This section presents the joint strategic needs assessment for the resident population of South Eastern Hampshire CCG (SEH 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 authorities are East Hampshire and Havant. It should be noted that parts of East Hampshire are in North Hampshire CCG and West Hampshire CCG. SEH CCG also covers a small area of Winchester district.

To place local figures into context, data are compared to England. Where this is not available comparison with Hampshire as a whole has been made.
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Key Findings

Demographics

- South Eastern Hampshire CCG has a population of 208,475 people which accounts for 15.8% of Hampshire’s population. It is relatively densely populated compared to Hampshire as a whole.
- The population of SEH CCG is generally older than that of Hampshire and England. Compared to England a slightly lower proportion of the population is aged 0-19 years old (23.4% compared to 24.0%). The proportion of young adults aged 20-39 is lower (20.6% in Havant and 21.6% in East Hampshire) than nationally (26.9%).
- The percentage of older residents is relatively high, 27.3% compared to 22.4% for England overall. Population growth is expected to be proportionately highest in people aged 60 and over. The only percentage drop in population expected is in the 15-29 year old age group and 30-44 year old age groups.

Deprivation

- SEHCCG is ranked 135th out of 212 CCGs in England in terms of deprivation (where 1 is the most deprived). As such its levels of deprivation are typical for England, but the CCG is the most deprived in Hampshire.
- Areas of deprivation are geographically focused, mainly in Havant. Leigh Park is the most deprived area of Hampshire. Across Havant and East Hampshire there are high levels of deprivation in relation to wider barriers (including household overcrowding and homelessness) and barriers to housing and services.
- Educational attainment in Havant is low with just over a half of 16 year olds getting 5 A*-C grades at GCSE. 25% of people aged 16+ have no qualifications in Havant.
- In 16-74 year olds 70.8% are economically active, which is strongly associated with better health. This is the lowest in Hampshire but higher than the national average of 69.9%

Children and young people

- SEH CCG has the highest proportion of children living in poverty in Hampshire (16.8%). The percentage in Havant is double that of East Hampshire, 22.5% compared to 9.3%. Deprivation is associated with poorer health.
- Havant has the second highest rate of teenage pregnancies in Hampshire (36.5 per 1,000 girls in 2009/11), although the rate is falling. The borough has the lowest levels of breast feeding and the highest levels of dental decay in children. The CCG has the highest admission rates for 15-24 year olds for
substance misuse, and the highest rates of school children with special education needs (SEN).

Health related behaviours

- The greatest lifestyle threat to health in the CCG is high rates of smoking in Havant’s adults (21.7% compared to 15.3% in East Hampshire and 20% in England). The directly age standardised rate of death wholly or partly attributable to smoking in Havant is higher than that for England.
- Sexual health in younger people is a concern with the highest rates of chlamydia diagnosis in Hampshire being found in Havant.

Long term conditions

- Compared to England’s CCGs, SEH CCG has relatively high recorded prevalence rates for a number of diseases. This reflects the relatively older population as well as it’s relative poverty compared to Hampshire.
- The most commonly diagnosed condition is hypertension (31,315 people in 2010/11). Rates of coronary heart disease, stroke, cancer, dementia and depression are all higher than the national average. Prevalence rates tend to be higher than the English average in Havant and lower than the English average in East Hampshire.
- There is considerable under diagnosis when QOF prevalence is compared to expected prevalence. In the CCG there are approximately 5,168 CHD patients, 2,141 stroke/TIA patients and 37,086 hypertension patients yet to be diagnosed.

People and society

- In 2012, 7,761 people aged over 65 years old were identified as being unable to manage at least one mobility activity on their own. SEH CCG has a relatively high percentage of residents who are carers, 10.5% compared to a Hampshire average of 10.1%.

Death

- SEH CCG has relatively high mortality rates compared to Hampshire as a whole. It has a significantly higher premature mortality (<75years) rate than Hampshire; 244(95%CI 232-256) per 100,000 compared to 220(95%CI 216-225) per 100,000. It also has the highest rate of preventable death in the county: 126(95%CI 118-134) per 100,000 compared to Hampshire’s 119(95%CI 116-122) per 100,000. Mortality rates are reducing over time.
Recommendations

It is important to support people maintaining the health throughout their lives to maximise their healthy lifespan. The CCG should:

- Ensure that commissioning plans are part of integrated pathways with other commissioners to address primary and secondary prevention particularly as the main cause of death is now cancers. Areas to focus on include breast feeding rates, smoking cessation, encouraging exercise, reducing adult and childhood obesity, and reducing the harm caused by alcohol.

- Chronic disease pathways should be linked to case ascertainment. COPD is potentially preventable as 90% of cases are attributable to smoking.

- Because SEH CCG has relatively high numbers of carers it is important that they have annual health reviews to ensure they can cope.

- Whilst housing, planning employment and education are outside the responsibilities of the CCG, they are crucial to good health. The CCG should work with partners to highlight the link between deprivation and health and link local people to effective interventions.

- Follow the evidence base in commissioning decisions:
  
  o Case finding through NHS Health Check and opportunistic assessments. This would have a significant impact by earlier intervention and diagnosis across a broad range of health issues
  
  o Immunisation: ensure adequate capacity and identification of eligible people to improve uptake of MMR and DTaP/IPV, the teenage booster and seasonal ‘flu.
  
  o Unscheduled care: Whilst the evidence base for reducing emergency admissions is scant, there is good evidence to prevent admissions for patients with heart failure and COPD.
  
  o CVD: identify gaps in the commissioning of services recommended in the CVD Outcomes Strategy, 2013. Possible priorities include the quality of hypertension and Peripheral Arterial Disease services, securing the long term funding of Familial Hypercholesterolaemia services, and reviewing 2013 NICE STEMI guidelines.
  
  o Rehabilitation: there are still opportunities for improving access to and outcomes from cardiac, stroke and pulmonary rehabilitation.
1. Demography

In the 2011 census the resident population of South Eastern Hampshire (SEH) CCG was 208,475 people, consisting of 101,296 men (48.6%) and 107,179 women (51.4%). This makes up 15.8% of the total resident population of Hampshire (ONS resident population, 2011). The geographical area of SEH CCG covers 34,918 hectares, with 6 people per hectare compared to 3.6 people per hectare in Hampshire¹. There are 87,014 households in SEH CCG.

The population pyramid (figure 1) shows that SEH CCG’s population is generally older than that of Hampshire and England. Relative to England SEH CCG a slightly lower proportion of children aged 0-19 (23.4% of the population compared to 24.0% in England, 48,620 children and young people in the CCG), SEH CCG has a lower proportion of 15-34 year olds (20.7% of the population, 43,208 people, compared to 26.9% in England). In contrast SEH CCG has a higher proportion of 40-54 year olds (21.4% of the population, 44,638 people, compared to 19.4% in England). SEH CCG also has a higher proportion of residents aged 60 or more (27.3% of the population, 56,845 people, compared to 22.4% in England).

