

Living and Working Well 2017/18

Public Health Intelligence

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1. Key messages

- Total adult (18+) population by age group
- Nationally, there have been improvements for all measures of personal well-being for those aged 30 to 34, 40 to 59 and 65 to 69 years, since personal well-being started being measured in 2011.
- Conversely, at national level, the proportion of adults with poor mental health scores has increased since 2012, from 15% to 19%. This increase is particularly apparent among young men aged between 16 and 34, and young women aged between 16 and 24. Although the survey covers Wokingham, the number of people sampled is too small to allow local breakdown.
- So it appears that health and wellbeing are increasing for the middle-aged, but not for the younger adults.
- There are estimated to be 3,142 people with undiagnosed diabetes in Wokingham.
- Physical activity – large number inactive adults
-
- Weight and obesity – excess weight
- Smoking
- Alcohol
- Mental health prevalence
- Sexual health
- Chlamydia?
- HIV

- Diabetes
- Cancer
- Respiratory disease
- Cardiovascular disease
- Chronic kidney disease
- Liver disease
- Long term neurological conditions
- Physical and sensory impairment
- Preventable sight loss
- Antimicrobial resistance
- Cancer screening
- Non cancer screening
- Communicable diseases

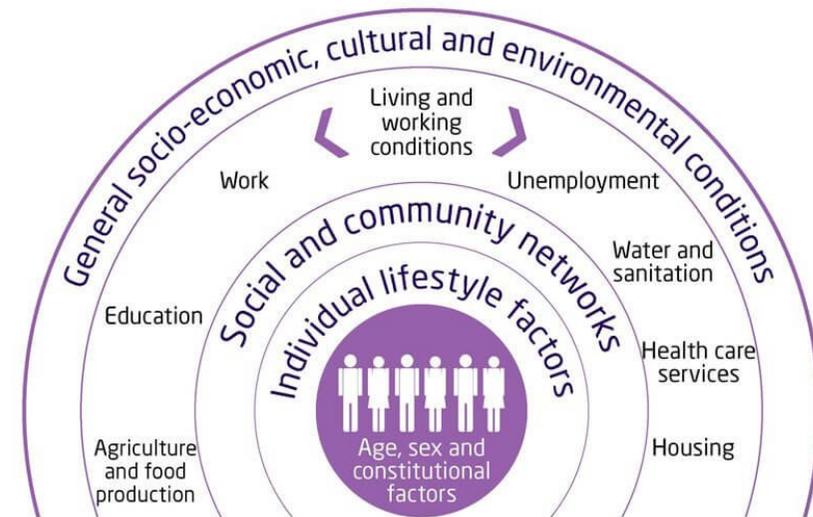
2. Introduction

This chapter looks at the health and wellbeing and health and care needs of the working age population in Wokingham borough.

Health is determined by a complex interaction between individual characteristics, lifestyle and the physical, social and economic environment. Current estimates are that about half of the health status of a population is due to the social and economic environment, about 15% from our genes, 25% from the health care system and 10% from the physical environment. The 2018 Annual Report from the Director of Public Health focuses on the impact of the physical environment, and particularly the effect of green space on the people of Wokingham.

The Borough Profile covers education, employment, deprivation and housing. This chapter covers issues that affect general wellbeing and mental health, numbers of people with mental health conditions, then moves on through lifestyle factors: weight, physical activity, alcohol, smoking and then moves on to specific conditions. Groups within the population such as carers, people of certain ethnicities, with learning disabilities and so on are discussed in the final Chapter – People and Places.

Diseases: sexually transmitted infections, diabetes, cancer, respiratory disease, cardiovascular disease, chronic kidney disease, liver disease, long-term neurological conditions, preventable sight loss, physical and sensory impairment.



Source: Dahlgren, G. and Whitehead, M. (1993) *Tackling inequalities in health: what can we learn from what has been tried?*

2.1 General health and wellbeing

Health is not just about the presence of disease or illness (be that physical or mental), but also about how well people are. As a nation we are living longer than ever before. The nature of health has changed dramatically over the last 150 years, so much so that we now often take for granted the dramatic gains made to society from improved public health.

Mental health and wellbeing are critical dimensions of health. We know that mental ill health is responsible for a high proportion of the overall burden of ill health and prevalence has been rising.

Wellbeing is a key issue for the Government, but very difficult to measure. To address this the Office for National Statistics is leading a programme of work to develop new measures of national wellbeing. People with higher wellbeing have lower rates of illness, recover more quickly and for longer, and generally have better physical and mental health.

Source: Department of Health: Our Health and Wellbeing Today (Nov.2010)

The Health Survey for England 2016 examines the prevalence of well-being and mental ill- health, using the Warwick-Edinburgh Mental Well-Being Scale (WEMWBS) and the 12-item General Health Questionnaire (GHQ-12). It compares wellbeing and mental ill health in different population groups by age, sex, region, household income and area deprivation as well as lifestyle factors, Body Mass Index (BMI) and physical activity.

WEMWBS is scored on a range from 14 to 70; average wellbeing scores for both men and women in England in 2016 were 50. This is a decline from 2015 when the scores for both sexes were 52.

Men and women living in more deprived areas had lower well-being scores, on average, than those living in less deprived areas, although magnitude of the difference was not very large. Those living in the most deprived areas had average wellbeing scores of 49 for men and 47 for women, compared with 52 and 51 respectively among those living in the least deprived areas.

The GHQ-12 is scored on a range from 0 to 12, with a score of 4 or more indicative of probable mental ill health. Women were more likely than men to report a GHQ-12 score of 4 or more (21% of women and 16% of men).

The proportion of adults with high GHQ-12 scores has increased since 2012, from 15% to 19%. This increase is particularly apparent among young men aged between 16 and 34, and young women aged between 16 and 24.

Source: NHS Digital: Health Survey for England (2016)

In the year ending September 2017, there continued to be slight improvements in the UK for average ratings of life satisfaction, feeling that the things done in life are worthwhile and happiness; but there was no overall change in reported anxiety levels.

In the year ending September 2017, women reported higher life satisfaction, worthwhile and happiness ratings compared with men but also reported higher levels of anxiety.

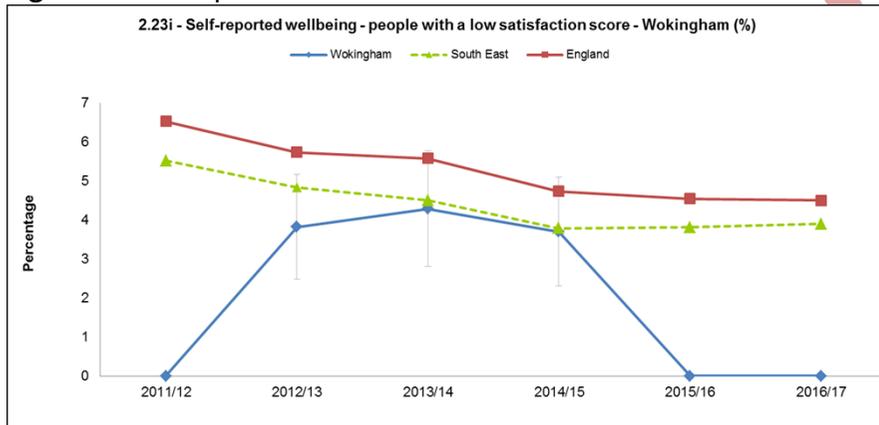
There have been improvements for all measures of personal well-being for those aged 30 to 34, 40 to 59 and 65 to 69 years, since personal well-being started being measured in 2011.

Source: Office for National Statistics: Personal well-being in the UK (October 2016 to September 2017)

The Office for National Statistics (ONS) measure personal well-being based on four questions included on the Integrated Household Survey. Responses are given on a scale of 0-10.

In 2016/17, 4.5% of people in England, and 3.9% of people in the South East Region responded with a low satisfaction score. This is a score between 0 and 4. The percentage for Wokingham is unknown due the number of cases being too small to calculate. In 2014/15 this score was recorded as 3.0%, which is the latest data recorded, and is highly unlikely to have changed within one year

Figure X: Self-reported low satisfaction



Source: Public Health Outcomes Framework

Happiness: the survey asked "Overall, how happy did you feel yesterday? (0 is 'not at all happy; 10 is 'completely happy').

The level of respondents report a low happiness score (0-4) has gradually decreased since 2011/12 from over 8% to about 6% in 2016/17. The same trend has happened nationally, but at a consistently higher level.

Figure X: Self-reported low happiness



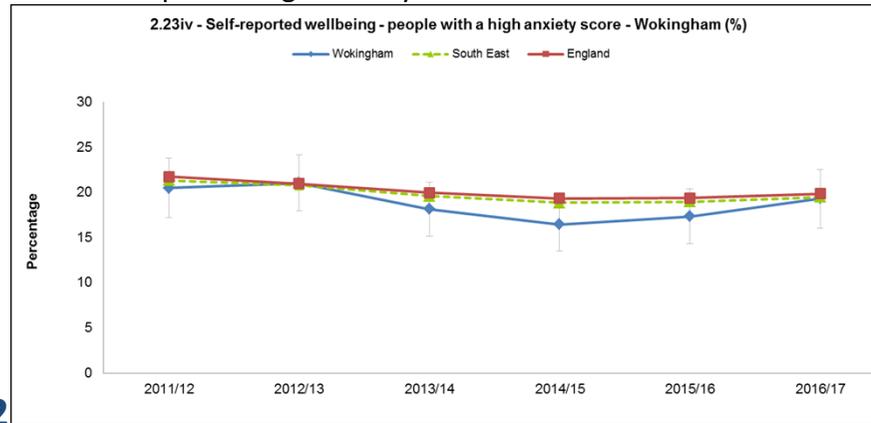
Source: Public Health Outcomes Framework

Anxiety: the survey asked "Overall, how anxious did you feel yesterday? (0 is 'not at all anxious'; 10 is 'completely anxious').

The self-reported wellbeing for people with a high anxiety score (respondents scoring 6-10 to the above question) in Wokingham was 19.3%. Again, since 2011/12 this has been statistically consistent. The lowest percentage for the LA was 16.4% recorded in 2014/15 and the highest was 21.0% in 2012/13.

Comparing the anxiety scores to England and the South East, Wokingham has stayed similar to both year on year. The 2016/17 figures for England and the South East were 20%.

Figure X: Self-reported high anxiety



2.2

Source: Public Health Outcomes Framework

2.3 Mental health (data being updated from shared services May 2018)

Mental health is not just the absence of a mental disorder. It is defined as a state of wellbeing in which every individual realises their own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make their contribution to society. – World Health Organisation definition.

Good mental health and resilience can be developed by certain key factors. These have been helpfully expressed as the 5 ways to wellbeing:

1. Get active
2. Keep learning

3. Take notice
4. Give
5. Connect

There is a good explanation of these on the MIND website:

<https://www.mind.org.uk/workplace/mental-health-at-work/taking-care-of-yourself/five-ways-to-wellbeing/>

We present intelligence on each of these 5 ways below.

1. Get active

Physical activity (data update from Shared services April 2018)

Sports England data

Local Sport and Leisure Team data to be brought in here

Travel to work patterns (active travel)

2. Keep Learning

Any Data on adult learning?

3. Take notice

Is there any intelligence we could add here?

4. Give

Volunteering – data from Involve?

5. Connect

Anything on number of clubs, etc??

