This section presents the joint strategic needs assessment for the resident population of North East Hampshire and Farnham Clinical Commissioning Group (NEHF CCG). Where possible and appropriate, data are presented for the CCG. Where data are not available by CCG the local authority districts which fall within the CCG boundary are presented. These local authority areas are Hart, Rushmoor and Waverley. It should be noted that only a part of Hart and the Farnham area of Waverley are included within this CCG area.

To place local figures into context, data are compared to other areas. Where available the preferred comparator is always England. Where this is not available comparison with Hampshire has been made.
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Key Findings

- The North East Hampshire and Farnham population is a relatively young population, with a higher proportion of people under the age of 15 years compared to Hampshire and England. This area also has higher numbers of working age people.

- The population is forecast to grow by 4,175 (2.6%) by 2018, which is higher than the predicted growth for England of 1.7%. There is a predicted increase in all population groups within NEHF CCG aside from 15-19 year olds. The predicted growth of 1,482 (12.5%) in the over 75 years population, which is higher than England, has significant implications.

- An ageing population will put pressure on health and social care services, as older people are more likely to have long term conditions with multiple disabilities and there will be changing demands on other services such as housing, transport and leisure. People over the age of 65 account for more than 60% of hospital inpatient stays and most health and social care costs.

- There are increasing numbers of older and vulnerable people living alone who are likely to have health and social care needs and attention needs to be given to how they can access care and support services. The aging population of carers will also have implications.

- The numbers of residents from minority groups, such as the Nepalese community, is relatively small (estimated at approximately 10,000 people) but potentially marginalised. It is important to continue to work with other local statutory organisations and voluntary groups to find efficient and cost effective ways of commissioning appropriately for minority groups.

- Deprivation and socio-economic disadvantage are associated with poor health outcomes. Overall, the CCG has very low levels of deprivation. Yet 20% of the population, over 40,000 people, live in the most deprived quintile nationally for health deprivation and disability. People living within deprived areas tend to have poorer health and be high users of healthcare services.

- The current economic situation is likely to adversely affect the health of some sectors of the CCG population with a disproportionate effect on vulnerable groups such as those with disabilities and young people leaving care.

- Cancer is now the leading cause of death, followed by circulatory disease and respiratory disease.
• Smoking, hypertension, obesity, physical inactivity and alcohol are the top five risk factors contributing to the overall burden of disease in the UK. Smoking rates in NEH&F CCG are lower than the national average, but smoking remains the single most important cause of ill-health and premature death in NEHF CCG. There is a particularly high rate of adult smoking in Rushmoor compared to Hart. Diet, obesity and exercise rates in NEHF CCG are slightly better than the national average, but still remain very low. Compared to the Hampshire average, alcohol specific hospital admissions in NEHF CCG are high.

• Immunisation uptake is relatively high. However, priority should be given to increasing uptake for Measles Mumps and Rubella in Hart. Seasonal flu vaccination uptake amongst ‘at risk’ groups is low and requires improvement. The teenage booster uptake appears to be particularly low and the causes for this require investigation. Particular emphasis should be paid to increasing uptake in marginalised populations e.g. Gypsies and Travellers.

• The greatest number of years lived with disability in the UK are due to mental and behavioural disorders and musculoskeletal disorders. The appropriateness of high hospital admission rates within NEHF CCG for falls and injuries, hip and knee replacement rates and facet joint injections should be explored to ensure people access evidence based healthcare.

• The prevalence of depression is higher than the national average. This could be due to better diagnosis. It is estimated that this will increase by 20% over the next 7 years. This is the highest increase across Hampshire. Appropriate anti-depressant prescribing and offering alternative approaches to increase mental well-being will be crucial in increasing mental health and maintaining costs.
Recommendations

Good maternal and infant health is key to the long term health of the population. We need to ensure we have adequate capacity in services for children and their families, at the same time as ensuring we scale up and target services and support for older people. Particular focus is required on support for working age adults and adults on retirement, who are the main carers for the young and older population.

The differences in population demographics between districts means the level of need for particular services and support will be different, so we must make sure we target our resources appropriately. To reduce the steepness of the social gradient in health, actions must be universal but with a scale and intensity that is proportionate to the level of disadvantage (as recommended in the Marmot report). It is important to identify needs in those areas where deprivation is high and ensure those residents are aware of and able to access healthcare services appropriately.

Prevention and mitigation of early disease through behaviour modification (smoking etc.) should form the foundation of managing the health of the population. This should take place alongside early detection of disease and evidence based management. Pathways and services for the high volume causes of death and causes of disability should be in line with best practice guidelines.

Services should be tailored around the needs of a population, using a ‘population healthcare’ approach and commissioning on the basis of patient outcomes. Men’s health and reducing emergency presentation of conditions through early identification are key priorities for NEHF CCG. Consideration of gender inequalities in accessing timely services could be an important element of this approach, particularly in relation to stroke prevention. Reduction in inappropriate care variation across general practices is another important aspect.

Action should be taken in conjunction with NHS England to increase immunisation rates with a focus on marginalised populations e.g. Gypsies and Travellers.
1. Demography

In the 2011 census the resident population of NEHF CCG was 205,729 people, consisting of 102,027 men (49.6%) and 103,702 women (50.4%). This makes up 15.6% of the total resident population of Hampshire\(^1\). The geographical area of NEHF CCG covers 18,637 hectares, with 11 people per hectare compared to the Hampshire figure of 3.6 people per hectare (ONS, 2011). Rushmoor is one of the most densely populated districts in Hampshire, with 24 people per hectare. There are 80,407 households in NEHF CCG.

The population pyramid (figure 1) shows that relative to England, NEHF CCG has a larger proportion of children aged 0-19 (25% of the population, 51,198 children and young people), a larger proportion of working age people aged 45-64 years (26% of the population, 52,218 people) and a lower proportion of people over the age of 65 years (15% of the population, 30,833 people).

Figure 1: North East Hampshire and Farnham CCG population pyramid for resident population, 2011 (ONS 2011 mid year population estimates for LSOAs)

\(^{1}\) ONS resident population, 2011.
Figure 2 shows that the Rushmoor population has a younger age profile than the Farnham and Hart; with 24,922 (26.4% of the population) aged 0-19 years in Rushmoor compared with 21,228 (23.2% of the population) in Hart and 10,062 (23.7%) in Farnham. There is also a larger proportion of people aged 20-44 years in Rushmoor than Hart and Farnham (39.5% of the population compared with 34.9% and 32% respectively). Hart and Farnham’s population profiles are more akin to the Hampshire population profile.

Figure 2: Population pyramids for the CCG’s constituent Local Authority areas: Rushmoor, Hart and Waverley (Farnham area only)
The population of NEHF CCG is projected to increase by 1482 (2.55%) by 2018, which is higher than the projected increase for Hampshire (1.77%) but lower than England (4.11%) over the same time period (figure 3). There is a projected increase in all population groups aside from 15-29 year olds, which is estimated to reduce by 756 (2.27%). The largest projected proportionate increase is for over 75 year olds, with an increase of 1,482 (12.49%), which is a higher rate than for Hampshire (9.94%) and England (10.56%). The 45-59 year old population is also projected to grow by 1,285 (4.05%), which is a higher proportion than for Hampshire (2.79%).

**Figure 3: Forecast change in the resident NEHF CCG population 2013 to 2018**
1.1. Ethnicity and residence in the UK

The 2011 Census showed that 85.9% of the population in NEHF CCG identified themselves as White British. This proportion is higher than the England (79.8%), but lower than Hampshire (91.8%). Non British White people make up a further 4.4% of the population. By Hampshire District, Rushmoor has the largest non-white population at 15.3% (up from 4.4% in 2001). About 2.7% of the NEHF CCG population have been resident in the UK for more than 2 years and less than 5 years, compared to 1.3% in Hampshire and 2.2% in England.

In North East Hampshire and Farnham CCG the largest ethnic groups other than White British as described by detailed Census ethnic group are Asian/Asian British: Nepalese (includes Ghurkha) (6,269 people), Indian or British Indian (2,280 people), White: Other Western European (1,721 people), White: Irish (1,577 people), Black/Black British: African (1,430 people).

What does this mean?

Good maternal and infant health is key to the long term health of the population. We need to ensure we have adequate capacity in services for children and their families, at the same time as ensuring we scale up and target services and support for older people.

The differences in population demographics between districts means the level of need for particular services and support will be different, so we must make sure we target our resources appropriately.

There are increasing numbers of people from Black and Minority Ethnic groups in Rushmoor. As the proportion is the same as the national average Rushmoor, we need to make sure that our services meet the needs of these people, so that everyone can be supported to take responsibility for their own and their families’ health and have timely access to services and interventions to improve health and wellbeing.
2. Health inequalities

Health inequalities are the avoidable differences in health, wellbeing and life expectancy between people. It is well know that age, sex, genetic make-up and lifestyle behaviours influence health. Other factors, which are known as the wider determinants also influence health. These include income, education, employment, housing and neighbourhood circumstances. The wider determinants of health can affect a person’s health directly as well as their ability to manage their own health. They also help explain the difference in health and life expectancy between the poorest and richest in society.

Life expectancy at birth is the average number of years a newborn could expect to live if he or she experienced the age-specific mortality rates in a given year. It is an indicator of current health and mortality conditions. The life expectancy at birth in NEHF CCG is 80.8 years for males (80.3-81.3) and 85.2 years for females (84.7-85.8), this is higher than England and South East (Figures 4 and 5). The male life expectancy at birth is the same as Hampshire (80.8; 80.6-81) and higher than Hampshire women (84.2 years; 84-84.4).

Although life expectancy at CCG level is higher than England and the South East, this masks differences at a lower geographical level. Figure 4 shows life expectancy at local authority level for males. Life expectancy at birth in Rushmoor for males is lower than England, although this difference is not statistically significant. Life expectancy for males in Hart is the highest of all Hampshire’s Districts.

