This section of the joint strategic needs assessment presents the relative needs of the resident population of North Hampshire CCG (NH CCG). Where possible, data are presented for the CCG as a whole. Where data are not available by CCG the local authority districts which fall within the CCG boundary will be presented. These are Basingstoke and Deane, East Hampshire and Hart. It should be noted that only a part of each of these districts is within the 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

Demography

- In 2011 the resident population of NH CCG was 214,038 people.
- NH CCG has a relatively young population, with a higher proportion of people under the age of 15 years old than Hampshire or England. The area has a slightly higher proportion of working age people, but a lower proportion of people over the age of 65 years old when compared to Hampshire.
- There is a projected increase in all population groups except for 15-44 year olds. The greatest projected proportionate increase is for over 75 year olds.

Health Inequalities and deprivation

- The life expectancy at birth in NH CCG is 80.5 years for males and 83.2 years for females. Life expectancy for males is similar to the Hampshire average but for females it is lower than the Hampshire average and varies between the constituent districts.

- Whilst NH CCG has a low overall level of deprivation when compared to England as a whole, it ranks as one of the worst CCGs (18th out of 212) for the geographical barriers sub-domain which measures road distances to key services.

- Pockets of deprivation exist in South Ham, Popley East and Chineham wards in Basingstoke and parts of Alton East Brooke ward in Alton affecting a substantial number of people who are consequently likely to have poorer health.

- Education and employment influence income and there is a well established link between income and health. Just over half of 16 year olds in Basingstoke and Deane achieve 5 A*-C GCSEs – below the Hampshire average (58.5%) and the England average (59.4%). However, more of the 16-74 year old population in North Hampshire 76.3% (119,012) are economically active than the 73.2% for Hampshire and 69.9% across England.

Children and young people

- There are approximately 52,178 children and young people aged under 20 in NH, which is around 25% of the total CCG population.
- North Hampshire has a higher birth rate than the county and national averages, which reflects the younger population.
- Teenage conceptions have reduced by a third over the last 15 years, but the current under 18 conception rate in Basingstoke and Deane is higher than the overall rate in Hampshire.

- In NH in 2012/13 60.7% of mothers were either partially or totally breastfeeding at their primary birth visit (9-14 days), but by the 6-8 week check this is reduced to just over 50%.

- Around 8% of 4-5 year olds in NH were obese, but this doubles to over 16% amongst 10-11 year olds, which high for Hampshire.

- Children’s dental health is good compared to the rest of England, but a greater proportion of children in Basingstoke and Deane have dental decay than in East Hampshire and Hart.
Recommendations

The increasing population with young and older people in the area will have implications for service planning, particularly as older people are high users of health and social care services. The prevalence of chronic and other health conditions increases with older age and functional abilities may decline. Health services need to ensure models of care cater for the changing needs of older people. The reduction in working age population is of significance for supporting the growing young and old groups of the population.

It is important to maintain the health of the population to maximise years of life lived in good health. The CCG needs to include plans for primary and secondary prevention in its commissioning plans.
1. Demography

In 2011, the resident population of North Hampshire (NH) CCG was 214,038 people, consisting of 106,170 men (49.6%) and 107,868 women (50.4%). This makes up 16.2% of the total resident population of Hampshire (ONS resident population, 2011). The geographical area of NH CCG covers 86,078 hectares, with 2.5 people per hectare compared to the Hampshire average of 3.6 people per hectare¹ (ONS, 2011). There are 87,166 households in NH CCG.

The population pyramid (figure 1) shows that the CCG has a relatively young population, with more people under the age of 15 years old compared to Hampshire and England. NH CCG has a larger proportion of children aged 0-19 than Hampshire (23.6% (50,276) of the population compared to 22.5%). The area has slightly higher numbers of working age people, but fewer people over the age of 65 years old compared to Hampshire.

Figure 1: North Hampshire CCG population pyramid for resident population, 2011 (ONS 2011 mid-year population estimates for Lower Super Output Areas (LSOAs))

The East Hampshire population within the CCG area is generally older than that of Hart and Basingstoke and Deane (figure 2). People aged 60 plus make up to 26.5% of East Hampshire’s residents (30,754 people), 23% of Hart’s population (21,056 people) and 20.5% of Basingstoke & Deane’s population (34,615 people). Approximately 3% of the population in East Hampshire are aged over 85 years compared to 2% in Hart and Basingstoke and Deane. 22.8% (26,487 people) of the population in East Hampshire are aged 0 to 19 years compared to 23.2% (21,228 people)

¹ ONS resident population, 2011.
people) in Hart and 23.9% (40,313 people) in Basingstoke & Deane; these are all comparable to Hampshire (23.3%).

**Figure 2: Population pyramids for the CCG’s constituent Local Authority areas: Basingstoke & Deane, Hart and East Hampshire.**
The population of NH CCG is projected to increase by 2.27% by 2018, which is more than the projected increase for Hampshire (1.77%) but less than England (4.11%) over the same time period (figure 3). There is a projected increase in all population groups aside from 15-44 year olds, which is estimated to reduce by 4.38%. The greatest projected increase is for over 75 year olds, with an increase of 14.41%, higher than in Hampshire (9.94%) and England (10.56%).

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

The 2011 Census showed that 89.1% of the population in NH CCG identified themselves as White British, which is higher than the England (79.8%), but lower than the Hampshire (91.8%) average. Non British White people make up a further 4.5% of the population and Asian/Asian British 3.5%. 1.1% has been resident in the UK for less than 2 years, compared to 0.8% in Hampshire and 1.8% in England.

In NH CCG the largest ethnic groups other than White British as described by detailed Census ethnic group are Indian or British Indian (2,698 people), White: Polish (1,983 people), White: Irish (1,619 people), Black/Black British: African (1,386 people), Asian/Asian British: Chinese (1,321 people).

The 2011 Census recorded 2,069 Gypsies and Travellers in Hampshire; the majority are of Romany Gypsy heritage with the second largest group being Irish Travellers. The greatest proportion of the population of these (0.3%) are in the district of Hart. There are four local authority maintained sites in Hampshire, two are located in Hart these are Star Hill in Hartley and Penny Hill in Blackbush.

What does this mean?

The increasing population with young and older people in the area will have implications for service planning, particularly as older people are high users of health and social care services. The prevalence of chronic and other health conditions increases with older age and functional abilities may decline. Health services need to ensure models of care cater for the changing needs of older people. The reduction in working age population is of significance for supporting the growing young and old groups of the population.