The 2018 DPH report, cited previously, gives the evidence base for how green space is beneficial for mental health. People who live in greener areas are more likely to report good mental health and wellbeing. Exposure to the natural environment can reduce stress, anxiety, blood pressure and anger.

Certain stressors lead to poor wellbeing and mental health. These would include home circumstances such as living with someone who makes demands (however unwittingly) for instance:

- a person requiring an amount of care over and above average family demands, whether adult or child
- a person with an addiction, be it substances or, for instance, gambling
- a person with mental health problems
- an abusive person

Social circumstances

- social isolation

- being poor (insufficient income to meet expected living standards)
- living in what you consider to be a poor environment

Life events, for instance:

- bereavement
- relationship breakdown
- loss of employment

and events which may be positive, but stressful:

- moving home
- leaving home
- starting a new job or course

Need to quantify as many of the stressors above as possible in Wokingham

Carers

9% of the population are carers, including 1.5% of the population who provide over 50 hours of unpaid care per week (source CCG Locality Profile) – probably means adult carer as registered with GP, but need to check.

There are xxx children with special needs creating xxx families with the demands that puts on parents (and other children)

Domestic violence is estimated to effect xxxx adults and xxxx children

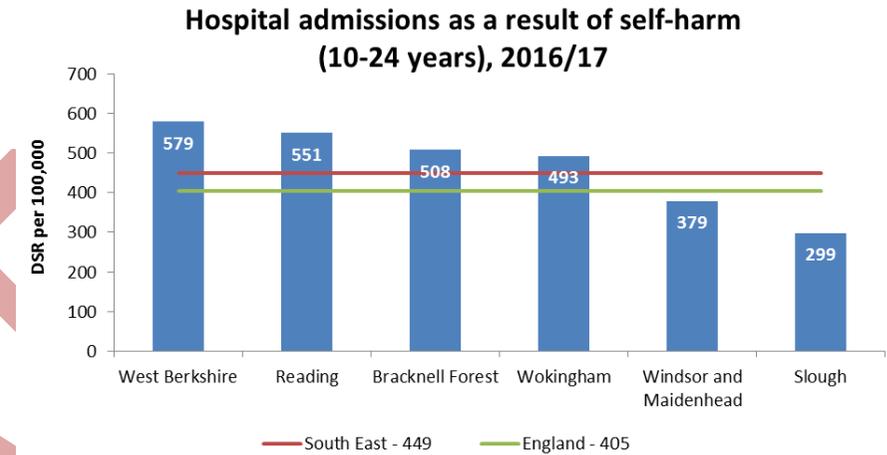
About 26% of people over 65 live on their own (source CCG Locality Profile)

Xxxx households are classified as low income, 6% of children live in low income families, xx% are classified as fuel poor. Xxxx claim benefits.

The food bank in Wokingham reports that it sees about xx people per week (are there other Food Banks – we need contacts)

Mental health profiles (PHE)

Figure X:



Mental health hospital admissions – Wokingham CCG – PHE Profiles

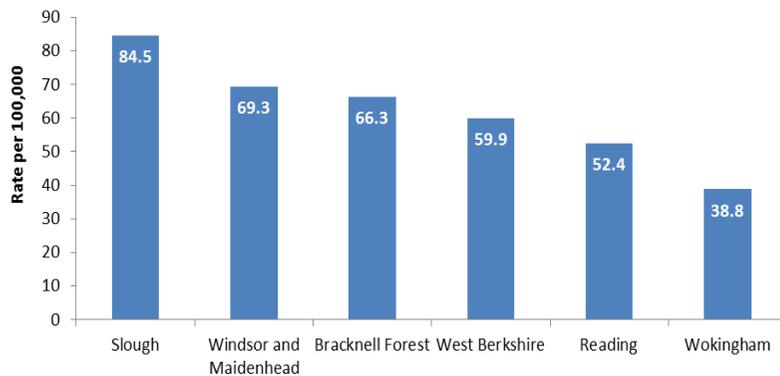
2.3.1 Depression and anxiety

Depression and anxiety are common conditions. Definitions vary, and severity varies, from a person feeling depressed or anxious at times but still able to carry out normal activities to severe incapacity. We can estimate prevalence in a number of ways. One is to simply ask people and there is a GP Patient Survey where a sample of patients are asked "What is the state of your health today?" those who answered "moderately anxious or depressed" are considered to be so. The results from this survey are shown in Fig X . About 8% of adults feel depressed or anxious in Wokingham, the national average is over 12%, so clearly there are positive factors going on locally to protect against depression and anxiety,

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Figure X:

Hospital admissions for self-harm standardised emergency admission ratio (all ages), 2016/17

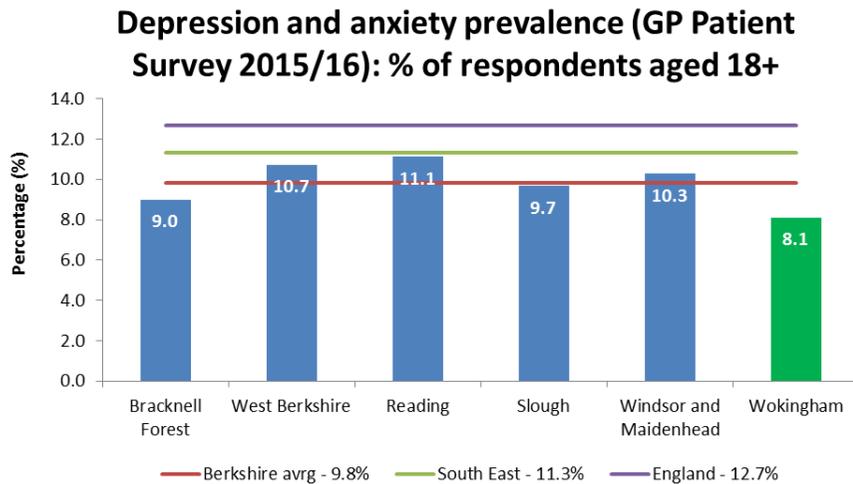


likely to be relative affluence, high levels of employment, high levels of green space and low crime rate

Adult Psychiatric Morbidity Survey, 2014

<http://content.digital.nhs.uk/catalogue/PUB21748/apms-2014-full-rpt.pdf>

Figure X: Prevalence of depression and anxiety



Source: Mental Health and Wellbeing JSNA (<https://fingertips.phe.org.uk/profile-group/mental-health/profile/mh-jsna>)

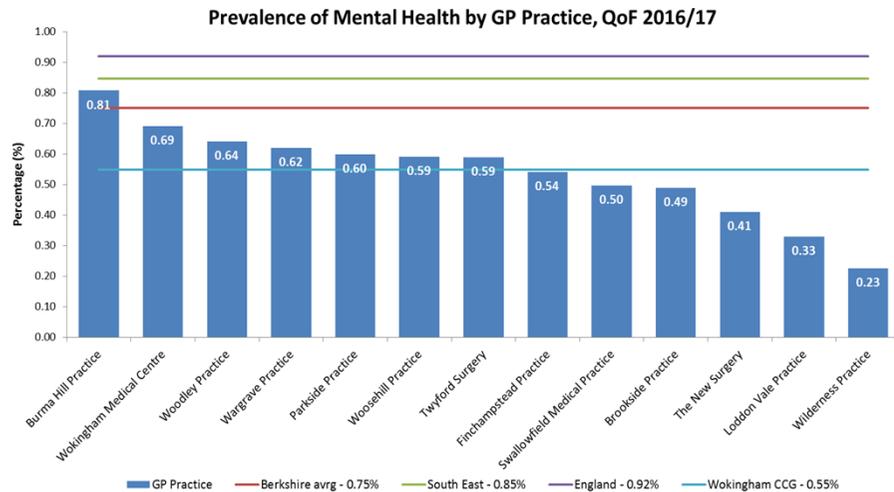
2.3.2 Severe mental health disorders

QoF prevalence

The percentage of patients aged 18 years and over with schizophrenia, bipolar affective disorder and other psychoses.

There are 892 persons in Wokingham who are on a GP Practice mental health register. This is equivalent of 0.55% prevalence. However, prevalence varies among GP Practices. Burma Hill Practice has the highest mental health prevalence with 0.81% and Wilderness Practice the lowest with 0.23%. The figure below illustrates mental health prevalence by GP Practice compared with Wokingham CCG, the Berkshire CCG average, the South East and England. There is a nearly 4-fold difference, and likely does not reflect a true variation in the prevalence of mental illness, but rather variation in practice, and the GP's propensity to diagnose and record mental illness on a patient's notes. There is still stigma attached to mental illness and a GP may discuss the issue with the patient and come to a joint decision not to register the diagnosis. Alternatively the practice may not recognise mental illness, A significant proportion of people that have depression are not diagnosed (1)

Figure X: Registered mental health prevalence by GP Practice



Source: <http://digital.nhs.uk/catalogue/PUB30124>

Table X: Number of patients with a mental health problem by GP Practice, QoF 2016/17

Practice name	List size (18+)
Burma Hill Practice	1,927
Wokingham Medical Centre	18,526
Woodley Practice	9,074
Wargrave Practice	5,597
Parkside Practice	10,919
Woosehill Practice	9,227
Twyford Surgery	9,691
Finchampstead Practice	11,880
Swallowfield Medical Practice	9,008
Brookside Practice	20,590

The New Surgery	5,525
Loddon Vale Practice	12,388
Wilderness Practice	1,822
Total	126,174

3. Healthy lifestyle

Physical activity
a lot to add here

3.1 Weight and obese adults

<https://www.helpguide.org/harvard/how-excess-weight-affects-your-health.htm>

Adult obesity and Diet (shared services April 2018)

Weight management strategy data

Healthy weight...

We are living in what has been termed an “obesogenic environment”, i.e. the way we are living makes us fat. This is complex and multifactorial, but involves:

- Availability (relatively low cost) of high sugar, high fat foods
- Natural response to sweet and high calorie food (tastes good), and natural inclination to not waste calories by moving around when we don't have to
- More sedentary lifestyle meaning we don't use up calories at a sufficient rate

- Promotion (advertising) of food, including unhealthy foods
- Cultural traditions of giving and receiving food unrelated to our biological need for it
- Food as entertainment
- Processing of foodstuffs (huge area in itself)
- Agriculture
-

Adult obesity rates are rising and driving an increased risk of chronic disease.

Obesity presents a major threat to health. It is associated with an increased risk of diseases including diabetes, heart disease, osteoarthritis and cancer. Estimates suggest that being overweight (BMI 25 to less than 30) reduces life expectancy by about three years, and being obese (BMI 30 or more) can reduce life expectancy by 10 years (*Source: Health Survey for England 2010*).

The table below indicates the extent to which obesity increases the risks of developing a number of diseases relative to the non-obese population. The relative risks are based on a comprehensive review of international literature that was carried out by the National Audit Office, to provide the best estimates that could be applied to the English population (*Source: [Tackling obesity in England. Report by the comptroller and auditor general HC220 Session 2000- 2001: 15 Feb 2001](#)*).