Figure 4: Male life expectancy at birth – local authority 2009-2011 pooled

Sources: ONS Annual Death Extract & ONS LSOA mid year population estimates. Comparators from ONS Life Expectancy Tables.
Life expectancy at birth for females is shown in figure 5. As with life expectancy for males, Hart has the highest female life expectancy across all Hampshire’s Districts. Female life expectancy in Rushmoor is also higher than England and the South East.

**Figure 5: Female life expectancy at birth – local authority 2009-2011 pooled**

![Life Expectancy Chart](image)

Sources: ONS Annual Death Extract & ONS LSOA mid year population estimates. Comparators from ONS Life Expectancy Tables.

### 2.1. Overall deprivation

The Index of Multiple Deprivation (IMD) ranks local areas across the country in terms of their relative deprivation as measured by a range of different factors, shown in figure 6.

NEHF CCG is ranked 207th out of 212 CCGs in England in terms of the IMD 2010 (where 1 is the most deprived). Figure 6 shows that pockets of deprivation exist around Aldershot and the lower super output areas (LSOAs) of North Town (Aldershot), Heron Wood (Aldershot) and Mayfield (Farnborough) are within the 20% most deprived wards in England. 16% (12,839) of households in NEHF CCG are deprived in two or more of the IMD domain, which is lower than the Hampshire average (17.9%).
Figure 6: North East Hampshire and Farnham CCG: Indices of Deprivation 2010, Overall Score. Lower Super Output areas ranked by National Decile.

Deprivation data from Department for Communities and Local Government.

Figure 7 shows that the area is in the top 100 most deprived for geographical barriers when compared to other areas in England (IMD 2010).

Figure 7: Indices of Deprivation 2010 - England ranks based on summary scores for North East Hampshire and Farnham CCG²

For further information on the Indices of Deprivation 2010 domains can be found at https://www.gov.uk/government/publications/english-indices-of-deprivation-2010

² Further information on the Indices of Deprivation 2010 domains can be found at https://www.gov.uk/government/publications/english-indices-of-deprivation-2010
About 20% of the population of NEHF CCG (40,143 people) live in the most deprived quintile nationally for health deprivation and disability; these are all concentrated in Rushmoor (figure 8). In contrast, 38% of the population (76,244 people) live in the least deprived quintile nationally for this domain. This domain measures premature death and the impairment of quality of life by poor health. It considers both physical and mental health.

About 19% of the population are in the most deprived quintile for the children and young people sub domain. This is a sub domain of the Education skills and training deprivation domain measuring the extent of deprivation in terms of education, skills and training in an area. This domain can be used as a proxy indicator showing educational disadvantage. IMD overall score suggests that over half the population in NEHF (59%) live in the 40% least deprived areas in England, this equates to 117,584 residents.

**Figure 8: Proportion of population living in each deprivation quintile in North East Hampshire and Farnham CCG IMD 2010.**

Source: IMD, 2010
2.2 Education, income and employment

The conditions in which people are born, grow, live, work and age result in avoidable differences in health and mortality. There is a social gradient to health - the lower a person’s social position, the worse their health. Inequalities exist in education, employment and income. The gap in educational attainment between children living in the most and least deprived areas of England can be seen throughout their school years, from school entry to GCSE grades. There is also a direct correlation between levels of educational attainment in youth and levels of ill-health in older age.

Whilst unemployment contributes to poor health, being in good employment is protective of health\(^3\). Both education and employment influence income and there is a well established link between income and health. For children, growing up in poverty is linked to lower educational attainment, unemployment or low paid employment in later life\(^4\).

2.2.1 Children and young people

Five A* to C GCSEs is used to measure educational attainment in 16 year olds. Deprivation is generally associated with worse GCSE results.

Figure 9 shows the percentage of Hampshire pupils (58.5%) at the end of key stage 4 achieving five or more A*-C grades including English and Maths at GCSE, compared to the pupils for Hampshire’s closest statistical neighbours. All have a similar rate. However, figure 10 shows whilst educational attainment for Hampshire increased performance has deteriorated when benchmarked against the comparator areas.

\(^3\) Marmot M. Fair Society, Healthy Lives. London: The Marmot Review

\(^4\) Griggs J, Walker R. The costs of child poverty for individuals and society. The Joseph Rowntree Foundation. October 2010
Figure 9: Percentage of pupils at the end of Key Stage 4 achieving 5+ A*-C grades including English at Maths GCSE at GCSE and equivalents.

Figure 10. Percentage of pupils at the end of Key Stage 4 achieving 5+ A*-C grades including English at Maths GCSE at GCSE and equivalents – Trend Data.
As can be seen from figure 11, just under 70% of children gained A*-C GCSE grades in Hart compared with about 45% of children in Rushmoor in 2011/12. This compares to just under 58.5% of children across Hampshire.

**Figure 11: District level information for pupils achieving five or more GCSEs (or equivalent) at grade A*-C, including English and Maths**

Skill levels among Hampshire’s adult population are generally higher than the national average. 16.1% of the NEHF CCG population has no qualifications (Census 2011) this is much lower than Hampshire (18.5%) and England (22.5%). The CCG also has a higher proportion of people with higher qualifications than Hampshire overall with 32% of the population having level 4 qualifications and above, compared to 27.4% overall.

The percentage of young people not in education, employment or training (NEET) in Hampshire was 5.3%. This is 1% lower than in 2008 and is below the England rate of 6.1%. However, in 2011/12, the proportion of young people leaving care and in employment, education or training in Hampshire was 46.2%, which is lower than the England average of 57.8%.

**2.2.2 Working age adults**

About 75.9% (113,244) of the 16-74 year old population in NEHF CCG is economically active - this is higher than Hampshire and England, 73.2% and 69.9% respectively. Figure 12 shows that the area has lower levels of lone parent households not in employment and households where either no one is in employment or one person has a long term disability than Hampshire and England.

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These low levels mask disparities at a local level as they present an average across the CCG. For example over half the lone parent households not in employment (823 people) are in the Rushmoor District.

**Figure 12: Characteristics of the working age population in North East Hampshire and Fareham CCG**

<table>
<thead>
<tr>
<th></th>
<th>North East Hampshire and Farnham</th>
<th>Hampshire %</th>
<th>England %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residents aged over 16 years old with no qualifications</td>
<td>16.1 (26,229 people)</td>
<td>18.5</td>
<td>22.5</td>
</tr>
<tr>
<td>Unemployed (16-74 years olds)</td>
<td>3.1 (4,585 people)</td>
<td>3</td>
<td>4.4</td>
</tr>
<tr>
<td>Unemployed 16-24 year olds</td>
<td>0.9 (1,302 people)</td>
<td>0.8</td>
<td>1.2</td>
</tr>
<tr>
<td>Unemployed 50-74 year olds</td>
<td>0.7 (1,065 people)</td>
<td>0.7</td>
<td>0.8</td>
</tr>
<tr>
<td>Never worked or Long term unemployed</td>
<td>3.1 (4,661 people)</td>
<td>2.9</td>
<td>5.6</td>
</tr>
<tr>
<td>Lone parent households not in employment</td>
<td>31.8 (1,320 people)</td>
<td>32.4</td>
<td>40.5</td>
</tr>
</tbody>
</table>

**2.2.3 Older adults**

The 2011 Census identified that 10.5% (8,431 households) of the NEHF CCG population were one person households for those aged over 65 years old. This is less than Hampshire (12.6%) and England (12.4%). Amongst those aged over 60 years, 8.9% were living in households affected by income deprivation\(^6\). This is lower than Hampshire (10.7%) and England (18.3%).

\(^6\) This can be defined as the proportion of adults aged 60 or over living on Income Support or income based Jobseeker’s Allowance or pension Credit (Guarantee) families.
2.2.4 Disability

Households where one of the members has a disability tend to have less overall income compared to households where there is no one living with a disability. People with disabilities who are in work are more likely than the rest of the working population to be on low hourly pay. Many disabled people spend periods of their working-age lives out of work and this increases their risk of poverty in later life. This is compounded by the extra costs associated with living with disabilities\(^7\).

The 2011 census showed that 5.2% (10,714) of people aged 16-64 years had their day to day activities limited a lot by their long term health condition or disability. Almost a half of these people are in Rushmoor. This is less than in Hampshire (6.7%) and England (8.3%). In NEHF CCG 0.3% (539 people) of people over the age of 18 years old were registered as having a learning disability, which is slightly less than Hampshire overall (0.4%)\(^8\).

2.3 Housing and homelessness

The relationship between housing and health is complex, however poor housing is associated with increased risk of cardiovascular diseases, respiratory diseases and depression and anxiety. In addition 45% of accidents occur in the home. Whilst social sector housing has improved, less than 50% of private rented homes housing people on benefits are considered decent (2008 data\(^9\)).

Homeless people die on average 30 years younger than the general population. Alcohol and drugs are a major cause of death in homeless people, and deaths resulting from external causes, suicide and accidents are more common than in the general population\(^10\).

The rate of statutory homelessness\(^11\) in Hampshire was 0.81 people per 1000 households in 2011-12, with the lowest levels in Hart. In the last three years (2009/10 to 2011/12) in Hart there was an average of 7 households per year and in Rushmoor 35 per year accepted as being homeless and in priority need.

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\(^7\) [http://www.equalityhumanrights.com/key-projects/triennial-review/](http://www.equalityhumanrights.com/key-projects/triennial-review/)

\(^8\) Data from the 2011-12 Quality and Outcomes Framework (QOF)


\(^11\) Lower tier local authorities have a statutory duty to provide suitable accommodation for people who are eligible for assistance; homeless through no fault of their own and who fall into a priority need group. Groups in priority need include: pregnant women; people with dependent children; 16-17 year olds; people aged 18-20 who have been previously looked after; people aged 21 years old and over who are vulnerable as a result of having been looked after; and vulnerable people, such as older people, those with mental ill health and mental and physical disabilities. People who fulfil these criteria are defined as falling into the group of ‘statutory’ homelessness.
Non statutory homelessness is difficult to measure but can be estimated from Supported Housing panel data.