Figure 1: South Eastern Hampshire CCG population pyramid for resident population, 2011

¹ ONS resident population, 2011.
Within SEH CCG, Havant’s population is generally older than that of East Hampshire’s (figures 2 and 3). People aged 60 and over make up 28.3% of Havant’s residents (33,098 people) compared to 26.5% of East Hampshire’s residents (30,754 people). East Hampshire has relatively high proportions of residents in their 40s and 50s. What both districts have in common is a relatively low proportion of young adults aged 20-39. In Havant 20.6% (24,099 people) are aged 20-39 and in East Hampshire 21.6% (24,612 people) are aged 20-39. In contrast 26.9% of England’s population are aged 20-39.

**Figure 2: Havant district population pyramid**

![Havant district population pyramid](image)

**Figure 3: East Hampshire district population pyramid**

![East Hampshire district population pyramid](image)
The population of SEH CCG is projected to increase by 4,551 (2.24%) 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 4 shows that the population is projected to increase in all age groups aside from 15-44 year olds, which is estimated to shrink by 1,682 (4.95%). The population of 0-14 year olds is set to increase by 1,601 (4.46%), which is more than in Hampshire (3.2%), but less than England (7.8%). However, the biggest percentage increase in population is projected to be in people aged 75 years and over at 9.6% or 1,993 people, which is similar to the estimated rate of increase for Hampshire (9.94%) and England (10.56%). East Hampshire is ageing faster than Havant with a projected increase in the 75 and over age group of 11.5% (1,195 people) in East Hampshire compared to 8.5% (1,078) in Havant.

**Figure 4: Forecast change in the resident South Eastern Hampshire CCG population 2013 to 2018**

1.1. **Ethnicity and residence in the UK**

The 2011 Census showed that 94.3% of the population in SEH CCG identified themselves as White British, which is high compared to England (79.8%) and Hampshire (91.8%). Non British White people make up a further 2.5% of the population. 0.5% has been resident in the UK for less than 2 years, compared to 0.8% in Hampshire and 1.8% in England. The number of gypsies and travellers in SEH CCG is thought to be low compared to other areas in Hampshire.

In the CCG the largest ethnic groups other than White British as described by detailed Census ethnic group are White: Irish (1,020 people), Mixed/multiple ethnic
group: White and Asian (954 people), White: Other Western European (937 people), Indian or British Indian (828 people), Mixed/multiple ethnic group: White and Black Caribbean (648).

What does this mean?

The 0-14 year old age group is increasing at a faster rate than that of Hampshire as a whole. Good maternal and infant health are the foundation of long term health. We need to ensure an adequate capacity of local maternity services and support for children and their families as well as working to improve the health of the coming generation by increased breast feeding rates.

The CCG has a low proportion of younger adults (aged 20-39). The percentage of 20-44 year olds is expected to decline further. This reduction in the proportion of younger adults may reduce the availability of carers for older relatives, putting further pressure on public sector services.

SEH CCG already has a higher proportion of older people than the English average, and the proportion of older people is expected to increase further. It will become increasingly important to maintain the health of people of all ages, including older people. When people have been admitted to hospital, access to appropriate rehabilitation and occupational therapy can help maintain independence for as long as possible.
2. Health Inequalities

Health inequalities are the avoidable differences seen 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 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.

Residents of deprived areas generally experience systemic socio-economic disadvantages such as low levels of economic activity, low incomes, poor health and reduced 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 SEH CCG is 80 years for males (79.5-80.5) and 83.4 years for females (82.9-83.9) (figures 5 and 6) which is statistically significantly lower than in Hampshire overall where it is 80.8 years old for men (80.6-81) and 84.2 years for women (84-84.4).

Figure 5: Male life expectancy at birth – CCG 2009-2011 pooled

![Life Expectancy at Birth](image_url)
Life expectancy is higher in East Hampshire than Havant, though not statistically significantly so. Life expectancy for men is 80.7 years (95%CI 80.1-81.4) in East Hampshire and 79.5 years (95%CI 78.8-80.1) in Havant. Life expectancy for women is 83.7 years (95%CI 83.1-84.3) in East Hampshire and 83.1 years (95%CI 82.4-83.7) in women.

There is a 6.1 year gap in life expectancy for men and 4.3 years gap for women between the most deprived and least deprived quintile of areas in Hampshire (figure 7). However the reality is more significant if the full extent of the gap in life expectancy is considered.

Figure 7: Life expectancy at birth by deprivation quintiles 2009 to 2011
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. SEH CCG is ranked 135th out of 212 CCGs in England in terms of the IMD 2010 (where 1 is the most deprived) (figure 8) and is more deprived than other CCGs in Hampshire. Areas of deprivation exist in Havant and the areas of Leigh Park, Wecock, Hayling West, Purbrook and Stakes are within the top 20% most deprived wards in England. Leigh Park is most deprived area in Hampshire. There are also pockets of relative deprivation in the north of the CCG around Whitehill Borden.

Figure 8: Map showing Index of Multiple Deprivation, 2010, for South Eastern Hampshire CCG

Over a fifth, 20.8% (6,025), of households in SEH CCG are deprived in two or more of the IMD domain2, which is more than in Hampshire (17.9%). Figure 9 shows that the area is in the top 100 most deprived for education, skills and training, barriers to housing and services, geographical barriers, wider barriers and children and young people sub domains, when compared to other areas in England (IMD 2010).

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Figure 9: Indices of Deprivation 2010 - England ranks based on summary scores for South Eastern Hampshire CCG

Source, IMD 2010

- The population of Havant (116,493 people) live in the most deprived quintile nationally for wider barriers, which includes household overcrowding and homelessness.
- 82% of the population (95,135 people) in Havant also live in the most deprived quintile for barriers to housing and services domain, which covers the physical proximity of local services.
- 42% of the population (48,802 people) in Havant live in the most deprived quintile for health deprivation and disability.

East Hampshire has much lower proportions of people living in the most deprived quintile for each domain. Over a quarter, 28% (31,518 people), of the population in this area live in the most deprived quintile for the geographical barriers subdomain, which relate to the physical proximity of local services. A fifth, 20% (22,255 people), live in the most deprived domain for wider barriers and 9% (10,149 people) live in the most deprived quintile for health deprivation and disability.
Figure 10: Proportion of population living in each deprivation quintile in Havant

Source: IMD, 2010

Figure 11: Proportion of population living in each deprivation quintile in East Hampshire
2.2. Education, income and employment

The conditions in which people are born, grow, live, work and age lead to 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. 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. 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.

21.7% of the SEH CCG population has no qualifications (Census 2011), which is more than Hampshire (18.5%) but less than England (22.5%). The CCG also has one of the lowest proportions of people with higher qualifications, with 26.7% of the population having level 4 qualifications and above, compared to 29.7% in Hampshire and 27.4% in England.

2.2.1. Children and young people

Educational attainment is strongly associated with better outcomes in life, including a lower risk of living in poverty and better health. Five A* to C GCSEs is used to measure educational attainment in 16 year olds. Deprivation is generally associated with worse GCSE results. Quality of schooling can minimise or compound this association.

Figure 12 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 13 shows whilst educational attainment for Hampshire has increased performance has deteriorated when benchmarked against the comparator areas.

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Figure 12. 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 13. 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 14: District level information for pupils achieving five or more GCSEs (or equivalent) at grade A*-C, including English and maths

Source: Department for Education

Havant's GCSE results are the second lowest in Hampshire with just over half of 16 year olds attaining 5 A* to C GCSEs\(^5\).

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 in England (57.8%).

