years) and by 1.6 years for females (from 78 to 79.7 years). Since the early 1980s, life expectancy has increased by 6.8 years for males and 5 for females (see Figure 1.1.2).

![Figure 1.1.2](image)

Change in life expectancy in Lanarkshire, Scotland and the UK

Further information on life expectancy is shown in A12 in the Statistical Appendix.
However, life expectancy is still below national levels; people in Lanarkshire live on average over a year less than others in Scotland (men 1.1 years less and women 1.2 years). Compared to the UK as a whole, men in Lanarkshire die 3.2 years earlier and women 2.9 years. This difference has increased over the last 10 years. Within Lanarkshire, life expectancy in South Lanarkshire is significantly higher than in North Lanarkshire; men and women in the South live 1.4 years longer on average than those in the North.

Deaths
There were 5,967 deaths in Lanarkshire in 2013, a decrease of 83 (1.4%) on 2012. Overall standardised mortality ratios (SMRs) in Lanarkshire remain well above the Scottish average for men and women and for those under 75 years and 75 years and over. Over the last 10 years, Lanarkshire’s SMR has ranged from 7.6% (in 2005) to 12.1% (in 2007) above the Scottish rate, and in 2013 was 9.7% above. The relative difference between Lanarkshire and Scotland continues to show a steady trend, with no evidence that the gap is narrowing.

The proportion of deaths caused by the so-called ‘big killer’ diseases of cancer, coronary heart disease (CHD) and stroke continues to decrease. In 2012, for the first time, it fell to below 50% of all deaths and in 2013 the proportion fell further to 48.9%. Over the past 10 years, this proportion has decreased by 8.2% (from 57.1% in 2004), mostly as the result of a decrease in deaths from coronary heart disease as shown in Figure 1.1.3. In 2013, the ‘big killer’ diseases accounted for 2,919 deaths: there were 1,656 deaths from cancer (27.8% of all deaths), 823 deaths from CHD (13.8%) and 440 deaths from stroke (7.4%).

The other major causes of death in 2013 were varied and the following accounted for just over a third of all deaths:

- Respiratory diseases (mainly COPD and pneumonia) – 855 deaths (14.3%)
- Mental and behavioural disorders (mainly dementia) – 457 deaths (7.7%)
- Diseases of the digestive system – 372 deaths (6.2%)
- Diseases of the circulatory system (other than CHD and stroke) – 348 deaths (5.8%)

Figure 1.1.3
Proportion of deaths caused by the ‘big killer’ diseases in Lanarkshire, 2004–2013

Source: National Records of Scotland

More detailed information on mortality is provided in the tables and charts in A6–A11 in the Statistical Appendix.
Key Points

- Lanarkshire’s population decreased slightly in 2013 but is projected to rise in future years.
- Population projections for Lanarkshire indicate that there could be 30,000 more people aged 75 and over by 2033, an increase of 72%.
- The number of live births in Lanarkshire in 2013 fell slightly to 6,068, the lowest number in over ten years. The number of stillbirths continues to decrease.
- Life expectancy is increasing in Lanarkshire but remains, on average, a year less than in Scotland as a whole and three years less than in the UK.
- There were 5,967 deaths in Lanarkshire in 2013. Death rates in Lanarkshire remain well above the Scottish average.
- Less than half of all deaths in Lanarkshire were due to the so-called ‘big killer’ diseases of cancer (27.8% of all deaths), coronary heart disease (CHD) (13.8%) and stroke (7.4%). The proportion of deaths from these diseases continues to decrease.

The statistics in this section were obtained from local analysis of data supplied by National Records of Scotland (NRS) or directly from NRS information published online at www.gro-scotland.gov.uk/statistics/index.html.

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1.2 The Health of Older People in Lanarkshire

Between 15% and 20% of people in different parts of Scotland are aged 65 and over and they account for over 40% of the total expenditure on health and social care services. In Lanarkshire, 17% of people are aged 65 and over, amounting to 96,930 people in total. As described in the previous section of this report, it is predicted that the number of older people in Scotland and in Lanarkshire will rise considerably over the next 20 years. This section focuses on a local analysis of the health status of older people in Lanarkshire and is based on responses to the health-related questions in the 2011 Census – this data was published in June 2014 and further detail is available online at www.scotlandscensus.gov.uk

Self-assessed health and health problems among older people

Figure 1.2.1 shows that most older people in Lanarkshire and Scotland report fair, good or very good health. The overall profile of general health reported in South Lanarkshire was better than in North Lanarkshire, but the reported profile for Scotland was better again. Related datasets from the 2011 Census show that the profile of general health reported among those aged 85 and over was noticeably poorer than for the 65–74 age group, while the reported health profiles for males and females were broadly similar across all of the age groups and geographies considered.

Figure 1.2.1
Self-assessed general health among people aged 65 and over

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Bad or very bad health</th>
<th>Fair health</th>
<th>Very good or good health</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Lanarkshire</td>
<td>19</td>
<td>37</td>
<td>44</td>
</tr>
<tr>
<td>South Lanarkshire</td>
<td>16</td>
<td>34</td>
<td>51</td>
</tr>
<tr>
<td>NHS Lanarkshire</td>
<td>17</td>
<td>35</td>
<td>47</td>
</tr>
<tr>
<td>Scotland</td>
<td>13</td>
<td>31</td>
<td>56</td>
</tr>
</tbody>
</table>

Source: Scotland’s Census 2011, National Records of Scotland

Table 1.2.1 shows that most older people report at least one long-term health condition and that around half of those indicate that this limits their activities of daily living by a lot. The most common health conditions reported were physical disability (around 25%), hearing loss or deafness (around 20%), visual loss or blindness (around 9%), and mental health (around 5%). As in Lanarkshire, around a third of older people in the NHS Greater Glasgow and Clyde area reported a long-term health condition that limited their activities of daily living by a lot, but the reported rates in other NHS board areas in the West of Scotland were lower.
### Table 1.2.1
Long-term health problems and limited daily activities

<table>
<thead>
<tr>
<th></th>
<th>One or more long-term health condition</th>
<th>Activities of daily living limited a lot</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Lanarkshire</td>
<td>70%</td>
<td>36%</td>
</tr>
<tr>
<td>South Lanarkshire</td>
<td>67%</td>
<td>31%</td>
</tr>
<tr>
<td>NHS Lanarkshire</td>
<td>69%</td>
<td>33%</td>
</tr>
<tr>
<td>Scotland</td>
<td>66%</td>
<td>28%</td>
</tr>
</tbody>
</table>

Source: Scotland’s Census 2011, National Records of Scotland

### Provision of unpaid care by, and self-assessed health of, older unpaid carers

Around 12% of older people (over 10,000 people aged 65 and over) in Lanarkshire report that they provide unpaid care to family members, friends, neighbours or others who have long-term physical or mental ill-health or problems related to old age; this compares to around 11% for Scotland as illustrated in Figures 1.2.2 and 1.2.3. The majority of older unpaid carers in Lanarkshire reported that they provide 50 hours or more per week of unpaid care, particularly in North Lanarkshire, whereas the majority in Scotland report providing less than 50 hours per week.

### Figure 1.2.2
Provision of upaid care by, and self-assessed health of, older unpaid carers (providing less than 50 hours of care per week)

Source: Scotland’s Census 2011, National Records of Scotland
The profiles of general health reported among older unpaid carers were broadly similar across North Lanarkshire, South Lanarkshire, NHS Lanarkshire, and Scotland. It is notable that between 15% and 20% of unpaid older carers report that their health is bad or very bad. Given that the amount of unpaid care provided in Lanarkshire is proportionately greater than in Scotland, and particularly in North Lanarkshire, the needs of unpaid carers should be understood and addressed in order to retain this important support function to the population of frail and ill people that live in the community.

Key Points

- The majority of older people in Lanarkshire report fair, good or very good health, even among those aged 85 and over. However, around one third report that a long-term health condition limits their activities of daily living by a lot.
- Over 10,000 older people in Lanarkshire report that they provide unpaid care to others, with around 1 in 5 of them reporting bad or very bad health.
- The predicted rise in the number of older people and the large numbers that provide unpaid care to others underline the importance of an asset-based approach to supporting and maintaining good health in this group.
Priorities for Action

- Older people who provide care should, in particular, be proactively supported through health promotion, health protection, and the planned provision of health and social care to those that need it.
- An asset-based approach to supporting and maintaining good health among older people (including those that provide unpaid care) includes encouraging and supporting them to be active in the sense of physical, social and psychological activity, and to be actively engaged and involved in their own health.

References


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The key function of the NHS Lanarkshire Health Protection Team (HPT) is in the prevention and control of communicable diseases and environmental hazards, with emergency planning also a key aspect of the work.

This chapter reports on specific examples of the HPT work in 2013/14 – a fire risk at a Wishaw tyre storage site, NHS Lanarkshire resilience and preparation for the Commonwealth Games in 2014, the expanded immunisation programme, particularly for childhood influenza vaccine, and the matrix covering the key screening programmes. Each of these sections comprised a very significant amount of work by HPT members working in partnership with colleagues. Each section highlights learning points and key priorities for action.

The HPT provides an emergency response rota of Consultants in Public Health Medicine (Health Protection), Health Protection Nurses and support staff during normal working hours. An out-of-hours rota comprises consultants, with input from specialty registrars. The HPT typically deals with enquiries covering a wide variety of different diseases and environmental hazards of varying severity and urgency. Examples include:

- viral diarrhoea outbreaks affecting care homes
- illnesses affecting children attending nurseries, primary or secondary schools
- meningococcal infection and contact tracing
- single and clustered legionella cases requiring investigation for common exposure
- gastro-intestinal disease, and food and water source investigation
- tuberculosis cases and management
- influenza cases and outbreaks
- illness abroad including potential viral haemorrhagic fever
- immunisation enquiries
- comment on new industrial planning applications and/or response to public concern about current industrial activities
- diesel spills
- problems with drinking water.

In preventing and reacting to disease and environmental issues, the HPT proactively and reactively links with colleagues within the Public Health Department, microbiology, infectious disease units, infection control, Lanarkshire NHS Board, primary and secondary care, North and South Lanarkshire Council environmental health officers, as well as other NHS health protection teams, Health Protection Scotland (HPS), Scottish Water, government veterinarians and Scottish Government.

During 2013, the health protection team received 1,619 recorded enquiries – a 47% increase since 2009 and a 15% increase from the previous year. A summary of the calls by source and topic are shown in the Table 2.1.1. The sustained increase in laboratory cases in 2012 and 2103 has been due in large part to an on-going transmission of pertussis (whooping cough). The Scottish Government Health Department continues to recommend vaccination of pregnant women from 28 weeks gestation to protect neonates and infants.
Table 2.1.1
Health Protection Team enquiries

<table>
<thead>
<tr>
<th>Source</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
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<tr>
<td>Laboratory</td>
<td>76</td>
<td>102</td>
<td>98</td>
<td>299</td>
<td>326</td>
</tr>
<tr>
<td>GP</td>
<td>86</td>
<td>63</td>
<td>86</td>
<td>99</td>
<td>130</td>
</tr>
<tr>
<td>Environmental health</td>
<td>46</td>
<td>53</td>
<td>59</td>
<td>42</td>
<td>24</td>
</tr>
<tr>
<td>School</td>
<td>30</td>
<td>27</td>
<td>69</td>
<td>75</td>
<td>61</td>
</tr>
<tr>
<td>Nursery/playgroup</td>
<td>47</td>
<td>32</td>
<td>97</td>
<td>58</td>
<td>44</td>
</tr>
<tr>
<td>Nursing home</td>
<td>46</td>
<td>64</td>
<td>60</td>
<td>90</td>
<td>56</td>
</tr>
<tr>
<td>Hospital ward</td>
<td>43</td>
<td>32</td>
<td>39</td>
<td>30</td>
<td>40</td>
</tr>
<tr>
<td><strong>Topic</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BBV exposure</td>
<td>7</td>
<td>4</td>
<td>2</td>
<td>0</td>
<td>13</td>
</tr>
<tr>
<td>Gastroenteritis</td>
<td>160</td>
<td>220</td>
<td>232</td>
<td>248</td>
<td>77</td>
</tr>
<tr>
<td>Immunisation/vaccine</td>
<td>243</td>
<td>266</td>
<td>278</td>
<td>291</td>
<td>306</td>
</tr>
<tr>
<td>Infection control</td>
<td>12</td>
<td>18</td>
<td>7</td>
<td>19</td>
<td>10</td>
</tr>
<tr>
<td>Water</td>
<td>4</td>
<td>9</td>
<td>2</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Other (environmental health)</td>
<td>13</td>
<td>15</td>
<td>7</td>
<td>5</td>
<td>13</td>
</tr>
<tr>
<td>Other (communicable diseases)</td>
<td>199</td>
<td>264</td>
<td>259</td>
<td>274</td>
<td>353</td>
</tr>
<tr>
<td><strong>Total no. of enquiries</strong></td>
<td>1103</td>
<td>1081</td>
<td>1265</td>
<td>1409</td>
<td>1619</td>
</tr>
</tbody>
</table>

Source: Communicable Diseases/Environmental Health Record Form Database

Notifications of communicable disease are shown in Table A16 in the Statistical Appendix. In early March 2014, HPS went live with the new Scottish health protection case management system, called HPZone Scotland. This was commissioned for NHS Scotland, with NHS Lanarkshire playing a lead role. HPZone Scotland is an electronic case management system recording case demographics, details on disease, actions and notes, as part of HPT management. The system generates the key actions needed for common severe illnesses, thereby helping to improve quality of response.