A survey of 142 homeless people in Hampshire found that the main health needs for homeless people are mental ill health, substance misuse, joint aches or problems with bones and muscles, chest pains and breathing problems and dental problems. Evidence shows that homeless people use proportionately more health services than the general population. Common reasons for visiting secondary care include alcohol, accidents and mental health. Hospital admissions in Hampshire show that homeless people are more likely to be men aged between 20-54 and emergency admissions.

2.4 Gypsies and travellers

Significant health inequalities exist between Gypsies and Travellers and the general population in England, even when compared with other socially deprived or excluded groups and with other ethnic minorities. The 2011 Census recorded a total of 2,069 Gypsies and Travellers living in Hampshire. However local estimates suggest the actual figure is likely to be between 4,690 and 7,630 people. Census 2011 data suggest that Hart has the highest proportion of the gypsy and traveller population across the county (0.3, 273 people) compared to Hampshire proportion of 0.16 and national proportion of 0.1. One of the four Hampshire County Council caravan sites, Penny Hill, is located in the NEHF CCG area.

There are no robust local data quantifying the prevalence of illnesses and lifestyle behaviours amongst the Gypsy and Traveller population in Hampshire. Evidence suggests that Gypsies and Travellers have a higher prevalence of risky lifestyle behaviours, a higher prevalence of long term conditions and are at increased risk of preventable childhood infections such as measles due to lower levels of vaccination.

What does this mean?

There is extensive evidence linking deprivation to poorer physical and mental health outcomes. A comprehensive approach is required to tackling the wider determinants of health, focusing on both short and long term outcomes.

NEHF CCG has relatively low levels of overall deprivation; however a marked gradient exists across the local population. Rushmoor has pockets of high deprivation around Aldershot and the lower super output areas (LSOAs) of North Town (Aldershot), Heron Wood (Aldershot) and Mayfield (Farnborough).

There is a marked difference in GCSE A*-C grades between the Rushmoor and Hart Districts. Educational attainment is strongly linked to lifelong health.
NEHF CCG has a lower proportion of lone parent households, older people affected by income deprivation and disability however the data suggest that the majority of these vulnerable households and people are concentrated in particular areas predominantly in the Rushmoor District. These population groups are potentially vulnerable to isolation and poorer health outcomes.

Inequalities are most marked in terms of health deprivation and disability; with greatest levels of deprivation in the Rushmoor area. Almost half of all people with limited day to day activities as a result of a long term health condition live within Rushmoor. This suggests the need for targeted activity within this area.

The unemployment rate is higher than Hampshire. Poorer physical and mental health is associated with unemployment.

A large population of Gypsies and Travellers live in Hart. One caravan site is within the area. There is a higher prevalence of health problems and increased risk of preventable childhood infectious disease, consequently a targeted response is required.
3. Children and young people

There are approximately 51,198 children and young people aged under 20 years in NEHF CCG, this is about 25% of the population\(^\text{12}\).

3.1 Births

Pooled data from 2009-11 show that the general fertility rate in NEHF CCG is 64.8 (62.9-66.8) live births per 1000 women aged 15-44 years old, which is similar to the Hampshire (64.3)\(^\text{13}\) and England (64.5%) rates.

Predicted future numbers of births based on ONS Interim 2011-based birth projections (2013 to 2021) are available for Hampshire and its local authorities. As data are not available by CCG, data from the two local authorities of Hart and Rushmoor that fall within the CCG boundary are presented (figure 13). It does not include data for Farnham. However at a district level there is uncertainty in the projection of births due to the smaller populations and these projections become increasingly unreliable as they look further forward in time. The projections suggest that births are levelling off. The revised projections indicate a decline in births and that fluctuate over time. It is hard to predict what future births will look like due to changing fertility rates and the size and age structure of the female population.

Figure 13: Birth projections for North East Hampshire and Farnham CCG from 2013 to 2021

Source: ONS Interim 2011-based Subnational Population Projections

\(^{12}\) 2011 Census
\(^{13}\) ONS annual birth extract
\(^{14}\) ONS Vital Statistics
3.2.  Teenage conceptions

Overall, Hampshire has seen a 35.1% reduction in teenage conception rates since the baseline in 1998. The annual rate of under 18 conceptions in Hampshire decreased from 25.2 per 1,000 girls in 2010 to 23.3 per 1,000 girls aged 15-17 years in 2011.

Data for the Farnham area of the CCG are not available. Data for the latest three year period 2009 to 2011, shows lower teenage conception rates in Hart (15.7%) and Rushmoor (24.6%) than Hampshire overall. These districts have also seen a sharper decline in the rates from 1998/2000 to 2009/11 than Hampshire.

In 2009/11, 44.4% of under 18 conceptions in Rushmoor ended in abortion which is lower than the Hampshire (48.7%), national (49.6%) and the South East region (51.2%) rates. Hart had a higher rate of under 18 conceptions which ended in abortion at 51.7%.

3.3.  Smoking in pregnancy

Smoking in pregnancy is important as it increases the risk of having a low birth weight baby and of infant death. The rate of smoking at the time of delivery in Hampshire is 11.8%, which is lower than the England average of 13.2% (2012-13).

3.4.  Infant and child mortality

Infant and child mortality rates are sensitive indicators not only of child health, but also of the general health of the population. Infant mortality is a reflection of the delivery of healthcare services to mothers and newborns, as well as the wider social determinants of health. Infant mortality rates are comparatively higher for low income families15 and there is a clear link between high levels of infant mortality, deprivation and poor health outcomes. It is therefore often used as a comparative measure of a nation’s health as well as a predictor of health inequalities. Evidence in the Marmot Review: Fair Society, Healthy Lives noted that factors including births outside marriage, maternal age under the age of 20 and deprivation, were independently associated with an increased risk of infant mortality16.

The infant mortality rate in NEHF CCG is relatively low at 2.1 children under one year old per 1000 births (1.2-3.5) but not significantly different to the Hampshire rate of 3.1 per 1000 births (2.6-3.7). This compares to the England rate of 4.4 per 1,000 live births (95% CIs 4.3-4.5) (Pooled data for 2008-10).

Over the past 30 years child death rates from respiratory and circulatory diseases in England and Wales have been falling, as they have for the whole population,

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16 http://www.ons.gov.uk/ons/dcp171778_300596.pdf
reflecting advances in medical care and general preventative measures. In 2011 congenital related conditions and cancers were the most common form of death for children aged under 16 years. However, childhood mortality between the ages of 0 and 14 is among the worst in Europe. Comparator European countries have improved their outcomes over the last 20 years while the UK has fallen behind in the rate of improvements where death rates remain higher for asthma, meningitis, pneumonia and diabetic ketoacidosis.

Local Safeguarding Children Boards are responsible for reviewing the deaths of all children from birth (excluding still born babies) up to 18 years. Child death review data collected and analysed by the Child Death Overview Panel (CDOP) includes identifying if there were any modifiable factors in the death. The Southampton, Hampshire, Isle of Wight and Portsmouth CDOP reviewed 70 Hampshire death notifications in the 0-18 population in 2011/12. This includes childhood mortality for specific conditions (meningococcal, group A streptococcal infections, septicaemia, asthma, lower respiratory tract infections, diabetes and epilepsy, cancer), suicide, work-related deaths, trauma and negligence, maltreatment and abuse.

3.5. Breastfeeding

Breastfeeding rates and good weaning practice are influenced by deprivation and act as an early contributing factor to the cycle of health and social inequalities\textsuperscript{17}. Only 42.2\% of mothers in the most deprived quintile in Hampshire initiate breastfeeding.

In NEHF CCG 60.4\% of mothers were breastfeeding at their primary birth visit (9-14 days). This reduced to 47.1\% at 6-8 weeks, which is higher than the Hampshire rate of 45.3\%. Rushmoor had a slightly lower proportion of women breastfeeding at 6-8 weeks of 43.6\% compared to both Hampshire (45.3\%) and England (47.2\%). Hart had a higher proportion of women breastfeeding at 6-8 weeks of 51.3\% (figures 9 & 10).

Figure 14: Percent of babies totally or partially breastfed at Primary Birth Visit 2012/13

Figure 15: Percent of babies totally or partially breastfed at 6-8 weeks 2012/13

3.6 Childhood obesity

Childhood obesity has short and long term consequences for an individual's health and rates increase with deprivation. Up to 79% of children who are obese in their early teens are likely to remain obese in adulthood. These children also have a higher risk of morbidity, and premature mortality in adulthood.

Pooled data for 2007/8 to 2011/12 show that within Rushmoor, 9.0% of 4-5 years olds are obese compared to 6.3% 4-5 year olds in Hart. The county rate is 8% and national rate 6%.

Obesity rates increase significantly with age in both districts. For 10-11 year olds, 18.3% were obese in Rushmoor. This is higher than the Hampshire rate of 15.4% and lower than the national rate of 19%. In Hart 12.6% of 10-11 year olds were obese. (NCMP three year rolling averages, 2007/08 to 2011/12).
3.7 Oral health

Overall, Hampshire’s five and twelve year old children have good dental health when compared to national figures, but there are variations in oral health at district level. There are inequalities in dental health, with children from areas of deprivation experiencing disproportionately higher levels of oral disease. Persistent dental health inequalities among Hampshire’s five year olds are reflected among twelve year olds as well.

Over a fifth of Hampshire’s five-year-olds experienced dental decay, but this varied from 13.4% in Winchester to 34.6% in Havant, and 30.9% in Rushmoor, compared to the England figure of 30.9%. The average Hampshire child aged five, had 0.7 decayed, missing (due to extraction) or filled teeth (dmft), compared to a national average of 1.1 teeth per child, and the South East average of 0.9 teeth per child.