Insert table here

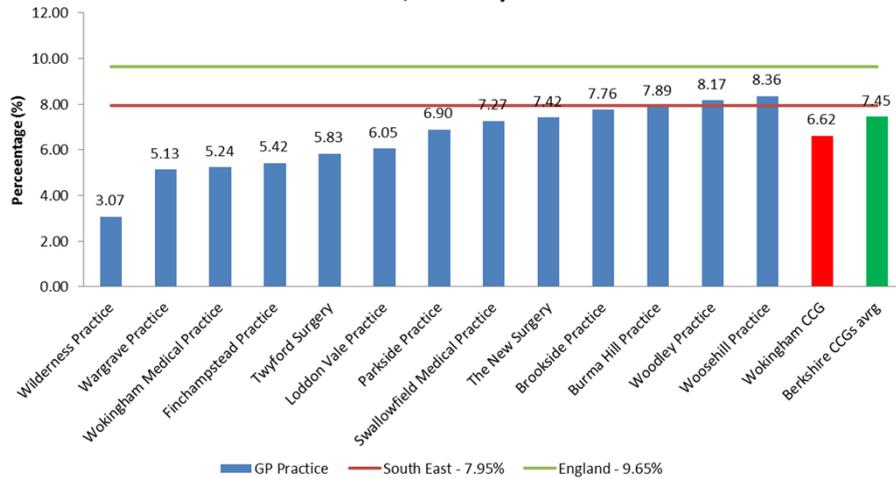
What data is available to monitor adult obesity?

We don't have comprehensive local data on adult weight in the way we do for children. The Household Survey for England has been measuring weights for many years, but this is a national survey, and therefore has very few respondents from Wokingham. From this source we know that the majority of the population carry excess weight (i.e. are overweight or obese. 2015 – local authority estimates.

GP Practices register people as obese when they are weighed – but these data are known to be very incomplete.

The prevalence of adult obesity as recorded by the GP Practice registers in Wokingham borough is currently 6.6%, which is lower than the average in of 7.4% in Berkshire and lower than the south east region and England. However, the prevalence of adult obesity varies greatly among practices and this can be seen of figure X. Woosehill practice has a higher prevalence (8.4%) of adult obesity than the South East and the Berkshire prevalence.

GP Practice registered prevalence of obesity in adults (18+) QoF 2016/17



Source: QoF 2016/17

Prevalence of overweight and obese adults (LSOA or ward?)

Hospital admissions for obesity

Finished Admission Episodes with a primary diagnosis of obesity, by region and Local Authority of residence, and gender

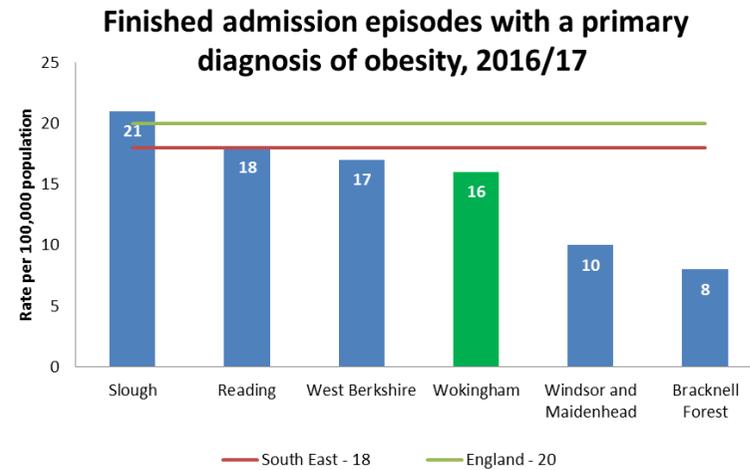
A finished admission episode (FAE) is the first period of inpatient care under one consultant within one healthcare provider. FAEs are counted against the year in which the admission episode finishes. Admissions do not represent the number of inpatients, as a person may have more than one admission within the year.

The primary diagnosis is the first of up to 20 (14 in 2006-07) diagnosis fields in the Hospital Episode Statistics (HES) data set and provides the main reason why the patient was admitted to hospital.

This is the tip of the iceberg – very few people are admitted to hospital with obesity as the primary diagnosis, but obesity is a major contributor to many other conditions.

ICD-10 Codes: E66 - Obesity.

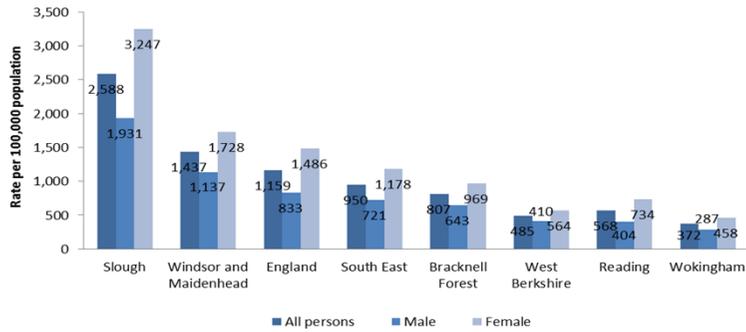
Figure X: Hospital admissions with a primary diagnosis of obesity



Source: NHS Digital (<http://digital.nhs.uk/pubs/sopad18>)

Figure X: Hospital admissions with a primary or secondary diagnosis of obesity

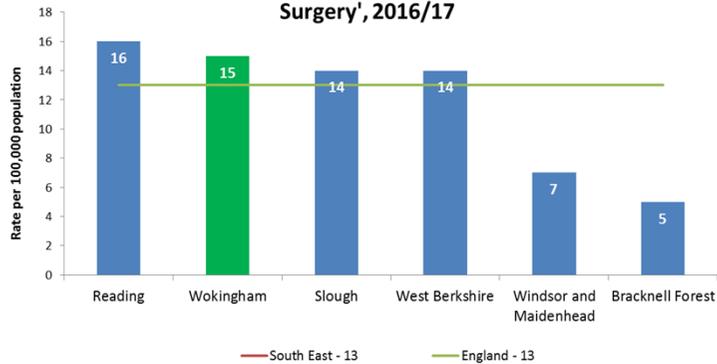
Finished admission episodes with a primary or secondary diagnosis of obesity, 2016/17



Source: NHS Digital (<http://digital.nhs.uk/pubs/sopad18>)

Figure X: Hospital admissions with a primary diagnosis of obesity and a main or secondary procedure of 'Bariatric surgery'

Finished consultant episodes with a primary diagnosis of obesity and a main or secondary procedure of 'Bariatric Surgery', 2016/17



Source: NHS Digital (<http://digital.nhs.uk/pubs/sopad18>)

Losing weight and being more physically active can reduce the risk of developing diabetes, and even reverse “pre-diabetes” – people whose blood sugar levels are higher than the normal range. This is the rationale for the introduction of the National Diabetes Prevention Programme.

Obesity is very strongly related to diabetes, both at population and at personal level.

3.2 Diabetes

On 31st March 2017, the recorded prevalence of diabetes for people aged 17 and over was 6.9% in England, which is over 3 million people.

Source: NHS Digital (2016); Quality and Outcomes Framework 2016/17: Report for England.

Public Health England estimate that the actual prevalence of diabetes in England was 8.7% in 2017, which means that there are a significant number of people who haven't been diagnosed with the condition. This is expected to increase to 9.5% by 2030.

Source: Public Health England (2015); Diabetes prevalence model for local authorities.

Wokingham CCG Comparator Group England

Number of people on the register in Wokingham CCG

Diabetes	4.8%	5.7%	6.9%	6,208	x
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Source: NHS Digital (2017); Quality and Outcomes Framework 2016/17: Report for England

The estimated prevalence of diabetes for people aged 17 and over in Wokingham CCG was 7.3%, which means that there were 3,142 people missing from Wokingham GP Registers in 2017.

The estimated number of people in Wokingham aged 16 and over with diabetes was 9,594 in 2017. This is 7.4% of the total population. The number of people with diabetes is estimated to rise to 12,328 people by 2039, which would be 8.5% of the projected population.

Nearly 3% of disability adjusted-life years (DALYs) in England are caused by diabetes, which is the 11th leading cause. DALYs are the number of healthy life years lost due to premature death combined with the number of years living in ill health, and are used to measure the total burden of a disease globally and nationally.

Key risk factors for diabetes in England include high body-mass index, high waist circumference, diet and low physical activity. There is a genetic component to propensity to diabetes. Diabetes is more commonly found in certain ethnic groups, e.g. Afro-Caribbeans and the risk of diabetes increases in people of Indian, Pakistani and Bangladeshi heritage when their BMI is only 23.5, compared to 27.5 in British whites.

Source: Global Burden of Disease (2015); GBD Compare Data Hub

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Source: Public Health England (2017); Diabetes prevalence model for local authorities

Care of people with diabetes

All people with diabetes aged 12 years and over should annually receive nine NICE recommended care processes and attend a structured education program when diagnosed. These include tests for glucose control, cholesterol, blood pressure and kidney function, as well as measurement of body mass index, foot examination and smoking history. The NHS Diabetes Eye Screening Programme provides the ninth care process and is required to complete a digital retinal screening annually to check for eye risk.

The National Diabetes Audit (NDA) measures the effectiveness of diabetes care against the NICE Clinical Guidelines and Quality Standards. The NDA found that in 2016/17, only 34% of people with Type 1 Diabetes and 48% of people with Type 2 diabetes received all 8 of NICE recommended care processes. This was the lowest level in the previous 5 years for both diabetes groups. Urine albumin and foot surveillance were the most missed care processes.

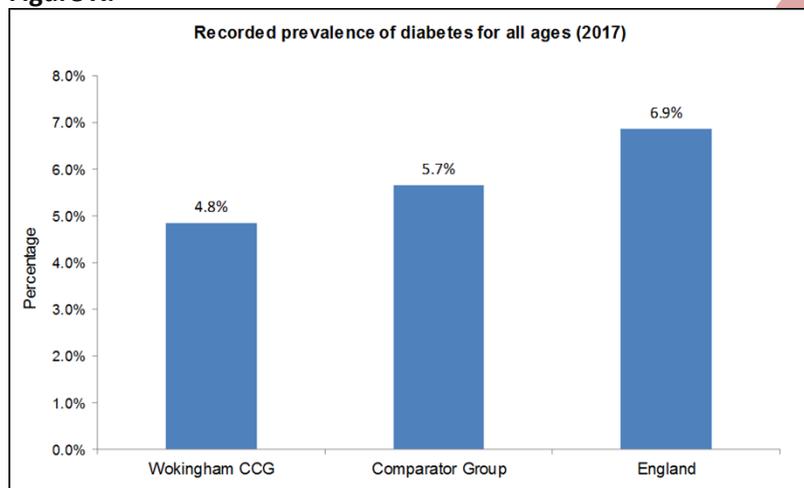
In 2016/17, 49% of people with type 1 diabetes in Wokingham CCG and 66% of people with type 2 diabetes received all 8 NICE recommended care processes in the year. These were both higher proportions than England'

In 2016/17, 22% of people with type 1 diabetes in Wokingham CCG and 42% of people with type 2 diabetes met all three treatment targets for glucose control, blood pressure and serum cholesterol. These were both similar to England's figures of 19.0% and 41.1% respectively.

In 2015, 390 people were newly diagnosed with diabetes in Wokingham CCG and 82% of these were referred to structured education. Nationally, 76% of newly diagnosed people were referred.

NHS Digital (2017); National Diabetes Audit Report 1: Care Processes and Treatment Targets 2016/17
Estimated vs QoF prevalence.