It is important to maintain the health of the population to maximise years of life lived in good health. The CCG needs to include plans for primary and secondary prevention in its commissioning plans.
2. Health inequalities

Health inequalities are the avoidable differences in health, well-being and life expectancy between people. It is well known that age, sex, genetic make-up and lifestyle behaviours influence health. Other factors, known as the wider determinants also influence health. These include income, education, employment, housing and neighbourhood circumstances. The wider determinants of health affect a person’s current and future 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 NH CCG is 80.5 years for males (80.0-81.0) and 83.2 years for females (82.7-83.6). Figure 4 shows that life expectancy for males is similar to the Hampshire average and higher than the average for England and the South East. Life expectancy for females is lower than the Hampshire average and only just higher than the average for England (figure 5). At a district level Hart males and females had a life expectancy at birth of 82.3 and 85.8 respectively. Basingstoke and Deane males and females had a life expectancy at birth of 80.3 and 82.9 years respectively. East Hampshire males and females had a life expectancy at birth of 80.7 and 83.7 years respectively.

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

![Life Expectancy at Birth](image)

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

NH CCG has a lower overall level of deprivation when compared to England as a whole, with a rank for the index of multiple deprivation (IMD) of 198 out of 212 CCGs. A large proportion of the 1% least overall deprived wards in England are situated within lower super output areas (LSOAs) in NH CCG.

Figure 6 presents the indices of deprivation domains for NH CCG by national rank. The CCG ranks as one of the worst CCGs (18th out of 212) for the geographical barriers sub-domain which measures road distances to key services.

Figure 6: Indices of Deprivation 2010 – England ranks based on summary scores for North Hampshire CCG²

Source, IMD 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
The favourable IMD rank at CCG level should not lead to the conclusion that deprivation is not an issue for NH, as pockets of deprivation exist affecting large numbers of the population. Figure 7 shows the Indices of Deprivation 2010 by LSOA ranked by national decile. Parts of South Ham, Popley East and Chineham wards in Basingstoke and parts of Alton East Brooke ward in Alton are ranked in the 3rd national decile.

**Figure 7: North Hampshire 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 8 shows for each of the domains of deprivation the proportion of the population for NH CCG living in each quintile.

- 57,083 people (28% of the NH CCG population) live in the most deprived quintile nationally for the geographical barrier sub-domain.
- 53,202 people (26% of the NH CCG population) live in the most deprived quintile nationally for the crime sub-domain.
Household overcrowding: the proportion of households within an LSOA which are judged to have insufficient space to meet the household’s needs

Homelessness: the rate of acceptances for housing assistance under the homelessness provisions of the 1996 Housing Act (at local authority district level), difficulty of access to owner-occupation (local authority district level), proportion of households aged under 35 whose income means they are unable to afford to enter owner occupation.

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 throughout life, in education, employment and income. Gaps in educational attainment between children living in the most and least deprived areas of England can be seen 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\textsuperscript{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\textsuperscript{4}.

2.2.1. Children and young people

Five A\textsuperscript{*} to C GCSEs is used to measure educational attainment in 16 year olds. Deprivation is associated with worse GCSE results. However quality of schooling can minimise or compound this association.

Figure 9 shows the percentage of Hampshire pupils (58.5\%) at the end of key stage 4 achieving five or more A\textsuperscript{*}-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 has increased performance varies year on year when benchmarked against the comparator areas.

Figure 9. Percentage of pupils at the end of Key Stage 4 achieving 5+ A\textsuperscript{*}-C grades including English at Maths GCSE at GCSE and equivalents.

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{figure9.png}
\caption{Percentage of pupils at the end of Key Stage 4 achieving 5+ A\textsuperscript{*}-C grades inc. English & Mathematics GCSEs at GCSE and equivalents in 2011/12 - Hampshire and child health comparator areas.}
\end{figure}

\textsuperscript{3} Marmot M. Fair Society, Healthy Lives. London: The Marmot Review

\textsuperscript{4} Griggs J, Walker R. The costs of child poverty for individuals and society. The Joseph Rowntree Foundation. October 2010
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.

Figure 11 shows that just over half of 16 year olds in Basingstoke and Deane achieve 5 A*-C GCSEs – below the Hampshire average (58.5%) and the England average (59.4%)\(^5\). Hart and East Hampshire had a higher percentage of children achieving 5 A*-C GCSEs than the national and Hampshire figure.

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

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The number 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%. In 2011/12, the proportion of young people leaving care and in employment, education or training in Hampshire was 46.2%, which was much lower than the England average of 57.8%.

### 2.2.2. Working age adults

Skill levels among Hampshire’s adult population are generally higher than the national average.

Of the 16-74 year old population in NH 76.3% (119,012) are economically active, compared to 73.2% in Hampshire and 69.9% in England. Figure 12 shows that NH has lower levels of adults with no qualifications than both Hampshire and England. Unemployment among young people, people of all ages and people who have never worked is at a similar level to Hampshire, but lower than England. It has lower levels of lone parents not in employment compared to both Hampshire and England. The most common industries for the economically active adult population to work in NH are wholesale, retail trade and motor vehicles, human health and social work activities, manufacturing and information and communication (ONS, 2011).

**Figure 12: Characteristics of the working age population in North Hampshire**

<table>
<thead>
<tr>
<th></th>
<th>North Hampshire CCG %</th>
<th>Hampshire %</th>
<th>England %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residents aged over 16 years old with no qualifications</td>
<td>16.9 (28,887 people)</td>
<td>18.5</td>
<td>22.5</td>
</tr>
<tr>
<td>Unemployed (16-74 year olds)</td>
<td>3.1 (4,766 people)</td>
<td>3.0</td>
<td>4.4</td>
</tr>
<tr>
<td>Unemployed (16-24 year olds)</td>
<td>0.8 (1,187)</td>
<td>0.8</td>
<td>1.2</td>
</tr>
<tr>
<td>Never worked</td>
<td>0.3 (401 people)</td>
<td>0.3</td>
<td>0.7</td>
</tr>
<tr>
<td>Lone parent households not in employment</td>
<td>31.8 (1,618 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% (9,112 households) of the NH CCG population were one person households where the resident was over the age of 65 years. This is lower than Hampshire (12.6%) and England (12.4%). Amongst those over the age of 60 years old, 10.0% (4,194 people) in NH are living in households
which are income deprived\textsuperscript{6}. This compares to 10.7\% in Hampshire overall and 18.3\% in England.

### 2.2.4. Disability

Disabled households tend to have less overall household income than those without a disability. Working disabled people are more likely than the rest of the working population to be on low hourly pay. The fact that disabled people often spend periods of their working-age lives out of work increases their risk of poverty in later life. These worse outcomes are compounded by the extra costs associated with living with disabilities\textsuperscript{7}.

The 2011 Census showed that 5.6\% (11,883) of those aged 16-64 years old had their day-to-day activities limited a lot by their long term health condition or disability. This is less than the Hampshire (6.7\%) and England averages (8.3\%).