A quarter of twelve-year-olds had dental decay in Hampshire, lower than the national prevalence (33.4%), however this included the fact that over twice as many children from Rushmoor (29.2%) experience dental decay, compared to just 13.5% of children from Hart.

3.8 Immunisation

Childhood immunisations protect individuals and the community against potentially serious infectious diseases. The uptake rate at 6 years of age is used to assess the impact on health of the individual and community.

Figures 16 and 17 show that the uptake rate for North East Hants and Farnham CCG for MMRx2 at 6 years of age is 91.23% and the uptake of the DTap/IPV booster is 93.6%. This is below the WHO target of 95% which is required to ensure herd immunity.

Figure 16: Proportion of children who have received 2 MMRs at 6 years by CCG 2012/13
The Teenage Booster vaccine Td/IPV (tetanus, diphtheria and polio) scheduled for all 13-18 year olds is available routinely on the NHS for all young people. Figure 18 shows that the uptake rate recorded on the child health system for NEHF CCG was the lowest in Hampshire at 43.5% which falls well below the DH recommended level of 90%.

**Figure 18: Proportion of children who have the school leaver booster by 18 years by CCG 2012/12**

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### 3.9 Hospital activity for children and young people

There were 31,882 per 100,000 first attendances at A&E (directly age standardised rates (DSR) for people under the age of 15 years old in NEHF CCG from 2009-12, which is significantly higher than the Hampshire rate of 25,569 per 100,000 population.
The male first attendance rate was significantly higher than the females; this gender difference is evident across the county districts. Looking at Hart and Rushmoor districts both had rates significantly higher than Hampshire at 26,701 and 37,311 respectively, Rushmoor rate is much higher suggesting approximately 11,500 more admissions per 100,000 population than Hampshire.

Levels of under 15 years old emergency admissions were significantly lower than the Hampshire rate (5,002 per 100,000 compared to 8,006 per 100,000). There were 9,487 per 100,000 admissions for all causes aged under 15 years, which is lower than the Hampshire rate of 12,804.

3.9.1 Emergency admissions for asthma, diabetes and epilepsy

Emergency admissions for asthma, diabetes and epilepsy for people under the age of 19 years old may reflect the way in which these long term conditions are managed. Pooled data from 2009-12 in NEHF CCG show that the rate is lower (237 per 100,000) than the Hampshire rate (275 per 100,000).

3.10. Injury and accidents

Unintentional injuries are the leading cause of death in children aged between 1 and 4 years and 15 to 19 years in England and Wales and are the second leading cause of death in children aged 10 to 14 years. Children from the most deprived families are 13 times more likely to die from unintentional injuries, and 37 times more likely to die in a fire than children living in the least deprived areas.
The rate of unintentional and deliberate emergency admissions for people under the age of 18 in the period 2009-12 for NEHF CCG was 830 per 100,000, which was lower than the Hampshire rate (1,066 per 100,000).

3.11. Substance misuse

Admissions for 15-24 year olds due to substance misuse were 953 per 100,000 people (DSR) in NEHF CCG, comparable to the Hampshire rate. Alcohol specific hospital admissions for people aged under 18 years old were 40 per 100,000 in NEHF CCG, (pooled data 2009-12). The CCG rate is not significantly different to the Hampshire rate of 34 per 100,000; however the Rushmoor District rate is significantly higher than Hampshire at 56 per 100,000 population however the small numbers must be taken into account. Female alcohol specific under 18 years rates are higher than males, this pattern is similar in all areas across Hampshire.

3.12. Sexual health

Acute STI all age 2011 rate in Rushmoor is 745.8 and in Hart 603.1 per 100,000 residents. 64% in Rushmoor and 56% in Hart of acute STI diagnoses are young people aged 15-24.

51,638 young people aged 15-24 in Hampshire were tested for Chlamydia in 2011/12 representing 34% of the 15-24 year old population. 2,987 (5.8%) of these tests were found to be positive providing a diagnostic rate of about 1,970 per 100,000 population. 97.1% of the positive cases received treatment. 2011 diagnosis data shows Rushmoor chlamydia diagnosis rate per 100,000 young people aged 15-24 is 1910, Hart diagnosis rate is 1572 per 100,000.

3.13. Vulnerable children and young people

3.13.1 Children in poverty

Tackling child poverty is vital in reducing inequalities and deprivation, improving the life chances of children and young people in low income families. The Income Deprivation Affecting Children Index represents the proportion of all children aged 0-15 living in income deprived households18 and can help to measure the levels of children living in poverty in an area.

3.972 (9.8%, 9.5-10.1) 0-15 year olds in the NEHF CCG area live in income deprived households this is significantly lower than the England average (21.7%), and Hampshire average (12.1%). However the district of Rushmoor has a significantly higher proportion of children affected by deprivation of 13.3% (2395). Conversely

18 This is defined as either families receiving Income Support, income-based Jobseeker’s Allowance, Pension Credit (Guarantee) or those not in receipt of these benefits but in receipt of Child Tax Credit with an equivalised income (excluding housing benefits) below 60% of the national median before housing costs.
Hart has the lowest proportion (6.1%) of children in income deprived households across the county accounting for 1131 children.

3.13.2 Children with disabilities

Children with disabilities and their families are one of the most vulnerable groups in Hampshire. However, defining and measuring the landscape of childhood disability is challenging due to the lack of an agreed definition. Overall, estimates of the number of disabled children in Hampshire range from 3,000 to 50,000 depending on the source and definition used. Around 7,040 children aged 0-17 years were disability living allowance (DLA) claimants in August 2012. The autumn 2012 Hampshire School Census records 17.2% (3,507) of school pupils in NEHF as having a special educational need (SEN), lower than the Hampshire overall at 19%. Of these, 2.8% (561) had a statement to identify their needs compared to 2.6% in Hampshire overall. A statutory assessment is only necessary if the school or early education setting cannot provide all the help that a child needs. These rates can only be used as indicative figures for the CCG as the proportions do not include data for the Farnham area.

Despite the lack of robust data on childhood disability, there is consensus that the population of children using services is increasing and so is the complexity of disability and need. Where we do have some data it clearly reflects this, for example, increasing NHS activity generated from technology-dependent children.

Several factors are associated with the increase in the numbers of disabled children and young people, including Hampshire’s rising birth rate (14.4% rise, from 13,320 in 2000 to 15,238 in 2011), better survival rates, improvements in care, increasing births at maternal age extremes, multiple pregnancies, assisted reproductive technology, preterm births, low birth weight and genetic abnormalities.

For information about safeguarding, Children Looked After, domestic abuse, young offenders and children with autism please see the Hampshire JSNA.

What does this mean?

A high proportion of A&E attendances and lower proportion of admissions may suggest inappropriate attendances. Work is needed to explore the reasons for attendances and seek alternative, more appropriate solutions.

Implications of teenage conceptions? Work is required through partnership working as well as healthcare interventions on reducing the teenage conception rate to ensure the downward trend continues
Analysis of which groups are more likely to have low breastfeeding rates is warranted to enable focused support.

Early intervention needed to prevent and reduce childhood obesity especially in Rushmoor. This should be linked to dental health and needs to link to health visiting developments led by NHS England.

There continues to be a need to increase MMR uptake particularly in Hart, including MMR1 and MMR2 and Td/IPV especially in groups at risk of low vaccination (looked after children, those with physical or learning disabilities, children of teenage or lone parents and vulnerable children e.g. travellers, asylum seekers or homeless)

Initiatives all link to work underway as part of the exiting Children and Young People’s Plan 2012-15

All healthcare professionals need to actively encourage seasonal flu vaccine: targeting the ‘at risk’ groups.
4. Health related behaviour

Lifestyle factors such as smoking, excessive alcohol intake, a poor diet and sedentary lifestyle increase the risk of disease. A recent study published in the Lancet\(^\text{19}\) concluded that tobacco, high body mass index and diet and physical activity made a significant contribution to disability adjusted life years lost in the UK in 2010.

4.1 Smoking and tobacco control

Tobacco use is the single most preventable cause of ill health in the UK and a major contributor to health inequalities. There is clear evidence that through reducing smoking prevalence we will improve healthy life expectancy as well as total life expectancy.

The proportion of adults estimated\(^\text{20}\) to be currently smoking is 14.5% in Hart and 24.3% in Rushmoor, compared to the Hampshire rate of 17.5%.

In 2012/13, rates of smoking amongst routine and manual workers were 20% in Hart, 30.5% in Rushmoor and 25.8% in Waverley, compared to 30% in Hampshire. The directly age standardised rate of hospital admissions wholly or partly attributable to smoking in people aged over 35 years old was 973 in Hart, 1,265 in Rushmoor and 797 per 100,000 in Waverley, compared to 1003 in Hampshire overall. These rates are significantly lower than the England rate.

The directly age standardised rate of deaths wholly or partly attributable to smoking in people aged over 35 years old was 145.3 per 100,000 in Hart, 224.9 per 100,000 in Rushmoor and 135.6 per 100,000 in Waverley, compared to 167.6 per 100,000 in Hampshire overall. Rates in Hart and Waverley are significantly lower than the England rate of 210.6 per 100,000 (2008-10). In Rushmoor the rate is not significantly different to the national average.

In 2011-12, 6.4% of all smokers aged over 15 years old in Hart and 11.8% of all smokers aged over 15 years old in Rushmoor were accessing NHS stop smoking services. There was a 4 week quitter success rate of 55% in Hart and 50% in Rushmoor.

4.2 Obesity and healthy eating

Overweight and obesity presents a major challenge to the current and future health of Hampshire. Being overweight or obese significantly increases the risks of

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\(^{20}\) 2011/12 Integrated Household Survey, ONS
developing and dying from cardiovascular disease, Type 2 diabetes, cancer and kidney and liver disease and the risk increases as the “body mass index” increases.