Figure X:



Source: NHS Digital (2017); Quality and Outcomes Framework 2016/17

Hospital admissions for diabetes

Prevalence estimates of diabetes by clinical commissioning group (CCG) and England

The data below gives the estimated number of people age 16 years or older who have diabetes (diagnosed and undiagnosed) by clinical commissioning group (CCG). The data relating to diabetes prevalence has been taken from the latest Health Surveys for England. Population data are based on the number of patients registered at a GP practice in April 2015. The year-on-year change in population by age, sex and CCG produced by the ONS was applied to the GP practice populations to produce population projections until the year 2035. The data has been adjusted for age, sex, ethnic group and deprivation. For further details of the methodology used to produce these estimates please refer to the technical document on the NCVIN website www.ncvin.org.uk

South East	E1200000 8	684,830	8.2%
NHS Wokingham CCG	E3800020 9	9,529	7.3%
England	E9200000 1	4,089,864	8.6%

<https://www.gov.uk/government/publications/diabetes-prevalence-estimates-for-local-populations>

ource: <http://digital.nhs.uk/catalogue/PUB30124>

3.2.1 Mental health services (Shared services April 2018)

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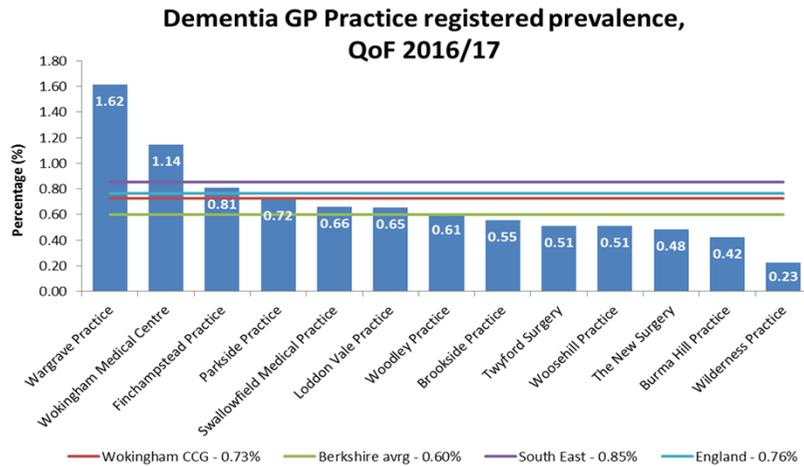
Hospital data (not very good)

Mental health dual diagnosis – Shared services TBC

LTC/Neurological conditions - Shared services TBC

3.2.2 Dementia

Figure X: Dementia prevalence by GP Practice



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3.3 more indicative of probable mental ill health. Women were more likely than men to report a GHQ-12 score of 4 or more (21% of women and 16% of men).

Alcohol and smoking – Shared Services May/July 2018)

3.4 Sexual health and HIV

Add GUMCad data and data from PHE sexual health profile

4. Health protection

4.1 Antimicrobial Resistance

4.2 Cancer screening

4.3 Non cancer screening

4.4 Communicable diseases (Shared services TBC)

TB – Shared services April 2018

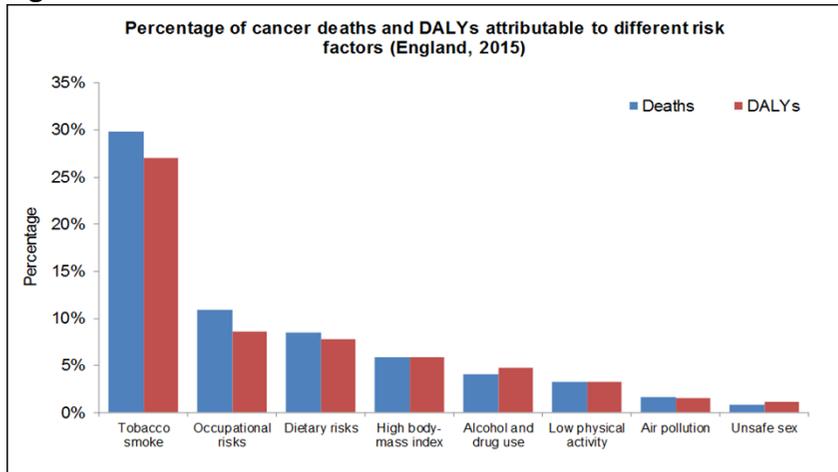
5. Health conditions

5.1 Cancer

Cancer is the leading cause of disability adjusted-life years (DALYs) in England at 18.8%. DALYs are the number of healthy life years lost due to premature death and years living in ill health. Lung cancer has the biggest impact (3.9% of all DALYs), followed by breast cancer (2.0%) and colorectal cancer (1.9%).

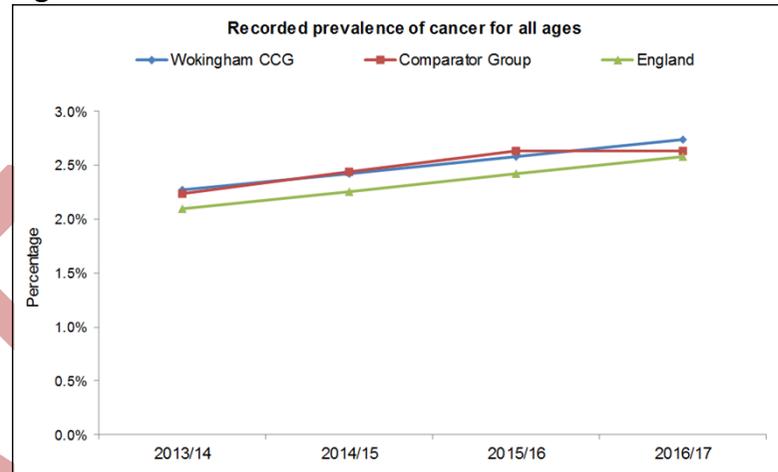
The main risks attributed to cancer deaths and DALYs in England are tobacco smoke, occupational risks, diet, high body mass index and alcohol and drug use. (Source: Global Burden of Disease (2015); GBD Compare Data Hub)

Figure X:



Source: Global Burden of Disease, 2015

Figure X:



Source: Public Health England (2017); Public Health Outcomes Framework

Figure X shows recorded cancer prevalence by GP Practice.

GP Practice recorded cancer prevalence in 2016/17

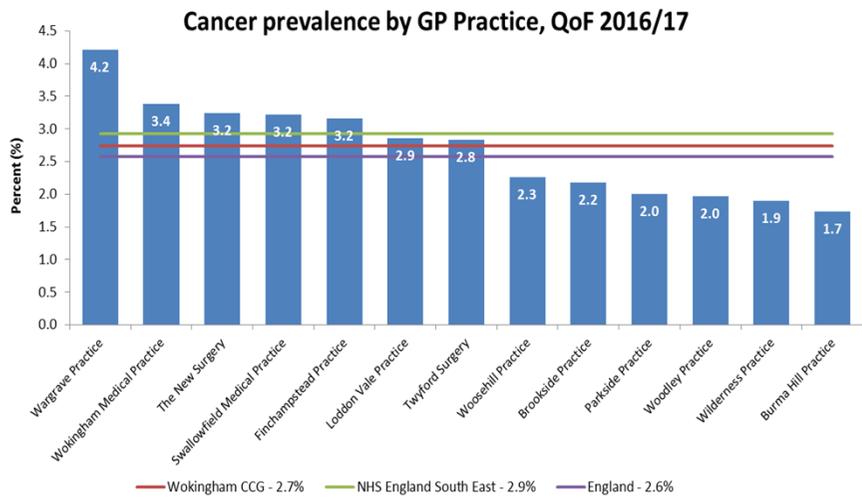
Figure X: Cancer prevalence by GP Practice

The GP Practice recorded prevalence of cancer in Wokingham has increased from 2.6% in 2015/16 to 2.7% in 2016/17. In terms of numbers this increase accounted to 309 additional patients on the register.

On 31st March 2017, the recorded prevalence of cancer was:

Wokingham CCG	Comparator Group	England	Number of people on the register in Wokingham CCG
2.7%	2.9%	2.6%	4,445

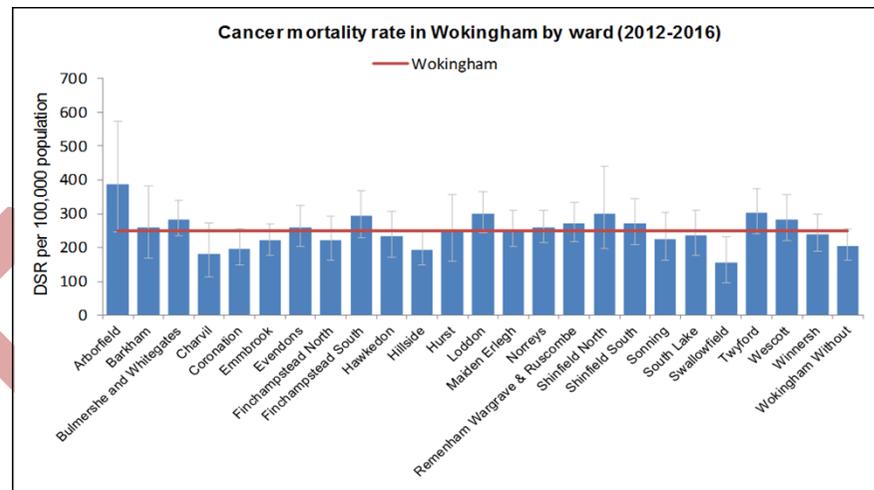
Source: NHS Digital (2017); Quality and Outcomes Framework 2016/17: Report for England



Source: QoF 2016/17 (<http://digital.nhs.uk/catalogue/PUB30124>)

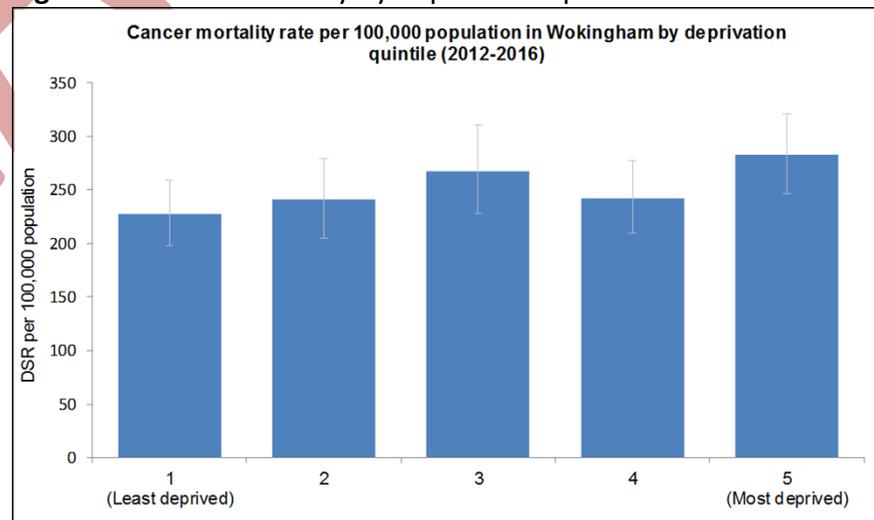
In 2016, 29.1% of all registered deaths in Wokingham were caused by cancer, compared to 28.0% in England. The percentages were different for men and women in Wokingham at 32.7% and 25.5% respectively.