In NH, 0.4\% of people (n=644) over the age of 18 years old were registered as having a learning disability\textsuperscript{8}. This is similar to the Hampshire level of 0.4\%. In 2009/10, two thirds of adults with learning disabilities who were known to Hampshire County Council’s Adult Services were judged to be in settled accommodation, which is more than national (61\%) and regional (63.2\%) levels. Some of these were living with their families. Over 88\% of people with learning disabilities were unable to find paid work for at least an hour a week.

### 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)\textsuperscript{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\textsuperscript{10}.

The rate of statutory homelessness\textsuperscript{11} in Hampshire was 0.81 people per 1000

\textsuperscript{6}This can be defined as the proportion of adults aged 60 or over living in Income Support or income based Jobseeker’s Allowance or Pension Credit (Guarantee) families.

\textsuperscript{7}http://www.equalityhumanrights.com/key-projects/triennial-review/

\textsuperscript{8}Data from the 2011-12 Quality and Outcomes Framework (QOF)

\textsuperscript{9}Houses of Parliament Parliamentary Office of Science and Technology. Housing and Health. Postnote. 371, January 2011


\textsuperscript{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 in to a priority need group. Groups
households in 2011-12, with the highest levels in areas of Gosport, Havant and East Hampshire.

Compared with other Hampshire Local Authority Districts, there are low levels of statutory homelessness in Basingstoke and Deane, with an average of 1 household a year accepted as being homeless from 2009 to 2012. This may be related to focused interventions to prevent homelessness, including work with the private sector to help individuals to secure accommodation. In the last three years (2009/10 to 2011/12) in Hart there was an average of 7 households per year. East Hampshire accepted an average of 59 households as being homeless and in priority need.

Non statutory homelessness is difficult to measure but can be estimated from Supported Housing panel data. This shows the highest numbers of applications to be amongst people with mental ill health, young people and people living in Fareham and Gosport, Basingstoke and Deane, the New Forest and Winchester.

A survey of 142 homeless people in Hampshire found the health needs identified by homeless people as 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. It is estimated that Gypsies and Travellers die on average 10-12 years younger than the general population.

Although the 2011 Census recorded a total of 2,069 Gypsies and Travellers living in Hampshire, 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 gypsy and traveller population across the county (0.3, 273 people), compared to Hampshire proportion of 0.16 and national proportion of 0.1. East Hampshire has an estimated 267 gypsies and travellers equating to a proportion of 0.23.
There are no robust local data quantifying the prevalence of illnesses and lifestyle behaviours amongst the Gypsy and Traveller population in Hampshire. Evidence suggests the key health problems experienced by Gypsies and Travellers include:

- Higher prevalence of long term conditions such as heart disease, diabetes, lung disease, and mental health problems
- Higher prevalence of risky lifestyle behaviours such as smoking, lack of physical activity, obesity and alcohol consumption
- Higher levels of domestic abuse amongst women
- Higher levels of dental health problems and fewer dental check-ups;
- Increased risk of preventable childhood infectious diseases such as measles because of lower levels of vaccination.

What does this mean?

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

North Hampshire CCG has relatively low levels of overall deprivation; however:

- there are areas of deprivation, and consequently poorer health in South Ham, Popley East and Chineham wards in Basingstoke and parts of Alton East Brooke ward in Alton;
- some people, particularly in rural areas live a considerable distance from key services, which challenges both statutory and voluntary agencies to make them more accessible whilst still being safe and cost effective;
- within NH there are groups who are potentially vulnerable to isolation and poorer health outcomes, including lone parent households, older people living in deprived households and people who homeless;
- we need a better understanding of how best to support the local gypsy and traveller community to improve their health.
3. Children and young people

There are approximately 52,178 children and young people aged under 20 in NH, which is around 25% of the total CCG population\(^{12}\).

3.1 Births

Pooled data from 2009-11 give a general fertility rate in NH CCG of 67.1 (65.1-69.1) live births per 1000 women aged 15-44 years old, which is higher than the Hampshire (64.3)\(^{13}\) and England (64.5%)\(^{14}\) 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 Basingstoke and Deane local authority are presented in figure 13. However at a local authority level there is greater uncertainty in the projection of births due to the smaller geographical areas and associated small populations that render the predictions increasingly unreliable the further they go forward. The projections suggest that the previous rise in births may be starting to level off. However, it is also 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 Hampshire 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 a rate of 25.2 per 1,000 girls in 2010 to 23.3 per 1,000 girls aged 15-17 years in 2011.

All Hampshire districts have seen a reduction in under 18 conceptions between 2008-10 and 2009-11. Reductions in districts covered by NH CCG range from -21.3% (23.6 to 18.6 per 1,000, East Hampshire district) to -8.4% (17.1 to 15.7 per 1,000, Hart district) (ONS, Conception Statistics England and Wales 2011). The rate of under 18 conceptions in Basingstoke and Dean in the period from 2009 to 2011 was 27.8 per 1,000, which is higher than the Hampshire rate but lower than the national rate over the same period.

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 rate 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 families\textsuperscript{15} 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 mortality\textsuperscript{16}.

The infant mortality rate in NH CCG is relatively low at 2.8 children under one year old per 1000 births (2.0-5.1) compared to a rate in Hampshire 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, reflecting advances in medical care and preventative measures generally. 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

\textsuperscript{15} http://www.childrenshealthwatch.org/upload/resource/Duncan2000.pdf
\textsuperscript{16} http://www.ons.gov.uk/ons/dcp171778_300596.pdf
improved their outcomes over the last 20 years while the UK has fallen behind in the rate of improvements with death rates remaining 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 data are reviewed by the Child Death Overview Panel (CDOP) which considers potential 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\(^\text{17}\). Only 42.2% of mothers in the most deprived quintile in Hampshire initiate breastfeeding.

Figure 14 shows that in North Hampshire in 2012/13 60.7% of mothers were either partially or totally breastfeeding at their primary birth visit (9-14 days).

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

By the 6-8 week check, rates of breast feeding reduced to 50.1% (figure 15), which is better than in Hampshire as a whole (45.3%), and England (47.2%).

Rates at the primary birth visit and at 6-8 weeks have increased slightly, but not statistically significantly over the last year. There is variation across the CCG area with higher breastfeeding rates in East Hampshire and Hart than in Basingstoke and Deane.

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, disability and premature mortality in adulthood.

Pooled data for 2007/8 to 2011/12 show that 7.9% of 4-5 years olds were obese in NH CCG. This was marginally below the Hampshire rate (8.0%), but not statistically significantly different from any of the other CCGs.

Among 10-11 years olds the rate of obesity in NH in the same period was 16.6%. This is above the Hampshire rate (15.4%), and joint highest in the county along with Fareham and Gosport CCG.

In both 4-5 year olds and 10-11 year olds in NH, the rates of obesity for 2007/08 to 2011/12 are below the England rates (9.6% and 19.0%, respectively).