HPZone Scotland enables real-time electronic sharing of case records, imports laboratory reports, links directly to HPS guidance on infectious diseases and environmental health processes, and shares non-patient identifiable data and common exposures across all health protection teams in Scotland. HPZone Scotland was a cornerstone of the enhanced response and surveillance supporting the Commonwealth Games in 2014.

**Key Points**

- The health protection team works in partnership to proactively and reactively deal with a wide variety of diseases, which may involve significant numbers of cases or pose a high degree of risk to the local population.
- The electronic case management system HP Zone Scotland will support and enhance local and national health protection management.
Priorities for Action

• To maintain an effective health protection response and continue to contribute to the national web of surveillance.
• To develop appropriate knowledge and skills and adapt local HPT procedures to optimise the benefits of HPZone Scotland.

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2.2 **Wishaw Tyre Fire Risk**

**Introduction**
In January 2013, the Scottish Environmental Protection Agency (SEPA) discovered the storage of unauthorised tyres at a tyre recycling site in Lanarkshire, 200 metres south-west of Wishaw General Hospital. Initial reports estimated one million tyres on the site, but this number was subsequently reduced, as greater order was brought to the site. The site was only authorised to hold 1,000 tyres, through an online licence exemption process.

**Background**
The Health Protection Agency reported that large waste tyre fires caused three out of eight major incidents in England which required the activation of the Air Quality Cell (air monitoring) between April and July 2010. Most such fires are suspected of being lit deliberately. Large tyre fires are very difficult to extinguish and have the capacity to burn for long periods. The resultant pollution can spread over a wide area affecting air, water, soil and herbage causing short- and long-term adverse health effects.

**Risks and challenges**
Airborne pollution from tyre fires includes a wide range of toxic chemicals such as: cyanide compounds, carbon monoxide, oxides of sulphur and nitrogen, hydrogen sulphide, particulate matter, and a range of carcinogenic organic compounds, including dioxins and polycyclic aromatic hydrocarbons. Contamination of waterways and land can occur through run-off of contaminated fire-fighting water.

The primary risk was that, depending on wind speed and direction and the size of the fire, the hospital might have been forced to evacuate hundreds of patients.

A significant fire would threaten the health of vulnerable individuals living in the area, particularly those with chronic lung conditions, e.g. asthma. Local transport and industry would have also been affected, for example, closing the West Coast Main Line and threatening nearby commercial premises, including a major Royal Mail distribution centre and the NHS West of Scotland Laundry.

**Methods**
A Contingency Planning Liaison Group and specialist sub-groups were set up to assess and manage the potential risks, arrange airborne hazard monitoring and provide sheltering and/or evacuation advice.

**Results**
A risk assessment considered the likelihood of an incident was low to medium but the impact could be very high. Following the work of the multi-agency group, a contractor, employed by SEPA with funding underwritten by the Scottish Government,
commenced work on the site. Installation of additional security measures and firebreaks reduced the interim risk, pending removal of chemicals and all but 1,000 of the tyres.

At that stage, the risk posed by the site was re-assessed as low, as the Scottish Fire and Rescue Service could rapidly extinguish any fire and the quantities of combustible materials were not excessive.

Conclusions
This incident demonstrated the strengths of multi-agency working and an excellent outcome was achieved. It highlighted various issues for the partners involved and these were followed up by the individual agencies.

Key Points

• The incident highlighted the extreme difficulty in, and risk of, completely evacuating a major acute hospital, containing many seriously ill patients, even over a period of hours or days.
• SEPA and other organisations including Police Scotland and the Scottish Fire and Rescue Service continue to closely monitor the site and provide appropriate advice to the occupiers.
• The investigation needed to be mindful of potential legal implications.

Priorities for Action

• In light of the serious risks posed by this site and to minimise the risk of the situation recurring, NHS Lanarkshire considers that an enhanced regulatory and monitoring regime should be put in place.
• Further consideration of whether hospitals should have plans to evacuate the whole hospital and under what circumstances these plans would be enacted.

References

Dr S Josephine Pravinkumar, Consultant in Public Health Medicine
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NHS Lanarkshire Resilience – Getting Ready for the Games

Introduction
Glasgow hosted the Commonwealth Games for the first time in 2014. To prepare for the Queen’s Baton Relay, the Games and associated events, comprehensive Scottish, regional and local arrangements were put in place, involving a range of multi-agency and single agency groups.

The opening ceremony on 23 July initiated 11 days of international competition, finishing with the closing ceremony on 3 August. The efforts of 4,500 athletes from 71 countries competing in 17 sports at 20 venues were reported on by 3,000 media personnel. On peak days, there were over 100,000 spectators. Altogether, 1.3 million tickets were available. Although 97% of the tickets were purchased within the UK, 43% of the tickets were sold outwith Scotland resulting in a large influx of visitors, with up to 50,000 extra people in Glasgow and the surrounding areas. There was a television audience of up to one billion people.

While major sporting events are not intrinsically high risk, they are complex, involve a wide range of public and private organisations, and require extensive planning. The worldwide media presence can result in problems being given greater coverage than if they had happened at any other time.

Events in Lanarkshire were the triathlons at Strathclyde Country Park on 24 and 26 July, and the cycle time trials on 31 July. The cycle route started and finished in Glasgow, but went out to Moodiesburn in North Lanarkshire. In addition, the mountain biking at Cathkin Braes in Glasgow bordered South Lanarkshire. These events posed particular planning difficulties as tickets were not required for much of the routes and the number of spectators could only be estimated.

Risks
National and local risk registers identified a number of risks which were successfully managed.

- **Contamination of Strathclyde Loch (triathlon swimming) by harmful organisms**: controlled by the preparation of guidance, regular water testing and the construction of a membrane barrier to separate a swim area from the rest of the loch.
- **Outbreaks of illness**: controlled by daily reporting arrangements and the introduction of the new national electronic disease reporting system, HPZone Scotland.
- **A mass casualty incident (either accidental or deliberate)**: controlled by a high level of security and inspections, a review of mass casualty arrangements, revalidation of protective suits used to decontaminate casualties exposed to harmful materials, and by additional resilience training and exercises.
• **Routine health care being affected due to travel disruption:** controlled by communications to ensure that staff and patients were aware of potential problems and that alternative arrangements were in place.

• **Staffing shortages caused by NHS staff taking leave to volunteer or spectate:** controlled by briefings and management action to ensure that leave was only granted if sufficient staff were available to provide routine services.

### Games time arrangements

- Daily teleconferences were held with Health Protection Scotland and NHS boards to quickly identify any outbreaks of illness.
- A Consultant in Public Health Medicine was based at the Multi-agency Coordination Centre (MACC) on the days when there were events in Lanarkshire.

### Legacy

NHS Lanarkshire hopes to build on the great success of the Games by encouraging people to increase their physical activity and improve their long-term health, through the Get Active Lanarkshire programme. It will also use the experience gained from the Games to inform its work on resilience.

### Key Points

- Extensive planning and response arrangements, involving multiple agencies, was undertaken.
- There was a high level of involvement by the Scottish Government.

### Priorities for Action

- Use the experience gained from the Games to inform resilience in Lanarkshire.

### References


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2.4 Expanded Immunisation Programme

Introduction
In December 2012, the Scottish Government informed NHS boards of planned changes to the routine immunisation programmes from 2013/14. These changes included:
• introduction of the rotavirus vaccine
• introduction of the shingles vaccine
• changed timing of the third dose of meningitis C vaccine
• extension of the annual seasonal flu vaccination programme
• a catch-up campaign for MMR vaccination.

Rotavirus
Rotavirus causes gastroenteritis in babies and young children, and can lead to dehydration and hospitalisation. Nearly all children will have at least one episode of rotavirus gastroenteritis before the age of five. Rotavirus immunisation commenced for all children born on or after 1 May 2013, administered orally at two and three months. By May 2014, the completed two-dose course uptake was 95.1% in NHS Lanarkshire compared to 93.0% nationally.

Shingles
Shingles (herpes zoster) is a painful viral infection of the nerve cells and surrounding skin, caused by reactivation of a latent varicella zoster (chickenpox) infection. The shingles vaccine was introduced on 1 September 2013 for both 70- and 79-year-olds and is administered by GPs. By May 2014, the completed two-dose course uptake was 95.1% in NHS Lanarkshire compared to 93.0% nationally.

Meningitis C (MenC)
The MenC vaccine at four months was discontinued on 1 June 2013 and was included in the teenage booster at year three in secondary schools from January 2014. A catch-up MenC programme will be introduced from August 2014 for first year UK and EU university students less than 25 years old.

Childhood flu
Influenza (flu) is a highly infectious viral infection of the respiratory tract. The risk of serious illness from flu is higher in young children, older adults, those with underlying health conditions and pregnant women. The annual seasonal flu vaccination programme will be extended over the next few years to include all those aged 2–17 years, delivered through GP practices for pre-school children, and primary and secondary schools for school-aged children. The recommended vaccine is Fluenz® which is administered using a nasal spray. From 1 October 2013, extension of the seasonal flu programme was phased to include 2- and 3-year-old children, additional needs schools and 20% of primary schools (around 26,000 children). Uptake figures are encouraging: 50.2% (Scotland 50.6%) in 2- and 3-year-olds and 74.6% (Scotland 67.2%) in primary-school-aged children. In 2014/15, the flu vaccine will be offered to 2- to 5-year-olds and primary-school-aged children.

MMR
A catch-up campaign for MMR vaccination was delivered in 2013 through GP practices for all children aged 10–17 years to reduce the risk of measles to Lanarkshire residents.
Key Points

• There has been a significant increase in the number and range of vaccines delivered through routine immunisation programmes.
• Uptake of new vaccines has been encouraging, particularly in relation to rotavirus, MenC and flu.
• Extension of seasonal flu vaccine to all children aged 2–17 years is a considerable operational challenge for the NHS workforce.

Priorities for Action

• In 2014/15, seasonal flu vaccination will be further phased to include all 2- to 5-year-olds and primary-school-aged children.
• Shingles vaccine will be offered to all 70-, 78- and 79-year-olds from 1 September 2014.
• Delivery of routine immunisation programmes will require continued effective partnership working between nursing staff, GPs, education departments and schools.

References


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### Table 2.5.1
Screening programmes in Lanarkshire

<table>
<thead>
<tr>
<th>Screening programme</th>
<th>Target population and time frame</th>
<th>Denominator</th>
<th>Standard</th>
<th>Uptake</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Universal newborn hearing screening</strong></td>
<td>All newborn babies born to Lanarkshire residents, January 2012 to March 2013</td>
<td>7,827</td>
<td>NHS QIS 5(b): 95% of babies should have completed the hearing screen by 10 weeks</td>
<td>99%</td>
<td>16 hearing losses detected</td>
</tr>
<tr>
<td><strong>Newborn bloodspot test screens for congenital hypothyroidism (CHT), phenylketonuria (PKU), cystic fibrosis (CF), medium-chain acyl-CoA dehydrogenase deficiency (MCADD) and sickle cell disorder (SCD)</strong></td>
<td>All newborn babies born to Lanarkshire residents, April 2012 to March 2013</td>
<td>6,151</td>
<td>NHS QIS 4(h): 99.5% of infants have a screening result available or are recalled for repeat testing by 20 days of age</td>
<td>99.9%</td>
<td>PKU: 0, CHT: 0, CF: &lt;5*, CF carrier: &lt;5*, MCADD: 0, SCD: 0, SCD carrier: 5</td>
</tr>
<tr>
<td><strong>Pre-school orthoptic vision screening (POVS)</strong></td>
<td>All resident Lanarkshire pre-school children aged 4 years, August 2012 to July 2013</td>
<td>6,194</td>
<td>Hall 4: all children should be offered a pre-school orthoptic vision screen aged 4</td>
<td>90%</td>
<td>1,249 referred for assessment</td>
</tr>
<tr>
<td><strong>Down’s syndrome screening in pregnancy</strong></td>
<td>Lanarkshire women booking to deliver at Wishaw General Hospital, 2012/13</td>
<td>5,193</td>
<td>No specific uptake target. Screening offered to all women. Uptake dependent on personal views/beliefs.</td>
<td>59%</td>
<td>&lt;5* cases of Down’s syndrome diagnosed antenatally</td>
</tr>
<tr>
<td>Screening</td>
<td>Target Population</td>
<td>Uptake</td>
<td>Key Outcome Measures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------------------</td>
<td>----------------------------------------------------------------------------------</td>
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<td>--------------------------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Fetal anomaly ultrasound scan</strong></td>
<td>Lanarkshire women booking to deliver at Wishaw General Hospital, 2012/13</td>
<td>5,193</td>
<td>No specific uptake target. Screening offered to all women. Uptake dependent on personal views/beliefs. 99% Around 60 anomalies reported antenatally</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Antenatal haemoglobinopathy screening</strong></td>
<td>Lanarkshire women booking to deliver at Wishaw General Hospital, 2012/13</td>
<td>5,193</td>
<td>No specific uptake target. Screening offered to all women. Uptake dependent on personal views/beliefs. 99% 24 haemoglobinopathies detected</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cervical screening</strong></td>
<td>All Lanarkshire female residents aged 20–60, to 31 March 2013</td>
<td>159,211</td>
<td>NHS Lanarkshire corporate objective: NHSQIS 1(a): a minimum of 80% of women aged 20–60 are screened at least once every 5 years 79.9% 44 cancers detected, 21 via screening programme</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Bowel screening</strong></td>
<td>All Lanarkshire female and male residents aged 50–74, to 31 March 2013</td>
<td>167,796</td>
<td>NHSQIS 2(b): a minimum of 60% of invited individuals respond to an invitation to participate in the bowel screening programme and complete the screening test 48.2% 119 cancers detected in second full round, August 2011–August 2013</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Breast screening</strong></td>
<td>All Lanarkshire female residents aged 50–70, 7th screening round, April 2010–March 2013</td>
<td>75,665</td>
<td>NBSP Standards: a minimum uptake of 70%, target 80% 71% 445 cancers detected</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Actual numbers where there are less than five cases have been suppressed due to potential risk of disclosure.
Key Points

- It is interesting to note that uptake for fetal anomaly scanning is significantly higher than for Down’s syndrome screening (99% versus 59%). This may be because women are less likely to view anomaly scanning as a ‘test’ and may be keen for an opportunity to see their baby.
- Breast screening uptake meets the minimum target of 70% but not the desired target of 80%.
- Uptake of bowel screening is significantly lower than the target, and is the lowest in Scotland.