It is estimated that 62% of the adult population in Hampshire is overweight (38%) or obese (24%). Future projections do not indicate any flattening out of the current rising trend but instead predict a significant rise in obesity and severe obesity. The prevalence of obesity and being overweight varies with age. For adults it is lowest in the 16-24 year old age group and gets generally higher in the older age groups for both men and women. Figure 20 shows the modelled prevalence of obesity by district. The rate for Rushmoor is to the England rate whereas the rate in Hart is significantly lower.

**Figure 20: Estimated prevalence of adults who are obese by local authority 2006-2008**

![Estimated Prevalence of Adults who are Obese (%) 2006-2008](image)

<table>
<thead>
<tr>
<th>District</th>
<th>% Obese Adults</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td></td>
</tr>
<tr>
<td>Hampshire</td>
<td></td>
</tr>
<tr>
<td>Emsworth</td>
<td></td>
</tr>
<tr>
<td>Eastleigh</td>
<td></td>
</tr>
<tr>
<td>Fareham</td>
<td></td>
</tr>
<tr>
<td>Gosport</td>
<td></td>
</tr>
<tr>
<td>Hart LAD</td>
<td></td>
</tr>
<tr>
<td>Havant</td>
<td></td>
</tr>
<tr>
<td>New Forest</td>
<td></td>
</tr>
<tr>
<td>Rushmoor</td>
<td></td>
</tr>
<tr>
<td>Test Valley</td>
<td></td>
</tr>
<tr>
<td>Winchester</td>
<td></td>
</tr>
</tbody>
</table>

4.3. **Physical activity** - See Hampshire JSNA chapter

4.4. **Alcohol**

Regularly drinking more than the government-recommended safe limit increases the risk of developing chronic diseases including liver disease, diabetes, cardiovascular disease and cancers of the breast and gastrointestinal tract.

Synthetic estimates suggest that 21.5% of people 16 and over in Hart are increasing risk drinkers, 6.4% are high risk drinkers and 19.5% binge drink. In Rushmoor, 20.7% are increasing risk drinkers, 7.1% high risk and 19.3% binge drink. 21.2% are increasing risk drinkers, 6.2% high risk drinkers and 17.6% binge drink in Waverley21.

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21 The UK Government recommends that women drink less than 15 units per week and men 22 units per week. Care must be taken when interpreting these data; the 95% confidence intervals are very wide, suggesting they are not very reliable.
Figure 21 presents the admission episodes for alcohol-attributable conditions. In Rushmoor the rate of hospital admissions for alcohol attributable conditions is significantly higher than the England rate.

**Figure 21: Admission episodes for alcohol-attributable conditions, all ages, 2010/11**

![Graph showing admission episodes for alcohol-attributable conditions for all ages in Rushmoor and England, 2010/11.](image)

In Rushmoor the rate of hospital admissions for alcohol attributable conditions is significantly higher than the England rate.

Figure 22 presents alcohol specific hospital admission for people aged under 18 years. Rushmoor has the second highest rate in the county although the rate is not significantly different to England. Harts rate is significantly lower than England.

**Figure 22: Under 18s admitted to hospital with alcohol specific conditions: Persons, crude rate per 100000 population**

![Graph showing under 18s admitted to hospital with alcohol specific conditions in Rushmoor and England, 2008/09-2010/11.](image)
There is an upward trend in the rate of alcohol related admissions. In Hampshire since 2002/03 there has been 9% average year on year growth in the rate of admissions. This is comparable to the England average year on year growth which is also 9%. For the local authorities in NEHF CCG the year on year average growth for Rushmoor and Hart was 11%.

The rates of alcohol attributable mortality are higher than England for females in Rushmoor and for men in Rushmoor and Waverley although the differences are not statistically significant.

4.5 Sexual health

Left untreated, sexually transmitted infections (STIs) can lead to a range of complications including ectopic pregnancy, infertility, disability, cancer and premature death. STIs are the main cause of infertility (particularly in women) and can also facilitate HIV transmission by increasing both HIV infectiousness and HIV susceptibility.

In 2011, Rushmoor ranked 99, Hart ranked 173 and Waverley was 245 out of 326 local authorities (where one is the highest) in England for rates of STIs. The rate of acute STIs in Hart was 603.1 per 100,000, in Rushmoor this was 745.8 per 100,000 and in Waverley 498.1 per 100,000 (all ages). Of acute STI diagnoses 56% were in young people aged 15-24 years old in Hart and 64% in Rushmoor. About 9% were in men who have sex with men.

In Hart, 1571.8 per 100,000 young people had a chlamydia diagnosis during the year, compared to 1,910.2/100,000 in Rushmoor, 1,047.1 in Waverley and 2,125 per 100,000 in England. Nationally it is recommended that we should achieve a diagnosis rate for chlamydia of 2,400 per 100,000.

The prevalence of HIV in Hampshire is low at 0.8 per 1,000 population aged 15-59 in 2009 (0.78 in 2008) with a national prevalence of 1.5 per 1,000 in 2011. Of those diagnosed, 58.3% in Rushmoor, 50.0% in Hart and 61.9% in Waverley were classified as having a late diagnosis of HIV, compared to 52.3% nationally. Late diagnosis of HIV is the largest predictor of HIV mortality and morbidity.

What does this mean?

Tobacco use and smoking are the single and greatest cause of poor health and preventable disease. There is a strong relationship between smoking and deprivation. Smoking cessation should form a key component of all chronic disease management pathways; adopting an ‘every contact counts’ approach. More targeted work is required for priority groups, e.g. pregnant women and in more deprived areas.
Hospital admissions for alcohol attributable conditions are higher than the Hampshire average. Strong partnership working is required to reduce alcohol related diseases.

High proportion of late HIV diagnoses. Late diagnosis of HIV is the largest predictor of HIV mortality and morbidity.

Healthcare providers should embed the physical activity pathway and brief interventions into practice, especially as part of delivering NHS Health Checks.
5. Long term conditions

5.1. Cardiovascular disease

Cardiovascular disease (CVD) can be thought of as a family of diseases with common risk factors, but different outcomes. Lifestyle risk factors for CVD, such as smoking, physical inactivity, poor diet, obesity and harmful alcohol intake are modifiable. Figure 23 shows the prevalence of the most common forms of CVD. These rates are not adjusted for age, making comparison difficult across areas as those with older populations tend to have higher rates of disease.

Figure 23: prevalence of the most common forms of CVD in North East Hampshire and Farnham CCG 2011/12

<table>
<thead>
<tr>
<th>CCG</th>
<th>CHD</th>
<th>Stroke/TIA</th>
<th>Atrial fibrillation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>QOF no.</td>
<td>QOF prevalence</td>
<td>QOF no.</td>
</tr>
<tr>
<td>NE Hants and Farnham</td>
<td>5656</td>
<td>2.6</td>
<td>3140</td>
</tr>
<tr>
<td>Hampshire</td>
<td>44334</td>
<td>3.3</td>
<td>24381</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CCG</th>
<th>Heart Failure</th>
<th>Heart Failure due to Hypertension</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>QOF no.</td>
<td>QOF prevalence</td>
</tr>
<tr>
<td>NE Hants and Farnham</td>
<td>1073</td>
<td>0.5</td>
</tr>
<tr>
<td>Hampshire</td>
<td>8339</td>
<td>0.6</td>
</tr>
</tbody>
</table>

CCG level expected prevalence rates are available for CHD, stroke/TIA and hypertension.

Figure 24: estimated number of patients missing from QOF disease registers 2011/12

<table>
<thead>
<tr>
<th>CCG</th>
<th>Coronary Heart Disease</th>
<th>Stroke/TIA</th>
<th>Hypertension</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>QOF prevalence %</td>
<td>Expected prevalence %</td>
<td>Undiagnosed no.</td>
</tr>
<tr>
<td>Fareham &amp; Gosport</td>
<td>3.8</td>
<td>5.4</td>
<td>3165</td>
</tr>
<tr>
<td>NE Hants and Farnham</td>
<td>2.6</td>
<td>4.4</td>
<td>3916</td>
</tr>
<tr>
<td>North Hampshire</td>
<td>2.7</td>
<td>4.5</td>
<td>3805</td>
</tr>
<tr>
<td>SE Hampshire</td>
<td>3.9</td>
<td>6.4</td>
<td>5168</td>
</tr>
<tr>
<td>West Hampshire</td>
<td>3.5</td>
<td>5.5</td>
<td>10670</td>
</tr>
<tr>
<td>Hampshire</td>
<td>3.3</td>
<td>5.4</td>
<td>28213</td>
</tr>
</tbody>
</table>

22 There are a broad range of diseases of the circulatory system. The highest prevalence cardiovascular diseases include hypertension, myocardial infarction, stroke and heart failure.

It is estimated that there may be 3,916 people with undiagnosed Coronary Heart Disease, 1,346 people with undiagnosed stroke or TIA and 34,370 people with undiagnosed hypertension in NEHF CCG (figure 24). The NHS Health Check programme provides an important opportunity to increase diagnosis and encourage participants to improve their lifestyles.

Between 2008/9 and 2011/12 CVD directly age standardised admission rates have increased from 1,130 per 100,000 people to 1,399 per 100,000 people in NEHF CCG. Both emergency and elective CVD admission rates are high for people in NEHF CCG.

Geographical inequalities are present at every stage of the care pathway for CVD from risk of developing the disease to choice of place of death. Outcomes tend to be worse the more deprived an area is. There may also be inequalities between the sexes with women being less likely to have access to planned hospital care. Of the cardiovascular diseases women are particularly prone to stroke.

Figure 25 shows the CVD mortality rate in NEHF CCG is 112 (95%CI 105-119) per 100,000, which is the lowest rate in Hampshire’s CCGs, and statistically significantly lower than the 132 (95%CI 130-135) per 100,000 for Hampshire overall.

**Figure 25: Directly standardised rate of mortality caused by cardiovascular disease 2009-2011**
### 5.2 Diabetes

There are 57,092 people in Hampshire and 8,512 in NEHF CCG with diabetes (QOF 2011/12 data, figure 26). In Hampshire, there are estimated to be a further 13,000 who have diabetes but have not yet been diagnosed. By 2020, there may be 87,000 people in Hampshire with diabetes.