Figure X: Cancer mortality by ward



Source: NHS Digital (2017); Primary Care Mortality Database

Figure X: Cancer mortality by deprivation quintile



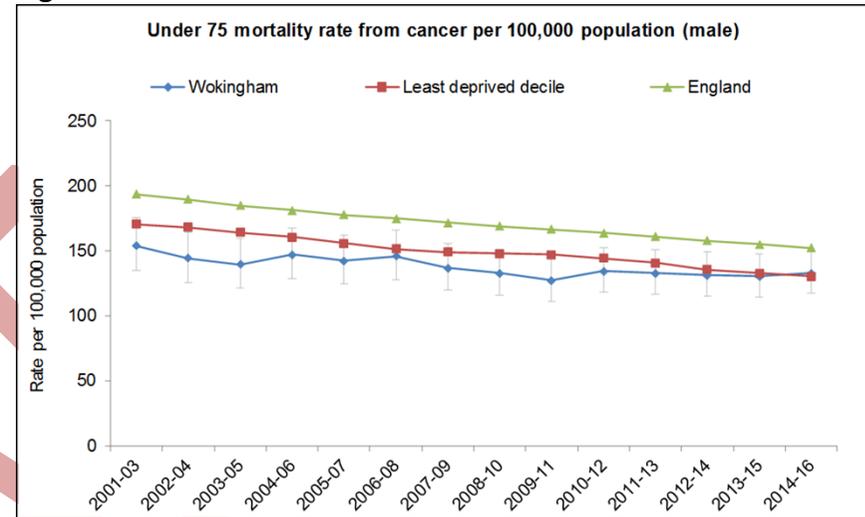
Source: NHS Digital (2017); Primary Care Mortality Database

Further, 45.8% of premature deaths (people aged under 75) in Wokingham were caused by cancer, compared to 40.2% in England. These varied between men and women - 42.4% for men; 51.4% for women. (Source: NOMIS (2017); Mortality statistics - Underlying cause, sex and age (2013 - 2016))

In 2014-16, the under 75 mortality rate from cancer was 119.3 per 100,000 people in Wokingham. This was significantly better than the England rate of 74.6 per 100,000 population and similar to the comparator group rate of 120.8. Wokingham's rate for men was higher at 130.1 per 100,000 population, compared to 104.6 for women. This is in line with the national picture.

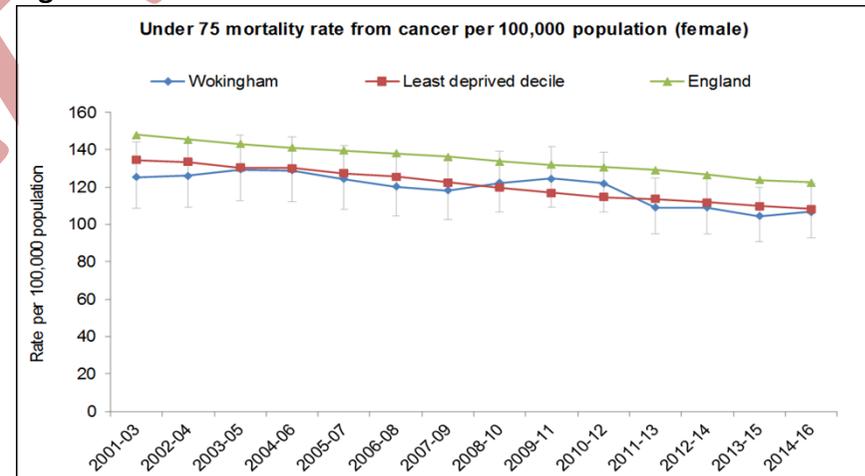
In Wokingham, 54.0% of premature deaths from cancer were considered preventable, compared to 58.0% nationally. In 2014-16, there were 64.3 premature deaths from cancer per 100,000 people that were considered preventable. The rate for men was higher again at 69.0 per 100,000 compared to 60.2 for women. (Source: Public Health England (2017); Public Health Outcomes Framework)

Figure X:



Source: Public Health England (2017); Public Health Outcomes Framework

Figure X:



Source: Public Health England (2017); Public Health Outcomes Framework

Figure X: Male premature mortality from cancer considered preventable

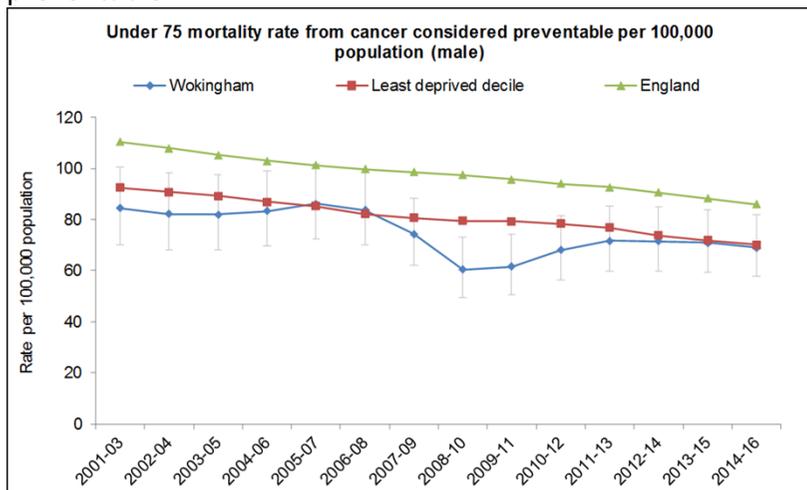
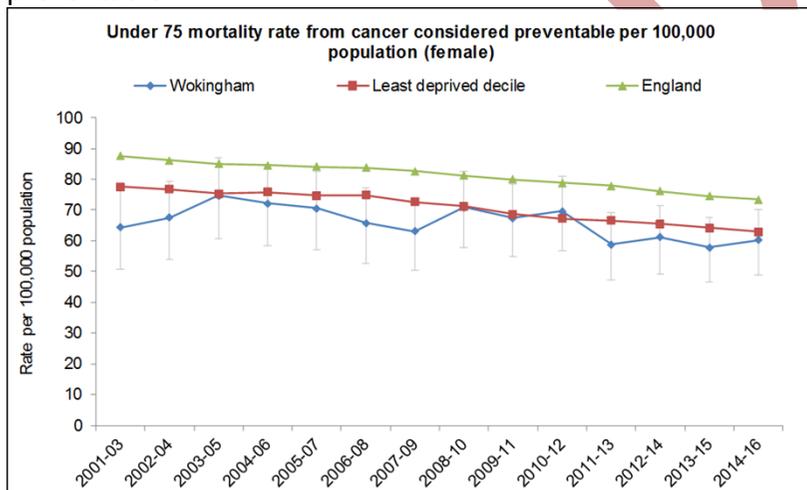


Figure X: Female premature mortality from cancer considered preventable



Cancer Information Network data

Cancer incidence

Cancer survival

Cancer recovery rates (low in females – CCG data)

Hospital admissions for cancer – CCG data

QoF data on cancer

5.2 Respiratory disease

The prevalence of disease is captured through the GP Quality and Outcomes Framework (QOF) on an annual basis. On 31st March 2016, the recorded prevalence of asthma in England was 5.9% and the prevalence of Chronic Obstructive Pulmonary Disease (COPD) was 1.9%.

Source: NHS Digital (2017); Quality and Outcomes Framework 2016/17: Report for England

6% of disability adjusted-life years (DALYs) in England are caused by chronic respiratory diseases, which is the 7th leading cause. DALYs are the number of healthy life years lost due to premature death and years living in ill health and are used to measure the total burden of a disease globally and nationally. When disease are looked at individually, COPD has the biggest impact (3.4% of all DALYs), followed by asthma (2.1% of all DALYs).

The main risks attributed to respiratory disease deaths and DALYs in England are tobacco smoke (72%) and air pollution (14%).

Source: Global Burden of Disease (2015); GBD Compare Data Hub

Respiratory diseases are the 3rd main cause of death in England, behind cancer and circulatory diseases. In 2016, 13.7% of all registered deaths in England were caused by respiratory diseases. The percentage was similar for men and women, at 13.7% and 13.6% respectively. 10.4% of premature deaths (people aged under 75) were caused by respiratory diseases.

Source: Office for National Statistics (2017); Deaths registered in England and Wales: 2016 - Data tables

In 2014-16, the under 75 mortality rate from respiratory diseases was 33.8 per 100,000 people. The rate for men and women differs, with a higher rate of 39.2 deaths per 100,000 for men compared to 28.7 for women.

55% of premature deaths from respiratory diseases were considered preventable in 2014-16. This means that the underlying cause could potentially be avoided by public health interventions in the broadest sense. In 2014-16, there were 18.6 premature deaths from respiratory diseases per 100,000 people that were considered preventable. The rate for men was higher again at 20.8 per 100,000 population, compared to 16.5 for women.

Source: Public Health England (2017); Public Health Outcomes Framework

"The National COPD Audit Programme published a report in November 2016, which looked at primary care. The aim was to provide recommendations regarding the care and diagnosis of people with COPD and support primary care clinicians. Key recommendations from the audit included:

- a diagnosis of COPD should be made accurately and early. If the diagnosis is incorrect, any subsequent treatment will be of no value
- people with COPD should be offered interventions according to value-based medicine principles
- people with severe disease should be identified for optimal therapy. COPD encompasses a broad spectrum of conditions and health statuses and a personalised approach is essential
- there should be better coding and recording of COPD consultations, prescribing and referrals"

Source: Royal College of Physicians (2016); National COPD Audit Programme: COPD in England - Finding the measure of success

On 31st March 2017, the recorded prevalence of respiratory diseases was:

	Wokingham CCG	Comparator Group	England	Number of people on the register in Wokingham CCG
Asthma	6.3%	5.8%	5.9%	10,277
COPD	1.0%	1.3%	1.9%	1,698

Source: NHS Digital (2017); Quality and Outcomes Framework 2016/17: Report for England

In 2016, 12.7% of all registered deaths in Wokingham were caused by respiratory diseases, compared to 13.7% in England. The percentages were different for men and women in Wokingham at 12.4% and 13.1% respectively.

6.3% of premature deaths (people aged under 75) in Wokingham were caused by respiratory diseases, compared to 10.4% in England. These varied between men and women: 8.4% for men; 3.5% for women.

Source: Office for National Statistics (2017); Deaths registered in England and Wales: 2016 - Data tables

In 2014-16, the under 75 mortality rate from respiratory diseases was 19.4 per 100,000 people in Wokingham. This was significantly better than the England rate of 33.8 per 100,000 population and significantly better than the comparator group rate of 24.3.

Wokingham's rate for men was higher at 25.3 per 100,000 population, compared to 14.1 for women. This is inline with the national picture.

In Wokingham, 49% of premature deaths from respiratory diseases were considered preventable, compared to 55% nationally. In 2014-16, there were 9.8 premature deaths from respiratory diseases per 100,000 people that were considered preventable.

Source: Public Health England (2017); Public Health Outcomes Framework

5.3 Cardiovascular disease

The prevalence of disease is captured through the GP Quality and Outcomes Framework (QOF) on an annual basis. On 31st March 2016, the recorded prevalence of circulatory disease in England was as follows:

- Atrial Fibrillation: 1.8%
- Coronary Heart Disease: 3.2%
- Heart Failure: 0.8%
- Hypertension: 13.8%
- Stroke and Transient Ischaemic Attack (TIA): 1.7%

Source: NHS Digital (2017); Quality and Outcomes Framework 2016/17: Report for England

Over 24% of people in England are estimated to have hypertension (high blood pressure), which is 13.5 million people. However, over 5.6 million of these are not diagnosed.

Source: British Heart Foundation (2016); High Blood Pressure: How can we do better?