Priorities for Action

- Health promotion interventions are underway to improve breast screening uptake, including awareness-raising campaigns, teaser letters and a possible pilot of text message reminders.
- Significant resources are being deployed to address poor uptake of bowel screening, including locally trained bowel cancer champions.

References


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3.1 ‘See me’ Mental Health Campaign in North West Unit – Growing Community Action to Reduce Stigma

Introduction
Stigma and discrimination is a significant barrier to achieving a mentally flourishing Scotland and Lanarkshire for all.1,2 Reducing stigma has remained a key commitment since the formation of the ‘see me’ programme in Scotland in 2002.3 The multi-agency Lanarkshire Recovery Network works to effect first-level change which supports individual recovery, and second-level change aimed at creating the conditions within communities that maintain recovery and promote wellbeing.4

Involving community assets
Involving people, organisations and communities in anti-stigma activities across Lanarkshire is supported via the ‘see me’ pledge signatory programme. This enables mainstream organisations and voluntary community groups to use their assets to become part of a movement which is combining community action to create the conditions for wellbeing and recovery. To date, 410 organisations have signed the pledge and a specific action plan in Lanarkshire has more than 70% of all pledge signatories in Scotland.

Community development
In Lanarkshire, the North West Health Improvement Team are focused on addressing the social determinants of mental health. The ‘see me’ pledge has been used by the Health Improvement Team to facilitate community ownership through joint working with their Community Forums (representative of residents, voluntary and religious organisations) and town centre activities. A total of 24 local agencies, organisations and employers have signed the ‘see me’ pledge and an individual action plan against which progress can be measured. Key to the success of the
programme has been the local co-ordination of action matched to each pledge signatory taking responsibility for embedding mental health within their day-to-day work.

Examples of ‘see me’ contributions include:
• Many local gala days had ‘see me’ and wellbeing as a key theme during the summer of 2013, facilitating local engagement, transferring the key messages in a fun and interactive way to families.
• The exhibition space at Airdrie Community Health Centre focused around ‘see me’ from October to December 2013 and highlighted the 2013 Scottish Mental Health and Arts Film Festival.
• The Scottish Community Choir of the Year, Soundsational, who are based within the North West Unit, signed the pledge and have been embedding mental health and wellbeing messages within their workshops and performances, making the choir more accessible.
• National recognition for this community asset-based approach has seen an Abronhill High School band called Falconhoof perform a local ‘see me’ song they had written and produced as part of the refounding of the national ‘see me’ campaign within the Scottish Parliament in January 2014.
• Links have been established with local libraries (pledge signatories) to set up information stands to display information and highlight where people can get assistance/help.

Newsletters and information stands have been produced and distributed within various community settings.

Key Points

• The ‘see me’ pledge facilitates an asset-based approach.
• Everyone has a part to play in reducing stigma so that individuals can feel connected and valued in their community.

Priorities for Action

• To continue to grow the local ‘see me’ movement for change.
• To evaluate the impact of the ‘see me’ campaign.

References

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3.2 Lanarkshire Healthy Weight Strategy

**Introduction**

The rapid increase in obesity is a major public health challenge. Obesity is complex and influenced by a range of factors. In Lanarkshire, 65% of adults are overweight (body mass index (BMI) of 25 kg/m² or above) and 28.3% are obese (BMI of 30 kg/m² or above). Obesity increases the risk of developing a range of chronic conditions and can lead to premature death.

*Preventing Overweight and Obesity in Scotland* outlined actions primarily for central and local government across four key priority areas: energy consumption, energy expenditure, early years and healthy working lives. Action on obesity must be taken on a number of fronts and in partnership. A Lanarkshire Healthy Weight Strategy to facilitate the achievement of healthy weight is being developed by a range of community planning partners and will present evidence-informed actions.

**Promoting and supporting healthier food choices**

Encouraging a healthier food environment across the private sector is a priority for action. The strategy will also:

- promote action across the early years
- ensure employees have the opportunity to make healthy food choices in the workplace
- support the third sector to improve access to healthier food in low income communities
- ensure consumers are able to make informed food choices.

**Physical activity and the environment**

Sedentary behaviour can be compounded by the obesogenic environment, that is an environment which encourages people to become overweight. The strategy will:

- promote and create opportunities for active travel and recreational activities
- encourage families, groups and individuals to take part in active play
- further develop and promote physical activity opportunities for older people
- maintain and develop open/greenspace/gap sites within and between communities.

**Weight management interventions**

*Weigh to go* is a community weight management programme for adults. The programme offers advice and support on nutrition, physical activity and behaviour change. *Weigh to go – new mum* is a similar programme for postnatal women to attend following pregnancy.

*Weigh to go* workplace champions have been introduced to NHS Lanarkshire. This, and the revised Healthy Eating Policy for staff and visitors, is important support for staff who want to improve diet and activity levels.

**Surgical intervention**

A common approach to planning weight management services and surgical intervention for the treatment of severe and complex obesity was agreed by the National Planning Forum. As a priority, national
Key Points

- Obesity is a major public health challenge.
- Action on obesity must be taken jointly by all community planning partners.
- The Lanarkshire Healthy Weight Strategy will support action across all levels.

Priorities for Action

- Ensure the Lanarkshire Healthy Weight Strategy is communicated widely.
- Continue to engage key community planning partners in the implementation of the strategy.
- Support individuals and groups to achieve a healthy weight.

References


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Improving Uptake of Cervical Screening – The Smear Amnesty

Despite the considerable benefits offered by cervical screening, which can identify changes which, if left alone, may become cancerous, one out of every four women does not take part.¹ Women from the most deprived communities are least likely to attend for cervical screening, yet, significantly, more are likely to be diagnosed with and die from the disease compared with women from the least deprived areas.² The peak incidence of cervical cancer is in women aged 30–35 years, therefore the impact for them, and their families, can be significant.³ Efforts to target non-attenders are worthwhile but often need innovative and flexible approaches.⁴

To help tackle low uptake of the programme locally, NHS Lanarkshire developed an award-winning (Jo’s Cervical Cancer Trust Highly Commended Award, 2012) Cervical Screening Toolkit which contains evidence-based, cost-neutral, cost-effective interventions to improve cervical screening uptake, including the innovative smear amnesty.⁵

What is a smear amnesty?
The smear amnesty offers a personalised approach to the invitation and engagement with non-attenders for cervical screening. Women in GP practices with the lowest levels of cervical screening uptake were targeted using a personalised smear invitation, teaser letter and information in an eye-catching pink envelope. Women were reassured that the smear taker would be female and that they could bring a buddy.

Amnesties were organised within GP practices and allowed longer appointments to facilitate engagement. Attention was paid to the environment itself (lighting, music, candles and massage) and amnesties were held in the evenings.

Smear amnesty findings
- To date, 31 smear amnesties across 13 practices, have attracted 212 women who had not attended screening for between four and 30 years.
- Practices which took part had higher uptake rates in the subsequent quarter following amnesties than control practices (range 0.5% to 2.9% higher).

A survey of attendees highlighted the following reasons for participating:
- Evening appointment (69.0%).
- Personalised invitation (61.5%) – “The pink envelope sealed the deal”.
- Information on risks of cervical cancer and benefits of screening (53.8%).

Unexpected benefits of the smear amnesty
- Highlighted cervical screening as an important issue in general practice.
- Motivated practices to ‘tidy up’ practice lists.
- Raised awareness of cervical screening information in other languages and formats.
- Practices proactively approached Health Improvement Teams to arrange smear amnesties.
Key Points

- Women from the most deprived areas are least likely to attend screening and are more likely to be diagnosed with cervical cancer.
- The smear amnesty offers a personalised approach which can encourage defaulters to attend for cervical screening.
- Smear amnesties have been popular and effective within Lanarkshire.

Priorities for Action

- To consider how attendance at smear amnesties influences subsequent screening participation.
- Compare the burden of disease picked up by amnesties with control practices.

References


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Improving Prisoner Health in Lanarkshire

The prison population reveals strong evidence of health inequalities and many prisoners have had little or no contact with health services prior to imprisonment. Prison enables access to vulnerable groups who would normally be hard to reach and therefore offers a key opportunity to address inequalities in health.

Documents have informed the development of a three-year Health Improvement Strategy for HMP Shotts (2013–2016).¹

Aims and outcomes
The aim of the strategy is to improve the health and wellbeing of prisoners, their families and staff working within HMP Shotts. A number of outcomes have been developed to assist the achievement of our vision including:

• health behaviour change
• creation of a healthy working, living and learning environment
• integration of health improvement into core business
• healthy prison strategies, regimes and policy.

Development of HMP Shotts Health Improvement Strategy 2013–2016

With the transfer of health care in November 2011, NHS Lanarkshire Health Improvement was tasked with transforming recommendations from the key drivers into a health improvement strategy for HMP Shotts. A multi-agency and multidisciplinary Health Improvement Steering Group was established to progress the strategy. Two approaches have been applied to improving health through the strategy. First, a whole prison setting approach involves work on all aspects of prison life which impact the wider determinants of health, such as education and life-skills. This approach works well in a prison setting as, uniquely, prisoners work, live, learn and play in the same environment. Second, topic specific actions aim to make health improvements across a range of health topics including diet, sexual health and tobacco use. A logic model and evaluation framework has been developed in order to evaluate the effectiveness of the strategy.

Health improvement in prisons
Health improvement in prisons has been part of government policy since 2005 with the publication of An Action Plan for Improving Oral Health and Modernising NHS Dental Services, the Equally Well Implementation Plan, the transfer of health care from Scottish Prison Service (SPS) to NHS Scotland (November 2011), and the publication of Better Health, Better Lives for Prisoners, the national health improvement framework for prisons.¹⁻³ The latter developments aim to provide a framework and vision towards supporting health and health improvement within prisons. These
Key achievements in 2013/14
The strategy has been shared nationally as an example of good practice. Good progress has been made over the last year including:
• the establishment of a prisoners’ forum
• health information resources for prisoners
• training of prison staff in health
• social marketing campaigns
• achievement of the Healthy Working Lives Silver and Gold Award
• a peer education initiative
• the Family Time project which offers facilitated relationship building for prisoners and their children.

Key Points
• A three-year Health Improvement Strategy for HMP Shotts (2013–2016) has been developed to improve the health status of prisoners, their families and staff.
• A Health Improvement Steering Group has been formed to enable multi-agency and multidisciplinary involvement in the delivery of this strategy.
• Good progress has been made in delivering all planned activity for 2013/14.

Priorities for Action
• Monitor and evaluate progress of the strategy with quarterly updates and annual reports from the Health Improvement Steering Group.
• Continue to work in partnership with key stakeholders from HMP Shotts and the third sector to ensure delivery of actions contained within the strategy.

References

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NHS Lanarkshire No Smoking Policy

Background
Tobacco use remains a significant preventable cause of ill health and premature death in Scotland.1

In 2013, the Scottish Government published Creating a Tobacco-Free Generation: A Tobacco Control Strategy for Scotland which aims to achieve a tobacco-free Scotland by 2034.1 This strategy states that NHS boards should be exemplars by implementing and enforcing smoke-free grounds by March 2015. The strategy also states that mental health services should ensure that indoor facilities are also smoke-free by 2015. These actions are monitored by the Scottish Government under the requirements of the Chief Executive Letter (CEL) Health Promoting Health Service: Action in Hospital Settings.2

Policy review
NHS Lanarkshire’s No Smoking Policy was updated in 2008 to include all NHS buildings, grounds and vehicles. An exemption was applied to designated rooms in adult care homes and psychiatric units.

Implementation of the 2008 policy was perceived to reduce the levels of smoking within hospital grounds initially. However, observations and complaints since suggest, while most smokers abide with the policy, there is a considerable minority who continue to smoke, particularly at hospital entrances.

In 2012, a review of the policy was commenced and a consultation was undertaken to elicit stakeholder’s views of the policy. The consultation elicited over 3,500 responses, 63% from staff and 37% from the public. Most positively, the consultation found 94% of respondents support smoke-free entrances and 71% of respondents stated that NHS grounds should be smoke free.