Across Hampshire the proportion of children who are obese almost doubles between Reception and Year 6.
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.

In 2007/08, a national survey found that 22.4% of five year olds in Basingstoke and Deane had experience of dental decay. The same figure for Hart and East Hampshire districts is 21.0% and 17.3%, respectively. These compare with the Hampshire proportion of 21.7%, although all three are lower than the same figure for England (30.9%).

In 2008/09, a national survey found that 27.5% of twelve-year-olds in Basingstoke and Deane had experience of dental decay. The same figure for Hart and East Hampshire districts is 13.5% and 22.9%, respectively. These compare with the Hampshire proportion of 25.2%, and all three are lower than the same figure for England (33.4%).

Of those twelve-year-olds with some decay, the mean number of teeth affected do not follow the same pattern. In spite of having the greatest proportion of children with some decay, the mean number of teeth affected in Basingstoke and Deane is not the highest of the three districts (1.80). The same figure for East Hampshire is 2.27, and for Hart 1.52. This compares with the Hampshire and England averages of 1.99 and 2.21, respectively.

3.8. Immunisation

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

Figures 17 and 18 below show that for NH CCG, 91.2% of 6 year olds had received the full MMR course (both the MMR1 and MMR2 vaccines), and 93.4% had received...
the DTaP/IPV booster. This is less than the WHO target of 95% which is required to ensure herd immunity.

**Figure 17: Proportion of children who have received 2 MMRs at 6 years by CCG 2012/12**

![Graph showing proportion of children who have received 2 MMRs at 6 years by CCG 2012/12](image)

**Figure 18: Proportion of children who have received dTaP/IPV at 6 years by CCG 2012/13**

![Graph showing proportion of children who have received dTaP/IPV at 6 years by CCG 2012/13](image)

The School Leaver Booster (SLB) boosts immunity against tetanus, diphtheria and polio. It is available routinely on the NHS for all young people aged between 13 and 18. The Department of Health target for the Td/IPV vaccination (tetanus, diphtheria and polio) is 90%. In North Hampshire in 2012/13 the proportion of 18 year olds who had received the SLB was 71.8%.
3.9. Hospital activity for children and young people

There were 21,226 per 100,000 first attendances at A&E (directly age standardised rates (DSR)) for people under the age of 15 years old in North Hampshire CCG from 2009-12, which is lower than the Hampshire rate of 25,569/100,000 (figure 20).

Figure 20: First attendances at A and E for children aged under 15 by CCG
Rates of emergency admissions for people under the age of 15 years old are the highest in Hampshire (10,764 per 100,000 compared to 8006 per 100,000) (figure 21).

**Figure 21: Emergency admissions aged under 15 by CCG**

![Chart showing emergency admissions by CCG](chart.png)

Sources: CDS received from Provider Trusts via SUS & ONS LSOA mid year population estimates

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 by GPs or in the supply of local hospital services. Pooled data from 2009-12 show that the rate for NH CCG is the highest in Hampshire: 413 per 100,000 compared to 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 emergency admissions for unintentional and deliberate injuries in people under the age of 18 from 2009-12 in NH CCG was 1,119 per 100,000, which was higher than the Hampshire rate (1066 per 100,000). Cycling casualties in the three districts that lie within the NH CCG boundary, Basingstoke and Deane, East Hampshire and Hart are 50, 26 and 34 per 100,000 (DSR). These are below the
highest rates seen in the districts in Hampshire of Gosport and Fareham (DSRs of 226 and 88 per 100,000, respectively).

3.11. Substance misuse

The admission rate for 15-24 year olds due to substance misuse was 762 per 100,000 people (DSR) in NH CCG. Rates were higher in Basingstoke and Deane and East Hampshire districts (DSRs of 854 and 748 per 100,000, respectively) than Hart (652 per 100,000).

Alcohol specific hospital admissions for people aged under 18 years old in NH CCG were 37 per 100,000, above the Hampshire average (34 per 100,000) due to high rates in Basingstoke and Deane (39 per 100,000).

3.12. Vulnerable children and young people

3.12.1. 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 households and can help to measure the levels of children living in poverty in an area.

4,521 (11.0%, 10.7-11.3) 0-15 year olds in NH CCG live in income deprived households. The level in NH is both lower than in England (21.7%), and Hampshire (12.1%).

3.12.2. Children with disabilities

Children with disabilities and their families are one of the most vulnerable groups in Hampshire. However, defining and measuring the extent of childhood disability is challenging due to the lack of an agreed consistent definition. Overall, estimates of the number of disabled children in Hampshire ranges 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 20.2% (5,607) of school pupils in NH CCG as having a special educational need (SEN) and of these, 2.9% (802) had a statement to identify their needs. A statutory assessment is only necessary if the school or early education setting cannot provide all the help that a child needs.

Despite the ambiguity and lack of robust data on childhood disability, there is a consensus that the population of children using services is increasing as is the

---

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.
complexity of disability and need. Where we do have data, this is reflected, 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 the rising birth rate (14.4% rise 2000 to 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?**

Continue work to reduce the teenage conception rate and the downward trend. Whilst the factors that increase the risk of teenage pregnancy are complex, health professionals have a vital role in preventing teenage pregnancy and supporting teenage mothers.

Identify which women are more likely to have low breastfeeding rates and work as part of multi-agency initiatives to encourage and maintain breastfeeding.

The causes of childhood obesity are complex but have long lasting implications for the life and health outcomes of the individual. The CCG should play a full part in implementing the Hampshire Healthy Weights strategy for children and further enhance work with families.

Work with partner agencies and GPs to increase immunisation uptake, 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).

There continues to be high overall rates of emergency admissions for under 15s, and particularly high rates for asthma, diabetes and epilepsy in under 20s which should be reviewed.
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 Lancet19 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 estimated20 to be currently smoking is 20.2% in Basingstoke and Deane, 15.3% in East Hampshire, and 14.5% in Hart district compared to the England rate of 20%. Smoking prevalence for Hampshire is 17.5%.

In 2012/13, estimated rates of smoking amongst routine and manual workers were 20% in Hart, 26.1% in East Hampshire and 31.2% in Basingstoke & Deane, compared to 30% in Hampshire and 30.3% in England.

The directly age standardised rate of hospital admissions wholly or partly attributable to smoking in people aged over 35 years old was 993 per 100,000 in Basingstoke and Deane, 862 in East Hampshire, and 961 in Hart district. Although all three districts are below the Hampshire and England rates (1000 and 1420 per 100,000, respectively) this is a cause of hospital admission that is preventable.

The directly age standardised rate of deaths wholly or partly attributable to smoking in people aged over 35 years was 181.5 per 100,000 in Basingstoke and Deane, 151.5 in East Hampshire, and 145.3 in Hart district. All three districts are lower than the England rate of 210.6 per 100,000 (2008-10).