High blood pressure is one of the leading causes of premature death and disability in England, according to the Global Burden of Disease study. In 2015 over 15% of all deaths were attributable to high blood pressure, which makes this the third main cause, behind tobacco smoke and dietary risks. 8% of all disability-adjusted life years (DALYs) were attributable to high blood pressure. (A DALY is the number of healthy life years lost due to premature death and years living in ill health).

The main causes of cardiovascular disease deaths and DALYs in England are high blood pressure, poor diet, high cholesterol and high body-mass index.

Source: Global Burden of Disease (2015); GBD Compare Data Hub

In 2016, 25.4% of all registered deaths in England were caused by diseases of the circulatory system. The percentage was marginally higher for men at 26.6%, compared to 24.2% of women. 21.5% of premature deaths (people aged under 75) were caused by diseases of the circulatory system. The percentage for these was also higher for men at 24.8%, compared to 16.8% of women.

Source: Office for National Statistics (2017); Deaths registered in England and Wales: 2016 - Data tables

In 2014-16, the under 75 mortality rate from cardiovascular disease was 73.5 per 100,000 people. This mortality rate has continued to decrease since 2001-03, when the figure was 138.0 per 100,000 people. The rate for men and women varies significantly, with a much higher rate of 102.7 deaths per 100,000 for men compared to 45.8 for women.

64% of premature deaths from cardiovascular were considered preventable in 2014-16. This means that the underlying cause could potentially be avoided by public health interventions in the broadest sense. In 2014-16, there were 46.7 premature deaths from cardiovascular disease per 100,000 people that were considered preventable. The rate for men was significantly higher again at 70.4 per 100,000 population, compared to 24.3 for women.

Source: Public Health England (2017); Public Health Outcomes Framework

On 31st March 2016, the recorded prevalence of circulatory diseases was:

		Wokingham CCG	Comparator Group	England	Number of people on the register in Wokingham CCG

<i>Atrial Fibrillation</i>	1.8%	2.0%	1.8%	2,869
<i>Coronary Heart Disease</i>	2.4%	2.7%	3.2%	3,862
<i>Heart Failure</i>	0.6%	0.6%	0.8%	994
<i>Hypertension</i>	12.4%	13.2%	13.8%	20,196
<i>Stroke or TIA</i>	1.4%	1.6%	1.7%	2,328

Source: NHS Digital (2017); Quality and Outcomes Framework 2016/17: Report for England

In 2016, 26.0% of all registered deaths in Wokingham were caused by diseases of the circulatory system, compared to 25.4% in England. The percentages were different for men and women in Wokingham at 28.4% and 23.7% respectively.

22.3% of premature deaths (people aged under 75) in Wokingham were caused by diseases of the circulatory system, compared to 21.5% in England. These were also higher for men at 27.1%, compared to 16.7% for women.

Source: Office for National Statistics (2017); Deaths registered in England and Wales: 2016 - Data tables

In 2014-16, the under 75 mortality rate from cardiovascular disease was 52.6 per 100,000 people in Wokingham. This was significantly better than the England rate of 73.5 per 100,000 population and similar to the comparator group rate of 56.3.

Wokingham's rate for men was higher at 68.4 per 100,000 population, compared to 35.5 for women. This is in line with the national picture.

In Wokingham, 66.4% of premature deaths from cardiovascular were considered preventable, compared to 63.6% nationally. In 2014-16, there were 33.7 premature deaths from cardiovascular disease per 100,000 people that were considered preventable. The rate for men was significantly higher again at 48.6 per 100,000, compared to 19.4 for women.

Source: Public Health England (2017); Public Health Outcomes Framework

Figure X: Mortality from cardiovascular disease and DALYs attributable to different risk factors

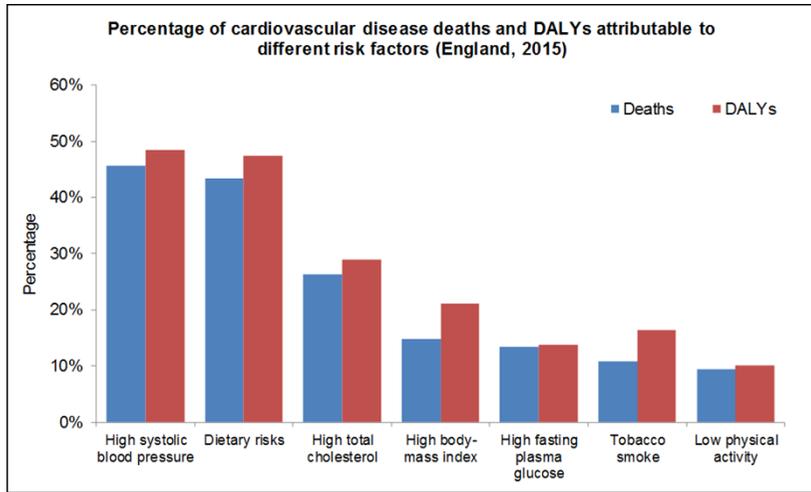


Figure X: Mortality from circulatory disease by ward

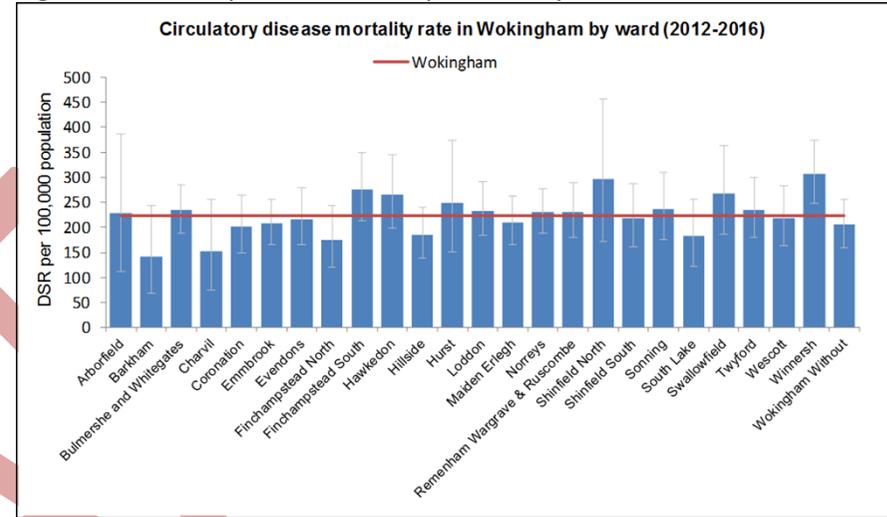


Figure X: GP Practice recorded prevalence of cardiovascular disease

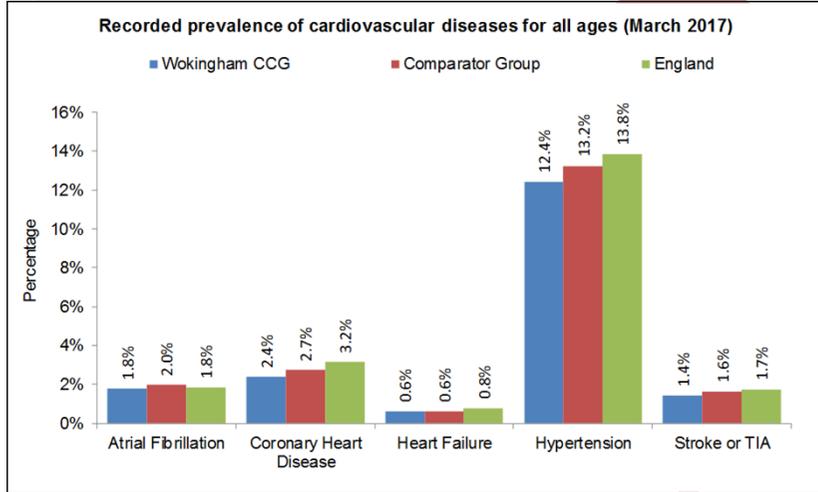


Figure X: Mortality from circulatory disease by deprivation quintile

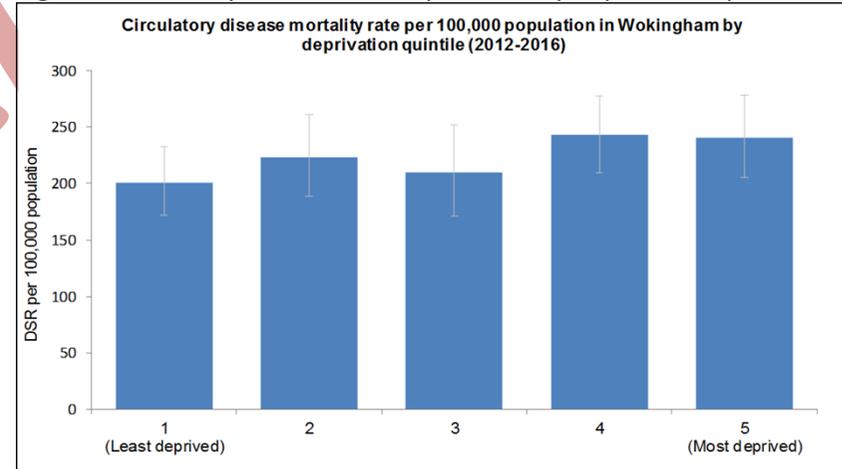
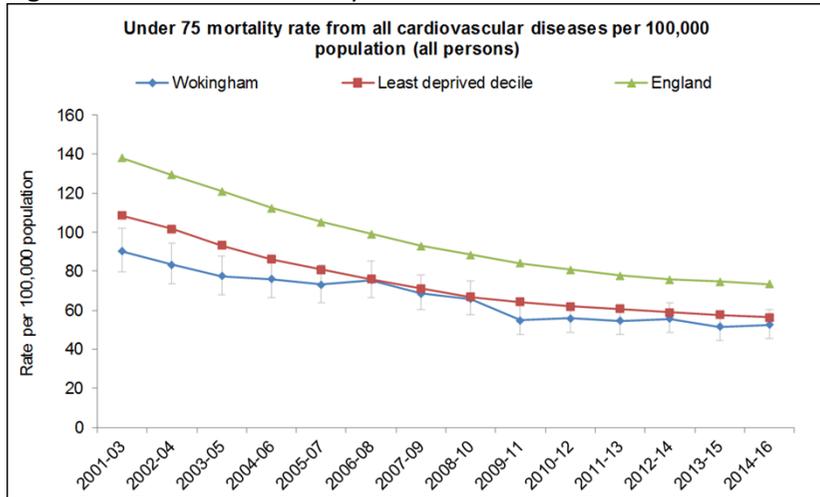


Figure X: Premature mortality from all cardiovascular diseases



Cardiac arrest

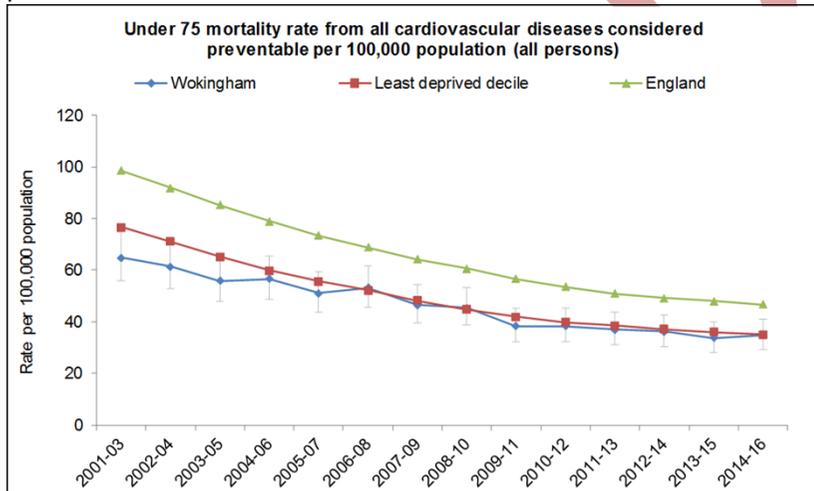
CVD

Stroke

Qof prevalence vs. estimated prevalence

Hospital admissions

Figure X: Premature mortality from all cardiovascular diseases considered preventable