Revised No Smoking Policy 2014
Reflecting the 2013 Scottish Government Tobacco strategy ambitions and the findings from the local consultation, the NHS Lanarkshire No Smoking Policy has been updated.

The key changes are:
• Smoking will not be allowed anywhere within NHS premises and grounds including mental health facilities. This ensures an inclusive and unambiguous approach.
• The use of e-cigarettes will be prohibited within NHS premises and grounds as there is currently insufficient evidence on both their safety and efficacy.

Policy implementation
There is no one solution to achieving smoke-free grounds. Successful implementation will require strong leadership and support from staff, patients and visitors.

Drawing on evidence from other NHS boards, an action plan is now being developed to support policy compliance.
Key Points

• Smoke-free NHS grounds are an issue of significant interest and consultation suggests overwhelming support for them, particularly hospital entrances.
• The policy has been revised to include all buildings and grounds including mental health sites and to prohibit the use of e-cigarettes.
• Successful policy implementation will require leadership from management, and support from staff, patients and the public.

Priorities for Action

• The revised policy requires to be well publicised through increased signage, patient literature and local media.
• All staff should be appropriately trained to enable them to confidently raise the issue of smoking and follow the nicotine addiction integrated care pathway.
• Management of the no smoking policy should be included as part of the annual self-assessment Control Book checklist.

References

2 Directorate for Chief Medical Officer, Public Health and Sport, Scottish Government. CEL 01 (2012). Health Promoting Health Service: Action in Hospital Settings.

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4.1 Childsmile Programme

Childsmile (www.child-smile.org.uk) is a national programme designed to improve the oral health of children in Scotland and to reduce inequalities both in dental health and access to dental services. It was developed from An Action Plan for Improving Oral Health and Modernising NHS Dental Services in Scotland.¹

Childsmile Nursery and School

Childsmile Nursery and School delivers a range of preventive care interventions for children, from the age of three until they leave primary school, who are at increased risk of dental disease. This programme commenced in NHS Lanarkshire in January 2010. Since then it has been extended to all 272 nurseries and 225 primary schools in Lanarkshire.

The Nursery and School Team consists of Extended Duty Dental Nurses and Dental Health Support Workers (DHSWs). They provide the main contact point for teachers, parents and school nurses in relation to fluoride varnish applications (FVAs). FVA is offered twice a year to children from the age of three until age six in priority nurseries and schools. The increase in FVAs since 2010 is shown in Table 4.1.1.

Childsmile Practice

Childsmile Practice has been operating since 2008 across NHS Lanarkshire. DHSWs make home visits to all families assessed as vulnerable by the Public Health Nursing Team. These visits aim to deliver specific oral health prevention advice and to facilitate attendance at a dental practice. DHSWs link these families up with dental practices to receive a more intensive programme of care. At the moment 109 practices across Lanarkshire participate in Childsmile Practice, providing a comprehensive preventive care package.

From October 2011, Childsmile became part of ‘mainstream’ NHS general dental services and was incorporated into the Statement of Dental Remuneration to shift the balance of care towards prevention instead of treatment. All NHS practices delivering care to children must deliver Childsmile interventions, including FVAs.²

Target for children’s oral health

In April 2010, the Scottish Government set a target for oral health. The target is to achieve at least 60% of 3- and 4-year-old children in each Scottish Index of Multiple Deprivation (SIMD) quintile to receive at least two FVAs per year by March 2014.

Table 4.1.1

<table>
<thead>
<tr>
<th>No. of FVAs</th>
<th>2010</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3890</td>
<td>14394</td>
<td>31176</td>
<td>42919</td>
</tr>
</tbody>
</table>

Source: Health Informatics Centre
There was extensive variation in FVAs between NHS boards. However, the same trend is observed with children in the more deprived SIMD quintiles being more likely to receive two or more FVAs. Details can be accessed from [www.scotland.gov.uk/About/Performance/scotPerforms/partnerstories/NHSScotlandperformance/ChildFluorideVarnishing](http://www.scotland.gov.uk/About/Performance/scotPerforms/partnerstories/NHSScotlandperformance/ChildFluorideVarnishing).

### Key Points

- Childsmile Nursery and School has been extended to all 272 nurseries and 225 primary schools across Lanarkshire providing twice yearly FVAs.
- DHSWs visit homes which are identified as vulnerable.
- DHSWs work across both programmes to facilitate an effective pathway which focuses on preventive dental care.

### Priorities for Action

- Sustain current levels of activity across Childsmile Nursery and School, and Childsmile Practice.
- Continue to develop our approach and work as effectively as possible with families identified as being vulnerable.
- Continue to support general dental practitioners and encourage the delivery of the full range of preventive services available for children.

### References


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4.2 Modernising Dental Services

The fundamental objectives of a modern dental service are to improve oral health and provide accessible services from premises that are fit for purpose to allow practices to deliver safe, person-centred and effective care. Through the Primary and Community Care Modernisation Programme (PCCMP) and the Scottish Dental Access Initiative, funding has been available to support improvements in dental practices to comply with the Equality Act 2010 and decontamination requirements.²,³

In addition, the past year has seen the introduction of new standards, guidance and requirements to assure and improve dental services, including:

- The revised dental practice inspection.⁴
- The new inspection protocol for practices which deliver conscious sedation.⁴
- General Dental Council (GDC) Standards for the Dental Team.⁵

Facilities

NHS Lanarkshire responded to the challenges in modernising dental services through active involvement with the dental profession. The PCCMP provided capital funding, enabling 16 practices in Lanarkshire to relocate or extend premises. NHS Lanarkshire also ensured that washer-disinfectors were fitted in all practices that did not have one, delivering compliance with the requirements of decontamination guidance.³ At all stages, the Primary Care team supported practices through these developments.

Practice inspections

In January 2013, the Scottish Government Health and Social Care Integration Directorate introduced a revised dental practice inspection process, combining the health board inspection with the vocational training inspection, thus avoiding duplication.⁴ The revised process incorporates the requirements for decontamination compliance, which also came into effect at the beginning of the year, and includes patient experience elements which satisfy Healthcare Improvement Scotland considerations.

In Lanarkshire, meetings were held with practitioners to provide information and resources to support them in meeting the demands of the inspection. It was recognised that the new inspection was more comprehensive, including observation of the decontamination process and a review of records, and that it would take significantly longer than the previous process. Implementation of the new inspection has been challenging, both for practices and for NHS Lanarkshire, but good progress is being made as experience is acquired.

At the same time, an inspection for practices delivering conscious sedation was introduced.⁴ Educational support and audit facilitation has again been provided in Lanarkshire for practitioners in order to raise awareness and assist them in putting the requirements fully in place.
**GDC Standards**

The GDC introduced new standards for dental practitioners and their teams in September 2013, with clearer guidance on what must be done by registrants to maintain registration. There is a greater focus on communicating effectively with patients in the standards, and the need for professional behaviour at all times from registrants is addressed. Dentists have been supported locally through educational meetings explaining the GDC Standards and the ethical practice principles that underpin them, and by the facilitation of record keeping audits.

**Key Points**

- Modern dental service requires a constant focus on improving standards of care and the quality of general dental services.
- With funding from PCCMP, a number of Lanarkshire practices have modernised their premises to meet new requirements.
- NHS Lanarkshire has played a pivotal role in promoting and supporting these improvements.

**Priorities for Action**

- Ensure access for patients to general dental practices that are fit for purpose.
- Lead initiatives to improve standards of care and modernise dental services.
- Support dental registrants to embed GDC Standards in their daily practice.

**References**


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Introduction
Hospital Standardised Mortality Ratio (HSMR) is a statistical tool that is used to compare mortality within hospitals over time, and to compare mortality between hospitals and a standard, while factoring out differences in case-mix (the type or mix of patients treated by a hospital). HSMR is calculated as the ratio of observed deaths in a hospital (total number of deaths within 30 days of hospital admission, irrespective of the place of death) to the number of predicted deaths for that hospital as determined by applying the HSMR statistical model to the available data on patients that have been admitted over a particular time period (usually three months). Using the persistent HSMR outlier status at Monklands Hospital, and to a lesser extent at Wishaw General and Hairmyres Hospitals, as a ‘smoke alarm’, a Health Improvement Scotland (HIS) Rapid Review of the Safety and Quality of Care for Acute Adult Patients in NHS Lanarkshire was conducted in autumn 2013. Part of NHS Lanarkshire’s work explored the factors that might be contributing to the persistent, raised HSMR.

HSMR as a statistical tool
HSMR is based on a statistical model and it can be affected by the quality of data feeding the model and the validity of assumptions that underpin it. Some potential shortcomings with HSMR are clearly outlined in a Faculty of Public Health Position Paper that describes some important differences in how hospitals and local healthcare systems are organised and some differences in coding practices. These factors and others can lead to problems in reliably interpreting HSMR data and in developing appropriate responses to improve care and offer assurance to the general public.

During 2013, Information and Services Division (ISD), part of NHS National Services Scotland, carried out some exploratory and sensitivity analyses to examine the robustness of the HSMR statistical model and to provide recommendations on future strategies for calculating HSMR. This work concluded that the Scottish HSMR model was fairly robust when applied to large hospitals (such as district general hospitals and teaching hospitals) in respect to coding errors, differences in how hospital care is organised, and some of the different characteristics of hospital catchment populations. The only factor that did affect the outlier status of some large hospitals was to replace the use of co-morbidities information from a previous hospital admission with information from the current admission.

The report from the HIS Rapid Review referred to a number of issues that had been previously highlighted by NHS Lanarkshire and ISD. ISD suggested
that late submission of SMR01 records was adversely affecting the HSMR data, particularly at Monklands, possibly related to the timeliness and quality of some hospital discharge reports. The overall findings are summarised in Table 5.1.1.

Table 5.1.1
ISD assessment of HSMR model issues raised in discussions with NHS Lanarkshire

<table>
<thead>
<tr>
<th>Factors potentially affecting HSMR in Lanarkshire</th>
<th>ISD assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality of clinical coding</td>
<td>Highly unlikely to affect HSMR</td>
</tr>
<tr>
<td>Hospital at home service at Monklands</td>
<td>Highly unlikely to affect HSMR</td>
</tr>
<tr>
<td>Accuracy of diagnosis on initial admission</td>
<td>Highly unlikely to affect HSMR</td>
</tr>
<tr>
<td>Palliative and end-of-life care</td>
<td>Highly unlikely to affect HSMR</td>
</tr>
<tr>
<td>Quality and timeliness of discharge documentation</td>
<td>May be impacting on HSMR through impact on submission of SMR01 records</td>
</tr>
<tr>
<td>Late submission of SMR01 records</td>
<td>Affects HSMR based on initial submission (some correction in the revised submission)</td>
</tr>
</tbody>
</table>

Deaths in Lanarkshire acute hospitals
There is no single benchmark that determines whether there is a mis-specification of the HSMR observed and predicted deaths for a given hospital. To examine this, Tables 5.1.2 and 5.1.3 provide information on total deaths (in and out of hospital) in the catchment populations for each Lanarkshire acute hospital for comparison purposes. The catchment populations for each acute hospital were obtained from the NHS Lanarkshire Change and Innovation Department.

Table 5.1.2
HSMR observed and predicted deaths and total deaths, 2012: comparison within NHS Lanarkshire

<table>
<thead>
<tr>
<th></th>
<th>Hairmyres</th>
<th>Monklands</th>
<th>Wishaw</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>HSMR predicted deaths: number (%) of NHSL total</td>
<td>999 (34%)</td>
<td>936 (32%)</td>
<td>1021 (35%)</td>
<td>2956 (100%)</td>
</tr>
<tr>
<td>HSMR observed deaths: number (%) of NHSL total</td>
<td>927 (32%)</td>
<td>982 (34%)</td>
<td>965 (34%)</td>
<td>2874 (100%)</td>
</tr>
<tr>
<td>Total deaths by catchment population: number (%) of NHSL total</td>
<td>1881 (29%)</td>
<td>2384 (37%)</td>
<td>2123 (33%)</td>
<td>6388 (100%)</td>
</tr>
</tbody>
</table>

Table 5.1.3
HSMR observed and predicted deaths and total deaths, 2012: comparison with Scotland

<table>
<thead>
<tr>
<th></th>
<th>Hairmyres</th>
<th>Monklands</th>
<th>Wishaw</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>HSMR predicted deaths: number (%) of Scotland total</td>
<td>999 (3.4%)</td>
<td>936 (3.1%)</td>
<td>1021 (3.4%)</td>
<td>2956 (9.9%)</td>
</tr>
<tr>
<td>HSMR observed deaths: number (%) of Scotland total</td>
<td>927 (3.5%)</td>
<td>982 (3.7%)</td>
<td>965 (3.6%)</td>
<td>2874 (10.8%)</td>
</tr>
<tr>
<td>Total deaths by catchment population: number (%) of Scotland total</td>
<td>1881 (3.4%)</td>
<td>2384 (4.3%)</td>
<td>2123 (3.9%)</td>
<td>6388 (11.6%)</td>
</tr>
</tbody>
</table>
Compared to Wishaw General and Hairmyres, Monklands seems to have the lowest predicted HSMR deaths as a proportion and the highest observed HSMR deaths as a proportion. However, even higher again is the proportion of the total deaths (in and out of hospital) that occur in the Monklands catchment population. The Scottish HSMR tool does not adjust for deprivation (unlike England) and it would be interesting to note if such an adjustment would significantly alter the persistent outlier status of Monklands.