2.2.2. Working age adults

Skill levels among Hampshire’s adult population are generally higher than the national average, however, 70.8% (105,644 people) of the 16–74 year old SEH CCG population are economically active, which is the lowest in the county and compares to 73.2% in Hampshire and 69.9% in England. Figure 15 shows that Havant has higher levels of over 16 year olds with no qualifications and lone parent households not in employment than both Hampshire and England. It also has higher levels of unemployment at all ages and people who have never worked or been unemployed for a long time. In comparison East Hampshire has lower or similar levels to Hampshire for all these indicators.

Figure 15: Characteristics of the working age population in Havant and East Hampshire local authority areas

<table>
<thead>
<tr>
<th></th>
<th>Havant %</th>
<th>East Hampshire %</th>
<th>Hampshire %</th>
<th>England %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residents aged over 16 years old with no qualifications</td>
<td>25%</td>
<td>16.9%</td>
<td>18.5%</td>
<td>22.5%</td>
</tr>
<tr>
<td></td>
<td>(24,746 people)</td>
<td>(15,857 people)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unemployed (16-74 years olds)</td>
<td>4%</td>
<td>2.6%</td>
<td>3%</td>
<td>4.4%</td>
</tr>
<tr>
<td></td>
<td>(3444 people)</td>
<td>(2133 people)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unemployed 16-24 year olds</td>
<td>1.1%</td>
<td>0.7%</td>
<td>0.8%</td>
<td>1.2%</td>
</tr>
<tr>
<td></td>
<td>(987 people)</td>
<td>(603 people)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unemployed 50-74 year olds</td>
<td>0.8%</td>
<td>0.7%</td>
<td>0.7%</td>
<td>0.8%</td>
</tr>
<tr>
<td></td>
<td>(720 people)</td>
<td>(558 people)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never worked or long term unemployed</td>
<td>4.3%</td>
<td>2.6%</td>
<td>2.9%</td>
<td>5.6%</td>
</tr>
<tr>
<td></td>
<td>(3690 people)</td>
<td>(2210 people)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lone parent households not in employment</td>
<td>43.4%</td>
<td>27.8%</td>
<td>32.4%</td>
<td>40.5%</td>
</tr>
<tr>
<td></td>
<td>(1614 people)</td>
<td>(649 people)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 2.2.3. Older adults

The 2011 Census identified 14% (12,142 households) of the SEH CCG population as one person households aged over the age of 65 years old. This is higher than Hampshire (12.6%) and England (12.4%). Amongst those over the age of 60 years old, 9.8% (2,708 people) in East Hampshire and 14.8% (4,810 people) in Havant are living in households which are income deprived\(^6\). This compares to 10.7% in Hampshire overall and 18.3% in England.

### 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

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\(^6\) 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.
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\textsuperscript{7}.

The 2011 Census showed that 7.8% (16,215) of those aged 16-64 years had their day-to-day activities limited a lot by their long term health condition or disability. This is more than Hampshire (6.7%) but less than England (8.3%).

In SEH, 0.5% of people (n=759) over the age of 18 years old were registered as having a learning disability. This is similar to the Hampshire level of 0.4%\textsuperscript{8}. In 2009/10, two thirds of adults with learning disabilities who were known to the County Council’s Adult Services were judged to be in settled accommodation, which is more than nationally (61%) and regionally (63.2%). 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 well described. Poor housing is associated with an 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).

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.

The rate of statutory homelessness\textsuperscript{9} in Hampshire was 0.81 people per 1000 households in 2011-12, with the highest levels in areas of Gosport, Havant and East Hampshire. In the last three years (2009/10 to 2011/12) in Havant there was an average of 89 households and in East Hampshire 59 households per year accepted as being homeless and in priority need.

In 2011-12, the rate of statutory homelessness in Havant was 1.06 per 1000 households, which was lower than both the South East (1.53 per 1000 households) and England (2.31 per 1000 households).

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

\textsuperscript{7} http://www.equalityhumanrights.com/key-projects/triennial-review/
\textsuperscript{8} Data from the 2011-12 Quality and Outcomes Framework (QOF)
\textsuperscript{9} District councils 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\textsuperscript{9}. Groups in priority need tend to be highly vulnerable, for instance some pregnant women, 16-17 year olds, and older people with mental health problems or disabilities.
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 their described health needs to be mental ill health, substance misuse, joint aches or problems with bones and muscles, chest pains, 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 (hospital) 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 as living in Hampshire. This included 267 people (0.23%) in East Hampshire and 64 people (0.05%) in Havant. Local estimates suggest the actual figure in Hampshire is likely to be much higher than the census data; between 4,690 and 7,630 people.

There are no robust 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 address inequalities in health which includes tackling the wider determinants of health, focusing on both short and long term outcomes.

Though fairly typical in terms of deprivation nationally, SEH CCG is the most deprived CCG in Hampshire with relatively high levels of overall deprivation, focused particularly in areas of Havant.

There are also areas of relative deprivation in the north of East Hampshire. East Hampshire has relatively high rates of deprivation related to wider barriers and barriers to housing and services. This is related to accessing housing and services in rural areas.
Leigh Park is the most deprived area in Hampshire. Improving the health of its residents should be a priority for the Havant’s Health and Wellbeing group.

There are opportunities to improve educational attainment for the children and young people of Havant with 25% of over 16s having no qualifications. Havant’s GCSE attainment is amongst the lowest in the county. Breaking the cycle of poor educational expectation/achievement will contribute towards addressing the inequality gap locally.

Over two thirds, 70.8%, of 16-74 year olds are economically active, which is lower than other CCGs in Hampshire, but higher than the English average. Non economically active people are likely to have worse health.

Havant has a higher concentration of groups who are potentially vulnerable to isolation and poorer health outcomes, including lone parent households, older people living in deprived households and homelessness.

There are more people with long term health conditions or disabilities than Hampshire, which may also increase the demand for health services.
3. Children and young people

There are approximately 48,620 children and young people aged under 20 in SEH CCG which is 23.4 % of the population\textsuperscript{10}.

3.1. Births

Pooled data for the general fertility rate in SEH CCG is 65.5 (63.3-67.6) live births per 1000 women aged 15-44 years old, which is slightly higher than in Hampshire (64.3)\textsuperscript{11} and England\textsuperscript{12} (64.5%) rates.

Predicted future numbers of births based on the ONS Interim 2011-based birth projections (2013 to 2021) are available for Hampshire and its local authorities (figure 16). As data are not available by CCG, data from the two local authorities of East Hampshire and Havant that fall within the CCG boundary are presented. However at a local authority level there is uncertainty in the projection of births due to the small geographical areas and small populations upon which the calculations are based that particularly affect the further forward in time they are projected. The projections suggest that births are levelling off.

Figure 16: Birth projections for South Eastern Hampshire CCG from 2013 to 2021

Source: ONS Interim 2011-based Subnational Population Projections

3.2. Teenage conceptions

Overall Hampshire has seen a 35.1% reduction in teenage conception rates since the baseline was established nationally in 1998. The annual rate of under 18 conceptions in Hampshire decreased to 23.3 per 1,000 girls aged 15-17 years in...
2011. However, Havant had the second highest rate in the county at 36.5 per 1,000 girls in 2009-11. The rate of under 18 conceptions in East Hampshire was almost 50% lower than in Havant in 2009-11 at 18.7 per 1,000 girls (ONS, Conception Statistics England and Wales 2011).