In 2011-12, 7.5% of all smokers aged over 15 years old in Basingstoke and Deane, 7.2% in East Hampshire and 6.4% in Hart District were engaged in NHS stop smoking services. The 4 week quitter success rate was 55% in Basingstoke and Deane, 48% in East Hampshire and 55% in Hart District.

4.2. Obesity and healthy eating

Overweight and obesity presents a major challenge to the current and future economic wellbeing and health outcomes of the people of Hampshire. Being

DOI: 10.1016/S0140-6736(13)60355-4
20 2011/12 Integrated Household Survey, ONS
overweight or obese significantly increases the risks of 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 change in the current rising trend but a significant rise in obesity and severe obesity. The prevalence of obesity and being overweight changes with age. For adults it is currently lowest in the 16-24 year old age group and gets generally higher in the older age groups for both men and women. Figure 22 shows the modelled prevalence of obesity by district. The rate for Basingstoke and Deane is similar to the England rate whereas the rates in East Hampshire and Hart are significantly lower.

**Figure 22: Estimated prevalence of adults who are obese by local authority 2006-2008**

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

4.3. Physical activity – see Hampshire JSNA

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 show that 27.5% of the Basingstoke and Deane population over the age of 16 years old who are identified as drinkers consume more than the
government recommendations\textsuperscript{21}. The equivalent figure for both East Hampshire and Hart districts is 27.9%.

Figure 23 shows there were 1,159.3 per 100,000 admissions for alcohol attributable conditions in Basingstoke and Deane in 2010/11. This is lower than both the national rate of 1,895.2 per 100,000 and the Hampshire rate of 1,357.4 per 100,000. The rate in East Hampshire and Hart districts is 1,161.4 and 1,498.4 per 100,000\textsuperscript{22}.

**Figure 23: Admission episodes for alcohol-attributable conditions: All ages, DSR per 100000 population, 2010/11**

The directly age standardised rate of alcohol specific hospital admissions for people under the age of 18 years old in 2009-12, in NH CCG was 37 per 100,000, which is higher than Hampshire (34 per 100,000). Figure 24 shows there is variation in the district rates with a particularly high rate in Basingstoke and Deane (45.6 per 100,000) compared to 23.9 per 100,000 in East Hampshire and 20.7 per 100,000 in Hart\textsuperscript{23}. However these rates are lower than the national rate of 55.8 per 100,000.

\textsuperscript{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 as they are derived from a statistical model.

\textsuperscript{22} Local Alcohol Profiles for England 2013

\textsuperscript{23} CDS received from Provider Trusts via SUS & ONS LSOA mid year population estimates
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 NH CCG the year on year average growth was highest in Hart (11%) followed by Basingstoke & Deane (10%) and East Hampshire (8%).

Alcohol attributable mortality (2010) for all the local authority areas in NH CCG have rates lower than the rate for England for males and females, but the difference is not 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, Basingstoke and Deane ranked 74, East Hampshire ranked 190 and Hart 173 out of 326 local authorities (where one is the highest) in England for rates of STIs.

The rate of acute STIs in Basingstoke and Deane was 813.3 per 100,000, comparable to the England rate (792.1/100,000). The rates in East Hampshire (580.9 per 100,000) and Hart (603.1 per 100,000) were significantly lower than the England rate. Over half of acute STI diagnoses were in young people aged 15-24.
years old: 55% in Basingstoke and Deane, 65% in East Hampshire and 56% in Hart. Infections in men who have sex with men account for 6.7% of infections in Basingstoke and Deane, and 7.0% and 8.7% in East Hampshire and Hart districts respectively.\(^{24}\)

The diagnosis rate for chlamydia in young people aged 15-24 was 1940.5 per 100,000 in Basingstoke and Deane, 1,898.6 in East Hampshire and 1,571.8 in Hart. This compares to 1,975 per 100,000 in Hampshire 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) compared to the national rate of 1.5 per 1,000 in 2011. However, for those diagnosed with HIV; 50.0% in Basingstoke and Deane, 47.1% in East Hampshire and 50.0% in Hart were classified as having a late diagnosis. This compares to the national level of 52.3%. Late diagnosis of HIV is the most important predictor of HIV mortality and morbidity.

**What does this mean?**

CCGs should ensure opportunities for reducing alcohol intake are taken through quality conversations with health professionals and support multi-agency work to reduce the impact of alcohol locally.

Whilst smoking cessation services have been relatively successful, concerted effort is needed to target communities where smoking is the norm, particularly in the Basingstoke and Deane area.

Obesity will have significant implications for the future and requires a systematic multi-agency strategic approach both locally and countywide.

There is a lack of data on levels of physical activity at a local level. However increased physical activity should be encouraged for everyone, but especially those at risk of or with chronic illness. General practices should consider using motivational interviewing techniques such as ‘Let’s Get Moving’.

\(^{24}\) Health Protection Agency Local Authority Sexually Transmitted Infections Epidemiology Reports: 2011
5. Long term conditions

Figure 25 shows a summary of the prevalence of long term conditions in NH CCG in 2010/11. The large diamond shows the average rank for the CCG and the dashed blue line shows the England average. Individual Practices are represented by the black vertical bars. The chart shows that NH CCG has a higher prevalence of hypothyroidism, cancer, palliative care, depression and chronic kidney disorder compared to the England average. However it is not possible to determine whether the data are significantly higher than England.

Figure 25: Summary of the prevalence of long term conditions from the QOF Disease register in NH CCG, 2010/11