**Key Points**

- Where HSMR flags up higher than expected mortality this may be due to deficiencies in the organisation of hospital care or due to deficiencies in the HSMR tool.
- If trusted evidence exists to show that processes of care are not the main contributor to a flagged HSMR level, the balance of probabilities will swing towards deficiencies in the HSMR tool, albeit that these deficiencies will not necessarily be remediable.

**Priorities for Action**

- A consistent approach to monitoring HSMR will be required until the end of 2015 because the Scottish Government patient safety programme target in relation to reducing HSMR at national level will require regular reporting until this time.
- After the end of 2015 the following issues should be considered in any revisions to the HSMR model:
  - Incorporate co-morbidities information from the current hospital admission to replace the use of co-morbidities information from the previous hospital admission.
  - Adjust HSMR data for socio-economic deprivation in Scotland, particularly to assess the impact on Monklands Hospital.

**References**


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5.2 A Review of NHS Homoeopathy Services in Lanarkshire

Background

NHS Lanarkshire contracts with NHS Greater Glasgow and Clyde for services from the Homoeopathic Hospital (now the Centre for Integrative Care or CIC). This includes homoeopathy but also other interventions such as mindfulness-based cognitive therapy (MBCT), HeartMath – a form of biofeedback, mistletoe for adverse effects of cancer treatment, and music and movement therapy. In 2012/13, 148 new outpatients and an estimated 890 return outpatients used the CIC, down from 179 and 1,076 respectively in 2011/12.

The Lanarkshire Homoeopathy Review Project Group was set up in November 2012 to review homoeopathy service use in Lanarkshire. Reviewing services is important because if they are not effective, resources are denied for other, more effective treatments.

Evidence gathered

The Group gathered evidence which included:

- A literature review including systematic reviews and meta-analyses (analyses of existing studies) on the therapies noted above.
- A survey of patients’ views using a modified Care Measure questionnaire.
- A survey of Lanarkshire GPs’ views using SurveyMonkey.
- A description of outpatient and inpatient, including the types of interventions used at the CIC and patient assessment.

Results

The literature review found that the evidence was either weak or lacking for homoeopathy, MBCT, HeartMath, mistletoe extracts for cancer patients, and music and movement therapy. Of 153 questionnaires from service users, 107 (69.9%) were completed. Of those, 76 (71.0%) were aged over 45, 74 (69.2%) had a disability or long-term condition, and 94 (87.9%) said the treatment made them feel better.

Of 57 GPs who replied (15.4%) out of a total of 370. Of those who replied, 19 (33.3%) rated the service of good/great value, 26 (45.6%) rated it of no/little value, and 12 (21.1%) were neutral. If homoeopathy services were not available, 34 GPs would refer patients to pain management, counselling, psychology, acupuncture or cognitive behavioural therapy.

The CIC produced three reports. The first reported on usage of therapies by 388 patients: 179 (46.1%) received homoeopathic treatment as part of a package of care, 129 (33.2%) received only homoeopathic treatment, and 80 (20.6%) received other care not including homoeopathic treatment. The second reported on 60 patients who attended the Wellness Enhancement and Learning (WEL) programme: 43 (71.7%) felt the programme was necessary for recovery, 44 (73.3%) felt it had a positive impact on their sense of wellbeing, 31 (51.7%) felt it had a positive impact on their physical symptoms, and 44 (73.3%) felt that it had a positive impact on their ability to cope with
stress. The third reported on assessments of homoeopathic intervention in new patients using the ‘Measure Yourself Medical Outcome Profile’ (MYMOP) questionnaire. In all four self-assessment measures, patients had reported improvements in the severity of main and second symptoms, wellbeing, and activity.

Conclusions
The findings from the literature are clear – there is insufficient or no evidence for homoeopathy or for the other interventions. The GP response rate is low but only a third rated the service of value. However, the treatments offered by the CIC are popular with patients. This highlights the issue when different aspects of quality run counter to one another, i.e. in this case ‘effectiveness’ (the treatments are ineffective) against ‘patient-centred’ (treatments that are popular with patients).

This work is now in the next phase. As agreed with Scottish Health Council, NHS Lanarkshire is engaging with stakeholders and sharing with them the findings of our work before a final decision is made.

Key Points
• There is little or no evidence in the literature for the effectiveness of a range of treatments provided by the CIC.
• The relatively small number of patients using CIC services state their health has improved.

Priorities for Action
• Collate the outcome of the engagement process.
• Conclude the process with a decision by Lanarkshire NHS Board on services provided by the CIC.

References
1 Homoeopathy Services for Lanarkshire Residents. Report of the Lanarkshire Homoeopathy Review Project Group to the NHS Lanarkshire Modernisation Board. 5 August 2013.

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Acknowledgements:
My thanks to colleagues in NHS Lanarkshire who helped in the review – Isobel Frize, Planning Manager and Colin Lauder, Head of Planning and Development.
The Health Service Response to a Rise in Cases of Syphilis

Syphilis is a sexually transmitted bacterial infection. Infectious early syphilis has re-emerged as an important disease in the UK, mostly among men who have sex with men but also among young heterosexuals.1,2

People may not always be aware they have syphilis infection. Those with symptoms may present to many services with a variety of clinical presentations. Syphilis is relatively easy to treat and cure. If left untreated, patients may develop severe, life-threatening disease five to thirty years later.3

An increase in the number of cases of syphilis diagnosed in Lanarkshire in 2012 among young heterosexuals led to the establishment of an incident management team which developed and implemented a syphilis prevention and control plan.4

Epidemiology of cases diagnosed during 2012 and 2013

During 2012 and 2013, 48 cases of syphilis were diagnosed – there were 20 females and 28 males, 56% of whom were less than 25 years old. Sexuality was heterosexual for 34 (20 females and 14 males), and MSM (men who have sex with men) or bisexual for 14 males.

Data for stage of syphilis at diagnosis shows a reduction in cases of primary and secondary syphilis and an increase in early and late latent syphilis.

Table 5.3.1
Stage of syphilis by year of diagnosis

<table>
<thead>
<tr>
<th>Stage</th>
<th>2012</th>
<th>2013</th>
<th>2012–2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary and secondary</td>
<td>15</td>
<td>11</td>
<td>26</td>
</tr>
<tr>
<td>Early and late latent</td>
<td>6</td>
<td>15</td>
<td>21</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>21</td>
<td>27</td>
<td>48</td>
</tr>
</tbody>
</table>

Source: National Sexual Health IT System (NaSH)

Syphilis may be transmitted to the fetus during pregnancy. High levels of antenatal testing for syphilis have been achieved. No cases of congenital syphilis have been diagnosed.

The Sexual Health Promotion Team

Key messages – to raise awareness of syphilis, to encourage testing, treatment and partner notification, and to promote prevention – were communicated to target populations by:

- Distribution of a leaflet to the service users of partner services.
- Dissemination of a detailed information sheet for staff working with target populations.
- Website www.lanarkshiresexualhealth.org updated with information and details of services.
- Questionnaire used to ascertain what prompted clinic attendance.
- Facebook advertising – encouraging those at risk to attend for testing.
- Letter sent to parents of pupils in secondary school years four to six
(S4 to S6) about key messages and planned input.

- Delivery of key messages to all S4 to S6 pupils in 44 secondary schools following discussion with education departments and the Scottish Catholic Education Service.

The Clinical Sexual Health Service
The NHS Lanarkshire Clinical Sexual Health Service has:

- Raised awareness among clinicians of the increase in cases and the indications for testing.
- Increased the provision of clinics for young people, set up quick check clinics and performed partner notification for all cases.
- Provided additional education and training.
- Expanded outreach work to engage with young people.

Key Points

- Syphilis can cause severe and life threatening disease.
- Syphilis increased among young heterosexuals in Lanarkshire in 2012 and 2013.
- A syphilis prevention and control plan was implemented.

Priorities for Action

- Awareness raising of the risk of syphilis, prevention measures and testing should continue.
- Sexual health services should be developed to improve access and increase capacity to diagnose people with syphilis.
- High levels of antenatal screening for syphilis should be maintained.

References

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Acknowledgement: Members of the Syphilis Incident Management Team
Reshaping Care for Older People

Background
Reshaping Care for Older People is a Scottish Government policy aimed at supporting an increasing proportion of older people at home, in keeping with the wishes of most older people. It requires that NHS boards, local authorities, third and independent sectors work in partnership along with older people and carers.

People in Lanarkshire are living longer and, generally, healthier lives. This means older people will make up a greater proportion of the population. Over the next 20 years, the number of adults aged 65 years and over is expected to double. Research shows that older people would prefer to remain in their own home, with support, if they are unable to look after themselves. The aim is to shift the balance of care so older people can live full, independent and positive lives in their own homes or a homely setting.

Demography – life expectancy
The shift in life expectancy, and the corresponding relative increase in years that people may expect to live in poor health, has implications for the way we support older people. The majority of people being admitted to hospital are aged 70 years and over. The highest proportional growth in our communities will be in those aged 80 years and over.

Healthy life expectancy estimates the number of years that men and women can expect to live in good health and, by implication, the number of years they might expect to live in poor health due to illness or disability. For example, in South Lanarkshire women can expect to live 55.6 years without a long-term condition. This means that these women may expect twenty years or more of life with a long-term condition.

Reshaping care pathway
The Scottish Government identified four key areas or ‘pillars’ to which investment was to be directed (see Figure 5.4.1). In determining these pillars, it is recognised that it is just as important to facilitate local communities to have networks of support in place for older people as well as to have targeted services when these are required.

After a period of extensive consultation, North and South Lanarkshire partners agreed their respective Joint Strategic Commissioning Plans 2013–2023. The plans outline partnership intentions in the provision and purchase of older people’s services within integrated health and social care services.

Figure 5.4.1
The four pillars of the reshaping care pathway

- Community capacity building
- Support for carers
- Preventative and anticipatory care
- Proactive care and support at home
- Effective care at times of transition
- Hospital and care homes
Key Points

- The proportion of older adults in the population is increasing.
- Reshaping Care for Older People aims to support more older people at home.
- Both North and South Lanarkshire Partnerships have agreed plans which outline how they will deliver older people’s services.

Priorities for Action

North Lanarkshire:
- Implementation of Community Capacity Building and Support for Carers Strategy.
- Implementation of a locality model for older people’s services in a whole-system outcome-based approach.
- Proactively supporting the workforce.

South Lanarkshire:
- Providing integrated health and social care support in people’s own homes.
- Developing enhanced models of shared and intermediate care in the community.
- Supporting older people to die well in their own home if that is their preferred place of death.

References


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Statistical Appendix

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A17 Dental registrations and participation. Dental health of children
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General notes:

- Lanarkshire has two Community Health Partnerships (CHPs) – North Lanarkshire and South Lanarkshire. The CHPs cover the same geographical areas as North Lanarkshire Council and South Lanarkshire Council. There are ten localities within the CHPs – six in North Lanarkshire (Airdrie, Coatbridge, North, Bellshill, Motherwell and Wishaw) and four in South Lanarkshire (Cambuslang/Rutherglen, East Kilbride, Clydesdale and Hamilton) – see map on page iv. The geographical area covered by NHS Lanarkshire is smaller than the combined CHP areas as Cambuslang/Rutherglen locality and part of the North locality (the Northern Corridor) lie within NHS Greater Glasgow and Clyde. Therefore people living in Cambuslang, Rutherglen and the Northern Corridor are residents of the NHS Greater Glasgow and Clyde area but have some of their health services delivered by NHS Lanarkshire through the CHPs. The tables in the Statistical Appendix indicate whether information relates to the Lanarkshire CHPs or NHS Lanarkshire. On 1 April 2014, changes to NHS board boundaries resulted in NHS Lanarkshire becoming coterminous with the CHPs and local authorities. This will be reflected in next year’s annual report.
- Populations shown and used in rates calculations are, for NHS Lanarkshire, the CHPs and Scotland, mid-year estimates produced by National Records of Scotland (NRS). Locality populations are from NRS small area population estimates at data zone level.