5.4 Chronic Kidney Disease

Chronic Kidney Disease (CKD) is a long term condition where the kidneys do not function properly. It does not usually cause symptoms until reaching a more advanced stage, but can be detected at earlier stages with blood and urine tests. There are five stages of CKD. For many people the disease can be halted in its progress if diagnosed early enough and managed effectively. In some people the disease is progressive and may be diagnosed too late for effective management. (Source: NHS Digital (2017); Quality and Outcomes Framework 2015/16: Report for England)

The prevalence of CKD is captured through the GP Quality and Outcomes Framework (QOF) on an annual basis. On 31st March 2017, the recorded prevalence of CKD in England was 4.1% and this included people that were at stage 3a to 5 of the disease. This was the same as the 2016 prevalence rate. (Source: NHS Digital (2017); Quality and Outcomes Framework 2016/17: Report for England)

Chronic Kidney Disease causes just under 1% of deaths and disability adjusted-life years (DALYs) in England. DALYs are the number of healthy life years lost due to premature death and years living in ill health.

Key risk factors for CKD in England include high blood pressure, high fasting glucose and high body-mass index.

A low glomerular filtration rate is also attributable to other deaths and DALYs from other causes, such as cardiovascular diseases. In total low glomerular filtration rate is attributable to over 3% of all deaths in England and 2% of DALYs.

Source: Global Burden of Disease (2015); GBD Compare Data Hub

In 2016, 0.7% (3,300) of all registered deaths in England were caused by glomerular and renal tubolo-intestinal diseases or renal failure.

Source: Office for National Statistics (2017); Deaths registered in England and Wales: 2016 - Data tables

On 31st March 2017, the recorded prevalence of Chronic Kidney Disease for people aged 18 and over was:

	Wokingham CCG	Comparator Group	England	Number of people on the register in Wokingham CCG
Chronic Kidney Disease	3.8%	3.9%	4.1%	4,770

Figure X:

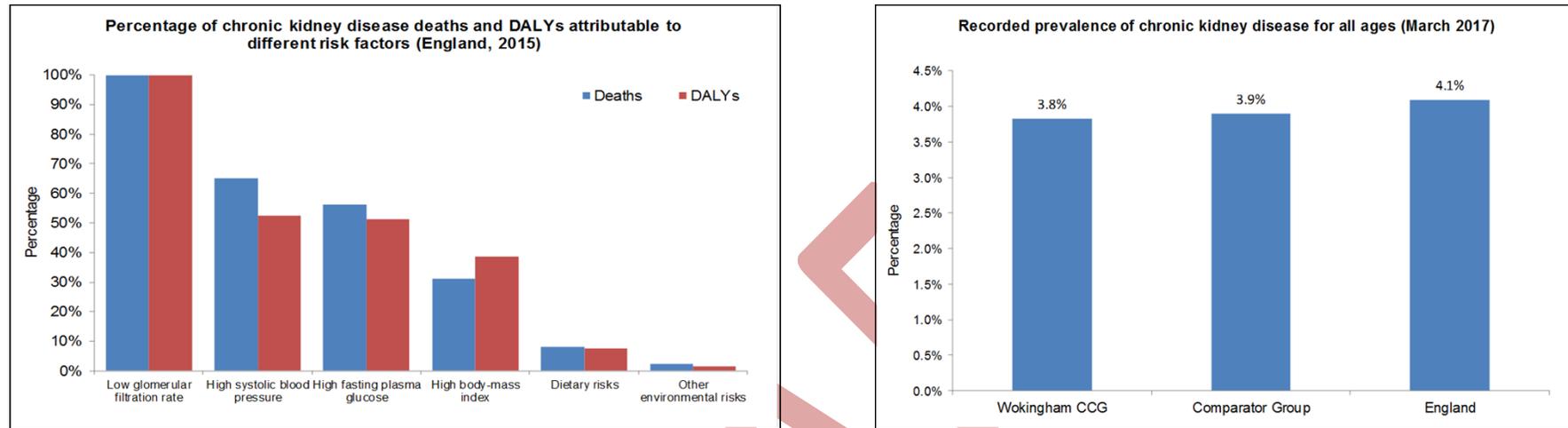


Figure X:

QoF registers vs hospital admissions

5.5 Liver disease

Hospital admissions

QoF register

Approximately 1.5% of disability adjusted-life years (DALYs) in England are caused by cirrhosis and other chronic liver diseases, which is the 14th leading cause. DALYs are the number of healthy life years lost due to premature death and years living in ill health and are used to measure the total burden of a disease globally and nationally.

The main risks attributed to cirrhosis and other chronic liver disease are alcohol use (58%) and drug use (28%).

Source: *Global Burden of Disease (2015); GBD Compare Data Hub*

"In 2014/15, there were over 61,000 hospital admissions in England with a primary diagnosis of liver disease. This was a rate of 119 per 100,000 population, which was a significant increase on the previous year. Rates for men were higher at 150.6 per 100,000 population, compared to 90.9 for women.

The rate of alcohol-specific hospital admissions in 2014/15 decreased slightly on the previous year. In total there were 191,370 admissions at a rate of 364 per 100,000 population. Again, the rate for men was much higher at 502 per 100,000 population, compared to 235 for women."

Source: *Public Health England (2017); Liver Disease Profiles*

"In 2016, there were 7,650 registered deaths in England from diseases of the liver, which was 1.6% of all deaths. 59% of these were from alcoholic liver disease.

The percentage of premature deaths (people aged under 75) from diseases of the liver were higher at 4.0% and 67% of these are from alcoholic liver disease."

Source: *NOMIS (2017); Mortality statistics - Underlying cause, sex and age (2013 - 2016)*

In 2014-16, the under 75 mortality rate from liver disease was 18.3 per 100,000 people. The rate for men and women differ, with a

higher rate of 23.9 deaths per 100,000 for men compared to 12.8 for women.

88% of premature deaths from liver disease were considered preventable in 2014-16. This means that the underlying cause could potentially be avoided by public health interventions in the broadest sense. Most liver disease is preventable and much is influenced by alcohol consumption and obesity prevalence. In 2014-16, there were 18.3 premature deaths from respiratory diseases per 100,000 people that were considered preventable. The rate for men was higher again at 23.9 per 100,000 population, compared to 12.8 for women.

Source: *Public Health England (2017); Public Health Outcomes Framework*

"Public Health England's Liver Disease Profile includes a number of other premature mortality rate indicators for specific types of liver disease. The table below highlights this data for 2014-16:

Type of liver disease	Number of premature deaths	Rate of deaths per 100,000 population	% of deaths from liver disease
Alcoholic Liver Disease	12,501	8.20	49.0%
Non Alcoholic Fatty Liver Disease	813	0.54	3.2%

Hepatitis B related end-stage liver disease

189 0.13 0.7%

Hepatitis C related end-stage liver disease

1009 0.67 4.0%

Source: Public Health England (2017); Liver Disease Profiles

In 2014/15, there were 116 hospital admissions in Wokingham with a primary diagnosis of liver disease. This was a rate of 76.8 per 100,000 population, compared to England's rate of 119.2. 58.6% of these admissions were for men.

The rate of alcohol-specific hospital admissions in Wokingham increased in 2015/16, however the rate was still significantly better than both England and the deprivation decile comparator group. There were 514 hospital admissions in Wokingham with a primary diagnosis of liver disease, which was a rate of 332.6 per 100,000 population. The majority (57.4%) of these admissions were for men.

(Source: Public Health England (2017); Liver Disease Profiles)

In 2016, 1.0% of all registered deaths in Wokingham were caused by liver disease, compared to 1.6% in England.

(Source: Office for National Statistics (2017); Deaths registered in England and Wales: 2016 - Data tables)

In 2014-16, the under 75 mortality rate from liver disease was 11.8 per 100,000 people in Wokingham. This was significantly better than the England rate of 18.3 per 100,000 population and significantly better than the comparator group rate of 13.3.

In 2014-16, there were 9.3 premature deaths from liver disease per 100,000 people that were considered preventable in Wokingham. This was significantly better than the England rate of 16.1 per 100,000 population and significantly better than the comparator group rate of 11.7.

(Source: Public Health England (2017); Public Health Outcomes Framework)

Figure X: Premature mortality from liver disease

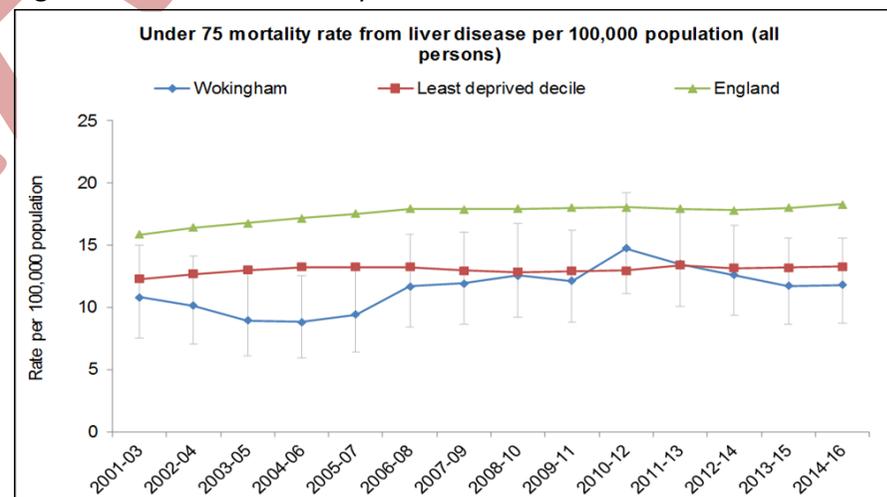
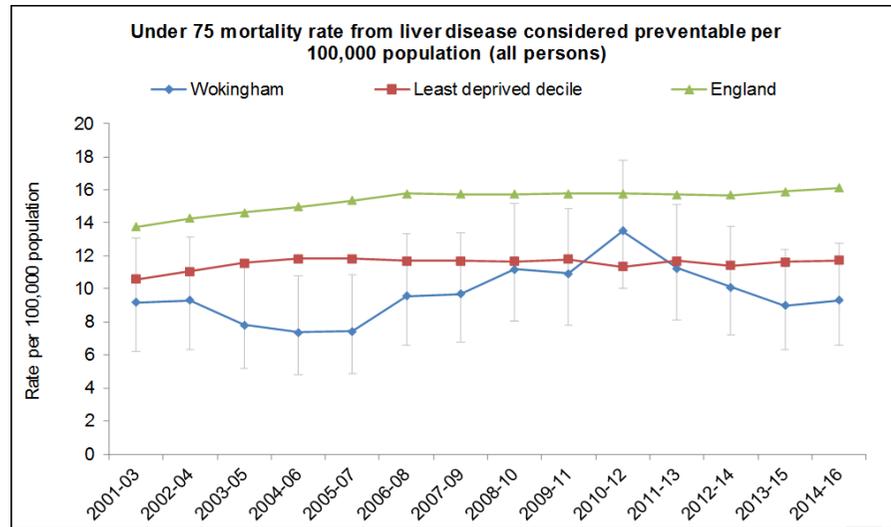


Figure X: Premature mortality from liver disease considered preventable



5.6 Long term neurological conditions

Neurological conditions result from damage to the brain, spinal column or peripheral nerves. There are over 600 types of neurological conditions. Examples include Parkinson's disease, motor neurone disease, and epilepsy. Some of these conditions are life threatening and many carry a significant burden to the individual, their family and to health and social care.