In 2009/11, 43.7% of under 18 conceptions in Havant ended in abortion which is lower than the Hampshire (48.7%), national (49.6%) and the South East region (51.2%) rates. This suggests that teenagers in more deprived areas are more likely to continue with their pregnancy.

### 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\(^\text{13}\) 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\(^\text{14}\).

Pooled data from 2009-11 show that the infant mortality rate in SEH CCG is 3.3 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.).

Rates for this indicator vary at district level and are higher in areas of deprivation. Infant mortality rates in Havant (4 per 1000 births, 2.7-8.1), were over double those in East Hampshire (1.8 children under one year old per 1000 births, 0.7-4) in 2009-11. 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


\(^{14}\) [http://www.ons.gov.uk/ons/dcp171778_300596.pdf](http://www.ons.gov.uk/ons/dcp171778_300596.pdf)
congenital related conditions and cancers were the most common cause of death for children aged under 16 years. However, childhood mortality between the ages of 0 and 14 remains 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 with death rates staying 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 is collected by the Child Death Overview Panel (CDOP) and includes identifying if there were any factors modifiable by public services in the death. The Southampton, Hampshire, Isle of Wight and Portsmouth CDOP reviewed 70 death notifications in the 0-18 population in 2011/12 of Hampshire children and young people.

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{15}.

SEH CCG, along with Fareham and Gosport has the lowest breast feeding rates in the county. About half (50.1\%) of mothers in SEH CCG were either partially or totally breastfeeding at their primary birth visit (9-14 days). This reduced to 38.1\% at 6-8 weeks compared to the England rate of 47.2\%.

This is due to particularly low rates in Havant which are the lowest in the county. At 9-14 days 41.8\% of Havant newborns were breastfeeding, compared to a county average of 58.2\%: and by 6-8 weeks only 29.3\% of mothers were breastfeeding, compared to 49.8\% of mothers in East Hampshire.

The previous existence of a baby milk factory in Havant is likely to have contributed to the local culture of infant feeding. Higher rates of deprivation in Havant are also likely to be a factor - only 42.2\% of mothers in the most deprived quintile in Hampshire initiate breastfeeding.

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 shows that 9% of 4-5 years olds and 17.2% of 10-11 years old were obese in Havant, which is higher than levels in Hampshire of 8%
of 4-5 year olds and 15.4% of 10-11 year olds (NCMP three year rolling analysis (period 2007/2008 – 2011/2012).

Figure 19: Percentage of eligible children found to be obese Year R and Year 6 by Hampshire CCG

There has been a non-statistically significant fall in obesity rates in Reception between 2007/08 and 2009/10. However this has not occurred in Year 6. Across all of Hampshire’s CCGs 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 inequalities in dental health, with children from areas of deprivation experiencing disproportionately higher levels of oral disease. In 2007/08, a national survey found that 34.6% of five year olds in Havant and 18.7% in East Hampshire had experience of dental decay. Levels in Havant are the highest in the county and higher than in England (30.9%). The average child in Havant aged five had 1.28 decayed, missing (due to extraction) or filled teeth, which is higher than the Hampshire (0.7 teeth per child), England (1.1 teeth per child) and the South East averages (0.9 teeth per child).

Among five-year-olds in Havant affected by dental decay, an average of 3.65 of their teeth were affected, which is higher than the Hampshire (3.04) and England averages (3.45).

Oral health problems persist after the loss of milk teeth. For twelve year olds 27% had dental decay in Havant and 22.9% in East Hampshire, which is lower than the national prevalence (33.4%). Of the twelve-year-olds in Havant who had dental decay, an average of 2.26 of their teeth was affected, resulting in the need for dental treatments.

3.8. Immunisation

Childhood immunisations are essential to 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. The uptake rate for SEH CCG for MMR 2 at 6 years of age is just under 92%.(Figure 20), whilst the uptake for dTaP/IPV (diphtheria, tetanus, pertussis and polio) is 92.8% and is the lowest rate in Hampshire (Figure 21). It is below the WHO target of 95% which is required to ensure herd immunity.

Figure 20: Proportion of children who have received 2 MMRs at 6 years by CCG 2012/13

<table>
<thead>
<tr>
<th>CCG</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hampshire</td>
<td>92.0</td>
</tr>
<tr>
<td>Fareham and Gosport</td>
<td>92.0</td>
</tr>
<tr>
<td>North East Hampshire and Farnham</td>
<td>92.0</td>
</tr>
<tr>
<td>North Hampshire</td>
<td>92.0</td>
</tr>
<tr>
<td>South Eastern Hampshire</td>
<td>92.0</td>
</tr>
<tr>
<td>West Hampshire</td>
<td>92.0</td>
</tr>
</tbody>
</table>
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 SEH in 2012/13 the proportion of 18 year olds recorded on the child health information system who had received the SLB was 76.5% - below the DH recommended level of 90%.

3.9 Hospital activity for children and young people

There were 18,668 per 100,000 first attendances at A&E (directly age standardised rates (DSR) for people under the age of 15 years old in SEH CCG from 2009-12, which is lower than the Hampshire rate of 25,465 per 100,000.
Levels of emergency admissions (8,793 per 100,000) and admissions for all causes (12,743 per 100,000 admissions) were both similar to the Hampshire rate.

### 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 show that the rate for SEH CCG was higher (303 per 100,000) than the Hampshire rate (275 per 100,000) and consistently higher in males than females. From 2008-11, rates in SEH CCG have reduced from 359 to 253 per 100,000.

### 3.10 Injury and accidents

Unintentional injuries are the leading cause of death in children aged between one and four years and 15 to 19 years in England and Wales and are the second leading cause of death in children aged ten 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 SEH CCG was 1,094 per 100,000, which was not significantly different to the Hampshire rate (1,066 per 100,000). In Havant in 2011, there were 84 per 100,000 (DSR) cycling casualties in 8-15 year olds: 75 per 100,000 were pedestrian casualties, which is the highest rate in the county.
3.11 Substance misuse

Admissions for 15-24 year olds due to substance misuse were 1,229 per 100,000 people (DSR) in SEH CCG, which is the highest rate amongst CCGs in the county. Havant has the highest rates in the county at 1,467 per 100,000 people, compared to 748 per 100,000 in East Hampshire and 920 per 100,000 in Hampshire. Alcohol specific hospital admissions for people aged under 18 years old were 30 per 100,000 in Havant and 20 per 100,000 in East Hampshire, which are both lower than the Hampshire rate of 34 per 100,000 (pooled data 2009-12).

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.

SEH CCG has the highest proportion of children living in poverty amongst all the CCGs in Hampshire at 16.8% of 0-15 year olds. 4,711 (22.5%, 21.9-23.1) 0-15 year olds in Havant live in income deprived households, which is the highest in the county and higher than in England (21.7%) and Hampshire (12.1%) and over double the proportion in East Hampshire (9.3%, 9-9.7).