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A1
**Sociodemographic summary by locality/CHP**

<table>
<thead>
<tr>
<th>Locality</th>
<th>Airdrie</th>
<th>Coatbridge</th>
<th>North</th>
<th>Bellshill</th>
<th>Motherwell</th>
<th>Wishaw</th>
<th>Cambusbarron/Rutherglen</th>
<th>East Kilbride</th>
<th>Clydebank</th>
<th>Hamilton</th>
<th>Lanarkshire CHPs</th>
<th>NHS Lanarkshire</th>
<th>Scotland</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated population, 2013 No.</td>
<td>57959</td>
<td>49500</td>
<td>84521</td>
<td>48826</td>
<td>41635</td>
<td>55289</td>
<td>58934</td>
<td>88437</td>
<td>61568</td>
<td>105913</td>
<td>337730</td>
<td>314850</td>
<td>852580</td>
</tr>
<tr>
<td>Estimated population by age group, 2013</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Under 5 %</td>
<td>6.1</td>
<td>6.2</td>
<td>5.7</td>
<td>5.5</td>
<td>6.4</td>
<td>5.8</td>
<td>6.1</td>
<td>5.2</td>
<td>5.2</td>
<td>5.6</td>
<td>5.9</td>
<td>5.6</td>
<td>5.7</td>
</tr>
<tr>
<td>5-14 %</td>
<td>12.0</td>
<td>11.9</td>
<td>12.2</td>
<td>12.0</td>
<td>11.6</td>
<td>11.3</td>
<td>10.7</td>
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<td>10.9</td>
<td>11.3</td>
</tr>
<tr>
<td>15-24 %</td>
<td>12.4</td>
<td>12.4</td>
<td>12.4</td>
<td>12.7</td>
<td>11.8</td>
<td>12.1</td>
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<td>12.3</td>
<td>11.1</td>
<td>11.5</td>
<td>12.4</td>
<td>11.7</td>
<td>12.1</td>
</tr>
<tr>
<td>25-44 %</td>
<td>26.6</td>
<td>27.5</td>
<td>25.6</td>
<td>26.3</td>
<td>27.9</td>
<td>26.3</td>
<td>27.1</td>
<td>23.7</td>
<td>23.5</td>
<td>26.1</td>
<td>26.5</td>
<td>25.1</td>
<td>25.8</td>
</tr>
<tr>
<td>45-64 %</td>
<td>27.4</td>
<td>26.9</td>
<td>28.1</td>
<td>28.6</td>
<td>25.9</td>
<td>27.3</td>
<td>28.2</td>
<td>29.6</td>
<td>30.3</td>
<td>28.2</td>
<td>27.5</td>
<td>29.0</td>
<td>28.2</td>
</tr>
<tr>
<td>65-74 %</td>
<td>9.2</td>
<td>8.3</td>
<td>9.7</td>
<td>9.5</td>
<td>8.9</td>
<td>9.3</td>
<td>9.1</td>
<td>9.5</td>
<td>10.9</td>
<td>10.3</td>
<td>9.2</td>
<td>9.9</td>
<td>9.5</td>
</tr>
<tr>
<td>75 and over %</td>
<td>6.2</td>
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<td>6.3</td>
<td>5.9</td>
<td>7.2</td>
<td>7.8</td>
<td>7.5</td>
<td>8.5</td>
<td>8.4</td>
<td>7.5</td>
<td>6.7</td>
<td>6.0</td>
<td>7.3</td>
</tr>
</tbody>
</table>

Proportion of data zones in the 15% most deprived data zones in Scotland, 2012

| No. | 28.8 | 40.0 | 5.7 | 25.0 | 20.2 | 30.4 | 28.2 | 0.0 | 5.0 | 22.1 | 23.9 | 13.3 | 18.8 | 18.2 | 15.0 |

Population of data zones in the 15% most deprived data zones in Scotland, 2013

| No. | 15135 | 18368 | 4722 | 12511 | 10114 | 16024 | 15575 | 0 | 3374 | 22395 | 76874 | 41344 | 118218 | 101982 | 760985 |

Housing tenure, 2011

| % | 61.4 | 57.1 | 70.4 | 59.2 | 54.2 | 55.8 | 85.5 | 73.8 | 67.7 | 65.8 | 60.8 | 68.3 | 64.5 | 64.1 | 62.0 |
| % | 30.4 | 34.7 | 20.3 | 34.1 | 38.0 | 37.1 | 25.9 | 16.7 | 23.7 | 24.9 | 31.1 | 22.6 | 27.0 | 27.3 | 24.3 |
| % | 7.5 | 7.5 | 8.6 | 6.1 | 7.2 | 6.3 | 7.9 | 8.7 | 7.2 | 8.5 | 7.3 | 8.2 | 7.7 | 7.8 | 12.4 |
| % | 0.7 | 0.6 | 0.7 | 0.7 | 0.6 | 0.8 | 0.7 | 0.8 | 1.4 | 0.8 | 0.7 | 0.9 | 0.8 | 1.3 | 0.8 |

Unemployment, April 2014

| No. | 1239 | 1480 | 1565 | 1443 | 1112 | 1459 | 1357 | 1420 | 1104 | 2867 | 8798 | 6748 | 15648 | 113661 | 105397 |
| % | 4.7 | 4.5 | 2.8 | 4.4 | 4.1 | 4.1 | 4.5 | 2.5 | 2.8 | 4.2 | 4.0 | 3.3 | 3.7 | 3.7 | 3.0 |

Long-term unemployment (1 year plus), April 2014

| % | 1.0 | 1.5 | 0.7 | 1.3 | 1.4 | 1.4 | 1.0 | 0.6 | 1.0 | 1.3 | 1.2 | 1.0 | 1.1 | 1.1 | 0.9 |

1 The 15% most deprived data zones in Scotland are from the Scottish Index of Multiple Deprivation (SIMD) 2012.
2 Populations are mid-2013 small area population estimates (SAPE) from NHS.
3 Housing tenure figures are from the 2011 Census and are based on the number of households rather than the number of dwellings.
4 Numbers claiming Jobseeker’s Allowance as a percentage of the population aged 16-64. Sources: National Records of Scotland, SIMD, Scottish Government, North Lanarkshire Council, South Lanarkshire Council.
A2

Estimated population
by age group and locality/CHP: 2013

| Age group | Airdris | Coatbridge | North | Bellshill | Motherwell | Wishaw | Cambuslang | Rutherglen | East Kilbride | Clydeholm | Hamilton | Lanarkshire | NHS Lanarkshire | Male | Female | Total |
|-----------|---------|------------|-------|-----------|------------|--------|------------|------------|--------------|------------|----------|-----------|--------------|----------------|------|--------|-------|
| Under 5   | 3512    | 3082       | 4830  | 2708      | 2645       | 3194   | 3589       | 4026       | 3173         | 5913       | 19971    | 17301     | 37272       | 16513          | 15831 | 32344  |
| 5-9       | 3464    | 3018       | 5201  | 2812      | 2463       | 3210   | 3279       | 4865       | 3208         | 5900       | 20268    | 17252     | 37520       | 16855          | 15990 | 32145  |
| 10-14     | 3517    | 2887       | 5129  | 2036      | 2357       | 3046   | 3020       | 5079       | 3388         | 5589       | 19538    | 16963     | 36501       | 16263          | 15832 | 32195  |
| 15-19     | 3642    | 2991       | 5311  | 3040      | 2442       | 3156   | 3238       | 5446       | 3633         | 5994       | 20916    | 18424     | 39340       | 18045          | 16832 | 34877  |
| 20-24     | 3571    | 3134       | 5173  | 3178      | 2500       | 3555   | 3446       | 5429       | 3162         | 6204       | 21111    | 18261     | 39372       | 17546          | 17205 | 34751  |
| 25-29     | 3587    | 3158       | 4737  | 3168      | 2749       | 3711   | 3546       | 4765       | 3000         | 6405       | 21110    | 17746     | 38856       | 16625          | 17537 | 34162  |
| 30-34     | 3905    | 3378       | 5195  | 3189      | 2932       | 3617   | 4291       | 4882       | 3276         | 6834       | 22214    | 19083     | 41297       | 17389          | 18462 | 35831  |
| 35-39     | 3550    | 3225       | 5392  | 2911      | 2731       | 3245   | 3558       | 4872       | 3613         | 6423       | 21054    | 18766     | 39820       | 16811          | 17555 | 34366  |
| 40-44     | 4087    | 3775       | 6297  | 3579      | 3218       | 3891   | 4452       | 6428       | 4566         | 7534       | 25655    | 23380     | 48625       | 20572          | 21914 | 42846  |
| 45-49     | 4686    | 3910       | 6897  | 3854      | 3395       | 4335   | 4460       | 7530       | 5002         | 8283       | 27057    | 25275     | 52323       | 22278          | 23768 | 46046  |
| 50-54     | 4220    | 3662       | 6256  | 3638      | 2903       | 3994   | 4429       | 7622       | 4866         | 7899       | 24801    | 24816     | 49687       | 21105          | 22531 | 46396  |
| 55-59     | 3642    | 3069       | 5461  | 3327      | 2463       | 3599   | 4154       | 6386       | 4553         | 7187       | 21561    | 21980     | 43541       | 16333          | 16880 | 30663  |
| 60-64     | 3369    | 2699       | 5121  | 2947      | 2036       | 3173   | 3888       | 4996       | 4239         | 6492       | 19221    | 162214    | 38496       | 16303          | 17405 | 33708  |
| 65-69     | 2098    | 2185       | 4750  | 2543      | 2097       | 2897   | 3075       | 4578       | 3808         | 6223       | 17440    | 17684     | 35124       | 14747          | 16196 | 30443  |
| 70-74     | 2346    | 1835       | 3464  | 1820      | 1713       | 2227   | 2268       | 3761       | 2891         | 4664       | 13505    | 13624     | 27129       | 10807          | 13218 | 24025  |
| 75-79     | 1789    | 1526       | 2615  | 1236      | 1228       | 1955   | 1988       | 3223       | 2178         | 3718       | 10549    | 11017     | 21566       | 9001           | 11024 | 10805  |
| 80-84     | 1100    | 1049       | 1661  | 918       | 912        | 1388   | 1383       | 2402       | 1613         | 2411       | 7028     | 7809      | 14837       | 5186           | 7908  | 13066  |
| 85 and over | 730    | 819        | 1051  | 642       | 753        | 996    | 1140       | 1897       | 1378         | 1940       | 4991     | 6255      | 11246       | 3119           | 6692  | 9811   |
| All ages  | 57959   | 49500      | 84521 | 48826     | 41635      | 65289  | 58934      | 88437      | 61566        | 105913     | 337730   | 314850    | 652580      | 276620         | 295680 | 672300 |

Source: National Records of Scotland
### Projected population

NHS Lanarkshire residents by age group and sex: 2023 and 2033 (2012-based)

<table>
<thead>
<tr>
<th>Age group</th>
<th>2023</th>
<th>2033</th>
<th>Source: National Records of Scotland</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td>Both sexes</td>
</tr>
<tr>
<td>Under 5</td>
<td>15984</td>
<td>15159</td>
<td>31143</td>
</tr>
<tr>
<td>5-9</td>
<td>16311</td>
<td>15549</td>
<td>31860</td>
</tr>
<tr>
<td>10-14</td>
<td>16708</td>
<td>16254</td>
<td>32962</td>
</tr>
<tr>
<td>15-19</td>
<td>16767</td>
<td>15856</td>
<td>32623</td>
</tr>
<tr>
<td>20-24</td>
<td>15729</td>
<td>15136</td>
<td>30865</td>
</tr>
<tr>
<td>25-29</td>
<td>17260</td>
<td>16290</td>
<td>33550</td>
</tr>
<tr>
<td>30-34</td>
<td>17156</td>
<td>17166</td>
<td>34322</td>
</tr>
<tr>
<td>35-39</td>
<td>16702</td>
<td>17628</td>
<td>34330</td>
</tr>
<tr>
<td>40-44</td>
<td>17548</td>
<td>18211</td>
<td>35759</td>
</tr>
<tr>
<td>45-49</td>
<td>16692</td>
<td>17279</td>
<td>33971</td>
</tr>
<tr>
<td>50-54</td>
<td>20147</td>
<td>21579</td>
<td>41726</td>
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<tr>
<td>55-59</td>
<td>21569</td>
<td>23113</td>
<td>44682</td>
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<tr>
<td>60-64</td>
<td>19749</td>
<td>21367</td>
<td>41116</td>
</tr>
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<td>65-69</td>
<td>16287</td>
<td>18074</td>
<td>34361</td>
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<tr>
<td>70-74</td>
<td>13390</td>
<td>15316</td>
<td>28706</td>
</tr>
<tr>
<td>75-79</td>
<td>10887</td>
<td>13321</td>
<td>24208</td>
</tr>
<tr>
<td>80-84</td>
<td>6661</td>
<td>9539</td>
<td>16200</td>
</tr>
<tr>
<td>85 and over</td>
<td>5730</td>
<td>10101</td>
<td>15831</td>
</tr>
<tr>
<td>All ages</td>
<td>281277</td>
<td>296938</td>
<td>578215</td>
</tr>
</tbody>
</table>
### Births

**NHS Lanarkshire residents by year: 2004–2013**

<table>
<thead>
<tr>
<th>Year</th>
<th>Live births</th>
<th>Stillbirths</th>
<th>All births (live and still)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>6497</td>
<td>35</td>
<td>6532</td>
</tr>
<tr>
<td>2005</td>
<td>6283</td>
<td>33</td>
<td>6316</td>
</tr>
<tr>
<td>2006</td>
<td>6584</td>
<td>38</td>
<td>6622</td>
</tr>
<tr>
<td>2007</td>
<td>6548</td>
<td>32</td>
<td>6580</td>
</tr>
<tr>
<td>2008</td>
<td>6848</td>
<td>36</td>
<td>6884</td>
</tr>
<tr>
<td>2009</td>
<td>6575</td>
<td>44</td>
<td>6619</td>
</tr>
<tr>
<td>2010</td>
<td>6445</td>
<td>36</td>
<td>6619</td>
</tr>
<tr>
<td>2011</td>
<td>6502</td>
<td>29</td>
<td>6481</td>
</tr>
<tr>
<td>2012</td>
<td>6145</td>
<td>24</td>
<td>6531</td>
</tr>
<tr>
<td>2013</td>
<td>6068</td>
<td>20</td>
<td>6169</td>
</tr>
</tbody>
</table>