<table>
<thead>
<tr>
<th>QOF Disease Register</th>
<th>Number (%)</th>
<th>Practice ranks chart</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coronary Heart Disease</td>
<td>5,658 (2.7%)</td>
<td><img src="#" alt="Graph" /></td>
</tr>
<tr>
<td>Stroke or Transient Ischaemic Attacks (TIA)</td>
<td>2,634 (1.3%)</td>
<td><img src="#" alt="Graph" /></td>
</tr>
<tr>
<td>Hypertension</td>
<td>25,207 (11.9%)</td>
<td><img src="#" alt="Graph" /></td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary Disease</td>
<td>2,349 (1.1%)</td>
<td><img src="#" alt="Graph" /></td>
</tr>
<tr>
<td>Hypothyroidism</td>
<td>7,263 (3.4%)</td>
<td><img src="#" alt="Graph" /></td>
</tr>
<tr>
<td>Cancer</td>
<td>3,338 (1.6%)</td>
<td><img src="#" alt="Graph" /></td>
</tr>
<tr>
<td>Mental Health</td>
<td>1,317 (0.6%)</td>
<td><img src="#" alt="Graph" /></td>
</tr>
<tr>
<td>Asthma</td>
<td>12,486 (5.9%)</td>
<td><img src="#" alt="Graph" /></td>
</tr>
<tr>
<td>Heart Failure</td>
<td>957 (0.5%)</td>
<td><img src="#" alt="Graph" /></td>
</tr>
<tr>
<td>Heart Failure Due to LVD</td>
<td>444 (0.2%)</td>
<td><img src="#" alt="Graph" /></td>
</tr>
<tr>
<td>Palliative Care</td>
<td>412 (0.2%)</td>
<td><img src="#" alt="Graph" /></td>
</tr>
<tr>
<td>Dementia</td>
<td>985 (0.5%)</td>
<td><img src="#" alt="Graph" /></td>
</tr>
<tr>
<td>Atrial Fibrillation</td>
<td>2,719 (1.3%)</td>
<td><img src="#" alt="Graph" /></td>
</tr>
<tr>
<td>Cardiovascular Disease Primary Prevention</td>
<td>2,269 (1.1%)</td>
<td><img src="#" alt="Graph" /></td>
</tr>
<tr>
<td>Diabetes Mellitus (17+)</td>
<td>8,878 (5.3%)</td>
<td><img src="#" alt="Graph" /></td>
</tr>
<tr>
<td>Epilepsy (18+)</td>
<td>1,179 (0.7%)</td>
<td><img src="#" alt="Graph" /></td>
</tr>
<tr>
<td>Depression (18+)</td>
<td>21,743 (13.1%)</td>
<td><img src="#" alt="Graph" /></td>
</tr>
<tr>
<td>Chronic Kidney Disease (18+)</td>
<td>6,905 (4.1%)</td>
<td><img src="#" alt="Graph" /></td>
</tr>
<tr>
<td>Obesity (16+)</td>
<td>16,033 (9.4%)</td>
<td><img src="#" alt="Graph" /></td>
</tr>
<tr>
<td>Learning Disability (18+)</td>
<td>639 (0.4%)</td>
<td><img src="#" alt="Graph" /></td>
</tr>
</tbody>
</table>


---

25 Individual practices are shown as vertical bars with the height of the bar proportional to each practices population. The blue box shows the range of the idle 50% of the practices in the CCG. The large diamond shows the average rank for the CCG and the dashed blue line shows the England average.
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 26 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 26: prevalence of the most common forms of CVD in North Hampshire 2011/2012

<table>
<thead>
<tr>
<th>CCG</th>
<th>CHD QOF No.</th>
<th>CHD QOF Prevalence %</th>
<th>Stroke/TIA QOF No.</th>
<th>Stroke/TIA QOF Prevalence %</th>
<th>Atrial Fibrillation QOF No.</th>
<th>Atrial Fibrillation QOF Prevalence %</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Hampshire</td>
<td>5708</td>
<td>2.7</td>
<td>2920</td>
<td>1.4</td>
<td>2805</td>
<td>1.3</td>
</tr>
<tr>
<td>Hampshire</td>
<td>44334</td>
<td>3.3</td>
<td>24381</td>
<td>1.8</td>
<td>22411</td>
<td>1.8</td>
</tr>
</tbody>
</table>

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

Figure 27: estimated number of patients missing from QOF disease registers

<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>Expected Prevalence %</td>
<td>Undiagnosed no.</td>
<td>Expected Prevalence %</td>
</tr>
<tr>
<td>Fareham &amp; Gosport</td>
<td>3.8</td>
<td>3165</td>
<td>1.9</td>
</tr>
<tr>
<td>NE Hants and Farnham</td>
<td>2.6</td>
<td>3916</td>
<td>1.4</td>
</tr>
<tr>
<td>North Hampshire</td>
<td>2.7</td>
<td>3805</td>
<td>1.4</td>
</tr>
<tr>
<td>SE Hampshire</td>
<td>3.9</td>
<td>5108</td>
<td>1.9</td>
</tr>
<tr>
<td>West Hampshire</td>
<td>3.5</td>
<td>10670</td>
<td>2.1</td>
</tr>
<tr>
<td>Hampshire</td>
<td>3.3</td>
<td>28213</td>
<td>1.8</td>
</tr>
</tbody>
</table>

It is estimated that there may be 3,805 people with undiagnosed Coronary Heart Disease, 1,251 people with undiagnosed stroke or TIA and 35,030 people with

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26 There are a broad range of diseases of the circulatory system. The highest prevalence cardiovascular diseases include hypertension, myocardial infarction, stroke and heart failure.
undiagnosed hypertension in NH CCG (figure 27). The NHS Health Check programme provides an important opportunity to increase diagnosis, optimise medical treatment and encourage lifestyle changes.

Between 2008/9 and 2011/12 CVD directly age standardised admission rates have increased 10.8% from 1,098 per 100,000 to 1,216 per 100,000 people in NH CCG, compared to a 4.3% increase across Hampshire overall.

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 apparently less likely to have access to planned hospital care. Of the cardiovascular diseases women are particularly prone to stroke.

The CVD mortality rate in NH CCG (figure 28) is 149 (95%CI 141-157) per 100,000 this is the highest rate for a CCG in Hampshire, and is statistically significantly higher than the Hampshire rate of 132 (95%CI 130-135) per 100,000 people. The CCG rate of preventable CVD mortality for people under 75 years old is 27 per 100,000 which is comparable to the Hampshire rate of 25 per 100,000.

Figure 28: Directly standardised rate of mortality caused by cardiovascular disease 2009-2011
5.2. Diabetes

There are 57,092 people in Hampshire and 9,258 in NH CCG with diabetes. A further 1,547 people in NH CCG may not have been diagnosed. By 2020, there may be 87,000 people in Hampshire with diabetes. There is a very strong link between deprivation, diabetes admissions and complications.

**Figure 29: Number of people with diabetes on QOF registers and estimated numbers with diabetes 2011-2012**

<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 North Hampshire CCG</td>
<td>9,258</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>
</tbody>
</table>

The prevalence of diabetes is comparable with Hampshire and lower than England and 17% more people are expected to have diabetes than are currently diagnosed (2008/09).

A marginally higher proportion of people than nationally achieve good blood glucose control (72.6% compared to 69.9% nationally) and have good blood pressure control (71.6% compared to 70.7% nationally).

Rates of elective admission for diabetes in NH CCG are over three times higher than Hampshire rate (163 admissions per 100,000 population compared to 53 per 100,000 in Hampshire). This may reflect local clinical practice.

The rate of all age hospital admissions where diabetes is the primary diagnosis is twice as high in NH CCG compared to Hampshire, 223 admissions per 100,000 and 115 per 100,000 respectively.

The amputation rate in NH CCG was not significantly different to the Hampshire rate at 10 amputations per 100,000 (76 amputations).

5.3. Liver disease

Liver disease is one of the few major causes of premature death that is increasing in England, whereas it is decreasing in our European neighbours. 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, lower than the national rate of 12 per 100,000. This equates to 304 deaths a year.