3.12.2 Children with disabilities

Children with disabilities and their families comprise one of the most vulnerable populations in Hampshire. However, defining and measuring the scale of childhood disability is challenging due to no agreed definition. Overall, estimates of the number of disabled children in Hampshire ranges from 3,000 to 50,000 depending on the source and the definition. Around 7,040 children aged 0-17 years were disability living allowance (DLA) claimants in August 2012. The autumn 2012 Hampshire School Census (figure 24) records 23.1% (5,668) of school pupils in SEH CCG as having a special educational need (SEN) which is the highest level amongst CCGs in the county. Of these, 2.8% (696) had a statement.

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

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16 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. Data we have reflect this, for example, the increasing NHS activity generated from technology-dependent children.

Several factors may help account for the increase in the numbers of disabled children and young people, including the rising birth rate (14.4% rise, from 2000-2011), better survival rates, improvements in care, more births at maternal age extremes, multiple pregnancies, assisted reproductive technology, preterm births, low birth weight, genetic abnormalities.

**Figure 24: Children with special educational needs by CCG**

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

**What does this mean?**

Poor health and life chances for children and young people are associated with deprivation. Because SEH CCG includes some of the most deprived areas of Hampshire local children and young people face more challenges than those within other CCGs in Hampshire.

Breastfeeding should be a priority for Havant’s health and wellbeing board.

Teenage pregnancy – while the downward trend is encouraging it should continue to be supported by NHS and local authority commissioners.

Young children’s parents should be encouraged to regularly visit their dentist. Healthy eating messages can be linked to reducing obesity as well.
Immunisation:

- MMR & dTaP/IPV vaccines - encourage parents to get their child vaccinated on time. Ensure there are sufficient clinic slots to allow this to occur.
- Teenage Booster: get all practices to search on their database to ascertain who has not been vaccinated and actively call.
- Seasonal flu vaccine: target the ‘at risk’ groups.

Identification and support of SEN should be a priority for teacher and teaching assistants’ personal professional development.

Initiatives to support struggling families should include initiatives to improve children’s health.
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, again demonstrated 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.\(^{17}\)

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. Smoking tobacco also has significant adverse health impacts on those people around the person smoking.

The proportion of adults estimated\(^ {18}\) to be currently smoking is 15.3% in East Hampshire and 21.7% in Havant compared to the estimates for England (20%) and Hampshire (17.5%). In 2012/13, rates of smoking amongst routine and manual workers were 27.6% in Fareham and 31.6% in Gosport, compared to 30% in Hampshire and 30.3% in England.

In 2012/13, rates of smoking amongst routine and manual workers were 38.7% in Havant and 26.1% in East Hampshire, 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 882 per 100,000 in East Hampshire and 1,079 per 100,000 in Havant. The rate in Havant is higher than in Hampshire (1,003 per 100,000) but lower than in England (1,420 per 100,000, 2009-10). The directly age standardised rate of deaths wholly or partly attributable to smoking in people aged over 35 years old was 211.2 per 100,000 in Havant and 151.5 per 100,000 in East Hampshire. Rates in Havant are higher than in England, which is 210.6 per 100,000 (2008-10).

When surveyed, the majority of people who smoke say they would like to stop. In 2011-12, 8.2% of current smokers aged over 15 years old in Havant and 7.2% in East Hampshire were accessing NHS stop smoking services. This compares to 6.4% in Hart, which has the lowest engagement rate and 14.1% in Gosport, which has the highest rate of engagement. There was a 4 week quitter success rate of 48% in East Hampshire and 46% in Havant.


\(^{18}\) 2011/12 Integrated Household Survey, ONS
4.2 Obesity

Overweight and obesity presents a major challenge to the current and future health of Hampshire. Being overweight or obese significantly increases the risks of developing and dying from cardiovascular disease, Type 2 diabetes, cancer, 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 suggest a significant rise in obesity and severe obesity. The prevalence of obesity and being overweight change with age. For adults it is lowest in the 16-24 year old age group and gets generally higher in older age groups for both men and women.

The prevalence of obesity in SHE CCG is more than the England average for Havant and statistically less than the England average for East Hampshire.

**Figure 25: Estimated prevalence of adults who are obese by local authority 2006-2008**

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

4.3 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 25.7% of the Havant population and 27.9% of the East Hampshire population over the age of 16 years old who are identified as drinkers consume more than the government recommendations\(^{19}\).

Figure 25 shows that in 2010/11, 1,755.3 per 100,000 people were admitted to hospital for alcohol attributable conditions in Havant. This is lower than the national rate of 1895.2 per 100,000 and higher than the Hampshire rate of 1357.4 per 100,000. The rate in East Hampshire was 1164.4 per 100,000, which is lower than both Hampshire and England (NWPHO, 2013).

**Figure 25: Admission episodes for alcohol-attributable conditions: All ages, DSR per 100000 population, 2010/11**

Figure 26 shows the directly age standardised rate of alcohol specific hospital admissions for people under the age of 18 years old in 2008/09 to 2010/11. Havant and East Hampshire have significantly lower than England under 18 alcohol specific rates.

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\(^{19}\) 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.
There has been 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 South Eastern Hampshire CCG the year on year average growth was highest for both East Hampshire and Winchester (both 8%) followed by Havant (7%).

Alcohol attributable mortality (2010) for the local authority areas of Winchester and East Hampshire in the South East Hampshire CCG has rates lower than the rate for England for males and females, but the difference is not significant. Havant male alcohol attributable mortality rate is higher than England but the female rate is lower; however neither rate is not statistically significant.

### 4.4 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, Havant ranked 158 and East Hampshire was 190 out of 326 local authorities (where one is the highest) in England for rates of STIs. The rate of acute STIs in Havant was 630.8 per 100,000 and in East Hampshire this was 580.9 per 100,000 (all ages). Of acute STI 74% of diagnoses were in young people aged 15-24.
years old in Havant and 65% in East Hampshire. About 7% of infections were in men who have sex with men.

In Havant 2,612.3 per 100,000 young people had a chlamydia diagnosis, which is the highest rate in the county. This compares to 2,989.6 per 100,000 in East Hampshire, 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. 80.5% of those offered an HIV test in East Hampshire and 78.3% in Havant accepted that offer, compared to a national level of 80.3%. Of those diagnosed, 47.1% in East Hampshire and 58.8% in Havant were classified as having a late diagnosis of HIV, compared to a national level of 52.3%. Late diagnosis of HIV is the largest predictor of HIV mortality and morbidity.

What does this mean?

The rates of smoking in adults were 21.7% in Havant, compared to 15.3% in East Hampshire and 20% in England. Directly standardised rates of death are higher in Havant than for England overall. GP practices in SEH CCG should opportunistically encourage smokers attending to attend NHS smoking cessation services. Publicity to encourage parents not to smoke near their children should be distributed widely.

While admission rates related to alcohol tend to be lower than national rates the impact of alcohol in an individual, their family and community is seen in many other ways including in contributing to the development of dementias. Opportunities should be taken for a discussion and brief intervention if appropriate at contact with healthcare professionals.

There is a lack of data on district level exercise. However physical activity should be encouraged, particularly in vulnerable groups, like older people and those not in education, employment or training (NEETS). General practices should consider using motivational interviewing techniques such as Let’s Get Moving.