In NEHF CCG, the prevalence of diabetes is lower than Hampshire and England with 22% more people expected to have diabetes than are currently diagnosed (2008/09). There is a very strong link between deprivation, diabetes admissions and complications.

There is a higher than national proportion of people achieving good blood glucose control (74.5% compared to 69.9% nationally) and a lower than national proportion of people achieving good blood pressure (68.4% compared to 70.7% nationally). Elective admissions for diabetes in NEHF CCG are lower than Hampshire (22 admissions per 100,000 population compared to 53 per 100,000 in Hampshire). The rate of all hospital admissions where diabetes is the primary diagnosis, for all ages was 83 admissions per 100,000 (figure 27). The amputation rate in NEHF CCG was not significantly different to the Hampshire rate at 8 amputations per 100,000.

#### Figure 26: Number of people with diabetes on QOF registers and estimated numbers with diabetes by CCG 2011/12

<table>
<thead>
<tr>
<th>Area</th>
<th>Number (QOF 2011/12)</th>
<th>Prevalence (QOF 2011/12)</th>
<th>Estimated Number</th>
<th>Estimated Prevalence</th>
<th>Lower uncertainty limit</th>
<th>Upper uncertainty limit</th>
<th>Estimated number of people unrecorded or undiagnosed</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Fareham and Gosport CCG</td>
<td>9120</td>
<td>5.7%</td>
<td>11,141</td>
<td>6.8%</td>
<td>5.0%</td>
<td>10.4%</td>
<td>2,021</td>
</tr>
<tr>
<td>NHS North East Hampshire and Farnham CCG</td>
<td>8512</td>
<td>4.9%</td>
<td>11,049</td>
<td>6.3%</td>
<td>4.4%</td>
<td>10.6%</td>
<td>2,537</td>
</tr>
<tr>
<td>NHS North Hampshire CCG</td>
<td>9258</td>
<td>5.4%</td>
<td>10,805</td>
<td>6.2%</td>
<td>4.5%</td>
<td>10.2%</td>
<td>1,547</td>
</tr>
<tr>
<td>NHS South Eastern Hampshire CCG</td>
<td>9882</td>
<td>5.8%</td>
<td>12,879</td>
<td>7.5%</td>
<td>5.5%</td>
<td>10.8%</td>
<td>2,997</td>
</tr>
<tr>
<td>NHS West Hampshire CCG</td>
<td>21947</td>
<td>5.0%</td>
<td>31,081</td>
<td>7.0%</td>
<td>5.1%</td>
<td>10.9%</td>
<td>9,134</td>
</tr>
</tbody>
</table>
Figure 27: All admissions for diabetes: Directly standardised rates (per 100,000) and 95% confidence intervals, 2009/10 to 2011/12

<table>
<thead>
<tr>
<th>Persons</th>
<th>95% CI</th>
<th>Comparison to Hampshire</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>DSR</td>
</tr>
<tr>
<td>Hampshire</td>
<td>4935</td>
<td>114.53</td>
</tr>
<tr>
<td>Fareham and Gosport CCG</td>
<td>526</td>
<td>81.45</td>
</tr>
<tr>
<td>North East Hampshire and Farnham CCG</td>
<td>533</td>
<td>82.62</td>
</tr>
<tr>
<td>North Hampshire CCG</td>
<td>1545</td>
<td>222.95</td>
</tr>
<tr>
<td>South Eastern Hampshire CCG</td>
<td>666</td>
<td>99.29</td>
</tr>
<tr>
<td>West Hampshire CCG</td>
<td>1766</td>
<td>101.53</td>
</tr>
</tbody>
</table>

5.3 Liver disease

Most liver disease is caused by obesity, infection with hepatitis, and harmful drinking, all of which are preventable. The death rate from preventable liver disease in Hampshire was 7 per 100,000 population from 2009 to 2011 (304 deaths), lower than the national rate of 12 per 100,000. The NEHF CCG rate of preventable liver disease was 5 per 100,000 population (31 deaths), which is not significantly different to Hampshire.

Hampshire is in the bottom fifth of areas in England in terms of Hepatitis B vaccination and Hepatitis C test uptake for injecting drug users and amongst prisoners.

5.4 Kidney conditions

This section considers two forms of kidney disease: Chronic Kidney Disease (CKD) and Acute Kidney Injury (AKI), which was formally known as Acute Renal Failure. CKD is characterised by abnormal kidney function and/or structure with deterioration occurring over a period of months or years. It is common and estimated to affect over 6% of English people, but often asymptomatic until it becomes advanced.

The prevalence of chronic kidney disease (CKD) in NEHF CCG is 3.8% (6,487 people) over the age of 18. This compares to a prevalence of 4.2% in Hampshire and 4.3% for England. The NHS Health Check programme provides an opportunity to identify people with CKD before they develop symptoms. It is estimated that there are 32,000 people with CKD in Hampshire yet to be diagnosed.

Unmodifiable risk factors for CKD include older age, sex (prevalence is higher in men), other forms of CVD, family history and South Asian and Black ethnicity (higher risk of needing renal replacement therapy). NEHF CCG has the highest percentage...
of South Asian and Black residents of Hampshire’s CCG, which may partly explain it’s relatively high prevalence of CKD.

Modifiable risk factors include hypertension, smoking, physical inactivity, poor diet and harmful use of alcohol.

Acute Kidney Injury (AKI) is characterised by a rapid reduction in kidney function. Causes include: infection, dehydration, shock, and acute illness. Less frequently it is caused by crush injury to the kidney, and obstruction of the urinary tract. It is relatively common affecting about 20% of hospitalised patients, with severe AKI affecting 1%. AKI is associated with poor outcomes and prolonged hospital stays. Even uncomplicated AKI has a mortality rate of up to 10% while over half patients with AKI as part of multi-organ failure die.

Risk factors for AKI include being 75 or older, CVD, CKD, having heart failure, peripheral arterial disease and diabetes. Nationally the treatment of AKI in hospitals can be poor. An audit from NCEPOD found that only 50% of AKI patients received good care overall though 30% of cases are preventable. Given the rise in population risk factors and mortality for CKD and AKI it is likely that need and demand for services will increase in the next decade. NICE has concluded that earlier detection and treatment of AKI would be cost saving.

5.5 Chronic Obstructive Pulmonary Disease (COPD)

There is one death every 20 minutes from COPD in England. The total annual cost to the NHS of COPD is over £800 million. Up to 90% of cases of COPD are caused by smoking and so are preventable. Most people with COPD have not been diagnosed and so are not receiving the right treatment and support to manage their condition. COPD is strongly related to deprivation. Incidence and mortality rates are higher in lower socio-economic groups, largely linked to higher smoking rates.

There are 2,575 people in NEHF CCG diagnosed with COPD, a prevalence of 1.2% which is lower than the national rate of 1.7%. There are thought to be a further 1,493 people with undiagnosed COPD in NEHF CCG. Performance against the QOF indicators for COPD in Hampshire is above the national average, but there is an exception rate of 11%.

There were 872 emergency COPD admissions in NEHF CCG between 2009/10 and 2011/12 where COPD was the primary diagnosis and over half were in people aged under 75 years old. The rate of emergency admissions for people under the age of 75 is 83 per 100,000, significantly higher than the Hampshire rate. It can be


attributed to the Rushmoor female rate which was the highest in the county (128 per 100,000 compared to 74 per 100,000 for Hampshire).

The death rate from COPD in NEHF CCG is 19 per 100,000 lower than the national rate of 26 per 100,000.

5.6 Cancer

Cancer incidence is rising in England. In contrast the trend in cancer incidence for Hampshire has been stable since 2001/2003. The directly age standardised incidence rate for all types of cancers (excluding non-melanoma skin) in Hampshire for 2008/10 is 367.8 per 100,000 population. This is lower than the England and South East England rates which are 386.9 and 368.3 per 100,000 respectively. The incidence rate is higher in men (389.7 per 100,000) than women (354.4 per 100,000). The incidence rate in NEHF CCG is lower than Hampshire and national rates at 303.5 per 100,000. This has decreased to 301.8 in 2009/11.

The trends in incidence of lung, bowel and breast cancers in Hampshire mirror the England trend but the incidence of prostate cancer in Hampshire as a whole is reducing while the England trend is upward. Incidence rates of lung, bowel and breast cancer are lower in NEHF CCG than national and regional rates. However in 2009/11 the prostate cancer incidence rate in Hart (124.4) was significantly higher than the national (105.8) and regional rate (104.5).

Figure 28 shows the cancer screening coverage in NEHF CCG and Hart and Rushmoor districts for each of the national screening programmes. Hart has higher coverage than Hampshire for breast, bowel and cervical cancers but this is still below the target. NEHF CCG has lower coverage than the target for all three cancers.
**Figure 28: Cancer screening coverage of screening in NE Hampshire and Farnham 2012**

<table>
<thead>
<tr>
<th>Type of cancer (target)</th>
<th>Hart (%)</th>
<th>Rushmoor (%)</th>
<th>NEHF CCG (%)</th>
<th>Hampshire (%)</th>
<th>England (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Breast (70%)</strong></td>
<td>66.8</td>
<td>61.6</td>
<td>64.6</td>
<td>61</td>
<td>60.9</td>
</tr>
<tr>
<td>36 month coverage, 47-73 years old. March 2012</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Bowel (60%)</strong></td>
<td>62.1</td>
<td>54.9</td>
<td>58.1</td>
<td>61.1</td>
<td>52.1</td>
</tr>
<tr>
<td>2.5 year coverage, 60-74 year olds. March 2012</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cervical (80%)</strong></td>
<td>79.2</td>
<td>77.5</td>
<td>78.4</td>
<td>78.5</td>
<td>75.4</td>
</tr>
<tr>
<td>3.5-5.5 year coverage, 25-64 year olds. March 2012</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Cancer is linked to numerous risk factors. It has been estimated that 43% of new cases of cancer are linked to lifestyle and environmental factors, with smoking alone accounting for almost 20% of new cases (23% in men and 16% in women). After smoking, dietary factors, being overweight or obese and harmful alcohol use are the biggest risk factors.