The mortality rate for preventable liver disease was 7 per 100,000 population (45 deaths a year), which is comparable 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 disease

This section considers two forms of kidney disease: Chronic Kidney Disease (CKD) and Acute Kidney Injury (AKI), 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 North Hampshire is 4.4% (7,468 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). NH CCG has the second highest proportion of South Asian and Black residents, which may partly explain the 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\textsuperscript{28}. 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\textsuperscript{29}.

5.5 Chronic Obstructive Pulmonary Disease (COPD)

There is 1 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 2,512 people in NH CCG diagnosed with COPD, a prevalence of 1.2%, compared to the England rate of 1.7%. There are thought to be a further 1,636 people with undiagnosed COPD in NH 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 808 emergency COPD admissions in NH CCG between 2009/10 and 2011/12 and over half were in people aged under 75 years old.

The rate of emergency COPD admissions for people under the age of 75 is 64 per 100,000 - this is not significantly different to the Hampshire rate of 72 per 100,000.

The mortality rate from COPD in NH CCG is lower than the national rate - 19 per 100,000 compared to 26/100,000.

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 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 386.9/100,000 and 368.3 respectively. The incidence rate is higher in men (389.7/100,000) than women (354.4/100,000). The incidence rate in NH CCG is higher than Hampshire and national rates at 387.0 per 100,000. This has increased to 398.5 in 2009/11.

The trend in incidence of lung, bowel and breast cancers in Hampshire mirror the England trend, but the incidence of prostate cancer in Hampshire is reducing while

\textsuperscript{29} NICE. Costing statement. Acute kidney injury: prevention, detection and management of acute kidney injury up to the point of renal replacement therapy. NICE, 28/8/13.
the England trend is upward. Incidence rates of lung and bowel cancer are lower in NH CCG than national, and similar to regional rates. Incidence rates of prostate cancer are lower than both national and regional rates. However, the breast cancer incidence rate in NH is consistently higher than the national and regional rate from 2002-04 to 2008-10.

Figure 30 shows the cancer screening coverage for each of the national programmes. Coverage targets for the three cancers have not been met by NH CCG as a whole.

**Figure 30: Cancer screening coverage in North Hampshire, 2008-10**

<table>
<thead>
<tr>
<th></th>
<th>No. of eligible women on last day of review period (47-73) - Mar 12</th>
<th>No. of women screened in previous 30 months (47-73) - Mar 12</th>
<th>36 month coverage % (47-73) - Mar 12</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Breast Coverage</strong></td>
<td><strong>England</strong> 8,421,181</td>
<td>5,124,671</td>
<td>60.9</td>
</tr>
<tr>
<td></td>
<td><strong>HAMPSHIRE</strong> 225,672</td>
<td>137,720</td>
<td>61.0</td>
</tr>
<tr>
<td></td>
<td><strong>North Hampshire CCG</strong> 33,856</td>
<td>20,819</td>
<td>61.5</td>
</tr>
<tr>
<td><strong>Bowel Coverage</strong></td>
<td><strong>England</strong> 7,944,844</td>
<td>4,141,939</td>
<td>52.1</td>
</tr>
<tr>
<td></td>
<td><strong>HAMPSHIRE</strong> 216,852</td>
<td>132,601</td>
<td>61.1</td>
</tr>
<tr>
<td></td>
<td><strong>North Hampshire CCG</strong> 31,072</td>
<td>18,326</td>
<td>59.0</td>
</tr>
<tr>
<td><strong>Cervical Coverage</strong></td>
<td><strong>England</strong> 13,463,227</td>
<td>10,146,655</td>
<td>75.4</td>
</tr>
<tr>
<td></td>
<td><strong>HAMPSHIRE</strong> 324,007</td>
<td>254,357</td>
<td>78.5</td>
</tr>
<tr>
<td></td>
<td><strong>North Hampshire CCG</strong> 54,579</td>
<td>41,889</td>
<td>76.7</td>
</tr>
</tbody>
</table>

Cancer is linked with numerous risk factors. It has been estimated that 43% of new cases of cancer are linked to lifestyle and environmental factors and that smoking accounts for almost 20% of new cases (23% in men and 16% in women).

In 2011/12 there were 3,811 people on GP cancer registers in NH CCG equating to 1.8% of the registered population. More people are surviving cancer and their needs are becoming increasingly important.

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30 Hampshire Open Exeter system
From 2009-12, the directly age standardised rate of admissions for cancer for people of under the age of 75 years old was 2,184 per 100,000 population in NH CCG, which was higher than the rate in Hampshire (1,860 per 100,000 population). Basingstoke and Deane has the highest overall rate of 2,256 per 100,000, and females have a significantly higher all cancer under 75 rate (females 2,571, males 1,941 per 100,000). The East Hampshire and Hart rates are 1,764 and 2,083, respectively, and in both cases the rate for females is slightly higher than males, but the difference isn’t as great as Basingstoke and Deane.

The rate of premature mortality (under 75 years old) from all cancers was 102 per 100,000 in NH CCG which is not significantly different from the England rate and above the Hampshire rate of 97 per 100,000. Between 2006-08 and 2009-11 the trend in premature mortality for the CCG is stable compared to a downward trend nationally.

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 information is for epilepsy. The prevalence of epilepsy in people aged 18+ in NH CCG is 0.7% (1,174 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 NH CCG is 2,420 per 100,000 population, which is significantly higher than the Hampshire rate of 2,125 per 100,000 and second highest rate in the county. Rates are higher in females (2,956 per 100,000) than in males (1,831 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 9 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.

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 as a result of physical health problems.

Many physical conditions also 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 1 in 6 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 in 10 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 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, 56 people died due to suicide or injury of undetermined intent in NH giving a rate of 8.8 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 NH CCG rate was 13.1 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 the NH CCG admission rates show an upward trend between the years 2008-09 and 2011-12.

Figure 31 presents the directly standardised admission rates for a number of mental health admissions in NH CCG compared to Hampshire. NH CCG admissions rates are similar to the Hampshire rate, and unlike some other of the CCGs and Hampshire overall, no gender differences are apparent for each mental illness.

### Figure 31: 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>NH CCG</th>
<th>Hampshire</th>
<th>Comparison to Hampshire</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Illness - All Admissions - Under 75 years</td>
<td>143</td>
<td>173</td>
<td>No significant difference</td>
</tr>
<tr>
<td>Mental Health Illness - All Admissions - All ages</td>
<td>154</td>
<td>177</td>
<td>No significant difference</td>
</tr>
<tr>
<td>Schizophrenia, schizotypal and delusional disorders - All admission types - Aged 15+</td>
<td>33</td>
<td>46</td>
<td>Significantly better</td>
</tr>
<tr>
<td>Unipolar depressive disorders - All admission types - Aged 15+</td>
<td>46</td>
<td>46</td>
<td>No significant difference</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 some form of dementia. Alzheimer’s disease is the most common form, accounting for 62% of all dementia. 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.