**General fertility rate (GFR)** – live births per 1,000 women aged 15–44

<table>
<thead>
<tr>
<th>Year</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>54.8</td>
</tr>
<tr>
<td>2005</td>
<td>53.3</td>
</tr>
<tr>
<td>2006</td>
<td>56.1</td>
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<tr>
<td>2007</td>
<td>55.9</td>
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<tr>
<td>2008</td>
<td>58.8</td>
</tr>
<tr>
<td>2009</td>
<td>57.0</td>
</tr>
<tr>
<td>2010</td>
<td>56.6</td>
</tr>
<tr>
<td>2011</td>
<td>57.7</td>
</tr>
<tr>
<td>2012</td>
<td>55.2</td>
</tr>
<tr>
<td>2013</td>
<td>55.4</td>
</tr>
</tbody>
</table>

Source: National Records of Scotland
## Births, perinatal deaths, neonatal deaths and infant deaths

**CHPs, Lanarkshire and Scotland: 2011–2013 (3-year average)**

<table>
<thead>
<tr>
<th></th>
<th>CHP</th>
<th>North</th>
<th>South</th>
<th>Lanarkshire CHPs</th>
<th>NHS Lanarkshire</th>
<th>Scotland</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Live births</strong> No.</td>
<td></td>
<td>3824</td>
<td>3383</td>
<td>7207</td>
<td>6238</td>
<td>57544</td>
</tr>
<tr>
<td><strong>Rate</strong>¹</td>
<td></td>
<td>56.4</td>
<td>56.9</td>
<td>56.6</td>
<td>56.0</td>
<td>54.7</td>
</tr>
<tr>
<td><strong>Stillbirths</strong> No.</td>
<td></td>
<td>14</td>
<td>13</td>
<td>28</td>
<td>24</td>
<td>269</td>
</tr>
<tr>
<td><strong>Rate</strong>²</td>
<td></td>
<td>3.7</td>
<td>3.9</td>
<td>3.8</td>
<td>3.9</td>
<td>4.7</td>
</tr>
<tr>
<td><strong>All births (live and still) No.</strong></td>
<td></td>
<td>3838</td>
<td>3396</td>
<td>7234</td>
<td>6263</td>
<td>57813</td>
</tr>
<tr>
<td><strong>Rate</strong>¹</td>
<td></td>
<td>56.6</td>
<td>57.1</td>
<td>56.8</td>
<td>56.2</td>
<td>55.0</td>
</tr>
<tr>
<td><strong>Perinatal deaths³</strong> No.</td>
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<td>24</td>
<td>18</td>
<td>41</td>
<td>37</td>
<td>372</td>
</tr>
<tr>
<td><strong>Rate</strong>²</td>
<td></td>
<td>6.2</td>
<td>5.2</td>
<td>5.7</td>
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<td>6.4</td>
</tr>
<tr>
<td><strong>Neonatal deaths⁴</strong> No.</td>
<td></td>
<td>12</td>
<td>7</td>
<td>19</td>
<td>17</td>
<td>146</td>
</tr>
<tr>
<td><strong>Rate</strong>⁵</td>
<td></td>
<td>3.1</td>
<td>2.1</td>
<td>2.6</td>
<td>2.7</td>
<td>2.5</td>
</tr>
<tr>
<td><strong>Infant deaths⁶</strong> No.</td>
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<td>16</td>
<td>8</td>
<td>24</td>
<td>22</td>
<td>214</td>
</tr>
<tr>
<td><strong>Rate</strong>⁵</td>
<td></td>
<td>4.3</td>
<td>2.4</td>
<td>3.4</td>
<td>3.6</td>
<td>3.7</td>
</tr>
</tbody>
</table>

1 Rate per 1,000 women aged 15–44.
2 Rate per 1,000 births.
3 Stillbirths and deaths in the first week of life.
4 Deaths at ages under 28 days.
5 Rate per 1,000 live births.
6 Deaths during first year of life.

Source: National Records of Scotland
# A6

## Deaths from all causes

NHS Lanarkshire residents by sex, age group and year: 2004–2013

<table>
<thead>
<tr>
<th>Number</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males</td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;75 years</td>
<td>1540</td>
<td>1569</td>
<td>1560</td>
<td>1610</td>
<td>1507</td>
<td>1461</td>
<td>1447</td>
<td>1409</td>
<td>1451</td>
<td>1388</td>
</tr>
<tr>
<td>75+ years</td>
<td>1288</td>
<td>1284</td>
<td>1272</td>
<td>1461</td>
<td>1345</td>
<td>1280</td>
<td>1391</td>
<td>1354</td>
<td>1409</td>
<td>1500</td>
</tr>
<tr>
<td>All ages</td>
<td>2828</td>
<td>2853</td>
<td>2832</td>
<td>3071</td>
<td>2852</td>
<td>2741</td>
<td>2838</td>
<td>2763</td>
<td>2860</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;75 years</td>
<td>1126</td>
<td>1056</td>
<td>1078</td>
<td>1100</td>
<td>1099</td>
<td>1053</td>
<td>1080</td>
<td>1046</td>
<td>1063</td>
<td>1037</td>
</tr>
<tr>
<td>All ages</td>
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<td>3025</td>
<td>3053</td>
<td>3121</td>
<td>3176</td>
<td>3030</td>
<td>3078</td>
<td>3089</td>
<td>3190</td>
<td>3079</td>
</tr>
<tr>
<td>Both sexes</td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;75 years</td>
<td>2666</td>
<td>2625</td>
<td>2638</td>
<td>2710</td>
<td>2606</td>
<td>2514</td>
<td>2527</td>
<td>2455</td>
<td>2514</td>
<td>2425</td>
</tr>
<tr>
<td>75+ years</td>
<td>3327</td>
<td>3253</td>
<td>3247</td>
<td>3482</td>
<td>3422</td>
<td>3257</td>
<td>3389</td>
<td>3397</td>
<td>3536</td>
<td>3542</td>
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<tr>
<td>All ages</td>
<td>5993</td>
<td>5878</td>
<td>5885</td>
<td>6192</td>
<td>6028</td>
<td>5771</td>
<td>5916</td>
<td>5852</td>
<td>6050</td>
<td>5967</td>
</tr>
</tbody>
</table>

## Standardised mortality ratio (SMR) – both sexes (Scotland=100)

![Standardised mortality ratio graph](source: National Records of Scotland)
### Deaths from all causes by sex, age group and locality/CHP: 2013

#### Number

<table>
<thead>
<tr>
<th>Locality</th>
<th>Airdrie</th>
<th>Coatbridge</th>
<th>North</th>
<th>Bellshill</th>
<th>Motherwell</th>
<th>Wishaw</th>
<th>Cambuslang/ Rutherglen</th>
<th>East Kilbride</th>
<th>Clydesdale</th>
<th>Hamilton</th>
<th>North</th>
<th>South</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Males</strong>&lt;75 years</td>
<td>159</td>
<td>138</td>
<td>189</td>
<td>121</td>
<td>89</td>
<td>180</td>
<td>171</td>
<td>156</td>
<td>130</td>
<td>270</td>
<td>876</td>
<td>727</td>
</tr>
<tr>
<td>75+ years</td>
<td>121</td>
<td>144</td>
<td>194</td>
<td>131</td>
<td>113</td>
<td>146</td>
<td>155</td>
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#### Standardised mortality ratio (SMR) 1

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1 Scotland=100. Source: National Records of Scotland
A8

Deaths from malignant neoplasms
NHS Lanarkshire residents by sex, age group and year: 2004–2013

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**Standardised mortality ratio (SMR) – both sexes (Scotland=100)**

Source: National Records of Scotland
## Deaths from coronary heart disease

**NHS Lanarkshire residents by sex, age group and year: 2004–2013**

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### Standardised mortality ratio (SMR) – both sexes (Scotland=100)

![Graph showing standardised mortality ratio over years](image)

Source: National Records of Scotland
Deaths from cerebrovascular disease
NHS Lanarkshire residents by sex, age group and year: 2004–2013

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Standardised mortality ratio (SMR) – both sexes (Scotland=100)

Source: National Records of Scotland
## Deaths from respiratory disease
### NHS Lanarkshire residents by sex, age group and year: 2004–2013

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<td>308</td>
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<td>326</td>
<td>328</td>
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<td>All ages</td>
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<td>478</td>
<td>495</td>
<td>487</td>
<td>441</td>
<td>460</td>
<td>488</td>
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<tr>
<td><strong>Both sexes</strong></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>&lt;75 years</td>
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<td>211</td>
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<td>247</td>
<td>241</td>
<td>270</td>
<td>246</td>
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<tr>
<td>75+ years</td>
<td>518</td>
<td>527</td>
<td>526</td>
<td>609</td>
<td>609</td>
<td>584</td>
<td>557</td>
<td>545</td>
<td>618</td>
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<tr>
<td>All ages</td>
<td>776</td>
<td>747</td>
<td>783</td>
<td>820</td>
<td>874</td>
<td>831</td>
<td>798</td>
<td>815</td>
<td>864</td>
<td>855</td>
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</table>

### Standardised mortality ratio (SMR) – both sexes (Scotland=100)

Source: National Records of Scotland
### A12

**Expectation of life**<sup>1</sup>


<table>
<thead>
<tr>
<th></th>
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<th></th>
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<td>North CHP</td>
<td>South CHP</td>
<td>NHS Lanarkshire</td>
<td>Scotland</td>
<td>UK</td>
<td>North CHP</td>
<td>South CHP</td>
<td>NHS Lanarkshire</td>
<td>Scotland</td>
</tr>
<tr>
<td>Age</td>
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<td>33.9</td>
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<td>35.5</td>
<td>36.6</td>
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<td>75</td>
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<td>11.1</td>
<td>11.2</td>
<td>11.9</td>
<td>11.4</td>
<td>12.2</td>
</tr>
</tbody>
</table>

---

Life expectancy at birth - males

Life expectancy at birth - females

---

1 Expectation of life is the average number of years left to a person of an exact age who is subject to the current mortality probabilities from birth.

Sources: National Records of Scotland, Office for National Statistics
### Cancer registrations¹,²
NHS Lanarkshire residents by sex, age group and year: 2003–2012

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Number</strong></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Males</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;75 years</td>
<td>1186</td>
<td>1136</td>
<td>1157</td>
<td>1225</td>
<td>1212</td>
<td>1255</td>
<td>1366</td>
<td>1420</td>
<td>1391</td>
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<tr>
<td>75+ years</td>
<td>490</td>
<td>555</td>
<td>542</td>
<td>585</td>
<td>629</td>
<td>587</td>
<td>727</td>
<td>679</td>
<td>711</td>
<td>715</td>
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<td>All ages</td>
<td>1676</td>
<td>1691</td>
<td>1699</td>
<td>1810</td>
<td>1841</td>
<td>1842</td>
<td>2093</td>
<td>2099</td>
<td>2102</td>
<td>2037</td>
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<td><strong>Females</strong></td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;75 years</td>
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<td>1187</td>
<td>1182</td>
<td>1188</td>
<td>1276</td>
<td>1303</td>
<td>1394</td>
<td>1442</td>
<td>1447</td>
<td>1474</td>
</tr>
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<td>75+ years</td>
<td>561</td>
<td>633</td>
<td>665</td>
<td>596</td>
<td>662</td>
<td>682</td>
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<td>796</td>
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<tr>
<td>All ages</td>
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<td>1820</td>
<td>1847</td>
<td>1784</td>
<td>1938</td>
<td>1965</td>
<td>2101</td>
<td>2141</td>
<td>2192</td>
<td>2270</td>
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<tr>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;75 years</td>
<td>2299</td>
<td>2323</td>
<td>2339</td>
<td>2413</td>
<td>2488</td>
<td>2558</td>
<td>2760</td>
<td>2862</td>
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<tr>
<td>75+ years</td>
<td>1051</td>
<td>1188</td>
<td>1207</td>
<td>1181</td>
<td>1291</td>
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<td>1511</td>
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<tr>
<td>All ages</td>
<td>3350</td>
<td>3511</td>
<td>3546</td>
<td>3594</td>
<td>3779</td>
<td>3827</td>
<td>4194</td>
<td>4240</td>
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</table>

### Standardised incidence ratio – both sexes (Scotland=100)

1. Cancer registration is a dynamic process. The figures presented here may therefore differ from previously published information. 
2. Non-melanoma skin cancer registrations are included. 