Havant has the highest chlamydia diagnosis rate in Hampshire. It also has relatively high reinfection rates. Barrier methods of contraception should be promoted, in addition to LARC. Havant has 58.8% of its HIV diagnoses being diagnosed late, compared to a national average of 52.3%. Encouraging earlier diagnosis will improve outcomes.
5 Long Term Conditions

SEH CCG has a higher prevalence of Cardiovascular disease (including coronary heart disease, stroke and atrial fibrillation), hypertension, hypothyroidism, cancer, asthma, palliative care, dementia, epilepsy, depression and learning disabilities compared to the England average. However it is not possible to determine whether the data are significantly higher than England.

5.1 Cardiovascular disease

Cardiovascular disease (CVD) can be thought of as a family of diseases with common risk factors, but different outcomes. It is the second most common cause of death. Lifestyle risk factors for cardiovascular disease (CVD), such as smoking, physical inactivity, poor diet, obesity and harmful alcohol intake are modifiable. Figure 27 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. Hypertension is the most common form of CVD in SEH and the county as a whole.

Figure 27: prevalence of the most common forms of CVD in South Eastern Hampshire 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>SE Hampshire</td>
<td>8062</td>
<td>3.9</td>
<td>4067</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 LVD</th>
<th>Hypertension</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>QOF no.</td>
<td>QOF prevalence %</td>
<td>QOF no.</td>
</tr>
<tr>
<td>SE Hampshire</td>
<td>1400</td>
<td>0.7</td>
<td>715</td>
</tr>
<tr>
<td>Hampshire</td>
<td>8339</td>
<td>0.6</td>
<td>4514</td>
</tr>
</tbody>
</table>

CCG level expected prevalence rates are available for CHD, stroke/TIA and hypertension (figure 28).

---

20 There are a broad range of diseases of the circulatory system. The highest prevalence cardiovascular diseases include hypertension, myocardial infarction, stroke and heart failure.
Figure 28: estimated numbers 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>

It is estimated that there may be 5,168 people with undiagnosed Coronary Heart Disease (CHD), 2,141 people with undiagnosed stroke or TIA and 37,086 people with undiagnosed hypertension in SEH CCG. 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 admissions have reduced from 1,157 per 100,000 people (1,116-1197) to 1,066 per 100,000 people (1,028-1,104) in SEH CCG. This is against an increase in CVD admissions in the county, which is due to an increase in elective work.

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.

CVD mortality rates are higher in SEH than Hampshire as a whole, but not statistically significantly so, with a CVD mortality rate of 141 (95%CI 135-148) per 100,000 compared to 132 (95%CI 130-135) per 100,000 people in Hampshire (figure 29). The rate of preventable CVD mortality for people under 75 years old is 24 (95%CI 20-27) per 100,000, which is similar to the Hampshire rate.
Figure 29: Directly standardised rate of mortality caused by cardiovascular disease 2009-2011

5.2 Diabetes

In 2011/12 there were 57,092 people in Hampshire and 9,882 in SEH CCG with diabetes (figure 30). A further 2,997 people in SEH 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 30: Number of people with diabetes on QOF registers and estimated numbers with diabetes by CCG 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 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>
</tbody>
</table>

Estimated prevalence data source: Diabetes Prevalence Model for Local Authorities and CCGs 2012 registered population

The prevalence of diabetes (5.8%) is higher than in Hampshire (5.3%) and the same as in England (5.8%) and 17% more people are expected to have diabetes than are currently diagnosed.
The proportion of people achieving good blood glucose control is 71.2% compared to 69.9% nationally and 72.9% achieved good blood pressure control compared to 70.7% nationally.

There is a statistically significantly lower rate of elective admissions for diabetes (29 admissions per 100,000 population) compared to Hampshire (53 per 100,000). However, emergency admissions (70 admissions per 100,000 population) are higher, though not statistically significantly, than the Hampshire rate (61 admissions per 100,000 population), which may mean diabetes care is not optimised.

The rate of all hospital admissions where diabetes is the primary diagnosis, for all ages was 99 admissions per 100,000 population, which was statistically significantly lower than the Hampshire rate of 115 per 100,000 population (figure 31).

The diabetic lower limb amputation rate (12 amputations per 100,000 population, 108 amputations) was similar to Hampshire (11 amputations per 100,000 population).

**Figure 31: 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

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 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 per year. The SEH CCG rate of preventable liver disease
deaths was 7 per 100,000 population (45 deaths), which is not significantly different to the Hampshire rate.

Hampshire is in the bottom fifth of local authorities 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 SEH is 3.9% (6,527 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 is a useful 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). SEH CCG has a relatively low proportion of South Asian and Black residents.

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

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services will increase in the next decade. NICE has concluded that earlier detection and treatment of AKI would be cost saving\(^\text{23}\).

### 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 3,545 people in SEH CCG diagnosed with COPD, a prevalence of 1.7%, the highest in the county and in line with the England prevalence. There are thought to be a further 3,589 people with undiagnosed COPD in SEH CCG.

There were 1,014 emergency admissions in SEH CCG between 2009/10 and 2011/12, where COPD was the primary diagnosis which is a rate of 103 per 100,000 population, higher than the Hampshire rate of 99 per 100,000 population.

The rate of emergency admissions for people under the age of 75 years old in SEH CCG was 79 per 100,000 population, which is higher than the Hampshire rate of 72 per 100,000 population.

SEH CCG has a death rate of 23 deaths per 100,000, which is slightly lower than the England rate of 26 deaths per 100,000.

### 5.6 Cancer

The incidence of cancer is rising in England. In contrast, the trend in cancer incidence for Hampshire has been stable since 2001/03.

The directly age standardised incidence rate for all types of cancers in SEH CCG was 385.4 per 100,000 population in 2008-10, which is higher than the South East (380.2 per 100,000) but lower than England (398.1 per 100,000). Rates are higher in men (408.5 per 100,000) compared to women (362.2 per 100,000). Figure 32 shows the incidence of different types of cancer in Havant and East Hampshire. The rate of all cancers and breast cancer in Havant and colorectal cancer in both areas are above the England rate.

Figure 32: Incidence of cancers in East Hampshire and Havant, 2008-10. Directly age standardised rates per 100,000 population (South West Cancer Register, ONS, UKCIS)

<table>
<thead>
<tr>
<th>Type of cancer</th>
<th>East Hampshire</th>
<th>Havant</th>
<th>South East</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>366.6</td>
<td>402.8</td>
<td>380.2</td>
<td>398.1</td>
</tr>
<tr>
<td>Lung</td>
<td>31.1</td>
<td>44.2</td>
<td>38.8</td>
<td>47.7</td>
</tr>
<tr>
<td>Breast (female)</td>
<td>124.2</td>
<td>138.8</td>
<td>127.5</td>
<td>125.7</td>
</tr>
<tr>
<td>Colorectal</td>
<td>48.6</td>
<td>49.3</td>
<td>46.2</td>
<td>47.9</td>
</tr>
<tr>
<td>Prostate</td>
<td>96.3</td>
<td>80.5</td>
<td>104.5</td>
<td>105.8</td>
</tr>
</tbody>
</table>

Figure 33 shows that the cancer screening coverage in SEH CCG for each of the national programmes is lower than the national target.