In 2011/12 there were 3,682 people on GP cancer registers in NEHF equating to 1.7% of the registered population.

From 2009-12, the directly age standardised rate of admissions for cancer for people of under the age of 75 years old all ages was 1,896 per 100,000 population in NEHF CCG, which was lower than the rate in Hampshire (1,860 per 100,000 population). Hart has a higher rate of 2,083 per 100,000, overall in Rushmoor the rate is 1,829 but males in Rushmoor have significantly higher all cancer under 75 rate of 2,058 per 100,000 population.

The rate of premature mortality (under 75 years old) from all cancers was 98 per 100,000 in NEHF CCG which is comparable with the Hampshire rate of 97 per 100,000 but lower than the England rate of 110/100,000. Between 2006-08 and 2009-11 the trend in premature mortality for the CCG is stable compared to a downward trend nationally.

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26 Hampshire Open Exeter system
5.7 Neurological conditions

There is a lack of available, local level data on long term neurological conditions such as multiple sclerosis or motor neurone disease. The only routinely available data are for epilepsy. The prevalence of epilepsy in people aged 18+ in NEHF CCG is 0.7% (1,191 people), which is the same as nationally and higher than the Hampshire average (0.7%, 7,958 people). The trend in epilepsy prevalence during the three year period from 2009/10 to 2011/12 was stable for Hampshire and England.

5.8 Chronic Pain

Chronic pain is defined as pain or discomfort that troubles a person all of the time or on and off for more than three months (CMO report, 2008). There are no data on chronic pain prevalence available at the Hampshire level. Application of the findings of the Health Survey for England 2011 to the county level showed that about one in three men and women suffer with chronic pain. Muscle, bone and joint pain are the main causes of chronic pain, with back pain and osteoarthritis together responsible for over half of all cases. Nationally, people with severe chronic pain are five times more likely to visit their GP, four times more likely to be anxious or depressed than those without pain and are significantly more likely to have longstanding illnesses.

The directly standardised hospital admission rate for chronic pain NEHF CCG is 2,590 per 100,000 population, which is significantly higher than the Hampshire rate of 2,125 per 100,000 and the highest rate in the county. Rates are higher in females (3,204 per 100,000) than in males (1,996 per 100,000).

The majority of people in chronic pain are medically managed in primary care. Local service user groups describe inadequate support, need for increased knowledge, awareness of services and education for healthcare professionals.

5.9 Mental health

Positive mental wellbeing reduces population mortality. Populations with good mental wellbeing also have improved overall health, recover more rapidly, are admitted to hospital less frequently and have high levels of employment and productivity. Underlying social, economic and environmental dimensions can affect a person’s mental wellbeing – such as employment status, education, health and community or neighbourhood characteristics.

Poor mental health both contributes to and is a consequence of wider health inequalities. It is associated with increased health-risk behaviour and increased morbidity and mortality from physical ill health. The prevalence of psychotic disorders amongst the lowest quintile of household income is nine times higher than in the highest. The social gradient is also evident for common mental health problems, with a two-fold variation between the highest and lowest quintiles. There are pockets of highest need in Rushmoor particularly around the Aldershot area.
People with mental illness have significantly higher rates of mortality and morbidity from illnesses such as heart disease, stroke, diabetes, respiratory disease and infections. Those with schizophrenia and bipolar disorder die an average of 25 years earlier than the general population, largely due to physical health problems.

Many physical conditions increase the chances of poor mental health. It is estimated that 12 to 18 per cent of all NHS expenditure on long term conditions is linked to poor mental health – at least £1 in every £8 spent.

About one in six of the adult population experiences mental ill health at any one time and 10% of children have a mental health problem. Half of lifetime mental illness is present by the age of 14.

One on ten new mothers suffers from postnatal depression, and around a fifth of working-age adults are affected by depression or anxiety at any one time. Half of all women and a quarter of all men will be affected by depression at some time in their life and 15% experience a disabling depression.

Serious mental health problems such as schizophrenia, psychoses & bipolar disease such as affect about 1% of the population.

Depression is the most common mental health disorder in later life but it is not a natural or normal part of ageing. Those with physical health problems have higher rates of depression, and up to 50% of older people in residential care have clinically severe depression, yet only between 10% and 15% receive any active treatment.

Between 2009 and 2011 59 people died due to suicide or injury of undetermined intent in North East Hampshire and Farnham giving a rate of 9.1 per 100,000 population. This is not significantly different from that of Hampshire or England, but all have increased since 2006/08. Males have a higher suicide rate and the NEHF CCG rate was 14.0 per 100,000 males compared to 4.4 per 100,000 female population.

One of the risk factors for suicide is intentional self harm and in 2009/11 the admission rate for intentional self harm was 221 per 100,000 people in NEHF CCG. There is a significant correlation between deprivation and self harm admissions, Hampshire rates suggest that people residing in the most deprived quintile are four times more likely to be admitted than those in the affluent quintile.

Figure 29 presents the directly standardised admission rates for a number of mental health admissions in NEHF CCG compared to Hampshire, NEHF CCG admissions rates are significantly lower then the Hampshire rate. Gender differences are apparent for each mental illness, females have higher rates of unipolar depressive
disorders whilst male delusional disorder rates are higher this is comparable with Hampshire.

**Figure 29: Mental health Admissions- Directly standardised rates (per 100,000) and 95% confidence intervals, 2009/10 to 2011/12 pooled**

<table>
<thead>
<tr>
<th>Admissions</th>
<th>Directly Age Standardised Rates per 100,000 population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Illness - All Admissions - Under 75 years</td>
<td>NEHF CCG 76</td>
</tr>
<tr>
<td>Mental Health Illness - All Admissions - All ages</td>
<td>NEHF CCG 77</td>
</tr>
<tr>
<td>Schizophrenia, schizotypal and delusional disorders - All admission types - Aged 15+</td>
<td>NEHF CCG 18</td>
</tr>
<tr>
<td>Unipolar depressive disorders - All admission types - Aged 15+</td>
<td>NEHF CCG 13</td>
</tr>
</tbody>
</table>

### 5.10 Dementia

Dementia describes a set of symptoms which include memory loss, mood changes and problems with communicating and reasoning. It is not an inevitable part of ageing. One in 6 people over 80 years and one in 14 people over 65 years old have a form of dementia. Alzheimer’s disease is the most common form, accounting for 62% of all dementia cases. Prevalence is higher in women and in older age groups.

Vascular dementia has the same risk factors as other forms of CVD and is potentially preventable.

NEHF CCG has a relatively younger population compared to Hampshire and this may explain the lower dementia prevalence rate of 0.45% (986 people) compared to Hampshire (0.65%) and England at 0.53%

There are estimated to be over 18,000 people with dementia in Hampshire, but only 8,695 people on GP dementia registers suggesting significant under identification.

There are an estimated 2,291 people in NEHF with dementia. In Hart and Rushmoor the number of people with dementia is predicted to increase by 37% between 2012 and 2020.

A national report found that older people with dementia who are receiving care in hospital following an emergency admission stay significantly longer than those without the condition and are more likely to be readmitted.²⁷

There has been some reluctance amongst clinicians to diagnose dementia in the past; but increasingly people with dementia and their carers have called for earlier diagnosis, as it allows them to take decisions and plan rather ignore symptoms until there is a crisis.

²⁷ Care Quality Commission [CQC] report, March 2013
People with dementia can live well with their dementia provided they and their carers have good, timely and person centred advice, support and care within a non-stigmatising and understanding community.

5.11 Musculoskeletal conditions

Pain is the predominant symptom in most people with musculoskeletal problems, causing limitation in function and resulting in long-term work disability with economic consequences for society. This also generates significant activity in the health and social care sector.

Between 2009 and 2012, the rate of hospital admissions as a result of falls and fall injuries in the 65 years and over population was 1,969 per 100,000 people in NEHF CCG, compared to a rate of 1,623 per 100,000 in Hampshire. Across Hampshire, NEHF CCG had the highest rate of hospital admissions as a result of falls and fall injuries in the 65 years and over population. Residents from the Farnham area of Waverley recorded the highest rate at 1,991 per 100,000 followed by Rushmoor (1,933/100,000) and Hart (1,847/100,000). Rates are significantly higher for females than males.

Hip fracture admission rates were 439 per 100,000 compared to the rest of Hampshire (455 per 100,000). Residents from the Farnham area of Waverley recorded a higher rate (481/100,000) than the Hampshire rate.

The rate of primary hip replacement procedures between 2009 and 2012 were higher at 105 per 100,000 in NEHF CCG, compared to 98 per 100,000 in Hampshire. This is driven by the high rates in Rushmoor (112/100,000) and the Farnham area of Waverley (110/100,000). The CCG also had the highest rate of revision hip replacement procedures at 19 per 100,000, driven largely by the revision activity in Rushmoor (21/100,000) and the Farnham area of Waverley (19/100,000), compared to the Hampshire rate (15/100,000). Hart had a lower rate of revisions at 14 per 100,000.

Knee arthroscopic activity shows that NEHF CCG had a rate of 224 per 100,000 compared to the Hampshire rate of 216 per 100,000. Rates are significantly higher for males than females. Procedure rates for knee replacements were higher in NEHF CCG at 106 per 100,000 compared to the Hampshire rate of 95 per 100,000. Hart and Rushmoor females had the highest rates in the county of 125 and 122 per 100,000 respectively.