Source: Scottish Cancer Registry, ISD
### Cancer registrations


<table>
<thead>
<tr>
<th>Year</th>
<th>Number</th>
<th>Trachea, bronchus and lung</th>
<th>Female breast</th>
<th>Large bowel</th>
<th>Prostate</th>
<th>Bladder</th>
<th>Stomach</th>
<th>Cervix</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>547</td>
<td>476</td>
<td>405</td>
<td>262</td>
<td>86</td>
<td>89</td>
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<td>2009</td>
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<td>507</td>
<td>418</td>
<td>269</td>
<td>93</td>
<td>82</td>
<td>39</td>
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</tr>
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</table>

**Standardised incidence ratio (2010–2012)**

#### Males

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Number</th>
<th>Trachea, bronchus and lung</th>
<th>Female breast</th>
<th>Large bowel</th>
<th>Prostate</th>
<th>Bladder</th>
<th>Stomach</th>
<th>Cervix</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;75 years</td>
<td>113.1</td>
<td>x</td>
<td>112.6</td>
<td>88.9</td>
<td>132.2</td>
<td>118.4</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>75+ years</td>
<td>112.9</td>
<td>x</td>
<td>95.8</td>
<td>93.1</td>
<td>97.2</td>
<td>124.1</td>
<td>x</td>
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</tr>
<tr>
<td>All ages</td>
<td>113.0</td>
<td>x</td>
<td>106.9</td>
<td>90.1</td>
<td>115.8</td>
<td>120.8</td>
<td>x</td>
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</table>

#### Females

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Number</th>
<th>Trachea, bronchus and lung</th>
<th>Female breast</th>
<th>Large bowel</th>
<th>Prostate</th>
<th>Bladder</th>
<th>Stomach</th>
<th>Cervix</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;75 years</td>
<td>110.6</td>
<td>102.1</td>
<td>103.5</td>
<td>x</td>
<td>115.1</td>
<td>93.9</td>
<td>112.5</td>
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<tr>
<td>75+ years</td>
<td>107.4</td>
<td>98.7</td>
<td>97.0</td>
<td>x</td>
<td>113.8</td>
<td>124.9</td>
<td>131.9</td>
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<tr>
<td>All ages</td>
<td>109.3</td>
<td>101.4</td>
<td>100.9</td>
<td>x</td>
<td>114.4</td>
<td>110.0</td>
<td>114.2</td>
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#### Both sexes

<table>
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<tr>
<th>Age Group</th>
<th>Number</th>
<th>Trachea, bronchus and lung</th>
<th>Female breast</th>
<th>Large bowel</th>
<th>Prostate</th>
<th>Bladder</th>
<th>Stomach</th>
<th>Cervix</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;75 years</td>
<td>111.9</td>
<td>102.1</td>
<td>108.7</td>
<td>88.9</td>
<td>127.2</td>
<td>110.0</td>
<td>112.5</td>
<td></td>
</tr>
<tr>
<td>75+ years</td>
<td>110.1</td>
<td>98.7</td>
<td>96.4</td>
<td>93.1</td>
<td>102.9</td>
<td>124.5</td>
<td>131.9</td>
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</tr>
<tr>
<td>All ages</td>
<td>111.2</td>
<td>101.4</td>
<td>104.1</td>
<td>90.1</td>
<td>115.3</td>
<td>116.6</td>
<td>114.2</td>
<td></td>
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</tbody>
</table>

---

1. Cancer registration is a dynamic process. The figures presented here may therefore differ from previously published information.  
2. Scotland=100.  
3. Not applicable.
### Cancer registrations¹

**by locality/CHP and site: 2012; standardised incidence ratios by locality/CHP, site and age group: 2010–2012**

<table>
<thead>
<tr>
<th>Age group</th>
<th>Locality</th>
<th>CHP</th>
<th>Lanarkshire</th>
<th>NHS Lanarkshire</th>
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<td>Airdrie</td>
<td>Coatbridge</td>
<td>North</td>
<td>Bellshill</td>
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<tr>
<td>Lung</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;75 years</td>
<td>115.9</td>
<td>123.4</td>
<td>100.7</td>
<td>132.0</td>
</tr>
<tr>
<td>75+ years</td>
<td>123.4</td>
<td>107.6</td>
<td>140.5</td>
<td>116.5</td>
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<tr>
<td>All ages</td>
<td>118.7</td>
<td>117.0</td>
<td>114.9</td>
<td>126.4</td>
</tr>
<tr>
<td>Female breast</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;75 years</td>
<td>99.7</td>
<td>103.9</td>
<td>97.3</td>
<td>108.1</td>
</tr>
<tr>
<td>75+ years</td>
<td>69.8</td>
<td>126.3</td>
<td>95.2</td>
<td>88.6</td>
</tr>
<tr>
<td>All ages</td>
<td>94.2</td>
<td>108.7</td>
<td>96.9</td>
<td>104.6</td>
</tr>
<tr>
<td>Large bowel</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;75 years</td>
<td>100.9</td>
<td>121.9</td>
<td>102.4</td>
<td>95.0</td>
</tr>
<tr>
<td>75+ years</td>
<td>104.2</td>
<td>105.2</td>
<td>97.1</td>
<td>98.3</td>
</tr>
<tr>
<td>All ages</td>
<td>93.7</td>
<td>101.1</td>
<td>99.4</td>
<td>109.1</td>
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<td>All cancers²</td>
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</tr>
<tr>
<td>&lt;75 years</td>
<td>96.0</td>
<td>104.0</td>
<td>98.0</td>
<td>90.9</td>
</tr>
<tr>
<td>75+ years</td>
<td>94.4</td>
<td>102.1</td>
<td>99.0</td>
<td>103.4</td>
</tr>
</tbody>
</table>

1 Cancer registration is a dynamic process. The figures presented here may therefore differ from previously published information. Source: Scottish Cancer Registry, ISD

2 All cancer sites, not just lung, female breast and large bowel. Non-melanoma skin cancer registrations are included.

3 Scotland=100.
### Notifiable diseases – confirmed notifications by year: 2009–2013

<table>
<thead>
<tr>
<th>Disease</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>Rate&lt;sup&gt;a&lt;/sup&gt;</th>
<th>2012</th>
<th>Rate&lt;sup&gt;a&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
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<td>Anthrax</td>
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<td>0</td>
<td>1</td>
<td>0</td>
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<td></td>
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<tr>
<td>Brucellosis</td>
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<td>1</td>
<td>0</td>
<td>1</td>
<td>0.2</td>
<td>0.0</td>
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</tr>
<tr>
<td>Cholera</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0.0</td>
<td>0.0</td>
<td></td>
</tr>
<tr>
<td>Haemolytic uraemic syndrome (HUS)</td>
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<td>0</td>
<td>1</td>
<td>0</td>
<td>0.0</td>
<td>0.0</td>
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<tr>
<td>Measles</td>
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<td>28</td>
<td>15</td>
<td>38</td>
<td>29</td>
<td>5.1</td>
<td>1.9</td>
<td></td>
</tr>
<tr>
<td>Meningococcal disease</td>
<td>22</td>
<td>12</td>
<td>21</td>
<td>9</td>
<td>16</td>
<td>2.8</td>
<td>1.7</td>
<td></td>
</tr>
<tr>
<td>Mumps</td>
<td>63</td>
<td>60</td>
<td>48</td>
<td>77</td>
<td>51</td>
<td>8.9</td>
<td>17.3</td>
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<tr>
<td>Necrotizing fascitis</td>
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<td>0</td>
<td>5</td>
<td>2</td>
<td>4</td>
<td>0.7</td>
<td>0.1</td>
<td></td>
</tr>
<tr>
<td>Pertussis (whooping cough)</td>
<td>13</td>
<td>5</td>
<td>7</td>
<td>259</td>
<td>327</td>
<td>57.1</td>
<td>38.9</td>
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<tr>
<td>Rubella</td>
<td>19</td>
<td>5</td>
<td>8</td>
<td>10</td>
<td>12</td>
<td>2.1</td>
<td>0.8</td>
<td></td>
</tr>
<tr>
<td>Tuberculosis (respiratory)</td>
<td>31</td>
<td>28</td>
<td>29</td>
<td>11</td>
<td>19</td>
<td>3.3</td>
<td>4.3</td>
<td></td>
</tr>
<tr>
<td>Tuberculosis (non-respiratory)</td>
<td>12</td>
<td>18</td>
<td>12</td>
<td>12</td>
<td>6</td>
<td>1.0</td>
<td>3.6</td>
<td></td>
</tr>
</tbody>
</table>

1 There were no notifications in Lanarkshire of the following diseases in the period shown: botulism, diphtheria, *Haemophilus influenzae* type b (Hib), paratyphoid, plague, poliomyelitis, rabies, SARS, smallpox, tetanus, tularemia, typhoid, viral haemorrhagic fevers, West Nile fever and yellow fever.

2 There were no notifications of clinical syndrome due to *E.coli* O157 infection. However, there were 13 cases of *E.coli* O157 infection in Lanarkshire in 2013. Figures on *E.coli* O157 are incomplete for Scotland and therefore rates cannot be shown.

3 From 2010 the following are no longer notifiable diseases: bacillary dysentery, chickenpox, erysipelas, food poisoning, legionellosis, leptospirosis, Lyme disease, malaria, puerperal fever, relapsing fever, scarlet fever, toxoplasmosis, typhus fever and viral hepatitis.

4 Rate per 100,000 population. Scotland rates for 2013 were not available when this report was in preparation.

.. Not available as the disease only became notifiable from 2010.

Source: Health Protection Scotland
Dental registration and participation
Dental health of children

<table>
<thead>
<tr>
<th>Age group</th>
<th>&lt;3</th>
<th>3–5</th>
<th>6–12</th>
<th>13–17</th>
<th>18–24</th>
<th>25–34</th>
<th>35–44</th>
<th>45–54</th>
<th>55–64</th>
<th>65–74</th>
<th>75+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registrations: NHS General Dental Service registrations as at 31 March 2014</td>
<td></td>
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<td>9894</td>
<td>17664</td>
<td>44695</td>
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<td>48444</td>
<td>68777</td>
<td>70535</td>
<td>79196</td>
<td>58524</td>
<td>40912</td>
<td>28959</td>
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<tr>
<td>Lanarkshire %</td>
<td>51.0</td>
<td>87.9</td>
<td>99.9</td>
<td>96.7</td>
<td>98.8</td>
<td>98.5</td>
<td>88.6</td>
<td>89.0</td>
<td>82.1</td>
<td>76.2</td>
<td>70.6</td>
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<tr>
<td>Scotland %</td>
<td>47.3</td>
<td>92.1</td>
<td>105.6</td>
<td>99.0</td>
<td>89.9</td>
<td>96.6</td>
<td>87.0</td>
<td>84.3</td>
<td>77.6</td>
<td>74.7</td>
<td>69.6</td>
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<tr>
<td>Participation: Registered patients participating in the NHS General Dental Service over a two-year period as at 31 March 2014</td>
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<td>15616</td>
<td>38957</td>
<td>28251</td>
<td>32818</td>
<td>47859</td>
<td>52696</td>
<td>60624</td>
<td>45276</td>
<td>30960</td>
<td>18486</td>
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<td>Lanarkshire %</td>
<td>97.7</td>
<td>88.4</td>
<td>87.2</td>
<td>83.7</td>
<td>67.7</td>
<td>69.6</td>
<td>74.7</td>
<td>76.5</td>
<td>77.4</td>
<td>75.7</td>
<td>63.8</td>
</tr>
<tr>
<td>Scotland %</td>
<td>97.9</td>
<td>89.1</td>
<td>84.8</td>
<td>82.0</td>
<td>67.9</td>
<td>68.6</td>
<td>74.1</td>
<td>76.7</td>
<td>77.8</td>
<td>77.4</td>
<td>66.0</td>
</tr>
</tbody>
</table>

1 NRS mid-year population estimates are used to calculate the percentage of people registered. Results for some age groups indicate that population denominators should be treated with caution.

Sources: Registrations and participation – ISD Scotland, Dental health of children – Scottish Health Boards’ Dental Epidemiological Programme and National Dental Inspection Programme
## Primary and booster immunisation uptake rates by 5 years old

by locality/CHP: evaluation period 1 April 2013 to 31 March 2014

<table>
<thead>
<tr>
<th>Locality \ CHP</th>
<th>No. in cohort</th>
<th>% completed primary course by 5 years</th>
<th>% completed booster course by 5 years</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Airdrie</td>
<td>Bellshill</td>
<td>Coatbridge</td>
</tr>
<tr>
<td></td>
<td>667</td>
<td>627</td>
<td>629</td>
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<tr>
<td>Airdrie</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Bellshill</td>
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<td></td>
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<tr>
<td>Coatbridge</td>
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<td></td>
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<tr>
<td>North</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Motherwell</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Wishaw</td>
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<td>Clydesdale</td>
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<td>East Kilbride</td>
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<td></td>
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<tr>
<td>North</td>
<td></td>
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<td></td>
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<tr>
<td>South</td>
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<tr>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scotland</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

1 Children reaching 5 years of age during the evaluation period 1 April 2013 to 31 March 2014 (i.e. born 1 April 2008 to 31 March 2009).
2 GP practices in NHS Lanarkshire grouped into localities/CHPs. Children resident in NHS Lanarkshire only.
3 Children resident in NHS Lanarkshire immunised in any NHS board.
4 *Haemophilus influenzae* type b vaccine.
5 Meningococcal serogroup C conjugate vaccine.
6 Pneumococcal conjugate vaccine.
7 Combined measles, mumps and rubella vaccine.

Source: SIRS, ISD Scotland
### Staff in Public Health

<table>
<thead>
<tr>
<th>Name</th>
<th>Designation</th>
<th>Email address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anne Alexander</td>
<td>Operational Services Manager</td>
<td><a href="mailto:anne.alexander@lanarkshire.scot.nhs.uk">anne.alexander@lanarkshire.scot.nhs.uk</a></td>
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</tr>
<tr>
<td>Dr Rachel Thorpe</td>
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</tr>
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<td>Trish Tougher</td>
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<tr>
<td>Christine Weir</td>
<td>Lead TB Liaison Nurse</td>
<td><a href="mailto:christine.weir@lanarkshire.scot.nhs.uk">christine.weir@lanarkshire.scot.nhs.uk</a></td>
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<td>Jim White</td>
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<td><a href="mailto:jim.white@lanarkshire.scot.nhs.uk">jim.white@lanarkshire.scot.nhs.uk</a></td>
</tr>
<tr>
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<td><a href="mailto:albert.yeung@lanarkshire.scot.nhs.uk">albert.yeung@lanarkshire.scot.nhs.uk</a></td>
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