Figure 33: Cancer screening coverage in SEH CCG

<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>Bowel Coverage (Target 60%)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>England</td>
<td>7,944,844</td>
<td>4,141,939</td>
<td>52.1</td>
</tr>
<tr>
<td>HAMPSHIRE</td>
<td>216,852</td>
<td>132,601</td>
<td>61.1</td>
</tr>
<tr>
<td>South Eastern Hampshire CCG</td>
<td>35,733</td>
<td>21,035</td>
<td>58.9</td>
</tr>
<tr>
<td><strong>Cervical Coverage (Target 80%)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>England</td>
<td>13,463,227</td>
<td>10,146,655</td>
<td>75.4</td>
</tr>
<tr>
<td>HAMPSHIRE</td>
<td>324,007</td>
<td>254,357</td>
<td>78.5</td>
</tr>
<tr>
<td>South Eastern Hampshire CCG</td>
<td>49,363</td>
<td>38,510</td>
<td>78.0</td>
</tr>
</tbody>
</table>

24 Hampshire Open Exeter system
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 and smoking accounts for almost 20% of new cases (23% in men and 16% in women).

In 2011/12 there were 4,463 people on SEH CCG GP cancer registers. This is 2.1% of the registered population, which is higher than the England and SE prevalence (1.8%) and has increased from 1.7% in 2009/10. More people are surviving cancer and their needs are becoming increasingly important.

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 1928 per 100,000 population in Havant, which was higher than the rate in Hampshire (1860 per 100,000 population) and East Hampshire (1764 per 100,000 population).

The rate of premature mortality (under 75 years old) from all cancers was 116 per 100,000 in Havant, which is the highest rate in the county and higher than the Hampshire (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 data are for epilepsy. The prevalence of epilepsy in people aged 18+ in SEH CCG is 0.8% (1,382 people), which is the same as nationally, and higher than in Hampshire (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 (in any diagnosis) for SEH CCG is 2,091 per 100,000 population, which is lower than the Hampshire rate (2,125 per 100,000 population). Rates are higher in females (2,667 per 100,000) than in males (1,534 per 100,000).
The majority of people in chronic pain are medically managed in primary care.

**5.9 Mental health**

Positive mental wellbeing reduces population mortality. Populations with good mental wellbeing also have better overall health, recover more rapidly, are admitted to hospital less frequently and have high levels of employment and productivity.

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.

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 in ten new mothers suffer 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, 10 per 100,000 population (39 people) in Havant and 7 per 100,000 people (24 people) died from suicide and injury of undetermined intent. This compares to 8.1 per 100,000 population (332 people) in Hampshire. SEH CCG had a higher rate of deaths from suicide and undetermined injury in 2009/11 (8 per 100,000) compared to 2006/08 (6 per 100,000). In addition, males have a higher suicide rate (15 per 100,000 population) compared to females (3 per population).
One of the risk factors for suicide is intentional self harm and in 2009/11 the SEH CCG rate for intentional self harm was 278 per 100,000 people, which is significantly higher than the Hampshire rate of 226 per 100,000. 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 least deprived quintile.

Figure 34 shows that SEH CCG has admissions rates for mental health illness which are significantly worse than the Hampshire rate. Gender differences are apparent for each mental illness, females have higher rates of unipolar depressive disorders and men have higher rates of unipolar delusional disorder rates.

**Figure 34: 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>SEH CCG 263 Hampshire 173 Comparison to Hampshire</td>
</tr>
<tr>
<td>Mental Health Illness - All Admissions - All ages</td>
<td>265 177</td>
</tr>
<tr>
<td>Schizophrenia, schizotypal and delusional disorders - All admission types - Aged 15+</td>
<td>62 46</td>
</tr>
<tr>
<td>Unipolar depressive disorders - All admission types - Aged 15+</td>
<td>86 46</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.

There are estimated to be over 18,000 people with dementia in Hampshire, but only 8,695 people on GP dementia registers. In SEH CCG population 0.7% of the population (1,549 people) are recorded as having dementia, similar to Hampshire and higher than the England prevalence of 0.5%. At a district level 843 people in East Hampshire and 842 people in Havant are recorded as having dementia. The POPPI tool estimates this to be much higher at 1,685 people in East Hampshire and 1,915 people over the age of 65 years old in Havant. It predicts these to further increase by 30% by 2020.

Dementia is currently under diagnosed, partly as a result of fear about being diagnosed with memory loss and partly because clinicians do not expect patients to
benefit from the diagnosis. In fact early diagnosis of dementia is associated with improved quality of life for patients and better outcomes.

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 as well as use of the health and social care sector.

Between 2009 and 2012, the rate of hospital admissions as a result of falls and fall injuries in people over the age of 65 years was 1,651 per 100,000 people in SEH CCG, compared to a rate of 1,623 per 100,000 in Hampshire. The rate was higher in Havant at 1,710 per 100,000 compared to 1,585 per 100,000 in East Hampshire.

Hip fracture emergency admission rates in people over the age of 65 in SEH CCG were 460 per 100,000 people, similar to the Hampshire rate. They were higher in East Hampshire (501 per 100,000), compared to the rest of Hampshire (455 per 100,000).

SEH CCG had the highest rate of primary hip replacement procedures (109 per 100,000 people) across Hampshire, significantly higher than the Hampshire rate (98 per 100,000). Residents in Havant recorded a higher rate at 112 per 100,000, compared to the East Hampshire rate (99/100,000). The rate of revision hip replacement procedures was 12 per 100,000 people, compared to a Hampshire rate of 15 per 100,000.

Knee arthroscopic activity shows that Havant has an age standardised rate of 180 per 100,000 people, compared to 235 per 100,000 people in East Hampshire and 216 per 100,000 people in Hampshire overall.

Admission rates for knee replacements were 97 per 100,000 people in Havant and 88 per 100,000 people in East Hampshire, compared to the Hampshire rate of 95 per 100,000 people. The overall CCG rate was 92 per 100,000.

There is a decline in facet joint activity in SEH CCG (117/100,000) in line with the lack of clinical effectiveness for this intervention. However residents in East Hampshire had a higher rate at 190 per 100,000 compared to Havant (90/100,000).
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 disease prevalence rates for QOF in SEH show that for a number of conditions (for instance coronary heart disease, stroke/TIA, hypertension, cancer, dementia and depression) there are higher rates locally than in England. This may reflect the older age profile of SEH as well as the relatively high deprivation rates in parts of the CCG.

Rising rates of long term conditions need to be managed, and as far as possible, avoided.

The quality of delivery and uptake of the NHS Health Check is an opportunity to diagnose pre-symptomatic chronic diseases. Encouraging participants to improve their lifestyles and attend behaviour change interventions will reduce risk of CVD, cancer, diabetes and other interventions.

Key priorities for action include:

Priorities for CVD commissioning may include: the quality of hypertension management and Peripheral Arterial disease in general practice, long term commissioning of Familial Hypercholesterolaemia services, reviewing 2013 NICE guidance on STEMIIs, and implementing Make Every Contact Count.

It is important to evaluate the IAPT programme and see whether there are other options for patients, such as the expert patient programme.

Rehabilitation is difficult to cost, but important for patients. There is a strong evidence base for rehabilitation in relation to cardiac, stroke and pulmonary patients.