The rate of dementia in Hampshire at 0.65% is significantly higher than the England rate of 0.53%. NH CCG has a relatively younger population structure compared to Hampshire, and may explain the lower dementia prevalence rate in NH CCG than Hampshire and England at 0.48% (1020 people).

There are estimated to be over 18,000 people with dementia in Hampshire, but only 8,695 people on GP dementia registers, which suggests that many people are not being identified.

The number of people with dementia in Hampshire is predicted to increase by over 30% from 18,323 in 2012 to 24,042 in 2020. Across Basingstoke and Deane, East Hampshire and Hart districts the number of people with dementia is predicted to increase by 32% between 2012 and 2020.
A national report found that older people with dementia who are receiving care in hospital stay significantly longer than those without the condition after being admitted for an emergency and are more likely to be readmitted\(^{31}\).

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.

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

Pain is the most prominent 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 1,633 per 100,000 people in NH CCG, compared to a rate of 1,623 per 100,000 in Hampshire. Rates are significantly higher for females than males.

Hip fracture admission rates were higher at 482 per 100,000 compared to the rest of Hampshire (455 per 100,000).

The rate of primary hip replacement procedures from 2009-12 was 93 per 100,000 in NH CCG, compared to 98 per 100,000 in Hampshire. Hip revision rates for the CCG were 18 per 100,000, compared to a rate of 15 per 100,000 in Hampshire.

Knee arthroscopic activity shows that NH CCG had a rate of 228 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 NH CCG at 100 per 100,000 compared to the Hampshire rate of 95 per 100,000.

Despite the lack of evidence for the effectiveness of facet joint injections, this remains a popular treatment, with a high, age standardised rate in NH CCG of 291 per 100,000.

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\(^{31}\) Care Quality Commission [CQC] report, March 2013
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?

North Hampshire has the highest rate of CVD mortality in the county. Concerted action is required to tackle lifestyle factors that increase the risk of CVD morbidity and mortality and maximise treatment opportunities

There are potentially large numbers of people with undiagnosed cardiovascular disease. There is good evidence that secondary prevention can reduce morbidity. CCGs should encourage case finding in people at higher risk of disease and fully implement the NHS Heath Checks programme with a particular focus on practices serving more deprived populations.

There is scope for increasing case finding in at risk patients and improving care processes for patients with diabetes. Elective admissions for diabetes are three time the county rate

Given the levels of obesity the number of people with diabetes will increase. Practitioners should give as much focus to primary prevention of diabetes, as well as good care and management.

Chronic disease pathways should be linked to primary prevention. COPD is potentially preventable as 90% of cases are attributable to smoking and potentially 1636 people are undiagnosed in North Hampshire.

Whilst the evidence base for reducing emergency admissions is scant, there is good evidence to prevent admissions for patients with heart failure and COPD.

The breast cancer incidence rate in North Hampshire is higher than the county and national rate, and breast cancer screening coverage targets have not been met.

North Hampshire has high rates of hospital admissions as a result of falls and hip fractures in people aged 65 and over. Promoting bone health by early detection of osteoporosis through bone mineral density (BMD) scans, falls and fracture risk assessment, falls prevention strategies, maintenance of mobility, correction of nutritional deficiencies, particularly of calcium, vitamin D and protein, and bone protection drugs, have been shown to significantly reduce the risk of hip fractures.

The CCG can achieve better musculoskeletal outcomes, using an integrated care pathway approach, starting with prevention: encouraging healthy behaviours (prevention); effective referral mechanisms; appropriate treatment; in orthopaedic, rheumatology and pain management services, across primary, community, acute
and social care; engaging patient organisations; self-management and shared decision making.
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 NH CCG was for domiciliary care (862 people, 57.2%) followed by residential care (250 people, 16.6%) and nursing care (208 people, 13.8%).

In 2012, 5,568 people aged over 65 years old in NH CCG were identified 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, get to the toilet or in and out of bed. In NH CCG 2,144 people over the age of 65 years old were coded as having a primary social care need as a result of dementia and this was the most common reason for increasing long term packages of social care.

Mental and behavioural disorders (including stress, anxiety and depression) and musculoskeletal disorders are the cause of the greatest number of years lived with disability in the UK. Currently we do not have Hampshire estimates of years of life lived with disability but know that about a fifth of our lifespan is spent in ill health.

6.2 Adults with care support needs

In April 2013, Hampshire County Council Adult Services supported 308 clients aged 18-64 years old in NH CCG with a substantial or critical learning disability with a package of care. Another 259 people with a substantial or critical physical disability were supported - there has been an increase across the County since 2010 in the number of clients in this group receiving support.

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 1,410 males and 160 females with autism aged 19 years old and above in NH CCG.

6.3 Carers

10.3% (21,922) people in NH 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). 6.4% (13,736 people) provide 0-19 hours of unpaid care a week, 1.0% (2,092 people) provides 20-49 hours a week and 1.7% (3,678 people) provides 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% are where people are
caring for someone with dementia and 22.4% for people with reduced mobility.

11,228 people aged over the age of 65 years old in NHF 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 need for support.

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.

In Hart, 0.04% (5 people) and 0.7% (150 people) in Basingstoke & Deane and 0.2% (26 people) in East Hampshire are identified as being young carers. These figures account for 21% of the total number of carers aged 0-24 in Hampshire.

In the CCG 4.2% (3,619 people) of the 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.
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. 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**

At a county level, all cause mortality has been falling, however in NH CCG, the female rate has remained fairly static only decreasing by 0.5% between 2006/08 to 2009/11 compared to the males rate which has decreased 4.3% over the time period. NH CCG all causes, all age death rate from 2009 to 2011 of 499 per 100,000 was significantly higher than the Hampshire rate of 468 per 100,000. Figure 33 presents the all age; all cause trend data for NH CCG.
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 NH CCG 31% of deaths were caused by cancer, 29% from circulatory disease and 13% from respiratory disease.

Figure 34 shows the all cause mortality under 75 years rate. NH CCG premature death is 228 per 100,000. This is not significantly higher than the Hampshire rate of 220 per 1000,000 and lower (better) than the national and South East region rates.
There were 901 preventable deaths\textsuperscript{32} in NH CCG from 2009 to 2011. This equates to a rate of 125 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 NH CCG the rate has fluctuated over the time period, as might be expected due to the small numbers being considered, overall there has been a small decrease between 2006/08 and 2009/11 from 132 per 100,000 to 125 per 100,000.

\textsuperscript{32}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 http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000044/par/E12000004/ati/102/page/6

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7.1 Preventable deaths

Figure 34: All cause mortality by CCG area directly standardised 2009-2011