Despite the lack of evidence for the effectiveness of facet joint injections, this has remained a popular treatment modality, with ready access and age standardised rate in NEHF CCG at 496 per 100,000.
5.12 Sight loss

An estimated 23,500 people in Hampshire over the age of 18 have some degree of sight loss. It is more common in older people and as the population of Hampshire ages, the prevalence of sight loss will increase. An estimated 30,000 people in Hampshire will be affected by sight loss by 2020.

What does this mean?

The CCG has an opportunity to reduce variation and inequalities in service provision through a population healthcare approach to commissioning to meet local needs.

The suicide rates locally relate to a small population and need to be considered in the context of those accessing mental health services at a time of significant economic downturn.

The increase in the older population implies the need to prepare for predicted increase in people with dementia. Early diagnosis and, partnership working with the development of Dementia Friendly communities will be important.

Further work to identify the scale of chronic pain in the population and improve support and care pathways including self care will improve peoples’ quality of life and be cost effective.

NEHF CCG has high rates of hospital admissions due to falls and fall injuries in people aged 65 and over. Promoting bone health is important as is addressing the precipitating factors that contribute to falls including dehydration, infection, alcohol use.

The data suggest Rushmoor’s high hospital admission rates for hip replacements to be a reflection of greater need. But the CCG’s high knee arthroscopic activity and admission rates for knee replacements in both Hart and Rushmoor are more likely to reflect supply induced demand, rather than need.

NEHF CCG can achieve better musculoskeletal outcomes, using an integrated care pathway approach, shared decision making, with good access to rehabilitation following joint replacement.

Concerted action is needed to address the continued high facet joint activity in the CCG despite the lack of a supporting evidence base.
6. People and society

6.1. Older people with care support needs

In April 2013 there were 9,929 people aged 65 and over with substantial or critical social care needs supported by Hampshire County Council Adult Services. In line with the rest of the county, the majority of this demand in NEHF CCG was for domiciliary care (54%, 563 people) followed by nursing care (18.5%, 193 people) and residential care (15.2%, 159 people).

In 2012, 5,782 (18.6%) of people aged over 65 years old in NEHF CCG were assessed as unable to manage at least one mobility activity on their own. This includes being unable to go outdoors, walk down the road, climb stairs, get around the house, to the toilet or in and out of bed. In the CCG 7.4% (2,291) of people over the age of 65 years old were estimated as having dementia. Dementia is the most common reason for increasing long term packages of social care.

6.2 Adults with care support needs

In April 2013 Hampshire County Council Adult Services supported 193 clients aged 18-64 years old in NEHF CCG with a substantial or critical learning disability with a package of care. 174 people with a substantial or critical physical disability were also supported. Since 2010, there has been an increase in the number of clients receiving support and who have these disabilities across Hampshire.

Adults with autism are more likely to be socially disadvantaged, educationally less well qualified, less intellectually able and possibly under-supported by services. Modelled estimates predict that there are 1,140 males and 130 females with autism aged 19 years old and above in NEHF CCG.

6.3 Carers

8.7% (17,911 people) in NEHF CCG provide unpaid care to family members or others because of long term physical or mental ill health or disability, or problems related to old age. This is similar to Hampshire and England (10.1% and 10.2% respectively). 6.2% (12,690 people) provide 0-19 hours of unpaid care a week, 1.0% (1,995 people) provide 20-49 hours a week and 1.6% (3,226 people) provide 50 or more hours a week.

Monitoring by Hampshire County Council Adult Services on the primary reasons for increasing care packages for all clients showed that 24% (3,320) of these increases are to support carers who are finding it difficult to cope, 40.1% where people are caring for someone with dementia and 22.4% for people with reduced mobility.

11,426 people aged over the age of 65 years old in NEHF CCG are predicted to be living alone by 2018. This increases with age and is predicted to increase in the
future, potentially leading to an increased role for support from Hampshire County Council Adult Services.

6.3.1 Young carers

Young carers are relied upon to undertake caring which can potentially affect their own development, well-being and education. A national study by The Children's Society *Hidden from View 2013*, reveals how young carers are gaining fewer qualifications and are therefore less likely to earn a decent living.

A small number of school pupils in Hart and slightly larger number in Rushmoor identified as being young carers. These figures capture 3% of the total number of carers aged 0-24 in Hampshire. 4.1% (3,328 people) of the NEHF CCG population live in a household where there are dependent children and one person with a long term disability. This may also provide an indication of the number of young people with caring responsibilities in the area.

What does this mean?

Increasing number of people are being identified as unable to manage without care. Over 3,000 people in the area are currently providing more than 50 hours or more unpaid care. Prioritise health support of carers.

Large numbers of people are living alone. This increases with age and is predicted to rise in the future, presenting more challenge for the support of such people if and when it becomes needed.
7. Death

There were 34,214 deaths in Hampshire from 2009 to 2011; a directly age standardised rate of 468 deaths per 100,000 population, which is significantly lower than the England rate of 553 deaths per 100,000 population.

The NEHF CCG all causes, all age death rate from 2009 to 2011 of 448 per 100,000 was significantly lower than the Hampshire rate of 468 per 100,000.

**Figure 30 – All cause mortality by CCG**

![Mortality Graph]

Figure 30 shows that since 2006/08 this rate has been falling, however the decrease in the male rate is slower compared to that for females. From 2006/08 to 2009/11 male all cause all age rate decreased by 4.5%, female rate decreased by 13%.
In 2011, approximately 30% of all deaths in Hampshire were caused by cancer, compared to 28% from circulatory disease and 13% from respiratory disease. In NEHF CCG, 31% of deaths were caused by cancer, 25% from circulatory disease and 14% from respiratory disease. The NEHF CCG premature death rate is 215 per 100,000 this is comparable with Hampshire’s rate of 220 per 1000,000 and lower (better) than the national and South East region rates.

Death rates are inversely related to deprivation, with directly standardised rates in the most deprived quintile being 57% higher than in the least deprived quintile (Figure 32).
Figure 32: All cause mortality by deprivation quintile directly standardised 2009/10-2011/12 pooled

7.1 Life expectancy

Life expectancy at birth is the average number of years a newborn could expect to live if he or she experienced the age-specific mortality rates in a given year. It is an indicator of current health and mortality conditions. The life expectancy at birth in NEHF CCG was 80.8 years for males and 85.2 years for females. Hampshire male life expectancy is comparable; the female Hampshire life expectancy is lower, with females in NEHF CCG living an average of one year longer. At a district level Hart males and females had a life expectancy at birth of 82.3 and 85.8 respectively. Rushmoor males and females had a life expectancy at birth of 79.2 and 84.3 respectively.

7.2 Preventable deaths

There were 778 preventable deaths\textsuperscript{28} in NEHF CCG from 2009 to 2011. This equates to a rate of 115 preventable deaths per 100,000 population, which is lower than Hampshire (119 per 100,000) and England (146 preventable per 100,000).

The rate of preventable deaths in Hampshire has decreased in the last five years, in NEHF CCG the rate has fluctuated over the time period, overall there has been a

\textsuperscript{28}Deaths that are considered to be potentially avoidable by public health interventions in the broadest sense Preventable deaths have been defined by the Public Health Outcomes Framework, further information is available \url{http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000044/par/E12000004/ati/102/page/6}
small decrease between 2006/08 and 2009/11 however there has been a slight increase in the male rate.

What does this mean?

NICE guidance summarises actions that should be taken to reduce premature deaths and inequalities through taking strategic and cross-organisation working on the following:

- Smoking cessation.
- Preventing harmful drinking.
- Physical activity including maximising local government opportunities to develop physical environments that support people to be more physically active e.g. through planning, transport etc.
- Healthy eating.
- Obesity.
- Type 2 diabetes.
- Heart disease and stroke.

Focus should also be on drivers of behaviours, including poverty, poor educational attainment, unemployment, housing issues.

As people live after cancer treatment we need to review their changing needs.

We need to do more to reduce inequalities in premature deaths, focusing more effort on men’s health. This will include and emphasis on factors that have the biggest impact on premature death – smoking, alcohol, physical inactivity, obesity – but also the hugely important drivers of these behaviours – poverty, poor educational attainment, unemployment, housing issues.

As life expectancy increases, we need to do more to reduce the number of years people are living with disability. Current data suggest that we live a fifth of our lives in poor health. The UK GBD study suggests the greatest burden is mental health problems (anxiety, stress and depression) and musculoskeletal problems including chronic pain. We need to investigate this and tailor our strategies and interventions accordingly.
# APPENDIX 1
## Routine Childhood Immunisations 2012-13

<table>
<thead>
<tr>
<th>When to immunise</th>
<th>Diseases protected against</th>
<th>Vaccine given</th>
</tr>
</thead>
</table>
| **Two months old**                    | Diphtheria, tetanus, pertussis (whooping cough), polio and *Haemophilus influenzae* type b (Hib)  
Pneumococcal infection               | DTaP/IPV/Hib + Pneumococcal conjugate vaccine, (PCV)                                   |
| **Three months old**                  | Diphtheria, tetanus, pertussis, polio and *Haemophilus influenzae* type b (Hib)  
Meningitis C                           | DTaP/IPV/Hib + MenC                                                                |
| **Four months old**                   | Diphtheria, tetanus, pertussis, polio and *Haemophilus influenzae* type b (Hib)  
Meningitis C  
Pneumococcal infection           | DTaP/IPV/Hib + MenC + PCV                                                          |
| **52 weeks of age but AFTER 1st birthday** | *Haemophilus influenza* type b (Hib) / Meningitis C  
Measles, mumps and rubella  
Pneumococcal infection               | Hib/MenC + PCV                                                                   |
| **Three years and four months or soon after** | Diphtheria, tetanus, pertussis and polio  
Measles, mumps and rubella             | DTaP/IPV or dTaP/IPV +MMR                                                        |
| **Girls aged 12 to 13 years**         | Cervical cancer caused by Human Papillomavirus types 16 and 18.                           | HPV                                                                          |
| **13 to 18 years old**                | Diphtheria, tetanus, polio                                                               | Td/IPV                                                                        |