Integrated care teams are a good start for closer working between the NHS and adult social care, but joint working can be developed further. However social care has a critical role to play in supporting patients with long term conditions. Social care early intervention input can keep people out of hospital, and away from intensive social care interventions for longer. Friendly neighbour schemes and other community based interventions reduce loneliness, and may have a role in keeping frail elderly patients independent of integrated care teams.
Planned care is often more cost effective than unplanned care. The evidence base for successful interventions is limited. SEH CCG has high rates of hospital admissions as a result of falls and fall injuries in people aged 65 and over, and admissions due to hip fractures are high in East Hampshire. 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. We also need to further investigate the causes of the falls to identify other preventable issues.

The data suggest SEH CCG’s high hospital admission rates for hip replacements, particularly in Havant, are a reflection of greater need. There’s a need to refocus musculoskeletal care and optimise 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.

The CCG needs to ensure and audit the use of evidence-based practice. For example, the National Institute for Health and Clinical Excellence (NICE) and the Cochrane Collaboration have published guidance on a number of musculoskeletal conditions. Compliance with the British Orthopaedic Association (BOA) Blue Book Standards, such as, ensuring prompt surgery within 48 hours, need to be supported. Access to an orthogeriatrician prior to surgery is one of the ways both length of hospital stay and mortality can be reduced, as the vast majority of hip fracture patients are old and frail.

Further work needs to be undertaken by the CCG to make an accurate assessment of musculoskeletal needs of the local population to inform the commissioning of services.
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 SEH CCG was for domiciliary care (829 people, 45.7%) followed by residential care (388 people, 21.3%) and nursing care (233 people, 12.8%).

In 2012, 18.2% (7,761) of people aged over 65 years old in SEH 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, to the toilet or in and out of bed. 7.2% (3,085) of people over the age of 65 years were estimated as having dementia. Dementia is the most common reason for increasing long term packages of social care.

6.2 Working age adults with care support needs

In April 2013 Adult Services supported 199 clients aged 18-64 years old in SEH CCG with a substantial or critical learning disability with a package of care. 130 people with a substantial or critical physical disability were also supported. Since 2010, across the county, there has been an increase in the number of clients receiving support and who have these disabilities.

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 1,430 males and 170 females with autism aged 19 years old and above in SEH CCG.

6.3 Carers

10.5% (21,922 people) in SEH 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 slightly higher than in Hampshire and England (10.1% and 10.2% respectively). 7% (14,578 people) in SEH CCG provide 1-19 hours of unpaid care a week, 1.2% (2,453 people) provide 20-49 hours a week and 2.4% (4,891 people) provide 50 or more hours a week.

Analysis of the primary reasons for accessing increased care packages in Hampshire showed that 24% (3,320) of these increases are to support carers who are finding it difficult to cope, with 40.1% where people are caring for someone with dementia and 22.4% for people with reduced mobility.

15,461 people aged over the age of 65 years old in SEH CCG are estimated to be living alone. This increases with age and is predicted to continue to increase.
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.

0.2% (26 people) of school pupils in East Hampshire and 0.5% (81 people) in Havant identified as being young carers. These figures capture 11% of the total number of carers aged 0-24 in Hampshire. 4.2% (3,579 people) of the SEH 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?**

The large numbers of people with care support needs suggests that there may be greater scope for the NHS and adult social care to work jointly on prevention. As the numbers are larger than the 1-5% of highest risk patients who are currently eligible for support from integrated care teams extending support to lower risk adults has a potentially greater impact on need for urgent care and social care interventions.

The carers of people with specific types issues may need particular support as demands on them are so intense, for instance following a severe stroke. Follow up and review of patients should incorporate a check of their carer. Annual reviews of carers health are available, but should be implemented as widely as possible.

There may be economies of scale in health improvement initiatives to work across CCG and district boundaries.
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.

- In 2009-11, SEH CCG had a death rate of 497 deaths per 100,000. This is statistically significantly lower in women compared to men and has fallen since 2006-8, when the rate was 538 deaths per 100,000.

Figure 35: All cause mortality by CCG

Figure 36: All cause mortality for SEH CCG directly standardised rolling 3 year average 2006-08 to 2009-11
In 2011, approximately 30% of all deaths in Hampshire were caused by cancer, compared to 28% from circulatory disease and 13% from respiratory disease. A similar trend was seen in SEH CCG.

SEH CCG had the second highest premature death rate in Hampshire at 244 (95%CI 232-256) per 100,000, which is statistically significantly higher than the Hampshire rate, 220 (95%CI 216-225) per 100,000; but which is lower (better) than the national rate and similar to the South East region rate (confidence intervals not available). This rate has been steadily decreasing since 2006, when it was 265 per 100,000.

Mortality rates are associated with deprivation, with mortality rates increasing with increasing deprivation (figure 37).

**Figure 37: Mortality from all cause by deprivation quintile**

There were 1004 preventable deaths\(^\text{25}\) in SEH CCG from 2009 to 2011. This equates to a rate of 126 (95%CI 118-134) preventable deaths per 100,000 population, which is the statistically significantly highest rate in the county and higher than the Hampshire rate (119 per 100,000, 95%CI 116-122 per 100,000). Rates are higher in males than females. The rate of preventable deaths in SEH has decreased

\(^{25}\) 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](http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000044/par/E12000004/ati/102/page/6)
since 2006, when it was 140 preventable deaths per 100,000. This decrease has been seen in both males and females.

**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.

CCGs should offer strategic direction to district Health and Wellbeing Boards.

SEH CCG has the highest rate of preventable disease in the county. The CCG should have specific strategic plans for prevention and reducing health inequalities to minimise preventable mortality.
### 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>
<tbody>
<tr>
<td><strong>Two months old</strong></td>
<td>Diphtheria, tetanus, pertussis (whooping cough), polio and <em>Haemophilus influenzae</em> type b (Hib) Pneumococcal infection</td>
<td>DTaP/IPV/Hib + Pneumococcal conjugate vaccine, (PCV)</td>
</tr>
<tr>
<td><strong>Three months old</strong></td>
<td>Diphtheria, tetanus, pertussis, polio and <em>Haemophilus influenzae</em> type b (Hib) Meningitis C</td>
<td>DTaP/IPV/Hib + MenC</td>
</tr>
<tr>
<td><strong>Four months old</strong></td>
<td>Diphtheria, tetanus, pertussis, polio and <em>Haemophilus influenzae</em> type b (Hib) Meningitis C Pneumococcal infection</td>
<td>DTaP/IPV/Hib + MenC + PCV</td>
</tr>
<tr>
<td><strong>52 weeks of age but AFTER 1st birthday</strong></td>
<td><em>Haemophilus influenza</em> type b (Hib) / Meningitis C Measles, mumps and rubella Pneumococcal infection</td>
<td>Hib/MenC MMR + PCV</td>
</tr>
<tr>
<td><strong>Three years and four months or soon after</strong></td>
<td>Diphtheria, tetanus, pertussis and polio Measles, mumps and rubella</td>
<td>DTaP/IPV or dTaP/IPV +MMR</td>
</tr>
<tr>
<td><strong>Girls aged 12 to 13 years</strong></td>
<td>Cervical cancer caused by Human Papillomavirus types 16 and 18.</td>
<td>HPV</td>
</tr>
<tr>
<td><strong>13 to 18 years old</strong></td>
<td>Diphtheria, tetanus, polio</td>
<td>Td/IPV</td>
</tr>
</tbody>
</table>