Approximately 4% of NHS spend is spent on neurological services and 14% of the social care budget is spent on people living with neurological conditions. An average clinical commissioning group (CCG) will have 59,000 patients with a neurological condition. People with a neurological condition are 35% more likely to die prematurely than those without a neurological condition. People

with a neurological condition have the lowest health-related quality of all people with any long term condition. (Source: NHS England)

In order to analyse local data in relation to neurological conditions, we first need to define the relevant diseases and conditions we are referring to. Two data sources have been used. These use slightly different criteria in order to capture data around neurological conditions. NHS England's Rightcare Neurology Focus Packs use the NHS Programme Budgeting definition and Public Health England's Neurology Hospital Activity Data Packs use the National Neurology Intelligence Networks definition. There are 335 diagnosis codes that are common to both definitions.

There are an additional 138 diagnosis codes included in the Neurology Intelligence Networks definition that are not included in the Programme Budgeting definition and a further 138 codes that are included in the Programme Budgeting definition but not in the Neurology Intelligence Network definition. For further information around defining neurological conditions for health intelligence purposes please follow this link: [PHE Neurology Data Compendium Definitions](#)

NHS England's RightCare programme aims to ensure the best possible care is delivered as efficiently as possible. It is grounded in ensuring that patients access the right care, in the right place, and at the right time. It has three components; intelligence, innovation, and implementation. As part of the intelligence component, NHS England has developed CCG data packs including a Neurological conditions focus pack. The packs identify variation in outcomes which commissioners should use, together with other local

intelligence, to ensure that plans focus on the biggest areas for potential improvement in outcomes, resource allocation, and in reducing inequalities. The data in the table below has been taken from the Neurological conditions focus pack. For further information on the Right Care programme including the full focus pack dataset and analysis tools please follow the link below.

Table X:

Indicator Name	Date	Numerator	Denominator	Value	National	Similar 10 Average*	5/Lowest 5 Average*	Compared to Similar 10	Compare to best/lowest 5
Headaches and migraine - Number of day case admissions per 1,000 population	2014/15	15	161,987	9	23	21	16	lower	lower
Epilepsy - Number of day case admissions per 1,000 population	2014/15	6	161,290	4	9	11	6	lower	same
Epilepsy - Number of emergency admissions by children per 1,000 population	2014/15	32	37,937	84	118	106	78	same	same
Tumours of the Nervous System - Number of day case admissions per 1,000 population	2014/15	Supressed	Supressed	Supressed	18	12	6	N/A	N/A
Multiple Sclerosis and Inflammatory Disorders - Number of day case admissions per 1,000 population	2014/15	112	162,791	69	80	105	64	lower	same
Parkinsonism and other Extrapyrmidal Disorders - Number of day case admissions per 1,000 population	2014/15	7	163,551	4	10	21	8	lower	same
Epilepsy (18+) - Prevalence	2014/15	802	123,295	1	1	1	1	same	same
Epilepsy mortality rate	2011-13	Supressed	Supressed	Supressed	1	2	Unable to calculate	N/A	N/A
New outpatient neurology appointments for those aged 20+ DSR per 100,000 population (consultant)	2013/14	1,298	117,567	1,120	944	818	986	higher	higher
% of the total population with a limiting long term illness or disability	2014/15	18,380	154,380	12	-	14	13	lower	lower

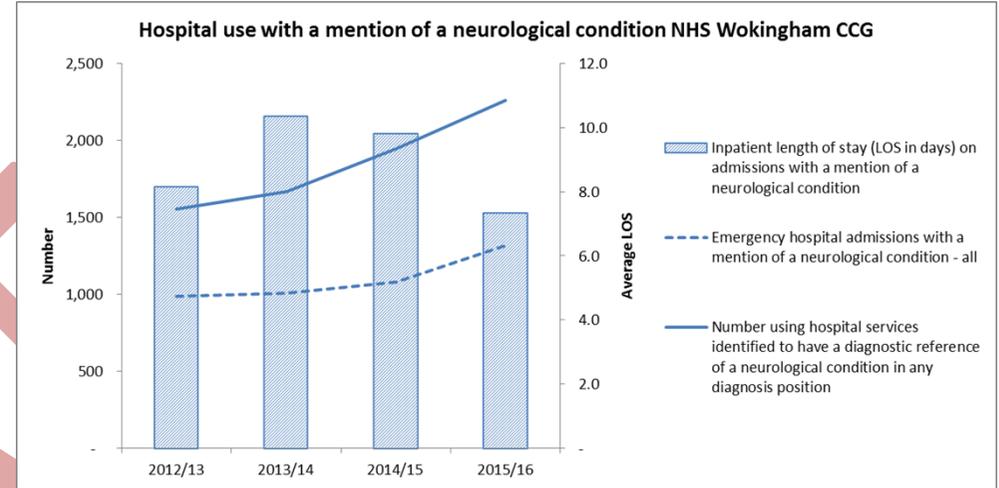
Source: Rightcare Neurology Focus Packs, NHS England

Table X:

Primary diagnosis	Date	Emergency hospital admissions with a mention of a neurological condition - all	Emergency hospital admissions with a mention of a neurological condition - under neurology consultant	Emergency hospital admissions with a mention of a neurological condition - neurology ward	Inpatient length of stay (LOS in days) on admissions with a mention of a neurological condition	Number using hospital services identified to have a diagnostic reference of a neurological condition in any diagnosis position
ALL DIAGNOSES	2015/16	1,317	29	8	7	2,259
Ataxia	2015/16	-	N/A	N/A		7
Central nervous system infections	2015/16	12	N/A	N/A	17	24
Cranial nerve disorder	2015/16	10	N/A	N/A	1	41
Development disorders	2015/16	*	N/A	N/A		23
Epilepsy	2015/16	98	N/A	N/A	5	296
Functional Disorders	2015/16	7	N/A	N/A	6	20
Headaches and migraine	2015/16	129	N/A	N/A	1	264
Motor neurone disease and Spinal muscular atrophy	2015/16	*	N/A	N/A		14
Multiple sclerosis and inflammatory disorders	2015/16	8	N/A	N/A	3	92
Neuromuscular diseases	2015/16	10	N/A	N/A	8	58
Parkinsonism and other Extrapryamidal disorders/Tic disorder	2015/16	11	N/A	N/A	16	219
Peripheral nerve disorders	2015/16	6	N/A	N/A	9	379
Rare and other neurological diseases	2015/16	28	N/A	N/A	5	230
Sleep disorders	2015/16	-	N/A	N/A		16
Spondylotic myelopathy and Radiculopathy	2015/16	20	N/A	N/A	4	467
Traumatic brain and spine injury	2015/16	45	N/A	N/A	6	52
Tumours of the nervous system	2015/16	22	N/A	N/A	14	57
Other primary diagnosis on admission*	2015/16	906	N/A	N/A	9	N/A

Source: Neurology services: hospital activity data, Public Health England

Figure X:



Source: Neurology services: hospital activity data, Public Health England

5.7 Preventable sight loss (shared service – August 2018)

PANSI estimates

Visual impairment

This above table is based on the prevalence of visual impairment in the UK, A review of the literature, by Tate, Smeeth, Evans, Fletcher, Owen and Rudnicka, RNIB, 2005. They report that "Most studies have been done in the older population and there is a scarcity of data in younger adult age groups in the UK. A review by Nissen et al of epidemiological studies performed in Western Europe, North America and Australia covering the age group 20 to 59 years found the prevalence of blindness was 0.08 and of visual acuity 6/24 to

6/48 was 0.07%. These figures agree well with the prevalence of registrations in a similar age range and we conclude that registration data provide reasonably accurate estimates of the prevalence of serious vision impairment in the younger adult age groups". The RNIB suggest a lower figure of 1 in 500 as an estimated basis of people who would be registerable. The Tate study also argues, as do others, that estimates of less than severe visual impairment are unreliable with a high degree of variance reported in self-report studies. A mean of the three figures, 0.065%, has been used as an estimate of the numbers of people with a severe visual impairment.

The prevalence rates have been applied to ONS population projections for the 18-64 population to give estimated numbers predicted to have a serious visual impairment and require help with daily activities, projected to 2035.

5.8 Physical and sensory impairment

Hearing loss

*Prevalence of hearing loss in the better ear averaged across the mid-frequencies (0.5, 1, 2 and 4KHz). Hearing loss is recorded in decibels Hearing Level (dBHL).

The term hearing loss is intended to be inclusive of those who identify as hard of hearing, deaf and Deaf, including those who use British Sign Language (BSL) as their first or preferred language.

Hearing loss is usually measured by finding the quietest sounds someone can hear using tones with different frequencies, which are heard as different pitches. The person being tested is asked to respond, usually by pressing a button, when they can hear a tone and the level of the tone is adjusted until they can just hear it. This level is called the threshold. Thresholds are measured in units called dBHL: dB stands for 'decibels' and HL stands for 'hearing level'.

The greater the threshold level is in dBHL the worse the hearing loss. Anyone with thresholds between 0 and 20 dBHL across all the frequencies is considered to have 'normal' hearing. The threshold of 25 dBHL indicates hearing loss; the threshold of 65 dBHL indicates severe hearing loss.

Evidence shows that unsupported hearing loss can have an adverse impact on a person's health and quality of life, for example people with hearing loss may find it difficult communicate with other people and have an increased risk of social isolation and other problems such as anxiety and depression. People with hearing loss may also face barriers to employment due to poor deaf awareness or the lack of communication support.

The prevalence rates have been applied to ONS population projections of the 18-64 population to give estimated numbers predicted to have some, or severe, hearing loss to 2035.

Age	Some hearing loss (%)	Severe hearing loss (%)
18-30	1.8	0
31-40	2.8	0.7
41-50	8.2	0.3
51-60	18.9	0.9
61-70	36.8	2.3
71-80	60.3	4
80+	93.4	22.3

25-34	52	54	54	51	48
35-44	125	123	123	124	119
45-54	136	134	133	130	130
55-64	271	296	327	327	324
Access to social care18-64	585	608	637	632	622

5.8 Access to social care/personalisation (shared services April 2018)

Table X: People aged 18-64 predicted to have some hearing loss, by age, projected to 2035

	2017	2020	2025	2030	2035
18-24	184	176	181	203	205
25-34	392	398	388	370	378
35-44	1,182	1,168	1,163	1,171	1,162
45-54	3,146	3,108	3,076	3,004	3,017
55-64	4,924	5,366	5,865	5,868	5,799
18-64	9,829	10,217	10,673	10,616	10,561

Table X: People aged 18-64 predicted to have severe hearing loss, by age, projected to 2035

	2017	2020	2025	2030	2035
18-24	0	0	0	0	0